Role of endoscopy in chronic diarrhoea when functional bowel disease is suspected

We thank Ong and colleagues[1] for their comment on the indication for lower GI endoscopy when functional bowel disease such as IBS diarrhoea predominant (IBS-D) is suspected.

In most patients with chronic diarrhoea, some form of endoscopic investigation will be necessary. However, it has been recommended that in young patients (less than 40 years) reporting 'diarrhoea' but who have other typical symptoms of a functional bowel disorder and negative initial investigations including faecal calprotectin, a positive diagnosis of IBS-D may be made in the primary care setting without recourse to further investigations.[2]

We are concerned that many patients with severe, persistent or atypical symptoms fail to have other specific treatable diagnoses made. Hence, the guidelines subsequently clarify this further within section 4.2, to state 'patients under 40 years without typical symptoms of functional bowel disorder and/or severe symptoms and documented diarrhoea (as previously defined) should have further evaluation'.[3] By this, we mean referral to specialist secondary care, which, usually will include lower GI endoscopic evaluation.

One of the reasons for this recommendation is that up to 10% of patients meeting the criteria for IBS-D actually have microscopic colitis (MC)[4] and 25% of MC occurs under the age of 45.[5] This risk increases if patients have other concurrent autoimmune conditions. Flexible sigmoidoscopy will detect the majority of patients with microscopic pathology.[6] Moreover, it should be noted that faecal calprotectin is often in the normal range in MC.[7 8] A clinical scoring system can also be applied to predict risk of MC and guide indications for lower GI endoscopy.[9] A further reason for secondary referral is to detect bile acid diarrhoea, which, occurs in over 25% of patients and is frequently missed.[10]

Clearly, clinical judgement needs to be applied in this large and varied group of patients, and this is especially true to identify those with severe, persisting or atypical symptoms who may need some additional investigation in order to identify treatable conditions. Naturally, this will require some reassessment of resources.

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Competing interests None declared.

Patient consent Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Arasaradnam RP, Walters JRF. *Gut* 2020;**69**:190–191.

Received 10 October 2018
Revised 7 November 2018
Accepted 7 November 2018
Published Online First 3 December 2018

Linked

► http://dx.doi.org/10.1136/gutjnl-2018-317574

Gut 2020;**69**:190–191. doi:10.1136/gutjnl-2018-317730

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REFERENCES

1 Ong J, Swift C, Allwood I, *et al*. Chronic diarrhoea: the indications for lower GI endoscopy when functional bowel disease is suspected. *Gut* 2019;68:2100.
2 NICE. *Irritable bowel syndrome in adults: diagnosis and management*, 2017.
3 Arasaradnam RP, Brown S, Forbes A, *et al*. Guidelines for the investigation of chronic diarrhoea in adults: British Society of Gastroenterology, 3rd edition. *Gut* 2018;67:1380–99.
4 Pardi DS, Kelly CP. Microscopic colitis. *Gastroenterology* 2011;140:1155–65.
5 Guagnozzi D, Arias Á, Lucendo AJ. Systematic review with meta-analysis: diagnostic overlap of microscopic colitis and functional bowel disorders. *Aliment Pharmacol Ther* 2016;43:851–62.

6 Shale MJ, Walters JR, Westaby D. Adequacy of flexible sigmoidoscopy with biopsy for diarrhea in patients under age 50 without features of proximal disease. *Gastrointest Endosc* 2011;73:757–64.
7 McFarlane M, Chambers S, Malik A, *et al*. Clinical outcomes at 12 months and risk of inflammatory bowel disease in patients with an intermediate raised fecal calprotectin: a 'real-world' view. *BMJ Open* 2016;6:e011041.
8 von Arnim U, Wex T, Ganzert C, *et al*. Fecal calprotectin: a marker for clinical differentiation of microscopic colitis and irritable bowel syndrome. *Clin Exp Gastroenterol* 2016;9:97–103.
9 Cotter TG, Binder M, Harper EP, *et al*. Optimization of a scoring system to predict microscopic colitis in a cohort of patients with chronic diarrhea. *J Clin Gastroenterol* 2017;51:228–34.
10 Bannaga A, Kelman L, O'Connor M, *et al*. How bad is bile acid diarrhoea: an online survey of patient-reported symptoms and outcomes. *BMJ Open Gastroenterol* 2017;4:e000116.