CORRESPONDENCE

Irritable Bowel Syndrome—The Main Recommendations

by Dr. med. Viola Andresen, Dr. med. Jutta Keller, PD Dr. med. Christian Pehl, Prof. Dr. rer. nat. Michael Schemann, Dr. med. Jan Peiss, Prof. Dr. med. Peter Layer in volume 44/2011

Woolly Explanation

The “first German S3 guideline on irritable bowel syndrome” suffers from a woolly explanation of the so called psychogenic factors and their treatment. A medical history taking into account the autonomic nervous system, which used to be among the standard tools of any confident doctor, seems to have faded into obscurity. The physical body is the main focus of medicine, its sensitivity and its associated subjective, sensitive correlates seem irrelevant. But according to Damasio, we need to newly define the word “psyche” and include body awareness (1).

Irritable bowel syndrome (the region with the traditional anatomical name “hypochondrium”) appears rarely as the only autonomic nervous syndrome. All autonomic nervous syndromes, fibromyalgia, fatigue, exhaustion, and many others are associated with a malfunction of the central correlations between amygdala, hypothalamus, pituitary, and the triggered changes to the control circuits. Relevant publications have mentioned a minimum of 120 substances that play a part as mediators and modulators in the context of stress reactions (2). According to these, irritable bowel syndrome develops especially as a sequela of amygdala activity that has become independent, triggered by diverse experiences of stress on the part of the individual. These indicate “high alert” at different degrees of intensity, although the current circumstances do not give a clue as to why. We refer to such forms of reaction as phobias. In case of arachnophobia, such inappropriate signals of stress are tied to a particular situation and they are self limiting. In autonomic activities of the amygdala, an erratic imbalance exists for years and decades, which is accompanied by diverse impairments of the own body (proprioception). Reference 3 includes a description of the most important symptoms in irritable bowel syndrome and other functional syndromes in their functional connection to the stress reaction and the proprioception. Professional medication treatment with SSRIs or SNRIs almost always yields complete success, especially in settings where psychotherapeutic successes remain incomplete.

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Dr. med. Ludger Albers
Wiesbaden
Dr.L.Albers@t-online.de

Conflict of interest statement

The author declares that no conflict of interest exists.

In Reply:

By necessity, any abbreviated version of the guideline published in its entirety elsewhere (1) is forced to bundle the most important practical recommendations. For this reason, several aspects were dealt with only briefly. On this background we wish to respond to the criticisms raised as follows:

- By contrast to what Albers suggests, the guideline includes among the essential basic diagnostic tools, especially for irritable bowel syndrome, a comprehensive medical history of the patient; we discussed the eminent importance of the history in a prominent position in our article.
- The particularities of psychological mechanisms were reflected in a main chapter, which was compiled in collaboration with many representatives from the respective medical specialties and medical specialty societies. The same applies for stress and extraintestinal symptoms.
- The pivotal key mechanisms of the syndrome, however, are biochemical and cellular malfunctions at the level of the mucosal integrity and the enteric nervous system. This was elucidated by a multitude of high quality studies and demonstrated in a convincing and reproducible manner.
- The “normal” interaction between gut and psyche plays an important part in irritable bowel syndrome: it may worsen symptoms, but it may also be used to alleviate symptoms. The guideline made a point of emphasizing both. This can be done, for example, by means of psychotherapy and/or low-dose antidepressants, with the latter aiming primarily to achieve pharmaceutical modulation of the enteric neurons and not the central nervous system. However, studies have yielded contradictory results with regard to therapeutic successes, which have thus far not been as compelling as our correspondent stated.
- By contrast, hypotheses that classify irritable bowel syndrome as a purely psychological disorder („autonomy of the amygdala“) or phobia

(„arachnophobia“) must be refuted, as they are entirely lacking any sound scientific basis. The psychosomatic “model” for gastric ulcers, which was employed for decades before *Helicobacter pylori* was discovered, was based on a similar misconception.

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Dr. med. Viola Andresen, MSc

Prof. Dr. med. Peter Layer

Israelitisches Krankenhaus

Hamburg

v.andresen@ik-h.de

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Professor Layer has received honoraria for acting as an adviser from Abbott, Solvay, Shire, and Norgine. He has received travel and hotel expenses from Shire and Norgine. He has also received honoraria for speaking from Falk, Movetis/Shire, Abbott/Solvay, Axcen, Boehringer, and Novartis. He has received honoraria for commissioned clinical studies from Axcen and Solvay.

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