



A summary of prescribing recommendations from NICE guidance

Irritable bowel syndrome in adults

NICE CG61: 2015

This guideline covers the diagnosis and management of adults with IBS in primary care.

| Definition of terms | |
|---------------------|--|
| IBS | irritable bowel syndrome |
| TCA | tricyclic antidepressant |
| SSRI | selective serotonin reuptake inhibitor |

Assessment and diagnosis

- ◆ Consider assessment for IBS if the person reports having any of the following symptoms for at least 6 months:
 - A** Abdominal pain or discomfort
 - B** Bloating
 - C** Change in bowel habit
- ◆ Ask people with possible IBS symptoms if they have any of the following 'red flag' indicators. If so refer them to secondary care for further investigation:
 - > unintentional and unexplained weight loss,
 - > rectal bleeding,
 - > a family history of bowel or ovarian cancer,
 - > if aged >60 years, a change in bowel habit lasting >6 weeks with looser and/or more frequent stools.
- ◆ Assess and clinically examine all people with possible IBS symptoms. Refer to secondary care if any of the following 'red flags' are found:
 - > anaemia,
 - > abdominal or rectal masses,
 - > inflammatory markers for inflammatory bowel disease.
- ◆ Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with [NICE pathway: ovarian cancer](#).
- ◆ Also see [NICE CG27: referral for suspected cancer](#)
- ◆ Consider diagnosing IBS only if the person has abdominal pain or discomfort relieved by defaecation, or associated with altered bowel frequency or stool form and at least two of the following:
 - > altered stool passage (straining, urgency, incomplete evacuation),
 - > abdominal bloating (more common in women than men), distension, tension or hardness,
 - > symptoms made worse by eating,
 - > passage of mucus.
- ◆ Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS and may be used to support diagnosis.

Diagnostic tests – see [NICE pathway: IBS](#)

Treatment and management

Physical activity – see [NICE pathway: IBS](#)

Diet

- ◆ Assess diet and nutrition and give the following advice:
 - > have regular meals and take time to eat,
 - > avoid missing meals or long gaps between eating,
 - > drink at least 8 cups of fluid per day, especially water or other non-caffeinated drinks such as herbal teas,
 - > restrict tea and coffee to 3 cups per day,
 - > reduce intake of alcohol and fizzy drinks,
 - > consider limiting intake of high-fibre food (e.g. high fibre or wholemeal flour and breads, cereals high in bran, and whole grains such as brown rice),

- > reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), often found in processed or re-cooked foods,
- > limit fresh fruit to 3 portions (of 80 g each) per day.
- ◆ People with diarrhoea, should avoid sorbitol, an artificial sweetener in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products.
- ◆ People with wind and bloating may find it helpful to eat oats (e.g. oat-based breakfast cereal or porridge) and linseeds (up to 1 tablespoon per day).
- ◆ Review the person's fibre intake and adjust (usually reduce) according to symptoms.
- ◆ Discourage intake of insoluble fibre (e.g. bran). If more fibre is needed, recommend soluble fibre e.g. ispaghula powder, or foods high in soluble fibre e.g. oats.
- ◆ If the person wants to try probiotics, advise them to take the dose recommended by the manufacturer for at least 4 weeks while monitoring the effect.
- ◆ Discourage use of aloe vera for IBS.
- ◆ If a person's IBS symptoms persist while following general lifestyle and dietary advice offer further dietary management – see [NICE pathway: IBS](#)

Pharmacological treatment

- ◆ Choose single or combination medication based on the predominant symptom(s).
- ◆ Consider offering antispasmodic agents taken as required alongside dietary and lifestyle advice.
- ◆ For diarrhoea: offer loperamide as first-line antimotility agent.
- ◆ For constipation: **first-line** consider offering laxatives but discourage use of lactulose.
- ◆ **Second-line:** consider linaclotide only if:
 - > optimal or maximum tolerated doses of previous laxatives from different classes have not helped, **AND**
 - > they have had constipation for at least 12 months.
- ◆ Advise people how to adjust doses according to response, shown by stool consistency. The aim is a soft, well-formed stool (Bristol stool form scale type 4).
- ◆ Follow up people taking linaclotide after 3 months.
- ◆ Consider TCAs **U** if antispasmodics, laxatives or loperamide have not helped. Start at a low dose (e.g. 5–10mg amitriptyline or equivalent), taken once at night. Review regularly. Increase the dose if needed, but not usually >30 mg.
- ◆ Consider SSRIs **U** only if TCAs are ineffective.
- ◆ Take into account possible side effects when offering TCAs or SSRIs. Follow up people taking these drugs after 4 weeks and then every 6 to 12 months.

Psychological interventions – see [NICE pathway](#)

Do NOT encourage use of acupuncture or reflexology for the treatment of IBS.

U Unlicensed indication. Obtain and document informed consent.

Recommendations – wording used such as 'offer' and 'consider' denote the [strength of the recommendation](#).

Drug recommendations – the guideline assumes that prescribers will use a drug's [Summary of Product Characteristics \(SPC\)](#) to inform treatment decisions.

Drug allergy: diagnosis and management

[NICE CG183; 2014](#)

This guideline offers advice on care of adults, children and young people with suspected or confirmed drug allergy.

Definition of terms

| | |
|------------------|---|
| DRESS | Drug reaction with eosinophilia and systemic symptoms |
| SJS | Stevens–Johnson Syndrome |
| TEN | Toxic epidermal necrolysis |
| NSAIDs | non-steroidal anti-inflammatory drugs |
| COX-2 inhibitors | cyclooxygenase 2 inhibitors |
| OTC | over-the-counter |

Assessment

- ◆ When a person presents with possible drug allergy, take a history and undertake a clinical examination.
- ◆ When deciding whether to suspect drug allergy be aware of the signs and allergic patterns of suspected drug allergy including timing of onset - see Box 1 and [NICE pathway: drug allergy](#).
- ◆ The reaction is more likely to be drug allergy if it occurred during or after use of the drug and the:
 - > drug is known to cause that type of reaction, or
 - > the person has previously had a similar reaction to that drug/drug class.
- ◆ The reaction is less likely to be caused by drug allergy if:
 - > there is a possible non-drug cause for the person's symptoms e.g. they have had similar symptoms when not taking the drug, **OR**
 - > the person has gastrointestinal symptoms only.

Measuring serum tryptase after a suspected drug-related anaphylactic reaction – see [NICE pathway: anaphylaxis](#).

Non-specialist management

General

- ◆ If drug allergy is suspected:
 - > consider stopping the drug suspected to have caused the reaction and advise the person to avoid it in future,
 - > treat the symptoms of the reaction if needed. Send people with severe reactions to hospital,
 - > document details of the suspected drug allergy in the medical records and provide information to the person.

NSAIDs

- ◆ Explain to people (and family members/carers as appropriate) with a suspected allergy to a non-selective NSAID e.g. ibuprofen, that they need to avoid all non-selective NSAIDs, including OTC preparations.
- ◆ For people who have had a mild allergic reaction to a non-selective NSAID but need an anti-inflammatory:
 - > discuss the benefits and risks of selective COX-2 inhibitors (including low risk of drug allergy),
 - > consider introducing a selective COX-2 inhibitor at the lowest starting dose with a single dose on the first day.
- ◆ **Do NOT** offer a selective COX-2 inhibitor to people in a non-specialist setting if they have had a severe reaction, (anaphylaxis, severe angioedema or an asthmatic reaction) to a non-selective NSAID.
- ◆ People with asthma who also have nasal polyps are likely to have NSAID-sensitive asthma unless they are known to have tolerated NSAIDs in the last 12 months.

Referral to specialist drug allergy services

It is not appropriate to refer all patients with a label of drug allergy to specialist drug allergy services.

General

- ◆ Refer people if they have had a:
 - > suspected anaphylactic reaction – see [NICE pathway: anaphylaxis](#).
 - > severe non-immediate cutaneous reaction e.g. DRESS, SJS, TEN.

Beta-lactam antibiotics

- ◆ Refer people with a suspected allergy to beta-lactam antibiotics if they:
 - > need treatment for a disease or condition that can only be treated by a beta-lactam antibiotic, **OR**
 - > are likely to need beta-lactam antibiotics frequently in the future e.g. people with recurrent bacterial infections or immune deficiency.
- ◆ Consider referring people if they are not able to take beta-lactam antibiotics and at least one other class of antibiotic because of suspected allergy.

Local anaesthetics

- ◆ Refer people if they need a procedure involving a local anaesthetic that they are unable to have because of suspected allergy.

General anaesthesia

- ◆ Refer people if they have had anaphylaxis or another suspected allergic reaction during or immediately after general anaesthesia.

Providing information and support

- ◆ Discuss suspected drug allergy with the person and family members/carers and provide written information in line with the recommendations in [NICE pathway: patient experience in adult NHS services](#). Record when and who provided the information.
- ◆ Ensure that the person and family members/carers are aware of the drugs/drug classes that they need to avoid. Advise them to check with a pharmacist before taking any OTC preparations, to carry information about their drug allergy at all times and to share this whenever they visit a healthcare professional or are prescribed, dispensed or are about to be given a drug.
- ◆ People who have undergone specialist drug allergy investigations should be given the following information:
 - > the diagnosis, drug name and whether they had an allergic or non-allergic reaction,
 - > the investigations used to confirm or exclude the diagnosis,
 - > drugs or drug classes to avoid in future,
 - > any safe alternative drugs that may be used.
- ◆ For people in whom allergy to a drug/drug class has been excluded by specialist investigation explain that they can now take this drug/drug class safely. Ensure that their medical records are updated.

Recording drug allergy status – see [NICE pathway](#)

Document new suspected drug allergic reactions –

see [NICE pathway](#)

Maintaining and sharing drug allergy information –

see [NICE pathway](#)

Box 1: Signs and allergic patterns of suspected drug allergy

Immediate rapidly evolving reactions

Anaphylaxis, urticarial or angioedema without systemic features, exacerbation of asthma

Onset: usually <1 hour after drug exposure (previous exposure not always confirmed)

Non-immediate reactions without systemic involvement

Widespread red macules/papules (exanthema-like), fixed drug eruption (localised inflamed skin).

Onset: usually 6 to 10 days after 1st drug exposure or within 3 days of 2nd drug exposure

Non-immediate reactions with systemic involvement

TENS or SJS. **Onset:** usually 7 to 14 days after 1st drug exposure or within 3 days of 2nd drug exposure

DRESS. **Onset:** usually 2 to 6 weeks after 1st drug exposure or within 3 days of 2nd drug exposure

Acute generalised exanthematous pustulosis. **Onset:** usually 3 to 5 days after 1st drug exposure.