

# **Irritable Bowel Syndrome (IBS)**

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Please read "What Everyone on Your Health Care Team Should Know About FMS and CMP".

IBS can be disruptive, affecting ability to travel, employment, social contact and other normal functioning. Recent research indicates that the same mechanism behind the central sensitization of fibromyalgia syndrome (FMS) may also be involved in IBS. <sup>(1)</sup> Approximately 20% of patients with IBS, and the IBS symptoms, can be worsened by coexistent FMS <sup>(2)</sup> and some myofascial trigger points (TrPs). IBS is characterized by at least two of these symptoms:

1. Abdominal discomfort or pain relieved by defecation.
2. Onset associated with change in frequency of stool.
3. Onset associated with change in appearance of stool.

Symptoms that are often associated with IBS include:

1. Fewer than three bowel movements a week.
2. More than three bowel movements a day.
3. Abnormal stool form (watery, loose or hard).
4. Straining, urgency, or feeling of incomplete passage.
5. Mucus in the stool.
6. Bloating/abdominal distension

Many conditions can cause symptoms like IBS, so they must be excluded by exam, careful history and tests. Care providers usually consider that IBS does not cause the following:

- Pain that awakens or interferes with sleep (if you have FMS as well, this may not be true).
- Diarrhea that awakens/interferes with sleep (if you have FMS as well, this may not be true).
- Blood in your stool (visible or occult).
- Weight loss.
- Fever.
- Abnormal physical examination.

Normally, people do not feel pain sensations from the bowel, only pressure sensations such as distension from gas. FMS patients often have hypersensitivity and allodynia. The gut may translate pressure as pain, and may be hypersensitive to that pain. FMS can intensify coexistent symptoms. IBS can be a multiple

perpetuating factor for FMS and TrPs. It can alter the absorption of nutrients through diarrhea, add pain, or promote toxin exposure through constipation. FMS patients often have sleep disturbances including fragmented and/or unrestorative sleep. It is important that anything that disturbs your sleep is brought under control. IBS itself can trigger central sensitization. <sup>(3)</sup>

IBS can also be intensified or perpetuated by myofascial TrPs in the abdominal areas, low back, pelvic floor or upper inner thigh. <sup>(4)</sup> An initiating factor, such as an intestinal flu, food poisoning or food sensitivity or even menstrual cramping, can set up myofascial TrPs that will continue the symptoms until the TrPs are treated. If the TrPs are the *only* perpetuating factor, successful treatment of the TrPs will successfully treat the IBS.

Abdominal TrPs can influence the function of your gut, and gut dysfunction can perpetuate the TrPs. The abdominal area is separated into four parts, called quadrants. TrPs usually refer pain in the same quadrant where they live but may transmit symptoms into other parts of the abdomen, as well as to the back. TrPs can cause more than just pain and muscle dysfunction. They can cause projectile vomiting, anorexia and nausea, as well as IBS symptoms. They may be perpetuated by such events as emotional stress, occupational strain, paradoxical respiration, and doing "fitness" exercises such as sit-ups.

Abdominal oblique TrPs cause pain that reaches into the chest, can cross the belly and hit the gut. Heartburn and acid reflux are common. There can be many TrPs in many layers of many muscles. TrPs around the inner rib edges may produce deep pain in the region of the stomach. What Travell and Simons call the "belch button" can occur at the back rim of some side abdominal wall muscles or in the membrane covering deep muscles of the trunk and back. These TrPs cause stomach problems with burping and gas and even cause projectile vomiting. Multiple TrPs can produce effects that, together, can mimic abdominal disease. Organ disease can activate TrPs that will then perpetuate the pain and other symptoms long after you recover from the disease.

The rectus abdominus is a long, flat muscle in the front center of the body. TrPs in its upper area can cause heartburn, uncomfortable abdominal fullness, indigestion, nausea and even vomiting. The vomiting is usually due to TrPs at the very bottom of the breastbone, especially on the left side. These TrPs can also refer pain across the upper abdomen between the rib margins.

Active abdominal TrPs, especially the rectus abdominus, can cause a lax, distended abdomen with excessive gas. Contraction of the abdominal muscles is inhibited by the TrPs so that you can't pull in your stomach. This can contribute bulk to the fat pad over the belly. TrPs in the rectus abdominus around the sides of the belly button can create sensations of abdominal cramping or colic, even in infants. Active TrPs in the lower rectus abdominus can mimic diverticulosis and pelvic disease. Gastrointestinal symptoms can also come from TrPs in the back muscles. Lower

abdominal pain, tenderness and spasm can also be referred from TrPs in the vaginal wall. Peptic ulcer, parasites, acute trauma, chronic occupational stress or an abdominal scar and adhesions will make you susceptible to abdominal TrPs. Other activating or perpetuating factors of these TrPs include total body fatigue, over-exercise, emotional tension, cold exposure, viral infections, yeast infections, constipation, poor posture, and body asymmetry. These stresses are additive. Many TrPs in the pelvic floor can contribute to painful defecation and IBS symptoms. They may not be causing all of the IBS symptoms, but they can be contributing, and treating the TrPs may substantially reduce the symptoms, allowing the balance to be treated by diet and stress reduction. For specifics on these and other contributing TrPs and what to do about them, see chapter 8 of "Fibromyalgia and Chronic Myofascial Pain: A Survival; Manual" edition 2 .

## References

1. Chang L, Berman S, Mayer EA et al. 2003. Brain responses to visceral and somatic stimuli in patients with irritable bowel syndrome with and without fibromyalgia. *Am J Gastroenterol* 98(6):1354-61.
2. Lubrano E, Iovino P, Tremolaterra F et al. 2001. Fibromyalgia in patients with irritable bowel syndrome. An association with the severity of the intestinal disorder. *Int J Colorectal Dis* 16(4):211-215.
3. Verne GN, Price DD. 2002. Irritable bowel syndrome as a common precipitant of central sensitization. *Curr Rheumatol Rep* 4(4):322-328.
4. Simons DG, Travell JG, Simons LS. 1999. Travell and Simon's Myofascial Pain and Dysfunction: The Trigger Point Manual, vol I ed. 2. Baltimore: Williams and Wilkins.