

LETTER TO THE EDITOR

A further exploration of patients with IBS in rural Crete

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Dear Editor

Having stumbled upon a research article published in your journal in August 2005, entitled 'Measuring the frequency of functional gastrointestinal disorders in rural Crete: a need for improving primary care physicians' diagnostic skills'¹, we were inspired to demonstrate a few aspects arising from a research study that took place in a rural primary health care center (PHC) in Heraklion, Crete, Greece.

The purpose of our research study was to record patients with irritable bowel syndrome (IBS) who met the Rome II criteria, and to analyze factors influencing the course and manifestation of the disease. This non-randomised, qualitative research study was conducted at a rural PHC in St Barbara, Heraklion, for a duration of 3 weeks (27/03/06 to 19/04/06). After consultation and clinical examination, a small population of 50 cases diagnosed with IBS was

recruited. The selected patients completed a questionnaire, drawn up in accordance with the Rome II criteria, and other relevant research studies involving risk and onset factors²⁻⁴. The factors included socio-economic status, daily stress (including unsatisfactory working environment and the stress of family life), dietary habits, gastroenteritis, smoking habits and alcohol use.

IBS is a widespread, functional disorder of the lower gastrointestinal tract characterized primarily by chronic abdominal pain and/or tenderness and altered bowel habits, in the absence of a demonstrable physical cause. IBS is a clinically defined illness frequently treated by family physicians.

Among the 50 cases recruited, 19 were male (38%) and 31 were female (62%). In the present study the occurrence of IBS was significantly higher among women than men, which



is in accord with previous studies^{1,5,6}, including the study in your journal. In our study 68% ($n = 34$) were between 37 and 55 years old, and 32% ($n = 16$) were aged between 22 and 36 years. The onset of the disease for the majority of the participants (80%, $n = 40$) occurred under the age of 35 years, which is in contrast to the results of the above-mentioned study ('IBS was found to be more common among people aged 65 years and older').

Having utilized the Rome II criteria for IBS (abdominal pain or discomfort relieved by defecation or associated with a change in frequency of stool or in the form of the stool) we were able to evaluate the incidence of symptoms the patients suffered. Regarding primary symptoms, 50% of the population ($n = 25$) complained of abdominal pain with altered bowel habits, 30% ($n = 15$) mentioned discomfort relieved by defecation with altered stool frequency, 12% ($n = 6$) were relieved by defecation and mentioned a change in stool form and, finally, 8% ($n = 4$) complained of all the above-mentioned symptoms. These results did not show significant gender-related differences. In addition, symptoms that cumulatively support the diagnosis of IBS, in our study, were abdominal distension (94%, $n = 47$), nausea (34%, $n = 17$) and the passage of mucus (12%, $n = 6$). These findings were more prominent in female cases.

In our research model we focused mainly on factors influencing the onset, clinical appearance and severity of the disease. As demonstrated by previous studies, infectious gastroenteritis appears to influence the onset of IBS, as was also reflected in our model. Sixteen percent ($n = 8$) of our participants associated a bout of gastroenteritis with the onset of the disease³, an aspect that was briefly mentioned in the article published in your journal. The article published in your journal identified a significant difference in the rates of occurrence between rural Crete and other European regions, given to the Mediterranean diet, traditional lifestyle and the concept of stress perceived by this milieu. Enhancing this notion, in our study we observed that the vast majority of IBS patients had adopted the modern, Western lifestyle, consisting of increased stress factors (poor economic and civil status, and unstable emotional health) and diets

generally containing less fiber and complex starch and more refined sugars and chemical additives (68%, $n = 34$)^{2,4}.

The limitations of our study, including the small non-randomized population group ($n = 50$) which is not representative of the region (the PHC is responsible for a population of approximately 2000 residents); methodological flaws; and the short duration of the study, do not permit valid judgments and comparisons to be made. Nevertheless, even though there are many differences in methodology (your study was retrospective over a period of 4 years and analyzed medical reports of patients with dyspepsia, IBS and gastroenteritis), the majority of our results appear consistent with this article and other relevant research studies.

The strong point of our study was the direct contact with recruited patients where all the above-mentioned aspects, factors and symptoms could be discussed during consultation. This is in contrast to your article where information was obtained from the registration books and medical files of five health care centers.

In conclusion, it is noted that most people with IBS simply accept their symptoms as a nuisance and never seek medical attention^{6,7}. It is plausible, therefore, to encourage general physicians to be more aware of these indications. On these grounds, it is feasible to emphasize the importance of physician knowledge of the Rome criteria, in order to evaluate and assess IBS cases, and also to analyze the impact of a patient's lifestyle on the disease activity. Therefore, future studies focusing on the impact of different cultural settings on manifestations of the disease may enlighten specialists and primary care physicians, in order to obtain a more thorough understanding of IBS.

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