How I help patients with bloating

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Bloating can be a distressing symptom. Here, Dr Heap presents his approach to helping patients with this difficult problem.

Remember

- People who complain of bloating may be more sensitive to apparently normal amounts of gas.[1] A recent study suggests that gas retention causes abdominal symptoms and distension through poor transit and gas pooling in the colon.[2] Muscle relaxation of the anterior abdominal wall is another possible mechanism.
- People with an increase in gut gas may develop gut hyperalgesia, even if the increased gas is still within the normal range. Theoretical ways to reduce discomfort include decreasing gut gas (by reducing air swallowing or gas production and increasing gas transit) or by reducing sensitivity.
- Psychological factors and stress influence pain thresholds. We all see patients whose gut symptoms (including bloating) settle down towards the end of a relaxed holiday. The problem is helping these patients when they return to work.
- Consider serious underlying organic disease, especially if the patient is older and has a recent onset of symptoms. Remember that bloating occurs in irritable bowel syndrome.

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Assessment

- Take a careful history. Find out what is causing the distress and why the patient is presenting. Are obvious psychological factors operating?
- A dietary history is important. Is the patient eating too much fibre? Determine whether bloating is an isolated problem or part of a set of symptoms that suggest irritable bowel syndrome.
- You should perform a physical examination, even though it is usually unhelpful. Observe for frequent belching and examine the abdomen.
- If you are in doubt after a careful history and physical examination, a plain abdominal x-ray or an abdominal ultrasound should help to rule out bowel obstruction, ascites, distended bladder or a huge ovarian cyst.
- Test for endomysial antibody if coeliac disease is a possibility. Investigations for suspected lactase deficiency were discussed in an earlier article in this series.[3]

Management

- Belching might be a response to irritation of the upper gastrointestinal mucosa, a reaction to stress or a habit. If appropriate, the patient should be encouraged not to belch.
- The patient should avoid food that may increase gas production and prepare foods differently when indicated (e.g. stir-fry rather than boil cabbage, soak beans overnight and discard soaking water). Foods that may contribute to bloating include: bran, beans, brassica vegetables (e.g. cabbage, cauliflower, turnip), milk products, large amounts of fructose-containing fruits, foods with sugar substitutes (e.g. sorbitol), and excessive amounts of carbonated beverages. High dose hormone replacement therapy can contribute to bloating in some women. The self-help booklet 'Windbreaks' by Terry Bolin and Rosemary Stanton (Bantam Books) can be very helpful.
- Drugs have little role in

management. However, antacids, H_2 receptor antagonists, charcoal, simethicone, prokinetics such as cisapride (Prepulsid), antispasmodics for pain and tricyclics are sometimes used, perhaps often as logical placebos. A small dose of amitriptyline ([Endep, Tryptanol], 10 to 25 mg at night) may decrease perceived pain caused by gas. Watch out for a series of new drugs targeting visceral hyperalgesia during your medical lifetime.

- Some bacteria produce gas; others actually consume it. Gut flora is poorly understood and attempts at manipulating it to cure bloating are not a therapeutic triumph.
- Explanation and reassurance are important and should be based on a careful history, physical examination and (when appropriate) investigations. However, some patients are difficult to help. Occasionally, dietary manipulations can be helpful, but patients usually won't volunteer clues to successful intervention unless you put aside the time to let them tell you what they have been eating. MT

References

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