Gynecological Aspects of Irritable Bowel Syndrome

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Thirty years ago, investigators noted that approximately half of the women attending a gynecology clinic had symptoms such as abdominal pain and/or discomfort and changes in bowel pattern which are compatible with a diagnosis of irritable bowel syndrome (IBS). Since this finding, studies have demonstrated a higher prevalence of gynecologic disorders, such as pain associated with menstruation (dysmenorrhea), premenstrual distress syndrome, chronic pelvic pain and endometriosis in women with IBS as compared to those without IBS. In a variety of cultures, more women seek health care services for symptoms of IBS when compared to men. Women with IBS are also more likely than those without IBS to have abdominal surgical procedures—including hysterectomy and cholecystectomy. A Cholecystectomy is a surgical procedure to remove your gallbladder. These observations have led a number of clinicians to ask questions as to whether and why gender differences exist. This article is intended to briefly address the state of science related to two areas. First, what is the overlap between gynecological and functional gastrointestinal (GI) symptoms and disorders (IBS, in particular)? Second, what potential mechanisms may account for these gynecological and gastroenterological conditions to occur so often together?

Symptom Overlap

Many women (with and without functional GI disorders) experience variations in GI symptoms—including abdominal pain, diarrhea, bloating, and constipation—during their menstrual cycle. Abdominal pain and diarrhea tend to increase in the late luteal (pre-menses, 3 days before the onset of menses) and reach a maximum of symptoms through the third day of menstrual flow. Bloating and constipation, on the other hand, tend to increase post ovulation (after day 14) and stay increased until the day before or the first day of menstrual flow. Women with IBS have overall higher levels of symptoms (more frequent, more bothersome) regardless of cycle phase and also demonstrate these same menstrual cycle related patterns. There is some evidence that women with IBS-M group may suffer the most severe symptoms, as compared to IBS-constipation (mid) and IBS-diarrhea (least severe). It is important to note that such GI symptoms are not directly linked to stereotypical menstrual cycle associated changes in mood (e.g., depression, anxiety, irritability). However, women with IBS also report other more frequent and more bothersome symptoms such as fatigue, backache, and insomnia.

IBS is often categorized based on the most common type of bowel pattern experienced. These groups include:

- **Irritable bowel syndrome with diarrhea (IBS-D)** – symptoms of diarrhea occur most often
- **Irritable bowel syndrome with constipation (IBS-C)** – symptoms of constipation occur most often
- **Irritable bowel syndrome mixed (IBS-M)** – symptoms of both constipation and diarrhea occur

Oral contraceptives containing estradiol and progestin appear to have little impact on GI symptom or bowel patterns related to the menstrual cycle. This may be due to the fact that most of these regimens include 7 days without hormone treatment that coincides with the premenstrual/menses phase of the cycle. Thus, even women on oral contraceptives experience a phase of ovarian hormone withdrawal. The linkages between hormone replacement therapy and symptom experiences in postmenopausal women remain to be studied.

For many women, the link between GI symptoms and their menstrual cycle may not be obvious. The use of a daily diary in which both menstrual cycle days and symptoms are tracked often helps women see patterns in their symptoms. This may provide reassurance that symptoms are cyclical and help women plan strategies related to diet or medications. While actual dietary intakes may not differ between women with and without IBS, it may be that sensitivity to particular foods (e.g., gas-producing) is greater in women with IBS, particularly around the time of menstruation.

Gynecological and gastroenterological disorders overlap

Women with IBS more frequently report painful menstruation (dysmenorrhea) and premenstrual syndrome (PMS) compared to those without IBS. In studies of menstruating women with IBS, approximately 45% also experienced dysmenorrhea and about 35% also reported PMS. Women with IBS reported higher levels of uterine cramping pain at menses than women without IBS. In another study approximately 30% of women with IBS reported a history of chronic pelvic pain. The symptoms of chronic pelvic pain are similar to IBS and include abdominal pain, bloating, pelvic pain and hypersensitivity. Other gynecologic diagnoses associated with chronic pelvic pain include endometriosis, prolapse, fibroids, ovarian remnant syndrome, myofascial pain, vulvodynia, painful bladder syndrome, pelvic congestion syndrome and vulvodynia. There is also an increasing amount of evidence suggesting there is up to a 2.5 times higher risk of IBS in women with endometriosis as compared to women without endometriosis. These overlaps in gynecological and gastroenterological conditions are important areas for further investigation.

Sexual functioning

Sexual functioning can be affected by both gynecological and gastroenterological conditions. Sexual dysfunction is reported by both men and women with IBS, as well as women with painful menstruation. Studies have found that approximately 30-50% of women with IBS report concerns related to sexual functioning. Sexual dysfunction can range from decreased sexual drive (the most common symptom reported by both men and women with IBS) to painful intercourse.

Summary

There has been increased attention given to the impact of IBS symptoms on women's lives. Chronic, persistent symptoms along with strategies to reduce symptom experiences can be disruptive to work and family responsibilities and reduce overall quality of life.

There is a clear need for greater collaboration among health care providers in the fields of gynecology and gastroenterology. Research focused on women with overlapping medical conditions including dysmenorrhea, IBS, chronic pelvic pain, endometriosis, PMS, and chronic constipation needs to focus on physiological factors, as well as psychological factors that may be amplified in these conditions. When speaking with your healthcare provider, a thorough explanation of both gastrointestinal and gynecological symptoms should be discussed.

About IFFGD

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