Introduction

Constipation is a symptom rather than a disease, as a result exploring the underlying cause of this symptom is critical in tailoring management. Therefore, this requires doctors to understand the pathophysiology of constipation and how this impacts on symptoms. Chronic constipation is defined as at least three months of unsatisfactory defecation characterised by infrequent stools, difficult stool passage, or both. Although healthcare professionals tend to focus on frequency, people with constipation are more troubled by other symptoms, such as straining, incomplete evacuation, hard stools and bloating. A more pragmatic definition relates to the person's own perception of their normal bowel habit with self-reported constipation symptoms such as straining, abdominal discomfort, gas, sensation of incomplete evacuation with symptoms present for greater than six months.

Constipation is common affecting approximately 10-20% of the general population. It has many causes and can be a consequence of a primary disorder of the gut, (chronic functional constipation or constipation predominant IBS), or due to another disorder, such as a side-effect of medications.

Constipation predominant IBS (IBS-C) explained

Constipation can be conceptualised as having three overlapping features. The first relates to colonic motility, ie the speed at which propagating peristaltic contractions, (peristalsis is a radially symmetrical contraction and relaxation of muscles that spreads in a wave down a tube), transit stool through the colon, which can be normal or retarded.

The second relates to the presence or absence of pain and finally the presence or absence of a functional or structural pelvic floor disorder. Taken in conjunction with an evaluation of symptoms, response to diet and laxatives, the past history and a clinical examination, these features allow for a clinically based diagnosis to be made. Whilst there is considerable overlap between chronic functional constipation and IBS-C, the main characteristic of the latter is chronic abdominal pain. However, it must be stressed that people often do not fit into a single diagnostic box and multiple diagnoses may co-exist in the same person and symptoms typically wax and wane over time. However, if certain features are present, such as bleeding from the back passage, if there is associated weight loss, then an urgent consultation with your GP is recommended.

Treatment of IBS-C

Currently, there isn’t a single magic bullet for treating IBS-C. The main goal of treatment is more than just increasing bowel frequency but also involves reducing abdominal discomfort and bloating.

There’s no one best approach to treating IBS-C. In reality, people often use a mix of treatments. These can include changes in diet, increasing the amount of exercise, stress management as well as medication. Dietary changes include increasing fibre intake, as fibre reduces constipation by softening the stool and making it easier to pass, although it can make bloating worse. Good sources of fibre include wholegrain bread, cereals and vegetables. If such measures don’t provide relief then the addition of laxatives may be helpful in some people. Laxatives can be divided into stimulants (bisacodyl and senna), osmotic laxatives (lactulose or polyethylene glycol) or stool softeners (docusate). For the majority of people, these treatments will ease symptoms sufficiently. However, in people with more severe symptoms there has been recent progress with newer drugs for IBS-C.

Conclusions

IBS-C is common and, like any other medical problem, varies in severity between individuals. In some people it can be severe and result in very debilitating symptoms. Newer treatments are helping people manage this condition more effectively and further interventions are currently in development so the future looks rosy.
What a glorious way to start the day with this yoghurt and oat based creamy breakfast. The recipe contains ground flaxseed to add lots of soluble fibre, a real treat for sluggish bowels!

Skrý yoghurt contains lactose, so if you are lactose intolerant and concerned about yoghurt, add lactase liquid. The dose recommended is five drops per pint, or four drops to convert a large pot of yoghurt (450g) for the Biocare liquid lactase product. This does contain glycerol, which is a polyol, but lactase enzymes should be included after the reintroduction phase of the FODMAP diet. You will be aware of whether you need to exclude polyols, although lactase drops are often used in very small amounts.

It is probably better to treat milk/yoghurt with lactase prior to drinking or using it in recipes, as this forgoes the complex vagaries of digestion.

The prepared yoghurt needs to be left for 24 hours in the fridge for the lactase to take effect. However, some people with lactose intolerance can manage yoghurt, as the manufacturing process means a lower level of lactose in yoghurt. Go with what you tolerate. If you have completed a FODMAP diet, you will know how much you can tolerate without symptoms.

The yoghurt can then be used to make up the bircher, which is usually left overnight.

**Ingredients (8 servings)**
- 200g of low fat low sugar Skyr or thick textured yoghurt
- 50ml of water
- 1 heaped tablespoon of ground flaxseed
- 1 teaspoon of lime curd (check labels for any fructose based syrups and avoid)
- 20g of pecan nuts
- 1 heaped tablespoon of oats
- 13g of dried blueberries or 80g of fresh.

**Method**
Add the flaxseed to the water, mix well.

Then add the yoghurt, oats, blueberries and lime curd to the mix.

Prepare this recipe the night before and it will be ready to eat the next day. Add the chopped pecans just before serving to retain the texture.

Drink a glass of fluid or cup of tea with this for additional fluid to help the flaxseed move through your bowel.

Recipe supplied by Julie Thompson, Registered Dietitian and Diet Adviser to The IBS Network.

www.calmgutclinic.co.uk
How diet and exercise can help relieve IBS

With spring in the air, we have brought together two experts to show how adapting your lifestyle can help relieve IBS symptoms, with particular attention on constipation.

Food for thought

Everyone’s IBS is different but, for many, certain foods can trigger symptoms. Often, it can be difficult to identify what component, if any, of the meal may be responsible.

For people with IBS-C, two aspects of diet are important considerations:

- fibre content of food – the part that is not digested in the gut and travels through the bowel
- fluid – the lubricant that helps the fibre pass through the gut.

To help relieve mild IBS-C, small dietary changes may be helpful, such as consuming between 10 – 15 cups of fluid a day, unless your doctor has advised you to restrict your fluid intake. Suitable fluids can include water, decaffeinated tea and diluted squash.

Three portions of fibre, which comes from wholegrain carbohydrates, should be consumed per day. Avoid increasing food containing wheat bran, although small amounts may be tolerated, such as wholemeal bread, wheat breakfast cereals and adding wheat bran to food. Wholegrain carbohydrates based on rice, corn, and oats are also suitable.

Other important fibre sources are fruit and vegetables. You should aim to have at least five portions a day. However, if you also suffer bloating, aim for no more than three portions of fruit (80g) and split these throughout the day.

If you have moderate to severe symptoms of IBS-C, try golden or milled linseeds. These form a ‘gel’ in the bowel and help retain fluid, keeping stools soft. They can also help with bloating. Chia seeds have the same effect, but can be expensive.

Start slowly with one tablespoon of linseeds added to soups, cereals, salads, and ensure you drink a cup of fluid with them. You can increase to a maximum of three tablespoons per day if needed, but please note, they can take a while to be effective.

Is the low FODMAP diet effective for IBS-C?

This question gets asked a lot but its effectiveness depends on a number of factors. For some, the low FODMAP diet works really well in relieving certain symptoms but it may not resolve constipation for all. Everyone’s IBS is individual to them so it may be worth trying alongside having adequate low FODMAP fibre and fluid sources. We would recommend that anyone following a low FODMAP diet is supervised by a Registered Dietitian.

If you have changed your diet and not found this effective in relieving symptoms, slowly re-introduce what you have restricted and discuss other options with your doctor.

By Julie Thompson
Registered Dietitian and Diet Adviser to The IBS Network.

Exercising a new lifestyle

While there is no specific research linking the benefits of exercise to relieving IBS symptoms, NHS choices’ state that anecdotal evidence suggests whilst exercise is not a cure for IBS it can help with general health, stress management, and easing of gastrointestinal problems like constipation.

NHS guidelines advise 150 minutes per week of moderate intensity exercise like swimming, walking, and cycling increases overall general health by improving circulation, posture and muscle strength. We know that finding time to carry out exercise can often be hard to fit into your busy week, so even exercising in 10-minute blocks is helpful. Try building small bite-sized exercise periods into your lifestyle. You may choose to walk part of your journey or get off the bus a stop earlier. Many places have local health walks with opportunities to join a strolling group, which can make the experience more sociable if you prefer.

Key tips for exercising:

- try and get into a regular routine that fits into your daily life
- choose something that you enjoy
- avoid exercising an hour before or after a meal, and an hour before going to bed.

Exercise can help reduce and manage the effects of stress on the gut. Activities such as Yoga, Pilates and Tai Chi can be beneficial for both posture and trunk muscle tone. Improving your posture allows the digestive system more space to work. As the intestines are made of muscle, developing the tone around the trunk and improving circulation together helps food move through the gut in a more rhythmical manner, reducing the risk of constipation.

Certain exercises and amount of time spent on physical activity may need to vary depending on your individual IBS symptoms. For example, you may prefer to exercise at home, or in a location which has easy access to a toilet.

Remember to check with your GP for advice before beginning any exercise programme to ensure it is right for you. This is particularly important if you haven’t exercised much before, or have other medical conditions.

By Kay Waller
Over the past 30 years, Kay has been a Chartered Physiotherapist employed in a variety of settings from working in the community to acute hospitals with patients with a wide spectrum of conditions.

What potential damage can exploratory investigations (colonoscopies, other camera examinations) cause?

There are always risks with exploratory investigations such as colonoscopies and endoscopies but these are rare. In some cases, complications of a colonoscopy may result in pain, bleeding, perforation, and risk of reaction to the sedative drugs.

An endoscopy can cause a sore throat, damage to dental crowns/bridgework, aspiration, bleeding, perforation, and risk of reaction to the sedative drugs.

If an exploratory investigation is recommended, your doctor will discuss the risks before asking you to sign a consent form to authorise the procedure.

What is the ‘protocol’ that Gastroenterologists follow before they would request investigations like colonoscopy?

We try not to carry out exploratory investigations, such as colonoscopies on everyone with IBS, as the test is uncomfortable and has some risks (see above).

However, if there are any of the following, then we would be more likely to consider it:

- patient choice, if they are adamant they want a colonoscopy, in general I would agree to undertake the investigation
- family history of bowel cancer in a first degree relative
- the person is over 45-50 years of age
- unusual symptoms are experienced, eg weight loss, bleeding from the bottom, diarrhoea at night.

If you have any concerns, we recommend discussing these with your doctor.

I’ve heard that colon hydrotherapy can help with constipation. Can you tell me a little more about this treatment and if it works?

People consult Colon Hydrotherapists for all sorts of reasons, but one of the main reasons is for help with their chronically constipated bowel.

Chronic constipation robs people of their energy and vitality. People feel ‘toxic’ and overloaded with putrefying, fermentative wastes, typically complaining of bloating and/or abdominal pain. Constipation should be taken very seriously due to the increased risk of developing painful haemorrhoids (piles), diverticular disease and in some cases colorectal cancer.

A skilled Colon Hydrotherapist can gently cleanse a constipated large intestine, through the introduction of warm, filtered water into the rectum via a single-use disposable speculum. The warm colonic water acts as a solvent, softening the impacted faeces, thereby allowing it to be pushed along, using the patient’s own peristalsis (bowel contractions), and down the colonic tubing, giving welcome relief to the patient on the couch.

Sometimes, if the faeces are very impacted, the Colon Hydrotherapist will regulate the temperature of the water, cooling it down, to further help instigate peristalsis, and using certain abdominal massage techniques during the treatment to help push the faeces along in a clockwise movement. The treatment time is approximately 30 minutes and is very gentle and painless.

If you are considering having colon hydrotherapy, consult a member of The Association of Registered Colon Hydrotherapists (ARCH). www.colonic-association.org
**Dr Nick Read**
Psychotherapist and Medical Adviser to The IBS Network

**Q**
A little while back you answered my question about cholecystectomy and diarrhoea, but I'm not sure what you mean when you say that you doubt a cholecystectomy will cure my IBS as I have gallstones because of constipation. Does this mean constipation causes gallstones? What would happen to my constipation if I had my gallbladder removed?

**A**
It was not my intention to undermine your confidence in cholecystectomy. There is indeed a well-documented association between constipation and gallstones. There are three conditions necessary for the creation of most gallstones; a supersaturated solution of cholesterol in the gallbladder, impaired contraction of the gallbladder and the presence of a nidus for crystallisation, either sloughed off cells or, more commonly, bacteria. Constipation is associated with slow transit, not only through the colon but also through the small intestine. The circulation of bile acid between the ileum (the end of the small intestine), where it is absorbed and the gallbladder is slowed and it is likely that bile remains in the gallbladder for longer. It is also possible that small intestinal transit encourages the overgrowth of bacteria in the ileum, degrading bile acids, and making them less efficient at maintaining cholesterol in solution. If, in common with many people who get gallstones, you also eat a diet rich in fat and are overweight, then this may also slow transit, optimise fat absorption and encourage the production and excretion of cholesterol. For females, high oestrogen levels may also encourage more cholesterol excretion. Unfortunately, medicine is not an exact science, and many factors contribute to most diseases.

If you are getting a lot of pain from your gallbladder, then a cholecystectomy may well give you relief, but if the pain and discomfort (and bowel disturbance) are coming from your IBS, cholecystectomy is not a cure for IBS. It might be that removing your gallbladder will cause a constant leak of bile acid into the bowel, stimulating it and helping to offset the constipation or even causing diarrhoea, but the decision about cholecystectomy needs to be made on the basis of the risks and discomfort of leaving a diseased gallbladder in place. I hope this information helps you in your discussions with your surgeon.

**Latest research:**
*investigating Hypermobile Ehlers-Danlos and IBS*

Hypermobile Ehlers-Danlos hypermobility type (hEDS) is an inherited disorder of connective tissue. Connective tissue refers to those proteins that allow cells of the body to adhere to one another, – the most common type being collagen. These patients have joint hyperextensibility (bendy joints) which is often associated with muscle and joint symptoms in particular pain.

hEDS is recognised as a condition which involves multiple parts of the body and produces symptoms such as palpitations (fast heart rate) and dizziness on change in posture, for example when moving from lying to standing, chronic pain, bladder problems and infections, anxiety and mood disorders, as well as pelvic organ prolapse. Notably, there is a high prevalence of gut symptoms in patients with hEDS.

Our group* recently investigated the relationship between hEDS and functional gastrointestinal disorders, such as IBS and functional dyspepsia (indigestion and food related symptoms) in an unselected group of patients referred to the gastroenterology clinic (13). In more than 500 included patients, 180 (33%) had hEDS. These patients described heartburn, fullness after meals, bowel habit alternating between constipation and diarrhoea, bloating, difficulty with swallowing in higher frequency than non-hypromobile patients. Furthermore, the prevalence of hEDS in IBS patients was approximately 40% and in patients with functional dyspepsia (unexplained indigestion, early fullness and discomfort after meals) was 50%. In 2013, another study from the USA showed that of 134 hEDS patients, 48% met criteria for IBS.

It therefore seems that hEDS is common in patients with IBS but why this association occurs requires further research. Once identified, it will be possible to develop treatments to improve symptoms. Nevertheless, the simple recognition that in almost half of patients with IBS there is an underlying disorder of connective tissue is a major breakthrough. Our understanding of management of these patients is improving. What is clear is that it is important for the medical community to recognise this association early and to manage patients in a multidisciplinary way in close collaboration with Rheumatologists, Pain specialists, Dietitians and Physiotherapists.

By Professor Qasim Aziz
Professor of Neurogastroenterology at Barts and The London School of Medicine and Dentistry.
I have had IBS for many years, and at times Crohn’s Disease with varying symptoms and treatments. This time last year I was suffering with diarrhoea on average about four to five times a day. My symptoms have never been as severe as for many people – they never stop me going out or working or living a relatively normal life. However, the symptoms are inconvenient, annoying and embarrassing and do not make me feel great or healthy.

Having been on a low fibre diet and finding this was no longer effective, I thought there must be something I eat regularly that is contributing to the problem. I figured that bread was one of the foods that I was eating every day – so I tried cutting this out for a couple of weeks and my symptoms improved.

I went to my GP for advice, hoping to be referred to a Dietitian. This followed a process of being referred to a hospital consultant and having a ‘pill camera’ to look for inflammation due to my history. Some inflammation was found but was inconclusive and a Coeliac test also came back negative. So, I asked again to be referred to a Dietitian and eight months after seeing my GP, I finally had my appointment. After listening, the Dietitian recommended the low FODMAP diet – I had looked into this before but had been put off as it looked too hard!

At The IBS Network event last year, the message was “do not attempt to do this unless under the guidance of a Dietitian” so, I was very pleased to finally have professional support, which also provided the motivation to follow their advice. The Dietitian went through the diet and the huge list of things to completely exclude for eight weeks (starting after my summer holiday last year so I could have ice-cream!).

I have to admit – the diet is very daunting. When you are used to eating wheat products, cow’s milk and a variety of fruit and vegetables every day, cutting out all the foods on the list is hard work. It has been challenging, just because of the time needed to dedicate to meal planning, shopping and cooking from scratch. Convenience foods do not really work. Having to find meals that my fussy little children will eat too, has added to the challenge!

The Kings College FODMAP app has been incredibly useful, especially in supermarkets – the first few shops took ages as I was scanning everything to look for the smiley face (allowed!). I have relied on the app, the Dietitian’s information and recipe booklet and the excellent ‘Cooking for the Sensitive Gut’ by Joan Ransley and Dr Nick Read (available via The IBS Network online shop).

There are also loads of recipes online but I find I can only cope with so many new dishes. It has also been a challenge for my mother who cooks for us once a week. I have turned down a lot of offers of biscuits at work and eaten quite a few chips and jacket potatoes. I have discovered a range of interesting new milks as well as some really tasty alternative recipes: buckwheat pancakes, yummy smoothies and delicious rice salads. However, I still miss cake. I have managed to stick to the diet, despite some conflicting advice in the various sources of information about what is allowed. I have also recorded everything I have eaten and my daily symptoms in a notebook.

So, was it worth it?

Well, I am pleased to report that my symptoms have greatly reduced. Most days, I now have bowel movements of a normal consistency – I probably still go the toilet more often than most people, but the frequency is less too. I think that stress still brings my symptoms on, but there is no doubt there has been a huge improvement.

What now? The Dietitian refused to tell me about the re-introduction phase before I had finished the elimination phase, but I am now starting it. I have to re-introduce one FODMAP food at a time for up to three days, recording symptoms and keeping the low FODMAP diet as a baseline. She said that there may only be a few problem foods – it could even be one or two. I am hoping so, as this phase may take another three months which is quite long enough, thank you!

Nicola was diagnosed with IBS over 18 years ago, experiencing symptoms ranging from bloating and wind in the early days, to diarrhoea and bloating but these have varied over the years. Nicola, who is married with two children, leads a busy life working part-time in an office, helping with community activities and tries to take regular exercise.
New Charity Ambassador shares his IBS life story

We are delighted to announce that Thomas Redgrave from musical theatre band and Britain’s Got Talent winner, Collabro, has become a Charity Ambassador for The IBS Network. By talking about his experience of having the condition, how it affects his life and ways he’s reduced symptoms, he hopes to overcome people’s embarrassment and the taboo surrounding the illness.

Thomas’ story

Bear with me. For the purposes of this piece, I will be referring to ‘taking a poo’ as ‘going to the toilet’ to avoid having to write it out numerous times!

I was always a child who had to go to the toilet a lot which never really affected me until I reached secondary school. As with many sufferers of IBS, I would go to the toilet to relieve the pain of bad abdominal cramps.

Whenever the pain and discomfort (not to mention embarrassment) occurred, I would go at every opportunity possible to avoid being stuck in a classroom full of my teenage peers and potentially unsympathetic teachers (although this may be unfair as I never informed anyone of my condition).

It’s obvious that I was giving myself a complex. I would dread any kind of social situation for fear of not knowing where the nearest toilet was. This anxiety was also a huge trigger for the cramps – the more I worried, the more pain I would have, and the more pain I had, the more I would worry. To this day, when arriving somewhere new, I scout out the nearest bathroom. It puts my mind at ease so that if I have to go I know exactly where it is. I would always consider toilets almost as ‘safe havens’.

As you can imagine, all of this made for quite a quiet child and, whilst having a core group of friends, I became introverted. Despite this, I enjoyed performing onstage at my local theatre.

Looking back on my time in musicals and plays, I don’t quite understand how the two managed to co-exist (my IBS and my performing), but they did and I believe I gained confidence through my acting and singing.

As I entered my late teens, I made a decision to start to understand and manage my IBS rather than let it dictate my life. Some triggers were obvious (anxiety, spice, sugar) but others developed over time as my body became less resistant to them. I soon discovered alcohol to be a significant trigger which, as an 18 year old at the time, seemed like the end of the world. However, with the stubborn attitude of my age, I resigned myself to drinking anyway and dealing with the consequences later, ie giving myself the day after as a recovery period. I hardly drink now as I associate alcohol with the pain it brings.

I continued acting and singing at college, then university which is where I came to decide that I didn’t want my IBS to hold me back. Now I live with the mantra that I will never allow my IBS to be an excuse or stop me doing what I want to do as I had done so many times as a child.

As a 27 year old, lucky enough to have a career in the band, Collabro, with three great guys who respect and don’t judge me, I’ve reached a point in my life where I’m comfortable discussing and even joking about my IBS, despite the pain it inflicts. I figured out a long time ago that, by making a joke of my condition, rather than feeling ashamed of it, I released its stranglehold on me mentally and, by being unabashedly open, my peers could be as comfortable dealing with it as I have become.

Unfortunately to a lot of people this may come across as crude and, in that instance, if people with IBS are to not feel ashamed to talk about their own bodies, changes must be made to raise awareness and better understanding of IBS.

One of the most difficult things is being on stage in front of an audience and having to smile through the pain and discomfort, but I do because I’m stronger than my IBS and it can’t stop me!

One huge thing that has helped me was having peers who understood. I found that the older I got the easier it was to find friends who didn’t judge me for something that I couldn’t help, who were considerate towards my condition, and who even gave me space when I needed it; some of them even going through similar situations themselves.

The term IBS is itself often used as a ‘blanket term’ and sometimes slapped onto any indefinite problem a person may have with their gut, stomach, or bowels. I believe this is due to a lack of research and understanding of this non-life threatening but heavily life affecting condition.

As I continued through my twenties (developing my most recent trigger of caffeine), I found people in similar situations who could openly talk about everything concerning their bowels. It’s comforting to be able to have a grown up discussion about IBS with someone who is also experiencing it (of which there are many). ‘Toilet talk’ is still seen as quite taboo and embarrassing to the general public. Even having IBS myself and speaking openly about it like this I still cringe and can’t bring myself to write ‘taking a poo’ as if it is a ‘dirty’ or ‘unclean’ word. Unfortunately, though I have found people to confide in, there are countless others who have no one to turn to in comfort of their condition. This can make it incredibly difficult for people to cope with the various ways IBS can manifest itself (I haven’t even touched on issues with metabolism or body dysmorphia).

As a 27 year old, lucky enough to have a career in the band, Collabro, with three great guys who respect and don’t judge me, I’ve reached a point in my life where I’m comfortable discussing and even joking about my IBS, despite the pain it inflicts. I figured out a long time ago that, by making a joke of my condition, rather than feeling ashamed of it, I released its stranglehold on me mentally and, by being unabashedly open, my peers could be as comfortable dealing with it as I have become.

By Thomas Redgrave, written partly on the toilet.
Our network of IBS support groups continues to grow with meetings now taking place in five different locations across the UK: in Alton, Durham, Leeds, London and Newcastle-upon-Tyne. Full details of days, times and venues for each group can be viewed on our website, or call us on 0114 272 3253.

If you are interested in setting up a support group in your area, please email sam@theibsnetwork.org for an application form. Training will be delivered by Gastroenterologists, other specialists in IBS and people who have learned to manage their condition. Trainee Leaders will also be given tips and practical information on setting up and running their own groups.

The next Support Group Leader training day takes place on 15 July 2017.

Thomas Redgrave from Collabro becomes Charity Ambassador

As featured in this edition’s real stories page, we welcome Thomas Redgrave from Collabro who has joined The IBS Network as an Ambassador for the charity.

Thomas, part of the world’s most successful musical theatre group, Collabro, shot to fame when winning Britain’s Got Talent in 2014. Since then, the four piece band consisting of Thomas Redgrave, Jamie Lambert, Michael Auger and Matthew Pagan, has gone on to release a number one debut album, performed at The Royal Variety Performance, and become enormously successful internationally.

Commenting on his decision to take on the role of Ambassador, Thomas said: “Having had IBS since I was a child, I know the impact it has long-term on so many people’s lives. I came forward as an Ambassador for The IBS Network to talk openly about my experiences, increase awareness of IBS, help the charity raise much needed funds and to break the taboo surrounding the condition.”

Alison Reid, CEO for The IBS Network added: “Since I first met Tom, I was really impressed by his candour in talking about his IBS. We’re delighted to have Tom on board and are excited to start planning future activity with him to increase public awareness of IBS and the important work of the charity over the coming months.”

Throughout April, we will be celebrating IBS Awareness Month to encourage more research, improve education and ensure effective self-management.

To mark IBS Awareness Month, we are offering the first 100 people who sign up to become members of The IBS Network in April the chance to receive a free Radar Key.* If your subscription is due to expire, or you know someone with IBS who is thinking of joining, visit our website or call 0114 272 3253.

Keep an eye out for more details of exciting offers, information, and fundraising plans in our next edition of Relief, on our website and social media channels.

*Offer only includes membership subscriptions paid in one instalment and excludes those paying by monthly Direct Debit.

The IBS Network Annual General Meeting (AGM)

29 April 2017 (2 – 4pm)

The IBS Network’s AGM will take place on Saturday 29 April 2017 at the Royal Victoria Hotel, Sheffield. The meeting will commence at 2pm with a debate between two leading Gastroenterologists on the challenges of making an IBS diagnosis. This will be followed by the formal part of the meeting at 3pm.

Numbers are limited to 100 so places will need to be reserved. Please email info@theibsnetwork.org or call our office to book your place before Friday 21 April 2017.

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