saje humans healing humans

SPECIALIST CARE FOR WHOLE-PERSON HEALTH

INFORMATION FOR

GENERAL PRACTITIONERS

REFERRAL INFORMATION

Disorders of Gut-Brain Interaction

BEHAVIOURAL AND MIND-BODY INTERVENTIONS FOR IBS AND FUNCTIONAL GI CONDITIONS

I accept referrals from general practitioners for patients with IBS and other Disorders of Gut-Brain Interaction (DGBI), including persistent symptoms where structural disease has been excluded or adequately treated.

CLINICAL FOCUS

SYMPTOMS AND THEIR IMPACT

Assessment of symptom experience, visceral sensitivity, GI-related distress and effects on daily life.

SELF-REGULATION SKILLS

Education and practice in attention, arousal regulation and responses to symptom flares.

FUNCTIONAL IMPACT

Exploration of avoidance, confidence, participation and the patient's individual treatment goals.

INDIVIDUALISED CARE

Care is tailored to the patient's history, goals and current treatment plan, with communication to the referrer where the patient consents.

MY APPROACH

COLLABORATIVE

I work closely with referring general practitioners, providing clear updates on progress where the patient consents.

CLINICALLY INFORMED

Assessment may inform the use of behavioural and mind-body approaches, including gut-directed clinical hypnosis, according to the individual patient.

INTEGRATED CARE

Provided alongside appropriate medical care. It does not replace investigation or treatment of structural gastrointestinal disease.

MY TRAINING AND BACKGROUND

I am a Specialist Anaesthetist (FANZCA), retired Army Medical Officer, and Fellow of the Australasian Society of Lifestyle Medicine (FASLM), with additional training in clinical hypnosis and behavioural medicine, including:

- Comprehensive Clinical Hypnosis and Strategic Psychotherapy Training (Yapko)
- Diploma of Professional Hypnotherapy (Jacquin Hypnosis Academy)
- Level 1 Mental Health Skills Training (GPMHSC)
- Level 2 Focused Psychological Strategies (GPMHSC)
- Motivational Interviewing and Foundations in CBT (Psychwire)
- IBS4IBS Hypnosis in IBS Training (Bremner – ex-Whorwell team)

DR MICHAEL AYLING
FANZCA FASLM

Consulting at Saje
Woollahra, Sydney
Telehealth available

saje humans healing humans

saje.com.au | +61 2 7235 0066

saje humans healing humans

BEFORE REFERRAL

Clinical information for suspected IBS

A POSITIVE DIAGNOSIS

IBS is diagnosed from a characteristic symptom pattern, a clinical assessment and limited, targeted investigation. Extensive testing is not required when the presentation is typical and alarm features are absent.

ROME V IBS DIAGNOSTIC CRITERIA

Recurrent abdominal pain or discomfort on average at least 3 days per month, associated with 2 or more of:

- related to defecation
- associated with a change in stool frequency
- associated with a change in stool form (appearance)

Rome V separates research criteria from clinical diagnostic criteria; clinical diagnosis also incorporates symptom bothersomeness, functional impact and clinical judgement.

BASELINE EVALUATION

- History and examination consistent with IBS, including bowel pattern and medication review.
- Full blood count and CRP (or ESR).
- Coeliac serology while consuming gluten: tTG-IgA plus total IgA; use appropriate IgG-based testing if IgA deficient.
- Age-appropriate colorectal cancer screening is current.

ALARM FEATURES

- Rectal bleeding or melaena; iron-deficiency anaemia.
- Unintentional weight loss, fever or a palpable abdominal/rectal mass.
- Nocturnal diarrhoea, persistent severe diarrhoea or raised inflammatory markers.
- New or clearly progressive symptoms, particularly later in life.
- Family history of colorectal cancer, inflammatory bowel disease or coeliac disease.
- Any other feature that makes structural, inflammatory, malignant, infectious or gynaecological disease plausible.

PHENOTYPE-DIRECTED TESTING

- Diarrhoea or mixed pattern: faecal calprotectin to assess for inflammatory bowel disease.
- Stool microbiology only where infection, travel or exposure history makes this relevant.
- Consider bile acid diarrhoea, microscopic colitis, malabsorption, endocrine disease or a defecatory disorder when suggested clinically.
- Endoscopy, imaging or other tests according to age, phenotype, examination and alarm features - not routinely for every patient.

PLEASE INCLUDE

- Relevant consultation notes and the working diagnosis.
- Results of blood, stool, endoscopic, histological or imaging investigations.
- Predominant bowel pattern, current medicines and treatments already tried.
- Any continuing medical follow-up or planned investigation.

Sources: Rome Foundation, Rome V (2026); ACG Clinical Guideline: Management of IBS (2021); British Society of Gastroenterology guideline for IBS (2021). Clinical judgement remains essential.

DR MICHAEL AYLING
FANZCA FASLM

Consulting at Saje
Woollahra, Sydney
Telehealth available

saje
saje.com.au | +61 2 7235 0066