



GHAPP

Gastroenterology & Hepatology
Advanced Practice Providers

IBS

clinical roundtable

December 2, 2022 IBS-C Edition



An IBS Clinical Roundtable was held on September 29, 2022 at the Fifth Annual GHAPP Meeting in Nashville, TN to discuss strategies for improving the care of patients with irritable bowel syndrome (IBS). A total of 12 APPs who specialize in gastroenterology participated in the event. The key messages from the discussion around IBS-C are summarized in this issue.

Acknowledging that the abdominal pain of IBS can overlap with many functional gastrointestinal disorders (FGIDs), the participants noted that the patient history determines whether they move towards a diagnostic pathway for IBS, chronic idiopathic constipation (CIC), or pelvic floor dysfunction. For patients without abdominal pain, the participants tend to evaluate for CIC rather than IBS-C. This type of work-up typically involves obtaining a thyroid stimulating hormone (TSH) and a complete blood count (CBC), particularly if symptoms have worsened. Conversely, a pelvic floor workup may be needed in patients with a complicated obstetric history, history of sexual abuse, or overlapping urinary symptoms. Some clinicians order a pelvic MRI with defecography in addition to anorectal manometry since it is better

tolerated and provides sufficient information to engage pelvic floor physical therapy. Evaluation for small intestinal bacterial overgrowth (SIBO) is common in patients who complain of bloating. However, perceptions and practices regarding breath testing in clinical practice differ considerably. While some clinicians order breath testing when patients complain of bloating, others wait until patients with a confirmed diagnosis of IBS-C fail to achieve improved bloating with an approved therapy. Some people also treat empirically for IBS-C without any testing. Other providers noted that they consider a gynecological work-up for some patients, including ultrasound and/or referral to gynecology.

Although many patients want to have testing for food intolerances, the participants noted that symptoms are not often attributed to food allergy and/or intolerance and do not pursue these tests since they are not consistent with guideline recommendations.

THE IBS-C work-up

Abdominal pain and bloating are key symptoms that drive the diagnostic approach to IBS-C in clinical practice.



So my algorithm is to confirm the diagnosis of IBS-C or CIC, to start them on an approved therapy, and optimize that. Then if they are still having bloating, especially if they have risk factors, I would consider the breath testing.

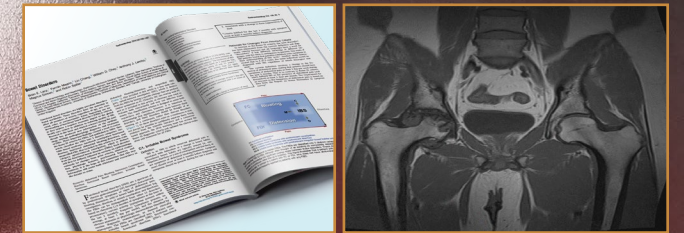
APP participant



If the chief complaint is bloating, my first question is what their actual bowel patterns are before jumping into FODMAPs and leaky guts and breath tests.

APP participant

RECOMMENDED^{1,2}



Positive diagnostic strategy vs diagnosis of exclusion

Anorectal physiology testing in patients with suspected pelvic floor dysfunction and/or refractory constipation

NOT RECOMMENDED^{1,2}



Routine stool testing
 Routine colonoscopy <45 years
 Food allergy or sensitivities testing
 Lactulose, glucose, or hydrogen breath testing

Which tests are recommended by the ACG and AGA guidelines for suspected IBS-C?

Despite the availability of Rome criteria for making a diagnosis of IBS without extensive testing, the participants agreed that many providers are not following current recommendations for diagnosing IBS. Although the advisors do not typically order colonoscopies in patients without alarm symptoms, particularly younger patients, they believe that many unnecessary colonoscopies are obtained in evaluating patients with suspected IBS. This is largely attributed to both provider and patient fears of missing organic disease, particularly colorectal cancer (CRC), rather than lack of knowledge regarding recommended diagnostic strategies for IBS. Some providers are reluctant to change their behavior to adapt to current guidelines, while others may be driven by financial incentives.

Time constraints and lack of resources are also barriers to following guidelines for diagnosing IBS. Given the high patient volume and limited time for visits in primary care practices, many primary care providers will refer patients who have chronic diarrhea or constipation rather than take the time to obtain the thorough history needed to diagnose IBS. Alternatively, ordering a battery of tests is likely faster than obtaining a thorough clinical history. Additionally, some practices lack timely access to resources that facilitate proper diagnosis (eg, manometry, pelvic floor testing).

TOO MANY colonoscopies?



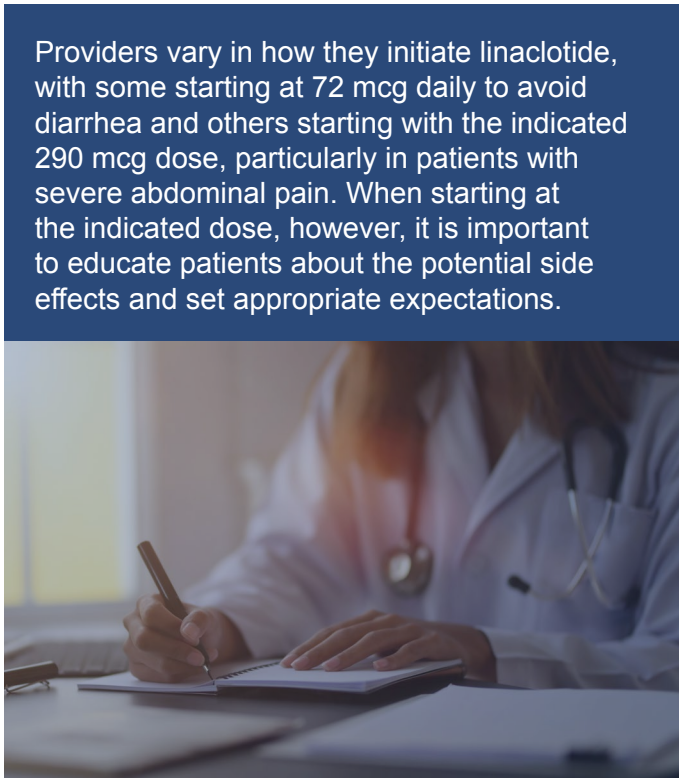
Recognizing that public awareness is greater for colon cancer than for IBS, patients often come in with the aim of ruling out colon cancer as the cause of their symptoms. Accordingly, many patients are reluctant to accept a diagnosis of IBS without undergoing colonoscopy. Some will even "doctor-shop" to find a clinician who will order extensive tests to reassure them they do not have CRC.

The participants emphasized the difficulty in convincing patients that additional testing is not needed to confirm their diagnoses, and commented that they often have to negotiate with patients to try a certain therapy before additional testing is ordered. The participants agreed that IBS-C patients have more difficulty accepting the diagnosis without extensive testing than IBS-D patients, likely because IBS-D patients will have undergone inflammatory stool studies (ie, fecal calprotectin or leukocytes) and testing for celiac disease.

Treatment approaches to IBS-C vary considerably and are often influenced by patient preferences, prior treatments, and insurance coverage. Although useful in some patients, fiber is not appropriate for patients who do not hydrate adequately or those with bloating. Several participants use polyethylene glycol (PEG) first-line, but they cautioned that this therapy may not be appropriate in patients who have prominent abdominal pain or bloating.

Patients are often involved in treatment selection, particularly those who are interested in holistic treatment. Treatment in this population typically begins with lifestyle alterations, such as diet and exercise. The participants often advise patients to increase their intake of fruits such as kiwi and papaya, noting that a dietitian referral can be very helpful in this regard.

Practice patterns regarding secretagogues vary considerably, with some providers moving to these agents first-line and others waiting until patients have failed fiber and OTC laxatives. The decision to start a secretagogue is driven by reimbursement, which often requires failure of at least 2 prior therapies. In such cases, clinicians often recommend PEG and provide patients with samples while waiting for prior authorization.



Providers vary in how they initiate linaclotide, with some starting at 72 mcg daily to avoid diarrhea and others starting with the indicated 290 mcg dose, particularly in patients with severe abdominal pain. When starting at the indicated dose, however, it is important to educate patients about the potential side effects and set appropriate expectations.

IBS-C management

Patient preferences, predominant symptoms, and reimbursement issues are key drivers of treatment choices in IBS-C.



ACG and AGA Recommendations for Pharmacologic Therapy of IBS-C

	ACG Recommendation ¹			AGA RECOMMENDATION ²		
	-/+	TYPE	QUALITY OF EVIDENCE	-/+	TYPE	CERTAINTY OF EVIDENCE
PEG	-	Conditional	Low	+	Conditional	Low
Lubiprostone	+	Strong	Moderate	+	Conditional	Moderate
GC-C agonists Linaclotide Plecanatide	+	Strong	High	+	Strong Conditional	High Moderate
Tegaserod	+	Conditional	Low	+	Conditional	Moderate
Tenapanor				+	Conditional	Moderate

+, Recommends or suggests use; -, Recommends or suggests against use.
¹Limited for use of tegaserod in women <65 years of age with ≤1 cardiovascular risk factors who have not adequately responded to secretagogues.
 ACG, American College of Gastroenterology; AGA, American Gastroenterological Association; GC-C, guanylate cyclase-C; PEG, polyethylene glycol.

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 If there's not a significant severe pain component even in the tertiary care center, I would still optimize PEG for the right patient. If there is significant pain and a lot of bloating which we know PEG can worsen, then I may skip that and go directly to an FDA-approved therapy.

APP participant

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 When a patient comes in, we determine what type of patient they are. Are they going to want a particular route, or is this going to be a patient who is more appropriate for medication? I think we have to personalize and individualize patient care, depending on their needs, their demands, their preferences.

APP participant



Current practice patterns indicate that education is needed to help community clinicians better understand and adhere to guidelines for IBS diagnosis and management. Given their role in referring patients, primary care providers are an important target for this type of education.

Various educational tools can be useful in improving clinician adherence to IBS guidelines. For example, a diagnostic algorithm for community practices has been developed and is available on the American Association of Nurse Practitioners (AANP) website.

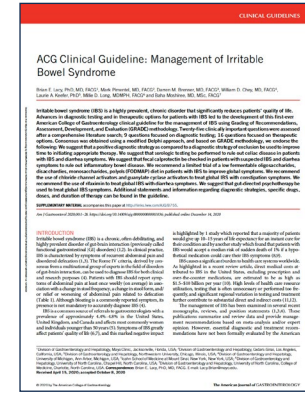
Recognizing the need to educate patients with IBS, the participants recommended the International Foundation for Gastrointestinal Disorders (IFFGD) website as a good resource for patients. Other useful resources include the book *Gut Feelings* and related podcasts, which discuss the brain-gut axis. Education on the dietary management is also an important need for patients.

EDUCATIONAL RESOURCES for managing ibs-c

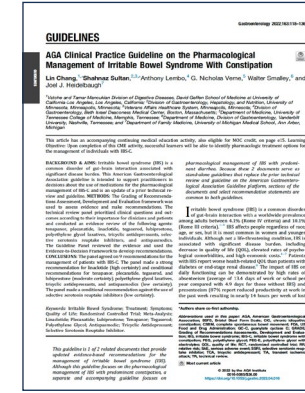
Various educational resources are available to help community clinicians better understand and adhere to current recommendations for managing IBS-C.



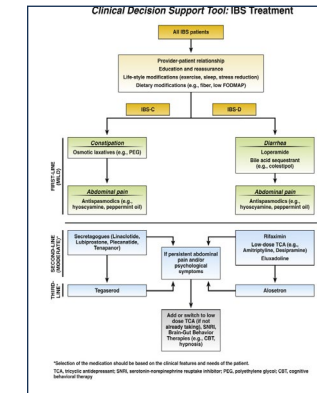
FOR CLINICIANS



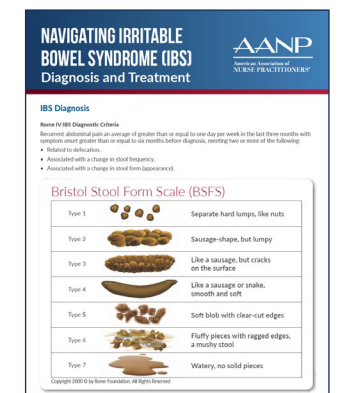
ACG Clinical Guideline: Management of IBS



AGA Clinical Practice Guideline for the Pharmacologic Management of IBS-C

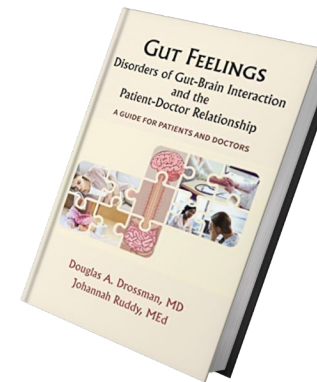


AGA Clinical Decision Support Tool for IBS Treatment

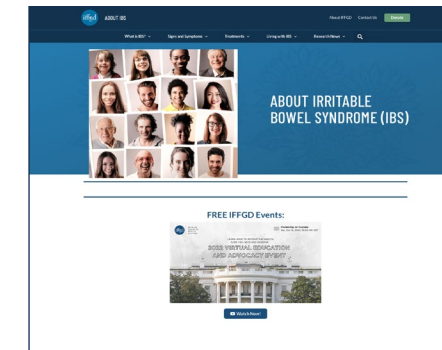


AANP Navigating Irritable Bowel Syndrome

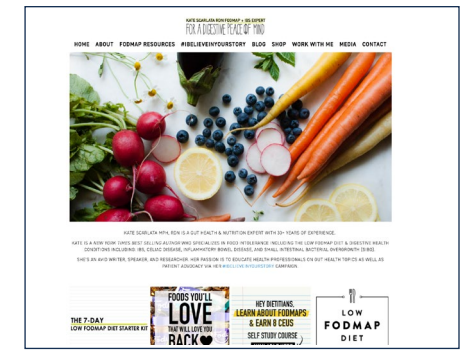
FOR PATIENTS



Gut Feelings—Disorders of Gut-Brain Interaction and the Patient-Doctor Relationship
Douglas A Drossman, MD



About IBS
International Foundation for Gastrointestinal Disorders



For a Digestive Peace of Mind
Kate Scarlata, RDN

References

1. Smalley W, Falck-Ytter C, Carrasco-Labra A, et al. AGA clinical practice guidelines on the laboratory evaluation of functional diarrhea and diarrhea-predominant irritable bowel syndrome in adults (IBS-D). *Gastroenterology*. 2019;157(3):851-854.
2. Lacy BE, Pimentel M, Brenner DM, et al. ACG clinical guideline: management of irritable bowel syndrome. *Am J Gastroenterol*. 2021;116(1):17-44.
3. Chang L, Sultan S, Lembo A, et al. AGA clinical practice guideline on the pharmacological management of irritable bowel syndrome with constipation. *Gastroenterology*. 2022;163(1):118-136.