GHAPP
Gastroenterology & Hepatology Advanced Practice Providers

IBS clinical roundtable

January 2023 IBS-D 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-D are summarized in this issue.

The participants believe that the most common tests used to evaluate patients with chronic diarrhea in clinical practice are stool studies and colonoscopy. Stool studies are performed very frequently in the community, often ordered by primary care providers. Many primary care providers are also ordering colonoscopies in this population. However, the participants noted that many community providers immediately refer patients with diarrhea to gastroenterologists since they do not have the time to evaluate suspected IBS.

Consistent with and American College of Gastroenterology (ACG) and American Gastroenterological Association (AGA) guidelines for IBS,[1-3] the participants routinely obtain celiac serologies and C-reactive protein (CRP) when evaluating patients with diarrhea. Some of the participants consider celiac serologies to be especially helpful in evaluating patients with prominent bloating. Participants typically order colonoscopies only in patients with elevated fecal calprotectin or CRP with suspected inflammatory bowel disease (IBD). Importantly, the term diarrhea must be included when ordering a colonoscopy since insurance reimbursement is unlikely if only IBS is cited.

The participants rarely order tests for bile acid diarrhea, commenting that their management does not change whether the patient has IBS-D or bile acid diarrhea.

THE IBS-D work-up

Adherence to current guidelines for diagnosing IBS-D is poor among community providers, with many clinicians ordering stool studies and/or referring patients with diarrhea without pursuing any evaluation.

> **From a community-based perspective, I see stool studies all the time. And we know that if someone has diarrhea that's chronic, it's unlikely that it's infectious. And I even see stool studies repeated, which I don't understand at all. And it comes not only from our GI counterparts but also from primary care doctors.**
>
> APP participant

Consistent with AGA guidelines, many patients with IBS-D are already receiving antidiarrheal agents when they are referred for specialist care. However, the participants also see patients from the community who have been prescribed inappropriate treatments, such as pancreatic enzyme replacement therapy, which they attribute largely to the effects of patient-focused advertising campaigns.

The participants agreed that rifaximin is the most common first-line therapy they prescribe for their patients with IBS-D. In addition to its efficacy, rifaximin is safe and its use is not limited by concerns over potential toxicities associated with other IBS-D therapies (eg, ischemic colitis with alosetron, pancreatitis with eluxadoline). However, in some cases there is a need to bridge treatment with loperamide while waiting for prior authorization for rifaximin.

Although eluxadoline is not used first-line due to safety concerns, it can be useful as alternative therapy in patients who fail rifaximin. Antispasmodics or peppermint oil are also used in these patients, while those with significant anxiety are typically referred to a psychologist or considered for treatment with a tricyclic antidepressant (TCA) or selective serotonin-norepinephrine reuptake inhibitor (SNRI).

The participants rarely use TCAs in their patients with IBS, although they do prescribe selective serotonin reuptake inhibitors (SSRIs) or SNRIs in those patients with severe anxiety about their symptoms. Acknowledging the limited data regarding SSRIs in IBS, these therapies are sometimes used to address the psychological component of the disease in patients with IBS-C. In patients with IBS-D and severe anxiety, participants often consider use of an SNRI despite a lack of data in this setting.

IBS-D management

Rifaximin is commonly used as first-line therapy in patients with IBS-D because it is safe, effective, and requires only a 2-week treatment course.

> **With rifaximin, you don't have to take it daily, you don't have to take it long-term. If you get better, you're better, and there's an option for retreat...if they can access it.**
>
> APP participant

ACG and AGA Recommendations for Pharmacologic Therapy of IBS-D

	ACG Recommendation[1]			AGA RECOMMENDATION[2]		
	–/+	TYPE	QUALITY OF EVIDENCE	–/+	TYPE	CERTAINTY OF EVIDENCE
Loperamide	–	Conditional	Low	+	Conditional	Very low
Rifaximin Retreatment[a]	+ 	Strong	Moderate	+ +	Conditional Conditional	Moderate Moderate
Alosetron[b]	+[b]	Conditional	Low	+	Conditional	Moderate
Eluxadoline	+	Conditional	Moderate	+	Conditional	Moderate
Bile acid sequestrants	–	Conditional	Very low			

+, Recommends or suggests use; –, Recommends or suggests against use.
[a]In patients with initial response to rifaximin who develop recurrent symptoms.
[b]Limited to women with severe symptoms who have failed conventional therapy.

ACG and AGA Recommendations for General IBS Pharmacotherapies

	ACG Recommendation[1]			AGA RECOMMENDATION[2]		
	–/+	TYPE	QUALITY OF EVIDENCE	–/+	TYPE	CERTAINTY OF EVIDENCE
Low FODMAP diet	+	Conditional	Very low			
Antispasmodics	–	Conditional	Low	+	Conditional	Low
Peppermint oil	–	Conditional	Low			
Probiotics	–	Conditional	Very low			
TCAs	+	Strong	Moderate	+	Conditional	Low
SSRIs				–	Conditional	Low
Gut-directed psychotherapies	+	Conditional	Very low			

FODMAP, fermentable oligosaccharides, disaccharides, monosacchardies, and polyols; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants.
+, Recommends or suggests use; –, Recommends or suggests against use.

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.

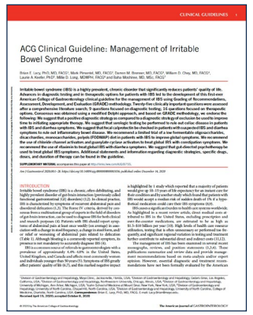
Various educational tools can be useful in improving clinician adherence to IBS guidelines. For example, a diagnostic algorithm for community practices has been developed and is available on the American Association of Nurse Practitioners (AANP) website.

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-d

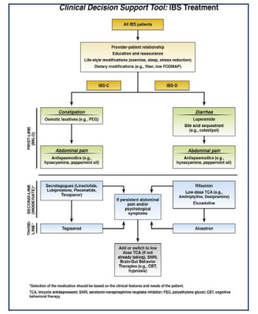
Various educational resources are available to help community clinicians better understand and adhere to current recommendations for managing IBS-D.

FOR CLINICIANS

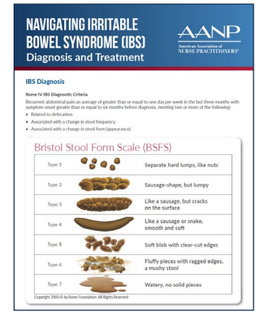


ACG Clinical Guideline: Management of IBS

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

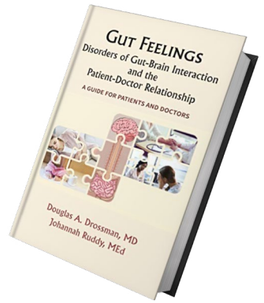


AGA Clinical Decision Support Tool for IBS Treatment

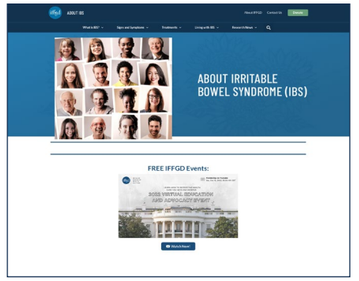


AANP Navigating Irritable Bowel Syndrome

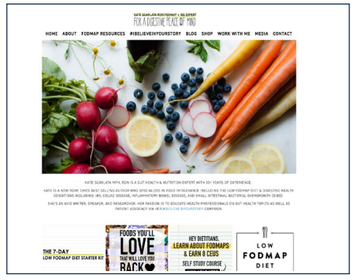
FOR PATIENTS



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-Yitter 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. Lembo A, Sultan S, Chang L, et al. AGA clinical practice guideline on the pharmacological management of irritable bowel syndrome with diarrhea. *Gastroenterology.* 2022;163(1):137-151.