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Diagnosing IBS-D: Best Practices for Primary Care Providers

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD, and this episode is supported by Salix Medical Affairs. And now, here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Brian McDonough. Today, I'm joined by Dr. Holly Greenwald to talk about the critical role of primary care providers in diagnosing irritable bowel syndrome with diarrhea, or IBS-D for short. She's an Assistant Professor of Clinical Medicine at the Temple University Lewis Katz School of Medicine. Dr. Greenwald, welcome to the program.

Dr. Greenwald:
Thanks for having me.

Dr. McDonough:
So to start us off, Dr. Greenwald, what are some of the common misconceptions about IBS-D, and how can they affect patients?

Dr. Greenwald:
There are many common misconceptions about irritable bowel syndrome with diarrhea, more commonly referred to as IBS-D. The first thing people can mix up is whether IBS-D is the same thing as IBD; three letters, a lot of the same letters, but they are very different. Irritable bowel syndrome with diarrhea, or IBS-D, is a gut-brain axis disorder that involves abdominal pain with diarrhea. IBD, or inflammatory bowel disease, is an autoimmune inflammatory condition of the gut that has a whole different pathogenesis and treatment pathway. So that's the first thing.

The other thing is that people are told, "It's just nervous stomach, it's just stress, it's all in your head," and they don't really understand what's driving this abdominal pain with diarrhea that really characterizes IBS-D. And so if you don't understand why you're having the symptoms, it can lead to a lot of misconceptions. It's also been considered, in the past, a diagnosis of exclusion, but the way we think about IBS-D now is very different. We don't look at it in those terms.

And the last misconception is that because people think it's just in your head, they don't think that there's any treatments for it. But there are a lot of treatments out there with a really good evidence base.

Dr. McDonough:
And how might these misconceptions contribute to unmet patient needs?

Dr. Greenwald:
I think getting the diagnosis right is part of leading to better outcomes for people. So if you're not understanding the disease where it starts and how to manage it, that can cause patients a lot of anxiety, unnecessary testing, and delay in diagnosis. And all of that can really impact someone's quality of life. Time missed at school, with family, or at work can really impact patients negatively. There's also a stigma when people are told this disease is all in your head, and that can lead to poor self-esteem and more anxiety.

Dr. McDonough:
So given these gaps in care and the impacts they can have on patients, Dr. Greenwald, let's zero in on how we can make an accurate diagnosis. What aspects of the patient's history and physical exam might indicate a patient has IBS-D?

Dr. Greenwald:
So from the start, irritable bowel syndrome with diarrhea is a clinical diagnosis. That means this is something I can diagnose in the

office, just with the history and physical exam. There are some key things that I'm listening for when someone is telling me about their symptoms: how long has this been going on? Is this a lifelong process? Is this chronic with everyday symptoms? Or is it intermittent, coming and going? Did it start after an event, whether that was a particularly stressful life event or a GI infection, and then the symptoms have lingered more? Those things might clue me in to irritable bowel syndrome.

I'm looking to find out the link between the pain and the change in the bowel habits. Based on the diagnosis criteria put out by the Rome Foundation, I'm looking for abdominal pain that is associated with a change in bowel habits, whether that's more frequent stools or the form of the stool has changed. I'm also looking at what type of diet a patient has. There are certain mimics of irritable bowel syndrome that may be related to what you're eating, as well as medications, family history, substance use disorder, and prior surgical history.

Dr. McDonough:
And rather than simply ruling out other conditions, how can we apply the positive diagnostic approach to examine clinical criteria and medical history in patients who may have IBS-D?

Dr. Greenwald:
So the first thing I'm listening for is, does your clinical syndrome you're coming to see me with fit with the criteria I mentioned? That's abdominal pain associated with a change in bowel form or frequency at least one day a week. That's the baseline criteria.

Then I'm listening for red flag symptoms. Are there things that make me doubt that this is irritable bowel syndrome? Those might be onset at a later age, especially over 50. The presence of blood in the stool is an alarm symptom. Is the diarrhea waking you up at night? That's also an alarm symptom. These types of things—like abnormal blood work that might have been present beforehand that shows anemia—tell me that something else might be going on and that a different workup might be needed.

But when I see a patient who tells me they have classic symptoms without any of these alarm symptoms, I think, this is most likely irritable bowel syndrome. And then I use those words and I tell them out loud, “This is most likely irritable bowel syndrome.” That's a positive diagnosis. I'm telling the patient, “This is what I think you have.” And then the next thing I do is order several tests to confirm my diagnosis. I say, “I'm ruling these things out, not because I think you have them, but because they are mimics and I don't want to miss them. But what I think you have, again, is IBS with diarrhea.” That makes the frame for the patient. They expect those tests to be negative, and they're not surprised when they are. And they're not feeling like, “Now we don't know what's going on because the tests were negative.” Instead, they have been told, “This is what you have, and I've excluded these other things.”

Dr. McDonough:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Holly Greenwald about diagnosing IBS-D in the primary care setting.

Now, to avoid gaps in communication, what are some key points to discuss with patients diagnosed with IBS-D?

Dr. Greenwald:
When I have made that positive diagnosis, gotten my confirmatory stool tests that have come back negative, and excluded celiac disease and inflammatory bowel disease, I say there are many treatments, and I review the pathophysiology of what we understand to be IBS. I think this is key to patients understanding what is going on with them.

The first thing I talk about is that I hate the name irritable bowel syndrome with diarrhea. I think that it doesn't really encompass what the disease is. The Rome Foundation, which is the group that categorizes these disorders, has renamed this type of disease a disorder of gut-brain interaction, or a DGBI. And that really captures the pathophysiology behind irritable bowel syndrome. So I always take a moment to describe how IBS is an abnormal connection between the brain and the gut. There was probably some type of trigger—whether that was an infection, a stressful event, or something else—that made that connection so strong that different things are triggering it, whether the system should be causing diarrhea or not. And that way, patients can understand a little bit more about their disease. We can focus on identifying triggers for their irritable bowel syndrome and move on to the next phase, which is focusing in on what is the most bothersome symptom. There are many treatments out there, both pharmacologic and non-pharmacologic that can help patients feel better.

A lot of patients pursue complementary and alternative medicine techniques, even before they come to see me as a gastroenterologist. And primary care doctors would be surprised to know how many patients are pursuing vitamin supplements, probiotics, massage therapy, acupuncture, and lots of other tools that are out there as they're trying to grapple with their symptoms. I think patients with digestive complaints pursue complementary and alternative medicine, and they don't often bring it up to them unless you ask. So as part of my standard practice, I ask people what they've been trying, and I'll enumerate these things so I get a better sense. And there is some role and some data for these as management tools for irritable bowel syndrome.

Dr. McDonough:
As we approach the end of our program, can you share some best practices for communicating with patients throughout the diagnostic journey?

Dr. Greenwald:
When you have somebody with irritable bowel syndrome with diarrhea, it can be so bothersome. It can ruin their day. They might not be able to do the things that they want to do. But knowing that a clinician understands their symptoms, has made a diagnosis, and is linking that to treatment can really help turn things around. They don't feel abandoned in that way. So I always recommend taking the time to explain IBS in the context of a disorder of gut-brain interaction, which is our current understanding. I recommend focusing in on the most bothersome symptom for them and linking that to a treatment option. And then keep in the back of your mind, what are those red flags and can't-miss symptoms that might point me in a different direction? And those should be re-evaluated when a patient with IBS comes to see you having a flare of their symptoms; we want to make sure we're still working with the right diagnosis.

Certainly, as patients become more complex in their disease severity, there can be a role for multidisciplinary care. When I have a patient with very difficult to control irritable bowel syndrome with diarrhea, I'll employ the assistance of a registered dietitian to help look at food choices and food groups that promote bloating and discomfort. That way, patients can avoid extremely restrictive diets that can be peddled online or by influencers on social media without making sure they're getting all the nutrients that they need.

With the role of this disease as a mind-body disorder, stress reduction can be incredibly important for these patients, and so working with a mental health team is paramount to care for some of my patients. And I've developed some very close bonds with my primary care colleagues who are seeing these patients maybe more than I am and have a better insight into their global care.

Dr. McDonough:
As those final comments bring us to the end of our program, I want to thank my guest, Dr. Holly Greenwald, for joining me to discuss key considerations for diagnosing IBS-D in the primary care setting. Dr. Greenwald, it was great having you on the program.

Dr. Greenwald:
Thank you so much.

Announcer:
This episode of *Clinician's Roundtable* was supported by Salix Medical Affairs. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!