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Rethinking IBS-C Goals: A Patient-Centered Approach

Announcer:
You're listening to *GI Insights* on ReachMD, and this episode is sponsored by Ardelyx. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *GI Insights* on ReachMD. I'm Dr. Charles Turck, and joining me to explore how we can set realistic patient-centered treatment goals in irritable bowel syndrome with constipation, or IBS-C for short, are Dr. Harish Gagneja and Rohit Singhania. Dr. Singhania is a board-certified gastroenterologist at Connecticut GIPC, and serves as Section Chief at Manchester Memorial Hospital in Connecticut.

Dr. Singhania, thanks for being here today.

Dr. Singhania:
Thank you for having me.

Dr. Turck:
And Dr. Gagneja is a board-certified gastroenterologist at Austin Gastroenterology in Texas. He's also a Master of the American College of Gastroenterology and Vice Chair of its Board of Governors, and a member of its Board of Trustees. Dr. Gagneja, it's great to have you with us as well.

Dr. Gagneja:
Thank you, Dr. Turck. Thank you for having me again. I appreciate it.

Dr. Turck:
So let's start with some background. Dr. Singhania, from your perspective, how has our understanding of treatment goals in IBS-C evolved over the years, particularly as we've shifted away from the idea of achieving a cure?

Dr. Singhania:
So the first thing that is important to understand is it's a disorder of brain-gut interaction. And so addressing that side of things is important.

Neuromodulation is an important component of this treatment and of this disorder. And sustained treatment is required to control these symptoms, rather than a short-term treatment. So I think those are the two key points.

And then the outcomes we are looking for are meaningful improvement in the quality of life and meaningful improvement in the global symptom perception of the patients. There used to be a time where we used objective markers, and bowel movements were the outcomes we were looking in clinical trials.

But even in all the studies now, we do what we call patient-reported outcomes. And, in that, one of the things that we measure in the studies that are done with this is how the patient is feeling. That matters. How is the quality of life of the patient, and is that being improved by what we are doing?

Dr. Turck:
Turning to you now, Dr. Gagneja, when we talk about meaningful improvement in IBS-C, what does that actually look like in clinical practice?

Dr. Gagneja:

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When we look at the response in a patient, even the studies define the response as a composite endpoint. What do I mean by that? What I mean by that is that, yes, frequency of bowel movement is important, but also you should look at the abdominal pain and bloating, and when you combine all those, that is really a composite endpoint you're looking at.

So we assess their bloating, their discomfort, and also their quality of life after starting the treatment. Success, really, when you really look at it, it is not one thing only; it's a multidimensional. You are looking at improvement in quality of life. You're looking at improvement in their bloating. You're looking at improvement in their abdominal pain and improvement in the frequency of bowel movement, but also one other symptom, which is very, very important: incomplete evacuation. Some people come to my office and all they have is they cannot evacuate completely. That is really bothersome for them. So you're going to look at that as well.

But sometimes, there are also tradeoffs. Sometimes, with the constipation relief, they start having diarrhea. So how do you put all that together? So that's where you really look at the overall picture of the patient and not just only one thing, which is an increased frequency of bowel movements.

Dr. Turck:
Given the multidimensional nature of this condition, Dr. Singhania, how might clinicians more effectively assess treatment response beyond traditional metrics?

Dr. Singhania:
Symptom diaries are a great way to assess the response, because recall is not very reliable when the patient is seeing you, say, in six weeks or eight weeks. So recording their symptoms and how many bowel movements they're having helps the physician review this in detail.

Also, global symptom relief scales are helpful in assessing the degree of benefit that the patient has and how they prioritize their symptoms. Sometimes, their symptom that's most interfering with their life or lifestyle would be pain or bloating rather than the fact that they're not having bowel movement.

Also in this, there's always discordance between objective measures and patient perception, so keep that in mind. And then brief structured check-ins intermittently, say, every month or every other month, can be very, very helpful in assessing a patient's adherence and compliance to treatment. By responding to treatment with those tools in your hand, we can make sure that the patients are taking their medication, assess them in a rapid fashion, not get into clinical inertia, and then modify treatment, assessing them for a switch or addition of therapies to get them to a better place.

Dr. Turck:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Harish Gagneja and Rohit Singhania about establishing practical and achievable treatment goals for patients with IBS-C.

So, Dr. Gagneja, up until this point, we've been talking about redefining success, but let's shift gears now and focus on aligning those goals with long-term management. Knowing that IBS-C is a chronic relapsing condition, how do you typically set expectations with patients early on?

Dr. Gagneja:
So, when we see patients first, you said it in your question: it's a chronic relapsing disease. So this is the one expectation I really have to set with my patients right upfront. If we're meeting this time, we're doing this, and we're talking about all this. But remember, this is a chronic condition that will go up and down. It will wax and wane. So we talk about that.

And symptoms will fluctuate. I also tell them that, because this is a disease that is multifactorial, and your mental status will also change your symptomatology and whether it's going to wax or wane. So over time you will have periods of stability, but you will also have periods where your disease is not under control.

So we need to talk about all that—exacerbation versus stability. And then, how do we follow that or manage that? So we should be a constant touchpoint for the patient, defining what partial response is, what complete response is. We talk about that as well.

And we are also flexible in our treatment plans. Sometimes, what happens is they're on a medication, and then the medicine is not working. Or it's working very well. Then we say, you know what? You can maybe decrease the frequency or dose of the medication. Or sometimes, if they're having exacerbation symptoms, then we say, let's add something else to it, so that we have a synergistic response.

So that's how we, overall, manage the patient's symptoms, because we really set this stage right up front that this is a chronic disease and we're going to continue to work together as a team. What I also tell my patient is that I am here for you. I know you leave your work, you are paying your copays, you are looking for some relief, but it is my duty to be your team member who's firm on your team. So let's

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work together and take care of this problem.

Dr. Turck:
And Dr. Singhania, when it comes to treatment selection, what's your approach to balancing clinical decision making with patient expectations around symptom relief?

Dr. Singhania:
Multimodality treatment is important. We start with prescription medications like secretagogues or prokinetics in patients who have, let's say, not had complete response to over-the-counter treatments. So once we start these medicines, then we reassess the patient for relief of symptoms.

And if the patient continues to have, let's say, pain that's persisting, then we add neuromodulators to address that component of visceral hypersensitivity and to modulate the central pain perception. And then we reassess. And usually, you give at least six weeks, 10 weeks, or 12 weeks, depending. Time goes by fast.

And then, to manage other symptoms like bloating and discomfort, diet plays an important role. There's a lot of fast food. There's a lack of fiber. There's a lack of understanding regarding the different types of fiber and what their roles are. The insoluble fiber causes bloating, and the soluble fiber helps with bowel movements and gut health. And then what's the role of fruits and vegetables? How do you incorporate regular timing? So I feel diet has a huge role to play in managing those symptoms and managing your stress.

Managing the entirety of your lifestyle also plays a part in managing this condition. So we address all of those when we talk to patients. So combination therapies are often needed. There is a secretagogue to manage the bowel movement. There's a pain component, and then there's a lifestyle component.

So we bring them all together, we tailor the approach to the typical patient, and we and try to meet them where they are. It may take time, so don't give up. Adjust treatment, modulate, address the symptoms that are not responding, and keep the wins that you have. And sometimes, you need to switch to another therapy. So we play with all these things and then, generally speaking, we can achieve good control and a great quality of life for a lot of patients.

Dr. Turck:
Before we come to the end of our program, Dr. Gagneja, would you walk us through how shared decision-making plays a role in setting realistic patient-centered goals and sustaining long-term engagement?

Dr. Gagneja:
If you really do not set the realistic goals upfront—and especially patient-centered goals—then you will have trouble with sustaining long-term engagement. So it's very, very important. So how do we do that? Number one, we define success upfront. How do we do that? What are the targets? What are we looking for as a team: the patient and me? How long are we going to use this treatment? If we're doing that, what are the trade-offs—cost or some other side effects? Some nausea? Sometimes, some of these medications cause diarrhea and urgency in bowel movements. So you have to discuss all that upfront with the patient so that they understand what they're getting into.

And once you discuss side effects and everything else upfront, when they're expecting it, you'll save a portal message, you'll save a call from the patient, and they'll know that it's coming, and it really will improve adherence for the patient.

Secondly, as we said earlier in the program, it is a chronic relapsing disease, so we clarify expectations when to discontinue medications and hopefully they do not prematurely discontinue those medications.

And also, treatment is individualized. Some patients want to have a bowel movement every day or every other day. Some are happy with two times a week and they're not having any other symptoms: no bowel pain, no bloating. Is it okay? Yes, it's okay, because really, the definition of constipation—or diarrhea, on the other hand, which is either three bowel movements a day, and more than that is diarrhea—is one bowel movement every three days.

Anything in between is normal, right? So that's what we define as gastroenterologists. So it's very important that we prioritize what the patient wants. Incorporating the patient's priorities and what their preferences are and what they're looking for is important. The other important thing is that we encourage really ongoing dialogue and also follow ups.

So when I start my patients on treatment, I follow up within a month the first time—or six weeks, I should say, because six weeks is the time when they really start getting a response. Then, next time, I follow up at three months. Now, if everything is set and we already set the goals of the treatment, I just follow them once every six months or once every year.

Dr. Turck:

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With those final thoughts in mind, I want to thank my guests, Dr. Rohit Singhania and Harish Gagneja, for joining me to share their insights on treatment goals and long-term management in IBS-C. Dr. Singhania, Dr. Gagneja, it was great speaking with you both today.

Dr. Gagneja:
Thank you very much. I thank you, Dr. Singhania, for joining me.

Dr. Singhania:
Thank you, Dr. Gagneja, for having me, and thank you, Dr. Turck. It was a pleasure.

Announcer:
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