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Managing Partial Response in IBS-C Care

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:
This is *GI Insights* on ReachMD, and I'm Dr. Charles Turck. Today, we'll be looking at partial response in irritable bowel syndrome with constipation, or IBS-C for short, and the clinical signals that support a shift to a new treatment class. Joining me in this conversation are Dr. Harish Gagneja and Rohit Singhania. Dr. Gagneja is a board-certified gastroenterologist at Austin Gastroenterology in Texas, and 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, welcome to the program.

Dr. Gagneja:
Thank you, Dr. Turck. Thank you for having me again on this program.

Dr. Turck:
Absolutely. And Dr. Singhania is a board-certified gastroenterologist at Connecticut GIPC, and serves as Section Chief at Manchester Memorial Hospital in Connecticut. Dr. Singhania, it's great to have you with us as well.

Dr. Singhania:
It's a pleasure. Thank you for having me too.

Dr. Turck:
I'd like to kick things off with a patient case. Dr. Gagneja, let's say you have a patient with IBS-C who's been on a secretagogue for about six weeks. They've had some improvement in stool frequency, but they're still having fewer than three complete bowel movements per week, along with persistent abdominal pain and bloating. How would you assess their response at this point?

Dr. Gagneja:
Great question. When we look at the response to IBS-C globally, we look at patients' frequency of bowel movements. We look at bloating. We also look at abdominal pain. So when you look at the global response to treatment, six weeks is not really enough.

I give it about 12 weeks or so. Six weeks is very good when you're looking at the frequency of bowel movements. But for persistent symptoms, if they're having partial relief already, I'll give them a little bit more time. And guidelines emphasize that as well, that you need to look at the global symptoms rather than just frequency of bowel movements. We know that IBS-C is multifactorial, so one factor is not going to change patients' overall perception of response. You also take into account patient's quality of life as well. How has their quality of life changed compared to what it was before?

Remember, we are gastroenterologists, so patients don't come to us. They are really taken care of by the primary care physicians, and when they are not responding to over-the-counter medications, or the class one and class two medications, as I call them. then they come to us. So if they're severe—let's say they're having one bowel movement every seven days—and now they're having two or three bowel movements every week, that's a good response for that patient.

So that's how I assess the response globally, as well as taking into account where the patient started and how the patient's quality of life is.

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Dr. Turck:
Now, Dr. Singhania, in the same patient case, what additional factors like symptom pattern, patient preferences, or treatment history would help guide your next steps?

Dr. Singhania:
Yeah, I think all three of those points are very, very important. I think patient preferences play into how they want to take their medicine, when they want to take their medicine, and what they want to take. Every patient is unique. We want to target treatment in a personalized fashion. So understanding the nuances of that is where the art and the science of medicine come together here.

And then, like Dr. Gagneja said, the bowel movements will give you an answer between four to six weeks, but the bloating, the pain, the global symptom improvement, the quality of life, that's something where we want to meet the patient, have a conversation about it, and understand what the key points are that are improving and how much relief the patient has.

One of the things that I use in my practice is I ask them through multiple angles. Let me use the word triangulate. So I'll ask them, how are you feeling? How much improvement do you have? And then I'll go to something like a scale: zero meaning no improvement, a hundred percent meaning completely fine. And then, where on that scale are you? And that will give me another sense.

So it's not just one response, but using multiple responses and multiple open-ended questions to assess what's really going on. And during that conversation, sometimes patients will reveal things that they themselves don't know are happening or going on. So that's what I would say.

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 what to do when a patient with IBS-C is only getting partial relief.

So with that case as a backdrop, let's get into some more specifics. Dr. Gagneja, what else can you tell us about how you decide when a therapy has truly fallen short versus just needing more time before we see an adequate degree of efficacy?

Dr. Gagneja:
The most important thing is, how much time is adequate trial duration? Is it four weeks, six weeks, eight weeks, 12 weeks? So I like to give 12 weeks—six weeks for the frequency of bowel movement only, but overall, 12 weeks.

But the second most important part is adherence. Is your patient is taking the medication that was prescribed? Was this medication even was covered by the insurance company? We look at whether they picked up the medication from the pharmacy. Yes, it was prescribed. But if they're not taking the medication, there's no response. So that is important.

The second thing is that studies will say, oh, three bowel movements a week. Those are usually what I call a home run. If you look at the study—3 percent placebo, 17 percent with the medication. 17 percent is not enough. But remember, studies are looking at the home runs. I always give this baseball analogy that you score runs by singles, double, triples, and home runs. So you don't always need to look at just the home runs. You look and see what the starting point was and where the patient is overall.

Also, you want to make sure that your patient's overall quality of life is better before you decide about switching your drug class. So meaningful quality of life—it's important to look at all the global symptoms, making sure that the patient is adhering to their medication, and adequate trial duration.

Dr. Turck:
And coming back to you, Dr. Singhania, what role can clinical decision inertia play at this stage, and how do you decide when it's time to move beyond dose adjustments within the same class, if that's even appropriate?

Dr. Singhania:
So, yes, clinical inertia is an important thing that we need to guard against in these patients, because the more we hesitate or not decide to change treatment or address the patient's symptoms, the more we are compromising the quality of life and leaving the opportunity on the table.

So it's a nuanced balance. Like Dr. Gagneja said, adherence is clearly important. Once you have confirmed, let's say, if you have confirmed adherence and the bowel movement is better, I look for subtle signs during my interview with the patient. Follow up is very important. And then with those subtle things, I'm triangulating, how much improvement is the patient really having? Are we hitting all of those four goals: quality of life, global symptom relief, pain, bloating—not just the bowel movement.

It's very easy to think of IBS-C as constipation, and to, once the patient is having diarrhea—which is a common side effect of many of these medicines—say, oh, you are treated, I can't do anything for you. But if you are treating the whole patient and the pain limits their

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quality of life, their ability to socialize, their ability to enjoy, and their ability to work efficiently, then you need to go beyond what you are doing, and you should not hesitate to try a class switch. And there are several options to address that problem.

Dr. Turck:
Now, before we wrap up, I have a question for each of you about how we can turn assessment into action. Starting with you, Dr. Gagneja, what are some practical steps clinicians can use to evaluate treatment trajectory and determine when it's time for a class switch?

Dr. Gagneja:
So, as I said before, earlier, I said the most important thing is looking at the three domains. I call it three domains, which are your frequency of bowel movements, abdominal pain, and bloating. So assess everything. Assess globally how your patient is doing, and assess what their quality of life is. For some patients, coming from not having one bowel moment a week to two bowel moments a week is probably good enough as long as, globally, they're feeling fine.

So, for that reason, I would say nothing needs to be changed, but I think the periodic reassessment is very important. So what I do is I look at those symptoms. At first, when I'm starting a treatment and they are suffering, I see them maybe in a month, then maybe in a three months. Once they stabilize, I'll see them probably in six months to 12 months. But I think periodic reassessment of global symptoms and looking at all of the three domains that are important before you make a decision regarding a class switch is key. I don't like to rush into a class switch.

The reason for that is that we have a limited number of treatment options available after you exhaust all of the over-the-counter treatment options, so you want to make sure that you maximize a class of drug before you move on to next one.

Dr. Turck:
And finally, Dr. Singhania, when you are considering a class switch, how do you approach conversations with patients who may be hesitant to give up even partial symptom relief?

Dr. Singhania:
So that's the most important conversation I think, and I completely agree with Dr. Gagneja. I think we're pointing to the same kind of direction where, if you're too fast to switch, you could lose the drug that is going to be effective with a little bit more time, when there's lack of adherence or some other problem. So it's a nuanced decision, and every patient is different. And so it takes time. Sometimes, some patients need more time if they haven't been adherent.

You bring them for follow up in three months or six months, and then, the most important conversation that I like to have with the patients is about the treatment trajectory. And I usually have that on the first visit when I'm prescribing these medicines. I like to clarify the goal. My goal is complete normalization, right? That is always my goal, that you shouldn't have any of these symptoms. Now, how likely is it that we are going achieve that goal, and what will our wins be along the way?

With IBS, we have to say that cure may not be the right goal. Control is better. And we are going to move stepwise. We're going to get some wins like Dr. Gagneja said: get the ones and the twos, rather than the home runs. So first, the stooling improves, then we reassess what the symptoms are. For example, pain is a common symptom, and bloating is a common symptom. If that's present, then you can consider some of the newer, different mechanisms of action.

Also, if pain is the predominant symptom, then if I may use the tricyclic antidepressants. Those medicines are also in part of the catalog.

You start with the over-the-counter treatments. You go to a regular secretagogue. You assess adherence, and you see how much of a response there is. Are there any side effects? And then you assess the pain and the bloating. And then, if those things have not improved with one treatment, then certainly, you can go to another one.

To address your main question, which was, how do I approach the conversation of partial response and patients not wanting to give up on that—it is a nuanced discussion. It is developing that patient-physician relationship and trust to say, hey, we can always come back to that. You will regain effect. But let's try, because we want to get you through that finish line. And without trying, we are not going to get it. So that is that individualized trust building. And it is a more personalized conversation, but certainly you'll be showing them the positive aspect of that—that hey, you could be even better, and this try is worth it. And that is sometimes worth talking about.

Dr. Turck:
Great comments for us to think on as we come to the end of today's program. And I want to thank my guests, Dr. Harish Gagneja and Rohit Singhania, for joining me to discuss how we can recognize when patients with IBS-C may be ready for a change in treatment class and the steps we can take to help them get there.

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Dr. Gagneja, Dr. Singhania, it was great having you both on the program.

Dr. Gagneja:
Thank you so much. Thanks for having me.

Dr. Singhania:
Thank you for having me.

Announcer:
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