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Optimizing IBS-D Treatment in Primary Care

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 sitting down with Dr. Sheila Reddy and Ms. Carol Antequera to discuss key considerations for primary care providers when developing personalized treatment plans for patients with irritable bowel syndrome with diarrhea, otherwise known as IBS-D.

Dr. Reddy is a board-certified gastroenterologist at Austin Gastroenterology in Texas. Dr. Reddy, welcome to the program.

Dr. Reddy:
Hi, thank you for having me.

Dr. McDonough:
Also joining us is Ms. Antequera, who's a physician assistant specializing in gastroenterology at the University of Miami Health System. Ms. Antequera, it's great to have you with us as well.

Ms. Antequera:
Thank you so much. It's a pleasure to be here.

Dr. McDonough:
Let's just dive right in starting with you, Ms. Antequera, what nonpharmacologic treatments are available to help manage IBS-D?

Ms. Antequera:
So the nonpharmacological options that we have for the treatment of IBS-D include dietary modifications, such as the low-FODMAP diet. This is a diet in which patients will be avoiding fermentable oligosaccharides, disaccharides, monosaccharides and polyols. Basically, it's a diet that really focuses on reducing those carbohydrates that can really lead to more gas and bloating, which, in turn, leads to patients having symptoms of pain, discomfort, and diarrhea. And so this diet can be really helpful for these patients, although it's not meant to be done forever. It's really for more of a short period of time—sometimes between six to eight weeks—and then they can start reincorporating some foods back into their diet. When we discuss the low-FODMAP diet, because it's a diet and we're just changing the types of foods that patients are eating and it's only meant to be followed for a specific period of time, this diet has been proven to be very safe. Although, as a small caveat, I do tend to be careful in patients who have a history of eating disorders with this diet, and I make sure that if they do have a history of an eating disorder and we're recommending the low-FODMAP diet, that I really make sure that they're working with a dietician every step of the way to ensure that this doesn't lead to them having relapse of their eating disorder.

So that's one option for sure. Another option, which is dietary, can also be avoiding those specific food triggers that trigger patients to have symptoms, like caffeine, alcohol, fatty foods, dairy for those patients that are lactose intolerant, and artificial sweeteners like sorbitol and xylitol, which can also lead to more symptoms of gas, bloating, and diarrhea for these patients.

Another option that they have available is what we call soluble fiber, or psyllium husk, and this can be used as a bulking agent. Many patients hear the term fiber and they think that it's used only for constipation, but fiber can also be used for diarrhea as a bulking agent, and this can also help patients to have more formed stools. It has proven to have some effectiveness in helping patients compared to placebo. Another option that patients have that they can use is peppermint oil. This is a supplement that they could take before meals,

and it can also help to improve some of those symptoms of abdominal pain, cramping, and diarrhea.

And then we always think about stress management and some lifestyle and behavioral changes, which can also be effective in helping patients reduce their symptoms. We always encourage stress management, mindfulness, meditation, and breathing exercises, which can reduce the flares of irritable bowel syndrome. We also recommend for patients to incorporate regular exercise into their daily activities; even just a brisk walk or yoga class can also help them improve their gut motility as well as reduce stress.

Something else that we also recommend is adequate hydration. We want to make sure that our patients are drinking enough fluids, especially because if they are having diarrhea, they can get dehydrated. We also recommend that they have good sleep hygiene because if we're not getting good sleep, then that can also lead to more symptoms and stress, which can also lead to flares of irritable bowel syndrome.

Psychological therapy options are also very helpful for patients, and this is also considered a nonpharmacological approach. One of the options is cognitive behavioral therapy. Iirritable bowel syndrome is a disorder of the gut-brain interaction, and these types of therapies really help patients become in tune with their body and really try and control their symptoms, as well as some of the other symptoms that they may feel with IBS, like gas, bloating, distention, and hypersensitivity. There's also gut-directed hypnotherapy, which is done by a special therapist who really focuses on gastrointestinal disorders.

And then, of course, there's also another therapy which we call biofeedback. And this therapy also helps to regulate stress and that gut-related response. It really deals with more of those pelvic floor muscles, which can sometimes be hypersensitive in these patients, and so they can also find relief by having biofeedback therapy.

Dr. McDonough:
And turning to you now, Dr. Reddy, can you tell us about pharmacological treatments for managing patients with IBS-D?

Dr. Reddy:
So oftentimes, when we're talking about prescribing medications for patients with IBS and diarrhea, we try to figure out our main symptom, whether it be diarrheal symptoms, pain, or a combination of both. And one of those treatment options I often start with is called rifaximin it’s an antibiotic. We often use this for something called small intestinal bacterial overgrowth as there’s supposed to be bacteria in our colon, but sometimes, that bacteria migrates into the small intestine, and when that does, it can cause symptoms of bloating and diarrhea. And we think that there could be an interplay with IBS symptoms as well. So a lot of times, we treat patients with this antibiotic that's gut selective, and in a way, we're trying to change the microbiome or clean out the microbiome that should not be there in the small bowel and see if those symptoms of diarrhea or bloating improve.

Another type of medication is a tricyclic antidepressant, and it's an older class of antidepressants that have been used in the past. Some of the names are amitriptyline or nortriptyline, and what this type of medication does is decrease the gut motility—so diarrheal symptoms improve—but then it can also help with the pain component by binding to some of those nerve receptors in the gut and decreasing that hypersensitivity or pain component of symptoms.

Another medication that is a little bit newer is called eluxadoline, and essentially, this medicine also works with the gut motility, and it can decrease diarrheal symptoms.

Another common medication that's over the counter that patients use for symptom control is loperamide, and it's an antidiarrheal that they can take as needed based on when they have flares of symptoms with IBS and diarrhea.

So with some of these agents, one of the main side effects could be constipation, so that's why it's important to first discuss how severe diarrhea symptoms are for the patients. If we start a more aggressive approach with some of these agents, it could cause more constipation if their diarrhea isn’t severe.

Also, with tricyclic antidepressants, it's an older class of antidepressant, but there is a psychologic component. So doing a good screening for mental health is important prior to starting these. Also, they can change some of the QTC prolongation of the heart, as far as their arrhythmias, so we want to make sure that they have a more frequent or recent EKG to review to ensure that there's no cardiac symptoms or prior history before we start these medications.

Also, with some of the medications that are prescribed—especially the eluxadoline—we want to make sure that they don't have a history of cholecystectomy, meaning they didn't have their gallbladder removed, because that's a contraindication to starting the medication.

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. Sheila Reddy and Ms. Carol Antequera about treating patients with IBS-D in the primary care setting.

So now that we have a better understanding of the available therapies for IBS-D, let's focus on how primary care providers can create personalized treatment plans. Dr. Reddy, what factors should we consider here?

Dr. Reddy:
Well, first, we have to talk about how severe their symptoms are. So many patients have symptoms that can come and go over the period of months or years, and some experience really severe daily symptoms. So the first thing I want to talk to them about is how severe are the symptoms? Meaning, is it affecting their quality of life? Is it daily? And that really helps us tailor in how aggressive we need to be with therapy and treatment.

Really, it's a combination of what's bothering them the most, whether it's diarrhea, pain, or a combination, and then also, how frequent the symptoms are. And then we really talk about whether they prefer pharmacologic agents versus some other methods, like diet as we talked about. And then talk to them about how this is a trial-and-error process. There's no one-size-fits-all approach for everyone. So we have to really talk about what they're willing to do and how much time they can give to, say, dietary therapy. And then also, if they're willing to take a medication, would the medication have some side effects like constipation if their diarrhea isn't severe enough? So having that kind of communication and then discussing what the options are is usually the first step after we do our initial work up.

Dr. McDonough:
As a quick follow-up to that, Ms. Antequera, how can integrative care plans help address patients' individual needs?

Ms. Antequera:
We really want to ensure that we are working with the patient in a shared decision-making model. We want to talk to the patient and make sure that we're addressing those symptoms that are really bothering them the most. And we want to make sure that we have a good relationship with our patients so that they can communicate with us, let us know what's going on, and have confidence that their treatment options are going to be helpful.

And so, because we have these integrated approaches, we also want to make sure that we use those behavioral and dietary interventions. We have dietitians to help with that, and they're also part of that multidisciplinary care team. We have psychologists as well as primary care doctors who are also really important in managing the care of these patients. So by having this multidisciplinary approach, we can offer a lot of support to our patients that they may otherwise not have. Because if we're all communicating together and trying to address the patient's symptoms, then that's what's really going to help the patient thrive.

Dr. McDonough:
And as we approach the end of our program, I just have one last question for you, Dr. Reddy. What are some communication strategies to educate and support patients as they navigate IBS-D?

Dr. Reddy:
One of the main things we want to do, especially when they come in with symptoms they could have been suffering from for a long time, is to really validate their experience. This is a really common illness. A lot of people have this. It's one of the most common reasons why people call out of work or school with these symptoms. So, validate that what they've experienced is real, that we have options for treatment, and that we understand how it's affecting their life.

And then, once we do that, studies have shown, overall, that better outcomes occur in IBS when we have really good communication between the provider and the patient and really frequent follow up. As we said, it's a trial-and-error process, so one type of treatment may not work for you initially, and so we're able to move through that process together. And they can feel very comfortable expressing to you, "This isn't working for me, let's move on to the next step," without feeling frustrated that there may not be options for treatment. As long as we're communicating with our patients closely and frequently, we're able to get a plan together for them that can work as long as we explore and take time.

A lot of times, we don't want to start medication immediately because we need to first see how they respond to nonpharmacologic agents, and so that requires follow up over time. But just allowing us to have a very open dialogue is a great place to start. And help them understand that we have lots of options for them and that we can work through that process together.

Dr. McDonough:
Those are great comments for us to think about as we come to the end of today's program. And I want to thank my guests, Dr. Sheila Reddy and Ms. Carol Antequera, for joining me to discuss how we can individualize treatment plans for patients with IBS-D in the primary care setting. Dr. Reddy, Ms. Antequera, it was great having you both on the program.

Dr. Reddy:
Thank you so much.

Ms. Antequera:
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!