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Reducing the Stigma Around IBS-D: Supportive Communication Strategies

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:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss how we can reduce the stigma surrounding irritable bowel syndrome with diarrhea, or IBS-D for short, is Dr. Paul Doghramji. Dr. Doghramji is a physician at Collegeville Family Practice and Pottstown Memorial Medical Center as well as the Medical Director of Health Services at Ursinus College in Pennsylvania. Dr. Doghramji, thanks for being here today.

Dr. Doghramji:
A pleasure to be here.

Dr. McDonough:
To begin, Dr. Doghramji, what kind of stigma surrounds IBS-D, and how might these manifest in patients and affect their quality of life?

Dr. Doghramji:
Well, there's a lot of stigma that's associated with IBS—specifically IBS-D—because of the type of symptoms that occur with it. And we have to understand that IBS, according to Rome IV Criteria, is a condition of recurrent abdominal pain. And these are people that are having pain often. Now, the criteria specifically say they have to have it at least once a week or so, but these patients typically have it almost every day. And the pain is associated with or related to defecation and associated with a change in the frequency of bowel movements to the point where they have pain often, they have to go to the bathroom often, and their bowel movements are usually very loose.

So, it's abdominal pain, it's a change in their stool. It's a difficult thing for them to go through and it's a difficult thing for them to talk about. So typically, they will have done some research on the internet and try to find out what's wrong with them—do they have celiac disease? Do they have a food intolerance? Do they have an infection? Do they have some kind of rare disease? They don't know what to do. They'll try certain things, and then they'll eventually, with all their anxiety, come to their clinician. But there's a stigma associated with it because they don't want to talk about this. And also, the clinicians, I have to say, aren't necessarily very pleased to talk about or to hear about abdominal pain that's been going on for so long and is associated with bowel movements. So as a result of that, there's anxiety on both parts during that first office visit and the many office visits that occur with patients with IBS-D.

Dr. McDonough:
And how can this stigma impact patient care?

Dr. Doghramji:
The patient may not be willing to understand the diagnosis or may not be willing to accept the diagnosis or the treatment plans. And then it goes back to the physician. The physician may not necessarily know how to establish the diagnosis and may not know about the stepwise treatment of IBS-D. But also, the clinician may not know about all the figurative hand-holding that you need to do for somebody with IBS-D—rule out certain conditions, and tell them that they're going to make things better. All these things have to happen. So because there's all this stigma, it can actually affect the care of the patients, such that oftentimes it goes poorly treated.

Dr. McDonough:
So now that we know how stigmas can impact patients with IBS-D, let's focus on how we can address them. Dr. Doghramji, what strategies can we use to reduce stigma and create a more supportive environment for our patients?

Dr. Doghramji:
The first thing that needs to happen is clinicians need to be a little bit more attuned to and know more about IBS—specifically, IBS-D. They need to know the Rome criteria. They need to know that these patients need a lot of hand-holding. They need to have reassurance. They need that information shared to them about IBS-D and what they can do. They need to know that dietary changes can be quite helpful. They need to know that medications in a stepwise fashion can be quite helpful in reducing the symptoms.

Remember, these patients oftentimes are affected so badly that they may not even be able to leave the house. I had a patient that came in the other day, for example, and halfway through, he said, “Doctor, my pain is really severe. Where’s your bathroom? Can I go right now? So sorry.” That patient needs to have reassurance that, “That's okay. It’s perfectly fine to be this way right now. But I know what I can do to help you.”

So the clinician needs to know about the condition and the clinician needs to know the stepwise treatment fashion that's there, and also the dietary changes that can be very helpful.

Dr. McDonough:
Building on that, what are some communication strategies we can use to normalize conversations about IBS-D?

Dr. Doghramji:
The main communication strategy is information to the patient and reassurance. Inform them what IBS-D is all about; there could be comorbidities.

You can tell them it's very common; a lot of people have this. Of all the IBS’s, IBS-D is about 40 percent of them, so it’s quite common, and it occurs earlier in life. So tell them that it's common and that it's something that happens to a lot of people. There are comorbidities with it and there are things that can be done to make things better. Providing information and reassurance is the way to de-stigmatize.

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. Paul Doghramji about destigmatizing IBS-D.

I would imagine, Dr. Doghramji, you have patients coming in who have been stressed out; there’s a lot of emotional issues, maybe they aren't getting support, and they feel stigma. When they come into you, what are some of the things you do to help them address that and to be not only a physician but a source of comfort?

Dr. Doghramji:
I know that these patients have gone through a lot already. They’re apprehensive, they’re anxious, they’re nervous, they're worried. So this is what we do as family physicians. We are person-to-person clinicians. We want to make sure that we understand where they are emotionally. And as such, reassurance begins right away. Let them know, “I understand where you're coming from.” And in fact, a lot of times, repeat what they're saying. So, “I understand you're having a lot of abdominal pain and it's really affected the way you go to the bathroom as often as you do, and it's affected your life. I understand that and I also do understand that you've probably done a lot of research and you're worried that you may have a serious condition. And I bet you've talked to a lot of other people about this, and they've made you feel even more anxious about what's going on. Let me reassure you that I'll be glad to do everything necessary to make sure there's nothing seriously wrong with you and also that, if this is IBS-D, which is what it sounds like it is, that there's a lot I can do for you. I can lessen your discomfort, lessen your bowel movements, and have you get much closer to a normal life.” That’s the kind of thing that should happen.

But again, a lot of patients also have some comorbidities that you have to get into. So the first visit may take a lot of time. They may have actual anxiety, generalized anxiety disorder, or panic disorder. They may have migraine headaches. They may have insomnia. And all those things have to be dealt with at the same time. So it's a complex situation that can happen to a lot of patients, but in time, in dealing with these patients and knowing that it does take time, you can get them to a much better place.

Dr. McDonough:
Now, in addition to those strategies, how else do you advocate for patients with IBS-D?

Dr. Doghramji:
Well, advocating for them oftentimes involves referring patients to a gastroenterologist when they need to have a test done. Sometimes

patients need to be reassured that they don't have something really, desperately wrong with them. And advocate with the gastroenterologist to handle a patient with care—of course, they probably do—but also, suggest to the clinician that you're looking for IBS-D and to rule out other things. So advocating them may be a very good idea when it comes to referring patients to a gastroenterologist.

Dr. McDonough:
As we approach the end of our conversation, Dr. Doghramji, do you have any final thoughts on how we can reduce the stigma around IBS-D and facilitate patient engagement?

Dr. Doghramji:
Absolutely. First and foremost, as I said, clinicians should be well adept and well versed in what IBS is, and they should know that these patients are already very apprehensive and anxious, so information and reassurance are the two most important things to do for patients. And then have a nice stepwise method of treatment of the condition, starting with the diet. Specifically, there's one called the FODMAP avoidance diet, which can be quite helpful for these patients. There are also some very good medications that can help. Bring the patients into your office often and inform them and reassure them that there's a lot that can be done to get them to a much better place with their abdominal symptoms.

Dr. McDonough:
As those final thoughts bring us to the end of today's program, I want to thank my guest, Dr. Paul Doghramji, for joining to share strategies to reduce IBS-D stigmas and misconceptions. Dr. Doghramji, it was great having you on the program.

Dr. Doghramji:
My pleasure.

Announcer:
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