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Addressing Underlying Factors in IBS-C: A Multifaceted Treatment Approach

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

Dr. Turck:
This is *GI Insights* on ReachMD, and I'm Dr. Charles Turck. Joining me today to discuss how we can integrate multiple mechanisms of action into the treatment of irritable bowel syndrome with predominant constipation, or IBS-C, is Dr. Michael Camilleri. He's a consultant in the division of Gastroenterology and Hepatology at Mayo Clinic and a Professor of Medicine, Pharmacology, and Physiology at Mayo Clinic College of Medicine and Science in Rochester, Minnesota. Dr. Camilleri, welcome to the program.

Dr. Camilleri:
Thank you, Dr. Turck. It's great to be here.

Dr. Turck:
Well, to start us off, would you provide us some background on the underlying mechanisms involved in IBS-C?

Dr. Camilleri:
From a clinical perspective, it's really important to appreciate that the symptoms of irritable bowel syndrome with constipation overlap with conditions that may be mimicking. And it's very important for us to recognize that, as providers, so that we can individualize treatment.

So what am I talking about? Well, the main symptoms of irritable bowel syndrome with constipation are constipation, needing to strain to have a bowel movement, abdominal pain, and abdominal bloating. Now, it's become very clear in clinical practice that there are many patients who have, for instance, a rectal evacuation disorder, who will present with straining, constipation, and then secondarily, they experience bloating and abdominal pain. Well, those are the symptoms of irritable bowel syndrome with constipation.

A second group are the patients who have chronic idiopathic constipation, and the constipation then causes pain. And when the patient has a bowel movement, the pain gets better. So, again, those are classical symptoms of irritable bowel syndrome with constipation.

So in clinical practice, it's very important for us to keep in mind that pain and constipation may be features of other pathophysiological mechanisms, like a rectal activation disorder or a disturbance of colonic transit, and that often helps us in our practice to try to individualize and be more successful in our treatment of the patient.

Dr. Turck:
So when we're treating patients with IBS-C, why is it so important to address multiple mechanisms at once?

Dr. Camilleri:
Let me give you an example. If I see a patient who has a lot of straining, constipation, difficulty with evacuation, the patient might tell me that sometimes they even have to digitate the anal canal or push on the back wall of the vagina if they've had children brought by vaginal delivery. Those are features that may suggest that they have an evacuation disorder. And then the digital rectal examination can also identify features that confirm the evacuation disorder. For example, when I examine the patient in the left lateral position, the perineal descent during straining may be limited. The patient may have an extremely high resting angle sphincter tone. When I ask the patient to expel my examining finger, they may have paradoxical contraction of the sphincter or of the pelvic floor. All of these are features that we can pick up in our clinical evaluation, and they help us determine whether we should be focusing our therapy with the aid of a physical therapist in addition to any pharmacological approaches that we use.

So this is why as we evaluate our patients with suspected irritable bowel syndrome with constipation, it is important for us to make sure that they don't have an evacuation disorder.

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. Michael Camilleri about how we can treat irritable bowel syndrome with constipation, or IBS-C, by addressing its multifactorial pathophysiology.

So, Dr. Camilleri, now that we have some insight into the mechanisms behind IBS-C, let's zero in on how we can apply what we've learned to clinical practice. Are there any other ways that a patient's symptoms can help shape our treatment strategy?

Dr. Camilleri:
Yes. Patient symptoms can often be very helpful, and then we can also apply some relatively simple testing to confirm. So let me give you a specific example. In patients with irritable bowel syndrome, when I hear there's predominant pain in the right side of the abdomen and a sense of fullness and bloating, it raises the question as to whether the patient might also have slow colonic transit. So, as I mentioned before, with these three conditions—slow colonic transit, irritable bowel syndrome with constipation, and rectal evacuation disorders—we can pick up a lot of clues from our history and examination.

And then, on examination, in the patient who has predominant pain on the right side with bloating, we can also determine whether there's a mass in the right side—right lower quadrant in particular—because that's where stool often accumulates in these patients. Again, a transit measurement, like a radio opaque marker transit measurement, can also identify the presence of slow colonic transit. This is relevant because as we choose our treatments, we might focus on different mechanisms of action of the different medications depending upon the nature of the symptoms, what we find on these relatively simple evaluations in the clinic, and on simple testing like transit measurements.

Dr. Turck:
Now, once we create a personalized treatment plan, what are some key considerations when monitoring these patients?

Dr. Camilleri:
In the monitoring, it's the sense of evacuation, the frequency of bowel movements, and the consistency, that we are trying to improve to facilitate defecation. And before that, our individualized treatment plan is going to be focused on, is the problem an evacuation disorder, in which case we're going to work with our physical therapy colleague? Is the problem slow colonic transit, in which case we can use an osmotic laxative, a secretory laxative, or sometimes even a colonic prokinetic agent, a medication that stimulates colonic contractile activity?

So this is where understanding the pathophysiological mechanism in each individual patient helps me in the clinic to determine my first interventions and then what might be my backup interventions.

Dr. Turck:
As we approach the end of our program, Dr. Camilleri, do you have any key take-home points you'd like to share with our audience?

Dr. Camilleri:
The principle is, let's understand the mechanism in each patient that we're seeing with these very common symptoms. And there are some very simple things that we've discussed, which we can do in the clinic and with simple testing. And if necessary, we can refer the patient, for instance, to a GI department for anorectal manometry to confirm the presence of a rectal evacuation disorder.

Sometimes a plain abdominal radiograph can also be helpful because of the distribution of stool and the degree of fecal loading; also, a sign that we see described in the literature sometimes is a rectal gas bubble, which we can see on the plain abdominal x-ray just above the pubic symphysis and below the level of the lumbosacral junction. And that rectal gas bubble can sometimes be another feature that suggests the presence of an evacuation disorder.

So the key principles for me are, let's try to understand the mechanism, and then let's use that understanding to decide—depending upon what patient has previously received and tried for therapy—to enhance that therapy with an osmotic laxative, a secretory agent, or a stimulant agent to help colonic motor function.

Dr. Turck:
Well, with those final insights in mind, I want to thank my guest, Dr. Michael Camilleri, for joining me to discuss the importance of using multiple treatment approaches to address the pathophysiology of irritable bowel syndrome with constipation. Dr. Camilleri, it was great having you on the program.

Dr. Camilleri:

Thank you for including me. Thank you.

Announcer:
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