Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/an-overview-of-guideline-updates-for-ibs-c/14616/

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

An Overview of Guideline Updates for IBS-C

Dr. Buch:

In 2022, the American Gastroenterological Association published the "AGA Clinical Practice Guideline on the Pharmacological Management of Irritable Bowel Syndrome with Constipation." What do these guideline updates recommend?

Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. Today we are honored to be joined by Dr. Arnold Wald, who will be sharing his insights. He is a Professor of Medicine at the University of Wisconsin and has special interest in studying colonic motility.

Welcome to the program, Dr. Wald.

Dr. Wald:

I'm happy to be here, Peter.

Dr. Buch:

Dr. Wald, let's dive right in with a look at definitions. How do functional constipation and irritable bowel syndrome with constipation, or IBS-C for short, compare? Is there any overlap between the two?

Dr. Wald:

Well, I think there is. I think it's true in clinical practice, and it's also been acknowledged by experts. There are overlaps, and it's very easy to move from one to the other. If you want to be a purist, however, I think you could pretty much divide them into separate categories based upon their clinical presentations.

So, with idiopathic constipation, or chronic constipation, one is dealing with a disorder, I think, of colonic and anal rectal function. Now, the major symptom, and what you would address as a clinician is bowel habits, and why patients are unhappy with them. Is it a question of too few or is it too difficult to have a bowel movement or a number of other issues. The concept of, we'll call it functional constipation, is one of colonic dysfunction. And so, you want to focus on improving bowel function as the patient defines it. Therefore, your treatment is really going to be focused on colonic function alone. And since we don't really exactly do diagnostic tests on the majority of people with chronic constipation, it really is pretty much an empirical approach using a variety of either laxatives or prokinetic agents as we see fit.

With irritable bowel with constipation, there is a constipation component, and so that's, perhaps, the overlap. The problem with irritable bowel syndrome is that there are other things that are not contained in purely constipation, and that's the concept of abdominal pain or discomfort. Most of the laxatives and other prokinetics that we deal with don't really deal with the issue of abdominal pain which characterizes irritable bowel syndrome, and now the concept of irritable bowel syndrome is one of a disorder of brain-gut interaction, whereas you could say that with constipation it's simply an issue of bowel function itself. So, now dealing with the abdominal pain component, which doesn't necessarily improve with improved defecation, becomes the major challenge in people with irritable bowel and for the practitioner who has to deal with that.

There are other symptoms associated with both, such as bloating and other nonspecific symptoms, but I think that the centrality of irritable bowel syndrome is the presence of abdominal pain or discomfort.

Dr. Buch:

Thank you very much for that clarification. So, let's focus on some fancy treatment options. So, you mentioned earlier about the standard treatment options, but again, once we need to go beyond them, we think about some of these medicines, including lubiprostone, tenapanor, plecanatide, plecanatide and tegaserod. So, how do you choose which is best for your patient?

© 2023 ReachMD

Dr. Wald:
Well, with like most things in medicine, it is a trial-and-error process. If you look at all the studies that have been done with all of the drugs that you've mentioned compared to placebo, the range is somewhere between 8 and 12 percent over placebo as they define it and upon which the FDA has approved these drugs for consumption. And the net result of all of these medications is to increase water secretion in the gut either by increasing chloride secretion, the first three drugs, or sodium secretion, which is tenapanor, and with that must come free water. So, the net result of all of those is to increase the amount of water going into the colon, and presumably, this increases colonic motility, and it will in turn treat constipation.

Now, if this were just chronic constipation, there are many other medications that are far less expensive and over the counter to do that, but the reason that you can't use those other drugs is that they don't address the abdominal pain, and so any of these drugs is going to have found some merit in treating IBS with constipation. The guidelines give strong recommendation or their top recommendation to linaclotide, but I don't really know that, that I would consider that a major reason to choose that over any of the others. Basically, it's whatever is going to work. And if this doesn't work, well then you try a different medication.

Dr. Buch:
So that's a wonderful segue to the question I'm going to ask you. And this is going beyond the guidelines. Have you ever had occasion to combine two of these medications that we were just talking about?

Dr. Wald:
So, given the fact that these are all secretory agents, I've never had to do that. And these are expensive drugs, and so not knowing that there's any data to support that, it would be kind of hard to do that, and it might not even pass muster with many of the insurance companies that are sort of underwriting our efforts here.

Dr. Buch:
So, let's continue. Realizing that prucalopride is not part of the algorithm, but where does prucalopride fit in treatment?

Dr. Wald:
Well, prucalopride is a 5-HT4 agonist, a complete agonist. That means it has only effects on the 5-HT4 receptor. And that makes it a prokinetic agent throughout the GI tract, not only the colon but in the upper reaches of the gut. But again, prucalopride only addresses the constipation part. And if this were constipation chronically, that would be a reasonable choice if the patient didn't respond to the less-expensive more available agents for patients, but there's no evidence that it works for irritable bowel, again, because it doesn't really seem to address the pain component

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Arnold Wald about guidelines for irritable bowel syndrome with constipation.

Dr. Wald, let's focus in a little bit more. Would you comment on the use of SSRIs and SNRIs for irritable bowel with constipation?

Dr. Wald:
That's an interesting question, Peter. We know that SSRIs work mainly on the serotonin 4 system, and in high doses they actually can promote more frequent bowel movements and even diarrhea. What they seem to do is to improve patients who have depression, but there's no evidence that they really work for patients with irritable bowel syndrome with constipation. So, if you have a patient with irritable bowel syndrome and they have depression and you can improve the depression with pharmacologic, it could make a difference in overall feeling, but there's no evidence that it's specific for irritable bowel syndrome itself.

Dr. Buch:
So, let's focus now on a specific category of patient. How would you approach management for elderly patients with irritable bowel and constipation?

Dr. Wald:
No different. I think that, for example, plecanatide as originally tested looked at 3 mg and 6 mg, and with the idea that maybe 3 mg would be safer in the elderly, and their study suggested that 3 mg a day above the age of 65 was as effective at 6 mg. The biggest problem is with linaclotide, which has worked on the large chloride channel, perhaps to some extent plecanatide and so if diarrhea becomes a problem, you simply either stop the medication or consider an alternative. Tenapanor, for example, is not absorbed at all, and so its pure function is going to be work on intestinal secretion, and that is going to be a question of avoiding dehydration and things of that nature. So, I don't see any of these as being contraindicated in the elderly. I think with lubiprostone, particularly at high doses, nausea had been a problem, but we're using smaller doses of lubiprostone for IBS-C 8 mcg twice a day as opposed to 24, and presumably, nausea is less of a problem. So, these drugs appear to be safe and tolerated at all ages.

© 2023 ReachMD

Dr. Buch:
Thank you. Now, the guideline didn't mention management with cannabinoids. What are your thoughts on their use for patients with IBS? We get those questions all the time, don't we?

Dr. Wald:
Well, simply put, Peter, there's no evidence to suggest that cannabinoids have a positive effect on irritable bowel syndrome of any type, including constipation. There is no randomized controlled trial of any cannabinoid with irritable bowel that's out there. And while people are tempted to think that there might be some usefulness because of the various effects on the cannabinoid system, there just isn't evidence for that yet. So, my take is that they probably won't be harmful, but there's no evidence that they're helpful, and therefore, they should remain as investigative only.

Dr. Buch:
Well stated. Finally, are there any other thoughts you would like to share with our audience?

Dr. Wald:
This is one of the disorders that has bedeviled us for many years, and, and I think that we're beginning to understand a little bit more the association between brain-gut interaction, and that's why these so-called disorders of function or functional bowel disorders, which irritable bowel has been one, we've really changed the terminology to say that it's a disorder of brain-gut interaction and all that entails. And so that has to do with the similarities between the enteric nervous system in the gut and the central nervous system in the spinal cord and the brain, and so one can imagine a lot of bidirectional issues going on that, that can affect patients with irritable bowel, ranging from stress, which we understand is a neurochemical response to others.

I think it's a misunderstood group, and I think in clinical practice, patients get labeled with irritable bowel syndrome in not a rigorous way, using it is almost a waste basket diagnosis. But I think that you can be very helpful with patients like this, and I think being comfortable with a number of different medications, is what one should keep in mind. If one drug doesn't work, try another one. It doesn't preclude it being effective. And with patients, I think you could make many of these patients a lot more comfortable.

Dr. Buch:
As we come to a close, I want to thank my guest, Dr. Arnold Wald, for discussing the guideline recommendations for irritable bowel syndrome with constipation. Thanks for a great discussion.

Dr. Wald:
I've enjoyed talking to you, Peter. Thank you.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can be Part of the Knowledge. Thanks for listening, and see you next time.

© 2023 ReachMD