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IBS at a Glance: An Overview of the 2020 IBS Guidelines

Dr. Nandi:
Welcome to *GI Insights* on ReachMD. I'm Dr. Neil Nandi. IBS, or irritable bowel syndrome, is one of the most common and challenging presentations we see in the GI clinic. No matter how frustrated clinicians are in diagnosing and managing, I guarantee that our patients are even more frustrated with the morbidity associated with suffering through symptoms, and the significant testing that has been associated with often extensive, and even invasive workups. If you are a clinician looking for more structure and evidence-based guidance, then fear not! On this episode, we will be reviewing just some of the many highlights from the American College of Gastroenterology's recently released Irritable Bowel Syndrome Clinical Guideline. In fact, I have the honor of hosting Dr. Brian Lacy, one of the lead authors of the manuscript released this past December 2020. Dr. Lacy is a renowned gastroenterologist at the Mayo Clinic, Jacksonville, and of course, the distinguished co-editor-in-chief of the American Journal of Gastroenterology. Notably, he was also a co-chair of the Rome IV committee and has authored well over 165 articles and six textbooks on GI motility and disorders of gut-brain interaction. In short, Dr. Lacy is The Man. Dr. Lacy, it is a privilege to have you on our program. Welcome.

Dr. Lacy:
Wow. Thank you, what a great introduction. That's so very thoughtful, and I sense the enthusiasm already. This will be a great conversation.

Dr. Nandi:
Well, we're very pleased to have you, and it's great to have an authority in the field, to talk to us about the latest in IBS. Now, I wanted to start off – one of the most striking things that I was pleased, really, to see in the guideline was the shift to possibly more precisely characterizing IBS, not as a functional GI disorder, but as a disorder of gut-brain interaction, or DGBI. Can you please enlighten our greater audience – is this the new term for clinicians to refer to what we would call functional disorders? And if so, why is this the shift in our lexicon so important?

Dr. Lacy:
All great questions, and I think it actually is an important transition and transformation. There were some, kind of, negative views about using the term, "functional bowel disorders," although I think we all recognized what they meant. It sometimes meant that, well, maybe we couldn't find an answer, or maybe there wasn't a solution, or maybe we really didn't know what was going on. And that's not true at all, and so the concept of using the term DGBI, or disorder of gut-brain interaction, really shows that we've learned so much about these disorders, especially IBS, in the past decade, and we recognize there is a huge connection between the brain and the gut, that brain-gut access. And as an example, we recognize that the gut microbiome – those four pounds of bacteria in your large intestine – play a huge role in intestinal sensation, intestinal motility, and affects brain function as well. And so, the whole concept of thinking about disorders of gut-brain interaction, we recognize that this now takes into account this bi-directional brain-gut access, and how important it is for these disorders, such as IBS.

Dr. Nandi:
I think that really makes a lot of sense. The importance of the microbiome, we're only just scratching the surface. Now, before we delve into diagnostic strategies and treatment algorithms, I also wanted to acknowledge upfront that clinicians may elicit features of anxiety, depression, or chronic pain associated with the GI symptoms as early as the initial encounter, and oftentimes we get stuck in the midst of testing, testing, testing. But one thing that the guidelines highlight is utilizing gut-directed psychotherapies, or even tricyclics. And my question for you is, although the gut-directed psychotherapy trials that have been done, per the guidelines, show very low quality of evidence, it also recognizes that treatment benefit is high, and long-lasting, with low risk of any adverse event. So I guess my question really is, how soon should clinicians think about implementing gut-directed psychotherapy or tricyclics, and if you have any insights onto

how a GI clinician can find a referral to such a specialist?

Dr. Lacy:
Lots of great questions, buried into one. And I'm gonna just make a brief commentary, and I like what you said initially, meaning be comfortable with this diagnosis, make the diagnosis early, and start treatment. Don't keep repeating tests, because that's frustrating to patients. It's expensive, and it delays treatment. Clinicians are really good at recognizing this and making this diagnosis. Make that diagnosis early on, and start treatment. And then this comes to your questions. So when would you use some of these therapies, which we used to consider alternative therapies, but which now should be really mainstream? As an example, would we use some type of psychotherapy, such as cognitive-behavioral therapy or hypnotherapy? The answer is absolutely, and don't be afraid to make those referrals early on. The data is actually pretty good. Unfortunately, compared to pharmacologic studies, we don't have six or eight large studies involving 5,000 patients, but we do have smaller studies involving reasonable sample sizes, showing that cognitive-behavioral therapy for a DGBI disorder, gut-brain interaction such as IBS, can be very effective at improving symptoms. Why? Because we're targeting the brain, and the brain affects the gut. Similarly, we know there's some good data about hypnotherapy. Matter of fact, there's a really interesting study, published a few years ago, showing that hypnotherapy was just as good at improving bowel symptoms as was the low FODMAP diet, which I know many of your listeners use. The art of this, though, is to figure out who, in your area is good at CBT or hypnotherapy, and that's sometimes tricky. Sometimes it's tricky for the patient because it's not always paid for by insurance companies, so there's a little bit of an art about that. That being said, for patients with mild to moderate IBS symptoms, those are things that could be started very early. You don't have to wait till the very end.

Dr. Nandi:
Yeah, that's really, I think, one of the most important points because so much time is spent from that initial clinic visit. The patient's been waiting for your first visit with the GI, and then many weeks to months, possibly, pass before their testing is done. But at least, you know, some type of gut-directed psychotherapy can start early. And again, low risk, you know, potential benefit, and if anything, lasting benefit. So maybe again, like you just said, start early with that and that might be a proactive way of managing some component of the symptoms, while the GI works to the diagnosis or etiology. So, you know, with that said, Dr. Lacy, let's talk about diagnostic approach. Traditionally, testing for IBS has been considered a diagnosis of exclusion, and yet, something that I read with great interest is a new term. What we want to do, right, is recommending a strategy of positive diagnostic strategy. So what does this mean? How do we employ it? And in fact, what kinds of high-yield tests should we be doing at the first visit? And which should we consider avoiding?

Dr. Lacy:
Great. So, remember, as a clinician, we see these patients all the time. This is a common problem, so we need to feel comfortable about it and recognize the fact that as we're taking that history and exam, remember we're thinking about all the great questions. How common of a disorder is it? IBS is common. Depending on which survey you use, it's five to ten percent of the population. Something like Zollinger-Ellison syndrome, too much acid because of a secreting tumor, is incredibly uncommon, so think about the prevalence. Think about the patient population. A younger patient having characteristic symptoms of abdominal pain that's a sine qua non, a keystone, and altered bowel habits. They are likely to have IBS. And so the whole idea is to make that diagnosis early, by doing a good history and exam, looking for those classic warning signs, making sure they're not losing weight unintentionally, they're not anemic, there's not a family history of cancer or celiac disease. That exam, by the way, is reassuring, so don't forget the value of that physician-patient relationship and that careful exam. And then, making the diagnosis, use the Rome IV criteria. We use criteria for other disorders. This is actually a good biomarker. We don't have a single laboratory test, a single biomarker for IBS, but we actually have a pretty good biomarker – history, exam, Rome IV criteria, and, as you mentioned, limited diagnostic tests. And what we now recognize is that simple tests, such as a blood count and a CRP, is probably all you need to do. If somebody comes in with more diarrhea symptoms, a fecal calprotectin is easy to do, and if you have a normal fecal calprotectin and a normal CRP, the likelihood of you having IBD, inflammatory bowel disease, is vanishingly small. You've made the diagnosis of IBS that day in clinic, and then decide what is their predominant symptom and get ready to start treatment.

Dr. Nandi:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Neil Nandi, and today I'm speaking with Dr. Brian Lacy about the ACG's hot off the press, 2020 IBS Clinical Guideline.

I did note that the guidelines discouraged the use of enteric stool testing, which is something reflexive I often see, and of food allergy and sensitivity testing, which I personally agree with. Can you elaborate upon that, because we see a lot of patients who come to the clinic bringing in microbiome studies and food allergy and third-party vendor sensitivity testing?

Dr. Lacy:
Yeah, so, you know, the nice thing about this guideline the first ever using grade recommendations, which is really the highest level of

evidence, is that we have nine questions that focused on diagnostic tests, and sixteen questions that focused on clinical therapies. And to that point, sometimes a guideline is just as valuable about saying what not to do as what to do. And as an example, think about some of the patients we all see in clinic with years of persistent IBS and diarrhea symptoms, as an example. The likelihood of finding anything in the stool sample is essentially zero. Stool samples are good for an acute illness, but not for a chronic illness. And so, we see, like you do people with years of IBS and diarrhea symptoms, having repeated stool samples, and of course, they're always gonna be negative or normal. So stop doing that. There's little yield and it's costly. Similarly, many patients are concerned about food allergies as a cause of their problems, but remember, food allergies are uncommon, less than 1% of the population. And the classic symptoms are mouth swelling, tongue swelling, tightness, you know, some nasal symptoms, some shortness of breath, that happens immediately after food ingestion. This is not those delayed symptoms that happen hours later or a day later, after eating a meal. And so, doing food allergy testing is very expensive, and it just sends the patient down the wrong path. They may be sensitive to foods, but they're not allergic. So, sometimes stopping tests is just as valuable as recommending common-sense tests that have good diagnostic value. That actually changes how you think about the patient.

Dr. Nandi:
I couldn't agree more. And I agree with the stool tests, the endless stool tests. I think they make the physician feel better more than the patient, that something's being done. You mentioned FODMAP regimen earlier. I hate the word "low FODMAP diet" because it always infers the stigma of weight loss. But obviously, if you're doing low FODMAP, we don't want you to lose weight, that means you're over-restricting the elimination phase. Can you talk a little bit about what is the diagnostic role for low FODMAP for our patients, and how long should we allow patients to try this regimen first?

Dr. Lacy:
Yeah, so, and I share your concerns about the word "diet," because don't forget, for many of these patients with persistent GI symptoms, and many of them have overlapping upper symptoms of dyspepsia, about 40% of IBS patients, they start to become nervous about eating, remember? Because eating oftentimes precipitates spasms, cramps, urgency. And you wanna be very careful that we don't send them down a pathway where they develop secondary eating disorders, such as an avoidant restrictive food intake disorder. So we have to be careful about that. So, what about the low FODMAP diet? I'm sure all of your listeners know this stands for fermentable oligosaccharides, disaccharides, monosaccharides, and polyols. The idea is that there are many foods that create distress in the GI tract. Why? These are high osmolar foods. They create this big osmotic load that stimulates the GI tract, moves things through the GI tract, causes bloating and distention. But also, when they reach the colon, they may ferment, they create short-chain fatty acids, they create a lot of gas, bloating, distention, urgency. So there's good biologic plausibility for taking foods high in FODMAP out of the diet. Your point is a great one, meaning that this is actually can be both a diagnostic strategy and a therapeutic strategy. So if you have somebody with IBS symptoms, and I think this does work a little bit better for those with IBS and diarrhea, and IBS with mixed symptoms, but also those with bloating predominant, a low FODMAP diet makes sense. However, it should be four weeks. If patients do not respond at all in four weeks, stop and go back to Plan B or Plan C, whatever you think is appropriate. If they do respond, and what I mean by responding is they note an improvement in their global IBS symptoms, less bloating, less gas, less distention, less urgency or diarrhea, then you continue, but then you need to modify, and I call it "personalize." We want to personalize the diet and you start adding foods back in until you reach a threshold. The art of that is to add foods back in in small amounts slowly, so they can monitor symptoms and decide which food they're really troubled by. Your point is also a good one. No patient should be on this for years, because there is a concern about micronutrient deficiencies, thiamine, and some of the B vitamins.

Dr. Nandi:
Yeah. And I think there's a lot of gems in there. I think that, you know, utilizing it, like you said, for a limited amount of time four weeks, you suggested, is really important. And if you're a clinician listening to this, and you're looking for nutritional resources there's also ACG's partner, GI On Demand, giondemand.com, where you can go to to get good, sound nutrition, and they feature certified dietitians, also in FODMAP and great patient education webinars and lectures, too. So that's a really relatively new but powerful resource for both clinicians and patients alike.

Dr. Nandi:
To our listeners, this was just some of the highlights of the ACG Clinical Guideline for irritable bowel syndrome. We will put show note links to the official guideline for ACG, IBS Clinical Guidelines, and also, to GI On Demand for good nutritional resource access. That is our time that we have for today. I want to thank Dr. Brian Lacy for joining me and for providing us all these great insights into the field of IBS.

Dr. Lacy:
What a great discussion. This is a lot of fun, and best wishes to everybody, and stay well.

Dr. Nandi:

For ReachMD, I'm Dr. Neil Nandi. To access this episode, and others from GI Insights, please visit reachmd.com/giinsights, where you can be part of the knowledge. Thanks for listening.