Transcript Details

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Improving IBS-C Outcomes Through Personalized Treatment

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

Dr. McDonough:
Welcome to *GI Insights* on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss how we can personalize IBS-C treatments with both pharmacological and nonpharmacological strategies is Dr. Christine Frissora. She's an Associate Professor of Medicine at Weill Cornell Medicine and Assistant Attending Physician at New York Presbyterian Hospital. Dr. Frissora, thanks for being here today.

Dr. Frissora:
Thank you for inviting me.

Dr. McDonough:
Let's dive in right away, Dr. Frissora. Can you tell us about available pharmacological options for IBS-C treatment?

Dr. Frissora:
We have several pharmacological options to treat IBS for constipation. One of them is linaclotide. It comes in three doses, and the lowest dose, 72 micrograms, is actually FDA approved for children. Another one that has a new mechanism of action is tenapanor, and that actually blocks sodium, so it's called a retainagogue. That's 50 milligrams twice a day. It's a newer drug, and some patients find it very effective. Plecanatide comes 3 milligrams, and that's the dose to treat both IBS and chronic idiopathic constipation. They do have a word of warning—if you're going to use prucalopride, it cannot be given to children because it can cause life-threatening dehydration. There's a drug called lubiprostone, which comes in two doses: 8 micrograms and 24 micrograms. It is approved to treat constipation; however, it can cause nausea and paroxysmal shortness of breath.

Dr. McDonough:
And when we're determining which therapy is appropriate, which patient-specific factors should you take into account?

Dr. Frissora:
In terms of patient age, for pediatric patients, the only drug that is FDA labeled for children is linaclotide at the 72 microgram dose. Otherwise, for children, you would have to use an osmotic like magnesium, polyethylene glycol, or lactulose—that sort of thing. In terms of other drugs for adults, the plecanatide is once-a-day dosing, the linaclotide is once-a-day dosing, and the tenapanor is BID dosing. So those are all things to consider.

One caveat about these drugs is, I usually give them to patients after dinner when they're home. And then, they wake up, they go to the bathroom, and they go to work. Because I find if I give them to patients in the morning, they're trying to get to work, drive to school, get their children up, and have a meeting, and they just simply cannot have fecal urgency in the morning. There's just no time. So I find it's better to give the medicines at night when they're home from whatever they're doing, and not when they're stuck in a tunnel somewhere.

Sometimes these medicines can cause diarrhea in the first day or two of treatment, and that will resolve. However, if the patient continues to report diarrhea, fecal urgency, or any of those kinds of symptoms, then I can decrease the dose or decrease the interval.

Dr. McDonough:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Christine Frissora about creating individualized treatment plans for patients with IBS-C.

So now that we've discussed pharmacological strategies, I'd like to zero in on some nonpharmacological options. Dr. Frissora, how can behavioral therapies play a role in IBS-C management?

Dr. Frissora:
There are some patients who tell me their gut is their stress barometer, so when they're stressed, their IBS acts up. And those are the patients where I will try to get a psychologist to work with the patient, or there are apps patients can use on their phone. One addresses hypnotherapy, and one addresses cognitive behavioral therapy. They can download the apps and use them. And they can be very helpful in a patient who is stressed.

There are other patients who don't want to take medicine, they don't want to take drugs. And for those patients, there's a new capsule called a vibrating capsule. They swallow the capsule at night, it causes peristalsis, and they go to the bathroom in the morning. So there are a few options for patients depending on what their lifestyle and preferences are.

Dr. McDonough:
And what about dietary modifications or other lifestyle adjustments?

Dr. Frissora:
In terms of diet, we do have the low-FODMAP diet—FODMAP stands for fructose, oligo, disaccharides, monosaccharides, and polyols. These are substances that are very hard for the human body to digest and absorb, and when the patient has malabsorption, the gut bacteria eat them, and then that causes gas, bloat, cramping, and so forth.

So I have looked at 225 of these patients looking for sucrose intolerance and found it in about 20 percent. Other investigators have looked at lactose intolerance, fructose intolerance, and fructan intolerance. So if you have a patient who tells you after they eat, they have symptoms of malabsorption—gas, bloat, cramping, they are the same symptoms as IBS symptoms—then think about if the patient could have malabsorption of some kind of carbohydrate or if they could have celiac disease. Think about a food allergy. Think about what is driving their gut symptoms, because often, when we look for these kinds of issues, we find them.

Dr. McDonough:
As we approach the end of our program, Dr. Frissora, do you have any final thoughts on how we can help patients achieve sustainable symptom relief and improve their quality of life?

Dr. Frissora:
Most patients with IBS have had, at some point, a trigger. The trigger could be a perforated appendix, food poisoning, or chemotherapy. There could be something that happened to the gut biome that caused this. Other patients have had a stressor, a divorce, a death, or a physical trauma that causes it. So each patient has their own story about how their gut ended up the way it is.

And we know that IBS is a brain/gut, psychosocial problem, so it is what the patient ate, what the patient feels, what the patient's gut biome is, and what the motility is. It can be a lot to sort out. So our job is to try to define what caused their IBS and then try to discover the ongoing triggers. And then we have to adjust all of that piece by piece and take care of the patient until we get them better.

Dr. McDonough:
With those key takeaways in mind, I want to thank my guest, Dr. Christine Frissora, for joining me to discuss how we can tailor pharmacological and nonpharmacological treatments to improve outcomes in IBS-C. Dr. Frissora, it was great having you on the program.

Dr. Frissora:
Thank you so much.

Announcer:
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