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Rethinking Treatment Success in Irritable Bowel Syndrome with Constipation

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

Dr. McDonough:
This is *GI Insights* on ReachMD, and I'm Dr. Brian McDonough. Joining me to discuss how clinicians can rethink the standard for symptom control in irritable bowel syndrome with constipation, or IBS-C for short, is Dr. Darren Brenner. He's a Professor of Medicine in Surgery in the Division of Gastroenterology, as well as the Director of the Neurogastromotility and Interdisciplinary Bowel Dysfunction Programs at Northwestern University Feinberg School of Medicine in Chicago.

Dr. Brenner, thanks for being here today.

Dr. Brenner:
Thanks so much for having me. I appreciate it.

Dr. McDonough:
So to give us some context, Dr. Brenner, what currently defines treatment success for IBS-C, and where do you think that definition may fall short in real-world practice?

Dr. Brenner:
I think that it's a very difficult question to answer, because, from a practical standpoint, as physicians and practitioners, we're always looking at the symptoms. We define irritable bowel syndrome as abdominal pain. Most of us still classify it with discomfort, bloating, distension, and changes in bowel habits.

So we can be very pragmatic. We can use the criteria used to define irritable bowel syndrome and say, do you meet these criteria anymore? Yes or no? But the reality of the situation is that, I think, in clinical practice, what we really need to be doing is to be stepping away from how we approach this disorder and look at it from the patient's perspective.

Because for the vast majority of patients, it's not about pain that is three out of 10 or four out of 10, or 10 percent better or 20 percent better. It's more about quality of life. Can I go out? Can I have dinner with my friends? Can I get on an airplane and travel overseas? Can I go to a wedding? These are the types of things that I hear every day from my patients.

So, from my perspective, we're thinking about, how do we know if there was a treatment success? It's if a person is able to live their life with improved quality of life at the level that they want to do so, much more so than shifting from two complete spontaneous bowel movements a week to three.

Dr. McDonough:
With that being said, a widely cited review in *Gastroenterology* notes that many patients continue to experience persistent symptoms despite standard therapies. In your experience, how often do patients fall into that partial responder category, where they improve somewhat, but still have meaningful residual symptoms?

Dr. Brenner:
I would say the vast majority. The reality of the situation, where we have to set standards or baselines, is that irritable bowel syndrome is a waxing and waning disorder. There's no cure for this particular issue. So, when people come in looking for cures, I have to be practical and explain, again, it's all about symptom improvement, symptom control, and getting you to that point where you can live your best life.

And this is something we have to address all the time. When we really look at this process, and you look at the clinical trial data—remember this is clinical trials—about two thirds to three quarters of all individuals will still say they have persistent symptoms that bother them, and that's not surprising. Because, thankfully, in 2026, we have multiple different therapeutics that can improve the global symptoms or the totality that is IBS.

And with IBS-C, we're talking about things like pain, discomfort, bloating, distension, less frequent bowel movements, harder stool strain, and incomplete evacuation. There are therapeutics out there, both pharmaceutical and otherwise, that can improve all of those symptoms. But the problem is, what we've also learned with respects to irritable bowel syndrome is that this is not a one-size-fits-all disorder.

I like to call this an N-of-one illness, meaning that everybody's cause for irritable bowel syndrome can be different. And the things that trigger exacerbations of symptoms can be completely different as well. So, for example, some people experience IBS symptoms because they have evidence of bile acid malabsorption. Some people have dysbiosis. Some have lost their barrier function, or they have damage to their intestinal epithelial barriers, and now there's permeability. Some don't eat the right foods, and then things can be triggered by stress. So the beauty of the illness is that everybody is different, and this is really why we don't have an algorithm for treating IBS-C, -D, or -M.

If we want to get better at treating this illness, get patients better, and get these patient-reported outcomes to say, yes, I'm doing well, instead of attacking the symptom profile, we have to identify the underlying causes, come up with accurate diagnostic strategies for those causes, and then treat the cause itself, not the symptom profile. And people will feel much, much better once we're able to do that.

Dr. McDonough:
Very interesting. Building off that, which symptoms are most likely to be underrecognized or underdiscussed during routine visits, especially in patients who seem to be doing okay on therapy?

Dr. Brenner:
Yeah, I think the major symptoms and the things that drive patients to come see us as practitioners are the abdominal symptoms: the pain, the discomfort, the bloating, the distension. And it's realizing, as practitioners, bloating and distension are completely different phenomenon, but to a patient, they're defined the same way. And they're treated differently. So these are the things that people are really suffer from.

The reality of the situation is, for the vast majority of people with irritable bowel syndrome, if we just attack the bowel symptoms, we can do a really good job treating those symptoms with over-the-counter therapies. That's why patients are really driven to see practitioners, because they're astute and they've done their homework. They can use Google AI or ChatGPT, and they say, what should I be using over the counter for my IBS symptoms? And it says, things like PEG 3350 for constipation or loperamide for diarrhea.

What the reality of the situation is, when we look at clinical trials, the data is finite. Over-the-counter therapeutics cannot improve the abdominal visceral sensory symptoms that are the sine qua non of irritable bowel, and that's why the average individual tries three to about three and a half therapeutics before they come to see us. So we have to do a better job at that.

The other thing we have to do is we have to get away from the idea of just looking at frequency and texture of stools. On the diarrhea side, things that really impact quality of life are urgency. Who wants to go out if, within 15 minutes, you're going to be stuck in your car in rush-hour traffic and have to go to the bathroom and have nowhere to go? And this is especially true with fecal incontinence. On the constipation side, there's the sensation of incomplete of evacuation: when am I going to have to go again? I get this urge over and over again. Or it's the sensation of, I just can't get this out. These can be major players in this process. Straining is a major player, beyond the fact that they only go a couple times a week and the stools are hard. So we have to drill down and tease out these more subsyndromic symptoms that are very common and very real, and try and tackle these for our patients as well.

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. Darren Brenner about moving beyond baseline symptom management in IBS-C.

So, Dr. Brenner, having explored partial response, let's shift gears and talk about what this really means for patients. How does under recognition of residual symptoms affect their quality of life and long-term engagement with care?

Dr. Brenner:
Yeah, so for partial response, to be able to assess that, very importantly, you have to assess a baseline response. And as we've discussed previously, that baseline response has to include the quality-of-life impact. Ask about things like work, social events, absenteeism, and presenteeism. Are you afraid to go out? These are the things that play a major role. And I know that we're discussing

this and I'm addressing this over and over again, because we've always learned that if there's something important, you'll hear it repetitively. And I can't stress this enough, because, realistically, in about 20 years of practice, I can probably count on two hands the number of times that I've read referring physician's notes or practitioner's notes, and they've made any comment on quality of life or baseline symptoms.

So there's lots of ways to do this. You can use simple scales. Ask your patients at baseline when you see them for the first time for their IBS symptoms: rate your pain on a scale of zero to 10. Rate your bloating and your discomfort. How often do you go to the bathroom? How is this impacting your quality of life? What can you do and not do? And then, when you give a therapeutic, use the exact same questions. Go back to what's there, and then ask the patient, have you had adequate relief? How are you doing? What percentage improvement have you had? Is this good enough for now or do you want to try and get further?

Because, realistically, there are other options now in 2026. I don't want to hear anymore from my patients, "I saw practitioner X and they shrugged their shoulders and said there's nothing I can do". On the IBS-D and IBS-C spectrum, Brian, there are at least 20 different interventions that I can think of for treating these disorders.

So we have to do better, and we have to do better by our patients. For the practitioners that want more validated scales, use things like the IBS Quality of Life Survey or the IBS Symptom Severity Scale, because these have thresholds that have been validated to show minimal clinically meaningful improvements over time. So you can use these as well if you want to use validated standardized scales to see how your patients are doing and if those patients are having a hard time voicing their response to therapies.

Dr. McDonough:
Knowing that, what practical approaches can clinicians take to better identify patients who are partial responders versus those who are truly well controlled?

Dr. Brenner:
Yeah, I think we just have to ask the right questions, right? Let the patient speak first, and then really try to drill down on what you need to know. You can go back to the symptoms. The symptoms are important. What were you at baseline in terms of pain? What are you now in terms of bowel movements? What percentage of the time are you having complete bowel movements? How many are you having a week compared to baseline?

And then, again, ask about the other symptoms—really focus on that quality-of-life piece. But, more importantly, ask the patient, you're back to see me—maybe because I asked you to come back in a month, but more likely because you are not where you want to be—so what is it that's keeping you from where you want to be? What are the major factors in your life that are playing a role? What are the biological factors that I can go after, and how can we meet that point where you want to be to live your best life?

In reality, we also have to be realistic. We know that some of our patients are not realistic in terms of the quality response that they want to have, and sometimes we just have to be honest about that as well. So I have people who say they have a partial response, but they actually, when you talk to them, have an 80 to 90 percent improvement from baseline. From that standpoint, from a practitioner standpoint, that is a significant improvement and may be the best we can get. So sometimes, again, we have to have realistic conversations with our patients about how much we can do to benefit them overall and in the long term.

Dr. McDonough:
Finally, Darren, at what point should clinicians consider moving beyond first-line therapy for these partial responders, and what factors should perhaps guide that decision?

Dr. Brenner:
Sure, I think when your clinical acumen says that the patient's not doing as well as you like, or the patient flat-out comes out and says, "This isn't working for me," or, "I'm having too many side effects," or, "Is there a way to switch it?" It's really that shared decision-making conversation that has to be had to determine when we should be switching or shifting gears and moving on to something else, or potentially adding on to whatever may already be partially working.

Dr. McDonough:
That's a great comment for us to think on as we come to the end of today's program. I want to thank my guest, Dr. Darren Brenner, for joining me to discuss how we can improve our approach to symptom control in irritable bowel syndrome with constipation.

Dr. Brenner, it was great having you on the program.

Dr. Brenner:
It was my pleasure. Thank you so much for having me.

Announcer:
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