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Understanding Practical Points in Evaluating & Treating IBS

Dr. Buch:
Diagnosing and treating irritable bowel syndrome, or IBS, can be challenging and can present many questions. Did I order enough tests? Am I missing something? Which is the best therapeutic approach to my patient? That's why we'll be taking a look at how we can answer these and other key questions.

This is *GI Insights* on ReachMD. I'm Dr. Peter Buch. Today I am pleased to discuss practical points in evaluating and treating IBS with a colleague of mine, Wendy Wright, an adult and family nurse practitioner from New Hampshire. Ms. Wright, I'm delighted to have you join us today.

Ms. Wright:
Thank you so much.

Dr. Buch:
Let's get started with a whole bunch of questions. Ms. Wright, lots of practitioners seem to be confused, so how do we diagnose irritable bowel syndrome in 2021?

Ms. Wright:
Yeah, so I think that's a really great question. Some of you may remember the term "Rome Criteria," and we're now at the Rome IV criteria, and generally the way we make the diagnosis is when the patient says to us, "You know, I've been having this recurrent abdominal pain," and it needs to be going on, on average, at least a day a week, and at least for the last three months. And then it's associated with two of the following: that recurrent pain is related to defecation, that there's a change in the frequency or the change in the form of the stool. So when we talk about IBS, remember it's kind of that global term under which there's IBS-D – diarrhea predominant, IBS-C – constipation, and then IBS-M, or the mixed subtype. We used to call it alternators, but we call it the mixed subtype. So what we do is we actually qualify that IBS by what proportion of days people spend each month in either the diarrhea, the constipation, or the mixed subtype. My understanding is that it's really an equal distribution. About one-third of individuals have the D, one-third the C, and one-third the M, but the diarrhea folks tend to be a little more vocal, because those are the folks that are obviously having diarrhea. Oftentimes when they've eaten in a restaurant, or they're stressed out, it will trigger some of those events. So that's how we actually make the diagnosis.

Dr. Buch:
So what are alarm symptoms, and why are they important in diagnosing irritable bowel syndrome?

Ms. Wright:
One of the things that we need to do, as clinicians who are evaluating these patients, is to make sure that we're not missing any type of underlying, worrisome, etiology. For instance, we wanna make sure we're not missing a colorectal cancer. We wanna make sure that we're not missing some type of inflammatory bowel disease, such as ulcerative colitis or Crohn's. One of the other things that comes to mind is, I had a patient come in who was having some constipation, having some bloating. She was 26 years old, and it's easy at that point to say, "Oh, it sounds like it could be irritable bowel." But constipation and bloating can also be an ovarian pathology. I went on to get a pelvic ultrasound, and this young woman had ovarian cancer. So that's what I mean when we say "alarm findings." We're trying to make sure that we're not missing any type of underlying, serious pathology, such as a malignancy or such as some type of inflammatory bowel disease. And then the other thing I would say, while I don't call them alarm findings, is I wanna make sure that there's nothing readily identifiable. Is it possible that this person has Giardia, a parasite, because they've recently traveled, or is it possible that they've got some other type of infection going on, such as a C. difficile from an antibiotic that they had recently taken? So, that's what we mean

when say alarm findings – just making sure that we're not missing something worrisome.

Dr. Buch:
You have a patient with irritable bowel syndrome that you've diagnosed for several years, and now they have alarm symptoms. So Ms. Wright, how would you approach that?

Ms. Wright:
Sure. So the person who has alarm findings – it's time for that patient to be evaluated, whether it be with a CBC to look and see if – are they losing blood? Because remember, the number one cause of iron deficiency anemia in anyone over the age of four is chronic, low volume blood loss. So, if I find an iron deficiency in someone with bowel changes, it makes me wonder where they're bleeding from. That person may need an upper and a lower endoscopy to rule out a malignancy. I also wanna think about – is it possible that this person has an inflammatory bowel issue? Ulcerative colitis or Crohn's? And that's where I might get some stool tests that we call fecal lactoferrin or fecal calprotectin. These are stool tests that we do to actually look for inflammation in the stool, basically, which would point us to those inflammatory bowel conditions, such as ulcerative colitis or Crohn's. And I think you bring up a really good point. Just because someone always had IBS, if something changes, we need to take that seriously, and we need to make sure that we're not missing one of those underlying pathologies that I've recently spoken about.

Dr. Buch:
I wanna add one other point and you and I have both faced these kinds of situations. We have a patient with irritable bowel syndrome, and now they have rectal bleeding. They say, "Oh, I swear it's my internal or external hemorrhoids." Ms. Wright, how do you approach that?

Ms. Wright:
Absolutely, and we get this all the time. Positive blood on stool cards is positive blood. It needs an evaluation.

Dr. Buch:
And again, I think we both wanna re-emphasize to the audience that there is a spike in young individuals with colon cancer. Could you just comment about that briefly?

Ms. Wright:
Sure. So I think one of the things we're seeing is that some of these cancers, particularly the cancers lower down in that GI tract – we're seeing that some of them are related to HPV, high-risk serotypes, HPV 16. So, we definitely are seeing that, and it's just incredibly frightening about the number of cases that I've seen in people in their 40s and 50s. So, I think it's really imperative to never assume, you know, when I teach nurse practitioners, I say, "Never assume that a 30-year-old female can't be having an MI." And don't assume that a 30-year-old can't have anal or rectal cancer, or some type of colorectal cancer. We have to make sure we're doing due diligence and making sure that that bleeding is not coming from something more worrisome.

Dr. Buch:
Well said. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Wendy Wright, a nurse practitioner, about diagnosing and treating irritable bowel syndrome. So Ms. Wright, now that we've talked about testing for irritable bowel syndrome, let's talk about how we can treat it. What frustrates practitioners the most when treating irritable bowel syndrome? And how do we overcome it?

Ms. Wright:
So, I think it's really interesting, because I often think about people with IBS kind of in that same category as people with fibromyalgia – that not one thing always works for everyone. And I think that this is a real issue. Many people don't tell us about it. The GI aisle in the pharmacies – the over-the-counter GI aisle is a billion dollar a year aisle. What that means is people are suffering, and they're suffering at home, and they don't always tell us about it. So oftentimes, by the time they see me, they've been suffering for years. Or, they've seen their mom have the same symptoms – or their dad – and they think, "Well this is just something I have to live with." So that's the bad news. The good news is, there's so much available. But I will tell you, I often have to try two and three and four types of agents before I can figure out which one works best. I guess for me, what frustrates me the most, is that old adage out there that you're gonna fix this by drinking more water. Drinking water is not gonna fix this issue, nor is bumping up your fiber to some unconscionable amount of fiber. All it's gonna do is bloat people and make them feel like a helium balloon. Yes we want people to eat fiber, but if it were that simple, people would have done that. One thing for my colleagues to say – people with IBS-D, think about celiac disease. It's estimated that up to five percent of people, particularly with the IBS-D subtype, have underlying celiac disease, so make sure you're thinking about that, because that certainly is something that we need to have in our head. Oftentimes, too, by the time people come to me, they've already done a diet elimination, right? They've eliminated lactose, they've eliminated fructose. They've tried a lot of different things – even the FODMAP diet, which for so many people is so hard to do. So now, it's time for me to begin my treatment. So the good news is,

lots of different options, whether you're the IBS-C, or IBS-D. Now for me, Peter, the hardest people for me to treat are those IBS-M types, because if I tip them over a little bit, they're gonna have a little more diarrhea than they like. So – those are, for me, the hardest people to treat, but we have lots of different options.

Dr. Buch:
I fully agree. For those who are not familiar with FODMAP, Wendy, could you just kindly define what FODMAP is?

Ms. Wright:
Sure. So the FODMAP diet it's a pretty intensive diet. And what it is, it's really sticking with a lot of the kind of basic foods, but it's eliminating some of those foods that can really be triggers for people with IBS, and then what a lot of my patients will do is they'll go to the real intense, kind of FODMAP diet, and then what they'll do is they'll start adding in a little bit of food to see if that food is truly something that will trigger their symptoms. What I hear from my patients, because that's often what happens when they go over to GI, is, "Well, I was told to go onto the FODMAP diet." They last a few weeks, and say, "This is just not something I can continue to live with." And I tell people, "Life is a choice, right? You can try it and if you can't do it, then what we have to do is find some way to meet in the middle, and maybe it's a modification in your diet – avoiding those trigger foods if you know what they are – and then maybe what we can do is use a little bit of medication on the back end to try to help you as well."

Dr. Buch:
In my particular situation, I always try to get my patients to dietitians to review the FODMAP diet. I have found that it takes a huge amount of time for that to be accomplished, and once you're on a FODMAP diet, it's very important to reintroduce foods over time, and that takes, again, an exorbitant amount of time, and that requires dietitian help as well. Could you comment on that?

Ms. Wright:
Yes, Dr. Buch, you're absolutely right. With the average primary care visit being 16 minutes, it's pretty darn hard to accomplish that kind of intervention in one visit. But I often tell my patients Rome wasn't built in a day. What you and I need to do is we need to have visits and we need to work on this together over a course. It needs to be trial and error, because there's no cookbook recipe. What works for you doesn't work for me, and vice versa, with patients. So, I think you're absolutely right. What we run into is not all of the insurance plans are gonna cover or pay. I often tell my patients, "Covering something is very different than paying for it." Most of the insurance plans will tell you that they cover X, Y and Z, but they don't pay for it, because it goes to your deductible. So having that conversation with a patient, seeing if they're willing to do that, I think it's really important, but a lot of patients cannot afford it.

Dr. Buch:
I agree. We try as best as we can. Getting on to the next question, what is your opinion about alternative therapies, like hypnosis, biofeedback, and acupuncture in treating irritable bowel syndrome?

Ms. Wright:
Well, so one of the things that it's my understanding about IBS is stress doesn't make IBS happen. You're genetically predisposed. There may be modeling at home, but there's a genetic predisposition. We also think that the gut microbiota plays a role. So for instance, if your lactobacilli are off, if you've got an infection there, and interestingly enough, we know that at least a third of individuals who develop IBS have that genetic predisposition, but it's a viral gastroenteritis, or some type of gastroenteritis that triggers it to occur. And so, I certainly believe that stress is a trigger for something that you're genetically predisposed to. So you know what? Do no harm is my principle. And if that persons says to me, "Biofeedback, meditation, hypnosis, yoga all work for me. They help me." Then if you can do it, awesome. The best drug is no drug at all, in my opinion, but if people need them, I'm thankful we have a toolbox that we can use with people. So I think one shoe doesn't fit all, and so whatever people can do to modify their stress – because absolutely, stress and anxiety play a huge roll in triggering the symptoms. If I had a dollar for every patient with IBS who said, "I was about to go into work," or, "I was about to go into a meeting, and I literally had to pull over and go to the bathroom." Stress is a big trigger, so whatever people can do to modify that, and to control it on their end I think it's critical.

Dr. Buch:
Thank you. And finally, are there any other insights you would like to share with our audience?

Ms. Wright:
Absolutely. Find a provider who wants to work with you. I know a lot of these people Dr. Buch, end up at your doorstep, but at the end of the day, they really don't need to be in your doorstep. If a primary care provider is knowledgeable about IBS, knows what those alarm features look like, there is no reason that this condition can not be managed in primary care. I read a study that about a half of these folks end up in your clinics. And I get it, because they may need to be scoped, but a lot of them end up there because providers don't take the time or don't wanna partner with these individuals to work on the symptoms. But the good news is, there's so much that we can

do if we partner with them and systematically work through all the different options.

Dr. Buch:
Well, that's all the time we have for today, but I want to thank Wendy Wright for joining me to share some practical points on effectively evaluating and treating irritable bowel syndrome. Ms. Wright, it was great speaking with you today.

Ms. Wright:
It was my honor, thank you so much.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this episode, and others from *GI Insights*, visit reachmd.com/gi/insights, where you can be part of the knowledge. Thanks for listening.