

Controversies In...Functional Bowel Disease

As part of our re-launch of the #FGdebate, we were joined by our previous editor-in-chief Anton Emmanuel to answer your questions and discuss challenging aspects of managing functional bowel disease. This article will summarise the main points covered in the event, which generate widespread engagement and over a million tweets by 24 hours after the event.

Are diagnostic tests for gastroparesis clinically useful and how should they be interpreted?

The discussion opened with evaluating the utility of available tests for gastroparesis. A major point to come through was the poor discrimination in current diagnostic tests between gastroparesis and functional dyspepsia (FD). Approximately 25-35% of patients with FD will have some delayed gastric emptying, (Ref) but this alone is insufficient to label as gastroparesis. Therefore, tests such as gastric emptying scintigraphy should be used judiciously, focussed on patients with co-morbidities relaying increased risk of gastroparesis such as diabetes, previous abdominal surgery and chronic opioid use.

How do we manage a consultation with a frustrated patient who has already tried multiple treatments without success?

It was clear from the contributions that clinicians find it challenging knowing how to manage and structure consultations for patients with functional bowel disease. It was recommended that 30 minutes is a minimum requirement for new patient consultations, in which listening to the patient's story is of paramount importance. Communication should involve an honest discussion about prognosis and managing expectations about the lack of 'magic bullet' cures. Care should be taken over ordering excessive tests, which have often already been done in the past, as this can perpetuate a false sense of hope about treatment goals and delay positive steps towards managing symptoms.

Box 1: Managing a difficult Consultation

Patient Concern: "None of the treatments work because they're for people with mental illness."

Reframe Understanding: "They are centrally acting analgesics used at lower doses than psychiatrists with few side effects."

Be familiar with available drug indications, doses, side effects and combinations, and non-pharmacological treatments (e.g. CDT, hypnotherapy).

However, it was emphasised that much can be gained by explaining the rationale for treatments clearly and revisiting previously 'failed' treatments that may not have been administered properly. A good example of this was the use of neuromodulators, which have a strong evidence base when dosed appropriately and given in the right combinations (Box 1).

All agreed that a clinical psychologist is a vital resource in a specialist FBD clinic, but availability is scarce due to funding restrictions.

Is small intestinal bacterial overgrowth (SIBO) under-diagnosed?

There was strong disagreement with data from some studies suggesting a high prevalence of SIBO in IBS-D, due to the limitations of hydrogen breath testing. The general view was that diagnosis should only be considered in at-risk groups such as scleroderma, previous abdominal surgery and jejunal diverticulosis.

Should we test for bile acid malabsorption (BAM) in patients with IBS-D?

BAM is present in about a third of patients with IBS-D, and eminently treatable with sequestrants (e.g. Questran and Colesevelam). Symptoms that point to this as an underlying cause include profuse

watery diarrhoea, urgency and nocturnal symptoms, +/- bloating. It is some clinician's practice to treat empirically but confirming the diagnosis with a SeHCAT scan was encouraged as patients find the treatment difficult to tolerate, and it can interfere with the absorption of other medications and fat-soluble vitamins.

What are the recommended treatments for IBS-D?

Once the diagnosis is confirmed and alternative causes of chronic diarrhoea have been excluded, the first line treatment is loperamide, which can most easily be gently titrated using the syrup preparation to avoid excessive swings to constipation. There are five drugs that show small but significant improvements in IBS-D based on FDA trial endpoints, although none are available currently in the UK. For patients with pain and bloating as part of the IBS-D symptom complex, a low FODMAP diet may be beneficial, although this needs proper dietician support to assist in structured reintroduction of food groups. A careful history (absence of pain temporally associated with altered bowel function) and examination (presence of paradoxical puborectalis contraction on attempted voiding) should eliminate the concern that the diarrhoea is related to IBS-C or overflow from idiopathic constipation.

Are there options for patients with IBS-C refractory to Linaclotide?

Forest plot data shows significant benefit of 5 drugs versus placebo for IBS-C based on FDA trial endpoints (Linaclotide 290mcg, Tenapanor 50mg, Lubiprostone 8mcg, Plecanatide 6mg and Plecanatide 3mg), but the effect size is smaller than for hypnotherapy. Linaclotide and lubiprostone are agents acting on intestinal chloride channels and are more specific agents than laxatives. Prucalopride can be an effective agent, and can overcome the constipating effect of low dose tricyclic antidepressants. For severely refractory patients, there is benefit to stopping all treatments and reassessing using a focussed symptom-based approach.

Should we be funding more clinical trials in IBS?

Clinical trials are not the only answer in improving the management in IBS, mainly because trial populations in tertiary centres are very different from the vast majority who are only seen in primary care. Of all patients with IBS, only 20% will consult a GP, and 3% will end up in specialist centres. Conversely, tertiary centre patients make up 85% of clinical trial cohorts. Therefore, data obtained from such studies may not be applicable to the unseen majority in the community.

One example cited of useful clinical trials in IBS was debunking the myth that it is an inflammatory condition, through two large trials showing no improvement with 5-ASAs. (Cite Spillar and Barbara Trials)

Commented [MB1]: Care IBS – D isn't IBS-C masquerading as diarrhoea with incomplete rectal evacuation

Commented [MB2]: Need to put in what it is as not that widely used

Commented [JM3R2]: Not sure how to do that without making it too long winded. Anton?

Commented [JM4]: Check with Alex Ford on sharing this and also data above

Commented [JM5]: What is the availability of this in NHS?

Key Take-Home Messages

1. Spend as much time as you can getting to know individuals struggles- book into the end of clinic.
2. Don't rely on complex tests and treatments- do the basics well, with psychology support.
3. Diarrhoea is more successfully treated than constipation.
4. Think about tricyclics, hypnotherapy and CBT for FD.
5. There is less SIBO and gastroparesis than you think!