

Tool Kit Beats Rx for Irritable Bowel Syndrome

BY BETSY BATES
Los Angeles Bureau

LOS ANGELES — An educational tool kit designed to improve patient-physician interactions during visits for irritable bowel syndrome had a greater impact on global symptom relief than did any medication ever studied for the enigmatic disorder.

Dr. Brennan M. Spiegel and associates at the University of California, Los Angeles, tested the tool kit in a randomized study of 73 patients with irritable bowel syndrome (IBS) symptoms who attended the gastrointestinal disease catchment clinic for the VA Greater Los Angeles Health Care System.

Follow-up surveys 3 months later found that patients assigned to the physician-patient intervention group were far more likely than were those who received standard care to say they had achieved relief of their global symptoms (20 of 36 patients, or 56%, compared with 5 of 34 patients, or 15%).

The intervention effect size of 0.75 “exceeds the largest effect size demonstrated in pharmaceutical studies for IBS,” Dr. Spiegel said at the annual Digestive Disease Week.

Although studies of alosetron using similar outcome measures had effect sizes between 0.2 and 0.5, “this does not mean ... that these agents are not effective. It does suggest that medical therapy alone may be suboptimal if it is not delivered in the context of a supportive and informative physician/patient interaction,” he said.

The multifactorial intervention consisted of a five-part tool kit that included:

- ▶ A waiting room questionnaire to document the patient’s primary concerns, fears, and opinions about what might be causing IBS symptoms.

- ▶ A laminated flash card for the physician that includes key components of an effective discussion of IBS, including reminders to ask about psychosocial elements of the disease, descriptions of IBS in lay language, and the fact that IBS is not a life-threatening disease.

- ▶ A worksheet and diagram of the brain and gut that the physician could use to depict a simple explanation of the complex neural circuitry linking the two.

- ▶ A multimedia patient educational kit, including a self-empowerment video, an explanation of the brain-gut axis in lay language, information about support groups, a dietary card, and educational materials about IBS from the National Institutes of Health.

- ▶ A letter, sent 1 month following the office visit, asking the patient, “How are you doing?” and providing information about how to contact the physician if symptoms had not improved. This correspondence also included more educational information about IBS.

Physicians were free to use or ignore the patient’s questionnaire, the flash card, and worksheet during the office visit; however most found that it actually “streamlined” the visit, Dr. Spiegel said.

Similarly, patients could read or dispose of the educational materials provided. Some told study investigators that they found the worksheet very important, while oth-

ers primarily relied on the diet cards they found in the take-home educational kit.

Whatever elements did the trick, the intervention clearly had an impact on patients, with significant differences seen in global IBS symptoms, satisfaction, and perceptions of their physicians’ interpersonal skills.

Ironically, the same physicians saw IBS patients assigned to the intervention group or to usual care.

When independent observers assessed physicians’ notes from the visits, they found “very large differences” between the intervention and standard care groups in terms of observations concerning patients’ quality of life and extraintestinal symptoms such as anxiety or depression. None of the physician notes documenting visits with control group patients mentioned patients’ fears and concerns or disease education efforts, while these elements appeared in their notes regarding 23% and 54% of intervention patient visits, respectively.

Dr. Spiegel prefaced the report on his findings by acknowledging the deep frustration many physicians feel in dealing with patients with IBS, since the disease is common and expensive, symptom expression is heterogeneous, the disease model is incomplete, and highly effective treatment options are scarce.

This frustration can spill over into office visits that leave neither party satisfied.

“Patients often feel uninformed after they have left the office and physicians often do a poor job of predicting patients’ severity when patients and physicians fill out the same questionnaire,” he said. ■

Obsessions and Compulsions Continue After Bulimia Remits

BY DIANA MAHONEY
New England Bureau

TORONTO — Comorbid obsessive and compulsive behaviors persist in women with bulimia nervosa, even after the abnormal eating patterns associated with the condition have been successfully treated, Dr. Jessica C. Morgan said at the annual meeting of the American Psychiatric Association.

This finding suggests that elevated obsessive and compulsive ratings may reflect a persistent trait characteristic in individuals who develop the eating disorder—a discovery that “could lead to new treatment strategies for managing anxiety symptoms in at-risk individuals, particularly those in the recovery stages of bulimia,” said Dr. Morgan of the department of psychiatry at Dartmouth Medical School in Hanover, N.H.

Because previous studies have linked obsessive and compulsive behaviors to the primary symptoms of bulimia, Dr. Morgan and her colleagues sought to determine whether remission from bulimia had an impact on co-occurring obsessive-compulsive symptoms.

Using subject self-ratings on the Maudsley Obsessive-Compulsive Inventory (MOCI), the investigators compared the obsessive-compulsive characteristics of 25 women with active bulimia, 21 of whom were in recovery from bulimia, and 28 healthy controls—all of whom were medication free at the time of the assessment. The investigators also looked at participants’ mean scores on

the Eating Attitudes Test (EAT), which assesses disordered eating attitudes, and the Spielberger Trait Anxiety Inventory (STAI), which tests for anxiety disorders.

“As we had expected, the MOCI scores for the bulimia group were significantly elevated, compared to those of the controls,” said Dr. Morgan, noting that the respective scores were 5.4 vs. 2.5 on the 30-item true-false questionnaire designed to assess overt rituals and their related obsessions. “The recovery group had similarly elevated MOCI scores [5.5],” she said, which suggests that those aspects of the disease associated with obsessive-compulsive behaviors were not affected by treatment.

In contrast, the EAT and STAI scores for the women in recovery were significantly reduced, compared with those of the women with active bulimia, “although they were still significantly higher than what we observed in the control group,” Dr. Morgan said.

The persistence of obsessive-compulsive symptoms after recovery from bulimia not only suggests that such behaviors may be trait related in affected individuals, but also raises the possibility that the behaviors contribute somehow to the pathogenesis of the eating disorder, she noted.

Although more research is needed to clarify the relationship between the co-occurring conditions, the demonstrated link between the two may help clinicians more readily identify bulimia patients at risk for lingering obsessive-compulsive symptoms, Dr. Morgan said. ■

Sleep Apnea Associated With Insulin Resistance in PCOS

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — A high risk for sleep apnea was common in women with polycystic ovary syndrome and was linked to high fasting insulin levels, Dr. Esra Tasali reported at a conference sponsored by the American Diabetes Association.

Among the women with normal glucose tolerance, insulin levels in response to oral glucose were twice as high in women at high risk for sleep apnea, compared with those at low risk.

This finding suggests that sleep apnea might worsen the metabolic consequences of insulin resistance, accelerating the conversion from normal to impaired glucose tolerance, Dr. Tasali said.

Although the study does not establish causation, Dr. Tasali recommended that women with polycystic ovary syndrome (PCOS) be systematically evaluated for sleep apnea, as its treatment might improve glucose metabolism.

A high risk for sleep apnea was observed in 30 of 40 women with PCOS, and 92% of the women had sleep problems, according to Dr. Tasali and her colleagues at the University of Chicago (*J. Clin. Endocrinol. Metab.* 2006;91:36-42).

Of the 40 women, 32 had previously been given an oral glucose tolerance test.

Glucose tolerance was normal in 19 women. In 22 women at high sleep apnea risk, average fasting insulin levels were significantly higher (168 pmol/L) than they were in the 10 women at low apnea risk (97 pmol/L). Among the 13 women with impaired glucose tolerance, glucose and insulin levels did not differ depending on the level of apnea risk.

Another cohort of eight women with PCOS underwent overnight polysomnography for symptoms suggestive of obstructive sleep apnea. Mean sleep efficiency

was 80% in the women with PCOS, compared with 92% in a control group of age-matched, nonobese women. The women with PCOS also had significantly longer mean sleep latency

(41 minutes vs. 10 minutes), and significantly shorter total sleep time (323 minutes vs. 442 minutes, a difference of almost 2 hours).

“Sleep apnea might be an intrinsic component of the metabolic disturbances that appear with” PCOS, Dr. Tasali said.

Furthermore, severity of sleep apnea as measured by the apnea-hypopnea index, and the degree of oxygen desaturations during rapid-eye-movement sleep, accounted for more than 90% of the variability in measures of glucose tolerance including hemoglobin A_{1c} levels.

Dr. Tasali had no conflict of interest to report regarding her presentation. ■



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DR. TASALI