IBS Workup Is Controversial, Despite Guidelines

Given a case report, experts agreed on the clinical utility of only two tests to rule out organic disease.

BY BETSY BATES
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LOS ANGELES — Even the experts disagree about what tests should be ordered to rule out organic disease in patients presenting with symptoms of irritable bowel syndrome, according to survey results presented at the annual Digestive Disease Week.

Dr. Brennan M. Spiegel and associates at the University of California, Los Angeles, surveyed 27 recognized experts in irritable bowel syndrome (IBS), 53 randomly chosen gastroenterologists from the American Gastroenterological Association, 89 primary care physicians, and 102 nurse-practitioners to determine whether various health care professionals consider IBS to be a diagnosis of exclusion.

Their results suggest that many physicians and other health care professionals are not following practice guidelines issued in 2002 by the American College of Gastroenterology (ACG), which emphasize the importance of assessing IBS symptoms and discourage extensive work-ups for patients who do not have alarming symptoms or findings on physical examination.

Survey respondents were presented with a fictitious patient scenario and asked what tests they would order to establish a diagnosis of IBS. In the vignette, the patient was a 42-year-old woman with a history of loose stools for many years and up to six bowel movements a day. She described crampy, left lower quadrant pain that improved with stool passage. Neither her history nor her physical exam revealed any alarming symptoms.

On that description alone, two-thirds of IBS experts were willing to endorse a diagnosis of IBS, compared with 34% of primary care physicians, 43% of gastroenterologists, and 41% of nurse-practitioners.

If one test is going to be ordered for patients meeting Rome II criteria for diarrhea-predominant or mixed IBS, a celiac disease panel is a good choice.

IBS experts were in strong agreement that two tests would be warranted to rule out organic disease: a complete blood count and a test for antibodies to celiac sprue. They also agreed on one inappropriate test: a breath test for small-intestine bacterial overgrowth.

"Everything else was uncertain, even among experts, about what to do," Dr. Spiegel said. Respondents showed "extreme variation" in the additional tests they said they would order, with some advocating a chemistry panel, erythrocyte sedimentation rate, thyroid stimulating hormone, stool white blood cell count, and other tests.

On average, the IBS experts said they would order a total of 2 tests, while gastroenterologists would order 3.9; primary care physicians, 4.1; and nurse-practitioners, 4.3.

The experts, chosen on the basis of their publications and selection for guidelines committees, were also far less likely than other health professionals to say they believed IBS was a diagnosis of exclusion; the rate was 8% of experts, compared with 42% of gastroenterologists and 72% of both primary care physicians and nurse-practitioners.

After adjustment was made for type of health professional, practice type, age, gender, and experience treating IBS patients, the belief that IBS is a diagnosis of exclusion predicted the desire to order 1.6 more tests and spend $364 more on diagnostic testing of the patient in the vignette.

"In general, this disconnect indicates that these guidelines, [which] have been much ballyhooed by the ACG and other groups, either are not being disseminated correctly or simply are not being followed or believed," Dr. Spiegel said.

An audience member praised the study, saying the findings were "dead on."

"I think we all realize that the diagnosis of IBS is probably imperfect and fraught with error," Dr. Spiegel responded.

Interim results of an unrelated study presented at the meeting suggest that if one test is going to be ordered for patients meeting Rome II criteria for diarrhea-predominant or mixed IBS, a celiac disease panel is probably a good choice.

A study from the National Naval Medical Center in Bethesda, Md., Walter Reed Army Medical Center in Washington, and the University of Maryland, Baltimore, attempted to identify organic gastrointestinal findings among 323 patients with IBS who received an extensive array of tests: complete blood count, comprehensive metabolic panel, thyroid function test, erythrocyte sedimentation rate, C-reactive protein panel, inflammatory bowel disease panel, hypolactasia (lactase deficiency) genetic assay, celiac disease panel, and colonoscopy with rectosigmoid biopsies.

A total of 9 of 323 patients, or 2.8%, were diagnosed with organic gastrointestinal disease based on the exhaustive testing. These included four, or 1.2%, with celiac disease; three with inflammatory bowel disease; one with malignancy; and one with sigmoid volvulus.

The only test that identified significantly more disease in IBS patients than in 241 controls was the celiac sprue test, reported Dr. Brooks D. Cash, director of clinical research and a gastroenterologist at the National Naval Medical Center. ■

Tool Facilitates Dialogue About IBS, Improves Symptoms

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.

For example, studies of alosetron using similar outcome measures had effect sizes between 0.2 and 0.5, he said.

"This does not mean by any means 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, said Dr. Spiegel.

Similarly, patients could read or dispose of the educational materials provided. Some told study investigators that they found the worksheet very important, while others primarily relied on the diet cards they found in the take-home educational kit.

'Medical therapy alone may be suboptimal if it is not delivered in the context of a supportive and informative physician/patient interaction.'

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.

"Unfortunately, data from our group and others demonstrate that there is a disconnect, oftentimes, between physicians and patients," he said.

"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."

The low-cost intervention, which will now be further tested, may help to bridge gaps in communication, fostering the physician/patient relationship as a cornerstone of treatment of IBS, said Dr. Spiegel. ■