

IBS Diagnosis Controversial, Despite Guidelines

BY BETSY BATES

Los Angeles Bureau

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 his-

tory 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.

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 gas-

troenterologists 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. ■

'These guidelines, [which] have been much ballyhooed by the ACG and other groups, either are not being disseminated correctly or ... are not being followed.'

Rifaximin-Loperamide Combination Knocks Out Traveler's Diarrhea Fast

BY BETSY BATES

Los Angeles Bureau

LOS ANGELES — A combination of rifaximin and loperamide, taken at the first sign of traveler's diarrhea, is the optimal way to treat an illness that affects 10 million American tourists a year, Dr. Herbert L. DuPont said at the annual Digestive Disease Week.

Rifaximin, a gut-selective antibiotic, and loperamide, an antiperistaltic agent, were tested alone and in combination in a randomized trial of 315 U.S. college students who developed acute diarrhea and at least one symptom of an enteric infection while studying in Mexico.

"The Imodium [loperamide] immediately stopped the diarrhea and the antibiotic cured the disease," Dr. DuPont said in an interview during the meeting.

"If they took Imodium alone, they got immediate improvement, but then they continued to be sick. Rifaximin by itself was slow to get going, but it cured the disease after 24-30 hours," he said.

"The combination zapped the thing rapidly and cured it, so we think it's probably the optimal

way to manage traveler's diarrhea," said Dr. DuPont, professor of medicine and epidemiology at the University of Texas, Houston, and chief of internal medicine at St. Luke's Episcopal Hospital, also in Houston.

The participants were assigned to receive either 200 mg of rifaximin three times daily for 3 days; 4 mg of loperamide initially, followed by 2 mg after each unformed stool, not to exceed 8 mg/day for 48 hours; or both of these regimens simultaneously.

During the 5-day study period, more than 75% of the students receiving rifaximin or the drug combination achieved a clinical cure, compared with 58% of those receiving loperamide alone.

The time from initiation of treatment to the passage of the last unformed stool was also shorter in patients taking the drug combination (27.3 hours) or rifaximin alone (32.5 hours) than with loperamide alone (69 hours), he reported.

Loperamide and the drug combination resulted in significantly fewer stools passed in the first 24 hours, but in the case of loperamide alone, the effect was

transient. Abdominal cramps were less frequent in patients taking the rifaximin-loperamide combination.

Finally, the participants' assessment of "complete wellness" was higher with rifaximin and the rifaximin-loperamide combination.

All of the treatments were well tolerated.

In the poster presentation, Dr. DuPont concluded that the drug combination "provides clinically relevant benefits vs. either agent alone, providing more rapid symptom relief and clinical cure ... [possibly representing] a new standard of care."

Although both drugs are available in many foreign countries, including Mexico, Dr. DuPont recommended that physicians prescribe the drugs to patients before they embark on journeys to developing countries, with instructions to take both medications according to the study schedule if they become ill.

Loperamide is available over the counter, and rifaximin is FDA approved for traveler's diarrhea.

Salix Pharmaceuticals Inc., maker of rifaximin, provided funding for the study. ■

Family History, Lifestyle Both Contribute to Ulcerative Colitis

LOS ANGELES — Former smokers and people with a family history of inflammatory bowel disease are at increased risk for developing ulcerative colitis, data from a case-control study of more than 1,400 patients have confirmed.

Family history of inflammatory bowel disease (IBD) was associated with the highest risk for developing ulcerative colitis.

Those patients with one relative with IBD had an adjusted odds ratio (OR) of 2.48 of having ulcerative colitis; those with two such relatives were at even higher risk (OR 6.8), Dr. Richard Gearry of the department of gastroenterology at Christchurch Hospital in New Zealand said at the annual Digestive Disease Week.

Other risk factors that were significantly associated with development of ulcerative colitis included being a former smoker at diagnosis (OR 1.82) and having used more than four courses of antibiotics a year as an adolescent (OR 1.71).

Factors that appeared to lower the risk included having had

an appendectomy (OR 0.45) and being breast-fed for more than 3 months (OR 0.71).

The study included more than 1,400 IBD patients, representing nearly all the IBD patients in the Canterbury, New Zealand, region.

Dr. Gearry and his colleagues recruited 668 patients with ulcerative colitis, 715 patients with Crohn's disease, and 599 sex and age frequency-matched controls.

All participants were asked to complete a self-administered survey containing questions that focused on more than 70 possible environmental risk factors.

About 95% of ulcerative colitis patients, 94% of Crohn's disease patients, and 84% of control subjects completed the survey.

Many of the risk factors identified in the study occurred during childhood, making it critical that researchers and clinicians be watchful of what is happening during that critical time before the development of IBD, Dr. Gearry said.

—Mary Ellen Schneider