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We've had a very interesting and useful discussion about the role of diet in the management of sufferers of IBS symptoms. But I'd like to turn now to Pali Hungin as our general practice representative here, and ask him how he starts the management of his sufferer with IBS symptoms.

Thank you, Richard. I think that the management has to be predicated on a good shared understanding between the doctor and the patient. They have to be speaking from the same sheet. I think it's important that the patient has a good understanding of what the problem is and what the likely direction is going to be in terms of management. From the point of view of the patient's overall care, it's important that the specific concerns and fears are addressed, and I think it's important to get out of the way, for example, a fear that there might be a cancer or something else that's bothering the patient.

After that, within the dialogue, which includes good quality education information for the patient, one can then start to tackle each problem in its own way. In my view the most pressing problems, or the most pressing symptoms, ought to be dealt with first. These could be different; these might actually not be directly related to the gastrointestinal symptom; it could be say poor sleep or anxiety. On the other hand the patient might have specific gastrointestinal symptoms which are a problem. The discomfort could be a problem, or the bloating. So my own approach is to ensure that we are working on the most troublesome problem and tackling it either by way of lifestyle changes or appropriate therapies.

So when you are thinking about appropriate therapies are you looking at a particular symptom or trying to embrace a number of symptoms with one treatment, and how do you assess the sorts of benefits and outcomes with the treatments that are currently available?

I think it's important for the therapy to be geared to the specific symptom. So for example, if a patient has a great deal of diarrhea or looseness which is causing the problem, that must be tackled with an appropriate anti-diarrheal. If it's constipation then medications or therapies that are specific to that. The same thing for bloating, for example, where one might use an anti-spasmodic. These do work in specific people fairly well. And for other symptoms that might be associated with IBS, again one will try to target things as closely as possible. We've talked about fiber, and this might be something that's appropriate for some people. But I

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think we should be clear about this, there's no global approach, and when I was less informed about irritable bowel syndrome I was terribly guilty of using what I would call "blunderbuss" therapy, a combination of anti-spasmodics, fiber, and sometimes anti-diarrheals, all in the same patient, without an understanding or an appreciation of what the chief problem was that I was trying to deal with and what it was the patient wanted me to deal with.

Does a specialist have a better armamentarium for managing these symptoms Anton?

As Pali has highlighted, the key issue is to focus on the most intrusive symptom. And if we take those sort of in turn really, so pain is often, is sort of a hallmark symptom, and once antispasmodic-type therapies have been tried unsuccessfully and patients are being seen, what we use quite successfully in a lot of patients is low doses of drugs called tricyclic antidepressants. These are drugs, as you know, which were used initially in much larger higher doses for treating anxiety and depression, but we use them in very modest doses in the gut. And sometimes a fifth or a tenth of the dose even the psychiatrists use. And we use those specifically for their effect on the gut, but of course they can have the side effect, unfortunately, of making some people a bit drowsy. The fact that it works in the gut doesn't stop it working to make people sleepy. But sometimes, as Pali said, that's a good thing; people can't sleep, and sometimes those so-called side effects are actually rather helpful.

But these drugs like amitriptyline or nortriptyline, as they're called, can be very helpful for some individuals. And so I think we're basically saying the same thing; it's some, it's not everyone. There's no blanket therapy. But as it's been alluded to, this is a sort of multifaceted problem.

And some concern for tricyclics, of course if you have a constipation-predominant IBS.

Absolutely. So these drugs do have another side effect, which we don't often want, which is to slow the bowel down. And so if your problem is also pain and constipation, that's not a good agent. But again, it's about focusing it around specific therapies.

Drugs that you would perhaps see contraindicated in this situation, opiates, for example?

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Absolutely. I would also strongly counsel, it's not patients, it's doctors who do this, let's face it, is against ever starting any drug which has a so-called opioid or opiate effect, so members of the codeine family, members of the morphine family. These are not helpful drugs; in fact they're actively unhelpful drugs for the patient with IBS, and they really should be resisted.

Now what about some of the other areas that perhaps some people would see as being fringe: hypnotherapy and psychotherapy and so on? There's some interesting literature here.

There's enormously important literature here. And I think, you know, I think as we've said several times now, this notion that the brain and the gut are separate things is erroneous, certainly as far as IBS patients are concerned. And so-called fringe therapies, if we're talking about psychological therapy or hypnotherapy, they are not fringe by any manner of means; these are mainstream therapies. The challenge is that they aren't widely available; these are often quite expensive to healthcare systems and their lack of availability doesn't make them fringe. The fact is that for some individuals, again, they are absolutely central to how patients can get better, and they offer a chance to tackle more than just the one key symptom. That's what's attractive about these therapies; there's a strong evidence base to support their use. They are also cost-effective, but they are hard to access for some of us in our healthcare systems.

But for a condition that may be life-long how do we see them fitting into that setting?

What has emerged over the last 20-30 years of research into these forms of therapy is that it's about having the right therapist and the right patient, getting a good interaction together. But if you can get that sort of key in the door, it can cause a result in long-term benefits. The improvements can be maintained over the long-term. Occasionally, patients need sort of top-off sessions, as it were, but it's important that good therapy involves having a relationship which allows patients to have a sort of revolving door to come back when needed. You can have your course of treatment and that's finite. And so hypnotherapy has a proven evidence base, cognitive behavioral therapy. Those are the two kernel therapies, but there are other forms of intervention.

So as a final intervention there, biofeedback, is that better for people with sort of real rectal symptoms and difficulty with evacuation and so on?

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So with the therapies we've mentioned today have been sort of primarily sort of working in the big brain, there are therapies which work on the sort of the local, on the pelvic floor area. So for those patients who have so-called rectal symptoms, where they don't feel they adequately empty, where they don't empty out very successfully themselves, where they strain to do so, getting the patient to be able to learn how to use what's down there, to sense what's down there appropriately, to be able to void more completely and satisfactorily, that can be done as a learning therapy with a one-on-one therapist sometimes using very simple equipment to help the patient become aware of what these kind of mysterious functions in our lower bowel are. That can be very effective, again, long-term therapy. So it's essentially around tailoring the patient's symptoms to the therapy available.

But I think the limitation of these therapies, whether it's cognitive behavioral therapy, hypnotherapy, or biofeedback, which Anton has mentioned, is not their efficacy, which is proven; it's their availability.

And because I think it is clear that just having any type of hypnosis is not going to work; it needs to be gut-directed hypnotherapy by an experienced practitioner.

Yes, I mean but it's resource-intensive and not widely available.

It's resource-intensive, it's intensive for the patient, and unfortunately it's not widely available.

So let's go back then to pharmacotherapy. We've had some tantalizing promise in recent years of a class of drugs which might be able to offer more than an attack on a single symptom, but to address some of the global symptoms that are related not only perhaps to the pain, but also the hypersensitivity aspect. And so what's the promise now for new therapy in this area, Eamonn?

Well, along the way we've mentioned a number of aspects, the spasm or motility problem, in particular we've emphasized the hypersensitivity. And a lot of very good research was done on these aspects, and along the way certain molecules were identified which seem to be good targets for drugs that might diminish sensitivity of the bowel or improve or modify motility in the bowel. And several drugs were developed to target these specific molecules thought to be involved in irritable bowel syndrome. Some of these worked only in diarrhea-type irritable bowel

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syndrome, some of them worked only in constipation-type irritable bowel syndrome. But unfortunately many of these, when they came to the clinic, failed. They just were not successful. And others, unfortunately, were withdrawn because they had side effects on the heart or on other parts of the body.

But there is good news, and that is that there are some new classes of drugs perceived to offer real promise. And I would like to emphasize one particular group, which are called the chloride channel activators. And basically what these drugs do is that they increase in a very subtle way the production of chloride, sodium, and water from the bowel, which is released into the intestine and helps to lubricate the stool. One of these chloride channel drugs, which is called linaclotide, also seems to stimulate motility, and very interestingly, to reduce that gut pain or sensitivity that Pali and Anton have emphasized. And this drug has been recently introduced into several European countries, as well as North America.

But one very important point about this class of drugs, these chloride channel activators, is that they act only in the gut. They're not absorbed into circulation, so they're very well tolerated and we don't have the worries about these heart problems, etc. that have been an issue with some of these other previous compounds that I mentioned. Several trials have shown that linaclotide, if it's taken once a day, for up to six months helps the main symptoms of irritable bowel syndrome as well as providing overall relief and actually even improving quality of life of the sufferer, but for the sufferer with irritable bowel syndrome with constipation. This will not be used in all patients with IBS because it works by increasing stool frequency and making the stools more soft. Obviously that's not going to work for the patient who already has diarrhea.

Well thank you, Eamonn. My colleagues have given us a very comprehensive overview of IBS and how sufferers can be helped by better understanding their condition and what to discuss with their healthcare provider. But one important question that sufferers will always have is "What's going to happen to me over time?" And the news there is that about two-thirds of people who have IBS symptoms will continue pretty much fluctuating with their abdominal pain and discomfort and their altered bowel habit over time. And that that can be well managed and give them a good daily quality of life if they attend to lifestyle and diet, along the lines that has been discussed today.

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Appropriate medications, used as we've heard, both in the primary care and specialist setting, can control individual symptoms and don't necessarily need to be taken on a long-term regular basis but, rather, intermittently address symptoms when they become difficult to manage. There's possibly up to a third of individuals who will improve with respect to their symptoms over time, and indeed, a small proportion of those may even get better and not have the recurrences.

But the really important point to get across from our discussions today are that IBS does not lead to cancer and is not associated with cancer in any way. We've heard that the sufferer should embrace the condition; it is a real condition. We have emphasized that it will not turn into anything else. The important messages we heard, particularly from Pali Hungin, is that the patient needs to understand their condition, and if they have continuing anxiety about it, joining a support group may be particularly helpful. They can update themselves on a regular basis through a reputable website and look after the lifestyle and diet and maintain the changes which they have made.

Keeping in touch with their physician is important, and I think physicians also should see patients on a regular, perhaps annual basis. One must, again, reiterate how the sufferer should make sure that their healthcare provider is up to date with any changes that may occur in their symptoms. These may signal the need for a further intervention of some kind if symptoms have become worse or become worrisome in any way. And everybody who presents with these IBS symptoms is different and the approach needs to be individualized.

Good news in all this is you're not alone. Irritable bowel syndrome is taken seriously by clinicians, as we've heard today; by researchers. There's a lot of exciting new information by those who fund research, particularly in pharmaceutical industry, and by society and healthcare providers.

So let's just go for a final word from my colleagues, from Pali Hungin.

I think IBS is an important condition for which physicians, family doctors, ought to prepare themselves in terms of current management, future developments. I think there's a great deal of promise there for the future.

Anton?

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For me, I think there is good news around IBS. This isn't a sort of a heartsink, or shouldn't be a heartsink for any doctor. And what's exciting is that it's about the things that we like as doctors and nurses; we like to communicate with the patients, we like to know their lives. And that's what's lovely about this. But it's now being allied to an increasing armentarium of drugs and other therapies which we have available to us. So I think it's a positive diagnosis and a positive therapeutic message we can give, rather than doom and gloom.

Eamonn?

Well I think the exciting thing about irritable bowel syndrome is what you just said, it's being taken seriously. And for me, as somebody who does research in irritable bowel syndrome, the fact that somebody is doing research in irritable bowel syndrome is totally different from when I started out in gastroenterology. So I have great optimism for the future of irritable bowel syndrome, and I think slowly but surely we are identifying causes for irritable bowel syndrome, and I think ultimately we will actually have several explanations for irritable bowel syndrome. So I am very optimistic.

On that very positive note I am delighted to thank my colleagues on your behalf. I think we've had a wonderful symposium and we very much hope that this is of value to all of you. Thank you for your attention.

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