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
Los Angeles Bureau

Los Angeles — Even the experts disagree 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 pain in her left lower quadrant and was prescribed 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 54% 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 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 1.9, primary care physicians, 4.1; and nurse-practitioners, 4.3.

The experts, chosen on the basis of their publications and selection for guideline 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.”

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

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.

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

“Surprisingly, the same physicians saw IBS patients assigned to the intervention group or to usual care,” Dr. Spiegel said.

When independent observers assessed IBS symptoms, the differences were significant for diarrhea-predominant or mixed IBS, a celiac disease panel is probably a good choice.

The low-cost intervention, which will 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.

Tool Facilitates Dialogue About IBS, Improves Symptoms

IBS experts were in strong agreement that two tests would be warranted 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.

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 pain in her left lower quadrant and was prescribed 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 54% 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 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 1.9, primary care physicians, 4.1; and nurse-practitioners, 4.3.

The experts, chosen on the basis of their publications and selection for guideline 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.”

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

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.

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

“Surprisingly, the same physicians saw IBS patients assigned to the intervention group or to usual care,” Dr. Spiegel said.

When independent observers assessed IBS symptoms, the differences were significant for diarrhea-predominant or mixed IBS, a celiac disease panel is probably a good choice.

The low-cost intervention, which will 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.