The Disorder, The Distress, The Doctor…

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Introduction

- The Disorder
  - Or perhaps…
  - What is it like to be a GP faced with an IBS patient?
- The Distress
  - Or perhaps…
  - How should a patient prepare for a GP consultation?
- The Doctor
  - Or perhaps…
  - What should an IBS patient expect as best practice from a GP?

The disorder…

- The Doctor's Diagnostic Comfort Zone for a disease or disorder.
  - Observable anatomical or physiological abnormality.
  - Symptoms and signs similar from individual to individual.
  - An easily measurable biomarker that accurately predicts the condition.

The disorder…

- Not so comfortable…
- The (so called) ‘Functional Disorder’
- Currently patho-physiological defects are:
  - non-existent,
  - poorly defined,
  - or highly variable.

The disorder…

- For too long, the historical approach, towards functional disease has been to describe them as ‘what they are not’ rather than positive entities.
- Sadly IBS exemplifies this and even sadder still is that this is still often the case amongst many clinicians, both generalist and specialist.

The distress…

- As clinicians we only know of the existence of a disease or disorder through the words and (suffering) of our patients.
- For those patients' who present with a functional disorder their history and experience is quite literally the key to diagnosis.
- If handled well, the consultation, with the doctor-patient relationship at its very core, can become a place of sanctuary for the sufferer.
- However, on the contrary, a poor attitude may signal a swift descent towards purgatory.

The distress…

- For our patients' with a functional disorder, the traditional format of the 'medical model' consultation is probably the most inappropriate.
- It is a purely organic approach to managing patients
  - The disease and diagnostic process are of central importance.
  - It's not interested in what patients think or feel.
  - It's not interested in what might be going on for them back in their own lives.
  - It's purely a functional model to do the main job of sorting out the problem and not necessarily the patient.

The distress…

- The ‘medical model’ consultation.
  - The first consultation type taught at medical school.
  - GP training spends time on ‘unpicking’ this model and introducing at least 14 other types of ‘consultation model’.
  - Specialist training by its very nature makes very little advance in addition to the ‘medical model’.
- The medical model has some positives and in truth all models oscillate between the cross-hairs.
- The horizontal represents the tension between the Doctor’s Agenda and the Patient’s Agenda, while the vertical represents the spectrum between being Task Orientated or Behaviour Orientated.

The distress…

- “All the tests have come back as normal, It sounds like Irritable Bowel Syndrome…”
- What do our patient’s think when they leave the consulting room

The distress…

- The fruitless pursuit of an anatomical cause often organically renders functional disorders ‘diagnosis of exclusion’.
- Sadly, such an exclusive approach fails to provide the patient with the dignity of a diagnosis, but it also generates needless tests and consultations.
- We say ‘diagnosis of exclusion’ the patient hears ‘dustbin diagnosis’.

The distress…

Doctor Centered

- It is easy to dismiss functional disease and feel good in the process as we reassure patient's that 'everything' is absolutely fine and even 'normal'

Patient Centered

- The patient is always relieved that 'nothing serious' has been found, but for them, they are most definitely 'not fine' and they certainly do not feel 'normal'

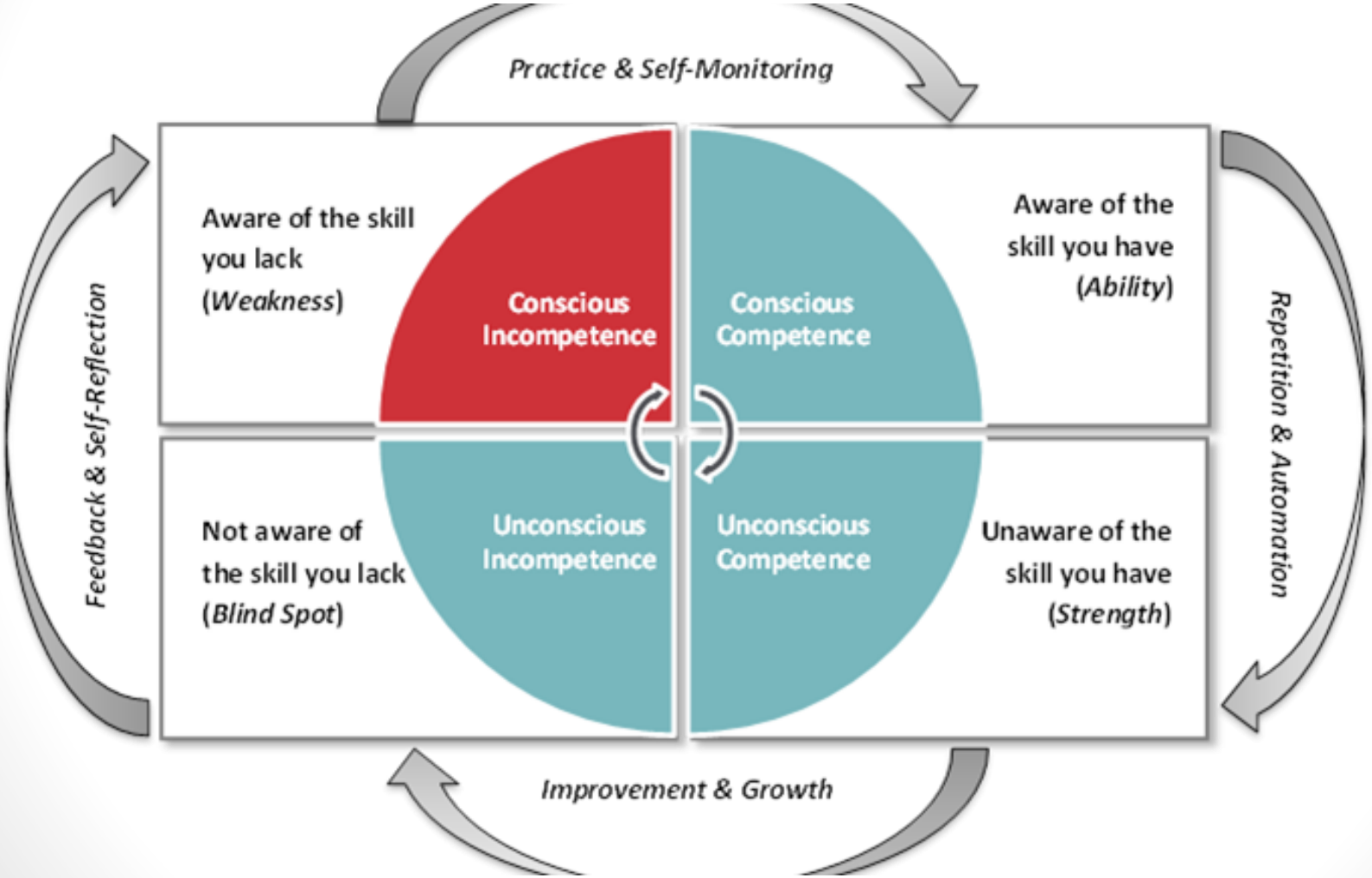
The distress…

- The dilemma?
- Resource allocation in health and elsewhere should satisfy two main ethical criteria.
  - First, it should be cost-effective—limited resources for health should be allocated to maximize the health benefits for the population served.
  - Second, the allocation should be equitable or just; equity is concerned with the distribution of benefits and costs to distinct individuals or groups.
- The maximization of benefits, which is associated with the general philosophical moral theory of utilitarianism or consequentialism, however, is routinely criticized for ignoring those considerations.

The distress…

- Functional disease is not life threatening, it is life-long and the associated science (currently) is very poor.
- There is logic and sympathy for the notion that ‘real’ disease with ‘real’ health impact is more important.
- In this day and age, Evidence Based Medicine can be seen as a ‘benign dictatorship’ and this may not always sit well with our increasingly ‘web-based, well informed’ patient population.
- Their very numbers and cost demand a more positive approach.

The doctor…


Practice & Self-Monitoring
Aware of the skill you lack (Weakness)
Conscious Incompetence
Conscious Competence
Aware of the skill you have (Ability)
Feedback & Self-Reflection
Repetition & Automation
Not aware of the skill you lack (Blind Spot)
Unconscious Incompetence
Unconscious Competence
Unaware of the skill you have (Strength)
Improvement & Growth

The doctor…

- John Dewy, 1859- 1952 (American philosopher who advocated progressive education)

- “The path of least resistance and least trouble is a mental rut already made. It requires troublesome work to undertake the alteration of old beliefs. Self-conceit often regards it as a sign of weakness to admit that a belief to which we have once committed ourselves is wrong. We get so identified with an idea that it is literally a pet notion and we rise to its defense and stop our eyes and ears to anything different”

The doctor…

- A positive diagnostic approach rather than a diagnosis of exclusion is not a particularly new or radical suggestion.
- An article in 1849 pertaining to IBS like bowel symptoms suggests that “one can tell, without more minute examination what the nature of the complaint is”

The doctor…

- A positive diagnostic approach needs (especially in the absence of an anatomical or biochemical marker) some robust evidence based criteria that will allay the fear of a missed diagnosis with respect to organic pathology.
- The Road to Rome… (WG Thompson, Gastroenterology 2006;130:1552-1556).

The doctor…

History of Diagnostic Criteria
The Manning Criteria for IBS (1978)
The Kruis Criteria for IBS (1984)
The Rome Guidelines for IBS (1989) (Rome-2 IBS Criteria)
The Rome Classification System for FGIDs (1990)
The Rome I Criteria for IBS (1992) and the FGIDs (1994)
The Rome II Criteria for IBS (1999) and the FGIDs (1999)
The Rome III Criteria (2006)
The Rome IV Criteria (in progress, due Spring 2016) …of interest, specific Primary Care involvement and Primary Care based guidance. Sub-Typing IBS – C,D and M

http://www.romecriteria.org

Appendix A Rome III Diagnostic Criteria for FGIDs

The doctor…

- Irritable bowel syndrome (IBS) is a gastrointestinal syndrome characterized by:
  - chronic abdominal pain.
  - altered bowel habits.
  - absence of any organic cause.
- The prevalence of IBS in North America estimated from population-based studies is approximately 10 to 15 percent.
- A population-based study in Europe found an overall prevalence of 11.5 percent (a value similar to that noted in reports in the United States); however, the prevalence varied widely among countries.

The doctor…

- IBS affects men and women, young patients, and the elderly. However, younger patients and women are more likely to be diagnosed with IBS.
- Approximately 15% of those affected seek medical attention.
- The absolute number of patients is still so large that IBS in its various forms comprises 25 to 50% of all referrals to gastroenterologists.
- IBS also accounts for a significant number of visits to GP's, and is the second highest cause of work absenteeism after the common cold.
- IBS has been associated with increased health care costs.

The doctor…

Rome III Criteria

C1. Irritable Bowel Syndrome

*Diagnostic criterion**

Recurrent abdominal pain or discomfort** at least 3 days/month in the last 3 months associated with *two or more* of the following:

1. Improvement with defecation.
2. Onset associated with a change in frequency of stool.
3. Onset associated with a change in form (appearance) of stool.

* Criterion fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.

** “Discomfort” means an uncomfortable sensation not described as pain.

The doctor…

- Supportive symptoms that are not part of the Rome III criteria include:
- Abnormal stool frequency (≤3 bowel movements per week or >3 bowel movements per day).
- Abnormal stool form (lumpy/hard or loose/watery).
- Defecation straining.
- Urgency.
- Feeling of incomplete bowel movement.
- Passing mucus.
- Bloating.

The doctor…

- Four subtypes of IBS:
- IBS - C (hard or lumpy stools ≥25 percent / loose or watery stools <25 percent of bowel movements).
- IBS - D(loose or water stools ≥25 percent / hard or lumpy stools <5 percent of bowel movements).
- IBS - M (hard or lumpy stools ≥25 percent / loose or watery stools ≥25 percent of bowel movements).
- IBS - U (insufficient abnormality of stool consistency to meet the above subtypes).

The doctor…

- The cause of irritable bowel syndrome (IBS) and the pathophysiology of the symptoms are unknown.
- Suggested underlying processes include [AGA, 2002]:
  - Abnormal gastrointestinal motility.
  - Visceral hypersensitivity.
  - Abnormal gastrointestinal immune function.
  - Abnormal autonomic activity.
  - Abnormal central nervous system modulation of the gastrointestinal tract.

The doctor…

- Theories of causation include:
  - Infection (for example following gastroenteritis) [Neal et al, 1997;Rodríguez and Ruigómez, 1999; Parry et al, 2003].
  - Inflammation.
  - Diet (such as increased fat or alcohol intake).
  - Antibiotics.
  - Surgery.
  - Family history.
- There is no conclusive evidence as to which factor, if any, is truly causal, or the extent to which they may be causal. It is likely that the cause of IBS is multifactorial [Francis and Whorwell, 1997; Maxwell et al, 1997].

The doctor…

- In General Practice there is currently no reliable, approved investigation to confirm a diagnosis of irritable bowel syndrome (IBS).
- For people who meet the ***diagnostic criteria*** for IBS, arrange the following tests to screen for other diagnoses:
  - Full blood count (FBC).
  - Erythrocyte sedimentation rate (ESR).
  - C-reactive protein (CRP).
  - Antibody testing for coeliac disease (presence of endomysial antibodies or tissue transglutaminase).
  - Faecal Calprotectin (in the patient with loose stools).

The doctor…

- For people who meet the diagnostic criteria for IBS, the following tests are *NOT* necessary to confirm the diagnosis:
  - Ultrasound.
  - Rigid/flexible sigmoidoscopy.
  - Colonoscopy.
  - Barium enema.
  - Thyroid function test.
  - Faecal ova and parasite test.
  - Faecal occult blood test.
  - Hydrogen breath test (for lactose intolerance and bacterial overgrowth).

The doctor…

- The NICE guidance CG61; currently outlines the evidence base for the available management options.
- Advice regarding diet and lifestyle.
- Drug Treatments:
  - Antispasmodics.
  - Antimotility Drugs.
  - Laxatives.
  - Tricyclic antidepressants and Serotonin Re-uptake Inhibitors.

The doctor…

- On the Horizon:
  - Current NICE Guidance CG61, published Feb 2008.
  - Next review date was March 2016, however, NICE state on their website "**Following the recent surveillance review decision, a rapid update of this guideline will be scheduled into the work programme".**
- New Medication, some already licensed, excellent data, first in class for IBS-C.
- Low FODMAP diet- fermentable oligo-, di-, and monosaccharides and polyols.
  - Promising results, Studies from an Australian Team, Study numbers have been low e.g. n-25, n-15.
  - Team at Kings College are championing here in the UK.

The doctor…

- From an accounting perspective…
- Bracknell and Ascot CCG – 136,163 patients registered over 15 practices.
- Top 10 National OPD appts by speciality 2012/13:
  - No.1 Ophthalmology >10,000
  - No.2 Trauma & Orthopaedics >6000
  - No.10 Gastroenterology <2000
- It seems we have ‘bigger fish to fry’ than Gastroenterology.
- For our ‘neighbour CCG, Slough’ Gastroenterology appears at position no. 7 at just over 2000 referrals.

The doctor…

- The question of over-investigation.
- The cost of reassurance?
- Hospital Episodes Statistics 2011/2012 to 2012/2013.
- Outpatient and Day Case Patients that have no further contact for 12 months following the diagnostic scope (excluding specific diagnosis including Cancer, IBD):
  - Bracknell and Ascot CCG.
  - 777 Scopes (53% of total scopes) at a cost of £456,325.
  - Slough CCG.
  - 613 Scopes (47% of total scopes) at a cost of £339,405.
- National Average 49% of all total scopes have no further specialist contact for at least 12 months.

Many thanks for your kind attention…

Any thoughts or questions?