

# Psychotropics Benefit Moderate to Severe IBS

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BOSTON — Judicious use of antidepressants can ameliorate the psychiatric stressors that exacerbate moderate to severe irritable bowel syndrome symptoms, Dr. Douglas A. Drossman said at a meeting on neurogastroenterology and motility.

These agents can also act directly in the gut to control bowel dysfunction, said Dr. Drossman, codirector of the University of North Carolina Center for Functional GI and Motility Disorders, in Chapel Hill. “The more severe the IBS, the more likely the patient is to have comorbid psychosocial factors,” Dr. Drossman said. “Any treatment that might reduce the stressor itself or the interpretation of the stressor through psychological pathways or through antidepressants is likely to have some benefit.”

One of the first hurdles is to confront maladaptive negative beliefs a patient may have that can undermine good outcomes. Patients who feel that they have no control over their symptoms, who “catastrophize” and believe their condition will never get better, or who have a history of abuse have poorer outcomes—regardless of their treatment or condition, Dr. Drossman said.

He urges clinicians to establish a productive physician/patient relationship at the outset by identifying patient worries, providing reassurance, explaining the physiologic basis of symptoms, setting realistic treatment goals and time frames, and addressing cost concerns.

When choosing an antidepressant for irritable bowel syndrome (IBS), clinicians must consider the medication class and features of a particular medication within the class. Tricyclic antidepressants (TCAs) with noradrenergic activity are useful for IBS with diarrhea, especially for those patients with comorbid pain and depression. Dr. Drossman does not favor TCAs such as amitriptyline, which may cause side effects that limit tolerability through anticholinergic and antihistaminergic effects. Instead, he recommends desipramine or nortriptyline.

Selective serotonin reuptake inhibitors (SSRIs) are a good choice for patients with IBS with constipation who may also have depression, panic or anxiety symptoms, or obsessive-compulsive disorders. This makes SSRIs appropriate for housebound patients who fear having an IBS episode while away from home. Dr. Drossman tends to stay away from short-acting agents such as paroxetine (Paxil), in order to minimize discontinuation side effects. He prefers medium-acting citalopram (Celexa) or escitalopram (Lexapro), or long-acting fluoxetine. SSRIs tend to have negligible effects on noradrenergic receptors and thus do not provide pain relief and may cause agitation because of serotonergic bursts when treatment is initiated, Dr. Drossman said.

Duloxetine (Cymbalta), a serotonin norepinephrine reuptake inhibitor (SNRI), has potent effects on noradrenergic and serotonergic receptors and minor effects on histaminergic and cholinergic systems. Because duloxetine is indicated for treat-

ing depression and managing neuropathic pain associated with diabetic peripheral neuropathy, it may be of particular benefit for a depressed IBS patient with prominent pain symptoms.

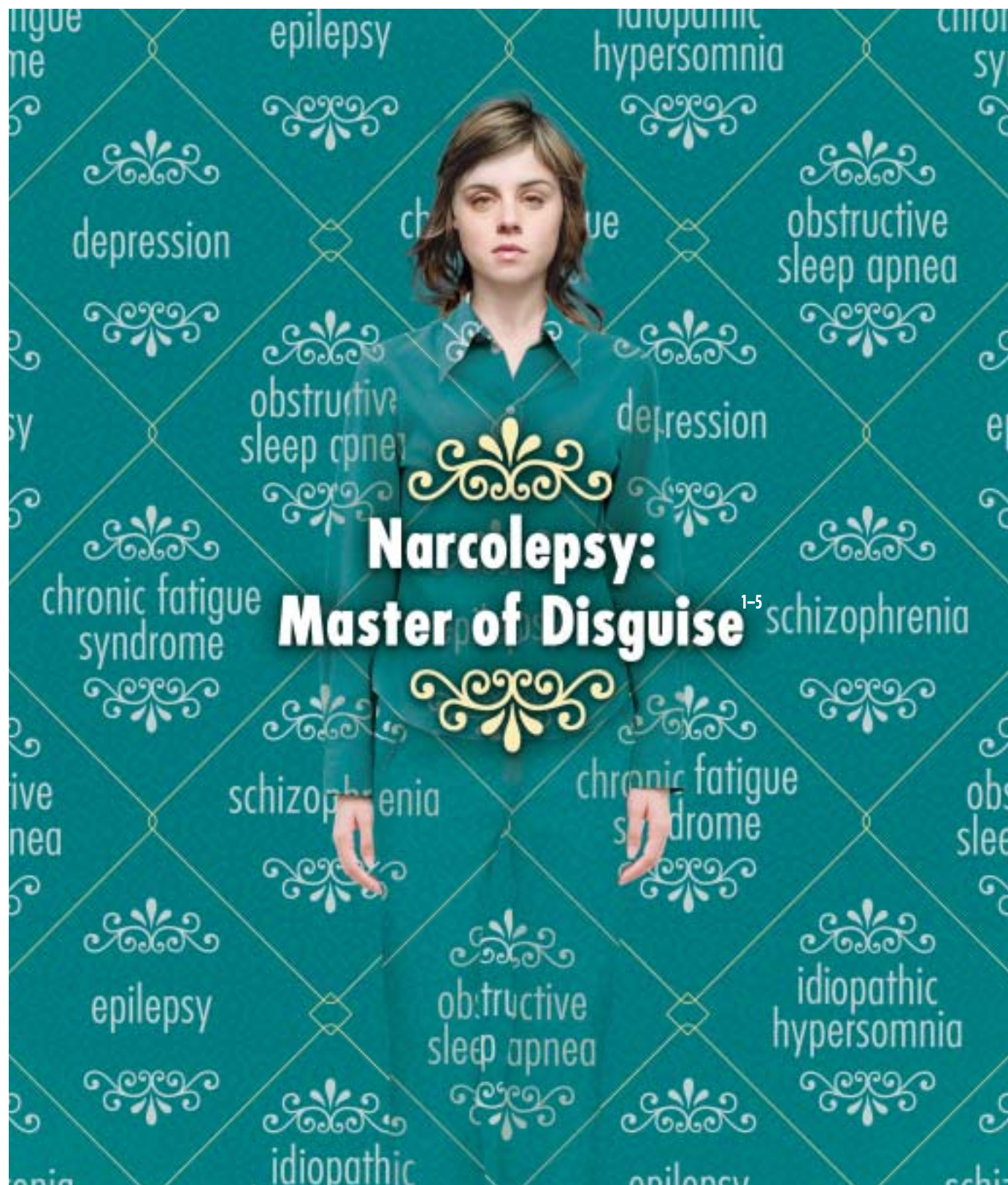
Sometimes, antipsychotics have a place in IBS management, Dr. Drossman said. “We are seeing an increasing use of antipsychotics in the primary care sector for conditions like anxiety and personality disorders—agents that [primary care physicians] would never have thought

about touching years ago,” he said.

Dr. Drossman uses quetiapine (Seroquel) for sedation to treat extreme anxiety and comorbid bipolar and personality disorders, and as augmentation with antidepressants, giving a 50-200-mg dose before bedtime—well below the typical antipsychotic dose of 400 mg. However, he cautions that physicians should consider psychiatric consultation before making this treatment decision.

Dr. Drossman begins pharmacotherapy

after symptomatic medical treatment and stress reduction techniques such as exercise and yoga fail. He starts with a low dose of a TCA, SSRI, or SNRI for 4-6 weeks, reevaluates the patient, increases the dose if necessary, and continues treatment for an additional 4-6 weeks. If symptoms are not controlled adequately, he may augment therapy by adding a drug from another class, such as buspirone, which has bowel-relaxing effects, or refer to a psychiatrist. ■



References: 1. Dauvilliers Y, Arnulf I, Mignot E. Narcolepsy with cataplexy. *Lancet*. 2007;369:499-511. 2. Thorpy M. Current concepts in the etiology, diagnosis and treatment of narcolepsy. *Sleep Med*. 2001;2:5-17. 3. Thorpy M. Therapeutic advances in narcolepsy. *Sleep Med*. 2007;8:427-440. 4. American Academy of Sleep Medicine. *The International Classification of Sleep Disorders: Diagnostic and Coding Manual*. 2nd ed. Westchester, Ill: American Academy of Sleep Medicine; 2005. 5. Green PM, Stillman MJ. Narcolepsy: signs, symptoms, differential diagnosis, and management. *Arch Fam Med*. 1998;7:472-478.

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Because many disorders have symptoms resembling those of narcolepsy—excessive daytime sleepiness, cataplexy, disturbed nocturnal sleep, hypnagogic and hypnopompic hallucinations, sleep paralysis—a differential diagnosis including narcolepsy is often required.<sup>2-4</sup>

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