Antidepressant Better Than Bulking Agent in IBS

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — An antidepressant often is better than a high-fiber bulking agent as first-line treatment for irritable bowel syndrome, at least for the diarrhea-predominant form of the disorder, Philip S. Schoenfeld, M.D., said at the annual meeting of the American College of Physicians.

Results from 14 well-designed clinical trials of the use of bulking agents for irritable bowel syndrome (IBS) "consistently show … that they are no better than placebo," said Dr. Schoenfeld, chief of the division of gastroenterology at the Ann Arbor (Mich.) Veterans Affairs Medical Center.

Worse, bulking agents usually cause uncomfortable bloating. In one study of psyllium (Metamucil), placebo patients actually did better than treated patients, said Dr. Schoenfeld, who was a member of the American College of Gastroenterology's task force that reviewed treatment evidence in 2002.

The only time to try a bulking agent is with a patient with constipation-predominant IBS who does not normally have bloating discomfort with the constipation, he said.

Tricyclic antidepressants, on the other hand, are good agents for pain control. Several studies have shown that tricyclics reduce abdominal pain. The most recent study—which met the criteria for good study design spelled out by the International Congress of Gastroenterology's Rome guidelines—showed a significant reduction of symptoms, Dr. Schoenfeld said.

The study used low-dose desipramine, which Dr. Schoenfeld said he prefers to use first. He uses it in patients with diarrhea-predominant IBS because tricyclics can cause constipation.

About one-quarter of patients don't tolerate tricyclic therapy; they can be switched to a selective serotonin-reuptake inhibitor (SSRI), with advice to use loperamide as needed.

Of the three well-designed trials that have tested the use of an SSRI, one showed significant symptom improvement, one showed a trend to improvement, and one showed decreased health care utilization, he said.

Although IBS has been called a diagnosis of exclusion, in practice it does not really need to be. That approach leads to a lot of expensive tests—40% of IBS patients, for example, get endoscopy at the time of initial diagnosis, Dr. Schoenfeld said.

Tricyclic antidepressants are good agents for pain control. The most recent study showed a significant reduction in symptoms of abdominal pain.

In the absence of specific danger signs, such as fecal blood, the incidence of other serious conditions in patients with IBS-like symptoms is generally about the same as in the general population (less than 1%). The exception is celiac sprue, which occurs about 10 times more often in patients with diarrhea-predominant IBS-like symptoms than it does in the general population.

Dr. Schoenfeld said that he prefers to test for serum celiac sprue using the tissue transglutaminase antibody test, because its sensitivity is almost 100%. There are false positives, but a negative test rules out the disorder.

In clinical trials, tegaserod maleate (Zelnorm) was effective in about 40% of patients. Yet about 30% of placebo patients had improvement, as they often do in IBS trials, so the absolute difference was only about 10%.

Tegaserod is worth a try in constipation-predominant, female patients; when it works, symptoms improve rapidly. But Dr. Schoenfeld does not continue a trial for very long because the drug is expensive. "It's not a miracle drug, and if they haven't improved in about a month they are unlikely to improve," he said.

He usually stops the drug after 8 weeks, as specified on the product label. IBS patients generally have flares and quiescent periods, and studies have shown the average flare lasts 6-8 weeks. Moreover, evidence indicates that response to the drug, when reinitiated, is exactly the same as the initial response.

Dr. Schoenfeld has a consultantship with Novartis Pharmaceuticals Corp., the maker of Zelnorm. ■