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Summary

How to select the best pharmacological options for our IBS patients?

Jan Tack

UEG Postgraduate Teaching Programme Vienna 2024 | Presentation

Education & Training | Neurogastroenterology & Motility | Small Intestine & Nutrition | Primary Care

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The speaker presented a systematic approach to selecting second-line therapies for IBS based on predominant symptoms, stool pattern, disease characteristics, and patient preferences, using a case of IBS-D following E. coli infection.

KEY POINTS

- The speaker categorized treatment options into three tiers: non-pharmacological/dietary approaches, medications targeting the bowel, and centrally acting agents, with selection driven by dominant symptom pattern (pain, bloating, constipation, or diarrhoea).
- For IBS-D with diarrhoea and pain, the speaker discussed ondansetron (reported as effective on stool consistency at average 5.6 mg daily in a UK study, with rapid onset within one week, but not effective on pain), bile acid sequestrants for post-infectious cases or those with cholecystectomy, and gel-based medical devices (Androgel reported as achieving close to 70% remission at week 16 in a placebo-controlled trial).
- The ATLANTIS trial of amitriptyline 10-30 mg daily in IBS-D, published one year ago in Lancet Primary Care, showed significantly higher responder rates than placebo; the speaker emphasized that these doses are below the centrally active range and effects are not driven by psychosocial comorbidity.
- Ebastine for pain showed a significantly higher response rate than placebo in a Belgian trial, but the overall response rate was low (12% vs 4%) and onset was late, mainly from week 6 onward.
- The speaker noted that the largest peppermint oil trial from the Netherlands failed to demonstrate benefit in the primary endpoint of abdominal pain response over placebo, and that many first-line therapies have less overwhelming evidence than desired.

– The speaker recommended discussing options with patients and letting patient preference guide the final choice, considering factors such as speed of onset, target symptoms, adverse event profile, cost, and access; for centrally acting agents, the speaker's rule of thumb is at least six months of treatment, stopping if the last three months were good.

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