IMC Case: An EBM Approach to IBS/Fibromyalgia

A 38 year old white female presents with a 5 month history of intermittent diarrhea and abdominal pain. She states the symptoms started shortly after she had to file bankruptcy secondary to "low cash flow". The patient states on most days of the month she will have dull, crampy aches in the lower abdomen which seem to improve somewhat when she has a bowel movement. She also feels "bloated" at times. She states on severe days she will have 5 or 6 loose, mushy stools. She believes the abdominal pain and change in bowel habits started concurrently. She denies any blood in the stools, although about 5 years ago she did have some blood on her tissue paper when wiping and was told by urgent care center she had hemorrhoids. She denies any weight loss, decreased appetite, or known family history of abdominal disorders. She has no nausea or vomiting. Further review of symptoms is remarkable only for poor sleep and diffuse musculoskeletal aches (pt reports previously being told she has fibromyalgia). Denies fever, chills, HA, dizzy, chest pain, palps, cough, wheeze, sob, dysuria, hematuria, or vaginal discharge. Menstrual periods are regular in frequency and duration, symptoms do not change with respect to menses. Pelvic exam including PAP and GC/Chlamydia screen done 3 months ago at Planned Parenthood within normal limits per patient. Has two healthy children (both via vaginal birth). No joint swelling or stiffness, no rash, no low leg pain or edema.

PMedHx: Fibromyalgia, Hemorrhoids
PSurgHx: tubal ligation (at age 31)
Allergies: NKDA
Medications: Acetaminophen 650 mg Q 6 hr prn "aches and pains"
Social: Smokes ½ ppd for 15 years; rare alcohol around holidays; denies illicits; works as cook at Wendy's part time (admits to "plenty of financial stress")
Family: Adopted, unknown at this time
ROS: As Above

Vitals: Temp 97.1 HR 65 BP 126/84 Resp 14 Pulse Ox 98%RA Ht 66 in Wt 170#
BMI 27.4 kg/m2
Gen: A&OX3, NAD, Pleasant, Obese
HEENT: PERRL, EOMI, oral mucosa moist, no oral lesions noted; turbinates pink and moist
Neck: Supple, no JVD, no nodes, no thyroidmegaly
Heart: RRR no murmur, gallop, or rub
Lungs: BCTA no wheeze, rhonchi, rale
Abdomen: Soft,+ BS, nondistended, diffuse lower abdomen tenderness, but no rebound, no involuntary guard, no rigidity; no mass, hernia, or bruit
Rectal: No perianal lesions, no masses, soft brown stool, hemoccult negative
Low leg: no edema, no clubbing, all distal pulses palpable, no lesions or rashes
Neuro: Grossly intact
Vasc: PPP

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Please Use the Annals of Internal Medicine In the Clinic Review Article to answer the following questions (you will need to sign in with your ACP password)
(Link: http://annals.org/aim/article/2629565/irritable-bowel-syndrome)

1. Does the patient meet the Rome IV criteria for IBS (box ITC 85)?

    - What are the differences between Rome III and Rome IV criteria (ITC 83)?

    - What groups are IBS more common in: men or women (ITC 82)?

    - What is the prevalence rate reported in the United States (ITC 82)?

    - What are the subgroups (defecation patterns) characteristic of IBS (ITC 82)? Which does are patient have?

2. You tell the patient that she appears to have diarrhea-predominant Irritable Bowel Syndrome (IBS-D). She quickly requests labs and x-rays to confirm.

    - The absence of which alarm features should reassure the clinician that IBS is the correct diagnosis (ITC 82 and ITC 83)?

    - What lab test(s) would you order on our patient (IT84)?

    - What would lead you to send an IBS patient to GI for colonoscopy evaluation (IT84)?

    - Is CT abdomen indicated if no alarm features are present (IT84)?

    - List differential diagnoses of IBS and their clinical characteristics and potential workup (IT86)

3. The patient asks for your advice on whether she should alter her diet or increase fiber in her diet? Please give her an evidence based answer.(IT87-88)

- The patient now asks for treatment options. Please briefly review the effectiveness of the following agents in treating IBS (Table IT90, text IT89-93).
    - antispasmodics
    - -antidiarrheals
    - -antibiotics
    - -probiotics
    - -alosetron (note, you will not prescribe this medicine!)
    - -lubiprostone
    - -antidepressant agents
    - -psychological therapies (IT88-89)
    - -herbal therapies

4. You start the patient on loperamide prn for frequent and loose stools and psyllium supplement daily. The tissue transglutaminase antibody comes back negative. The patient calls you in two weeks to let you know that the loperamide has helped increase the form to her stools, but she is still having bloating and abdominal cramping which are relieved somewhat with stooling. The patient states she is very "strapped for cash" and can only afford drugs on the $4 program. Michelle Cudnik, PharmD (IMC clinical pharmacist) shows you her $4 program list, and you decide to prescribe nortriptyline 10 mg HS. The patient calls you in 3 weeks and states "You are the best doctor I have ever had". Apparently her abdominal symptoms are better, she feels like she is sleeping better, and the "fibro has calmed a bit". She is having only a mildly dry mouth as far as side effects, so you increase her nortriptyline to 25 mg HS. Utilize the following link to American Pain Society Fibromyalgia guidelines to answer the following questions: http://jama.ama-assn.org/cgi/reprint/292/19/2388

    - What is the diagnosis of fibromyalgia syndrome based on?

- What are some other medical and nonmedicinal therapies utilized to treat fibromyalgia syndrome patients, and what is their strength of evidence for efficacy? (attention to box 1, pg 2390 of guidelines)

- What are the 3 steps in the stepwise approach to fibromyalgia management recommended? (see Box 2, pg 2393)

5. The patient starts an exercise program at your recommendation, continues the nortriptyline, and is feeling much better. Her energy is greatly improved, and on her free time she does some research and locates her natural mother who is alive and healthy at age 55. Her natural mother states that her natural father died at age 48 with colon cancer. Besides contacting your lawyer (just kidding, remember you have followed guideline medicine to this point), what would you do now?

- Should suggesting to the GI doctor to obtain random biopsies during the colonoscopy be considered? Why or why not? What diagnosis are you thinking about? (re-visit IBS paper IT87)

Utilize the following link to AGA colonoscopy guidelines to answer (attn.Table 1 pg 845 of guidelines):
http://www.gastrojournal.org/article/S0016-5085(12)00812-8/pdf

- When should repeat colonoscopy be performed if:
  - 6 small tubular adenomas are found
  - no adenomas are found
  - 1 tubular adenoma >10 mm
  - 1 small hyperplastic polyp in rectum or sigmoid
    - 10 small tubular adenomas

*yes, typically the GI specialist makes this decision, but sometimes you will see patients in IMC who have moved into area, lost contact with GI, or for

some other reason not know when to follow up. Please also note there are other guidelines involving this issue!

Case by Rex Wilford, DO. Last update 6-2017