Psychiatry in Medical Settings

Functional Gastrointestinal Disorders (FGIDs)

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Disclosure
• No financial or other conflicts of interest.

Off-label use
• Antidepressants

Over-the-counter products
• Dietary supplements
• Fiber laxatives
Presentation Goals

1. Brief history of FGIDs
2. Classification of FGIDs – examples of definitions
3. Psychosomatic assessment and treatment of FGIDs.
History

1962 – Chaudhary and Truelove retrospective review of IBS in UK
1978 – Manning criteria for IBS
   "Towards positive diagnosis of the irritable bowel.” Br Med J
1989 – beginnings of the Rome consensus process
1999 – Rome II Criteria for FGIDs
2006 – Rome III Criteria for FGIDs
   35 disorders in adults, 18 in children/adolescents
Rome III Diagnostic Criteria for FGIDs

- Six major domains for adults
  - A. Functional esophageal disorders
  - B. Functional gastroduodenal disorders
  - C. Functional bowel disorders
  - D. Functional abdominal pain syndrome
  - E. Functional gallbladder and sphincter of Oddi disorders
  - F. Functional anorectal disorders

*Drossman, Gastroenterology 2006;130:1377-1390*
A3. Functional Dysphagia

Diagnostic criteria* must include all of the following:

1. Sense of solid and/or liquid foods sticking, lodging, or passing abnormally through the esophagus

2. Absence of evidence that gastroesophageal reflux is the cause of the symptom

3. Absence of histopathology-based esophageal motility disorders

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

Drossman, Gastroenterology 2006;130:1377-1390
B4. Rumination Syndrome in Adults

Diagnostic criteria must include both of the following:

1. Persistent or recurrent regurgitation of recently ingested food into the mouth with subsequent spitting or remastication and swallowing.
2. Regurgitation is not preceded by retching.

Supportive criteria

1. Regurgitation events are usually not preceded by nausea.
2. Cessation when the regurgitated material becomes acidic.
3. Regurgitant contains recognizable food with a pleasant taste.

*Drossman, Gastroenterology 2006;130:1377-1390*
Psychosomatic view of FGIDs - general

• Psychological trauma and adverse life events
  • Cause or risk factor for poorer outcome?

• Demands – not just “stress”
  • Psychological – affected by positive and negative events
  • Physical – post-infectious onset, dietary factors

• Psychiatric comorbidity
  • Mood, anxiety, traumatic stress, other functional disorders

• Quality of life and disability
  • At least as problematic as structural and metabolic disorders
Psychosomatic view of FGIDs - general

- Health care seeking
  - Determined more by psychological than physical factors
  - Example – patients seeking care for IBS have greater
    - Pain severity
    - Pain duration
    - Illness anxious worries (cause and consequences)
    - Anxiety and depressive comorbidity
    - Tendency to conceptualize their symptoms in physical terms
      - solely a bowel problem
Psychosomatic view of FGIDs - mechanisms

- Throat
- Substerum
- Abdomen
- Rectum

CONDITIONING  PAIN  BRAIN-GUT DYSREGULATION
Psychosomatic Treatment of FGIDs - general

1. Facilitate patient understanding of disorder.
2. Recommend simple behavioral and lifestyle changes.
   • Dietary changes, stress management, habit reversal therapies
3. Reinforce plans for symptomatic medical therapies.
4. Select appropriate psychopharmacologic medication.
5. Select appropriate symptom mgmt or FGID-specific medication.
6. Consider layered treatment -- add second form to the first.

Levy et. al., Gastroenterology 2006;130: 1447-1458
Psychosomatic Treatment of FGIDs - specific

Mechanism = Conditioning, Treatment = Habit Reversal

1. Esophageal and Gastroduodenal Disorders
   • Globus, Aerophagia/Belching, Vomiting, Rumination
   • Treated with diaphragmatic breathing
     • Reverses diaphragm and abdominal wall actions

2. Anorectal disorders
   • Dyssynergic defecation (pelvic floor dysfunction)
   • Treated with pelvic floor retraining
     • Reverses perineal + abdominal overstraining
Psychosomatic Treatment of FGIDs - specific

Mechanism = Pain, Treatment = Non-opioid pain relief, improved QOL

1. Abdominal Pain Disorders
   • Functional dyspepsia
   • Functional abdominal pain syndrome
   • Treated with pain rehabilitation strategies/programs
   • Realistically reduce exacerbating factors (diet, stress)
   • Realistically increase healthy behaviors (sleep, exercise, social)
   • Psychotherapy – various
   • Medications for visceral hypersensitivity
     • Low dose tricyclic antidepressants
     • SNRIs?, mirtazapine?
     • **Avoid opioids**

Psychosomatic Treatment of FGID - specific

Mechanism = Brain-Gut Dysregulation (±Pain), Treatment = Regulation

- Bowel Disorders
  - Irritable bowel syndrome
    - IBS-D – diarrhea predominant
    - IBS-C – constipation predominant
    - IBS-A – alternating periods of diarrhea and constipation
- Behavioral and lifestyle changes
  1. Diet – limit triggers (watch for excessive restriction)
    - Carbohydrates, spicy or fatty foods, milk products, coffee, alcohol and caffeine
  2. Diet – add potentially useful supplements
    - Probiotics, lactobacillus, fiber
  3. Bowel habits – strive for regular schedule
Psycosomatic Treatment of FGIDs - specific

Mechanism = Brain-Gut Dysregulation (±Pain), Treatment = Regulation

• Irritable bowel syndrome

4. Psychotherapies (meta-analyses consistently show benefit)
   • Various psychotherapies: CBT (21) = hypnosis (4) = psychodynamic psychotherapy (3) ≥ relaxation (2)
   • Reduced general IBS symptoms (large effect)
   • Improved IBS-related QOL (large effect)
   • Improved mental health, daily functioning (moderate effect)
   • Reduced abdominal pain (small effect)
   • Diarrhea or constipation (no significant effect)
   • Number needed to treat = 3

Psychosomatic Treatment of FGIDs - specific

Mechanism = Brain-Gut Dysregulation (±Pain), Treatment = Regulation

• Irritable bowel syndrome

5. Physical symptoms Rx – Antispasmodics and anti-diarrheals
   • Anticholinergics, opioids, barbiturates, combinations

6. Psychotropics – for IBS and co-existing anxiety/depression
   • Tricyclic antidepressants – IBS-D
   • SSRIs – IBS-C
   • SNRIs – may cause loose stools or constipation

7. IBS-specific drugs
   • Linzess (linaclotide) – IBS-C, guanylate cyclase-C agonist
   • Amitiza (lubiprostone) – women IBS-C, chloride channel-2 activator
   • Lotronex (alosetron) – women IBS-D, 5-HT₃ agonist
   • Xifaxan (rifaximin) – IBS-D, antibiotic (bacterial overgrowth?)
   • Viberzi (eluxadoline) – IBS-D, μ-opioid agonist, δ-opioid antagonist
Conclusions -- FGIDs

• GI medicine
  • First to conceptualize functional disorders systematically

• Rome III criteria for FGIDs
  • Positively defined sets of diagnostic criteria

• Psychosomatic treatment strategies
  • Education and engagement in goal of control not cure
  • Esophageal and anorectal disorders - habit reversal therapies
  • Functional dyspepsia and pain disorders – pain rehab strategies
  • IBS – stepped therapy
    • Diet, bowel habits, psychotherapy, psychotropic Rx
    • Symptom-specific Rx – antispasmodics, antidiarrheals
    • IBS-specific medications