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Rapid Response to Cognitive Behavior Therapy for Irritable Bowel Syndrome: Stepping Into a Stepped Care Model of Treatment Delivery


Background & Aims. Cognitive behavior therapy (CBT) is recognized as an empirically validated treatment for IBS (Rome III, 2006). But little is known about how it works for whom and for which patients (and least effective). Part of the problem is that researchers have focused attention on the predictive power of baseline demographic and clinical features (e.g., distress, bowel habit, symptom duration) that generally have a small, inconsistent link to treatment outcome. A potentially more useful approach emphasizes the variation of treatment factors occurring during therapy. The broader psychotherapy outcome research indicates that specific patterns of symptomatic change occurring over the course of treatment reveal important prognostic information about treatment response. Generally, rapid responders are significantly more likely to do better at the end of the acute phase of CBT and sustain gains at long-term follow-up than slow responders. Rapid response to CBT can therefore inform treatment planning and enhance our understanding of how treatments work. Method. We assessed rapid response in 71 Rome II diagnosed IBS patients who were randomly assigned to 1 of 2 10-week conditions of an NIH clinical trial: self-administered CBT (4 sessions; N = 35) or therapist-administered CBT (10 sessions, N = 36). Rapid responder status was defined on the basis of patients’ responses to 2 binary Adequate Relief measures (pain, bowel problems) and IBS Symptom Severity Scale. Results. Rapid response (Yes on both Adequate Relief measures and ≥50 unit IBSSQ reduction by week 4) characterized 29% of its, was unrelated to demographic features (e.g., age, gender, education, symptom duration, bowel problems), or baseline indices of psychological functioning (SF-36, BSI). Participants with rapid response at week 4 were more likely (p < 0.05) to report stronger internal locus of control (IBS-LOC), self-efficacy expectancies for managing IBS (IBS-SE), and motivation problems (p < 0.05), or baseline indices of psychological functioning (SF-36; BSI). Participants with IBS according to the Rome II criteria. Fifty-four patients (45 %) were responders to the start of education. Results: We included 121 patients (mean age 39 (18-68) years; 101 women) with IBS according to the Rome II criteria. Fifty-four patients (45 %) were responders to the start of education. Conclusion: Rapid response to CBT can therefore inform treatment planning and enhance our understanding of how treatments work. Aims: To evaluate the effect of biofeedback therapy on abdominal bloating, with or without visible abdominal distention, in female patients with non-D IBS or FC to determine the predictors of response to such therapy. Methods: Consecutive female non-D IBS and FC patients with abdominal bloating and without aerophagy referred for biofeedback therapy were studied (n=50, age 48±14 y). Entry criteria: Rome II non-D IBS or FC, 2 or more symptoms of pelvic floor dysynergia, 2 or more physiological criteria of pelvic floor dyssynergia. A comprehensive 6 visit individualised biofeedback program was performed including instruction on isometric abdominal bloating technique, manometric-biofeedback to achieve adequate rectal pressure and anal relaxation, balloon expulsion retraining, sensory retraining. The primary outcome measure was: balloon bloating score (CBS, steep flow fow form, flat flow form, balloon expulsion time, rectal pressure with strain, quality of life and bowel satisfaction were assessed. Results: Participants were subdivided according to the presence (D, n=28) or absence (ND, n= 22) of visible abdominal distension. Both groups reported significantly decreased bloating with biofeedback (D by 20%, ND by 36%; p<0.01), they also improved in satisfaction with bowel movements (D by 20%, ND by 117%, each p<0.001) and in quality of life (D by 36%, ND by 34%; each p<0.001). Predictions of improvement in bloating were prolonged balloon expulsion time at baseline (p=0.004) for ND, and improvement in evacuation time (p<0.001) for D. Overall for both groups, improvement in evacuation time predicted improvement in bloating (p<0.05); there was a trend for an association with improvement in straining rectal pressure (p=0.09). Conclusion: Biofeedback therapy is a treatment option for patients with bloating and constipation, with or without visible abdominal distension. The predictors of response to therapy was improvement in evacuation time rather than a change in stool form or frequency. There was a trend for improvement in rectal pressure with strain as a predictor. The mechanism of improved bloating may relate to greater efficiency of evacuation, and perhaps improved abdilomino-phreric-co-ordination, rather than alterations in transit.

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Long Term Effects of Hypnotherapy in Refractory IBS

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Background: Hypnotherapy is considered to be an effective treatment in irritable bowel syndrome (IBS) but few studies report long-term efficacy data. This is a retrospective study to further evaluate the long-term effects on IBS symptoms of hypnotherapy. We also studied health care seeking behavior and intake of IBS-symptom modifying drugs before and during long-term follow-up after hypnotherapy. METHODS: A questionnaire (Subjective Assessment Questionnaire (SAQ); Gomkalldahl et al Gut 2003) was sent to all 244 patients who had received hypnotherapy at three different hospitals because of IBS refractory to standard management at. In total 212 patients (187 females, 25 males, mean age 46.5 (25-72) years) responded (response rate 87%). All patients had received gut-directed hypnotherapy 1 h/ week for 12 weeks from specially trained psychologists. The use of SAQ was based on the findings that such assessment is comparable to the validated IBS Symptom Severity Scale (Francis et al APT 1997). Response to therapy was defined as a change to less severe symptoms with one step on a seven-graded Likert scale. In addition, patients were asked to report their changes in healthcare seeking behavior, their use of IBS-symptom modifying drugs and quality of life. At baseline, 78% of patients reported more than 1 of 2 non-pharmacological treatment and 37% used hypnotherapy as a regular treatment. This long-term follow up was performed 2-7 years after treatment (mean 4 years). RESULTS: The proportions of responding patients as assessed directly after the treatment period and at long term follow up was 77% and 79 % respectively. Eighty-seven percent of immediate responders maintained their SAQ improvement during the long term follow up. Eighty-seven percent of all patients judged the treatment as meaningful. The responders reported a reduction of visits to a GP for GI symptoms, a GP for other symptoms or any visits to a Gastroenterologist with 50 %, 16 %, and 47 % respectively. Seventy-eight percent of responders used less symptom modifying drugs after hypnotherapy and 37 % actively used the hypnotherapy technique on a regular basis, of which 28 % used the taped sessions. Among the 29% of patients who had tried other types of non-pharmacological treatment (60 % found it useful), 50% were considered as non-responders to hypnotherapy. There were no significant differences between the groups regarding referral status, age, sex, predominant bowel habit, symptom duration, psychological symptoms or level of perceived knowledge about IBS assessed at baseline. Conclusion: A structured patient education seems to be most efficacious in patients with moderately severe GI symptoms and somewhat better quality of life. Patients with severe GI symptoms and very poor quality of life might need more support than what is offered in a structured patient education in a group setting. These results can be used to optimize patient selection and enhance cost benefit for this intervention.

Anorectal Biofeedback Therapy Improves Bloating in Irritable Bowel Syndrome and Functional Constipation

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Background: There are few effective treatment options for abdominal bloating. The abdilomino-phreric-incoordination and abdominal wall dystyoni documented in such patients may have a surgical basis. Anorectal biofeedback is an effective treatment for women with non-diarrhea predominant irritable bowel syndrome (non-D IBS) and functional constipation (FC) but its effect on abdominal bloating is unknown. Aims: 1) to evaluate the effect of biofeedback therapy on abdominal bloating, with or without visible abdominal distention, in female patients with non-D IBS or FC. 2) to determine the predictors of response to such therapy. Methods: Consecutive female non-D IBS and FC patients with abdominal bloating and without aerophagy referred for biofeedback therapy were studied (n=50, age 48±14 y). Entry criteria: Rome II non-D IBS or FC, 2 or more symptoms of pelvic floor dysynergia, 2 or more physiological criteria of pelvic floor dyssynergia. A comprehensive 6 visit individualised biofeedback program was performed including instruction on isometric abdominal bloating technique, manometric-biofeedback to achieve adequate rectal pressure and anal relaxation, balloon expulsion retraining, sensory retraining. The primary outcome measure was: balloon bloating score (CBS, steep flow form, flat flow form, balloon expulsion time, rectal pressure with strain, quality of life and bowel satisfaction were assessed. Results: Participants were subdivided according to the presence (D, n=28) or absence (ND, n= 22) of visible abdominal distension. Both groups reported significantly decreased bloating with biofeedback (D by 20%, ND by 36%; each p<0.01), they also improved in satisfaction with bowel movements (D by 20%, ND by 117%, each p<0.001) and in quality of life (D by 36%, ND by 34%; each p<0.001). Predictions of improvement in bloating were prolonged balloon expulsion time at baseline (p=0.004) for ND, and improvement in evacuation time (p<0.001) for D. Overall for both groups, improvement in evacuation time predicted improvement in bloating (p<0.05); there was a trend for an association with improvement in straining rectal pressure (p=0.09). Conclusion: Biofeedback therapy is a treatment option for patients with bloating and constipation, with or without visible abdominal distension. The predictors of response to therapy was improvement in evacuation time rather than a change in stool form or frequency. There was a trend for improvement in rectal pressure with strain as a predictor. The mechanism of improved bloating may relate to greater efficiency of evacuation, and perhaps improved abdilomino-phreric-co-ordination, rather than alterations in transit.