Is There Anything I Can Do for the Refractory Functional GI Patient?

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What are functional disorders?

What are functional disorders?

- Groups of symptoms that are not attributable to recognized structural or biochemical causes
- Examples:
  - Irritable bowel syndrome
  - Functional dyspepsia
- Common in the population

Rome III Committee Syndromes

- Functional esophageal disorders
  - Functional heartburn
  - Functional chest pain
  - Functional dysphagia
  - Globus

Rome III Committee Syndromes

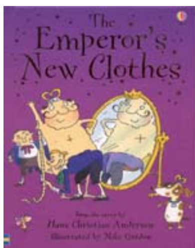
- Functional gastroduodenal disorders
  - Functional dyspepsia
  - Belching disorders
  - Nausea & vomiting disorders
  - Rumination syndrome

Rome III Committee Syndromes

- Functional bowel disorders
  - Irritable bowel syndrome
  - Functional bloating
  - Functional constipation
  - Functional diarrhea
  - Unspecified functional bowel disorder
- Functional abdominal pain syndrome

Rome III Committee Syndromes

- Functional gallbladder & SO disorders
  - Functional gallbladder disorder
  - Functional biliary SO disorder
  - Functional pancreatic SO disorder
- Functional anorectal disorders
  - Functional fecal incontinence
  - Functional anorectal pain
  - Functional defecation disorders



Functional Syndromes:

Entity or Illusion?

Functional syndromes

Entity

- Single underlying problem or process that leads to symptoms
- Phenotypic distinctions are meaningful for management
- Treatment of underlying process might lead to successful management

Functional syndromes

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Illusion

- Clusters of symptoms are due to different disease processes
- Further investigation might lead to specific diagnosis
- Treatment of specific problem might lead to successful management

General aspects of management

Dr. Drossman's Ten Commandments

1. Obtain the history through a nondirective, non judgmental patient-centered interview.
2. Conduct a careful examination and cost-efficient investigation.
3. Determine how much the patient understands about the illness and his or her concerns.

Drossman DA. Gastroenterology 2006;130:1377—1390.

Dr. Drossman's Ten Commandments

4. Provide a thorough explanation of the disorder that takes into consideration the patient's beliefs.
5. Identify and respond realistically to the patient's expectations for improvement.
6. When possible, provide a link between stressors and symptoms that are consistent with the patient's beliefs.

Drossman DA. Gastroenterology 2006;130:1377—1390.

Dr. Drossman's Ten Commandments

7. Set consistent limits.
8. Involve the patient in treatment.
9. Make recommendations consistent with patient's interests.
10. Establish a long-term relationship with a primary care provider.

Drossman DA. Gastroenterology 2006;130:1377—1390.

Graded approach to management

- Mild symptoms
  - Education
  - Reassurance
  - Elimination of symptom-inducing foods and medications

Drossman DA. Gastroenterology 2006;130:1377—1390.

Graded approach to management

- Moderate symptoms
  - Symptom monitoring
  - Symptom-directed drug therapy
  - Psychological treatments

Drossman DA. Gastroenterology 2006;130:1377—1390.

Graded approach to management

- Severe symptoms
  - Physician approach
    - Base testing on objective findings
    - Set realistic goals for treatment
    - Shift responsibility to patient
    - Change focus from treatment to adaptation to chronic illness

Drossman DA. Gastroenterology 2006;130:1377—1390.

Graded approach to management

- Severe symptoms
  - Antidepressant drug therapy
  - Pain treatment center referral

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Refractory symptoms may be due to…

- Nonadherence with recommendations
- Primary treatment failure
- Comorbid conditions
  - Including psychiatric problems

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EXPLORE THESE POSSIBILITIES WITH PATIENT

In addition…

- Rethink the diagnosis
  - Further testing may be needed
- Review treatment options
- Consider psychiatric consultation
- Obtain second (third, fourth…) opinion