



<b>Body System: Gastrointestinal</b>		
<b>Session Topic: Irritable Bowel Syndrome (IBS)</b>		
<b>Educational Format</b>		<b>Faculty Expertise Required</b>
<b>REQUIRED</b>	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
<b>OPTIONAL</b>	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>
<b>Professional Practice Gap</b>	<b>Learning Objective(s) that will close the gap and meet the need</b>	<b>Outcome Being Measured</b>
<ul style="list-style-type: none"> <li>Knowledge gaps related to applying evidence-based diagnostic criteria for the evaluation of IBS in patients who present with recurrent and episodic abdominal pain.</li> <li>Knowledge gaps related to the identification of red flags indicating a need to investigate for other diseases, and subsequent referral and follow-up with a gastroenterologist.</li> <li>Knowledge gaps related to the use of evidence-based treatment strategies that foster patient adherence.</li> <li>Knowledge and practice gaps with regard to coaching patients in the use of food diaries; diagnosing IBS (e.g. Rome III, Bristol scale); understanding the safety and efficacy of current and new medications; and counseling patients about diet and lifestyle modification.</li> </ul>	<ol style="list-style-type: none"> <li>Apply evidence-based diagnostic criteria to evaluate patients presenting with recurrent or episodic abdominal pain for IBS.</li> <li>Establish referral and follow-up protocol with a gastroenterologist for patients exhibiting red flags for other which endoscopic evaluation should be considered.</li> <li>Consider when treatment with antidepressants and psychological therapies may be helpful for improving IBS symptoms.</li> <li>Develop treatment plans that involve positive patient-physician communication, shared decision making, and follow-up strategies that result in symptom relief and improved quality of life.</li> </ol>	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.



ACGME Core Competencies Addressed (select all that apply)		
X	Medical Knowledge	Patient Care
X	Interpersonal and Communication Skills	Practice-Based Learning and Improvement
	Professionalism	Systems-Based Practice
Faculty Instructional Goals		
<p>Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.</p> <ul style="list-style-type: none"> <li>• Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy &amp; reference citations</li> <li>• Facilitate learner engagement during the session</li> <li>• Address related practice barriers to foster optimal patient management</li> <li>• Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the <u>References</u> section below are a good place to start <ul style="list-style-type: none"> <li>○ Visit <a href="http://www.aafp.org/journals">http://www.aafp.org/journals</a> for additional resources</li> <li>○ Visit <a href="http://familydoctor.org">http://familydoctor.org</a> for patient education and resources</li> </ul> </li> <li>• Provide tools, resources, and strategies to foster the implementation of evidence-based IBS diagnosis and management guidelines into practice</li> <li>• Provide case-based examples to illustrate the identification of red flags indicating the need for further evaluation of other diseases and possible referral</li> <li>• Provide specific strategies and resources for developing collaborative treatment plans that involve positive patient-physician communication, shared decision making, and follow-up strategies that result in symptom relief and improved quality of life</li> </ul>		

**Needs Assessment:**

With between 2.4 and 3.5 million annual physician visits, irritable bowel syndrome (IBS) is the most common functional gastrointestinal (GI) disorder in the U.S.<sup>1</sup> IBS treatment in the U.S. has an estimated cost between \$1.7 billion and \$10 billion (excluding prescription and OTC drug costs), and nearly \$20 billion in indirect cost.<sup>2</sup> The 15 million office visits for abdominal pain in 2010 do not account for the 76% of IBS sufferers who are undiagnosed.<sup>3</sup>

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment Survey indicate that family physicians have gaps in the knowledge and medical skill to manage patients with IBS; counsel patients regarding diets, and nutrition; and order appropriate diagnostic testing in the diagnosis of IBS.<sup>4</sup> Additionally, CME outcomes data from 2014 AAFP Assembly: *Irritable Bowel Syndrome (IBS): Evidence-Based Approach* sessions suggest that family physicians have knowledge and practice gaps with regard to coaching patients in the use of food diaries; diagnosing IBS (e.g. Rome III, Bristol scale); understanding the safety and efficacy of current and new medications; and counseling patients about diet and lifestyle modification.<sup>5</sup>



Physicians tend to have no or limited knowledge of appropriate diagnostic criteria for IBS; therefore approaching IBS as a diagnosis of exclusion, and perform more unnecessary tests as a result.<sup>6-9</sup> Diagnosing patients who present with abdominal pain can be challenging to properly evaluate without overusing diagnostic tests and consultation.<sup>10</sup> ROME III is often cited as the preferred diagnostic tool, however, it is more commonly used in research and less often in clinical practice; therefore, family physicians should consider the diagnosis and management of IBS as outlined by Thad Wilkins, MD; Christina Peptone, MD; Biju Alex, MD; and Robert R. Schade, MD in the September 1, 2012 issue of American Family Physician. Evidence-based clinical recommendations from that article are summarized as follows:<sup>11</sup>

- The absence of abdominal pain can be used to rule out IBS.
- Routine blood and stool studies are not recommended in the diagnosis of IBS.
- Routine testing for celiac disease should be considered in patients with diarrhea-predominant or mixed presentation IBS.
- The presence of alarm features in patients with IBS symptoms should prompt additional testing with colonoscopy and biopsy to evaluate for other conditions.
- Exercise, probiotics, antibiotics, antispasmodics, antidepressants, psychological treatments, and peppermint oil may improve IBS symptoms.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Additionally, IBS is a complicated condition which requires physicians to identify and treat associated psychosocial factors (e.g. depression) for optimal patient management.<sup>11,12</sup> The goals of IBS treatment are symptom relief and improved quality of life and include therapies to improve symptoms, improve stool frequency, and treat associated psychological factors.<sup>11</sup> Effective treatment can be achieved with positive patient-physician communication, shared decision making, and effective follow-up strategies that should result in fewer return office visits for IBS.<sup>13-15</sup> Family physicians should develop evidence-based treatment strategies that may include exercise, OTC laxatives, antidiarrheals, probiotics, antibiotics, antispasmodics, selective C-2 chloride channel activators, antidepressants, CAM therapies, 5-HT<sub>3</sub> antagonists, or 5-HT<sub>4</sub> antagonists depending on diagnosis and IBS severity score.<sup>11</sup> Family physicians should utilize evidence-based recommendations for the diagnosis and management of IBS, such as those release by the American College of Gastroenterology.<sup>16</sup>

A recent review of the literature suggests a need to provide continuing medical education to physicians with regard to the following:



- As patients tend to “migrate” over time from one diagnosis to the other, which, coupled with limited knowledge of diagnostic criteria, likely enhances the challenge of making an accurate diagnosis in primary care and specialty practices<sup>17-19</sup>
- Antidepressants and psychological therapies are effective in treating the symptoms of IBS.<sup>20</sup>

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Irritable bowel syndrome: diagnostic approaches in clinical practice<sup>6</sup>
- Diagnosing the patient with abdominal pain and altered bowel habits: is it irritable bowel syndrome<sup>10</sup>
- Diagnosis and management of IBS in adults<sup>11</sup>
- Thinking on paper: documenting decision making<sup>15</sup>
- ACG Releases Recommendations on the Management of Irritable Bowel Syndrome<sup>16</sup>
- An evidence-based position statement on the management of irritable bowel syndrome<sup>21</sup>
- Evidence-based position statement on the management of irritable bowel syndrome in North America<sup>22</sup>
- How to reduce your malpractice risk<sup>23</sup>
- Thinking on paper: documenting decision making<sup>15</sup>
- Simple tools to increase patient satisfaction with the referral<sup>24</sup>
- Exam documentation: charting within the guidelines<sup>25</sup>
- Health Coaching: Teaching Patients to Fish<sup>26</sup>
- Simple tools to increase patient satisfaction with the referral process<sup>24</sup>
- Engaging Patients in Collaborative Care Plans<sup>27</sup>
- Encouraging patients to change unhealthy behaviors with motivational interviewing<sup>28</sup>
- FamilyDoctor.org. Irritable Bowel Syndrome | Overview (patient resource)<sup>29</sup>

References

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