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What did I learn from Dr. Drossman a.k.a Doug? My visiting experience

This year, April 2015, Drossman Gastroenterology hosted a visiting scholar from Malaysia, Yeong Yeh Lee, MD PhD. Dr. Lee is a prominent gastroenterologist, also an associate of the Rome foundation, who has researched and published widely in the field of motility and FGIDs. With the International Fellowship Exchange Program (IFEP) award from the American College of Physicians (ACP), of which he is a fellow (FACP), he spent time seeing patients with Doug and his able assistant, Kellie Bunn. He spent two days per week at the clinic with a chance to observe and interact with first-time patients and follow-up visits. Following were accounts of his learning experience.

FGIDs are what I commonly see in my clinical practice because of my special interest in this area. There comes to a point, especially with complex cases, that management becomes challenging and demanding for me. The biopsychosocial approach [1], an integral strategy adopted by Doug in his practice, and that I had come to learn, would be the solution I am looking for to address my patients' complex problems. As doctors, what we commonly see in our patients is the disease paradigm, and therefore when we did not see any organic explanations to an illness or symptoms, we end up in a dilemma. But in the biopsychosocial approach, disease and illness are actually seen as being connected between the mind and the body, providing a 'holistic' rather than a 'dualistic' view. Factors affecting early life including genetics and environment (for example, physical and psychological abuse) [2] can also affect 'functional' bowel symptoms. How do I apply this approach in actual clinical practice? There are three important points i.e. good doctor-patient relationship, use of psychotropic agents and behavioral coping strategies.

A most important approach is to develop a good communication and doctor-patient relationship [3]. It is all too common for doctors to provide ineffective comments, for example "It is all in your mind", and "Do not worry, it is not serious". What strained the doctor-patient relationship is that doctors frequently underestimate the severity of illness and that patients frequently do not acknowledge their psychological distress. This is can be rectified through effective communication, and I have seen for myself during my time with Doug, how this process does lead to a more satisfying therapeutic relationship. In patient-centered care, what patients really want is for their doctors to provide clear information about how the brain-gut connection affects their symptoms, and for their doctors to provide positive empathy and support and mutually agreed treatment goals. A cornerstone to an effective relationship is building trust, and providing accessibility is useful. A number to contact is a typical follow-on at the end of a consultation process in Doug's practice [4].

The use of psychotropic agents is one approach that is shown to modulate the descending pain inhibition pathway from the brain but at the same time it allows positive neurogenesis to take place [5]. I have observed the use of psychotropic agents, in the right context and with close monitoring of side-effects, can be especially helpful. Although the effect may only take place couple of weeks later and the symptoms do not always go away completely but a large majority of patients reported benefits over long term based on satisfaction surveys. A very important point for psychotropic use is augmentation, where two or more agents are combined for better efficacy and also with less side-effects since lower doses can be used, for example, duloxetine (Cymbalta) and quetiapine (Seroquel) [6]. A table of common psychotropic agents I have encountered in Dr. Drossman's practice is given below.

Table: Common psychotropic agents used in Drossman Gastroenterology

Group	Name

Tricyclic antidepressant	Amitriptyline Imipramine
Selective serotonin reuptake inhibitor (SSRI)	Fluoxetine (Prozac) Citalopram (Celexa)
Serotonin-norepinephrine reuptake inhibitor (SNRI)	Duloxetine (Cymbalta) Venlafaxine (Effexor) Milnacipran (Savella)
Atypical antipsychotics	Quetiapine (Seroquel) Aripiprazole (Abilify)
Tetracyclic	Mirtazepine (Remeron)
Azaspirodecanediones	Buspirone (Buspar)
Atypical antidepressant	Bupropion (Wellbutrin)
NMDA antagonist	Memantine (Nemanda)

As you can see from the table, tricyclics for example amitriptyline and imipramine have potent anticholinergic and antihistaminic effects and therefore side effects including constipation, dry eyes/mouth and sedation are common. The SSRIs, for example celexa and prozac are good for anxiety but not as helpful for pain. SNRIs, for example duloxetine and atypical antipsychotics for example quetiapine, do not have the side effects of tricyclics, and are effective for pain besides depression. Other agent to consider for pain include mirtazapine (Remeron) which is also useful if patients complain of nausea and anorexia. Bupropion is also good for anorexia and with less sexual side-effects. Buspirone (Buspar) is good for functional dyspepsia where it relaxes the gastric fundus, and at the same time, it has anti-anxiety agent. Aripiprazole (Abilify) is an atypical antipsychotic similar to quetiapine that is not sedating. Memantine is used in Alzheimer's disease but it also relieves neuropathic pain, and in Doug's practice, this agent is only considered for refractory abdominal pain.

The third and final point is behavioral coping strategies. There are a number of reasons why psychological interventions are useful in FGIDs. Stressful life events often trigger symptoms in many patients, and that history of childhood abuse is commonly associated with FGIDs. Furthermore, co-morbid psychiatric disorders including anxiety and depression are highly prevalent in this group of patients. But most importantly, psychological treatment really works. This has been supported by a number of well-conducted research [7]. Some effective interventions include cognitive behavioral therapy (CBT), hypnosis, relaxation therapy and biofeedback. The challenge is to get patient to agree for consultation with a psychological therapist. This can be facilitated by adequate explanation, reassurance of diagnosis and also continuation of care. It is important for patients to identify suitable therapist who can work with them.

As a conclusion, despite the short-time I had with Doug, the learning experience was just great because of the sheer volume and diversity of cases. This is a lifetime experience, to sit beside a great teacher and an astute clinician. It will bring changes to how I approach my patients from now on. Thank you very much, Doug!

References

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