Educational needs related to irritable bowel syndrome with constipation (IBS-C) management across disciplines: a comparison of nurse practitioners, physician assistants, and physicians

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Introduction and purpose

Despite availability of multiple treatment options for irritable bowel syndrome with constipation (IBS-C), optimal management of the condition remains challenging. This study was designed to investigate the educational needs and practice differences amongst primary care and gastroenterology nurse practitioners (NPs), physician assistants (PAs), and physicians, and highlight areas for continuing education.

Methodology

A case-based survey was developed with input from a gastroenterology specialist and pilot tested with the target audience. Survey instruments and protocols were determined to be exempt from review by an independent IRB.

Surveys were fielded to gastroenterology and primary care physicians, NPs and PAs currently practicing in the United States from January to February 2024 using national mailing lists and lists of clinicians who have previously opted-in for similar educational research.

HCPs had to see patients with IBS-C to be included in the results. To determine differences in management and perceptions by clinical group, subanalyses were conducted.

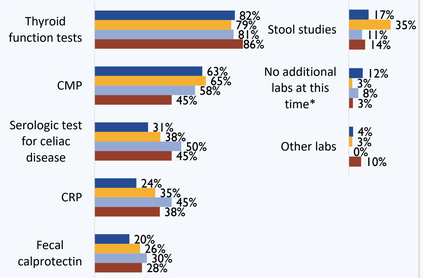
HCP sample demographics

Responses from 410 HCPs, including 63 NP/PAs were analyzed.	Primary care provider physicians (PCPs) (n = 222)	Primary care provider NPPAs (PCP NPPAs) (n = 34)	Gastro physicians (GIs) (n = 125)	Gastro NPPAs (GI NPPAs) (n = 29)
Patients seen per week, mean (SD)	109 (56.8)	87 (48.8)	84 (45.5)	62 (36.8)
% in an academic practice setting	15%	3%	31%	24%
Years in practice, mean (SD)	23 (9.3)	18 (6.3)	22 (9.9)	12 (5.9)
Patients with IBS per month, mean	34 (47.0)	23 (18.1)	63 (49.8)	56 (36.0)
% with IBS-C predominant	42%	38%	48%	45%

Diagnostic testing

Patient Case 1 Summarized:
- Previously healthy 25-year-old with 6 months of abdominal pain 4-5 days per week and pain improvement after defecation
- Several days between bowel movements, hard and pellet-like stools. No family history of IBD, colorectal cancer, or celiac disease
- Healthy diet, unpredictable mealtimes, walks 3-4 times per week. Feels stressed but not increased.
- No weight loss, rectal bleeding, or nocturnal symptoms reported.

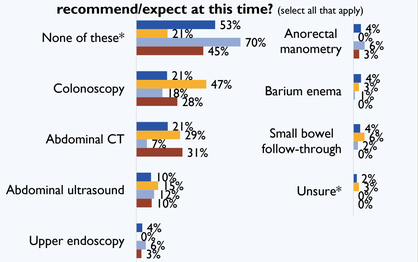
Which of the following additional labs would you recommend <u>at this time</u>? (select all that apply)



*exclusive answer option

- CMP, CRP, thyroid function tests, fecal calprotectin, and serologic test for celiac disease were normal. Stool studies are unremarkable.

Which of the following additional diagnostic tests would you recommend/expect at this time? (select all that apply)

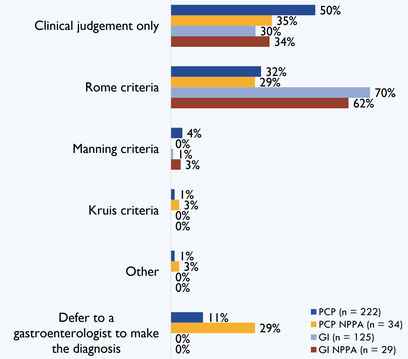


PCP (n = 222) PCP NPPA (n = 34) GI (n = 125) GI NPPA (n = 29)

In a patient initially presenting with IBS-C symptoms, about half of GIs, but fewer PCPs and NP/PAs recommended serologic tests and/or CRP. A higher proportion of GI NP/PAs and PCP NPs/PAs selected additional diagnostic testing compared to GIs and PCPs.

Diagnostic criteria

What criteria do you predominately use in making a diagnosis of IBS?

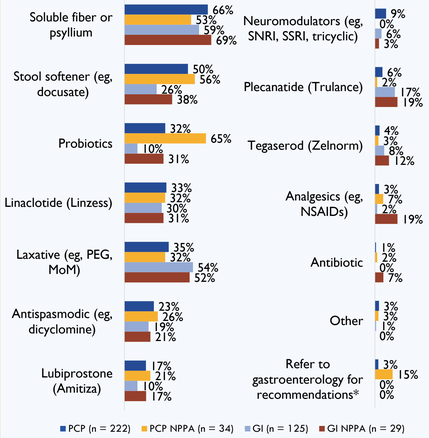


PCP NPs/PAs are also more likely than PCPs to defer to gastroenterology specialists when diagnosing IBS-C with a third of PCP NPs/PAs and half of PCPs using clinical judgement alone.

Initial IBS-C management

Patient Case 1 is diagnosed with IBS-C and presents to discuss options

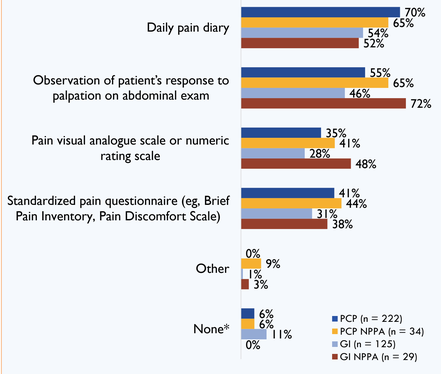
What pharmacotherapy would you recommend at this appointment as part of your initial management of this patient's IBS-C? (select all that apply)



GI and PCP NPs/PAs are more likely to use probiotics in initial management of a patient with IBS-C than physicians.

Pain evaluation

In addition to the patient's description, what tools/techniques would you use in evaluating her pain? (select all that apply)

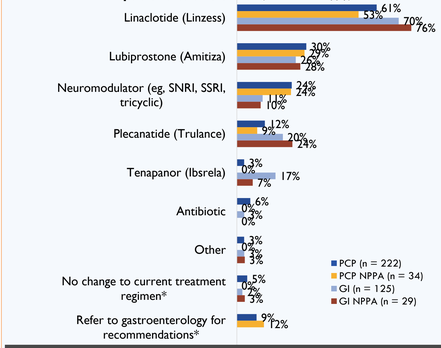


In evaluating pain in their patients with IBS-C, NPs/PAs are more likely than physicians to observe patients' response to palpation on abdominal exam.

Recurrent IBS-C management

Patient Case 2 Summarized:
- Patient presenting for follow-up of IBS-C diagnosed 2 years ago after 6 months constipation, occasional diarrhea, bloating, and tenesmus. Previous diagnostic workup at time of diagnosis including colonoscopy and lab testing.
- Averages 2 bowel movements a week with straining, feelings of incomplete evacuation; bloated. Turns down social events due to discomfort and time on toilet. Currently taking stool softeners, laxatives, and probiotics.

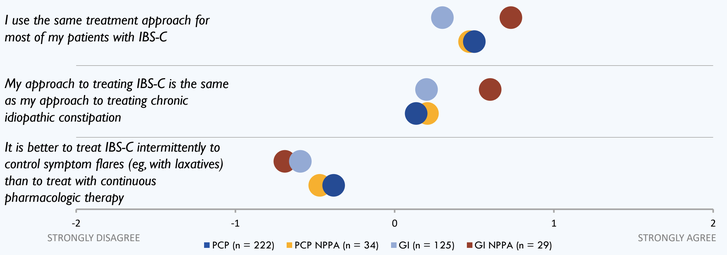
Would you begin/expect to begin any new therapies for the patient at this time? (select all that apply)



GI HCPs are more likely to prescribe medications approved for IBS-C in a patient with persistent constipation who is avoiding social events due to discomfort than primary care HCPs, whereas primary care HCPs are more likely to prescribe neuromodulators.

Treatment approach

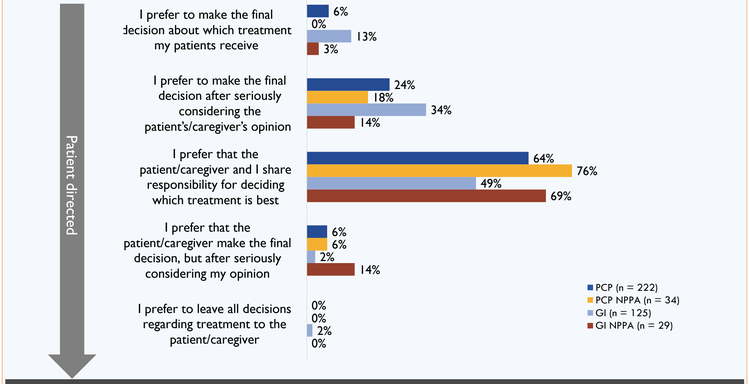
Rate your level of agreement with each of the following statements



For treatment, gastroenterology NPs/PAs are more likely to use the same treatment approach to treat IBS-C and idiopathic constipation compared with gastroenterology physicians.

Shared decision making

Which approach best characterizes how you prefer to make treatment decisions for patients with IBS-C?



NPs/PAs are more likely to report preference to participate in shared decision-making with their patients with IBS-C than physicians.

Conclusions

- ❑ Education on managing patients with IBS-C should be targeted to the specific challenges and needs of key clinical specialties and roles.
- ❑ This study highlighted practice differences and areas of ongoing educational gaps for HCPs, thus informing on key areas to consider when developing specific NP-focused future educational and informational initiatives.

DISCLOSURES:
This study was funded by Ardelyx, Inc. This poster is intended for healthcare professionals. DPR is an employees of Ardelyx, Inc. Other authors have nothing to disclose.

For more information about this study, contact Emily Belcher at emily.belcher@ceoutcomes.com

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IBSRELA® (tenapanor) is indicated for treatment of irritable bowel syndrome with constipation (IBS-C) in adults

Important Safety Information

WARNING: RISK OF SERIOUS DEHYDRATION IN PEDIATRIC PATIENTS

- **IBSRELA is contraindicated in patients less than 6 years of age; in nonclinical studies in young juvenile rats, administration of tenapanor caused deaths presumed to be due to dehydration.** ***[see PI Contraindications (4), Use in Specific Populations (8.4)]*****.**
- **Avoid use of IBSRELA in patients 6 years to less than 12 years of age.** ***[see PI Warnings and Precautions (5.1), Use in Specific Populations (8.4)]*****.**
- **The safety and effectiveness of IBSRELA have not been established in pediatric patients less than 18 years of age.** ***[see PI Use in Specific Populations (8.4)]*****.**

CONTRAINDICATIONS

IBSRELA is contraindicated in patients less than 6 years of age due to the risk of serious dehydration.

IBSRELA is contraindicated in patients with known or suspected mechanical gastrointestinal obstruction.

WARNINGS AND PRECAUTIONS

Risk of Serious Dehydration in Pediatric Patients

IBSRELA is contraindicated in patients below 6 years of age. The safety and effectiveness of IBSRELA in patients less than 18 years of age have not been established. In young juvenile rats (less than 1 week old; approximate human age equivalent of less than 2 years of age), decreased body weight and deaths occurred, presumed to be due to dehydration, following oral administration of tenapanor. There are no data available in older juvenile rats (human age equivalent 2 years to less than 12 years).

Avoid the use of IBSRELA in patients 6 years to less than 12 years of age. Although there are no data in older juvenile rats, given the deaths in younger rats and the lack of clinical safety and efficacy data in pediatric patients, avoid the use of IBSRELA in patients 6 years to less than 12 years of age.

Diarrhea

Diarrhea was the most common adverse reaction in two randomized, double-blind, placebo-controlled trials of IBS-C. Severe diarrhea was reported in 2.5% of IBSRELA-treated patients. If severe diarrhea occurs, suspend dosing and rehydrate patient.

MOST COMMON ADVERSE REACTIONS

The most common adverse reactions in IBSRELA-treated patients (incidence ≥2% and greater than placebo) were: diarrhea (16% vs 4% placebo), abdominal distension (3% vs <1%), flatulence (3% vs 1%) and dizziness (2% vs <1%).

For additional safety information, including the Boxed Warning, please see full Prescribing Information: click here.

IBS-C, irritable bowel syndrome with constipation.

IBSRELA (tenapanor hydrochloride). Prescribing information. Ardelyx, Inc; 2025.
Available at: https://www.ibsrela-hcp.com/PI