

Integrated care for disorders of gut-brain interaction



The Article by Chamara Basnayake and colleagues,¹ published in *The Lancet Gastroenterology & Hepatology*, convincingly supports the merits of integrated care for patients with functional gastrointestinal disorders, also known as disorders of gut-brain interaction.² For many decades, the standard of care for disorders of gut-brain interaction has revolved around physicians recommending over-the-counter or prescription medications to relieve specific symptoms. Although these medications have provided relief for many patients with these disorders, credible scientific data is available for only selected medical treatments used in clinical practice. Furthermore, of the medications that have been tested in randomised, controlled trials, less than half of patients with disorders of gut-brain interaction typically report improvement in their overall symptoms and the therapeutic benefit, with a few exceptions, in the range of 7–15% greater than that seen with placebo.^{3,4} The marginal efficacy and potential for medication-related adverse effects has not gone unnoticed by patients who are increasingly seeking a more holistic approach to address their gastrointestinal symptoms.

Over the past 20 years, there has been a gradual evolution in the care of patients with disorders of gut-brain interactions. The largest evidence base exists for irritable bowel syndrome (IBS). When diet and behavioural interventions started to receive attention in the early 21st century, gastroenterologists were understandably skeptical both about their efficacy and where these methods might fit into the existing treatment algorithm for IBS. Furthermore, there were, and still remain, practical concerns about the availability of professionals to properly deliver these services, as well as insurance coverage and affordability. By 2020, most key opinion leaders and gastroenterologists believe these non-medical strategies benefit patients with IBS.⁵ For example, a recent survey of gastroenterologists in the USA found that more than 90% feel that diet interventions work as well or better than other IBS treatments.⁶

It should come as no surprise that gastroenterologists are increasingly using a multidisciplinary approach, incorporating diet and behaviour interventions into the care of patients with disorders of gut-brain

interaction. More than 75% of US gastroenterologists provide dietary advice to most of their patients with IBS and more than half view dietary interventions as a first-line therapy for these patients. In the USA, only around a third of gastroenterologists rarely or have never referred their patients with IBS to a registered dietitian.⁶ Although the adoption of these therapies is encouraging, enthusiasm should be tempered by the realisation that multidisciplinary care, in which providers from different disciplines independently provide their services, is not the same as integrated care, in which a team of different providers work collaboratively to provide a more holistic treatment plan (appendix).⁵

The study by Basnayake and colleagues¹ is one of the first randomised studies to show the benefits of team-based, integrated care compared with standard care—in which a gastroenterologist provided the majority of care, but could have obtained a consultation with an independent dietitian or behavioural therapist.¹ The results were striking, 26 (57%) of 46 patients in the standard care group, compared with 82 (84%) of 98 patients in the multidisciplinary care group, had global symptom improvement (risk ratio 1.50 [95% CI 1.13–1.93]; $p=0.00045$). This study also showed larger improvements in psychological status, quality of life, and lower cost per successful outcome with integrated care compared with standard care. Of note, the standard care in this study might not be standard care for many patients with IBS who do not have the possibility of seeing a gastrointestinal dietitian or behavioural therapist. In retrospect, it would have been interesting if the authors had included a third group in which only care from a gastroenterologist was offered.

The authors should be congratulated for completing this challenging study. That said, readers should take note of several issues that could have influenced the results. The study employed two separate groups of physicians who were said to have similar levels of experience. Although similar levels of experience for the providers is reassuring, other potential sources of bias exist that need to be considered in this open-label, practical clinical trial. For example, did doctors who usually practiced in a team-based, multispecialty practice now have to work in a more traditional system with which they were not as familiar or comfortable?

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Another issue is whether the study's inclusion and exclusion criteria or its base in a tertiary care centre might have unintentionally biased enrolment towards patients with diet or stress and anxiety related problems who would be more likely to benefit from the integrated, multispecialty care model.

The results of this study usher in a new gold standard for the care of patients with gastrointestinal conditions. Although this study provides evidence for an integrated care model for patients with disorders of gut-brain interaction, it is probable that such a model will benefit a wide range of other gastrointestinal diseases. However, integrated care models are best suited to health systems or large groups, and practices with a small number of health-care providers are unlikely to have the clinical volume necessary to support a registered dietitian or behavioural therapist. Creative clinical care models that use or make available shared resources will be necessary for integrated care to reach its fullest potential.

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