STANDARDIZED PATIENT PROTOCOL

Eastern Virginia Medical School
Case Title: Constipation - IBS
P Educa _X___
Communication_____X_______
Anticipated time needed: __30___ minutes

Setting: Gastroenterologist's private office

PATIENT DEMOGRAPHICS: to be used for recruiting the Standardized Patient

a) age range ………….. 30-50
b) gender …………….. female
c) race ……………….. non-specific
d) socioeconomic/ educational level …………..non-specific
e) background …………
f) case specifics ………….
g) specific affect to be simulated …………anxiety and frustration

SUMMARY OF CASE

Opening Statement:

"I have been constipated off and on since college. I have tried everything and I don't know what to do."

Chief Complaint:

The patient has the chief complaint of severe constipation intermittently for years.

History of Present Illness:

For the past 3 years, the patient has been experiencing intermittent constipation and bloating. The symptoms began in high school and worsened in college. She has periods of constipation that vary from days to weeks, sometimes severe sometimes light (waxing and waning.) It is followed by periods of normal stool. Over the last several months (3-4), she has increased urgency and muscle spasm (cramping.) She is also having achy lower back pain, level 4-6, (no radiation of back pain) and feelings of incomplete evacuation.

The frequency is 1 bowel movements per day. She describes the stool color as dark brown, sometimes with mucus and once with a little bright red blood. She also describes it as changing from being pellet-like (hard and marble-like. = scybalous) and sometimes looks like small pieces of ribbon. She only has approximately one tablespoon of stool per movement, and afterward, has urgency and tenesmus. Her stools are hard to pass, she has to sit on the toilet for ½ an hour, and she feels a "bloating and fullness." Sometimes the stool comes out easily depending on what she eats.

The abdominal pain is what made her seek help. The symptoms have gotten worse over time, the abdominal pain (cramping) is recurrent and on the pain scale is a 5-7 level. She describes the pain as being in her outer lower stomach, bilaterally. It is relieved with defecation and is associated with the urgency but still sense of incomplete evacuation.
The symptoms are aggravated by food or drinks like chocolate, milk products, spicy foods, alcohol, caffeine, and fatty foods. (When she eats these things – they start to affect her within 1-2

hours, and the symptoms are worse for up to 12 hours.) Her symptoms are also exacerbated by stress and sugar substitutes like sorbitol and fructose. Because she understands these triggers, she avoids intake of these foods and drinks. She has also made an effort to have a low-fat heart healthy diet with natural soluble fibers, including oatmeal, cooked legumes, and vegetables in moderation. *(If asked about diet or foods that bother her she will answer: I try to follow a pretty bland diet – any thing that sounds good or tastes good I stay away from. No fats, milk, cheese, Mexican, garlic, chocolate. Even the new sugar substitutes hurt my stomach and cause constipation. I try to stay with the diet type foods. But I have to say that I've been so hungry and I do cheat a lot. SP will only talk about alcohol and caffeine if asked)*

She has not been getting enough sleep, and also states that her symptoms are worse when she is sleep-deprived and before her menstrual cycle. Physical considerations that aggravate her symptoms include stress, lack of sleep and pre-menstrual days.

Once, last week, she noticed a little bit of bright red blood in her stool, for which her intern referred her to the Gastroenterologist.

Current Medications: Pepcid AC PRN (as needed), Ca Mg 333mg PO BID (2 times a day tablets) Total daily calcium 1200mg, Tums for reflux 1–2 tabs PO PRN (as needed), MiraLax 1 capful QHS (before bed) with unsatisfactory results. (Stools still dry and hard.) *MD should move to discontinue MiraLax and switch to tegaserod.*

Past Medical History:

Generally healthy. Pattern began in adolescence (high school).

Severe constipation, mild reflux controlled with antacids, lifestyle (diet) modification.

Past Medications:

The patient has seen many physicians and initially was prescribed:

Metamucil began with 1 Tbsp nightly and increased to 2 Tbsp BID over a period of one month, but she discontinued due to cramping and gas.

She also was treated with **Lactulose** 30 cc PO BID which caused abdominal discomfort and bloating and did not improve urgency, spasm, or incomplete evacuation. She used the **Lactulose** for 6 weeks.

She was then tried on **Methylcellulose**, one tablespoon a day, increasing slowly to 3 Tbsp BID but she found that unpalatable. While it caused less gas and cramping than Metamucil, it did nothing to improve the visceral symptoms or bloating. She discontinued **Methylcellulose** because it was unpalatable and did not relieve symptoms and was inconvenient to mix with water.

3 weeks later her physician changed her to chewable **Equalactin**, starting with 1 tablet PO QD increasing to 1 tablet QID. This slightly improved her frequency and stool consistency. But still she had tenesmus, incomplete evacuation, and abdominal discomfort/bloating that interfered with her daily activities.

Her doctor offered **MiraLax** powder 1 capful QHS, which she currently uses, but complains about the granular taste.

She next tried **Cytotec** 200 micrograms BID which caused cramping, and although her stool was more frequent and softer, it made the urgency worse.

When under the care of an internist, **Paxil** 10 mg PO QD was prescribed and she gained 10 pounds and experienced anorgasmia (inability to reach orgasm), and states she would never try an antidepressant again. Subsequently, a gastroenterologist prescribed **Bentyl** 20 mg PO PRN which caused urinary retention, drowsiness, blurred vision, nausea, and dry mouth. The Bentyl did help the abdominal pain "A little bit," but did not improve the tenesmus (constant feeling the need to empty the bowel) , incomplete evacuation, bloating, or constipation.

She has tried over-the-counter medications, such as **Milk of Magnesia**, 30 cc PO QHS, which caused nausea and dyspepsia.

Past Surgical History: Gynecologist performed laparoscopy, which showed no endometriosis or adhesions (2 years ago – female SPs only).

Family History:

Cousin with Crohn's disease – diagnosed in his 30's, now in his 40's and doing fine. Patient only interacts with him a large family functions. Does not know many details of his disease.

No family history of similar problems, lymphoma or gastrointestinal cancer.

Social History:

- She has her own accounting firm (She is a per diem tax accountant) and the tax season is now beginning. She started the company from home 5 years ago; she has now expanded to outside of the home and has hired 3 employees to work for her. She is unable to handle all of her accounts at work and is stressed by her growing firm. "I just can't function the way I need to."
- She is married, with two children (ages 12 and 14)
- Drank beer in past, but has not had any in years because of physician's recommendation.
- No cigarettes.
- No recreational drug use.
- The constipation doesn't wake her from sleep, but she has not been getting adequate sleep due to work. She knows this aggravates her symptoms.

Effects of symptoms on daily life: She cannot take her children out on the weekends or at night because she is too uncomfortable and has to sit on the toilet for half an hour with spasm and discomfort, but unable to defecate.

- Patient concerns: abnormal life forever

Current Stress: work

- She was raised in a happy home and had some anxiety during college, but basically functions very well except for her bowel disorder. She has a healthy psychosocial profile.

Presentation: Frustrated, concerned, and maybe even tearful but NO depression

Standard Questions/Challenges to Interviewer:

"I want to live like a normal person, what can I do?"

Aimi – make some challenges up

She is very frustrated and does not want to be "*passed off*" once again

CHART INFORMATION
Mrs. Aimi Coker
Age 30
January 2, 2007

HPI:

For the past 3 years, the patient has been experiencing intermittent constipation and bloating. The symptoms began in high school and worsened in college. She has periods of constipation that vary from days to weeks, sometimes severe sometimes light (waxing and waning.) It is followed by periods of normal stool. Over the last several months she has increased urgency and muscle spasm (cramping.) She is also having achy lower back pain, (no radiation of back pain) and feelings of incomplete evacuation.

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She has not been getting enough sleep, and also states that her symptoms are worse when she is sleep-deprived and before her menstrual cycle. Physical considerations that aggravate her symptoms include stress, lack of sleep and pre-menstrual days.

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Past Medications: Metamucil, Lactulose Lactulose, Methylcellulose, Equalactin,
Cytotec, Paxil, Bentyl

Follow up in 3 weeks after labs.

LABORATORY Results
CBC______________WNL
ESR______________WNL
Chem 20 WNL
Stool Occult Blood neg
C.Diff___________WNL
TSH______________WNL
T4_______________WNL
Colonoscopy______normal

Mrs. Coker has returned for her follow up visit. Discuss diagnosis of IBS

CHECKLIST
Target Audience: Resident and CME

Introduction
_______ Doctor introduces self by name
_______ Doctors identifies her role in helping the patient
_______ Doctor asks or uses the patient's name

Reviews any changes from last visit.

Discuss Initial Diagnostic Impression:
_______ Confirm possible diagnosis – Irritable Bowel Syndrome
________ Educate/Explains process of disease, including the role of the central nervous system and serotonin.
_______ Discusses impact on quality of life

Diagnosis:
_______ Establish a positive diagnosis of IBS.

Management:
_______ Confirm positive diagnosis

_______ Discuss proceeding with a colonoscopy or sigmoidoscopy, depending on:
The patient's concern about colon cancer; Age;Whether stool guaiacs are positive or negative. Findings on rectal exam.
________ Suggest dietary modification, avoiding chocolate, milk products, spicy foods, alcohol, caffeine, fatty foods, stress, sugar substitutes, insomnia.
_______ Encourage dietary modification, exercise, and drinking water.
________ Review the functional diet for constipation. Encourage calcium magnesium supplements, pears, peaches, fruits, and water.
_______ Review that the patient has already failed current therapy, including Milk of Magnesia, MiraLax, fiber, Lactulose, Cytotec, Bentyl, and methylcellulose.
________ Since the patient is reluctant to have antidepressants due to the fear of weight gain; therefore, offer tegaserod.
________ Instruct the patient that on tegaserod, she may not have to eat as many fruits and vegetables as she has been eating and, if she gets diarrhea, to hold the dose.
_______ Schedule a follow-up in three weeks or sooner, if needed.
________ Discuss if the patient develops any bleeding, abdominal pain, or discomfort, call immediately and to hold medications.

Communication: MIRS & ABIM scales