



International Foundation for
Functional Gastrointestinal Disorders

IFFGD

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Digestive Health Matters

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Dream for Tomorrow

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found visions of change
– for many, of healthier
tomorrows.”*

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Play List:

Looking at You

the Subdudes - New Orleans flavored

When She Smiles

Jeff Lorber - contemporary jazz

Seven Angels On A Bicycle

Carrie Rodriguez - alternative country/bluegrass

Cool Of The Night

Joyce Cooling - bluesy-jazz

La Cumbia del Mole

Lila Downs - world music by the Latin Grammy winner

Free

Alex Bugnon - cool R&B/contemporary jazz

Jitterbug Swing

John Hammond - American roots/blues

Always Thinking of You

Nick Colieonne - contemporary jazz

Donde Vayo

Willie & Lobo - Gypsy violin and flamenco guitar magic

Festival Of The Goddess

David Arkenstone - instrumental enchantment

Is it More than Simple Heartburn?

Gastroesophageal reflux disease, or GERD, is a common disease that affects men, women, and children. The most frequent symptom is heartburn. It is estimated that about 1 out of 5 people experience heartburn and/or acid regurgitation weekly, and up to 1 out of 15 experience heartburn once per day. Symptoms of GERD vary from person to person. Most people with GERD have mild symptoms, with no visible evidence of tissue damage and little risk of developing complications.

Heartburn and acid regurgitation are so common that they may not be associated with a disease like GERD. All too often, symptoms are either self-treated or mistreated. Serious complications can result if GERD is not treated properly. Consultation with a physician is essential to proper diagnosis and treatment of GERD.

GERD is a chronic disease; it occurs over a long term. Treatment usually must be continued, even after symptoms have been brought under control. Ways to effectively treat GERD range from lifestyle measures to the use of medication to surgical procedures.

Many people experience heartburn. If it occurs now and then just after a meal, and less than once per week, it is likely a “benign” condition. Heartburn that occurs weekly, becomes more severe, or occurs at night and wakes a person from sleep, may be a sign of a more serious condition. A visit to the doctor is advised.

Talking to your doctor

When you visit your doctor you will want to know what is wrong, what the doctor can do to treat it, and what you can do to better manage it. Your doctor will begin by taking a history asking you to describe the symptoms and what you think seems to bring them on or make them better. This will be followed by a physical examination, possibly diagnostic tests, a diagnosis, and a discussion of treatment options.

Be prepared – Before your appointment, prepare to provide your doctor with the following information:

- List of when your heartburn occurs (time of day, after meals, etc.)
- The severity of your heartburn
- How often your heartburn occurs (per week)
- Other symptoms
- How your symptoms affect your daily activities
- How your symptoms affect your sleep

- What diet and lifestyle changes you have made to relieve your symptoms
- If these diet and lifestyle changes have been effective in providing relief
- What antacids and other over-the-counter medications you have used
- What relief (if any) these medications have provided

Questions to ask your doctor – Here are some questions to ask your doctor during your appointment:

- How can I tell the difference between simple heartburn and a more serious condition?
- Do I have GERD?
- How is GERD treated?
- What medications are available for GERD?
- Is there a cure?
- How can I manage my symptoms?
- What happens if my symptoms become worse?

Like other chronic diseases, managing GERD can be a challenge. Effective management is often dependent on a successful patient-doctor relationship. Although the time you spend with your doctor may be limited, you can help ensure that effective two-way communication takes place during your visit by being prepared.

Heartburn and acid regurgitation are so common that they may not be associated with a disease like GERD.



Courageous Stories: Shared Experiences of Living with a Digestive Disorder

I always had stomach aches as a child. As a young adult, the heartburn became like an inner furnace in my chest. Then I was pregnant and so when I complained to the doctor I was told that it is a fact of life because of my situation. Living on antacids became routine. Eating small meals, sleeping high on cushions during the years of childbirth was acceptable. I had gone to a gastroenterologist after my first child and complained to him about the heartburn and back pain. He wasn't concerned about the heartburn.

After my youngest child was born, my back pain became more intense. An orthopedist could not find anything wrong. Acupuncture gave me some relief.

Then the attacks started. With a sore tummy, painful to eat or drink, and constant heartburn, I had gone back to the doctor several times. He told me I had a virus. Finally, I told him I feel silly about complaining, but I have constant headaches, stomach aches, a hard time eating and drinking, and a lack of general energy.

My family doctor decided that perhaps because of my taking so much NSAID's I gave myself a stomach ulcer. He gave me a proton pump inhibitor (PPI). It was like magic. I was able to sleep through the night. I made an appointment with a gastroenterologist again (12 years after the first one). He was upset that I had not come sooner. The endoscope showed that I have no ulcers in the stomach, but I have esophagitis. In addition to continuing on the PPI he suggested I try to make some lifestyle changes. That part of the plan is the most difficult. Being a mother of five young children and a working mother (I'm an RN) on shift work makes a routine lifestyle impossible. It took me a year and a half to get it organized. I am taking a year off shift work by opening a small home business. This way I am home all the time, can sleep every night, and enjoy family weekends.

“Courageous Stories” is a feature on IFFGD’s web sites; this story appears on www.aboutgerd.org. We invite you to share your story – it can be therapeutic for you as well as others who suffer.

Did you Know – Heartburn is not the only Symptom of GERD

Chronic heartburn is the most common symptom of GERD. Acid regurgitation (refluxed material into the mouth) is another common symptom. But numerous less common symptoms other than heartburn may be associated with GERD. These may include:

- Belching
- Difficulty or pain when swallowing
- Waterbrash (sudden excess of saliva)
- Dysphagia (the sensation of food sticking in the esophagus)
- Chronic sore throat
- Laryngitis
- Inflammation of the gums
- Erosion of the enamel of the teeth
- Chronic irritation in the throat
- Hoarseness in the morning
- A sour taste
- Bad breath

Chest pain may indicate acid reflux. Nevertheless, this kind of pain or discomfort should prompt urgent medical evaluation. Possible heart conditions must always be excluded first.



Tips for Controlling Simple Heartburn

Heartburn is among the most common of symptoms. A 1988 Gallup poll reported that 2 out of 5 adults in the U.S. experience heartburn at least once a month and 1 out of 5 experience it weekly. Heartburn is often described as a burning discomfort that begins in the chest behind the breastbone and radiates to the neck and throat.

The stomach produces a very strong acid. If acid escapes back from the stomach into the esophagus, or food pipe, it irritates or damages it. This back-flow of acid – gastroesophageal reflux – is sometimes called acid reflux or acid indigestion. We experience heartburn when this reflux occurs.

What can you do to help prevent heartburn?

Here are some suggestions.

- Does your heartburn occur after meals or if you lie down too soon after a meal? Maintaining an upright posture until the meal is digested may prevent the heartburn. Don't lie down within 3 hours of eating when acid production is at its peak. Plan early dinners and avoid bedtime snacks. Try having the main meal at noon and a lighter one at dinnertime. Avoid exertion after a meal, especially tasks that require bending or lifting.
- Does the heartburn occur when you lie down in bed at night? Try raising the head of the bed or inserting a triangular wedge beneath your mattress or pillow to keep your esophagus above the stomach.
- Consider what you eat. Certain foods are best avoided before you lie down or exercise. These differ from person to person, but common offenders are fats, onions, alcohol and chocolate. If you notice another food that bothers you, try avoiding or reducing it in your diet to see if that helps.
- Are you taking medications? Some oral medications such as potassium supplements or the antibiotic tetracycline will burn if allowed to rest in the esophagus. Always swallow medication in the upright position and wash it down with plenty of water.

Heartburn is often described as a burning discomfort that begins in the chest behind the breastbone and radiates to the neck and throat.

- Watch your weight. Excess abdominal fat puts pressure on the stomach and the loss of even a moderate amount of weight makes many people feel better. Pregnancy is often troubled by heartburn, particularly in the first three months. Generally, if there has not been too much weight gain, a woman's heartburn improves after delivery.

If these measures fail, an antacid or alginic acid may provide rapid temporary relief of intermittent heartburn, particularly if brought on occasionally by foods or various activities. There is now a proton pump inhibitor (PPI) available over-the-counter that reduces acid production, which may be safely taken for up to 14 days until the heartburn subsides. If needed regularly, for more than two weeks, consult a physician for a diagnosis and appropriate treatment.

If the heartburn occurs on two or more days per week despite the measures discussed above, you should consult your family doctor. If you are over 50 years, your heartburn occurs with exercise, or you have a family history of heart disease, you should promptly see a physician to be sure that your heart is not the source of the pain. See your doctor promptly if you experience difficulty swallowing, vomiting, passing blood, or significant weight loss. If your heartburn is accompanied by breathing difficulties or hoarseness, you should seek advice from your doctor.



Dietary Aspects of Irritable Bowel Syndrome (IBS)

By: Peter J. Whorwell, M.D., Professor of Medicine and Gastroenterology, University of Manchester, Manchester, United Kingdom

Many patients with irritable bowel syndrome (IBS) comment that their symptoms appear to deteriorate following a meal. In many individuals this is merely a nuisance but in others it can be much more of a problem. For instance, some sufferers find it easier to go without a meal altogether in order to get through a day where they have a commitment which is outside their normal routine.

Not surprisingly, this apparent relationship between food and symptoms leads to patients concluding that they must have some form of dietary allergy or intolerance. However, they also often notice that a food appears to upset them one day but not another, which causes further confusion. As a consequence, many patients go looking for a diet or a test that might help sort all this out and unfortunately, especially with the advent of the Internet, there is a bewildering amount of often conflicting advice available, frequently associated with a considerable cost.

Firstly, it is important to realize that a whole variety of factors affect IBS – and diet is just one of these.

Fortunately, it is usually reasonably easy to tackle the dietary aspects of IBS as long as you understand a few basic principles. Firstly, it is important to realize that a whole variety of factors affect IBS – and diet is just one of these. Therefore if other factors, such as stressors or hormonal changes, are more active on a particular day, then diet is more likely to push your symptoms “over the edge” than on a day when the other factors are absent. Secondly, it needs to be realized that parts of a “healthy diet” may actually make the symptoms of IBS worse. Thirdly, simply eating (smelling, tasting, or chewing food) can activate the gut even before the food is swallowed. In this particular instance it is the *process* of eating that is causing symptoms rather than what you eat.

Four common food offenders

For those who suspect food is a factor in their symptoms, there are 4 foods that most often seem to be involved. These foods are fiber, chocolate, coffee, and nuts. By taking a systematic approach you should be able to sort out which, if any, has an affect on your symptoms. Make a list and, one at a time, eliminate a food from your diet for about 12 weeks to see if you notice improvement. If you do *not* notice improvement after 12 weeks, begin eating that food again and try eliminating the next food on your list.

Begin with fiber. We showed, many years ago, that the food which most commonly upsets IBS is fiber. There are two types of fiber – *soluble* which is found more in fruit and vegetables, and *insoluble* which is mainly derived from cereal. It seems to be the *insoluble* variety that causes most problems and therefore the simple maneuver of removing cereal fibers (commonly found in brown bread, whole grain bread, some breakfast cereals, cereal bars, and crispbreads) from the diet may be helpful. On the other hand, some patients do find cereal fiber improves their symptoms. If so, continue it. But if it does not improve your symptoms or appears to upset you, be bold and completely exclude it for several weeks to see if your symptoms improve. If there is no change after 12 weeks, there is no point in continuing as it is obviously not the right approach for you.

Next move on to one of the other foods to be wary of: chocolate, coffee, and nuts. As explained above, it is important to leave them out of your diet one at a time, otherwise you will not be able to identify which one is causing the problem. With regard to coffee, it does not necessarily seem to be the caffeine that causes the problem, as tea can usually be continued without affecting symptoms. Caffeine containing drinks may cause problems, more because they are gassy rather than a result of their caffeine content. Somewhat surprisingly, spicy foods do not necessarily cause a great deal of trouble although not everyone can tolerate them.



It may not be the food source

What do you do if it is the process of eating rather than what you eat that is upsetting you? This is a more difficult question to answer. It is worth considering different patterns of eating. Some patients find their symptoms are not as bad if they eat little and often rather than eating larger and fewer meals. If you are constipated, try to make sure you have breakfast, as this is the meal that is most likely to stimulate the colon and give you a bowel movement. Another approach is to try and reduce the “reactivity” of your gut with medication. An antispasmodic (e.g., Bentyl, Levsin, Librax) taken before eating is worth trying; or if your problem is diarrhea after meals, try taking a small dose of loperamide (e.g., Imodium, Pepto Diarrhea) before meals. The tricyclic antidepressants are particularly good at “calming the gut down” and quite often reduce the over-reactivity associated with eating. However, they need to be taken on a long-term basis. It is noteworthy that at the low doses required to calm the gut (much less than used to treat depression), they do not cause much in the way of side effects.

Summary

In conclusion, diet can be important in IBS but is not always the answer. Try the various dietary manipulations mentioned here for a reasonable length of time, about 12 weeks. If they do not work there is little point in continuing with them. In general, it is worth remembering that if you have to question whether a particular approach has helped your problem, it probably has not worked and should be discontinued. ●

Courageous Stories: Shared Experiences of Living with a Digestive Disorder

I am 35 years old and have suffered with GI problems since the age of 12. I remember the very first episode being so painful I buckled over in my chair at the dinner table, wrapping my arms around my middle in agony from the cramps. For years doctors told my Mom that I was just eating too fast, swallowing air, suffering from growing pains and any other useless fact they could provide. Fact was I was in pain but no one seemed to know what was wrong and I couldn't make the cramps happen on command.

My father passed away from colorectal cancer when I was 11 so when I turned 32 I went for a colonoscopy to begin my 5-year checkups because of my family history with cancer. For whatever reason, the procedure triggered one of those nasty cramping episodes. Despite the mild drugs I was given to feel little discomfort during the procedure I felt these cramps full on as though I were completely coherent. After the procedure was finished the doctor asked me a series of questions and for the first time ever I felt like I was being listened to. He asked me if I had heard of IBS . . . never. So he explained it to me and I was in tears. I finally had answers. Every single symptom he mentioned, I had at one time or another.

I've been managing my IBS with diet and exercise for the last 3 years. I notice that if I don't eat exactly right or I don't get at least of 30 minutes of exercise (as simple as a brisk walk) my symptoms get worse. For me, eating enough fiber helps but I have to be careful just how much I eat . . . too much roughage and I'm camping out in the bathroom. Not enough roughage and I'm suffering stabbing pains of constipation. Drinking plenty of water helps, stress seems to make it worse.

I was prompted to do a search for information about IBS because I haven't had an episode in months and suddenly I'm getting all too cozy with the washroom again. The most embarrassing part is the audible movement of gas through my colon. Co-workers at the next desk can hear me in a shared office space. It's also very painful . . . and then the urge comes on fast and furious and I have to politely excuse myself. I've been relieved to read about all your information on your website as well as reading other people's stories. I don't feel as alone.

“Courageous Stories” is a feature on IFFGD's web sites; this story appears on www.aboutibs.org. We invite you to share your story – it can be therapeutic for you as well as others who suffer.



The Medical History: How to Help Your Doctor Help You

By: W. Grant Thompson, M.D., Emeritus Professor of Medicine, University of Ottawa, Ontario, Canada

The most important interaction between patient and doctor is the medical history. Through listening to the story of the patient's illness and asking relevant questions, a physician may often make a diagnosis, or at least begin to understand the nature and location of the complaint. Then, he or she is in a position to plan the examinations and tests necessary to identify the disease and commence treatment. By facilitating the interview, patients can make this process more efficient leading to prompt, more precise diagnosis and treatment.

Timeliness

Be sure to be on time for your appointment. Tardiness not only compromises your own time with the doctor, but may also interfere with that of others. While doctors are notoriously behind in their schedules, part of that is due to some patients' inefficient use of time. Lack of time can interfere with your healthcare.

Chief complaint

It helps if you are able to state concisely your chief symptom, complaint, or problem. This focuses the discussion. Sometimes there is more than one symptom, or a combination of symptoms. For instance, a person with IBS (irritable bowel syndrome) might have a constellation of related symptoms. In this situation, it is important to clearly identify which symptom(s) are of most concern to you. Since most doctors only allot a few minutes to each visit, this enables them to focus on your major concerns and choose treatments that will provide the most relief. On the other hand, specialists have a little more time and would want to deal with all the problems within his or her expertise. Presentation of a long written list of complaints is unlikely to be helpful. Describe those that most trouble you now. Whereas a family doctor or internist can

deal, at least initially, with all medical problems, specialists must remain within their area of expertise. It is of little use to complain to an orthopedic surgeon about stomach pain unless you have a referral in mind. Usually, your family doctor best handles referrals.

History of the illness

You should describe the story of your main complaint in your own words. A written history is no substitute. The manner in which you describe your symptom is as important to the doctor as the presence of the symptom itself. State when and how the symptom, say pain, began. Where is it located? Is it steady or intermittent? Does eating, exercise, traveling, stress, or other factors make it worse or better? How does this complaint interfere with your life, job, or personal relationships? Are there associated symptoms such as diarrhea, headache, or blurred vision? What diagnosis, if any, have you received for this? What treatments have you undergone? While it is OK to venture your own diagnosis, it is essential that the doctor make up his or her own mind.

It is important to describe all factors that might bear on the complaint, but too much information can be counter-productive. The doctor should help here by prompting or steering the conversation back to the point. If there are two unrelated problems, deal with them sequentially to avoid confusion. Keep in mind that time is valuable and avoid digressions. Brief discussion of the weather or other neutral topic helps put people at ease and establish rapport, but too much can displace discussion of the illness.

Do not be shy. If there is a gut problem, a detailed description of your defecation pattern and the nature of the stool is

vital information. Similarly, the nature of your urine and other bodily discharges are sometimes keys to diagnosis. Sexual habits may also be important. Indeed omission of such information can delay diagnosis. No doctor will laugh or be derisive of your description. Remember, they deal with such material daily.

Documentation

While the description of the complaint should be verbal, there are certain routine facts that every doctor should have. A written list of these may help.

Demographics – It is helpful to indicate at the top of any list your age, sex, occupation, marital status and ethnic background. Some diseases are unique to certain occupational, ethnic, or geographic backgrounds. Include any insurance information.

Medications – A list of your current medications is essential. Perhaps your complaint is due to an adverse reaction to a treatment. Drugs that your doctor might consider for your present complaint may interact with current drugs. The list should include the dose and the frequency of the medication, and the length of time you have been taking it.

Other Treatments – Have you received any other treatments? Your doctor will want to know what has been tried in order to plan management. Moreover, not all "alternative" treatments are harmless. Tobacco, alcohol, and recreational drug use is important.

Sensitivities – This list should include drugs to which you have had an adverse reaction such as a rash, jaundice, or gastrointestinal upset. Allergies to insect stings, hay fever, allergic asthma, or contact dermatitis are also important. Many reported sensitivities are



unsubstantiated. As this could rule out use of certain drugs or diets, you should indicate any evidence that they are truly present.

Previous illnesses – This should include the important illnesses you have had in the past, especially those that have led to disability, hospitalization, or surgery. In the case of surgery, it is important to be sure what was removed and what was left in. It may also be helpful to indicate the doctors who treated you for these illnesses because your present doctor may wish to contact them. Inheritable diseases such as heart disease or cancer in first degree relatives should be listed as well.

These lists should be as brief as possible and clearly written so the doctor can include them for future reference in your record. This avoids the need for the doctor to write down the lists you give him verbally, avoids mistakes, and saves time for you to describe your main complaint.

The most important interaction between patient and doctor is the medical history.

Additional information

To help your doctor deal promptly with your complaints you should bring with you any pertinent medical documents you have. If you have been to the emergency room or other doctors for this complaint, their reports are important. If you have had laboratory tests or other such information, have them sent, have the doctor's secretary obtain and send them, or bring the results to the doctor yourself. In the case of relevant x-rays or electrocardiograms, you should bring the actual pictures or tracings as well as the reports. Otherwise, valuable time will be lost while the doctor tracks down this information. If another doctor refers you, do not assume he or she will automatically send this material. You can check this out beforehand through the referring doctor's secretary.

Communication

One doctor should be in charge of your total medical care and records. Normally this is your family doctor or internist (primary care doctor). He or she should make (or know of) all referrals, and should write referral notes that state the problems the specialists are to address. You should insist that each consultant send his or her report to your primary care doctor indicating the diagnosis, recommended tests, and treatments, and who is responsible for them. This ensures that your doctor has your complete record and permits him or her to supervise your overall care.

Conclusion

In modern medical practice, a shortage of doctors and economic reality contrive to limit the time physicians have to see patients. Timeliness and a concise statement of the main problem(s) along with a clear history of these problems can save time for the essentials. These should be verbal, but pertinent lists of medications, previous illnesses, and sensitivities can go directly into the records without the need for transcription. Ensure at the time of the visit that your doctor has vital information for the complaint including x-rays, electrocardiograms, lab results, and reports of previous health encounters such as the emergency department. Attention to such details and ensuring their communication can help your doctor help you. ●





Clinical Corner

Answers to your Questions about Digestive Health

Do you have a question about digestive health? We want to help.

If you or a family member is struggling with chronic or recurring GI symptoms, you probably know how challenging it can be to find reliable treatment information. We want to help you find ways to manage symptoms and understand why they occur. We are always happy to hear from you, so please send us your question.

Answers are provided by digestive health professionals familiar with these disorders. In this issue you'll find answers to these questions:

- Will strenuous physical activity or exertion put pressure on the intestine and cause diverticular pouches in a susceptible person?
- Is it true that people with IBS cannot absorb vitamin B12 through foods eaten, nor by taking vitamin pills? Could a B12 deficiency affect digestion? If so, will getting B12 injections improve IBS?
- How might using antibiotics to treat infection by killing bacteria, lead to *C. diff* infection? Will taking probiotics at the same time help?

If you have a question, please contact us by mail at: IFFGD, PO Box 170864, Milwaukee, WI 53217.
Or email to: clinicalcorner@iffgd.org

Question – Will strenuous physical activity or exertion put pressure on the intestine and cause diverticular pouches in a susceptible person?

Answer – To answer this question we will begin by describing what diverticula are and what leads to their development. The wall of the large intestine (or the colon) is usually relatively smooth, particularly in younger individuals. As people get older their colons are more liable to develop bulges or outpouchings, which develop in weak sites in the intestinal wall. They have been likened to air bubbles developing in the inner tube of a tire. Multiple diverticula are very common in people over the age of 50–60

years. This condition is called diverticulosis. Most people are unaware of the presence of diverticula as they do not generally cause symptoms. However, complications can develop in diverticula, the more ominous being infection (diverticulitis), bleeding, and/or perforation.

The causes of diverticulosis are not entirely clear, but there seems to be a consensus that low-fiber diets are the primary cause. This is consistent with epidemiological data showing that diverticulosis was relatively rare in the Western world prior to the processing of food that removed its fiber content, and that it is still rare in underdeveloped parts of the world. Fiber helps to make stool soft

and bulky. Low-fiber diets are more likely to cause constipation and straining, which generate pressure on the intestinal wall and, over time, lead to the development of diverticula.

With this background we can try to answer the question. There is no evidence that exercise, even strenuous, can cause diverticulosis. In fact, daily exercise, which is recommended for many health reasons, may help prevent the development of diverticula since regular exercise can reduce constipation, hard stools and straining, thus lowering the pressure on the wall of the intestine that causes diverticulosis.



Diverticula that have already formed cannot be eliminated. However, adding fiber to the diet and exercising regularly could possibly prevent diverticular formation. Of course, older individuals or patients with chronic illness should consult their physicians before embarking on an exercise program.

– Ami D. Sperber, MD
– Roy Dekel, MD

Question – I have been told that people with IBS cannot absorb vitamin B12 through foods eaten, nor by taking vitamin pills and that you cannot digest completely without this vitamin. Is this true? If so, will getting B12 injections improve my IBS?

Answer – Vitamin B12 digestion requires release from the stomach of an enzyme, intrinsic factor. The B12-intrinsic factor combination is absorbed in the last part of the small intestine called the terminal ileum. One of the hallmarks of IBS is that there are no obvious abnormalities in membrane (mucosa) that lines the ileum. People with IBS absorb vitamin B12, and all other vitamins and minerals, appropriately, using the same mechanisms as people without IBS. Extra B12, or any other vitamin or mineral is unlikely to change IBS symptoms. Additionally, patients should be aware that extreme doses of some vitamins can be toxic.

– A. Sidney Barritt, MD

Question – My doctor wants to put me on broad spectrum antibiotics to prevent infection from a cut I got on my leg while working with power tools. I read recently that *C. diff* and *Candida* are organisms in the gut that can cause GI problems to people who are on long courses of antibiotics, and now I'm a little confused. How can I get an infection from an organism when I'm already on antibiotics to prevent infection?

Also, if probiotics are good for the gut, would it help if I took probiotics at the same time as I am taking the antibiotics to make sure I don't get GI problems?

Answer – Proper antibiotic use is a sometimes confusing and controversial topic. There are millions of different microbes that live with us and in us and can be classified as viruses, bacteria, fungi, and parasites. Some of these organisms cause us harm, others may benefit us. When your doctor prescribes antibiotics, the goal is to eliminate or reduce the growth rate of pathogenic bacteria while your immune system does the rest. Different antibiotics have different spectra of activity and are designed to treat certain classes of bacteria. The ideal way to treat bacterial infections is to use the most specific, that is the “narrowest spectrum,” antibiotic possible that will kill the offending bacteria. When we use “broad spectrum” antibiotics, multiple types of bacteria, even beneficial ones, can be affected.

The gastrointestinal tract is one location where there are multiple strains of “good” or beneficial bacteria. These bacteria cause humans no harm and assist with digestion and the absorption of vitamins and minerals. Under normal circumstances there may be a few colonies of “bad” or pathogenic bacteria in our digestive tracts, like *Clostridium difficile*, a.k.a. *C. diff*, or even fungi like *Candida albicans* (Candida infections are also known as yeast infections). These microbes normally do not cause any problems, however, as they are outnumbered by the “good” bacteria and thus have no room to flourish and grow. When broad spectrum or even certain narrow spectrum antibiotics are taken, even for legitimate or life-saving reasons, the “good” bacteria may be depleted, allowing overgrowth of the “bad” bacteria.

The most common scenario of “bad” bacterial overgrowth is *C. diff* associated diarrhea or pseudomembranous colitis, occurring after broad spectrum antibiotic use. This infection results in copious foul smelling diarrhea with mucous under most circumstances. The patient is ill and often has a fever and abdominal pain. This is a serious infection that requires

medical attention with prompt testing and treatment. Antibiotic use can also lead to overgrowth of *Candida*, especially in the mouth or vagina. Symptomatic yeast infections of the intestines are exceedingly rare. *C. diff* infections are treated with an antibiotic, usually metronidazole, which has specific activity against *C. diff*. *Candida* infections are treated with antifungal medicines, usually fluconazole, which treats the most common forms of yeast.

Probiotics are often used *after* a course of antibiotics are completed. Probiotics, via pills, activated yogurt cultures, or powders, help supply the intestinal tract with the “good” bacteria that may have been harmed by antibiotic use. Probiotics cannot be used at the same time as antibiotics because the antibiotic would destroy the probiotic along with the pathogenic bacteria. There is some data that suggests some people with IBS may have fewer colonies of “good” bacteria and probiotics may help restore proper bowel function.

It is important to keep your doctor aware of any new symptoms that occur while on antibiotics, especially diarrhea or a new fever. Millions of people use antibiotics everyday for a variety of infections and the vast majority of suffers experience no untoward effects. Prior to starting any medication, however, you should discuss the risks, benefits, and potential side effects with your physician.

– A. Sidney Barritt, MD

Contributors:

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IFFGD INDUSTRY COUNCIL

When IFFGD began, in 1991, there was little communication between patients living with functional gastrointestinal (GI) and motility disorders and the companies with the means to develop treatment products and services. Subsequently, IFFGD has worked hard to make the needs of our members known – not only to the clinicians who see patients, but also to the researchers and providers of diagnostic and treatment methods and tools.

In 1998, in an effort to strengthen our voice, we formed the IFFGD Industry Council. The Council provides a forum to help ensure that the voice of our membership is heard. The purpose of the Industry Council is to help fulfill the mission of IFFGD: to inform, assist, and support people affected by gastrointestinal disorders, or bowel incontinence.

We invite participation from companies with a demonstrated interest in these disorders. While we are grateful to our Industry Council members for their support, we do not endorse any specific product or company. IFFGD retains unrestricted control over the planning, content, objectives, methods, and execution of all initiatives and projects.

IFFGD INDUSTRY COUNCIL
Takeda Pharmaceuticals North America, Inc. and Sucampo Pharmaceuticals, Inc.

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Medtronic Gastroenterology

Ethicon Endo-Surgery Inc and its InScope Division

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Industry Sponsored Clinical Trials

A clinical trial is a research study to answer specific questions about new products, therapies, or new ways of using known treatments. Through these research studies, investigators find new and better ways to treat, control, prevent, diagnose, or detect conditions, or to improve the quality of life for those with an illness. Trials can take place in a variety of locations, such as hospitals, universities, doctors' offices, or community clinics.

Although efforts are made to control risks to clinical trial participants, some risk may be unavoidable because of the uncertainty inherent in clinical research involving new medical products. It's important, therefore, that decisions to participate in a clinical trial are made only after obtaining a full understanding of the entire process and the risks that may be involved.

Choosing to participate in a clinical trial is an important personal decision. It is often helpful to talk to a physician, family members, or friends about deciding to join a trial. General information about clinical trials can be found at this IFFGD web page, www.giResearch.org/AboutClinicalStudies.html or at this National Institutes of Health web site, www.clinicaltrials.gov, among others.

After identifying some trial options, the next step is to contact the study research staff and ask questions about specific trials. Here is a list of studies, sponsored by members of the IFFGD Industry Council, which are currently seeking participants.

Gastric Stimulation for Vomiting, Nausea and Related Symptoms Associated with Gastroparesis Using Enterra Gastric Stimulation System

Purpose of Trial: A research study to determine if an implanted device (Enterra Therapy) to stimulate the stomach will improve symptoms (such as nausea and vomiting) associated with gastroparesis (a disorder in which the stomach takes too long to empty its contents).

Sponsored by: Medtronic, Inc. Find more details on-line at: www.giresearch.org/IndustryStudies.html.

Locations and Contact Information:

- Indianapolis, IN, St. Vincent Hospital – Contact: Kativa Leal, RN, (317) 338-6743
- Louisville, KY, University of Louisville – Contact: Jennifer Koopman, (502) 852-3365
- San Francisco, CA, California Pacific Medical Center – Contact: Lesley Scott, MS, (415) 600-1593
- Santa Ana, CA, Lovelace Scientific Resources – Contact: Selene Alvarez, CRC, (714) 444-4048
- Washington, DC, George Washington University – Contact: Elizabeth Drenon, (202) 741-3168



Digestive Health Research: A Sampling of Recently Published Studies

Why is Medical Research Important?

Although great progress has been made over the past decades, much remains to be understood about the functional and motility GI disorders. To those affected by chronic symptoms it may often seem like what we do not know outweighs what we do know. While our understanding is improving important questions remain:

- What causes these disorders?
- Why do certain people get them?
- How do we best treat the conditions?
- How do we prevent and cure them?

Medical research is needed to explore these questions. Through research, answers will be found, and the burden of illness endured by those affected will be relieved.

The good news is researchers are starting to understand some of the biological mechanisms responsible for the symptoms people feel. Clinicians are examining various treatments to determine which are most effective. With this increased understanding, new treatment approaches and medications are being developed. Some are now available to help certain groups of patients. We do not have all the answers yet, but we are getting closer.

In this column we report just a few research studies that provide clues to better understanding GI disorders. Each new study adds another small piece to the puzzle, making the big picture clearer. If you are interested in learning more about medical research, please visit our web site at www.giresearch.org.

Is childhood GERD a risk factor for adult symptoms?

A study in Texas examined the prevalence and risk factors for current gastroesophageal reflux disease (GERD) symptoms in 113 young adults (mean age 18 years) with a history of childhood GERD (mean age at the time of childhood diagnosis was 10 years). Almost half of the young adults with a history of GERD as children reported that they currently suffer from heartburn and reflux symptoms a minimum of once every week with most of these taking medications to control their symptoms.

The study cautions that the prevalence of GERD found in this group is considerably higher than previously found in a group of this age. Nevertheless, they conclude that childhood GERD should be considered a risk factor for adolescent and adult GERD.

Source : El-Serag HB, Richardson P, Pilgrim P, Gilger MA. Determinants of gastroesophageal reflux disease in adults with a history of childhood gastroesophageal reflux disease *Clin Gastroenterol Hepatol* 2007 Jun;5(6):696-701.

Is there a relationship between IBS, dyspepsia, and quality of life in GERD sufferers?

Numerous studies show patients diagnosed with GERD are more likely than others to also suffer from irritable bowel syndrome (IBS) or functional *dyspepsia* (pain or discomfort in the upper abdominal area). A recent study in The Netherlands confirmed this and examined health-related quality of life in these individuals. In patients with GERD (confirmed through a 24-hour pH monitoring test that measures reflux), 25% had dyspepsia, 35% had IBS, and 5% had both. Only 35% had neither IBS nor dyspepsia.

Researchers used a questionnaire with 9 subscales to measure health-related quality of life (HRQoL) in the study participants. Patients who had only GERD had lower scores on 1 of the 9 subscales. GERD patients who also had functional dyspepsia had lower scores on 6 subscales. GERD patients with IBS scored lower on 8 subscales. Patients with GERD, IBS, and functional dyspepsia scored lower on 7 subscales.

The study found that in patients with proven GERD, functional dyspepsia and IBS are more prevalent than in the general population. Those GERD patients who also have functional dyspepsia and/or IBS have a much lower HRQoL. This study and others suggest that a generalized disorder of visceral sensitivity might be a feature common to GERD, functional dyspepsia, and IBS and that heightened perception or sensitivity within the digestive tract may be the main factor affecting health related quality of life in appropriately treated GERD.

Source: De Vries DR, Van Herwaarden MA, Baron A, Smout AJ, Samsom M. Concomitant functional dyspepsia and irritable bowel syndrome decrease health-related quality of life in gastroesophageal reflux disease *Scand J Gastroenterol* 2007 Aug;42(8):951-6.



Home Based Guided Imagery to Treat Pediatric Functional Abdominal Pain

Making one of the most effective treatments for FAP available to the majority of children with this disorder

By: Miranda A. L. van Tilburg, Ph.D., University of North Carolina
Center for Functional GI and Motility Disorders, Chapel Hill, NC

Dr. van Tilburg is the recipient of the 2007 IFFGD Research Award for Junior Investigator – Pediatrics. Her research has been looking at ways to design interventions and tools that help patients and families better manage GI symptoms.

Introduction

Functional Abdominal Pain (FAP) is a common childhood disorder defined by the American Academy of Pediatrics and the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition as “long lasting intermittent or constant abdominal pain without evidence of an organic cause.” It afflicts 8–20% of children and is associated with disability and decreased quality of life.

FAP is a frustrating condition for the family. The stomachaches and accompanying symptoms are unpredictable and not easily modifiable. Children may miss school and miss out on other things such as peer and family events. Many parents feel unable to cope and rely on medical professionals for diagnosis and treatment. Since there is no readily identifiable cause for FAP, treatment is focused on reductions of symptoms and disability rather than a cure. Standard medical care consists of reassurance that nothing major is wrong with the child, education, setting of realistic treatment goals and medications to relieve symptoms. This approach is helpful, but in many cases children continue to have debilitating symptoms and are in need of additional therapies.

Guided imagery: a non medicated way to control pain

Behavioral treatments have been shown to be effective for the treatment of FAP. Guided imagery and self-hypnosis, which are two related techniques, are widely used to treat all sorts of pain – from headaches and stomachaches to pain resulting from medical procedures such as bone marrow aspirations, in both children and adults. Two recent placebo controlled studies, one by Weydert and colleagues (published in *BMC Pediatrics* 2006) and another by Vlieger and colleagues (published in *Gastroenterology* 2006), show that guided imagery and self-hypnosis are very effective at treating FAP, with 70%–85% of patients cured at follow-up.

In guided imagery the therapist uses verbal guidance to help the patient experience detailed vivid imagery that has beneficial effects on their behavior, cognitions, emotions, or physiology. An example that is often used to demonstrate the effect of guided imagery on your body is to imagine that you are holding a fresh, juicy lemon in your hand. As you pick up the lemon you are struck by its bright yellow color and feel the bumpy texture of its skin. You cut a piece of the lemon and can smell the lemon’s tart aroma that

fills the air. Imagine you stick this piece in your mouth and suck on it. You can taste the sour flavor as the juices roll over your tongue . . . More than likely your body reacted in some way to that imagery. For example, you may have begun to salivate. Children are especially good candidates for guided imagery as they are used to imaginative play and have a natural ability to get absorbed in stories and experience them vividly in their mind.

Making guided imagery available to all FAP patients

Guided imagery is very effective for pain control, widely liked by children, and has no known side effects. However, guided imagery is currently not available to the majority of children with pain problems. There is a shortage of trained therapists who specialize in pediatric pain and the treatment is costly and time consuming. To overcome these challenges, Olafur Palsson, Psy.D., Marsha Turner, M.S., and I developed a 2-month home based program in which guided imagery is delivered through audio and video materials that can be prescribed by any health care professional such as a therapist, pediatrician, or school nurse who do not need to be trained in guided imagery and do not need to deliver any of the treatment in person. We therefore eliminated the need for a therapist and for weekly visits as well as greatly reducing the cost of the treatment.



The treatment materials are given to the child who can use them independently at home. These materials consist of a bag containing:

1. An instructional DVD that is watched by the children and their parents
2. Three biweekly sessions and a booster session of about 25 minutes each, delivered through CDs.
3. Three daily sessions (one used each day) delivered through CDs.
4. A calendar on a clipboard showing the child when to use the sessions. The child puts stickers on the calendar after practice sessions to track compliance.

All materials are self-explanatory. Parents are assigned as 'problem solvers' and clinicians are 'on call' if problems arise.

In a randomized trial we compared the home based guided imagery program described above to standard medical care in a group of 30 children. All children reported that they enjoyed listening to the CD's; compliance was 98.5%; parents did not need to be involved; and nobody contacted the research staff with questions, showing the acceptability and feasibility of the treatment. Abdominal pain frequency and duration were significantly lower after treatment in the guided imagery group versus the standard medical care group. Eighty-five percent (85%) of children in the guided imagery group were defined as treatment successes with parents reporting their child's symptoms to be somewhat to remarkably better.

Thus, home-based guided imagery is successful at treating children's pain, is low in cost, and easy to administer. The treatment was well liked and accepted by both parents and children who felt a new sense of control over the pain. It gave families a non-medicated alternative to treating their child's pain. We included



This picture shows a child receiving guided imagery treatment at home. All that is required from the child is to listen to the CDs daily (or at least 5 days each week) and imagine as well as he or she can everything that is heard in the recordings.

children who were new to a pediatric GI clinic. These were not only patients where prior treatment was unsuccessful, children with severe symptoms or children with a concurrent psychiatric diagnosis. In fact the treatment worked well for children independent of these factors and can therefore be applied as a first line treatment modality. One of the children in our study gave us this great quote: *"I used to use medications for my stomachaches. But now guided imagery is my medication and it doesn't even taste bad."*

How can I obtain the program?

Currently the program is only available to children participating in research studies at the University of North Carolina at Chapel Hill and Goryeb Children's Hospital in New Jersey. We are working

hard to make this treatment available within the next year for limited use. Clinicians working with chronic pain patients can sign up for our e-mail list at www.childpainsolutions.com. We will notify them about any developments in the availability of this treatment.

We do not intend to make this program available directly to the general public any time soon. During its testing phases – which may take several years – the program can only be prescribed by a health care provider. If you are a parent of a child suffering from functional abdominal pain, please contact your health care provider. ●

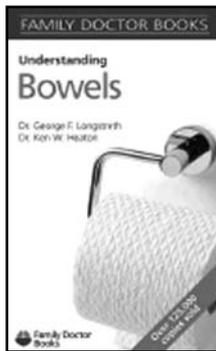


Books of Interest

Here is a list of books, authored by knowledgeable healthcare professionals, which provide trustworthy information about a variety of topics relating to gastrointestinal disorders and digestive health. These books are published by outside publishers – not by IFFGD.

Title: Understanding Your Bowels
Author: George F. Longstreth, M.D. and Ken W. Heaton, M.D.
Publisher: Family Doctor Publications (2006)
Pages: 140 (paperback)
ISBN-10: 142850012X

Here is a concise, easy to read book designed to help any reader understand how their bowels work, what can go wrong, and what can be done to fix the problems.



Topics range from chronic symptoms such as constipation, diarrhea, or bloating to disorders such as IBS or diverticulosis. An explanation of the physician visit and tests will help patients get the most out of their doctor visit. Originally published in Great Britain, the book has recently been re-published for U.S. readers.

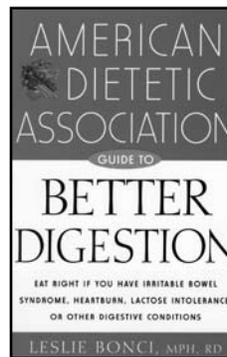
Dr. Heaton and Dr. Longstreth are prolific writers and dedicated clinicians with many years of experience in the field of digestive health and illness. Dr. Longstreth is Chief of Gastroenterology with the Kaiser Permanente Medical Care Plan and is Clinical Professor of Medicine at the University of California San Diego School of Medicine. Dr. Heaton was until recently Reader in Medicine at the University of Bristol, U.K. and Honorary Consultant Physician to the United Bristol Hospitals Trust. Together they have written this user-friendly volume. The book contains colorful and understandable illustrations, a list of useful resources, and a helpful glossary of terms. Recommended for anyone seeking to understand a bowel disorder and how to find help. Available through booksellers.

Title: American Dietetic Association Guide to Better Digestion
Author: Leslie Bonci, R.D., M.P.H.
Publisher: Wiley (2003)
Pages: 256 pages (paperback)
ISBN: 0471442232

Leslie Bonci is the director of sports medicine nutrition for the Department of Orthopedic Surgery and the Center for Sports Medicine at the University of Pittsburgh Medical Center

and is an adjunct assistant professor of nutrition at the University of Pittsburgh School of Health and Rehabilitation Sciences. Backed by the American Dietetic Association, this user-friendly guide shows you how to analyze your eating habits so that you can map out a dietary plan to manage and reduce the uncomfortable symptoms of digestive disorders.

You'll find practical recommendations for implementing changes in your lifestyle and advice on steering clear of common dietary mistakes. Your meals will be pleasurable and nourishing experiences—not painful ones—when you discover how to make the best and most comfortable food choices so you can embark on the road to digestive health. Available through booksellers.



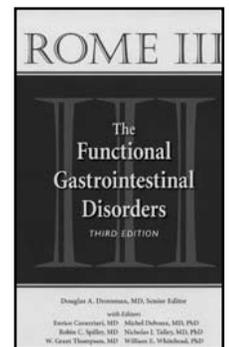
Title: Rome III: The Functional Gastrointestinal Disorders
Senior Editor: Douglas A. Drossman, M.D.
Pages: 1,048 pages (hardback)
ISBN: 096568376 (hardback); 0965683753 (paperback)

Five years in the making, *Rome III* is designed for “one stop” learning for health professionals. It serves as a valuable resource to general and specialist physicians, mental health professionals, and basic and clinical investigators involved

in the study and care of patients with functional GI disorders. The Rome teams of internationally recognized investigators and clinicians have again come together to produce a new standard for the evaluation and care of patients having these complex and prevalent disorders. *Rome III* provides the most up-to-date information on the epidemiology, pathophysiology, diagnosis, and treatment of irritable bowel syndrome and over 20 more functional GI disorders commonly seen in clinical practice.

This third edition is expanded with 17 chapters to address the needs of both investigators and clinicians. New chapters include pharmacology and pharmacokinetics, sociocultural influences relating to gender, age, and cultural influences, functional abdominal pain, and two chapters on pediatrics for the neonate/toddler and child/adolescent.

Includes “red flag” questions to aid the clinician in identifying symptoms and signs that would suggest further evaluation (to exclude other diagnoses) or when needed to make a referral. A table is included that compares the Rome II and new Rome III diagnostic criteria. Available online at www.romecriteria.org



Announcements

The U.S. National Institutes of Health (NIH) will be conducting an NIH State-of-the-Science Conference on Prevention of Fecal and Urinary Incontinence in Adults on December 10–12, 2007

Fecal and urinary incontinence – the inability to control bowel movements or urination, respectively – are conditions with ramifications that extend well beyond their physical manifestations. Many people find themselves withdrawing from their social lives and attempting to hide the problem from their families, friends, and even their doctors. The embarrassing nature of these conditions poses a significant barrier to seeking professional treatment, resulting in a large number of unreported, untreated individuals. Therefore, it is difficult to determine the accurate prevalence of these conditions, as well as any associated medical history trends. Incontinence is more likely to affect the aging population, although it is not considered a normal consequence of aging. As baby boomers approach their 60s, the incidence and public health burden of incontinence are likely to increase.

Fecal incontinence is a serious and embarrassing problem that affects up to 5 percent of the general population and up to 39 percent of nursing home residents. It affects people of all ages, but is more common in women and the elderly. Bowel function is controlled by three factors: rectal sensation, rectal storage capacity, and anal sphincter pressure. If any of these are compromised, fecal incontinence can occur. This condition can have many causes, including constipation, diarrhea, complicated childbirth, muscular or nerve damage, reduced storage capacity due to scarring or irritation, or pelvic dysfunction.

Because incontinence is likely widely under-diagnosed and under-reported, it has been difficult to identify both at-risk and affected populations. Also, because the biological mechanisms that cause both fecal and urinary incontinence are not well understood, it has been difficult to develop robust prevention and management strategies. Toward that end, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the Office of Medical Applications of Research (OMAR) of the National Institutes of Health (NIH) will convene a State-of-the-Science Conference from December 10 to 12, 2007, to assess the available scientific evidence relevant to the following questions:

- What are the prevalence, incidence, and natural history of fecal and urinary incontinence in the community and long-term care settings?
- What is the burden of illness and impact of fecal and urinary incontinence on the individual and society?
- What are the risk factors for fecal and urinary incontinence?
- What can be done to prevent fecal and urinary incontinence?
- What are the strategies to improve the identification of persons at risk and patients who have fecal and urinary incontinence?
- What are the research priorities in reducing the burden of illness in these conditions?

Nancy J. Norton of IFFGD will be among the presenters at the conference. She will be addressing *The Impact of Fecal and Urinary Incontinence on Health Consumers – Barriers on Diagnosis and Treatment – A Patient Perspective*.
<http://consensus.nih.gov/2007/2007IncontinenceSOS030main.htm>



IFFGD at Medical Meetings

IFFGD attends and exhibits at many national and international meetings of healthcare professionals to raise awareness about our mission – to improve the lives of those affected by digestive disorders. The meetings provide IFFGD with an opportunity to talk with healthcare professionals one-on-one about treating patients with a functional or motility GI disorder or incontinence. These exchanges provide insights that help us fine-tune our programs aimed at improving the doctor-patient experience, and ultimately, the care patients receive.

Upcoming meetings include:

- American Academy of Family Physicians Scientific Assembly; October 4–6, 2007; Chicago, IL
- American College of Gastroenterology Annual Meeting; October 12–17, 2007; Philadelphia, PA
- U.S. National Institutes of Health (NIH) State-of-the-Science Conference on Prevention of Fecal and Urinary Incontinence in Adults; December 10–12, 2007; Bethesda, MD

Zelnorm available to U.S. patients under restricted access program

On July 27, 2007 the U.S. Food and Drug Administration (FDA) approved a protocol that allows limited access to the drug tegaserod maleate (Zelnorm) for the treatment of chronic idiopathic constipation, or of IBS where constipation is the predominant bowel symptom. Access will be restricted to women under the age of 55 who meet special enrollment criteria administered through their doctor. Women interested in obtaining Zelnorm are encouraged to contact their doctor.

On March 30, 2007 the drug's maker, Novartis Pharmaceuticals, suspended U.S. marketing and sales of Zelnorm as a result of an FDA request in order to permit further discussion of its benefit/risk profile. According to Novartis, this decision was based on a review of a new retrospective analysis of pooled clinical trial data which showed that the incidence of cardiovascular ischemic events was higher in patients taking Zelnorm than in those taking placebo; however, no causal relationship between Zelnorm and cardiovascular ischemic events has been demonstrated.

Novartis has extensively studied Zelnorm and believes that this medicine provides important benefits for appropriate patients. Novartis is in discussions with the FDA to better understand the findings and to determine appropriate next steps.

More information on this topic is available on IFFGD's web site at www.aboutibs.org.



IFFGD Advisory Board Member Named One of the Best Doctors in Arkansas

IFFGD Advisory Board Member, Kevin W. Olden, M.D., University of Arkansas for Medical Sciences, Little Rock was named one of Arkansas's best doctors by The Best Doctors in America Inc.TM. Olden was one of four doctors listed for the specialty of Gastroenterology. The full list recognized doctors from over 60 different specialties.

Arkansas Times. Arkansas's Best Doctors 2007 From bench to bedside. <http://www.arktimes.com/Articles/ArticleViewer.aspx?3FArticleID%3D6ebdd1ec-a0fc-49a1-9a4a-75564796821f>. (Arkansas Times 8/2/2007; accessed 8/24/2007).

Help Change a Life

Are you concerned about the need for more digestive disease research? Frustrated that not enough is being done to find better ways to diagnose and treat these diseases?

There are many ways that you can make a lasting, meaningful contribution to the field of digestive disease research. Here are a few ideas.

Make a donation. Every dollar counts. We are not a government-funded agency and rely on donations to carry-on our efforts. Donating is easy. Call us toll-free at 1-888-964-2001, donate securely online by going to our web page at www.iffgd.org/donate, or donate by mail at IFFGD, PO Box 170864, Milwaukee, WI 53217.

Form a Circle of Friends: Send an email or letter to your circle of friends or acquaintances. Be the first contributor (let them know you plan to give \$amount to support IFFGD) and ask them to match your donation, or give as much as they are able. We will be happy to provide a sample email/

letter along with text to explain specific digestive disorders such as IBS, GERD, incontinence, Hirschsprung's disease, chronic intestinal pseudo-obstruction (CIP), or other GI disorders and the need for research support. Collect the donations and forward them to IFFGD, along with contact information for the contributors so we can send personalized thank-you notes. Whether you send 1 or 100 emails or letters, any donations that result will make a positive difference in the work of IFFGD.

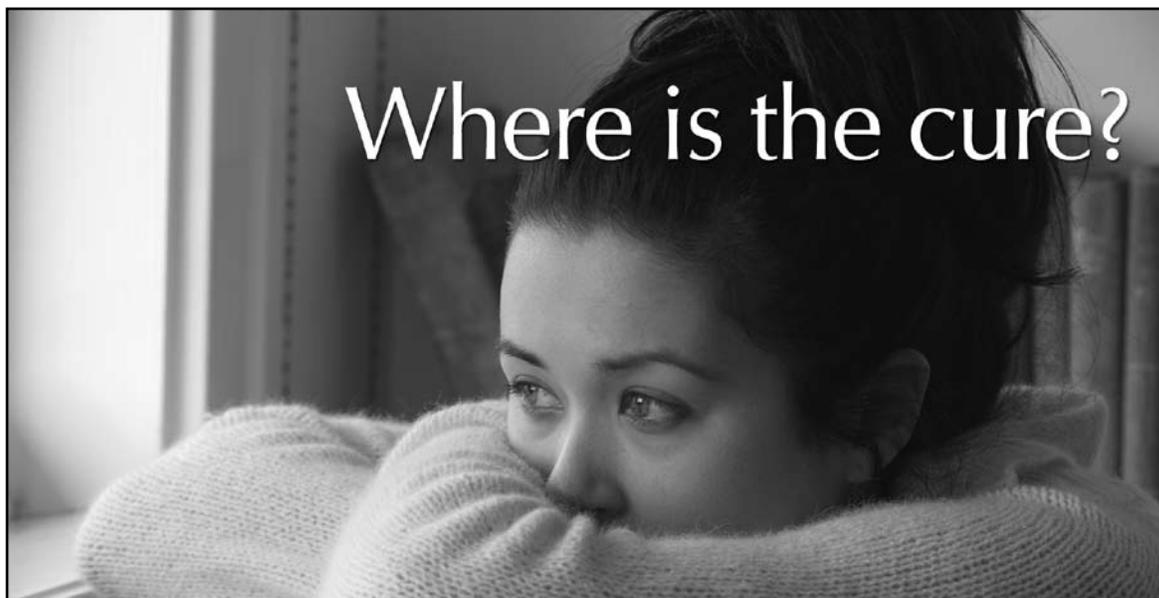
Matching Gifts: Many companies have a mechanism that allows its employees to contribute to a charity while matching the gift. Check with your company. We would be happy to provide them with details about IFFGD and information about digestive disorders.

Join The 10 For 5 Circle: To belong, members agree to donate \$10,000 a year for five years. IFFGD will use your donation as an award to a researcher. Recipients will be chosen by our selection committee of leading clinicians/scientists who will review proposals submitted by researchers. As a

member of The 10 For 5 Circle, you will receive updates on the awardee's research activities, and, with your permission, you will be recognized prominently in IFFGD publications.

Join the Founders' Circle: As a member of the Founders' Circle, you will demonstrate your commitment to digestive disease research by agreeing to donate \$100,000 a year for five years. In turn IFFGD will establish a research grant in your name. Recipients will be chosen by our selection committee of leading clinicians/scientists who will review proposals submitted by researchers. In addition to having an award established in your name, members of The Founders' Circle will be recognized prominently in IFFGD publications, and you will receive updates on the research you supported.

The research you support could change the way digestive diseases are treated and diagnosed. You can make a difference; you can help change a life. Please take action. Contact IFFGD today. ●



Where is the cure?

There is hope in research

To learn more, visit IFFGD.org or call toll-free 1(888)964-2001



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Occasionally, specific products are cited in articles or acknowledgments. However, no endorsement is intended or implied. Our intention is to focus on overall treatment or management issues or strategies.

The articles in *Digestive Health Matters* are in no way intended to replace the knowledge or diagnosis of your doctor. We advise seeing a physician whenever a health problem arises requiring an expert's care.

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