ORIGINAL ARTICLE

Polar vectors as a method for evaluating the effectiveness of irritable bowel syndrome treatments: An analysis with pinaverium bromide 100 mg plus simethicone 300 mg po bid

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KEYWORDS
Irritable Bowel Syndrome; Clinical studies; Outcome measures; Polar vectors; Bristol Stool Scale; Pinaverium bromide plus Simethicone

Abstract
Background: Irritable Bowel Syndrome (IBS) is a disorder characterized by abdominal pain or discomfort associated with changes in bowel habit. Currently there are no objective outcome measures for evaluating the effectiveness of treatments for this disorder.
Aims: To determine the usefulness of a method of analysis that employs polar vectors to evaluate the effectiveness of IBS treatments.
Methods: Data from a Phase IV clinical study with 1677 active IBS-Rome III patients who received 100 mg of pinaverium bromide + 300 mg of simethicone (PB + S) po bid for a period of four weeks were used for the analysis. Using the Bristol Stool Scale as a reference, the consistency and frequency of each type of bowel movement were recorded weekly in a Bristol Matrix (BM) and the data were expressed as polar vectors.
Results: The analysis showed a differential response to the PB + S treatment among the IBS subtypes: in reference to the IBS with constipation subtype, the magnitude of the vector increased from 10.2 to 12.5, reaching maximum improvement at two weeks of treatment ($p<0.05$, Scheffé). In the IBS with diarrhea and mixed IBS subtypes, the magnitude of the vector decreased from 19 to 14 ($p<0.05$) and from 16.5 to 13 ($p<0.05$), respectively, with continuous improvement for a period of four weeks. There was no definable vectorial pattern in the unsubtyped IBS group.

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Conclusions: Analysis with polar vectors enables treatment response to be measured in different IBS subtypes. All the groups showed improvement with PB+S, but each one had its own characteristic response in relation to vector magnitude and direction. The proposed method can be implemented in clinical studies to evaluate the efficacy of IBS treatments.

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PALABRAS CLAVE
Síndrome de Intestino Irritable; Estudios clínicos; Variables de desenlace; Vectores polares; Escala de Bristol; Bromuro de pinaverio más Simeticona

Introduction

Irritable bowel syndrome (IBS) is a functional gastrointestinal disorder characterized by abdominal pain or discomfort associated with changes in bowel habit. Based on the predominant bowel habit, it is classified into subtypes that, in accordance with the most recent Rome III criteria, are IBS with diarrhea (IBS-D), constipation (IBS-C), mixed (IBS-M), and unsubtyped (IBS-U).

In the absence of a biological marker in IBS, diagnosis is based on the Rome III clinical criteria that have been developed to classify functional gastrointestinal disorders (FGIDs); but there are no objective outcome measures for evaluating the efficacy of treatments for this disorder. Regulatory agencies have recently shown an interest in defining such objective outcome measures for the clinical trials that evaluate the medications presently being developed for IBS. The evaluation of pharmacologic efficacy must encompass several aspects, including the intensity of cardinal symptoms (abdominal pain and/or bloating) that can be evaluated with a visual analog scale (VAS), as well as changes in bowel habit (e.g. stool consistency that can be evaluated using the Bristol Stool Scale, or stool frequency that can be analyzed through symptom diaries). The Bristol Stool Scale has been recommended by the Rome III committee. It is a tool that enables bowel movements to be classified into seven categories, according to consistency: type 1, separate hard lumps, like nuts (hard to pass); type 2, sausage-shaped but lumpy; type 3, like a sausage but with cracks on the surface; type 4, like a sausage or snake, smooth and soft; type 5, soft blobs with clear-cut edges; type 6, floppy pieces with ragged edges, a mushy stool; and type 7, watery, no solid pieces, entirely liquid. A matrixial table or Bristol Matrix (BM) can be constructed by simultaneously recording the changes in consistency using the Bristol Stool Scale and measuring evacuation frequency. This matrix integrates the two variables (omnibus variable) and can serve as an efficacy measure for evaluating pharmacologic treatments for IBS. Data from the BM can be graphed as a series of points or vectors in a two-dimensional space. In response to treatment effectiveness, improvement in stool frequency and consistency (type) recorded in the BM will be reflected as a movement of the vectors, and depending on the IBS subtype, this movement can be in the same or in opposite directions. For example, in patients with IBS-C, improvement means diminishing in evacuation consistency, going from a Bristol type 1 or 2 to a type 3 or higher, accompanied by increased evacuation frequency (moving from left to right in the BM).
Polar vectors for clinical trials in IBS: A study with pinaverium bromide plus simethicone

In contrast, in patients with IBS-D, clinical improvement should be from left to right, whereas for IBS-D and IBS-M it should be from right to left.

Design

An open, prospective, descriptive, and multicenter study was conducted. Treatment was PB + S for a period of four weeks. Stool consistency and frequency and improvement in cardinal symptom intensity (abdominal pain and bloating) were evaluated on a weekly basis.

Data collection instrument

The intensity of abdominal pain and bloating were evaluated by the patients through a 10-cm-long VAS for each symptom. Stool consistency (type) was recorded according to the Bristol Stool Scale on a 7-day format that also took into consideration the frequency of all types of bowel movements (Fig. 2). This format, or BM, was used during the four weeks of treatment. With the BM data, a vectorial calculation was made (see the statistical analysis) to evaluate the changes obtained with PB + S treatment.

Statistical analysis

An omnibus variable was created that included two variables: consistency (type) and frequency of evacuations obtained from the BM. Given that the aim was to demonstrate the treatment changes through graphs, a two-dimensional configuration using polar vectors was decided upon. Polar vectors are dimensionless and can be evaluated in less than 25% of bowel movements; IBS-M: hard or lumpy stools in at least 25% and loose or watery stools in at least 25% of bowel movements; and IBS-U: modifications in stool consistency but insufficient to be classified as IBS-D, IBS-C, or IBS-M. Active IBS was defined as the presence of abdominal pain and/or discomfort at least twice a week during the previous seven days.

(b) For exclusion – The presence of alarm symptoms over the past 6 months, e.g.: involuntary weight loss, anorexia, inexplicable anemia, palpable lymph nodes or masses, fever, digestive tract bleeding, the suspicion or confirmed presence of malignant disease in any system or organ; women who were suspected of being pregnant, women who were pregnant, or who were breastfeeding; the suspicion or confirmed presence of rectoanal stricture; esophageal varices; a history of chronic non-specific ulcerative colitis, Crohn’s disease, or rectoanal ulcer; major upper or lower abdominal surgery; digestive tract malformation; or bowel obstruction.

Figure 1 Improvement of abdominal pain and bloating in relation to the Bristol Matrix. A scale that corresponds to stool consistency measured by the Bristol Stool Scale is shown. For IBS-C, improvement should be from left to right, whereas for IBS-D and IBS-M it should be from right to left.

Methods

Population

The data used in this analysis were obtained from a Phase IV clinical study that included 1677 patients with active IBS in accordance with Rome III criteria. Patients were recruited by 1303 physicians with different specialties throughout the Mexican Republic. Selection criteria were:

(a) For inclusion – Patients of both sexes who were ≥18 and ≤50 years of age and who had a body mass index (BMI) <50. Clinical diagnosis of IBS according to the Rome III criteria: presenting with recurring abdominal pain or discomfort for at least three days a month in the last three months that was associated with 2 or more of the following characteristics: (1) improvement with defecation, (2) onset associated with a change in stool frequency, and (3) onset associated with a change in stool form (appearance). In addition, based on the Rome III classification, patients were categorized according to bowel habit as IBS-D, IBS-C, IBS-M, and IBS-U. IBS-D was identified by loose or liquid stools in at least 25% and hard or lumpy in less than 25% of bowel movements; IBS-C: hard or lumpy stools in at least 25% and loose or liquid stools in at least 25% of bowel movements; IBS-M: hard or lumpy stools in less than 25% of bowel movements; and IBS-U: modifications in stool consistency but insufficient to be classified as IBS-D, IBS-C, or IBS-M. Active IBS was defined as the presence of abdominal pain and/or discomfort at least twice a week during the previous seven days.

(b) For exclusion – The presence of alarm symptoms over the past 6 months, e.g.: involuntary weight loss, anorexia, inexplicable anemia, palpable lymph nodes or masses, fever, digestive tract bleeding, the suspicion or confirmed presence of malignant disease in any system or organ; women who were suspected of being pregnant, women who were pregnant, or who were breastfeeding; the suspicion or confirmed presence of rectoanal stricture; esophageal varices; a history of chronic non-specific ulcerative colitis, Crohn’s disease, or rectoanal ulcer; major upper or lower abdominal surgery; digestive tract malformation; or bowel obstruction.

Statistical analysis

An omnibus variable was created that included two variables: consistency (type) and frequency of evacuations obtained from the BM. Given that the aim was to demonstrate the treatment changes through graphs, a two-dimensional configuration using polar vectors was decided upon. Polar vectors are dimensionless and can be evaluated based on their magnitude, and direction. A vector is a point in space (it can be multidimensional), that has a distance from its point of origin and can move in any direction. Its coordinates are simply the distance from the origin and the angle in relation to a horizontal plane.

The vector calculation was made in the conventional manner:

\[ r = \sqrt{x^2 + y^2}, \]

where \( r \) is the magnitude of the vector and \( y \) is the equivalent of the hypotenuse of a right triangle and therefore is...
shows the demographic and clinical character-
and the local regulations con-

The patients were instructed to identify the type of defecation 
according to the Bristol Stool Scale are at the top of the diary . 

The magnitude of the vector was reduced in the patients 
with IBS-D and IBS-M. In the IBS-D patients the vector began 
at a magnitude of 19.0 and it went toward a magnitude of 
13.0 ( p < 0.05). There was important improvement in these two IBS subtypes 
during the second treatment week, and unlike the IBS-C 
group, it continued during weeks 3 and 4. The IBS-U group 
showed erratic behavior with no definite pattern in relation 
to vector magnitude and direction (Fig. 4).

Discussion

This study demonstrates that the transformation into polar 
vectors of the combination of the type of stool consistency 
according to Bristol Stool Scale, and the frequency of each 
of those stool types evaluated in a BM, is a useful method 
for evaluating IBS pharmacologic treatments, as it was the
This has led to continuous meetings Nevertheless, certain psychome- the in an effort to define the reported outcome In the last few years, This can be difficult when it entails and evaluating the changes in stool consistency

Table 1 Patient clinical characteristics according to IBS subtype.

<table>
<thead>
<tr>
<th></th>
<th>IBS-C (N = 723)</th>
<th>IBS-D (N = 94)</th>
<th>IBS-M (N = 812)</th>
<th>IBS-U (N = 48)</th>
<th>Total (N = 1677)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women/men (%)</td>
<td>81.7/18.3</td>
<td>56.4/43.6</td>
<td>74.8/25.2</td>
<td>77.1/22.9</td>
<td>76.8/23.2</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Age in years</td>
<td>36.3 (9.0)</td>
<td>37.8 (8.7)</td>
<td>37.3 (8.5)</td>
<td>36.8 (9.0)</td>
<td>36.9 (8.8)</td>
<td>0.13</td>
</tr>
<tr>
<td>BMI</td>
<td>26.1 (4.8)</td>
<td>26.9 (4.4)</td>
<td>26.4 (4.8)</td>
<td>26.0 (4.4)</td>
<td>26.3 (4.8)</td>
<td>0.39</td>
</tr>
<tr>
<td>Heart rate x min</td>
<td>75.8 (7.4)</td>
<td>76.7 (7.3)</td>
<td>76.6 (7.7)</td>
<td>76.3 (7.8)</td>
<td>76.3 (7.6)</td>
<td>0.19</td>
</tr>
<tr>
<td>Respiratory rate x min</td>
<td>18.8 (3.0)</td>
<td>19 (3.0)</td>
<td>19 (3.0)</td>
<td>18.2 (3.0)</td>
<td>18.9 (3.0)</td>
<td>0.29</td>
</tr>
<tr>
<td>Systolic BP (mmHg)</td>
<td>115 (10.0)</td>
<td>118 (13.0)</td>
<td>116 (11.0)</td>
<td>117 (12.0)</td>
<td>116 (11.0)</td>
<td>0.08</td>
</tr>
<tr>
<td>Diastolic BP (mmHg)</td>
<td>74 (8.0)</td>
<td>76 (7.0)</td>
<td>74 (7.0)</td>
<td>74 (8.0)</td>
<td>74 (8.0)</td>
<td>0.34</td>
</tr>
</tbody>
</table>

BMI: body mass index; min: minutes; BP: blood pressure. Data expressed as mean (standard deviation).

Contrast carried out with \( \chi^2 = 33.8, \) gl = 8. The remaining contrasts were carried out through one-way ANOVA.

A current limitation in the development of new IBS therapeutic options is the lack of validated outcome measures that objectively record their efficacy in clinical studies; the fact that there are no biological markers for the diagnosis of IBS also has to be taken into account. In the last few years, the most widely used primary outcome measures in IBS clinical studies have been global variables of binary response: adequate improvement of abdominal pain and discomfort or satisfactory relief of IBS symptoms, that followed the Rome recommendations. Nevertheless, certain psychometric aspects of these variables have not been adequately validated and therefore are not presently accepted by the regulatory agencies. This has led to continuous meetings between the representatives of those agencies, experts on the subject matter, and representatives of the pharmaceutical industry, in an effort to define the reported outcome measures for the patients, the so-called PRO or Patient Reported Outcomes. This can be difficult when it entails evaluating the results in patients with FGIDs that do not have an organic or structural lesion and whose evaluation is made through symptom-based criteria.

The method of analysis used in this study has taken the current tendencies and recommendations into account, such as including diagnosed patients through the Rome III criteria and evaluating the changes in stool consistency and frequency. In addition, it was based on the collection of symptoms through diaries and the weekly evaluation of treatment response. It also contemplated the variables in a multidimensional context and evaluated the individual response in the different IBS subtypes.

Figure 3 Changes in the intensity of abdominal pain and bloating. The intensity of abdominal pain and bloating was evaluated by the patients through a 10 cm VAS. The changes in time were significant (\( p < 0.001, \) repeated measures MANOVA) for pain (A) and bloating (B). The contrast between subtypes showed no significant difference. Blue: IBS-C, red: IBS-D, green: IBS-M, and pink: IBS-U. The figure shows means ± SE.
Figure 4  
Polar vectors showing the changes in magnitude ($r$) and direction, during four weeks of treatment with PB + S, according to each IBS subtype. Notice that the vectorial magnitude axes were adjusted according to the space covered during the four weeks and therefore, at its maximum improvement ($r < 12.5$), IBS-C did not reach the lower end of IBS-M ($r > 13$); in addition, considering the magnitude of the vector, there is overlapping in the IBS-D, IBS-M, and the IBS-U spaces. The letters correspond to homogeneous Scheffé groups in the post hoc analysis. See the statistical analysis section for details.

A first limitation of the suggested method is the fact that the physician must graph the weekly vector results himself; however, it is possible to develop computerized programs that can facilitate the follow-up of changes that occur in the patients and that can show the results of different treatments. A second limitation is that this method is applicable exclusively to medications that have an effect on stool consistency and frequency, and as a result, a third limitation is the fact that polar vectors do not evaluate the effect of treatment on abdominal pain or discomfort (abdominal bloating) that are key symptoms in IBS. However, it is worth noting that a recent review of the literature on questionnaires used in IBS to create a framework by which PRO can be developed for this disorder, established that abdominal pain and discomfort are two different symptoms. Therefore, questions about discomfort response should be avoided, because it is very nonspecific. In the future, evaluations will have to be made on whether improvement in stool consistency and frequency not only reduces abdominal pain, but also other symptoms such as associated anxiety, and also whether the effect on pain and anxiety can be analyzed through vectors. A fourth limitation of this study is that the clinical significance of the change in vector magnitude and direction has not been determined. Regulatory agencies have emphasized the importance of identifying objective endpoints that would allow clinically significant improvement to be established, and thus report the percentage of patients that manage to go beyond that endpoint. Finally, the vectorial method was studied in patients who were seen in private medical practices in Mexico and it is necessary not only to validate the results in studies on open populations, but also on subjects from other cultures and in other languages.

In conclusion, polar vectors can be useful in clinical trials for the integral evaluation of the changes in stool consistency and frequency in response to an IBS treatment. Vectorial analysis shows that the combined therapy of PB + S, administered for at least four weeks, differentially modifies the frequency and consistency of bowel movements in all IBS subtypes, but with differences in the magnitude and velocity of the change between them. It should be pointed out that, even though the polar vectors analyzed in this study did not evaluate the response to pain and/or subjective abdominal bloating, the improvement of these symptoms analyzed through VAS was also significant for all the IBS subtypes. It is necessary to apply this method of analysis in placebo-controlled studies in order to confirm the results observed in this study.

Financial disclosure
This study was financed by Takeda México S.A. de C. V.
Conflict of interests

Dr. Juan Carlos López-Alvarenga is currently a Biometric Scientist for Clinical Trials of Takeda México SA de CV. Has received research grants by Silanes, Roche, Servier. Has been a speaker for Takeda, Roemmers, Bayer, Roche and Novartis.

Dr. Sergio Sobrino-Cossío has been a speaker for Takeda México SA de CV, Astra, Ferrer, Olympus, Boston Scientific, Trasmédica, Wilson Cook.

Dr. José-Maria Remes-Troche is a member of the Advisory Board of Takeda Pharmaceuticals, Alfa-Wasserman and Janssen. Has been a speaker for Nycomed-Takeda, Advance Medical, Astra-Zeneca and Bristol-Myers-Squibb. Has received a research grant from Sanofi-Pasteur.

Dr. Jazmín Chiu-Ugalde and Dr. José Antonio Vargas-Romero, are employees of the Medical Direction of Takeda México SA de CV.

Dr. Max Schmulson has served as a consultant for Procter and Gamble, Novartis, Schering-Plough, Alfa-Wasserman, Janssen, Nestle Ltd and Almirall. Has been a speaker for Takeda México SA de CV, Schering-Plough, Mayoli-Spindler, Alfa-Wasserman, Janssen and Novartis. Has received research grants from Takeda México SA de CV and Nestle Ltd.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at doi:10.1016/j.rgmx.2012.10.003.

References


