A double blind randomized controlled trial of a probiotic combination in 100 patients with irritable bowel syndrome

Étude randomisée en double insu contre placebo sur l’efficacité d’un mélange probiotique chez 100 patients présentant des troubles fonctionnels intestinaux

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Summary

Objectives. — The purpose of this study was to evaluate the effects of a probiotic combination on symptoms in patients with irritable bowel syndrome (IBS).

Methods. — We investigated the efficiency of a probiotic dietary supplement, containing four strains of lactic acid bacteria, on symptoms of IBS. One hundred and sixteen patients with IBS fulfilling the Rome II criteria were randomized in a parallel group, double-blind study to receive a placebo or a probiotic combination (1 × 10¹⁰ cfu once daily) for four weeks. The symptoms that were monitored weekly included discomfort, abdominal pain, and stool frequency and quality. Quality of life was assessed before and at the end of the treatment using the SF36 and FDD-quality-of-life questionnaires.

Results. — One hundred subjects completed the study (48 probiotic combination, 52 placebo). The probiotic combination was not superior to the placebo in relieving symptoms of IBS (42.6 versus 42.3% improvement). However, the decrease of abdominal pain between the first and the fourth week of treatment was significantly higher in probiotic treated patients (−41.9 versus −24.2%, P = 0.048). Interesting findings from the IBS sub-groups were also observed such as a lower pain score at end point in patients with alternating bowel habits (P = 0.023) and...
Introduction

Irritable bowel syndrome (IBS) is a frequent disorder affecting twice as many women as men. Symptoms include abdominal pain and/or discomfort often associated with abnormal bowel habits [1] which alter the quality of life [2]. There is presently no curative treatment but various therapies may help to alleviate the symptoms [3]. The majority of them target gastrointestinal motility, and/or visceral sensitivity or psychological components of the disease [4]. Recent studies have suggested that intestinal microbiota play a role in the pathogenesis of IBS. IBS occurs more frequently after intestinal infection or antibiotic treatment and exhibits also some signs of minimal intestinal inflammation [5, 6]. This provided a rationale to evaluate probiotics to correct the altered microflora and improve symptoms of IBS [7]. Probiotics are live microorganisms which when consumed in adequate amounts confer a health benefit on the host [8]. They can influence immune functions, motility, and the intraluminal milieu [9]. Evidence for the clinical efficacy of some strains or combination of several strains has been obtained for various intestinal disorders including gastroenteritis, antibiotic-associated diarrhea, *Clostridium difficile* infections, pouchitis and prevention of the relapse of ulcerative colitis [10]. The effects of probiotics may differ greatly between two closely related strains (even thus within the same microbial genus and species) and they cannot therefore be extrapolated from one strain to another [11]. Recent trials have shown the potential benefits of some probiotics, especially strains of bifidobacteria or lactobacilli, on symptoms of IBS [12–14] however, only three of these trials included more than 60 subjects [14–16].

The aim of the present study was to examine whether oral administration of a probiotic dietary supplement, for four weeks, would decrease IBS symptoms and improve the quality of life in patients suffering from IBS.

Materials and methods

Study population

One hundred and sixteen patients fulfilling the Rome II criteria for IBS [1] were enrolled in this controlled, double-blind, randomized study. The recruitment and the diagnostic work up were performed by 23 French general practitioners across France between September 2004 and January 2006. The study was approved by the “CCPPRB HEGP-Broussais” Ethics Committee on July 20th 2004.

The exclusion criteria were: the presence of any active organic gastrointestinal disease, abdominal surgery in the past (except for appendectomy and cholecystectomy), any concomitant disease susceptible to influence IBS, pregnancy, and an abdominal discomfort/pain score inferior to 1 at the time of randomization. All patients gave written informed consent prior to the study after they had read materials describing the study and been verbally briefed on the double-blind nature of the study, the treatment conditions,
the evaluative method, and the study procedures. Any medications, which could influence IBS, had to be discontinued before entry into the trial and during its entire duration. This included intestinal motility modifiers, antidepressants, opioids, narcotic analgesics and antispasmodic agents. The use of laxatives or loperamide was discouraged and had to be recorded by the patients who needed them transiently. The consumption of probiotic containing drugs, dairy products or food supplements was forbidden during the one week run-in period and during the entire trial.

Study protocol

This was a randomized, double-blind, parallel-group, placebo-controlled, four-week, study in out-patients. At baseline, physicians recorded the patients’ age, gender, weight and medical history and classified their predominant disturbances of bowel function as constipation-predominant (C-IBS), diarrhea-predominant (D-IBS) or alternating (A-IBS) according to the Rome II criteria [1].

Patients with a discomfort/pain score superior or equal to 1 at baseline (Week 0 [Wk0]) were randomized (using a randomization table and sealed envelopes). The discomfort/pain score was assessed using a 0-3 likert scale (0: none, 1: tiny; 2: moderate, 3: severe) [18].

Patients were randomized to receive either the probiotic combination (containing 1.10^10 cfu B. longum LA 101 (29%), L. acidophilus LA 102 (29%), L. lactis LA 103 (29%) and S. thermophilus LA 104 (13%), 2.3 g glucids including 1.9 g starch, 0.027 g proteins, 0.015 g lipids/sachet) or the placebo (of identical composition except for the bacteria) for four weeks. Each treatment was provided in identical sachets and taken once daily in the fasting state, at least three hours after a meal and 15 min before the next meal. The powder had to be dissolved in water 10 min before its ingestion. At the end of the protocol, patients had to bring back the empty sachets.

Each week, the patients filled in a questionnaire regarding their symptoms. Primary efficacy was assessed using a binary scale based on the patient answers to the following question: “Did you have satisfactory relief of your overall IBS symptoms during the last week?” [17]. The patients were also asked each week to answer the following question: “Compared to the way you usually felt before entering the study, how would you rate your relief of symptoms of abdominal discomfort/pain during the last week? Possible answers were: completely relieved, considerably relieved, somewhat relieved, unchanged or worse” [18]. Secondary endpoints included weekly assessment of discomfort/pain [18], abdominal pain using a 10 cm visual analogue scale (0: not at all; 10: acute, unimaginable), and stool frequency and consistency measured by subjective evaluation (very hard, hard, mould, soft, liquid). Additionally, patients completed the IBS specific FDD-quality-of-life (QOL) [19] questionnaire and the validated French version of the generalist SF-36 [20] questionnaire at baseline and at the end of the four weeks treatment to assess their quality of life and well-being.

Statistical methods

Week 0 (Wk0) was considered the baseline. As designated by the protocol, the primary comparisons for efficacy were the weekly “satisfactory relief” and the pain/discomfort score in the last week of the treatment period (Wk4). Differences between the treatment groups were analyzed applying the two-sided t-test at a significance level of α = 0.05, or Fisher exact test, as appropriate. Answers on visual analogue scales were measured in centimetres of the distance separating the point corresponding to the answer given by the subject from the origin of the analogue scale. These results were used for the statistical analysis. The values were compared by a nonparametric test of Wilcoxon’s rank-sum test. The percentage of variation were calculated using the formula [(Wk4–Wk0)/Wk0] × 100. The analyses were done for the whole population and for the IBS subtypes (C-IBS, D-IBS and A-IBS).

We arbitrary chose “satisfactory relief” according to the Rome II criteria and a hypothesis 20% of positive responses to the primary endpoint in the patients receiving the placebo (17) and 50% in the probiotic group. It was calculated that 96 patients were required to complete the study in order to detect this difference with a 90% power and α = 0.05. In order to compensate for dropouts, it was planned to recruit 110 patients. All data were collected and analyzed independently of the investigators, who did not have access to the data until the study had been completed. Thereafter, investigators had full access to all data.

Results

Subjects

One hundred and sixteen were screened of whom 106 fulfilled the inclusion criteria and were randomized (six declined, four had a pain/discomfort score < 1). Five patients in the probiotic group and one patient in the placebo one were excluded from the study because of low compliance and not having returned the diary and the empty sachets. Thus, the efficacy evaluation included 100 patients, 48 in the probiotic group and 52 in the placebo group. No significant differences were observed between the groups at baseline (Table 1). Patients were predominantly female (76%, n = 76), with a mean age of 46 years and a discomfort/pain score of 2.12 (range 1.2-3). Within the total population 29% were classified as constipation-predominant IBS (C-IBS), 29% as diarrhea-predominant IBS (D-IBS), 41% as alternators (A-IBS), and 1% non-classified.

Table 1 Characteristics of the patients receiving the probiotic combination and those in the control group.

<table>
<thead>
<tr>
<th>Subtype of IBS (%)</th>
<th>Probiotic</th>
<th>Placebo</th>
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<tbody>
<tr>
<td>C-IBS</td>
<td>25.0</td>
<td>32.7</td>
</tr>
<tr>
<td>D-IBS</td>
<td>29.2</td>
<td>28.8</td>
</tr>
<tr>
<td>A-IBS</td>
<td>45.8</td>
<td>36.5</td>
</tr>
<tr>
<td>ND</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Discomfort/pain score</td>
<td>2.14 ± 0.39</td>
<td>2.10 ± 0.45</td>
</tr>
<tr>
<td>ND: not determined.</td>
<td></td>
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Response to treatment

Primary efficacy variable

The proportion of patients with satisfactory relief of overall IBS (Fig. 1) and of abdominal discomfort/pain increased with time in both treatment groups. At week four, the percentage of patients with satisfactory relief was not significantly different between the two treatment groups (42.6 versus 42.3% for probiotic and placebo respectively).

Secondary efficacy variables

Abdominal pain improved significantly during the study (P < 0.02 for all comparisons) in both treatment groups, and in the three IBS sub-groups. The decrease in abdominal pain score between the
Figure 1  Percentage of patients with satisfactory relief from symptoms of IBS, in the probiotic group (solid line) and in the placebo group (dotted line).

Pourcentages de patients présentant un soulagement de leurs symptômes associés aux TFI, dans le groupe probiotique (trait plein) et dans le groupe placebo (pointillés).

First and the fourth week of treatment was significantly higher in the probiotic treated patients (−41.9% ± 44.6 versus −24.2% ± 51.1, P = 0.048). There was also a trend for a lower abdominal pain score at the end of treatment in the probiotic group when compared to the placebo (2.7 ± 2.1 in the probiotic group versus 3.3 ± 2.2 for the placebo, P = 0.054) (Fig. 2A). In the A-IBS group, interesting results were observed with a significant decrease of abdominal pain (2.5 ± 1.7 in the probiotic group versus 3.6 ± 2.1 in the placebo group, P = 0.023) (Fig. 2B).

The number and consistency of stools were not significantly different between the probiotic group and the placebo group (not shown). In the constipated population (C-IBS), the number of stools was significantly higher in the probiotic treated group compared to placebo (Fig. 3). This was observed from the first week of treatment (P = 0.043 at the end of the first week; P = 0.026 at the end of the second week, P = 0.049 at the end of the third week).

There was no significant difference in the evolution of quality of life scores (SF-36 and FDD-QOL) between the probiotic and placebo groups. In contrast to placebo treated patients, patients supplemented with the probiotic combination reported a significant improvement regarding flatulence (P = 0.037), waking up during the night because of abdominal pain (P = 0.031), and needing to loosen their belt or lie down after meal (P = 0.010) (Table 2). Bloating improved in both groups: P = 0.013 and 0.028 for the probiotic and placebo groups respectively.

Discussion

Several clinical trials recently evaluated the efficacy of probiotics on IBS but many are derived from open studies and there are considerable differences in trial design and the probiotics employed [12,13]. Their primary end points were also often not clearly stated and only three, including the present study, included more than 100 patients [14,21]. Results cannot be extrapolated from one probiotic to another and depend on the dose [14]. The rationale for trying probiotics on IBS relies on their potential effectiveness on intestinal motility, microflora, inflammation and pain [22].

Figure 2  Abdominal pain score in total IBS subjects A; in the alternators sub-group B, in the probiotic group (solid line) and in the placebo group (dotted line).

Scores de douleur abdominale chez la totalité des patients avec IBS A ; dans le groupe avec alternance diarrhée-constipation B, dans le groupe probiotique (trait plein) et dans le groupe placebo (pointillés).
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For example, L. paracasei NCC2461 significantly attenuated muscle dysfunction in a murine model of postinfective IBS [21]. The probiotic yeast Saccharomyces boulardii modulated the expression of neuronal markers in the submucous plexus of pigs [24]. L. farciminis treatment prevented stress induced hypersensitivity, increase in colonic paracellular permeability, and colonocyte myosin light chain phosphorylation in rats [25,26]. Recently, Rousseaux et al., showed that oral administration of specific Lactobacillus strains induced, through the NF-κB pathway, MOR1 and CB2 expression and contributed to the modulation and restoration of the normal perception of visceral pain [27]. There also seems to be an inflammatory component and a dysregulation of pro- and anti-inflammatory cytokines in patients with IBS [15]. Most interestingly, B. infantis 35624 was shown to restore the balance of pro- and anti-inflammatory cytokines in the patients [15]. Double blind randomised controlled trials also showed that B. animalis 173-010 shortened the colonic transit time in healthy women [28]. However, the fine mechanisms for these effects are still poorly understood and need further study.

This study was the first trial with this product (combination of four lactic acid bacteria strains) and we had to arbitrarily choose the duration of the product ingestion (four weeks) and the primary end point. We chose to limit the duration of the trial to four weeks as we thought that this was a sufficient period of time for patients to wait for results; however, longer studies may be useful in the future. The evaluation of the effects on IBS is difficult and there is no gold standard. There are no biological markers for IBS nor any obvious markers to use when assessing the severity of IBS symptoms. We arbitrarily decided to use a subjective global assessment of IBS symptoms improvement as the primary endpoint, individual IBS symptoms as secondary endpoints and validated quality-of-life questionnaires as proposed in the guidelines of the Rome Committee on treatment trials; however, other authors have chosen to focus on the improvement of specific symptoms such as bloating.

The results of this study indicate that supplementation with a specific combination of probiotics for four weeks was not superior to the placebo in relieving IBS symptoms. In agreement with many studies on IBS, we observed a high placebo responses rates. In clinical IBS trials, it is not uncommon to have placebo rates as high as 50% [29]. We cannot exclude therefore that the sample size of this study resulted in a lack of power to detect a significant improvement with the probiotic treatment compared with placebo.

Analysis of the IBS sub-groups showed interesting results. A significant reduction in the intensity of the abdominal pain was observed in the alternators subtype, and the mechanism for this effect is not established. Moreover, we observed a significant increase in the number of stools per day in the constipated patients. This strongly suggests that this probiotic supplementation could be effective to alleviate specific IBS symptoms and that these subgroups and specific endpoints warrant further investigation. The probiotic combination used in this study needs also to be evaluated further to determine the optimal regimen in terms of duration and dosage. It would be interesting to consider the instability between D-IBS and C-IBS, with a tendency to move to A-IBS [30].

Global quality of life scores were not significantly different between the probiotic and placebo groups. The study was not designed to detect significant change in quality of life and it is usually very difficult to show an amelioration of quality of life with a treatment of such a short duration (four weeks) and a small number of subjects. However, our data showed positive and significant evolutions in quality of life scores for the probiotic group from the beginning to the end of the completion for specific items relative to discomfort and to digestive disorders, mainly flatulence and bloating.
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References


