Irritable Bowel Syndrome

DIAGNOSIS—SYMPTOM-BASED CRITERIA[1-5]

Rome IV criteria[1*]

Recurrent abdominal pain on average at least 1 day/week in the last 3 months, associated with at least 2 of the following:

- Defecation
- Change in stool frequency
- Change in stool appearance

In clinical practice, the frequency criteria may be reduced and duration shortened to at least 2 months if symptoms are bothersome[2†]

- Interfere with daily activities or require attention
- Cause worry or interfere with QOL

The need for diagnostic testing is minimal in the absence of alarm features[‡]

- Anemia due to iron deficiency
- Family history of IBD, colon cancer, or celiac disease
- New symptom onset after 50 years of age
- Nocturnal diarrhea
- Recent antibiotic use
- Rectal bleeding not attributable to anal fissures or hemorrhoids
- Unintentional weight loss (eg, >10% in 3 months)

IBS is NOT a diagnosis of exclusion[§]

Positive diagnostic strategy

- ☑ Medical history (eg, diet, medications)
- ☑ Physical exam and evaluation of GI symptoms
- ☑ Limited laboratory testing
- ○ When clinically indicated, colonoscopy/ other appropriate tests

ACG and AGA suggest:

- ○ Serologic testing for **celiac disease** in patients with diarrhea
- ○ **Fecal calprotectin/lactoferrin** and **CRP** (markers of inflammation) testing to rule out **IBD** in patients with diarrhea without alarm features
- ○ **Anorectal physiology** testing in patients with symptoms of pelvic floor disorder and/or refractory constipation unresponsive to standard therapy

Scan to view

ACG Guideline

AGA Quality Indicators

Bristol Stool Form Scale to Distinguish IBS Subtypes

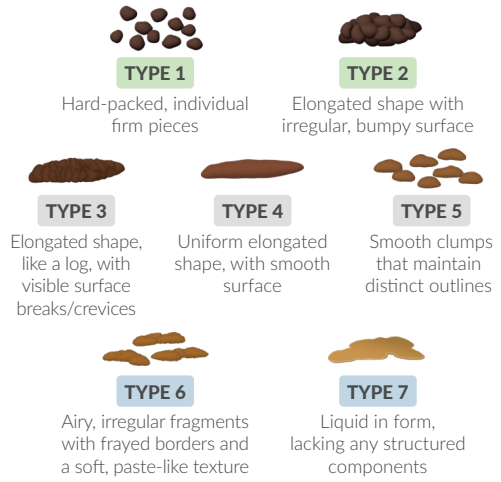
IBS subtype and treatment are determined by stool consistency/form

IBS with constipation
IBS-C
Hard/lumpy stools >25%
Loose/watery stools <25%

IBS with mixed bowel habits
IBS-M
Hard/lumpy stools >25%
Loose/watery stools >25%

IBS with diarrhea
IBS-D
Hard/lumpy stools <25%
Loose/watery stools >25%

Unclassified IBS: IBS-U
Bowel habits cannot be categorized as IBS-C, IBS-D, or IBS-M



Adapted from Rome Foundation, Bristol Stool Form Scale, and Lewis SJ, Heaton KW. *Scand J Gastroenterol*. 1997;32(9):920-924.

ACG guideline and AGA quality indicators recommend a positive diagnostic strategy to expedite therapy initiation and enhance cost-effectiveness. Early IBS diagnosis reduces patient suffering and improves health-related QOL and work productivity.[3,4,6-8]

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COLLABORATIVE PATIENT COMMUNICATION: IBS DIAGNOSIS AND TREATMENT PLAN[9-11]

~1 in 5 patients may not feel comfortable discussing their GI symptoms with an HCP[¶]
Absence of a reliable biomarker for IBS diagnosis poses challenges in making and communicating a diagnosis

Relationship between provider and patient

Listen actively

Communicate in a patient-centered manner and address the patient's needs and priorities

Show empathy and validate patient's beliefs and concerns

Symptom assessment

Identify patient's most-bothersome symptoms

Assess symptom severity and impact

Determine non-GI symptoms and comorbid conditions that may impact treatment approach

Exacerbating and alleviating factors

Understand factors contributing to IBS development (eg, infection, genetic predisposition, psychological factors) and those increasing symptom flares (eg, certain foods, stress)

Avoid stereotyping and bias in symptom presentation (eg, females and pain intensity[#12])

Overall treatment plan

Develop treatment plan that includes targeting most-bothersome symptoms

Explain treatment options and obtain mutual agreement with patient

Education and reassurance

Provide a clear, confident, and positive diagnosis affirming that IBS is a real condition

Explain that IBS is a dysregulation of the brain-gut axis

Explain pathophysiologic mechanism(s) of most-bothersome symptoms for patient's IBS subtype

Set realistic treatment expectations (eg, symptoms being targeted with treatment, anticipated duration of treatment, and time to symptom relief)

Offer oral, written, and digital educational resources tailored to the patient's educational level and interest. Provide proper context and confirm understanding of information provided

Disclaimer: The information provided here is intended for general educational purposes only. Individual situations will vary, and this information is not a substitute for professional medical expertise. It does not represent medical or legal advice or opinion.

*Criteria fulfilled for previous 3 months with symptom onset ≥6 months prior to diagnosis.[1] †If symptoms are bothersome, a lower frequency and shorter duration (≥2 month) may be considered if there is clinical confidence that other diagnoses have been sufficiently ruled out based on presentation and additional investigations, as necessary.[2] ‡While comprehensive, this list may not represent all possible alarm symptoms. See references 4 and 5 for more information. §Physical exam should include abdominal and rectal assessment; it should exclude presence of alarm features, central nervous system disorders, and spinal lesions. Laboratory testing should include a complete blood count if not recently performed, and thyroid-stimulating hormone and serum calcium levels should be measured when clinically indicated. National guidelines should be followed related to screening colonoscopy: the presence of alarm symptoms or a family history of colorectal cancer should prompt earlier intervention.[1] ¶Survey of US adults who meet criteria for IBS, based on responses, who had never sought care for their cardinal symptoms.[9] #Female patients have historically received less attention than male patients, including assessment of physical pain and intensity.[11,12]

ACG = American College of Gastroenterology; AGA = American Gastroenterological Association; CRP = C-reactive protein; GI = gastrointestinal; IBD = inflammatory bowel disease; IBS = irritable bowel syndrome; IBS-C = irritable bowel syndrome with constipation; IBS-D = irritable bowel syndrome with diarrhea; IBS-M = irritable bowel syndrome with mixed bowel habits; IBS-U = irritable bowel syndrome unclassified; QOL = quality of life.

References
1. Lacy BE, et al. *Gastroenterology*. 2016;150:1393-1407. **2.** Drossman DA, Tack J. *Gastroenterology*. 2022;162(3):675-679. **3.** Lacy BE, et al. *Am J Gastroenterol*. 2021;116(1):17-44. **4.** Hung KW, et al. *Gastroenterology*. 2025;168(3):612-622.e4. **5.** Arnold MJ. *Am Fam Physician*. 2023;108(5):527-529. **6.** Black CJ, Ford AC. *Frontline Gastroenterol*. 2020;11(2):140-147. **7.** Goodoory VC, et al. *Aliment Pharmacol Ther*. 2022;56(5):844-856. **8.** Frändemark Å, et al. *BMC Gastroenterol*. 2022;22(1):73. **9.** Almario CV, et al. *Gastroenterology*. 2023;165(6):1475-1487. **10.** Chang L. *Gastroenterology*. 2021;161(4):1092-1098.e3. **11.** Drossman DA, Ruddy J. *Clin Gastroenterol Hepatol*. 2020;18(7):1417-1426. **12.** Zhang L, et al. *J Pain*. 2021;22(9):1048-1059.