IBS Diagnosis

Rome IV IBS Diagnostic Criteria
Recurrent abdominal pain an average of greater than or equal to one day per week in the last three months with symptom onset greater than or equal to six months before diagnosis, meeting two or more of the following:
- Related to defecation.
- Associated with a change in stool frequency.
- Associated with a change in stool form (appearance).

Bristol Stool Form Scale (BSFS)

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shape, but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage, but cracks on the surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blob with clear-cut edges</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces</td>
</tr>
</tbody>
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**IBS Subtypes**

Based on the patient's predominant bowel habits recorded according to the BSFS:

- IBS with predominant constipation (IBS-C): >25% BSFS types 1 and 2 and <25% types 6 and 7.
- IBS with predominant diarrhea (IBS-D): >25% BSFS types 6 and 7 and <25% types 1 and 2.
- IBS with mixed bowel habits (IBS-M): >25% BSFS types 1, 2, 6 and 7.
- Unclassified IBS (IBS-U): no type >25%.

**Positive Diagnostic Strategy**

No laboratory test can diagnose IBS. However, limited laboratory testing can assist in making a diagnosis of IBS.

- Complete blood count (all patients).
- Fecal calprotectin or fecal lactoferrin (patients with diarrhea).
- C-reactive protein (patients with diarrhea).
- Serologic testing for celiac disease (patients with diarrhea).
  - Immunoglobulin A (IgA) total and tissue transglutaminase IgA have the highest sensitivity, specificity and cost-effectiveness.
  - If IgA deficient, test deaminated gliadin immunoglobulin G (IgG).

**Summary of Positive Diagnostic Strategy for IBS**

Adapted from Chang L. Gastroenterology. 2021;161:1092-1093

Additional testing may be needed in patients with alarm features:

- Acute symptom development.
- Fever.
- Onset age older than 50 years.
- Rectal bleeding or melena.
- Nocturnal diarrhea.
- Progressive abdominal pain.
- Unexplained weight loss.
- Laboratory abnormalities (e.g., iron deficiency anemia).
- Family history of inflammatory bowel disease (IBD), celiac disease or colorectal cancer.

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Helping Patients Navigate the IBS Journey

First-Line IBS Treatments by Predominant Symptom
(NOT AN ALL-INCLUSIVE LIST)

Global IBS symptoms (e.g., pain or discomfort, bloating, distress):
• Low FODMAP or NICE diet trial for pain and diarrhea.
• Physical activities, such as yoga.
• Neuromodulators, such as tricyclic antidepressants, for pain.
• Gut-directed psychotherapies, including cognitive behavioral therapy and gut-directed hypnotherapy, for cognitive-affective states.

<table>
<thead>
<tr>
<th>IBS-C</th>
<th>IBS-D</th>
<th>IBS-M/IBS-U</th>
</tr>
</thead>
</table>
| • Lubiprostone.  
• Linaclotide  
• Plecanatide. | • Eluxadoline.  
• Rifaximin. | • Treat predominant symptom(s). |

DIAGNOSIS
50%-75%
Proportion of people with IBS symptoms who do not seek medical care.

Four years
Average time to IBS diagnosis.

TREATMENT
15%
Proportion of patients who have received prescription medications for IBS.

50%-68%
Proportion of patients using over the counter and prescription medications against guideline recommendations.

REFERRAL
~50%-70%
Proportion of patients with IBS-C or IBS-D who may not respond to first-line prescription treatment.

• Develop a strong relationship with patients.
• Proactively ask patients about bowel issues, including changes in bowel habits and duration.

Use positive diagnostic strategy to make diagnosis of IBS.

Many new and effective drugs are available for the management of IBS — review recent guidelines and the chart below for first-line treatment recommendations.*

Familiarize yourself with guideline recommendations for subtype-specific IBS treatments.

• Facilitate relationships with local gastrointestinal (GI) specialists.
• Refer patients to academic or tertiary care center for additional treatment.

DIAGNOSIS

TREATMENT

REFERRAL
Clinical Resources for NPs Managing IBS

American Gastroenterological Association (AGA) guidelines

- **Diet for IBS management.**
- **Laboratory evaluation for IBS-D.**
- **Pharmacologic management** (update in progress).

American College of Gastroenterology (ACG) guidelines

- **IBS Management.**