IRRITABLE BOWEL SYNDROME (IBS) DIAGNOSTIC PATHWAY[1-6]

Recurrent abdominal pain associated with altered bowel movements

Elicit detailed history of symptoms, conduct abdominal/rectal exam, and order appropriate laboratory tests

(See section A on reverse for more information on patient assessment)

Are any alarm features present?

- Patient age >50 years
- Blood in stool
- Anemia
- Fever
- Unintentional weight loss
- Family history of inflammatory bowel disease, celiac disease, or colon cancer
- Nocturnal diarrhea
- Recent antibiotic use
- Travel history to regions with recognized diarrhea-related pathogens
- Abdominal mass or evidence of defecatory disorder

NO

Does the patient meet Rome IV diagnostic criteria?

Recurrent abdominal pain ≥1 day per week, on average, associated with 2 or more of the following: (1) defecation; (2) a change in stool frequency; (3) a change in stool form

NO

YES

Criteria fulfilled for the last 3 months with symptom onset at least 6 months ago

NO

YES

Affirmative IBS diagnosis

Evaluate stool consistency using the Bristol Stool Form Scale for IBS subtyping*

(See section C on reverse for more information on IBS subtyping)

YES

Consider alternative diagnoses

Perform additional investigations, as required

(See section B on reverse for more information on additional tests and differential diagnoses)

IBS-Constipation (IBS-C)
Hard/lumpy stools >25%

IBS-Mixed (IBS-M)
Mixed-stool pattern

IBS-Diarrhea (IBS-D)
Loose/watery stools >25%

The Rome Foundation suggests for clinical practice, a diagnosis may be made with a lower symptom frequency and a shorter duration (8 weeks or more) than those required above, provided that symptoms are bothersome for the patient (i.e., interfering with daily activities/quality of life) and there is clinical confidence that other diagnoses have been sufficiently ruled out.[7]

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*Patients who meet the diagnostic criteria for IBS but whose bowel habits cannot be accurately categorized into one of these three groups should be categorized as IBS-Unclassified. Adapted with permission from © 2006 Rome Foundation. This diagnostic pathway is provided as a reference tool only and is not a substitute for clinical judgment. Each healthcare provider is solely responsible for any decisions made or actions taken in reliance of this information.

IRRITABLE BOWEL SYNDROME (IBS) DIAGNOSTIC PATHWAY[1-6]

A PATIENT ASSESSMENT

PATIENT HISTORY

Symptom history

- Predominant or most bothersome symptom(s) (e.g., diarrhea, pain, bloating)
- Symptom triggers (e.g., relationship to food, stress, physical activity)
- Dietary habits (e.g., intake of caffeine, sodas, poorly absorbed carbohydrates)
- Impact of symptoms on daily quality of life

Comorbidity

- Other medical conditions (e.g., diabetes, lupus)
- Other gastrointestinal (GI) disorders (e.g., dyspepsia, GERD)
- Other functional non-GI disorders (e.g., fibromyalgia)
- Psychiatric comorbidity

Previous investigations and treatments

- Prior GI-related investigations and results
- Prior interventions, or medications (over-the-counter or prescription) used and responses

Personal history and expectations

- Prior abuse history/psychological distress
- Patient's goals and expectations

PHYSICAL EXAM

- Generally normal in patients with IBS
- Rectal exam may elicit co-existing defecatory disorder
- Pelvic exam important if co-existing pelvic pain

B ADDITIONAL TESTS AND DIFFERENTIAL DIAGNOSES

DIAGNOSTIC TESTS FOR IBS

- If not previously performed, complete blood count should be considered
- Celiac serology, C-reactive protein, and fecal calprotectin may be considered, particularly for patients with symptoms of IBS-D or IBS-M
- In the absence of alarm features, additional tests are NOT required to make an affirmative IBS diagnosis
- The symptom-based Rome diagnostic criteria have a 98% positive predictive value for IBS

DIFFERENTIAL DIAGNOSES

In patients with alarm features, or patients who do not meet diagnostic criteria for IBS, further investigation of the following may be warranted:

- Abdominal wall pain
- Bile acid malabsorption
- Celiac disease
- Colon cancer
- Defecatory disorder
- Dyspepsia
- Endometriosis
- Inflammatory bowel disease
- Microscopic colitis
- Narcotic bowel syndrome
- Small intestinal bacterial overgrowth

C BRISTOL STOOL FORM SCALE FOR IBS SUBTYPING*

IBS subtypes are based on the predominant stool form on days with at least one abnormal bowel movement. Threshold for classification of IBS subtypes based on proportion of abnormal bowel movements.

1	2	3	4	5	6	7
						
Separate hard lumps, like nuts.	Sausage-shaped but lumpy.	Like a sausage or snake but with cracks on the surface.	Like a sausage or snake, smooth and soft.	Soft blobs with clear-cut edges.	Fluffy pieces with ragged edges, a mushy stool.	Watery, no solid pieces.

Hard/lumpy stools

IBS-C	>25%
IBS-D	<25%
IBS-M	25–75%

Normal consistency stools

Loose/watery stools

IBS-C	<25%
IBS-D	>25%
IBS-M	25–75%

References: 1. Lacy BE et al. *Gastroenterology.* 2016;150(6):1393-1407. doi:10.1053/j.gastro.2016.02.031 **2.** Lacy BE et al. *Am J Gastroenterol.* 2021;116(1):17-44. doi:10.14309/ajg.0000000000001036 **3.** Lacy BE. *Int J Gen Med.* 2016;9:7-17. doi:10.2147/IJGM.S93698 **4.** Black CJ. *Aliment Pharmacol Ther.* 2021;54(suppl 1):S33–S43. doi:10.1111/apt.16597 **5.** Farmer AD et al. *CMAJ.* 2020;192:E275-E282. doi:10.1503/cmaj.190716 **6.** Moayyedi P et al. *United European Gastroenterol J.* 2017;5(6):773-788. doi:10.1177/2050640617731968 **7.** Drossman DA et al. *Gastroenterology.* 2022;162(3):675-679. doi:10.1053/j.gastro.2021.11.019

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