# 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 Family history of inflammatory · Travel history to regions with bowel disease, celiac disease, recognized diarrhea-related · Blood in stool or colon cancer pathogens Anemia · Nocturnal diarrhea · Abdominal mass or evidence Fever of defecatory disorder · Recent antibiotic use · Unintentional weight loss NO YES DOES THE PATIENT MEET ROME IV DIAGNOSTIC CRITERIA? CONSIDER ALTERNATIVE DIAGNOSES Recurrent abdominal pain ≥1 day per week, on average, Perform additional investigations, as required NO associated with 2 or more of the following: (1) defecation; (See section B on reverse for more information on (2) a change in stool frequency; (3) a change in stool form additional tests and differential diagnoses) NO Criteria fulfilled for the last 3 months with symptom onset at least 6 months ago YES **IBS-Constipation (IBS-C)** AFFIRMATIVE IBS DIAGNOSIS Hard/lumpy stools >25% Evaluate stool consistency using the IBS-Mixed (IBS-M) **Bristol Stool Form Scale for IBS subtyping\*** Mixed-stool pattern

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.<sup>7</sup>

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

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

<sup>\*</sup> 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.

## 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 affirmartive IBS diagnosis
- The symptom-based Rome diagnostic criteria have a 98% positive predictive value for IBS

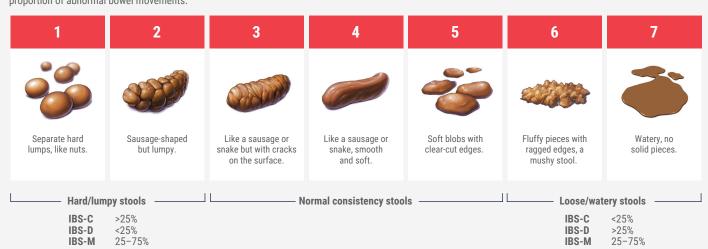
#### **DIFFERENTIAL DIAGNOSES**

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

# **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.



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.000000000001036 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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