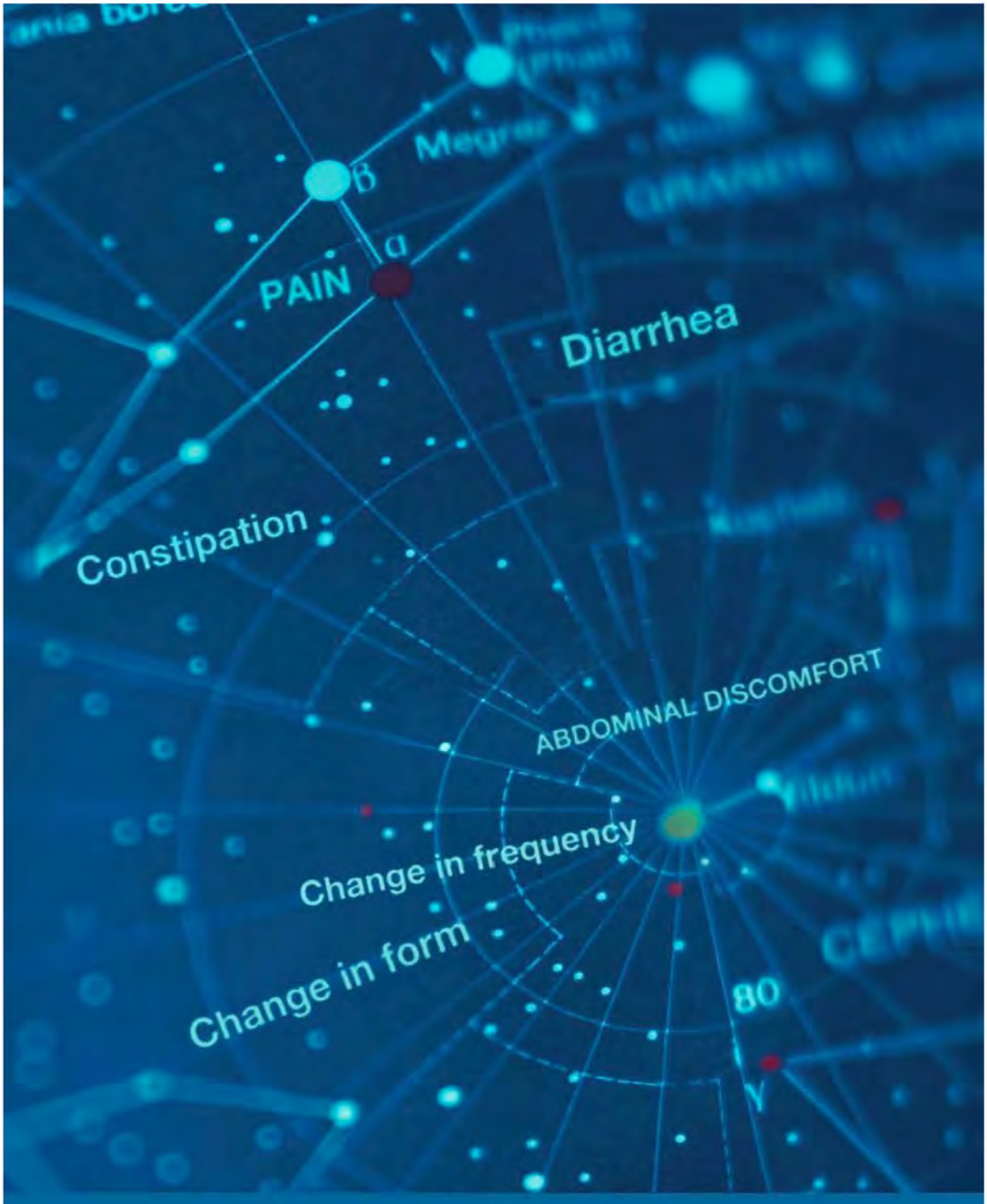

Reporter's Guide to Irritable Bowel Syndrome
Second Edition

With 2016 Rome IV Addendum

Constellation of Symptoms

IBS affects tens of millions of Americans and is characterized by a constellation of symptoms that are often painful and can significantly disrupt a person's quality of life.

iffgd

Dear Reporter:

The International Foundation for Functional Gastrointestinal Disorders (IFFGD) is pleased to provide you with the Second Edition of the *Reporter's Guide to Irritable Bowel Syndrome,* your resource on Irritable Bowel Syndrome (IBS). I founded IFFGD in 1991 with a mission to educate, raise awareness and improve care for conditions ranging from IBS to gastroesophageal reflux disease (GERD).

While the debilitating effects of IBS are increasingly being reported in the news, there is still a need to further educate both those who suffer from IBS and the general public. The *Reporter's Guide to Irritable Bowel Syndrome* is designed to provide you with accurate information about IBS and help you cover the condition.

In this guide you will find:

- Background information about IBS
- Other Resources
- Frequently asked questions
- A glossary of medical terms
- Suggested story angles and reasons for writing about IBS

In addition to referring to this informative guide, I also encourage you to suggest that your readers visit IFFGD's website at **www.aboutibs.org** if they want to learn more about IBS, its symptoms and when to seek medical care.

IFFGD is dedicated to informing, assisting, and supporting people affected by gastrointestinal disorders. We have been working since 1991 to broaden understanding about gastrointestinal disorders and support research.

IFFGD welcomes your inquiries, and we look forward to working with you as we continue to shed more light on IBS.

Sincerely,

Nancy J. Norton
President and Founder
IFFGD
December 2015

IBS: A BACKGROUND GUIDE

INTRODUCTION

It may come as a surprise to you, since it's often regarded as a trivial condition, but irritable bowel syndrome (IBS) is one of the most burdensome chronic ailments being reported by patients in the United States today.

Patients with IBS visit the doctor more frequently, use more diagnostic tests, consume more medications, miss more workdays, have lower work productivity, are hospitalized more frequently, and consume more overall direct costs than those without IBS.[1]

IBS is thought to afflict an estimated 10 to 15 percent of Americans.[2] Although only less than half of people with IBS seek healthcare,[3] it is a common diagnosis.

There are between 2.4 and 3.5 million physician visits annually for IBS in the U.S.[4] While the majority of patients are thought to be seen first by primary care providers,[5] IBS accounts for an estimated 36 percent of patients seen in gastroenterology practices.[4]

Obsolete references to IBS include "spastic colon," "mucous colitis," "spastic colitis," "nervous stomach," or "irritable colon."

The illness affects both men and women. In the United States and Canada women comprise about 60–65 percent of diagnosed sufferers and men 35–40 percent.[6] Onset can begin anytime from adolescence to adulthood, with most sufferers under the age of 50.[1]

IBS can cause those who have it a world of suffering and expense, and severely limit their quality of life. People being treated for IBS have lower measures of physical, social, and emotional wellbeing than population norms and those with other chronic illnesses.[7,8]

"When someone who doesn't have IBS gets a gastrointestinal infection, it can be quite disabling and routine daily activities often slow down or stop,'' said Douglas A. Drossman, MD, Drossman Gastroenterology, Chapel Hill, NC. "Try thinking about that happening every day or several times a week; that's what IBS is – a condition that affects your life on a daily basis."

In a survey, conducted in 2007 by IFFGD in collaboration with the University of North Carolina in Chapel Hill, more than 40 percent of those with IBS said they feel that they are losing a great deal or quite a bit of control over their lives due to their IBS.[9] Four out of 5 reported pain as the most frequent factor contributing to severity of their IBS. Of those reporting pain, one-fourth describe the pain as constant. Severity is an issue that clearly impacts people's lives, with social limitations, the inability to leave home, and work and school limitations reported by over half as major factors.

The causes of this most challenging gastrointestinal disorder are obscure. Symptoms appear to result from a disturbance in the interaction between the gut, brain, and nervous system that alters the regulation of bowel motor or sensory function.

IBS patients reported restricting activities on average 20% of days (73) in a year.[9]

IBS is common and people may sometimes have another coexisting disorder that, while not responsible for their IBS symptoms, can make their IBS symptoms feel worse. Doctors can help sort this out.

Better awareness of IBS is needed to inform the millions of undiagnosed people about treatments that can improve their quality of life. Sufficient research dollars must be allocated so investigators can uncover the cause of this disorder, and develop additional treatments.

WHAT IS IBS?

Irritable bowel syndrome is a long-term (chronic) or recurrent disorder of gastrointestinal (GI) functioning where abdominal discomfort and/or change in bowel habit results from increased response of the intestines to a variety of influences like dietary factors, infection, or stress. Typically, the symptoms include intermittent abdominal pain accompanied by diarrhea, constipation, or alternating episodes of each. Other symptoms such as bloating may also be present.

HOW DOES IBS OCCUR?

While the exact cause of IBS is unknown, many experts believe it stems in part from abnormalities in gut (intestinal/bowel) motility, sensation, and secretion. These activities are regulated by the brain, and these brain-gut interactions may also be impaired.

But while most IBS patients exhibit one or more of these abnormalities, they do not explain all of the symptoms of IBS. Altered gut immune activation, intestinal permeability, and altered gut bacteria have also been identified in some IBS patients.[6]

Because a clear structural cause has not been found, some have erroneously speculated that IBS may be emotional or psychological in nature, but studies have shown that psychiatric disorders do not cause IBS.

Although IBS is now a medically recognized disorder, the causes are just not seen through routine blood tests, x-rays or endoscopy; rather a diagnosis is made using well accepted diagnostic criteria.

SYMPTOMS

The main symptom of IBS is abdominal pain or discomfort. In addition, the typical IBS patient will experience a change in stool frequency and/or form – diarrhea, constipation, or an alternation between these states.

Other common symptoms include bloating, gas, passage of mucus, straining, urgency, or a feeling of incomplete evacuation.

Patients are subdivided into IBS types, which are based on their principal stool form. These include diarrhea predominant IBS (IBS-D), constipation predominant IBS (IBS-C), and mixed IBS (IBS-M) where stool form fluctuates.

Those symptomatic of IBS experience constellations of several symptoms. The most frequently reported factors contributing to the severity of their IBS were pain (80%), bowel difficulties (74%), and bloating (69%).[9]

Symptoms can begin to occur anytime during adolescence or adulthood. One day, out of the blue, a person will begin to feel abdominal pain and an associated change in their bowel habit, or it may develop after a gastrointestinal infection (gastroenteritis). In some cases it develops gradually over many years.

Symptoms can range from a mild nuisance to debilitating pain and bowel urgency. Imagine having symptoms similar to stomach flu on a chronic basis – abdominal pain, diarrhea, constipation, gas, or bloating that wax and wane but never permanently go away.

The flare-ups are often unpredictable, and those with moderate to severe symptoms may find themselves planning their lives around where the next bathroom is, just in case they need it.

Many times this "bathroom mapping" is an attempt to avoid an aspect of the disorder that is rarely talked about, bowel incontinence, or accidental bowel leakage, which can be socially and emotionally devastating.

IBS is not life-threatening, but it may have a severe impact on quality of life. Nevertheless, while currently there is no cure, symptoms often can be reduced and managed with lifestyle changes, medications, non-medication therapies, or combinations of approaches.

DIAGNOSIS

A physician can generally diagnose IBS by:

- Recognizing certain symptom details
- Performing a physical examination
- Undertaking limited diagnostic testing

Characteristic symptoms include abdominal pain or discomfort for several months that is associated with at least two of the following symptoms: it improves with defecation, it is associated with a change in stool frequency, and/or it is associated with change in form – chronic or recurrent diarrhea, constipation or both in alternation.[10] The symptoms can occur over a single long period or in several shorter bouts.

Medical opinion has changed regarding how to diagnose IBS. The older view emphasized that IBS should be regarded primarily as a "diagnosis of exclusion." Diagnosis was made only after diagnostic testing, often extensive, to exclude many disorders that could possibly cause the symptoms.

The newer approach bases diagnosis on defined patterns of signs and symptoms typical of IBS, revealed through a history and physical examination, and limited diagnostic testing. IBS is a condition with well-defined clinical features, and specific diagnostic criteria. This understanding can reduce unneeded testing.

There is no test for IBS. Laboratory blood and stool tests, x-rays, and endoscopic procedures, such as colonoscopy, may be performed fitting to the patient's symptoms, age, and overall health status. These tests are usually normal, showing that no other condition is present.

In fact, the absence of certain "red flag" (Table 1) signs that are not characteristic of IBS, such as blood in the stool or fever, provides confidence that diagnostic testing to rule out other conditions is not needed.

Typical "red flag" signs that call for special attention:

- New symptom onset at age of 50 or older
- Anemia and other abnormal blood tests
- Blood in the stools
- Fever
- Nighttime symptoms that awaken the person
- Unintentional weight loss
- Change in the individual's typical IBS symptoms (like new and different pain)
- Recent use of antibiotics
- Family history of other GI diseases, like cancer, inflammatory bowel disease, or celiac disease

Table 1

The "Rome Criteria" (Table 2) are accepted as the current standard method for characterizing IBS symptoms. These are a collection of the most common symptoms that typify the disorder established by leading gastroenterologists from around the world at a series of meetings that began in Rome in 1988. The criteria are periodically reviewed and revised as new scientific data accumulates.

Despite these defined criteria, those with IBS report that it takes more than 6 years from onset to diagnosis, and say they consulted with more than 4 different physicians or health care providers in their lifetime about their IBS.[9]

The key to achieving relief for IBS is for people to embrace the understanding that IBS is a complex motility (motor) and sensory disorder. It may have physical and stress-related dimensions. A strong partnership between a knowledgeable patient and an empathetic, knowledgeable health care provider can produce significant improvement and control over symptoms for individuals with IBS.

Rome Criteria[11]

Symptom criteria*, as defined by the Rome III committees in 2006, are as follows (in the absence of structural or metabolic abnormalities to explain the symptoms):

Recurrent abdominal pain or discomfort** at least 3 days per month in the last 3 months associated with two or more of the following:

1. Improvement with defecation
2. Onset of pain associated with a change in frequency of stool (that is more or less frequent, often greater than three bowel movements per day or fewer than three bowel movements per week
3. Onset pain associated with a change in form (appearance) of stool (such as becoming lumpy/hard or loose/watery stool)

* Criterion fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.
** "Discomfort" means an uncomfortable sensation not described as pain.

Symptoms supportive of the diagnosis of IBS include:

- Abnormal stool passage (straining, urgency, or feeling of incomplete evacuation)
- Passage of mucus
- Bloating

Table 2

TREATMENT

All treatment should begin with an accurate diagnosis, which helps assure appropriate treatment, and minimizes unnecessary risk and expense from unneeded tests.

Next, the physician should validate and explain the patient's very real illness, even in the absence of objective physical findings. With this understanding the physician and patient establish an effective relationship through which they attempt to manage symptoms over time.

> "Good communication between the doctor and the patient is an essential part of care for people with symptoms of IBS. Most of the relevant information that is used to make a diagnosis is gathered by health care providers while talking with and listening to their patients. Also, effective communication during the course of care has been shown to significantly increase patient satisfaction, symptom improvement, daily function, and quality of life for patients."
>
> – Douglas A. Drossman, MD

General measures such as obtaining education about IBS, and identifying factors that trigger or worsen symptoms, such as certain foods or stress, are important starting points to help control IBS symptoms.

Because the exact cause of IBS is not fully understood, there is no cure as of yet. Treatments are aimed at alleviating symptoms.

Treatment may begin with implementing lifestyle changes, which may be associated with symptoms. Medications that regulate bowel function or relax intestinal spasm may be helpful.

In people with more severe symptoms other approaches such as relaxation techniques, biofeedback therapy, gut-directed hypnosis, and cognitive behavioral therapy can help ease symptoms and restore a sense of control over the disorder. Sometimes low dose antidepressants are used to decrease intestinal hypersensitivity and to help the brain control the pain better.

Many with the disease have relatively mild symptoms that can be sufficiently treated with diet and lifestyle changes. Others may need to take medications.

Medications currently approved for IBS may work for some, but not all patients. And they are meant to be used in conjunction with other treatment approaches.

Experts suggest patients work closely with their doctors to learn as much as possible about IBS and to seek to find out what triggers their symptoms and what, if anything, works to alleviate them.

Treatment and management approaches vary depending on the severity of the IBS in the individual. Unlike many diseases where severity can be measured by abnormality in blood or tissue markers, severity in IBS is determined by symptom reports and patient experiences.

Thus, severity is defined by a composite of not only reported physical symptoms, but also the related degree of disability and limitations on activities. Among patients about 40 percent have mild IBS, 35 percent moderate IBS, and 25 percent have severe IBS.[12]

In **mild IBS,** symptoms occur infrequently and only occasionally interfere with normal daily functioning. Many of these patients may be helped with the adoption of lifestyle changes, including dietary changes, such as eliminating the consumption of foods that seem to trigger symptoms.

Meals that are too large or high in fat, caffeine, or alcohol may provoke symptoms. Poorly absorbable, highly gas-forming carbohydrates found in certain fruits, vegetables, and sweeteners are associated with increased symptoms in people with IBS and improvement can occur by reducing these types of foods (also called a low FODMAP diet)

When dietary factors appear to influence symptoms, guidance needs to be provided by a knowledgeable health care professional (like a physician or registered dietitian) who can assess individual circumstances while helping make sure that nutritional needs are being met through a balanced diet and healthy eating habits.

Complimentary or Alternative Medicine (CAM) Therapies

If conventional medical therapies prove unsuccessful or have unwanted side effects, many people choose to pursue complementary or alternative therapies (CAM). These can include herbal therapy, dietary measures, acupuncture, massage, mind-body therapies, and movement or breathing exercises.

When trying a CAM therapy, it is important that patients work together with their CAM practitioner, primary care provider or gastroenterologist to find the appropriate treatment or combination of treatments from the many conventional and complimentary or alternative options available.

In those with **moderate IBS**, symptoms occur more frequently and often interfere with daily activities. These patients, in addition to dietary and lifestyle changes, may want to make use of a daily diary to help identify factors that trigger symptoms. A *Personal Daily Diary* can be obtained by contacting IFFGD. IBS sufferers in this group may benefit from use of medications.

With **severe IBS**, symptoms are frequent and intense and chronically interfere with daily life. Treatment approaches, in addition to those listed above, range from cognitive-behavioral therapy to drug therapy and pain management programs.

Because no one combination of therapies is effective for every person, IFFGD recommends working with a medical professional to tailor an appropriate treatment program.

Medications

While no drug has been proven generally effective for all IBS sufferers, there are times when doctors may prescribe medications for specific indications, such as diarrhea, constipation, cramping, or pain. Newer medications aim at treating multiple symptoms.

Anti-diarrheal agents can prevent or relieve symptoms of diarrhea but are not helpful for pain. Laxatives can help treat constipation but not necessarily pain. Antispasmodics may reduce bowel spasms and relieve abdominal pain or discomfort in some persons, particularly if symptoms occur soon after eating. Antidepressants in low doses may help relieve abdominal pain as well as bowel symptoms.

The effectiveness of various agents differs between individuals and must be carefully chosen by the physician and patient. Many patients are on combinations of therapies.

Newer Medications

There are currently several prescription drugs FDA approved to treat the multiple symptoms of IBS, including pain.

The drugs approved to treat IBS-D include alosetron (Lotronex), rifaximin (Xifaxan), and eluxadoline (Viberzi).

Alosetron was first FDA approved in 2000. It blocks serotonin signals that transmit sensory information from the gut to the brain and helps to reduce diarrhea and abdominal pain. Alosetron is prescribed for the treatment of women diagnosed with severe diarrhea-predominant IBS. The drug was voluntarily withdrawn in 2000 and reintroduced in the U.S. under a Risk Management plan to reduce potential serious outcomes of an adverse event.

Rifaximin (Xifaxan) and eluxadoline (Viberzi) were both FDA approved in 2015 to treat IBS-D in adult women and men.

Rifaximin is an antibiotic, which is only slightly absorbed in the gut, used to help improve pain and stool consistency.

Eluxadoline reduces bowel contractions by modifying mixed opioid receptor activities. It helps to reduce abdominal pain and improve stool consistency. It received FDA approval with the recommendation that it be classified as a controlled substance.

Drugs approved to treat IBS-C include lubiprostone (Amitiza) and linaclotide (Linzess).

Lubiprostone was FDA approved in 2008 as a treatment for adult women. It helps improve pain and stool consistency by promoting secretion through chloride channels in the bowel which in turn promotes peristalsis, increasing the amount of fluid that flows into the bowel and allowing the stool to pass more easily.

Linaclotide, in a class of medications called guanylate cyclase-C agonists, was FDA approved in 2012 as a treatment for adult women and men with IBS-C. It works by increasing the movement of contents through the GI tract and by blocking pain signals in the intestines.

An earlier drug for IBS-C treatment, tegaserod (Zelnorm), was voluntarily pulled from the market in 2008 due to safety concerns. It is only available in the U.S. for emergency use under a policy regulated by the FDA.

Disclaimer: IFFGD does not support or endorse specific treatment options.

COST IN DOLLARS AND QUALITY OF LIFE

The cost of IBS is high. Direct costs of IBS have been estimated to be approximately $1.5 billion and as high as $10 billion adjusted costs (excluding the costs of prescription and over-the-counter drugs). Patients with IBS are reported to annually account for up to 3.65 million physician visits.[13,14]

Misdiagnosis, under-recognition by patients and physicians leading to multiple physician visits, multiple medications, and unnecessary diagnostic tests, procedures, and surgeries all contribute to higher direct medical costs.[14]

Indirect costs, including work absenteeism and presenteeism (i.e., decreased work productivity), of IBS have been estimated as high as $20 billion annually based only on IBS patients who sought medical attention.[14] In one study, over 2,000 patients with IBS in the U.S. and 8 European countries reported missing an average of 4 to 11 days of work during the previous year compared with 1.5 to 6 days reported by control

subjects.[13] Another survey of 5,430 U.S. households found that illness caused the average IBS patient to miss 13 days per year from work or school compared to 5 days per year by those without a GI disorder.[15]

SUMMARY

IBS is very common: 10 to 15 percent of Americans are estimated to have IBS. The condition stems from an apparent disturbance in the interaction between the gut, the brain, and the nervous system that regulates the digestive tract.

Because the cause is not easy to understand, some have dismissed the illness as being psychosomatic in nature. But experts have dismissed the idea that IBS is all in the heads of sufferers. Leaders in the field now agree IBS is very real and have come up with a concrete way to diagnose it, based on symptom patterns.

Treating IBS requires effective communication between patients and clinicians. Patients benefit from education about the disorder. A strong partnership between a knowledgeable patient and an empathetic, knowledgeable health care provider can produce significant improvement and control over symptoms for individuals with IBS.

IBS causes sufferers to lose time at work and gets in the way of the leisure-time activities they enjoy. The cost of caring for these patients has been pegged at $21.5 billion per year. Although there is no cure as of yet, many patients are helped by diet and lifestyle changes and relaxation techniques. For some, a handful of drugs have proven useful.

There are other medications in development, but more research is needed. With 10 to 15 percent of Americans suffering from IBS, the development of effective new treatment options could have a profound impact of the quality of life of millions of people.

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FREQUENTLY ASKED QUESTIONS

What is IBS?

IBS is best understood as a long-term or recurrent disorder of gastrointestinal functioning where the intestines are overly sensitive to factors that normally affect the gut such as diet, hormonal factors, activity and stress. It usually involves the large intestine (colon) and small intestine with disturbances of intestinal/bowel (gut) motor function (motility), sensation, and secretion. These gut related activities are regulated by the brain. This may also be impaired, which is why IBS is often called a brain-gut disorder. These disturbances can produce symptoms of abdominal pain or discomfort, bloating or a sense of gaseousness, and a change in bowel habits (diarrhea and/or constipation).

What causes IBS?

The exact cause of IBS is unknown, but symptoms seem to be related to abnormal GI sensation and motility, which may result from disordered brain-but interactions, genetic factors, infection, and altered bacterial flora. It is likely that multiple factors influence symptoms.

Who is likely to develop IBS?

IBS can afflict anybody, although about two-thirds of those diagnosed are women and one-third are men. Onset can begin anywhere from adolescence to adulthood.

How common is IBS?

IBS affects an estimated 10 to 15 percent of the population, or as many as 40 million Americans.

What is the test for IBS?

There currently is no consistent biological marker of IBS that can be tested to make the diagnosis. Research interest is underway to find a biological marker, or set of markers. They include use of a blood test, stool sample, or tissue sample from the colon. These would enhance the diagnostic accuracy of symptom criteria currently used in making the diagnosis.

How is IBS diagnosed?

Because IBS is a "functional'' gastrointestinal disorder, meaning there is no structural cause to be detected, it is diagnosed based on a detailed medical history, specific constellation of symptoms, and a physical examination. Diagnostic tests may be performed depending on a person's medical history and the presence of signs or symptoms suggestive of another disorder. Tests are usually normal in patients with IBS.

What is the Rome Criteria?

The Rome Criteria is a classification system that applies lists of symptoms and criteria generally agreed upon by experts to diagnosis a functional gastrointestinal disorder, such as IBS. These symptom-based criteria are modified at times as new knowledge comes to light, making diagnosis more precise. The Criteria are determined and published by the nonprofit Rome Foundation (*www.RomeCriteria.org*). The latest revision is known as Rome III; Rome IV will be released in the Spring of 2016.

Why is IBS so challenging to patients and physicians?

Patients with IBS have normal diagnostic tests, which is quite different from other well accepted conditions such as diabetes or peptic ulcers that can be easily detected on tests alone. Symptoms are variable, their onset is often unpredictable, and their course can vary from day to day, month to month and year to year. Unlike conditions with one or two causes, IBS is influenced by multiple factors, making it more difficult to treat.

How is IBS currently treated?

Because there is no cure, IBS is treated by trying to manage symptoms. Patients should work in partnership with their physicians to come up with strategies, which may include diet and lifestyle changes, stress management, behavioral therapy, drug therapy, or pain management.

What is post-infectious irritable bowel syndrome (PI-IBS)?

Unlike inflammatory bowel diseases, such as Crohn's disease or ulcerative colitis, in IBS there is usually no obvious infection or inflammation seen by colonoscopy or x-ray. However, microscopic changes may exist. In post-infectious IBS, individuals who had no previous IBS symptoms develop them after a GI infection even after the infection has cleared. In these cases there may be microscopic signs of changes in the immune cells of the colonic lining. Experiencing severe stress at the time of the GI infection increases the risk of PI-IBS.

What is the relationship of stress to IBS?

Stress can be understood as anything that can stimulate the GI tract, including diet, hormonal changes, physical activity, and psychological stress. Stress is defined as a perceived or actual disturbance in the balance between mind, brain, and body. It can occur with or without conscious feelings of anxiety, distress, or anger. There are various types of stressors, which may impact IBS symptoms. Heightened sensitivity of the bowel in IBS can be in response to internal and external stressors. When stress is a factor, patients should work with their health care providers in developing a management plan to address it in order to decrease symptoms and improve overall quality of life.

Is there an increased risk for developing IBS in war veterans?

IBS and other functional GI disorders disproportionately impact veterans and active duty military personnel. Soldiers deployed to combat areas face a heightened chance of developing IBS due to their exposure to risk factors such as GI infections and severe stress. For this reason, the Department of Veterans Affairs (VA) has put in place a "presumptive service connection" rule regarding applications for disability benefits for veterans affected by functional GI disorders who served in Southwest Asia during the Persian Gulf War.

Is IBS a psychological disorder?

No – IBS is not a psychological condition. In all persons psychological stress can affect physical symptoms. Likewise, among people with IBS stress often affects gastrointestinal symptoms and the reaction to them. Additionally, having the disorder can itself cause psychological distress. Therefore, if any ongoing psychological disturbance is present, it makes sense to seek help and bring it under control.

GLOSSARY OF TERMS

BOWEL: Intestines or gut.

COLITIS: Inflammation of the colon. This is not IBS

COLON: The large intestine.

COLONOSCOPY: Examination of the interior of the colon using a flexible viewing instrument.

COMPLIMENTARY OR ALTERNATIVE MEDICINE (CAM):
Complementary medicine refers to therapies that are done *in addition to* conventional, or mainstream, medical treatments; alternative therapies are done *instead of* conventional medical treatments.

CONSTIPATION: Reduced stool frequency, or hard stools, difficulty passing stools, or painful bowel movements.

CROHN'S DISEASE: A chronic form of inflammatory bowel disease.

DIARRHEA: Passing frequent and loose stools that can be watery. Acute diarrhea goes away in a few weeks, and becomes chronic when it lasts longer than four weeks.

DIGESTIVE TRACT: A group of hollow organs that forms a long, twisting tube extending from the mouth to the anus through which food is ingested, digested and expelled.

FUNCTIONAL GASTROINTESTINAL DISORDER: A variable combination of chronic or recurrent gastrointestinal symptoms not explained by structural or biochemical abnormalities.

GASTROINTESTINAL: Relating to the stomach and intestines.

GUT: Intestines.

INFLAMMATORY BOWEL DISEASE (IBD): Long-lasting problems that cause inflammation and ulcers in the gastrointestinal tract. The most common disorders are ulcerative colitis and Crohn's disease.

INTESTINES: Also known as the gut or bowels, is the long, tube-like organ in the human body that completes digestion or the breaking down of food. Consists of the small intestine and the large intestine.

IRRITABLE BOWEL SYNDROME (IBS): A functional bowel disorder in which abdominal discomfort or pain is associated with a range of symptoms. Typically these include intermittent abdominal pain accompanied by diarrhea, constipation, or alternating episodes of both.

MOTILITY: Ability of the digestive tract to propel its contents.

PEPTIC ULCER DISEASE: The presence of raw, crater-like breaks in the mucosal lining of the stomach or duodenum.

ROME CRITERIA: Criteria generally agreed upon by experts to diagnose IBS.

STRESS: The neurophysiological and subjective response to stimuli.

SYNDROME: A set of symptoms or conditions that occur together and suggest the presence of a certain disease or an increased chance of developing the disease.

STORY ANGLES

A Common but Misunderstood Health Condition

Many persons still believe that IBS is a psychological condition that is "all in the heads" of sufferers, even though leading researchers say that is not the case. The lack of a visible marker for the disorder is puzzling and challenging to patients and physicians alike.

Post-infectious IBS

It is becoming clear that a significant number of people develop IBS after an acute bout of a GI infection. What are the risks and how can they be reduced?

IBS: Affects Men, Too

About two-thirds of IBS sufferers are women. Studies reveal that men comprise about one-third of sufferers. It is incorrect to characterize IBS as a "woman's disease."

IBS: Researching the Brain-Gut Connection

Although IBS is characterized by symptoms including abdominal pain and altered bowel habits, scientists are focusing on much more than simply controlling diarrhea and constipation. They are looking at the brain and how its interaction with the gut is causing these symptoms to manifest themselves.

Good and Bad Gut Bacteria

We know that the right balance of gut flora is important to digestive health. What can change the balance causing illness? Is there a benefit from "good" bacteria?

Alternative Treatments for IBS

While approved drugs to treat IBS symptoms are few at present, alternative therapies including lifestyle changes, hypnosis, meditation, and stress management can help some people.

Awareness may Avoid Surgical Risks

Surgery is not a treatment for IBS. Yet patients with IBS have significantly higher rates of abdominal and pelvic floor surgery. Thus, they are exposed to increased risks, including morbidity and mortality associated with anesthesia and surgery, worsening of IBS symptoms due to surgery, and an increased economic burden. Better awareness of the symptoms, diagnosis, and appropriate treatments of IBS will eliminate these risks.

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IFFGD is a nonprofit education and research organization whose mission is to inform, assist and support people affected by gastrointestinal disorders.

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ADDENDUM[1] REPORTER'S GUIDE TO IRRITABLE BOWEL SYNDROME 2ND EDITION

ROME IV

November 2016

In 2016 the Rome Foundation published *Rome IV: Functional Gastrointestinal Disorders; Disorders of Gut-Brain Interaction*, the fourth edition of their diagnostic criteria for functional digestive conditions.

Rome IV defines IBS as a functional bowel disorder in which recurrent abdominal pain is associated with defecation or a change in bowel habits. Disordered bowel habits are typically present (constipation, diarrhea, or a mix of constipation and diarrhea. Symptoms of abdominal bloating or distension also may be present.

Clinicians are encouraged in Rome IV to make a positive diagnosis of IBS based on symptoms, emphasizing that IBS is not a diagnosis of exclusion.

Rome IV recommends the diagnosis of IBS should be made based on 4 key aspects: clinical history; physical examination; minimal laboratory tests; and colonoscopy or other appropriate tests (when clinically indicated).

> The goal of diagnostic criteria is to provide a readily useable framework that can be easily applied, recognizing that no single test, and no single definition, is perfect. For example, limited testing may be required to distinguish some organic bowel disease having symptoms that can mimic IBS. However, for the majority of patients, when diagnostic criteria for IBS are fulfilled and alarm features are absent, the need for diagnostic tests should be minimal.
>
> – Rome IV

Rome IV Diagnostic Criteria* for Irritable Bowel Syndrome

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

1. Related to defecation
2. Associated with a change in frequency of stool
3. Associated with a change in form (appearance) of stool

* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.

Reference

1. Mearin F, Lacy BE, et al. Bowel disorders. *Rome IV: Functional Gastrointestinal Disorders; Disorders of Gut-Brain Interaction*, Fourth Edition, Volume II. Edited by Douglas A. Drossman, M.D., (senior editor), Raleigh, NC, The Rome Foundation, 2016.