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WORKING TEAM REPORT*

Irritable Bowel Syndrome: Guidelines for the Diagnosis

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A functional gastrointestinal disorder may be defined as a variable combination of chronic or recurrent gastrointestinal symptoms not explained by structural or biochemical abnormalities. The IBS is a functional gastrointestinal disorder attributed to the intestines: with symptoms of abdominal pain; disturbed defaecation [urgency, straining, feeling of incomplete evacuation, altered stool form (consistency) and altered stool frequency/timing]; and bloatedness (distension). Functional gastrointestinal symptoms are prevalent in Western society, and cultural and psychological factors are important in determining the sub-group who seek medical attention. Our report sets out guidelines for the diagnosis of the IBS. We emphasise the importance of a careful history and a positive diagnosis, since there are no diagnostic physical findings and no diagnostic tests. It is a relapsing disorder troubling people over many years, yet there is no evidence that life expectancy is altered by the IBS. An initial positive diagnosis is a safe one and seldom needs revision. A change in the clinical picture may imply superimposition of another disorder. Given the prevalence of IBS, the disorder will often co-exist with asymptomatic organic diseases (e.g. gallstones).

INDEX TERMS: Irritable Bowel, Functional Bowel Disease, Positive Diagnosis, Diagnostic Guidelines, IBS Guidelines.

In October 1986, the organisers of the XIII International Congress of Gastroenterology established a working team, consisting of the authors, to develop guidelines for the diagnosis of the irritable bowel syndrome (IBS), for presentation in Rome in 1988. Because the IBS is very common, and often prompts many tests to exclude other diseases, the organising committee recognised that a diagnostic protocol for IBS would be welcomed by practising doctors.

The working team corresponded for the first year, and met in Rome in November 1987 to prepare the first draft of the guidelines. This draft was sent to 16 colleagues (from seven countries) noted for their research in the irritable bowel. The document was revised in light of their comments and presented at the Congress in September 1988. This publication is the final report resulting from that meeting.

Based as far as possible on the published data, the guidelines constitute a consensus on the definition and diagnosis of this very common condition. The emphasis is on a *positive diagnosis*, rather than the exhaustive use of tests to exclude other diseases. The guidelines are intended to be of practical use to practising physicians. Researchers may need to use more restrictive criteria within these guidelines.

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1. Definition

Functional gastrointestinal disorder

A variable combination of chronic or recurrent gastrointestinal symptoms not explained by structural or biochemical abnormalities. This may include syndromes attributed to the oesophagus, stomach, biliary tree, small or large intestines, or anus.

Irritable bowel syndrome

A functional gastrointestinal disorder attributed to the intestines:
- — abdominal pain;
- — symptoms of disturbed defaecation [urgency, straining, feeling of incomplete evacuation, altered stool form (consistency) and altered bowel frequency/timing];
- — bloatedness (distension).

2. Epidemiology

Functional gastrointestinal symptoms are reported by

about 30% of adult westerners, and 8-19% have symptoms consistent with a diagnosis of IBS (1-5). While most persons with IBS do not see physicians for these complaints, the disorder accounts for 20-50% of referrals to gastroenterology clinics (6-10).

Social and cultural factors may influence the prevalence of IBS in clinical practice. It is rarely diagnosed in Uganda (11,12) but is well recognised in the Indian subcontinent (13-17), Japan (18,19) and South America (20). In South African blacks it is rarely diagnosed in rural areas, but appears to be as common in urban populations as in other industrialised countries (21). Females are more likely to consult physicians in Western countries, but represent only 20-30% of IBS patients in India and Sri Lanka (13-17). Population-based studies are needed to determine the true prevalence of the IBS.

3. Symptom criteria for IBS (1,2,22-24)

Continuous or recurrent symptoms of:

1. Abdominal pain, relieved with defaecation, or associated with a change in frequency or consistency of stool;
   and or
2. Disturbed defaecation (two or more of):
   a. altered stool frequency,
   b. altered stool form (hard or loose/watery),
   c. altered stool passage (straining or urgency, feeling of incomplete evacuation),
   d. passage of mucus;
   e. *usually with*
3. Bloating or feeling of abdominal distension.

There are often upper gastrointestinal (25) and other somatic and psychological symptoms (26), at least in those patients seen by the specialist.

4. Physical findings

A physical examination is important to exclude other diseases, which of course may co-exist with the IBS (27). In addition, physical examination is essential since it provides a foundation for the doctor to reassure the patient. There are no proven discriminating physical signs of the IBS. Abdominal tenderness may be present.

5. Psychological features

It is known that stressful stimuli may alter gut function (28-30). Stressful life events frequently precede the onset of IBS symptoms, or at least the reporting of them to a doctor (31-34). In response to stressful stimuli, the intestines of IBS patients react more strongly and the patients report symptoms more than normals (35,36).

Studies indicate that mood and personality disturbances, psychiatric disease and illness behaviour are all more common in IBS patients than in other patients and normals (37-43). However, people with IBS who do not consult physicians appear to have psychological profiles similar to those without symptoms (44-45). Thus, it may be the person's psychological state as much as the somatic symptoms that bring him/her to medical attention. It is still unclear to what extent IBS symptoms represent normal perception of abnormal function or abnormal perception of normal function (46).

Since psychological factors appear to influence health care seeking, they require careful attention in patient assessment.

6. Appropriate investigation

Since the IBS is a common and benign disorder and should be diagnosed positively from the history, care should be taken to avoid unnecessary investigations. Such investigations may be costly and harmful.

Blood should normally be drawn for a complete (full) blood count and erythrocyte sedimentation rate (or plasma viscosity). A single sigmoidoscopy (rigid or fibre-optic) is recommended since inflammation can be excluded, or melanosis coli might be found signalling laxative abuse. In addition small, round "scybala", ribbon stools or mucus may be seen, and reproduction of the pain helps convince the patient of its source.

Further testing depends upon the individual situation. Fever, anaemia, leucocytosis, bleeding or weight loss will require additional study. The physician's decision to test further may be influenced by age of the patient, nature and duration of symptoms, region of practice, costs and other factors, but common sense must prevail. Tests may include stool examination for occult blood, leucocytes, ova and parasites, and further colon investigation (colonoscopy or air contrast barium enema). In many instances none of these is indicated. The presence of diverticula on a barium enema does not change the diagnosis (47,48).

It is important to make the diagnosis and explain it to the patient at the initial visit, if possible.

7. Diagnostic tests of the IBS

Many have sought to identify a physiological abnormality that is unique to IBS subjects (49-53). While as a group IBS patients show an exaggerated or altered response to various physiological stimuli (35,36,54,55), no test has been established as a diagnostic standard for the individual with IBS. Furthermore, these tests do not yet clarify how the symptoms are generated.

8. Prognosis and safety of the diagnosis

There is no evidence that predisposition to other diseases and life expectancy are altered by the IBS, but most patients remain symptomatic many years following diagnosis (56-59). This is a relapsing disorder, and often affects people for long periods of their lives. An initial positive diagnosis of the IBS is a safe one (6, 58-60) and seldom needs revision over time. A change in the clinical picture, however, may warrant additional investigation. All the same, the simple persistence of symptoms does not justify suspicion of another diagnosis. Further investigation which might serve to undermine the patient's confidence in the diagnosis should be resisted.

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APPENDIX

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