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Summary

Diagnosis and management of IBS: Past, present and future

Christopher Black

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Neurogastroenterology & Motility | Primary Care

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The speaker presented evidence that IBS subgrouping should integrate psychological comorbidity with bowel habit and pain, not rely on stool pattern alone, to enable earlier multidisciplinary treatment for high-severity patients.

KEY POINTS

- Rome 4 criteria increased diagnostic specificity but identified patients with more severe symptoms (47% vs 9% in Rome 3) and higher rates of anxiety and depression; Rome 5 returns toward Rome 3 definitions and requires prospective validation.
- In the speaker's latent class analysis of over 800 Rome 4 IBS patients, seven clusters emerged; clusters combining high GI symptoms with psychological comorbidity (clusters 2, 4, 5, 6) had worse 12-month outcomes, higher healthcare costs (approximately £1,200 vs £300), and greater work impairment.
- Patients in high-psychology clusters remained stable over time, suggesting current treatments do not modify psychological state, which the speaker identified as a driver of symptom severity.
- For diarrhoea, the speaker reported that ondansetron showed efficacy across three pooled trials; the low FODMAP diet ranked first in a six-trial network but was not superior to sham or traditional dietary advice.
- The speaker stated that tricyclic antidepressants were the most effective treatment for abdominal pain in network meta-analysis; the Atlantis trial showed amitriptyline achieved significant separation from placebo at six months but not three months.
- The speaker proposed mapping evidence-based therapies to these clusters, recommending early multidisciplinary intervention for high GI-plus-psychology groups rather than reserving psychological treatments as last resort.

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