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Summary

IBS patient: To treat or to scope

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Hepatobiliary | Primary Care | Neurogastroenterology & Motility | Endoscopy

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The speaker argued that most patients meeting Rome criteria for IBS do not require colonoscopy, and that diagnosis should rely on typical symptoms, limited investigations including coeliac serology and stool tests, with early treatment initiation rather than exhaustive investigation.

KEY POINTS

- The speaker reported that Rome IV criteria have 82% sensitivity and high specificity for IBS, and that in their cohort of Rome IV IBS patients, the most commonly missed organic disease was bile acid diarrhea, affecting about a quarter of those presenting with IBS-D symptoms.
- A meta-analysis the speaker cited of nearly 30,000 IBS patients undergoing colonoscopy showed no difference in yield of IBD, microscopic colitis, or cancer between IBS and non-IBS groups, with colorectal cancer rare particularly in younger patients without alarm features.
- The speaker stated that faecal calprotectin has 93% sensitivity and 96% specificity for IBD screening, and that FIT has 91% sensitivity and 75% specificity for significant pathology, making stool tests useful for risk stratification.
- Colonoscopy should be prioritized for patients with red flag symptoms such as older age, rectal bleeding, anemia, weight loss, recent bowel habit change, or concerning family history, according to the speaker.
- The speaker emphasized that even when investigation markers are present, most patients with typical IBS symptoms will not have an alternative diagnosis, so early symptom treatment should not be delayed while awaiting test results.
- Microscopic colitis is more common in older patients, women, and those using PPIs or NSAIDs, while features favoring IBS over microscopic colitis include meal-related symptoms, intermittent symptoms, and long symptom duration, the speaker noted.

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