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Summary

IBS: A positive diagnosis or a diagnosis of exclusion?

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UEG Postgraduate Teaching Programme Vienna 2024 | Presentation

Education & Training | Neurogastroenterology & Motility | Small Intestine & Nutrition | Primary Care

October 13, 2024

The speaker presented a strategy for making a positive diagnosis of IBS by using clinical acumen and limited investigations to exclude organic disease in patients with compatible symptoms, emphasizing that Rome IV criteria alone are insufficient without ruling out alternative diagnoses.

KEY POINTS

- The speaker stated that Rome IV criteria perform modestly in distinguishing IBS from organic disease, and symptoms of abdominal pain, bloating, and altered bowel habit can overlap with coeliac disease, IBD, microscopic colitis, bile acid diarrhea, and other conditions.
- In patients presenting with IBS-type symptoms, the speaker reported that coeliac disease prevalence is four-fold higher than controls (4% versus 1%) and microscopic colitis is present in around 10% of those with diarrhea-predominant symptoms.
- A systematic review cited by the speaker found that approximately 30% of individuals with IBS-diarrhea presenting to secondary or tertiary care have bile acid diarrhea, though the speaker cautioned that selection bias limits generalizability.
- The speaker advocated a limited workup (coeliac serology, fecal calprotectin, stool cultures, CA125 as appropriate) in the absence of alarm features, citing a Danish primary care trial showing no difference in diagnostic yield or quality of life between limited and extensive investigations but lower cost with the limited approach.
- The speaker emphasized communicating both what the patient does not have (IBD, cancer, coeliac disease) and what they do have (IBS), then proceeding to dietary, drug, and psychological therapies, and noted that Leeds group data showed the IBS diagnosis remained stable over four years in all but four of nearly 400 patients.

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