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GI learning, personalised

Summary

IBS: Young and old (Complete Session)

UEG Week Barcelona 2026 | Presentation

October 20, 2026

Three case presentations illustrate age-appropriate diagnostic and management strategies for irritable bowel syndrome across paediatric, adult, and primary care settings, emphasising positive diagnosis using Rome criteria, avoidance of unnecessary investigation, and stepwise treatment incorporating brain-gut behavioural therapies.

KEY POINTS

- The speakers presented a 14-year-old with IBS-C managed initially with macrogol, a 34-year-old with IBS-M treated with amitriptyline up to 30 mg and relaxation training, and a 17-year-old diagnosed in primary care with IBS-M using Rome 5 criteria and managed with dietary counselling and symptomatic treatment.
- The Rome 5 Bowel Disorder Committee recommends that compulsory blood tests in suspected IBS are CBC, CRP, and coeliac serology only; faecal calprotectin should be reserved for diarrhoea-predominant patients with clinical suspicion of inflammation, and colonoscopy only for alarm features or cancer risk, to avoid unnecessary investigations that may undermine GP trust and cause patient harm.
- In paediatric IBS, the speakers stated that psychological interventions including cognitive behavioural therapy and hypnotherapy show substantial efficacy for pain reduction, and that online or CD-ROM guided programmes can be effective when in-person access is limited.
- For adult IBS with predominant pain, the speaker reported amitriptyline as the first-line neuromodulator, starting at 10 mg and titrating to 30 mg, with constipation as a known side effect that is generally not problematic at the low doses used.
- The speakers emphasised a biopsychosocial model and multidimensional clinical profiling to guide both diagnosis and treatment escalation, stressing that explanation, reassurance, and a strong patient-provider relationship are foundational before pharmacotherapy or specialist referral.

– In the paediatric case, the speaker stated that when constipation coexists with mildly elevated faecal calprotectin, laxative treatment should be initiated first and calprotectin repeated after bowel normalisation, rather than proceeding directly to endoscopy; the privately repeated calprotectin in that patient was negative.

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