



Irritable Bowel Syndrome

Diagnose it **POSITIVELY** on criteria plus a short test set, then treat the subtype

Rome V
2026 criteria

ROME V CRITERIA (MAY 2026) *what changed from Rome IV, and why it matters*

THE CRITERIA

Recurrent (not continuous) abdominal pain OR discomfort, on average at least 3 days per month in the past 3 months, with two or more of: related to defecation, a change in stool frequency, a change in stool form. Supportive: in women, not related only to menses. IBS is a disorder of gut-brain interaction: visceral hypersensitivity and central amplification, so normal tests do not mean nothing is wrong.

WHAT CHANGED

Discomfort is back (Rome IV required pain, excluding patients who do not call it pain). **Threshold back to 3 days a month** from Rome IV's weekly, which had halved prevalence (4.1% vs 10.1%) and selected a sicker minority. **New: the pain cannot be continuous**; constant pain is centrally mediated abdominal pain syndrome and needs centrally directed treatment, not bowel drugs.

SUBTYPE BY BRISTOL FORM

On days with an abnormal stool, off laxatives and antidiarrheals. **IBS-C**: over 25% Bristol 1-2, under 25% Bristol 6-7. **IBS-D**: the reverse. **IBS-M**: over 25% of each. **Why it matters**: secretagogues work only in IBS-C; rifaximin, eluxadoline and alosetron only in IBS-D.

⚠️ ALARM FEATURES

Any one ends the IBS pathway: **onset after 45-50**, rectal bleeding or melena, iron deficiency anemia, unintentional weight loss, fever, **nocturnal diarrhea**, family history of colorectal cancer, IBD or celiac disease, a mass, recent antibiotics (C. difficile). From 45, colorectal cancer screening must be current regardless.

THE TEST SET (ACG 2021) *short on purpose: a positive strategy is a strong recommendation with high-quality evidence*

Test	Who, and the threshold that matters
CBC	Everyone. Anemia is an alarm feature and the cheapest one to find.
CRP + fecal calprotectin <i>strong, moderate</i>	IBS with diarrhea and no alarm features. Calprotectin 40 µg/g or below, or CRP 0.5 mg/dL or below, leaves a 1% or lower probability of IBD (Menees 2015), which is what lets you diagnose IBS-D without a colonoscopy. A raised value does not diagnose IBD but earns a scope.
tTG-IgA with total IgA <i>strong, moderate</i>	IBS with diarrhea, while still eating gluten . Celiac disease hides in "IBS" for years and its treatment is entirely different; IgA deficiency gives a falsely negative tTG-IgA.
⚠️ NOT routine	Stool pathogen testing (only with travel, Giardia or outbreak exposure, recent antibiotics, immunosuppression). Colonoscopy under 45 without warning signs (conditional against; when scoping an older patient with watery diarrhea, biopsy the normal-looking colon for microscopic colitis). Food allergy or IgG "sensitivity" panels : never (IgG reflects exposure, not intolerance).
Anorectal manometry	IBS-C with straining, incomplete evacuation or digital maneuvers, or refractory constipation: dyssynergia responds to biofeedback, not another laxative, and is why a secretagogue "fails".

TREATMENT BY SUBTYPE *ACG 2021 and AGA 2022 side by side; they disagree on antispasmodics and PEG*

Agent	Dose	Why, and what to watch
Psyllium (all subtypes) <i>ACG strong, moderate</i>	3-4 g daily, build over 1-2 weeks to about 10 g daily	Softens IBS-C stool and absorbs water in IBS-D. Not bran : insoluble fiber worsened symptoms and was no better than placebo (Bijkerk 2009).
Low FODMAP diet <i>ACG conditional, very low</i>	Limited, dietitian-led: 2-6 weeks restriction, then reintroduction, then personalize	Pain responders 51% vs 23% in the US trial (Eswaran 2016). Indefinite restriction harms nutrition, the microbiome and eating behavior . Probiotics (against) and fecal transplant (strongly against) are not supported.
Low-dose TCA (amitriptyline, nortriptyline) <i>ACG strong, moderate</i>	10 mg at bedtime, up 10 mg every 1-2 weeks to 30-50 mg	Visceral pain neuromodulation plus slowed transit, so best in IBS-D; may worsen IBS-C. ATLANTIS (2023): 10-30 mg beat placebo at 6 months. Say it is a pain modulator at this dose . Beers list: prefer nortriptyline in older adults. SSRIs are not IBS drugs.
Antispasmodics <i>ACG against, AGA for (both low)</i>	Dicyclomine 20 mg four times daily, up to 40 mg after 1 week, stop at 2 weeks if no benefit ; hyoscyamine 0.125-0.25 mg SL every 4 h as needed, max 1.5 mg/day	Antimuscarinic relief of postprandial cramping; US agents have the weakest data in the class. Anticholinergic load, Beers list; contraindicated in glaucoma, BPH or obstructive uropathy, GI obstruction, severe UC, myasthenia, reflux esophagitis. Dicyclomine is never given IV .
Brain-gut therapy (CBT, gut-directed hypnotherapy) <i>ACG conditional</i>	4-10 sessions; home-based CBT works	Treats the central amplification; 61% vs 44% improvement with home-based CBT (IBSOS 2018). An AGA 2025 quality indicator. Never opioids : narcotic bowel syndrome worsens the pain.
IBS-C: secretagogues <i>linaclotide strong, high (both)</i>	Linaclotide 290 mcg daily 30 min before breakfast; plecanatide 3 mg daily; tenapanor 50 mg twice daily before meals; lubiprostone 8 mcg twice daily with food (women)	Guanylate cyclase-C agonists raise cGMP, which secretes fluid and dampens visceral afferents, so pain improves beyond the laxative effect (responders 34% vs 14-21%). Diarrhea is the class effect; all contraindicated in obstruction. PEG improves stool form but not pain (ACG against for global symptoms, AGA for). Tegaserod was withdrawn in 2022 .
IBS-D: rifaximin <i>ACG strong, moderate</i>	550 mg three times daily for 14 days ; retreat up to twice	Non-absorbed; the effect outlasts the course. Adequate relief 40.7% vs 31.7% (TARGET 1 and 2), repeat courses 38.1% vs 31.5% (TARGET 3). Modest gain, no anticholinergic or ischemic downside.
⚠️ Eluxadoline <i>conditional, moderate (both)</i>	100 mg twice daily with food ; 75 mg if intolerant, OATP1B1 inhibitors, hepatic impairment, eGFR under 60	Gut-restricted mixed opioid agent. Contraindicated without a gallbladder (sphincter of Oddi spasm, pancreatitis, deaths in the first week), with over 3 drinks a day or alcohol use disorder, any pancreatitis history, severe hepatic impairment, severe constipation.
⚠️ Alosetron <i>women, severe IBS-D only</i>	0.5 mg twice daily ; 1 mg twice daily after 4 weeks if needed; stop if no control after 4 weeks at 1 mg	5-HT3 antagonist. Boxed warning: ischemic colitis (about 3 per 1,000 in 6 months) and serious constipation complications (1 per 1,000). Stop at the first constipation, rectal bleeding or new pain; never restart after ischemic colitis.
Loperamide / bile acid sequestrant	Loperamide 2-4 mg as needed, max 16 mg/day; cholestyramine 4 g once or twice daily	Loperamide helps frequency and urgency, not pain. Suspect bile acid diarrhea after cholecystectomy or ileal disease: US testing is limited, so a 2-4 week sequestrant trial is both treatment and diagnostic test.

PEARLS & PITFALLS

- **Post-infectious IBS is common**: about 10% develop IBS in the year after infectious enteritis, a fourfold risk (Klem 2017). "I was fine until that trip" supports the diagnosis.
- **Change one thing at a time, reassess at 4-8 weeks, and stop what has not worked**. The placebo response is 30-40%.
- **Peppermint oil** (enteric-coated, 180-250 mg before meals) is safe and cheap but missed its primary endpoints in PERSUADE (2020); use the coated form or it causes heartburn.
- **Re-screen alarm features at every visit**. IBS does not protect against IBD, celiac disease or colorectal cancer, and a changed pattern after 45 is a new problem.

References: Rome V criteria, Rome Foundation 2026 · ACG Clinical Guideline: Management of IBS, 2021 · AGA Clinical Practice Guidelines on the pharmacological management of IBS-C and IBS-D, 2022 · AGA quality indicators for IBS, 2025 · FDA prescribing information for each agent.

Educational aid; verify against current guidance, local formulary and patient factors.

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