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Diagnosing IBS-C: From Clinical Clues to Confident Calls

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And now, here are Drs. Darren Brenner and Kyle Staller.

Dr. Brenner:
Hi. My name is Darren Brenner, and I am a professor of Medicine and Surgery and Director of Gastrointestinal Motility Program at Northwestern University's Feinberg School of Medicine in Chicago, Illinois.

Today, I'm joined by my colleague, Dr. Kyle Staller, to discuss how we can confidently diagnose irritable bowel syndrome with constipation, or IBS-C.

Dr. Staller, would you mind introducing yourself?

Dr. Staller:
Absolutely. Hi, I'm Dr. Kyle Staller, a Gastroenterologist at Massachusetts General Hospital in Boston, where I specialize in neurogastroenterology. I also serve as the director of the Gastrointestinal Motility Laboratory here at Mass General. I'm excited for our conversation today.

Dr. Brenner:
Thanks, Dr. Staller. So let's start by setting the stage—how common is IBS, and why can diagnosing it be such a challenge?

Dr. Staller:
Well, IBS affects about 10 to 15 percent of the US population.[1-3] Among those with IBS-C, the majority remain undiagnosed—only 24 percent have a diagnosis, while 62 percent remain undiagnosed and seeking care.[4]

In fact, the 2015 "IBS in America" survey, which was one of the most comprehensive surveys of both patients and physicians ever conducted, evaluated a subset of 976 patients diagnosed with IBS-C.

What stood out was that only a quarter of patients were diagnosed within the first year of experiencing symptoms. And despite consulting multiple providers each year, patients' average time from symptom onset to a formal diagnosis was four years.[5]

Dr. Brenner:
Right. And if we look at the full population of over 2,600 patients surveyed, which included patients both with IBS-C or D, patients

consulted on average two or more providers per year before receiving a diagnosis[5] and this really highlights how fragmented and lengthy the diagnostic journey can be. And there are several contributing factors resulting in this delay.

One, is the lack of a specific biomarker or diagnostic test for irritable bowel syndrome.[6]

Consequently, both providers and patients may lack confidence in the Rome criteria symptom-based diagnosis, especially since IBS symptoms are heterogeneous and can be difficult to objectively quantify.[7,8] These criteria might feel too restrictive in everyday practice.[8]

Dr. Staller:
Exactly. And there's often a breakdown in communication between patients and providers as well.[8] Patients might wait to see if their symptoms resolve on their own, or they may try at least three over-the-counter medications on average before speaking with a provider about what they're experiencing.[5]

And lastly, some patients don't consider their IBS symptoms severe enough to justify seeking medical attention, which can further delay diagnosis.[5]

Now, if we zero in on the impact of delayed diagnosis, Dr. Brenner, what kind of consequences do these delays have for patients?

Dr. Brenner:
Well, when IBS goes undiagnosed, patients can experience prolonged pain, suffering, and anxiety due not only to IBS, but its associated comorbidities.[9] This is particularly relevant for our patients with IBS-C, who often feel misunderstood or even embarrassed talking about their symptoms.[7,10,11]

There are also impacts on the healthcare system associated with the performance of unnecessary tests and increased costs. If we can diagnose IBS earlier, then we can help improve these patients' quality of life while avoiding superfluous and invasive testing.[9]

Dr. Staller:
I completely agree, Dr. Brenner. So, let's take a moment to talk about those diagnostic pitfalls—could you share an example?

Dr. Brenner:
Of course. One that comes up often is whether a colonoscopy is warranted for patients under 45 who are suspected of having IBS. It's often done for reassurance, but the evidence and guidelines don't support this approach unless alarm symptoms are present.[12,13]

In a retrospective study of 458 patients under 50 with IBS who had a colonoscopy for "peace of mind," the results yielded no significant improvements in patient assurance. Furthermore, the colonoscopy didn't improve quality of life or psychological outcomes.[12]

Dr. Staller:
Right. And notably, the study defined reassurance as a negative patient response to the question, "Do you think something serious is wrong with your body?"[12] So colonoscopy didn't meaningfully shift that viewpoint for patients.

Dr. Brenner:
For those just tuning in, you're listening to ReachMD. I'm Dr. Darren Brenner, and today I'm joined by Dr. Kyle Staller as we discuss diagnostic pitfalls and strategies for IBS-C in the primary care setting.

So let's shift our focus to making a timely and accurate diagnosis. Dr. Staller, what steps can primary care providers take to confidently diagnose irritable bowel syndrome with constipation?

Dr. Staller:
Great question. As we briefly touched on earlier, the ACG guidelines recommend a positive diagnostic strategy for IBS-C rather than one of exclusion.

This means starting with a careful clinical history to rule out alarm features, followed by a physical exam to identify any signs of organic gastrointestinal disease. And we can reserve minimal diagnostic testing for when it's truly appropriate.[13]

In the absence of a consistent biological marker for IBS, we're encouraged to rely on validated symptom criteria and thoughtful clinical judgment instead of extensive workups.[13]

Dr. Brenner:
Right. So, we should begin by confirming that a patient is experiencing abdominal pain associated with altered bowel habits. Then, we

should assess for the presence of alarm features, including:

- age over 50,
- an acute change in symptoms,
- anemia or blood in stool,
- unexpected or unintentional weight loss, or
- a family history of inflammatory bowel disease, celiac, or colorectal cancer.[14]

If none of these red flags are present, we can assess whether the patient meets the Rome IV criteria, which were predominately developed for research purposes. These criteria include recurrent abdominal pain at least once a week, on average, over the last three months. That pain should be associated with at least two of the following:

- alterations in the pain with defecation, meaning it can get better or worse, or
- a change in stool form, or
- stool frequency.[13,14]

Symptom onset should also date back at least six months.[13,14]

However, it's important to note that the duration criteria are more flexible in clinical practice. Since timely diagnosis is necessary, it's suggested that symptoms should be present for eight weeks. That said, clinicians may choose to move forward with a diagnosis even earlier if they're confident that other conditions have been ruled out, or if symptoms are infrequent or intermittent.[1,4] Ultimately, this approach can help support a confident diagnosis of IBS-C without delay or referrals.[13]

Dr. Staller:
I'll add that if alarm features are present or the Rome IV criteria aren't met, that's when we can investigate further and consider alternative diagnoses.[13] But in most cases, providers are fully equipped to make this call.

Dr. Brenner:
Absolutely. If the aforementioned criteria are met, minimal diagnostic testing is necessary. The ACG guidelines strongly recommend obtaining a fecal calprotectin, or CIP, to help rule out IBD, or inflammatory bowel disease, and a serum IGA and tissue transgutaminase, IgA, to rule out celiac in individuals meeting criteria for IBS-D.[13]

And just to iterate, a routine colonoscopy is not recommended to help diagnose IBS in patients under 45 without alarm features. The ACG guidelines also don't recommend stool testing for enteric pathogens or food allergy or sensitivity panels unless there are reproducible symptoms related to an allergy.[13]

Dr. Staller:
Now, I think that it's worth briefly discussing another condition that often comes up in the differential: chronic idiopathic constipation, also known as CIC. Dr. Brenner, how do you typically distinguish CIC from IBS-C?

Dr. Brenner:
That's a great question. CIC and IBS-C share a number of overlapping symptoms, which can make them challenging to distinguish, like infrequent bowel movements, straining, and the sensation of incomplete evacuation.[15-17] That's why diagnosis is often guided by the primary symptom. For example, abdominal pain is typically a more pronounced primary symptom in IBS-C than in CIC, and that can help guide therapeutic decisions.[16]

We can also take a symptoms-based approach when diagnosing CIC. Key signs include:

- fewer than three bowel movements per week,
- straining,
- hard or lumpy stools,
- or needing manual maneuvers to facilitate with defecation, among others.[18-20]

Now remember, these symptoms need to be present in at least 25 percent of bowel movements.[18-20]

Dr. Staller:
And just like with IBS-C, we should check for alarm features. In their absence, we can often make a confident clinical diagnosis of CIC

without additional testing. However, in the presence of alarm features, or if the patient is over 50 and newly symptomatic, further workup is usually warranted. In those cases, we might consider stool studies, colonoscopy, endoscopy, or even imaging, like a CT scan.[18-20]

It's also important to rule out other causes of secondary constipation, such as medications, diabetes, and depression.[18-20]

Dr. Brenner:
Right. There's no single test to confirm CIC, so it really does come down to taking a thorough history, assessing symptoms carefully, and doing a focused physical exam, just as we emphasized with irritable bowel syndrome with constipation.[18-20]

Now, while a systematic strategy is essential for diagnosing diseases like IBS-C and CIC, fostering a strong patient-provider relationship is as equally important.[6,7,14,21] Dr. Staller, I'd love to hear your thoughts on ensuring strong communication with your patients.

Dr. Staller:
Well, first and foremost, it's important to build trust with our patients.[7,22] This is particularly relevant because patients with IBS often feel that healthcare providers don't understand their concerns.[23] On the other hand, providers have also reported their own frustration when treating their patients with IBS.[7,24] So to build a strong relationship with my patients, I focus on asking open-ended questions, like "What symptoms are bothering you the most?" or "What activities do you avoid due to your symptoms?" Simple questions like these can lead to a two-way dialogue.[7,22]

And how about you, Dr. Brenner? What strategies do you use to effectively communicate with your patients?

Dr. Brenner:
For me, it's about actively listening while validating the patient's experience, educating them on IBS-C, and collaborating on a plan. When patients feel seen and involved in mutual goal-setting, they're more likely to share the details we need to make a confident diagnosis.[7,14]

Dr. Staller:
Well, as those great insights bring us to the end of today's discussion, I'd like to thank Dr. Darren Brenner for joining me to share his perspective on how we can more confidently diagnose IBS-C.

Dr. Brenner:
Likewise, Dr. Staller. I really enjoyed our conversation, and it's always great to talk about how we can better support our patients and colleagues.

ReachMD Anouncer:
This medical industry feature was sponsored by the AbbVie Medical Affairs and Health Impact department and Ironwood Pharmaceuticals, Inc. For more information on IBS-C, please visit essentialsofIBS.com. If you missed any part of this discussion, visit Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

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