

Simple guide to identifying and investigating IBS symptoms

History suggestive of IBS

Longstanding sub-acute symptoms, especially onset in teenage years or in weeks to months after acute gastroenteritis.

Abdominal pain that is:

- relieved or improved by defaecation
- associated with more frequent or looser stools
- associated with a change in stool form e.g. pellets
- associated with visible abdominal distension
- radiates into lower back or down anterior thighs
- associated with deep dyspareunia or bladder instability
- associated with rectal mucus production or tenesmus
- associated with fatigue when pain is worse

History that might suggest other pathology - refer

- persistent rectal bleeding
- progressive weight loss
- persistent diarrhoea (never has a normal motion)
- constant pain, especially away from midline
- nocturnal pain
- family history of colorectal cancer in first degree relative

Investigations (after abdominal system exam including rectal exam)

- FBC – if anaemic, check Fe studies
- coeliac serology
- CRP
- thyroid function test
- if constipation-predominant, check Ca/phosphate (hyperparathyroidism)
- if upper abdominal pain is prominent, check liver enzymes – if liver enzymes abnormal then do abdominal USS
- faecal calprotectin in young patients with family history IBD, localised abdominal pain, or extra-intestinal symptoms e.g. back or joint pain
- faecal occult blood testing (serial) should be considered in older patients with recent persistent worsening of symptoms

If the symptoms on history are consistent, there are no symptoms or history suggesting other pathology, and the investigations are normal, then initial management should be dietary manipulation, +/- psyllium, +/- laxative prescription.