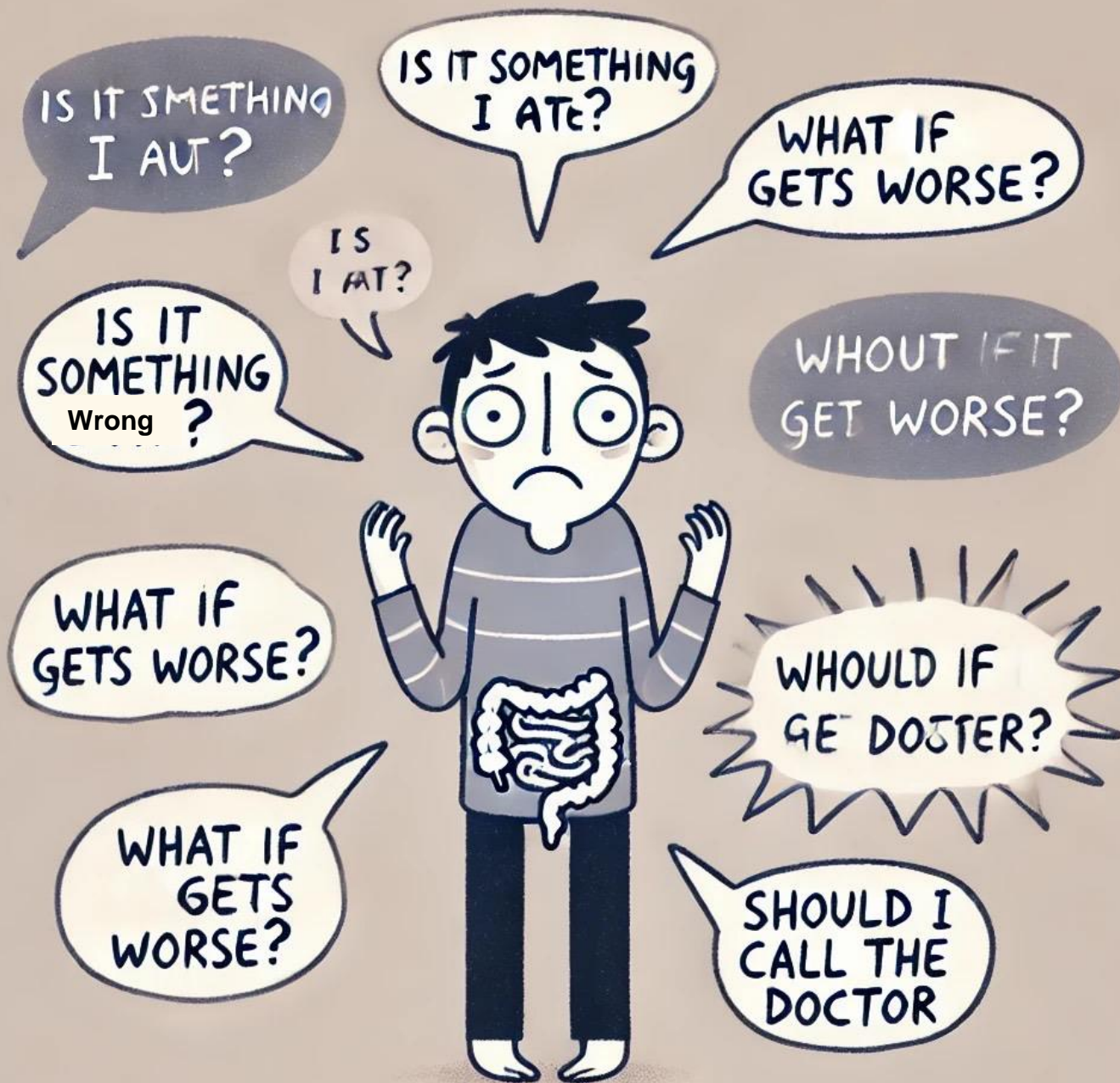


IBS guideline and management update

林穎正/連漢仲

13th September, 2024



IRRATBLE BOWEL SYNDROME

腸躁症佔了GI
OPD **10-20%!!**

Chey, W. D., et al. (2015).
American Journal of Gastroenterology.

British Society of Gastroenterology guidelines on the management of irritable bowel syndrome

Dipesh H Vasant ,^{1,2} Peter A Paine,³ Christopher J Black ,⁴
Lesley A Houghton ,^{5,6} Hazel A Everitt,⁷ Maura Corsetti,⁸ Anurag Agrawal,⁹
Imran Aziz ,¹⁰ Adam D Farmer,^{11,12} Maria P Eugenicos,¹³ Rona Moss-Morris,¹⁴
Yan Yiannakou,¹⁵ Alexander C Ford ¹⁶

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► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/gutjnl-2021-324598>).

For numbered affiliations see end of article.

Correspondence to

Professor Alexander C Ford,
Leeds Gastroenterology
Institute, St James's University
Hospital, Leeds, UK;
alex12399@yahoo.com

DHV and PAP are joint first authors.

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ABSTRACT

Irritable bowel syndrome (IBS) remains one of the most common gastrointestinal disorders seen by clinicians in both primary and secondary care. Since publication of the last British Society of Gastroenterology (BSG) guideline in 2007, substantial advances have been made in understanding its complex pathophysiology, resulting in its re-classification as a disorder of gut-brain interaction, rather than a functional gastrointestinal disorder. Moreover, there has been a considerable amount of new evidence published concerning the diagnosis, investigation and management of IBS. The primary aim of this guideline, commissioned by the BSG, is to review and summarise the current evidence to inform and guide clinical practice, by providing a practical framework for evidence-based management of patients. One of the strengths of this guideline is that the recommendations for treatment are based on evidence derived from a comprehensive search of the medical literature, which was used to inform an update of a series of trial-based and network meta-analyses assessing the efficacy of dietary, pharmacological and psychological therapies in treating IBS. Specific recommendations have been made according to the Grading of Recommendations Assessment, Development and Evaluation system, summarising both the strength of the recommendations and the overall quality of evidence. Finally, this guideline identifies novel treatments that are in development, as well as highlighting areas of unmet need for future research.

EXECUTIVE SUMMARY OF RECOMMENDATIONS

Doctor-patient communication

- Establishing an effective doctor-patient relationship and a shared understanding is key to the management of IBS. Such a relationship can lead to improved quality of life and symptoms, reduce healthcare visits and enhance adherence to treatment (recommendation: strong, quality of evidence: low).

(abdominal pain or discomfort, in association with altered bowel habit, for at least 6 months, in the absence of alarm symptoms or signs) is more pragmatic and may be more applicable to patients with IBS in primary care than diagnostic criteria derived from patients in secondary care, such as the Rome IV criteria (recommendation: weak, quality of evidence: low).

- All patients presenting with symptoms of IBS for the first time in primary care should have a full blood count, C reactive protein or erythrocyte sedimentation rate, coeliac serology and, in patients <45 years of age with diarrhoea, a faecal calprotectin to exclude inflammatory bowel disease. Local and national guidelines for colorectal and ovarian cancer screening should be followed, where indicated (recommendation: strong, quality of evidence: moderate).
- Clinicians should make a positive diagnosis of IBS based on symptoms, in the absence of alarm symptoms or signs, and abnormalities on simple blood and stool tests (recommendation: strong, quality of evidence: moderate).
- Referral to gastroenterology in secondary care is warranted where there is diagnostic doubt, in patients with symptoms that are severe, or refractory to first-line treatments, or where the individual patient requests a specialist opinion (recommendation: weak, quality of evidence: low).
- There is no role for colonoscopy in IBS, other than in those with alarm symptoms or signs, or those with symptoms suggestive of IBS with diarrhoea who have atypical features and/or relevant risk factors that increase the likelihood of them having microscopic colitis (female sex, age ≥ 50 years, coexistent autoimmune disease, nocturnal or severe, watery, diarrhoea, duration of diarrhoea <12 months, weight loss or use of potential precipitating drugs including



Doctor-patient communication

- ▶ Establishing an effective doctor-patient relationship and a shared understanding is key to the management of IBS. Such a relationship can lead to improved quality of life and symptoms, reduce healthcare visits and enhance adherence to treatment (recommendation: strong, quality of evidence: low).
- ▶ Patients with IBS would like increased empathy, support and information from clinicians about the nature of the condition, diagnosis and symptom management options (recommendation: strong, quality of evidence: low).

Symptoms compatible with IBS, in the absence of alarm symptoms or signs

Empathy and active listening skills are key

Use the Bristol stool chart to assess predominant stool type, on days when the stools are abnormal

IBS-focused history taking:

- Onset and duration of symptoms
- Evidence of onset postinfection, following recurrent antibiotic use, or after acute or chronic stress or psychological trauma
- Confirm relationship between abdominal pain and change in bowel habit (cardinal symptoms)
- Elicit extraintestinal symptoms (back pain, urological, and gynaecological)
- Other functional non-gastrointestinal disorders
- Comorbidities (including psychological) and previous surgery
- Medications (including opioids)

Baseline investigations in primary care, or at first appointment in secondary care:

- Full blood count, C-reactive protein or erythrocyte sedimentation rate, and coeliac serology
- Faecal calprotectin (if diarrhoea and age <45 years)

Consider whether the patient needs any further investigations (see Box 1)

No

1. **Make a positive diagnosis of IBS**
2. **Explanation of the condition in the context of the gut-brain axis**
3. **Discuss treatment options** (diet, drugs, and psychological)
4. **Consider patient's previous treatments and preferences**
5. **Manage expectations and agree follow-up plan** (explain there is no cure for IBS, that treatments aim to improve quality of life, and are likely to be necessary long-term. Patient education and engagement is key to successful management.)

Box 1

- Colonoscopy if raised faecal calprotectin* or suspected microscopic colitis (female, age ≥ 50 years, co-existent autoimmune disease, nocturnal or severe watery diarrhoea, duration of diarrhoea <12 months, weight loss, or use of potential precipitating drugs e.g., non-steroidal anti-inflammatory drugs or proton pump inhibitors)
- SeHCAT† scanning or serum 7 α -hydroxy-4-cholesten-3-one if bile acid diarrhoea suspected
- Consider anorectal physiology for IBS with constipation and co-existing symptoms suggestive of a defaecatory disorder, or faecal incontinence

Yes

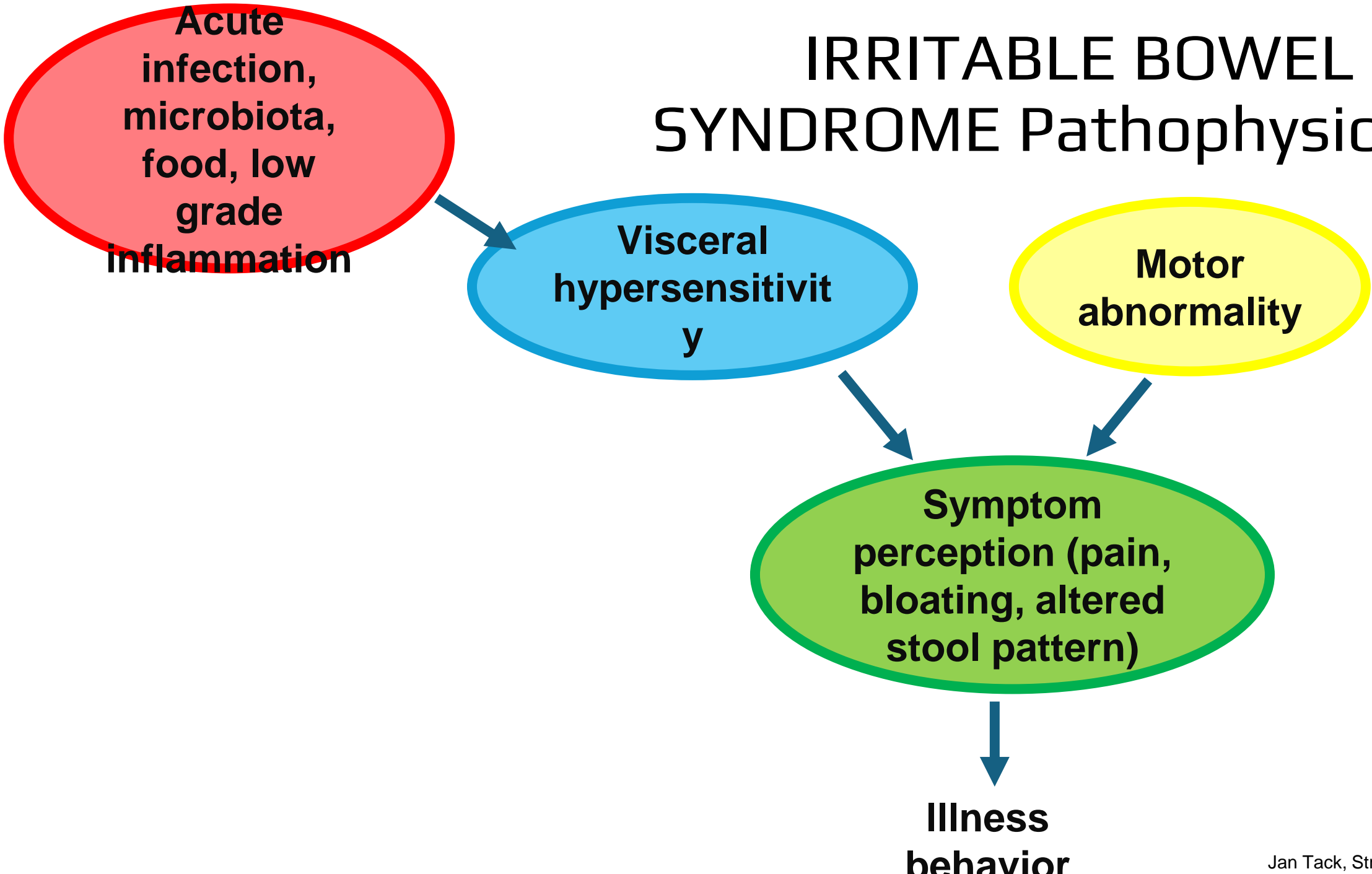
Explain a diagnosis of IBS is still likely and the rationale for further investigations

Investigations normal

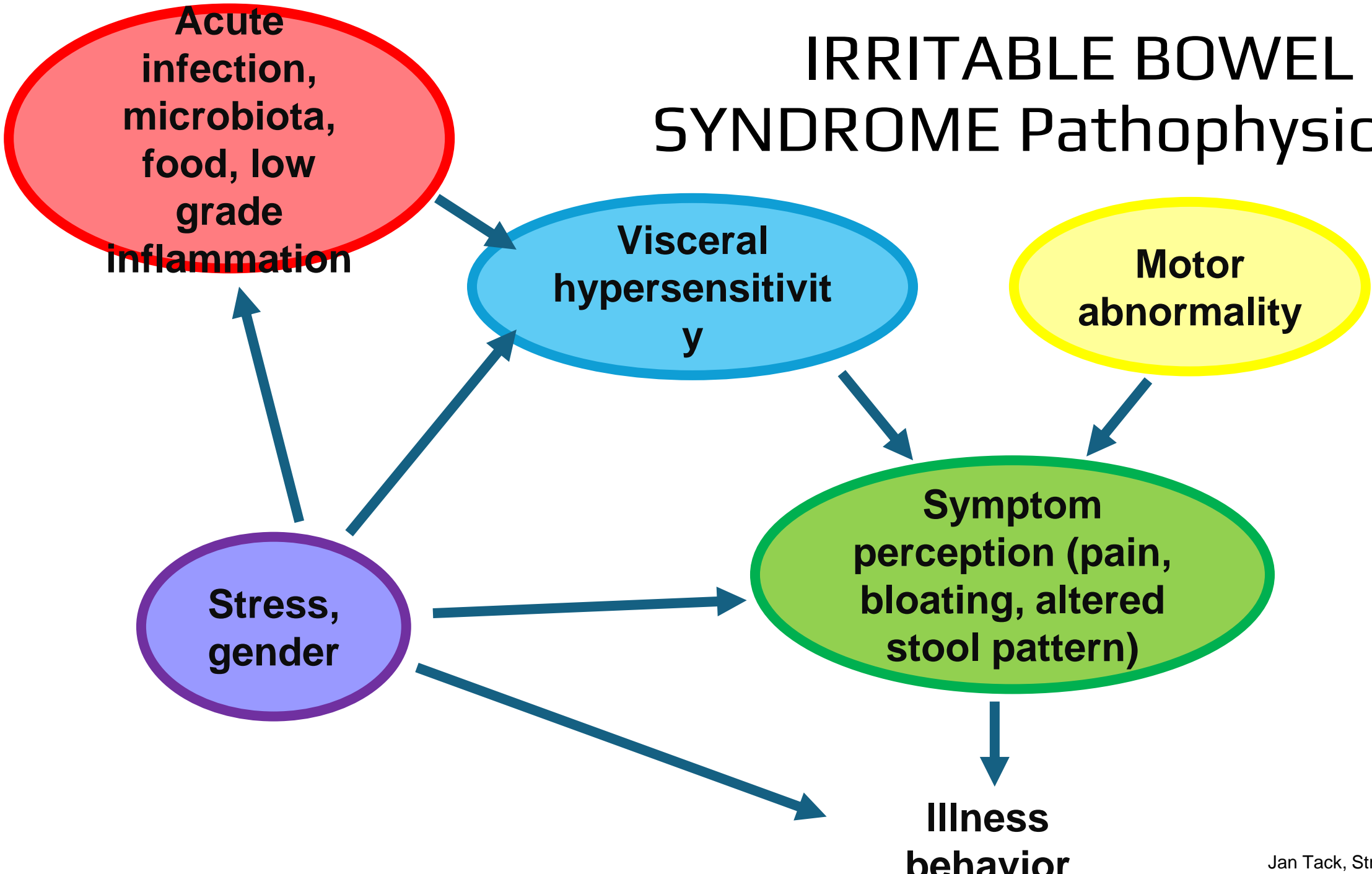
Investigations abnormal

Treat organic disease accordingly

IRRITABLE BOWEL SYNDROME Pathophysiology



IRRITABLE BOWEL SYNDROME Pathophysiology

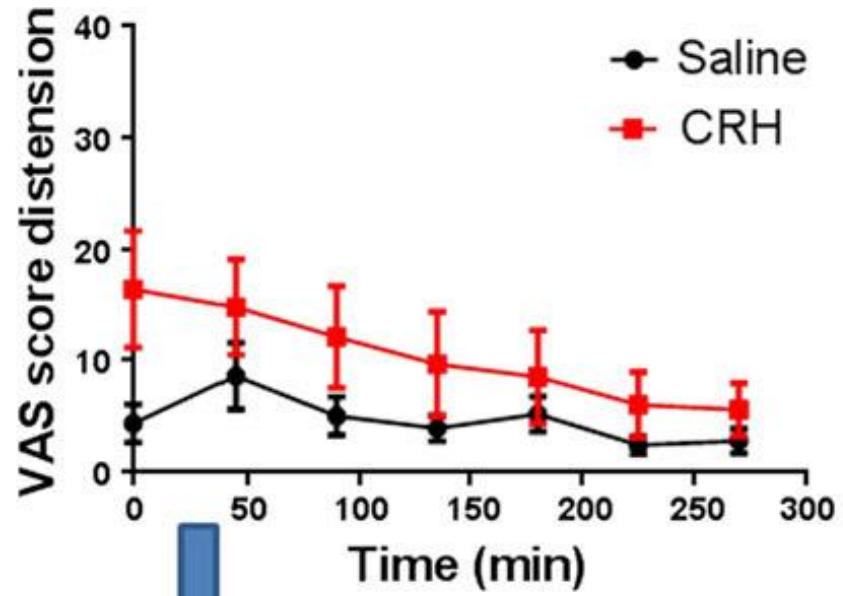


12-year prospective follow up

Baseline IBS 2.1*
higher risk of
Anxiety

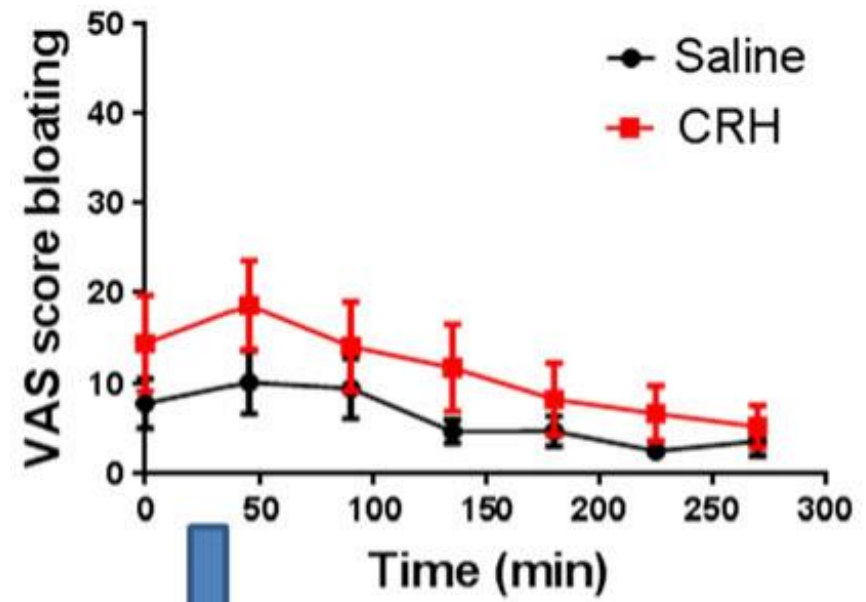
Baseline anxiety
4* higher risk of
IBS

Impact of bi-
directional
interactions



↑
Injection

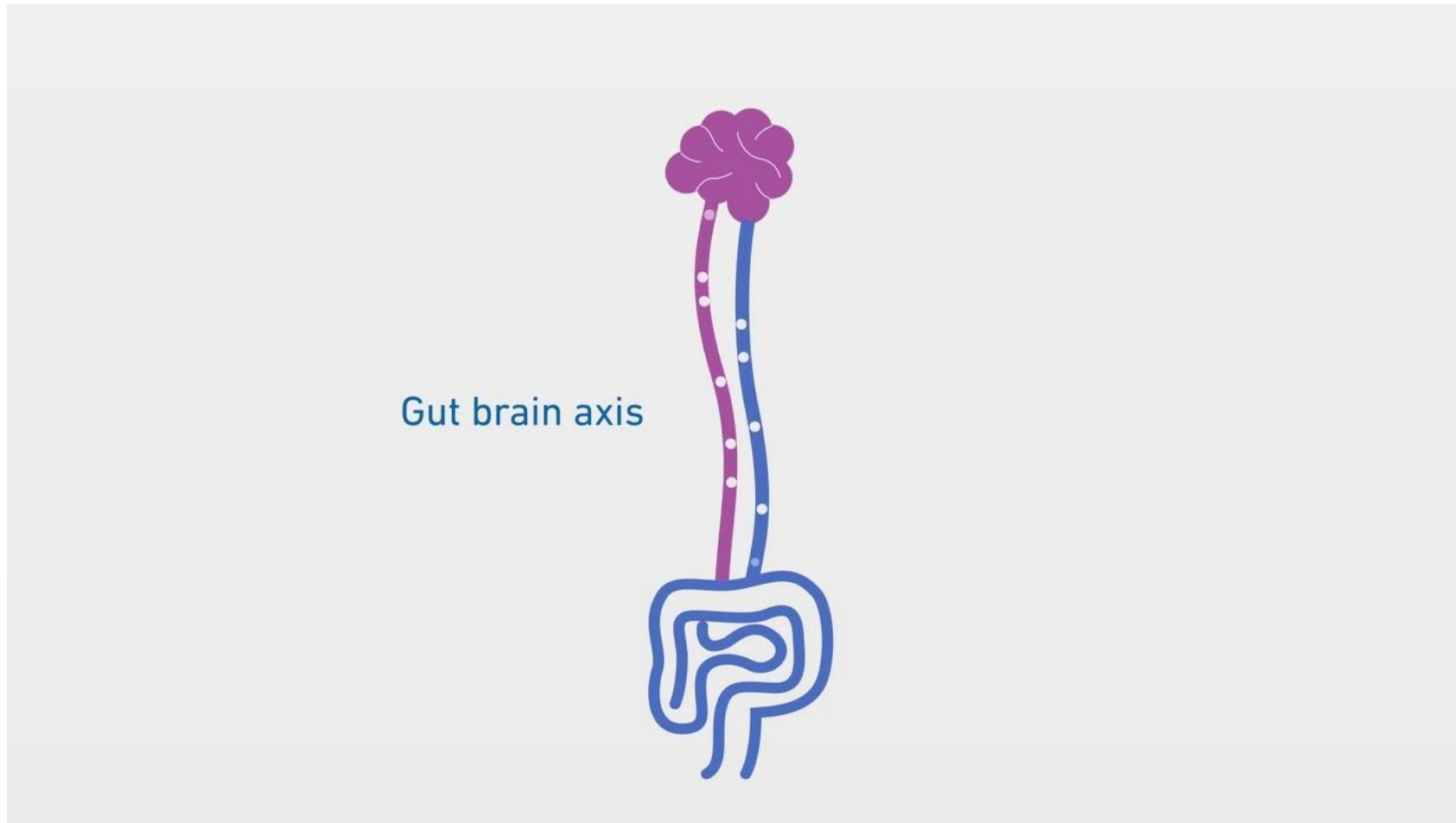
Meal



↑
Injection

Meal

Disorders of Gut-Brain interaction (DGBI)





同理心Empathy (1)

- Evidence suggests that **2 minutes** of active listening at the beginning of a consultation gives the patient the feeling of having being listened to.

BMJ 2002;325:682–3.

同理心Empathy (2)

- It is useful to screen for potential symptom triggers, including previous acute enteric infection, present in approximately 10% of people with IBS, antibiotics or psychological stress.
- This demonstrates to the patient that the clinician is interested in understanding their disorder.

腸躁症診斷標準 (ROME IV)

ROME IV CRITERIA FOR IBS

過去三個月，
平均每週腹痛大於一次
類似狀況已經超過半年

腹痛，並伴隨下面敘述兩項甚至三項

- ① 腹痛的發生或緩解與排便相關
- ② 排便頻率改變
- ③ 排便型態改變

Diagnosis, investigation and education(1)

- ► **The National Institute for Health and Care Excellence** guideline definition of IBS (abdominal pain or discomfort, in association with altered bowel habit, for at least 6 months, in the absence of alarm symptoms or signs).
- ► All patients presenting with symptoms of IBS for the first time in primary care should have a **full blood count, C reactive protein** or **erythrocyte sedimentation rate, coeliac serology**; in patients < 45 years of age with diarrhea, a **faecal calprotectin** to exclude inflammatory bowel disease.

Diagnosis, investigation and education(2)

- ► Local and **national guidelines** for **colorectal** and ovarian cancer screening should be followed, where indicated (recommendation: strong, quality of evidence: moderate).
- ► Clinicians should make a **positive diagnosis** of IBS based on symptoms, in the absence of **alarm symptoms** or signs, and abnormalities on simple blood and stool tests (recommendation: strong, quality of evidence: moderate).
- ► There **is no role for colonoscopy** in IBS, other than in those with alarm symptoms or signs.

Diagnosis, investigation and education(3)

- ► IBS with diarrhoea who have atypical features and/or relevant risk factors that increase the likelihood of them having **microscopic colitis**
 - -female sex
 - -age ≥ 50 years
 - -coexistent autoimmune disease
 - -nocturnal or severe, watery, diarrhoea
 - -duration of diarrhoea < 12 months
 - -weight loss
 - -use of potential precipitating drugs including non-steroidal anti-inflammatory drugs, proton pump inhibitors, etc
- (recommendation: strong, quality of evidence: moderate).

Diagnosis, investigation and education(4)

- ► In those with symptoms suggestive of IBS with diarrhoea, but with atypical features such as nocturnal diarrhoea, or a prior cholecystectomy, **23-seleno-25-homotaurocholic acid scanning or serum 7 α -hydroxy-4-cholesten-3-one** should be considered to exclude bile acid diarrhoea (recommendation: strong, quality of evidence: low).
- ► In patients with IBS and coexisting symptoms suggestive of a **defaecatory disorder** or faecal incontinence, anorectal physiology tests can be considered, where available, to select those who might benefit from biofeedback (recommendation: weak, quality of evidence: low).

Diagnosis, investigation and education(5)

- ► There is no role for testing for exocrine pancreatic insufficiency, or for hydrogen breath testing to rule out small intestinal bacterial overgrowth or carbohydrate intolerance, in patients with typical IBS symptoms (recommendation: strong, quality of evidence: weak).
- ► The diagnosis of IBS, its underlying pathophysiology and the natural history of the condition, including common symptom triggers, should be explained to the patient.
- ► This should introduce the concept of IBS as a disorder of gut-brain interaction, together with a simple account of the gut- brain axis and how this is impacted by diet, stress, cognitive, behavioural and emotional responses to symptoms, and post-infective changes (recommendation: strong, quality of evidence: weak).

	ACG (USA)	BSG (UK)	JSGE (Japan)
Rome Criteria Version	Rome IV	Rome IV	Rome IV
Diagnostic Tests for IBS	Based on symptoms: abdominal pain related to defecation, changes in stool frequency/form	Symptom-based diagnosis focusing on abdominal pain and bowel habits	Symptom-based, using Rome IV criteria with focus on chronic abdominal discomfort
Use of Colonoscopy	Recommended if alarm symptoms (e.g., weight loss, rectal bleeding)	Recommended for atypical symptoms or if patients fail initial management	Recommended for alarm symptoms or risk factors (e.g., family history of colon cancer)
Use of Laboratory Tests	Routine blood tests (e.g., CRP, fecal calprotectin) to rule out IBD	Routine blood tests (including celiac screening) to exclude other conditions	Recommended for ruling out organic diseases (e.g., fecal occult blood test, CRP)
Other Diagnostic Approaches	Consider food allergies, psychological assessment	Screening for celiac disease, use of fecal calprotectin	Consider psychosomatic aspects

First-line treatments (1)

- ▶ All patients with IBS should be advised to take regular exercise (recommendation: strong, quality of evidence: weak).
- ▶ First-line dietary advice should be offered to all patients with IBS (recommendation: strong, quality of evidence: weak).
- ▶ Soluble fibre, such as **ispaghula**, is an effective treatment for global symptoms and abdominal pain in IBS, but **insoluble fibre** (eg, wheat bran) should be avoided as it may exacerbate symptoms.
- ▶ Soluble fibre should be commenced at a low dose (3–4 g/day) and built up gradually to avoid bloating (recommendation: strong; quality of evidence: moderate).

First-line treatments (2)

▶ A diet low in fermentable oligosaccharides, disaccharides and monosaccharides and polyols, **as a second-line dietary therapy**, is an effective treatment for global symptoms and abdominal pain in IBS, **but its implementation should be supervised by a trained dietitian** and should be **reintroduced** according to tolerance (recommendation: weak, quality of evidence very low).

▶ **Probiotics, as a group, may be an effective treatment** for global symptoms and abdominal pain in IBS, but it is not possible to recommend a specific species or strain. It is reasonable to advise patients wishing to try probiotics to take them for up to 12 weeks, and to discontinue them if there is no improvement in symptoms (recommendation: weak, quality of evidence: very low).

First-line treatments (3)

▶ **Certain antispasmodics** may be an effective treatment for global symptoms and abdominal pain in IBS. **Dry mouth, visual disturbance and dizziness** are common side effects (recommendation: weak, quality of evidence: very low).

First-line treatments (4)

- ▶ **Peppermint oil** may be an effective treatment for global symptoms and abdominal pain in IBS. Gastro-oesophageal reflux is a common side effect (recommendation: weak, quality of evidence: very low).
- ▶ **Polyethylene glycol** may be an effective treatment for constipation in IBS. Abdominal pain is a common side effect (recommendation: weak; quality of evidence: very low).

	AGA (USA)	BSG (UK)	JSGE (Japan)
Dietary Modifications	Limited trial of low FODMAP	NICE, fiber (psyllium)	General suggestions
Pharmacological Treatment - IBS-C	Polyethylene glycol, lubiprostone, linaclotide	Psyllium, osmotic laxatives	Lubiprostone, linaclotide
Pharmacological Treatment - IBS-D	Alosetron, rifaximin, loperamide	Loperamide, bile acid sequestrants	Ramosetron, loperamide
Non-Pharmacological Approaches	Psychotherapy, cognitive behavioral therapy (CBT), probiotics	Probiotics, behavioral modifications	Psychotherapy, probiotics, kampo medicine (herbal remedies)



NICE IBS Guidelines

Diet & Nutrition

Diet and nutrition should be assessed for people with IBS and the following general advice given:



Timing of meals

Have regular meals and take time to eat.
Avoid missing meals or leaving long gaps between eating.



Fluid intake

Drink at least 8 cups of fluid per day, especially water or other non-caffeinated drinks.
Restrict tea and coffee to 3 cups per day.
Reduce intake of alcohol and fizzy drinks.



Food (& Fiber) intake

Take soluble fiber. Limit intake of high-fiber food (eg wholemeal or high-fiber flour and breads, cereals high in bran, and whole grains such as brown rice).
Reduce intake of 'resistant starch', which is often found in processed or re-cooked foods.
Limit fresh fruit to 3 portions per day (~80 g per portion).



Probiotic

People with IBS who choose to try probiotics should be advised to take the product for at least 4 weeks while monitoring the effect.
Probiotics should be taken at the dose recommended by the manufacturer



Refer Dietitian

If a person's IBS symptoms persist while following general lifestyle and dietary advice, offer advice on further dietary management including exclusion diets (for example, a low FODMAP diet)
Preferably by a healthcare professional with expertise in dietary management.

Second-line treatments (1)

- **Tricyclic antidepressants** used as gut-brain neuromodulators are an effective second-line drug for global symptoms and abdominal pain in IBS. They can be initiated in primary or secondary care, but careful explanation as to the rationale for their use is required, and patients should be counselled about their side-effect profile. They should be commenced at a low dose (eg, 10 mg amitriptyline once a day) and **titrated slowly** to a maximum of 30–50 mg once a day (recommendation: strong, quality of evidence: moderate).

Second-line treatments (2)

- (IBS-D)
- Selective serotonin reuptake inhibitors; **Eluxadoline**, a mixed opioid receptor drug; 5-Hydroxytryptamine 3 receptor antagonists; The non-absorbable antibiotic **rifaximin**
- (IBS-C)
- **Linaclotide**, a guanylate cyclase-C agonist; **Lubiprostone**, a chloride channel activator; **Plecanatide**, another guanylate cyclase-C agonist; **Tenapanor**, a sodium-hydrogen exchange inhibitor; **Tegaserod**, a 5-Hydroxytryptamine 4 receptor agonist

Psychological therapies

- ▶ IBS-specific **cognitive behavioural therapy** may be an efficacious treatment for global symptoms in IBS (recommendation: strong, quality of evidence: low).
- ▶ **Gut-directed hypnotherapy** may be an efficacious treatment for global symptoms in IBS (recommendation: strong, quality of evidence: low).
- ▶ **Psychological therapies** should be considered when symptoms **have not improved after 12 months of drug treatment**. Referral can be made at an earlier stage, if accessible locally, and based on patient preference (recommendation: strong, quality of evidence: low).

Management of severe or refractory IBS (1)

- Severe or refractory IBS symptoms should prompt **a review of the diagnosis**, with consideration of further targeted investigation (recommendation: weak, evidence: very low).
- Severe or refractory IBS should be managed with an integrated **multi-disciplinary** approach (recommendation: weak, evidence: very low).

Management of severe or refractory IBS (2)

- ▶ **Iatrogenic harms** due to **opioid** prescribing, unnecessary **surgery** and unproven unregulated diagnostic or therapeutic approaches **incentivized**(誘因) by financial or reputational gain should be avoided (recommendation: strong, evidence: very low).
- ▶ Use of **combination gut-brain neuromodulators**, termed augmentation, may be considered for more severe symptoms, with vigilance for risks of serotonin syndrome (recommendation: weak, evidence: very low).

- 66歲男性

- 1. CML, CP, under TASIGNA 300MG bid since 1011004 (bcr-abl)
- 2. Type 2 DM, under Glucophage and insulin control with peripheral neuropathy

2023/04/20 **blockage, severe abdominal pain**, cramping,
unable to defecate. contact with biofeedback

2023/05/11 contact with biofeedback, tumor markers

2023/05/18 most bothersome symptom: mid-night discomfort at
3 o'clock

2023/06/08 Cymbalta (duloxetine) cap 30mg intolerance due to
(dizziness), try neurontin this time, (low dose), dietary record

2023/06/15 dietary record and conslife, keep neurontin

2023/10/12 **admission for refractory abdominal pain**

2023/11/09 keep cymbalta

2023/12/07 keep cymbalta

2024/01/04 keep cymbalta

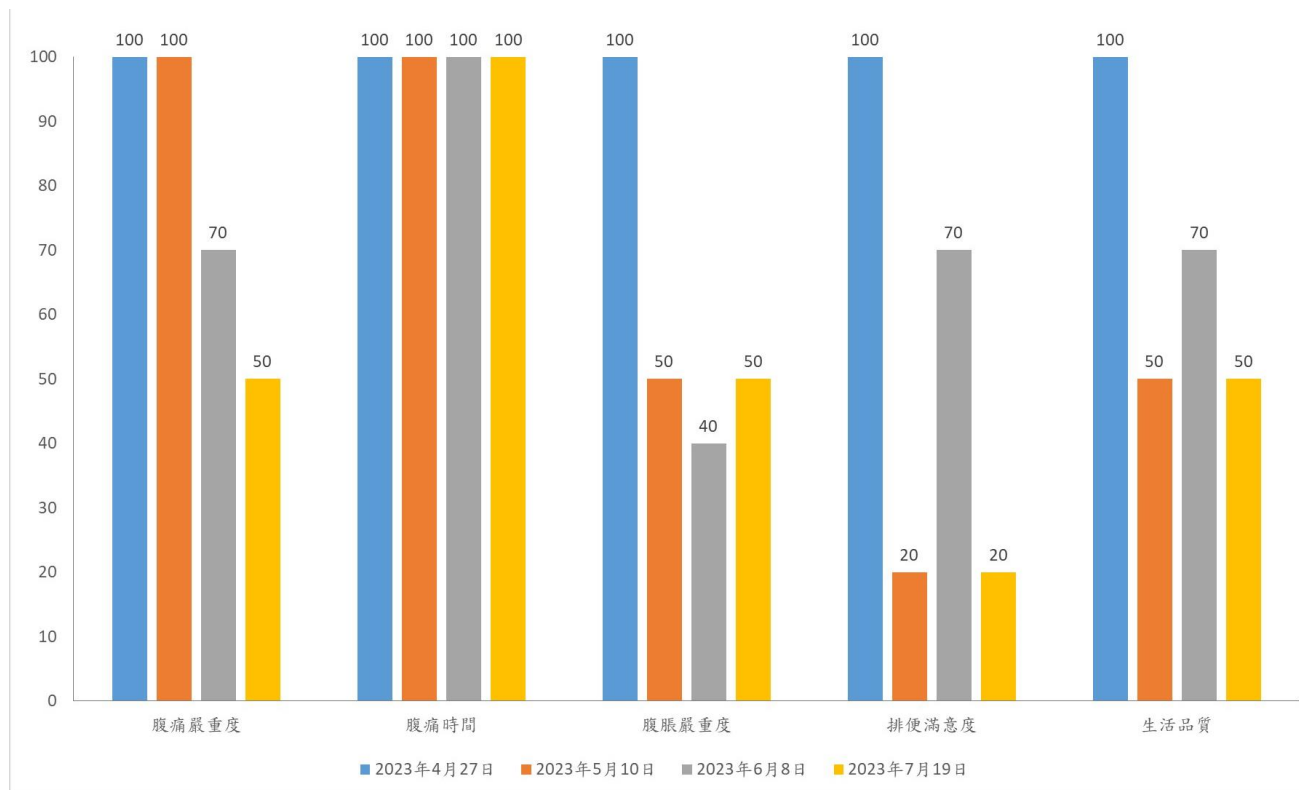
2024/02/29 pain less, but discomfort increased

2024/04/25 OK, but discomfort in the early morning

2024/06/20 generally OK, but discomfort in the early morning,
BW increase

2024/09/12 less mid-night or early morning discomfort,





處方名稱	天數	劑量	單位	頻次	途徑	總量	單位	慢箋	自購	磨粉	M值	註	明細
▶ (健喬) Mag. Oxide tab 250mg	28	2	TAB	TID	PO	168	TAB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3*		明細
Duphalac syrup 300mL	28	30	ML	QD	PO	3	BOT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8*		明細
Nexium tab 40mg	28	1	TAB	QDPRN	PO	28	TAB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8*		明細
Miyarisan BM powder 1Gm	56	1	PAC	TID	PO	168	PKG	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	XX		明細
Conslife tab	84	1	TAB	HS	PO	84	TAB	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	8*		明細
Gasmin tab 40mg	28	2	TAB	TID	PO	168	TAB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2*		明細
Mosad tab 5mg	28	1	TAB	TID	PO	84	TAB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6*		明細
Sunpylon tab 50mg	84	1	TAB	HS	PO	84	TAB	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10*		明細
Duxetine cap 30mg	28	1	CAP	QD	PO	28	CAP	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6*		明細
KoceL powder 6Gm	28	0.50	PKG	QD	PO	14	PKG	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1*		明細

Research (1)

- ▶ Successful completion of large clinical trials will require **pragmatic** inclusion criteria, **minimisation of the participant trial burden** and **effective recruitment strategies** that reach into **community settings**. **Virtual** (remote access) trial approaches will reduce geographical exclusion.
- ▶ A priority-setting partnership would best discern valuable research questions.
- ▶ (設定優先事項的合作夥伴關係最能識別有價值的研究問題)

Research (2)

- **Characterisation** of the illness to understand predictors (clinical, genetic, psychological and biological) of outcome and treatment response, determinants of refractory illness and burden of illness (particularly with respect to workplace productivity) by conducting large-scale epidemiological studies with extended observation.
- **Trials of novel treatments**, including pharmacological, dietary and behavioural therapies, device-based treatments and faecal microbiota transplantation. There is also a need for development of **visceral analgesics**. Consideration should be given to stratifying randomised controlled trials by IBS severity and subtype, burden of extraintestinal symptoms and psychological comorbidity.

Research (3)

- A better understanding of **treatment combinations** to uncover augmentation effects between therapies, and to assess the value of multidisciplinary approaches.
- **Modulation of pain and psychological responses** using pharmacological (eg, serotonin norepinephrine reuptake inhibitors) or behavioural approaches (eg, cognitive behavioural therapy used earlier in the disease course or via digital provision), and comparison of cognitive behavioural therapy with gut-directed hypnotherapy.
- **Med-tech approaches** (web-based, apps and devices) to behavioural modification.

Patient summary (1)

- IBS is a common condition, which is caused by problems arising **between the gut and the brain**. It consists of symptoms like abdominal pain linked to changes in bowel frequency or appearance of stools, and often bloating. Problems in IBS have been found in the nervous system supplying the gut, often making it more sensitive. Psychological factors (including stress), certain foods and the micro-organisms (bugs) living in the gut can all play a role in triggering symptoms. **Occasionally, it can start after a gut infection, or antibiotic use, but more often there is no clear origin.**

Patient summary (2)

- General practitioners will carry out some blood tests, including one to rule out coeliac disease (an immune reaction to gluten) and, if diarrhoea is present, a stool test to rule out inflammation.

Patient summary (3)

- If there are concerning symptoms, including bleeding from the back passage, substantial weight loss or anaemia, a strong family history of cancer, or the patient is older, then the general practitioner will refer to a hospital specialist for further tests. **The specialist may request a camera test of the large bowel, known as a colonoscopy**, or do extra tests to look for other causes of diarrhoea or constipation, especially if the patient's symptoms are less typical of IBS.

Patient summary (4)

- Regular exercise, making some simple dietary changes, and adopting healthy eating patterns will help many patients. Some patients find reducing dietary fibre improves symptoms, while others may find that a soluble fibre supplement helps. Referral to a dietitian can be helpful if these first-line approaches to diet do not help. Taking supplements of probiotics (often referred to as ‘friendly bacteria’) may also help, but these can be expensive. Some patients may require different medications, depending on their main symptom.

Patient summary (5)

- Some medications have most of their effect on the gut itself, others work both at the level of the gut and the brain (called 'neuromodulators' as they help to reduce nerve sensitivity). Some drugs that have good evidence are unfortunately not available, or are too expensive, in some countries.

Patient summary (6)

- There is good evidence that psychological treatments directed against IBS symptoms, especially **cognitive behavioural therapy (CBT)**, and **hypnotherapy**, are helpful for many patients' symptoms, but unfortunately these are not always readily accessible. Work is being done to improve access to these.

Patient summary (7)

- **Very severe symptoms** that do not respond to some of the above treatments are rare. However, patients whose symptoms do not improve may be left feeling desperate, and therefore vulnerable to approaches which are not proven, expensive or high risk. **It is recommended that patients in this position are supported by a multidisciplinary specialist team to help reduce harms, such as unwarranted tests or operations, or harmful drugs.**

	ACG (USA)	BSG (UK)	JSGE (Japan)
Recommended Diet	-	NICE dietary advice	Eliminating foods that exacerbate IBS symptoms, such as lipids, caffeine, spicy food, and milk and dairy products
Low FODMAP Diet	Limited trial of low FODMAP	Considered for non-responders to general dietary advice	In Japan, evaluation of the low FODMAP diet has not shown clear advantage to date and requires further consideration
Fiber Recommendations	Soluble fiber like psyllium, avoid insoluble fiber	Psyllium (soluble fiber) recommended, avoid bran	Bulking polymer intake or dietary fiber intake is an effective
Probiotics Use	We suggest against probiotics for the treatment of global IBS symptoms	Probiotics suggested, trial for at least 4 weeks	Probiotics are effective in treating IBS

感謝大家聆聽~