

# Rome V Updates: Irritable Bowel Syndrome (IBS)

Ten years after its last revision, Rome V provides updated clinical guidance and diagnostic standards for bowel disorders, including IBS<sup>1</sup>



## Rome V diagnostic criteria for IBS<sup>1</sup>

Recurrent, **but not continuous**<sup>1</sup> abdominal pain **or discomfort**<sup>2</sup> on average at least **3 days per month**<sup>3</sup> in the past 3 months, associated with 2 or more of the following criteria:

- Defecation
- Change in frequency of stool
- Change in form (appearance) of stool

Supportive criteria: Abdominal pain/discomfort should not be only related to menses.<sup>4</sup>  
Onset of symptoms at least 6 months before diagnosis.

## What's changed from previous criteria?<sup>1</sup>

### Rome IV:

- 1 Did not specify continuity of pain
- 2 Included abdominal pain only
- 3 Required pain at least 1 day per week
- 4 Did not clarify to rule out menstrual pain/discomfort

Diagnostic criteria adapted from Corsetti M et al. *Gastroenterology*. 2026;170(6):1261-1282. Licensed under CC BY.

Rome V criteria are intended to reflect more recent estimates of IBS epidemiology<sup>1-3</sup>

Revised thresholds increase the prevalence of patients meeting IBS diagnostic criteria<sup>2</sup>

4.1%

Rome IV  
(global estimate)

8.9%

Rome V  
(global estimate)

Rome IV results were based on a survey from 2017-2018 in 26 countries (N=54 127).  
Rome V results were based on a survey from 2024-2025 in 15 countries (N=30 000).



Rome V helps alleviate diagnostic barriers for patients with less severe symptoms<sup>3</sup>

Flip to see how to implement a positive diagnostic approach for IBS with diarrhea (IBS-D) ➡

# Diagnosing IBS-D

## Rome V Reinforces a Positive Approach

### For a positive diagnosis of IBS-D:



#### Symptoms fulfill the Rome V criteria<sup>1,3</sup>

- If symptoms are **bothersome** to the patient, diagnosis can be made with a **lower frequency** and **shorter duration** (8 weeks or more)\*



**Bothersome symptoms** interfere with life activities and/or impact the patient enough to seek medical care<sup>3</sup>

\*Provided there is clinical confidence that other diagnoses have been sufficiently ruled out based on presentation and additional investigations as needed.<sup>3</sup>

#### IBS-D SUBTYPING

#### Verify predominant stool form for IBS-D<sup>1,†</sup>

>25% of BMs are diarrhea  
(BSFS type 6 or 7) **AND** <25% of BMs are hard,  
lumpy stool (BSFS type 1 or 2)  
OR patient reports **abnormal BMs are usually diarrhea**

†Evaluated only when the patient is not taking medications used to treat bowel habit symptoms.



#### Any alarm features are ruled out<sup>1</sup>

- Anemia
- Rectal bleeding
- Unexplained weight loss
- Nocturnal diarrhea
- Symptom onset after age 50
- Fecal incontinence
- Family history of CRC, IBD, or celiac disease

Limited diagnostic testing includes CBC, CRP, and celiac serology for all patients showing symptoms.



#### Normal physical examination<sup>1</sup>

- No tenderness, distension, and/or masses



**Most patients with IBS-D have multiple burdensome symptoms (abdominal pain, diarrhea, bloating, urgency)<sup>4</sup>**

**Rome V** supports making a positive IBS-D diagnosis using symptom-based criteria and limited diagnostic testing<sup>1</sup>



Scan to access the Rome V Classification of Bowel Disorders

Content contained in this educational disease-state resource is being provided by Salix Pharmaceuticals for informational purposes only. Clinicians should use their own clinical judgment in diagnosing patients.

BM, bowel movement; BSFS, Bristol Stool Form Scale; CBC, complete blood count; CRC, colorectal cancer; CRP, C-reactive protein; IBD, inflammatory bowel disease.

**References:** 1. Corsetti M et al. *Gastroenterology*. 2026;170(6):1261-1282. 2. Palsson OS et al. *Gastroenterology*. 2026;170(6):1408-1416. 3. Drossman DA et al. *Gastroenterology*. 2026;170(6):1083-1098. 4. AGA. *IBS in America: Survey Summary Findings*. December 2015.

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