Functional bowel disorders and functional abdominal pain

W G Thompson, G F Longstreth, D A Drossman, K W Heaton, E J Irvine, S A Müller-Lissner

Abstract
The Rome diagnostic criteria for the functional bowel disorders and functional abdominal pain are used widely in research and practice. A committee consensus approach, including criticism from multinational expert reviewers, was used to revise the diagnostic criteria and update diagnosis and treatment recommendations, based on research results. The terminology was clarified and the diagnostic criteria and management recommendations were revised. A functional bowel disorder (FBD) is diagnosed by characteristic symptoms for at least 12 weeks during the preceding 12 months in the absence of a structural or biochemical explanation. The irritable bowel syndrome, functional abdominal bloating, functional constipation, and functional diarrhea are distinguished by symptom-based diagnostic criteria. Unspecified FBD lacks criteria for the other FBDs. Diagnostic testing is individualized, depending on patient age, primary symptom characteristics, and other clinical and laboratory features. Functional abdominal pain (FAP) is defined as either the FAP syndrome, which requires at least six months of pain with poor relation to gut function and loss of daily activities, or unspecified FAP, which lacks criteria for the FAP syndrome. An organic cause for the pain must be excluded, but aspects of the patient’s pain behavior are of primary importance. Treatment of the FBDs relies upon confident diagnosis, explanation, and reassurance. Diet alteration, drug treatment, and psychotherapy may be beneficial, depending on the symptoms and psychological features.

Keywords: functional bowel disorder; functional constipation; functional diarrhea; irritable bowel syndrome; functional abdominal pain; functional abdominal bloating; Rome II

The functional bowel disorders and functional abdominal pain are common and cause much suffering. As these entities are identified by symptoms and patient care is highly individualized, a symptom-based classification has great importance, particularly for use in clinical trials (table 1).

The 1998 Working Team assessed the terminology and results of relevant clinical research in order to revise the diagnostic criteria, comment further on diagnosis, and summarize treatment recommendations.

C. Functional bowel disorders
A functional bowel disorder (FBD) is a functional gastrointestinal disorder with symptoms attributable to the mid or lower gastrointestinal tract, including the irritable bowel syndrome (IBS), functional abdominal bloating, functional constipation, functional diarrhea, and unspecified functional bowel disorder.

Subjects with a FBD may be divided into the following groups:

Abbreviations used in this paper: FBD, functional bowel disorder; IBS, irritable bowel syndrome; FAPS, functional abdominal pain syndrome.

Table 1 Functional gastrointestinal disorders

<table>
<thead>
<tr>
<th>Group</th>
<th>Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Esophageal disorders</td>
<td>A1. Globus</td>
</tr>
<tr>
<td>A2. Ruminationsyndrome</td>
<td></td>
</tr>
<tr>
<td>A3. Functional chest pain of presumed esophageal origin</td>
<td></td>
</tr>
<tr>
<td>A4. Functional heartburn</td>
<td></td>
</tr>
<tr>
<td>A5. Functional dysphagia</td>
<td></td>
</tr>
<tr>
<td>A6. Unspecified functional esophageal disorder</td>
<td></td>
</tr>
<tr>
<td>B. Gastrointestinal disorders</td>
<td>B1. Functional dyspepsia</td>
</tr>
<tr>
<td>B1a. Ulcer-like dyspepsia</td>
<td></td>
</tr>
<tr>
<td>B1b. Dysmotility-like dyspepsia</td>
<td></td>
</tr>
<tr>
<td>B1c. Unspecified (non-specific) dyspepsia</td>
<td></td>
</tr>
<tr>
<td>B2. Aerophagia</td>
<td></td>
</tr>
<tr>
<td>B3. Functional vomiting</td>
<td></td>
</tr>
<tr>
<td>C. Bowel disorders</td>
<td>C1. Irritable bowel syndrome</td>
</tr>
<tr>
<td>C2. Functional abdominal bloating</td>
<td></td>
</tr>
<tr>
<td>C3. Functional constipation</td>
<td></td>
</tr>
<tr>
<td>C4. Functional diarrhea</td>
<td></td>
</tr>
<tr>
<td>C5. Unspecified functional bowel disorder</td>
<td></td>
</tr>
<tr>
<td>D. Functional abdominal pain</td>
<td>D1. Functional abdominal pain syndrome</td>
</tr>
<tr>
<td>D2. Unspecified functional abdominal pain</td>
<td></td>
</tr>
<tr>
<td>E. Biliary disorders</td>
<td>E1. Gall bladder dysfunction</td>
</tr>
<tr>
<td>E2. Sphincter of Oddi dysfunction</td>
<td></td>
</tr>
<tr>
<td>F. Anorectal disorders</td>
<td>F1. Functional fecal incontinence</td>
</tr>
<tr>
<td>F2. Functional anorectal pain</td>
<td></td>
</tr>
<tr>
<td>F2a. Levator ani syndrome</td>
<td></td>
</tr>
<tr>
<td>F2b. Proctalgia fugax</td>
<td></td>
</tr>
<tr>
<td>F3. Pelvic floor dyssynergia</td>
<td></td>
</tr>
<tr>
<td>G. Functional pediatric disorders</td>
<td></td>
</tr>
<tr>
<td>G1. Vomiting</td>
<td></td>
</tr>
<tr>
<td>G1a. Infant regurgitation</td>
<td></td>
</tr>
<tr>
<td>G1b. Infant rumination syndrome</td>
<td></td>
</tr>
<tr>
<td>G1c. Cyclic vomiting syndrome</td>
<td></td>
</tr>
<tr>
<td>G2. Abdominal pain</td>
<td></td>
</tr>
<tr>
<td>G2a. Functional dyspepsia</td>
<td></td>
</tr>
<tr>
<td>G2b. Irritable bowel syndrome</td>
<td></td>
</tr>
<tr>
<td>G2c. Functional abdominal pain</td>
<td></td>
</tr>
<tr>
<td>G2d. Abdominal migraine</td>
<td></td>
</tr>
<tr>
<td>G2e. Aerophagia</td>
<td></td>
</tr>
<tr>
<td>G3. Functional diarrhea</td>
<td></td>
</tr>
<tr>
<td>G4. Disorders of defecation</td>
<td></td>
</tr>
<tr>
<td>G4a. Functional fecal retention</td>
<td></td>
</tr>
<tr>
<td>G4b. Functional constipation</td>
<td></td>
</tr>
<tr>
<td>G4c. Functional fecal soiling</td>
<td></td>
</tr>
<tr>
<td>G4d. Non-retentive fecal soiling</td>
<td></td>
</tr>
</tbody>
</table>
(1) non-patients: those who have never sought health care for the FBD;
(2) patients: those who have sought care for the FBD; (a) incident cases: those who have sought care for the FBD for the first time in the past year; (b) prevalent cases: those who have ever sought care for the FBD.

Symptoms of a FBD must have been present for 12 weeks or more within the past 12 months; the 12 weeks need not be consecutive. The diagnosis always presumes the absence of a structural or biochemical explanation for the symptoms.

The Working Team changed the definitions of IBS, functional abdominal bloating and functional constipation from a “disorder” to “disorders” to acknowledge multiple pathophysiologic possibilities. For IBS, “discomfort” was added to “pain” to broaden symptom description, and “distension” was deleted.

To clarify how discomfort and pain are temporally related to a change in frequency and form of stool, “onset” was added to the relevant symptom features. The symptom criteria for IBS were changed (a) by designating the non-pain-related, the second part of the previous criteria, as nonessential due to their poor clustering in factor analyses; (b) their lesser prevalence in men; and (c) the partial duplication in the retained, pain-related criteria.

Furthermore, these symptoms were clarified by replacing the term “altered” with “abnormal.” The criteria for functional constipation were expanded due to the overlap between it and the functional anorectal disorders (see Functional disorders of the anus and rectum).

C1. Irritable bowel syndrome
IBS comprises a group of functional bowel disorders in which abdominal discomfort or pain is associated with defecation or a change in bowel habit, and with features of disordered defecation.

Surveys of Western populations have revealed IBS in 15–20% of adolescents and adults, with a higher prevalence in women; the prevalence is variable in other populations. IBS has a chronic relapsing course and overlaps with other functional gastrointestinal disorders. It accounts for high direct medical expenses and indirect costs, including absenteeism from work.

### DIAGNOSTIC CRITERIA
At least 12 weeks, which need not be consecutive, in the preceding 12 months of abdominal discomfort or pain that has two of three features:
1. Relieved with defecation; and/or
2. Onset associated with a change in frequency of stool; and/or
3. Onset associated with a change in form (appearance) of stool.

The following symptoms cumulatively support the diagnosis of IBS:
- abnormal stool frequency (for research purposes “abnormal” may be defined as >3/day and <3/week);
populations, usually with a female predominance.\textsuperscript{14,15} \textbf{DIAGNOSTIC CRITERIA} At least 12 weeks, which need not be consecutive, in the preceding 12 months of: (1) Feeling of abdominal fullness, bloating, or visible distension; and (2) Insufficient criteria for a diagnosis of functional dyspepsia, IBS, or other functional disorder.

**DIAGNOSTIC COMMENTS**
Functional bloating is usually absent on awakening and worsens throughout the day. It may be intermittent and related to ingestion of specific foods. Excessive burping or farting may be present, but these are not necessarily related to the bloating. Diarrhea, weight loss, or nutritional deficiency should alert the physician to investigate for another disorder.

**TREATMENT RECOMMENDATIONS**
There is no proved effective therapy for functional bloating, and its cause is unknown, so only education and reassurance are recommended. The common practice of restricting certain “gas-forming” foods may be beneficial but even patients with confirmed lactase deficiency can drink 250 ml milk with no or negligible bloating.\textsuperscript{17}

**C3. Functional constipation**
Functional constipation comprises a group of functional disorders which present as persistent difficult, infrequent or seemingly incomplete defecation.

Constipation occurs in up to 20% of populations, depending on demographic factors, sampling and the definition used. It is more common in women and is usually found to increase with age.\textsuperscript{3,18} \textbf{DIAGNOSTIC CRITERIA} At least 12 weeks, which need not be consecutive, in the preceding 12 months of two or more of: (1) Straining in >1/4 defecations; (2) Lumpy or hard stools in >1/4 defecations; (3) Sensation of incomplete evacuation in >1/4 defecations; (4) Sensation of anorectal obstruction/blockade in >1/4 defecations; (5) Manual maneuvers to facilitate >1/4 defecations (e.g., digital evacuation, support of the pelvic floor); and/or (6) <3 defecations/week. Loose stools are not present, and there are insufficient criteria for IBS.

**DIAGNOSTIC COMMENTS**
The physician should clarify what the patient means by constipation, as patients describe it in various ways.\textsuperscript{18} Many, if not most patients actually have the rectal symptoms of IBS with or without lumpy stools.\textsuperscript{20} Evaluation of the patient’s general health, psychological status, use of constipating medications, dietary fiber intake, and medical illnesses (e.g., hypothyroidism) is important. In patients who do not respond to fiber supplementation, measurements of whole gut transit time\textsuperscript{21} and anorectal function\textsuperscript{22} may be indicated to place them in a physiological subgroup.

**TREATMENT RECOMMENDATIONS**
Dietary fiber increases fecal bulk by providing indigestible matter and promoting fecal water holding and bacterial proliferation.\textsuperscript{21} Other useful bulking agents include psyllium, methylcellulose, and calcium polycarbophil. Severely constipated patients may respond to polyethylene glycol solution.\textsuperscript{23} Otherwise, stimulant laxatives such as bisacodyl, sodium picosulfate, or sennosides may be tried. Specific treatment for patients in the anorectal dysfunction subgroup is discussed in Functional disorders of the anus and rectum.

**C4. Functional diarrhea**
Functional diarrhea is continuous or recurrent passage of loose (mushy) or watery stools without abdominal pain.

A British population survey of stool form (a scale previously validated against symptoms and transit time\textsuperscript{21}) revealed liquid stools were the predominant type described by 5.3% of men and 4.3% of women.\textsuperscript{25} Liquid stools were more common in women under 50 years of age than in older women.

**DIAGNOSTIC CRITERIA** At least 12 weeks, which need not be consecutive, in the preceding 12 months of: (1) Liquid (mushy) or watery stools; (2) Present >3/4 of the time; and (3) No abdominal pain.

**DIAGNOSTIC COMMENTS**
Pseudodiarrhea (frequent defecation and urgency with solid stools) must be distinguished from diarrhea. Chronic diarrhea without pain is caused by many diseases indistinguishable by history, which should be excluded by diagnostic testing. Basic evaluation includes routine blood and stool tests plus sigmoidoscopy with biopsy. Features atypical for a functional disorder (e.g., large volume stools, rectal bleeding, nutritional deficiency, and weight loss) call for more extensive studies of intestinal structure and function—for example, radiography, duodenal biopsy, and serum hormone assay.

**TREATMENT RECOMMENDATIONS**
Discussion of possible psychosocial factors, symptom explanation, and reassurance are important. Restriction of foods which seem provocative may help. Empiric antidiarrheal therapy (e.g., diphenoxylate or loperamide) is usually effective, especially if taken prophylactically, such as before meals. The occasional patient responds to cholestyramine. Fortunately, spontaneous remissions are common.\textsuperscript{26}
C5. Unspecified functional bowel disorder

An unspecified functional bowel disorder is defined as functional bowel symptoms that do not meet criteria for the previously defined categories.

D. Functional abdominal pain

Functional abdominal pain describes continuous, nearly continuous, or frequently recurrent pain localized in the abdomen but poorly related to gut function.

Functional abdominal pain is divided into two categories.

D1. Functional abdominal pain syndrome

Functional abdominal pain syndrome (FAPS), also called “chronic idiopathic abdominal pain” or “chronic functional abdominal pain,” describes pain for at least six months that is poorly related to gut function and is associated with some loss of daily activities.

FAPS occurs in 1.7% of people, mainly women, and is associated with significant absenteeism from work and physician visits. Over time, patients with FAPS tend to have many specialist referrals, diagnostic tests and major abdominal and pelvic operations.

DIAGNOSTIC CRITERIA
At least six months of:
(1) Continuous or nearly continuous abdominal pain; and
(2) No or only occasional relation of pain with physiological events (e.g., eating, defecation or menses); and
(3) Some loss of daily functioning; and
(4) The pain is not feigned (e.g., malingering); and
(5) Insufficient criteria for other functional gastrointestinal disorders that would explain the abdominal pain.

DIAGNOSTIC COMMENTS
Aspects of the patient’s pain behavior are of primary importance. Typically, the pain is described in emotional or bizarre terms, involves a large anatomic area, is associated with other painful symptoms, and is part of a continuum of painful experiences over many years. Usually, patients urgently report pain as extremely intense, and they request many diagnostic studies or surgery, focus primarily on the illness, and relentlessly seek pain relief and validation that the pain is “organic.” They often ignore or deny a role for psychosocial contributions and absolve personal responsibility for self-management, while placing high expectations for relief on the physician. Pain behavior may diminish when the patient is distracted or not aware of being observed. A spouse or parent may be so affected by the patient’s illness as to report the history. Requests for narcotics are common. FAPS may co-exist with a structural disease (e.g., chronic pancreatitis) or FBD (e.g., IBS). The observation of a lack autonomic arousal, eye closure during abdominal examination, and diminished pain behavior with stethoscope application to the abdomen are typical. Multiple abdominal scars are common.

TREATMENT RECOMMENDATIONS
Management depends on an effective doctor–patient relationship, including reasonable goals, regular appointments and, in some cases, concurrent psychological treatment. Analgesics are ineffective, and narcotics should be avoided. Concurrent depression should be treated. Low doses of antidepressants can reduce pain as well as insomnia. Anxiolytic therapy, if used at all, should be limited in duration. Various types of psychotherapy have been tried without critical evaluation. A multidisciplinary pain management program may be the most promising approach.

D2. Unspecified functional abdominal pain

Unspecified functional abdominal pain is functional abdominal pain which fails to meet criteria for FAPS (D1).


For further information and updates on *Rome II*, visit our website at: www.romecriteria.org
Functional bowel disorders and functional abdominal pain

W G Thompson, G F Longstreth, D A Drossman, K W Heaton, E J Irvine and S A Müller-Lissner

_Gut_ 1999 45: II43-II47
doi: 10.1136/gut.45.2008.ii43

Updated information and services can be found at:
http://gut.bmj.com/content/45/suppl_2/II43

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

- Colon cancer (1547)
- Irritable bowel syndrome (327)
- Constipation (198)
- Diarrhoea (663)

Notes