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 therapy, and psychotherapy may be beneficial, depending on the symptoms and psychological features.

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

Table 1  Functional gastrointestinal disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Esophageal disorders</td>
</tr>
<tr>
<td>A1.</td>
<td>Globus</td>
</tr>
<tr>
<td>A2.</td>
<td>Rummination syndrome</td>
</tr>
<tr>
<td>A3.</td>
<td>Functional chest pain of presumed esophageal origin</td>
</tr>
<tr>
<td>A4.</td>
<td>Functional heartburn</td>
</tr>
<tr>
<td>A5.</td>
<td>Functional dysphagia</td>
</tr>
<tr>
<td>A6.</td>
<td>Unspecified functional esophageal disorder</td>
</tr>
<tr>
<td>B.</td>
<td>Gastroduodenal disorders</td>
</tr>
<tr>
<td>B1.</td>
<td>Functional dyspepsia</td>
</tr>
<tr>
<td>B1a.</td>
<td>Ulcer-like dyspepsia</td>
</tr>
<tr>
<td>B1b.</td>
<td>Dysmotility-like dyspepsia</td>
</tr>
<tr>
<td>B1c.</td>
<td>Unspecified (non-specific) dyspepsia</td>
</tr>
<tr>
<td>B2.</td>
<td>Aerophagia</td>
</tr>
<tr>
<td>B3.</td>
<td>Functional vomiting</td>
</tr>
<tr>
<td>C.</td>
<td>Bowel disorders</td>
</tr>
<tr>
<td>C1.</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>C2.</td>
<td>Functional abdominal bloating</td>
</tr>
<tr>
<td>C3.</td>
<td>Functional constipation</td>
</tr>
<tr>
<td>C4.</td>
<td>Functional diarrhea</td>
</tr>
<tr>
<td>C5.</td>
<td>Unspecified functional bowel disorder</td>
</tr>
<tr>
<td>D.</td>
<td>Functional abdominal pain</td>
</tr>
<tr>
<td>D1.</td>
<td>Functional abdominal pain syndrome</td>
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<td>D2.</td>
<td>Unspecified functional abdominal pain</td>
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<td>E.</td>
<td>Biliary disorders</td>
</tr>
<tr>
<td>E1.</td>
<td>Gall bladder dysfunction</td>
</tr>
<tr>
<td>E2.</td>
<td>Sphincter of Oddi dysfunction</td>
</tr>
<tr>
<td>F.</td>
<td>Anorectal disorders</td>
</tr>
<tr>
<td>F1.</td>
<td>Functional fecal incontinence</td>
</tr>
<tr>
<td>F2.</td>
<td>Functional anorectal pain</td>
</tr>
<tr>
<td>F2a.</td>
<td>Levator ani syndrome</td>
</tr>
<tr>
<td>F2b.</td>
<td>Proctalgia fugax</td>
</tr>
<tr>
<td>F3.</td>
<td>Pelvic floor dysynchrony</td>
</tr>
<tr>
<td>G.</td>
<td>Functional pediatric disorders</td>
</tr>
<tr>
<td>G1.</td>
<td>Vomiting</td>
</tr>
<tr>
<td>G1a.</td>
<td>Infant regurgitation</td>
</tr>
<tr>
<td>G1b.</td>
<td>Infant rumination syndrome</td>
</tr>
<tr>
<td>G1c.</td>
<td>Cyclic vomiting syndrome</td>
</tr>
<tr>
<td>G2.</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>G2a.</td>
<td>Functional dyspepsia</td>
</tr>
<tr>
<td>G2b.</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>G2c.</td>
<td>Functional abdominal pain</td>
</tr>
<tr>
<td>G2d.</td>
<td>Abdominal migraine</td>
</tr>
<tr>
<td>G2e.</td>
<td>Aerophagia</td>
</tr>
<tr>
<td>G3.</td>
<td>Functional diarrhea</td>
</tr>
<tr>
<td>G4.</td>
<td>Disorders of defecation</td>
</tr>
<tr>
<td>G4a.</td>
<td>Infant dyschezia</td>
</tr>
<tr>
<td>G4b.</td>
<td>Functional constipation</td>
</tr>
<tr>
<td>G4c.</td>
<td>Functional fecal retention</td>
</tr>
<tr>
<td>G4d.</td>
<td>Non-retentive fecal soiling</td>
</tr>
</tbody>
</table>

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.

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C1. Irritable bowel syndrome

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

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. IBS can be classified according to symptom features. 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);
- Abnormal stool form (lumpy/hard or loose/watery stool);
- Abnormal stool passage (straining, urgency, or feeling of incomplete evacuation);
- Passage of mucus;
- Bloating or feeling of abdominal distension.

These symptoms can be used to subclassify patients with predominant diarrhea or constipation for entry into clinical trials (table 2).

TABLE 2 Supportive symptoms of the irritable bowel syndrome

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fever than three bowel movements a week</td>
<td></td>
</tr>
<tr>
<td>2. More than three bowel movements a day</td>
<td></td>
</tr>
<tr>
<td>3. Hard or lumpy stools</td>
<td></td>
</tr>
<tr>
<td>4. Loose (mushy) or watery stools</td>
<td></td>
</tr>
<tr>
<td>5. Straining during a bowel movement</td>
<td></td>
</tr>
<tr>
<td>6. Urgency (having to rush to have a bowel movement)</td>
<td></td>
</tr>
<tr>
<td>7. Feeling of incomplete bowel movement</td>
<td></td>
</tr>
<tr>
<td>8. Passing mucus (white material) during a bowel movement</td>
<td></td>
</tr>
<tr>
<td>9. Abdominal fullness, bloating or swelling</td>
<td></td>
</tr>
</tbody>
</table>

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 defeation; 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. Functional bowel disorders and functional abdominal pain

### 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.

#### 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. Functional constipation

### Diagnostic Criteria

At least 12 weeks, which need not be consecutive, in the preceding 12 months 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. Many, if not most patients actually have the rectal symptoms of IBS with or without lumpy stools. 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 and anorectal function 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. Other useful bulking agents include psyllium, methylcellulose, and calcium polycarbophil. Severely constipated patients may respond to polyethylene glycol solution. 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) revealed liquid stools were the predominant type described by 5.3% of men and 4.3% of women. 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.
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 absolute 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).


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