therapies are available. Individuals with Rome IV-defined IBS had more severe symptoms, and higher levels of mood disorder and poor psychological health, compared with those who only met the Rome III criteria for IBS ($P < 0.001$).

Conclusions Moving from the Rome III criteria to Rome IV IBS has substantial implications, both for individuals who believe they suffer from IBS, and for the spectrum of disease severity seen. Understanding the impact of these changes on clinical trials of novel therapies will be important.

Abstract OWE-13 Table 1. Reasons for not Meeting the Rome IV Criteria for IBS Among those Meeting the Rome III Criteria.

	Met Rome III criteria, but not Rome IV criteria, for IBS (n = 286)
Reported abdominal discomfort, rather than abdominal pain (%)	26 (9.1)
Did not report abdominal pain at the required frequency (%)	253 (88.5)
Other reasons (%)	7 (2.4)

OWE-14 SYMPTOM BURDEN IN CHRONIC CONSTIPATION IS PREDICTED BY SENSORY DOMAINS, NOT STOOL FREQUENCY

^{1,2}James Ruffle*, ³Linda Tinkler, ³Christopher Emmett, ¹Qasim Aziz, ^{1,4}Adam Farmer, ³Yian Yiannakou. ¹Blizard Institute, Wingate Institute Of Neurogastroenterology, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK; ²Department of Radiology, University College London Hospital Trust, London, UK; ³Durham Bowel Dysfunction Service, County Durham and Darlington NHS Trust, UK; ⁴Department of Gastroenterology, University Hospitals Midlands NHS Trust, Staffordshire, UK

10.1136/gutjnl-2019-BSGAbstracts.393

Introduction Clinical practice and trial endpoints studying chronic constipation typically define therapeutic success by

increasing stool frequency, using this as a marker for improvement in symptom burden and patient quality of life (QOL). *However*, given constipation engenders numerous other distressing symptoms, such as abdominal pain, bloating, tenesmus or nausea and vomiting, we investigated the predictors of symptom burden and QOL.

Methods 768 patients attending with chronic constipation to a tertiary service underwent quantification of symptom measures in a prospective cohort study design. The validated PAC-sym and -qol questionnaires were used as markers for overall symptom burden and QOL. Transit studies were performed in all patients using radio-opaque marker technique. Effect sizes of demographics, stool frequency and GI symptoms in accounting for total symptom burden and QOL were calculated. Analyses were multiple comparison corrected by false discovery rate.

Results

Predictors of symptom burden frequency and severity of pain (including relation to defecation attempts) were the strongest predictors (all $\text{corr-}p < 0.0001$, Cohen's D ~ 0.8 , large effect size) (Fig 1). Frequency of stool passage was a weak predictor ($\text{corr-}p < 0.0001$, Cohen's D ~ 0.48 , small-medium effect size). **Predictors of quality of life:** abdominal bloating and pain severity were the strongest predictors of QOL (all $\text{corr-}p < 0.0001$, Cohen's D > 0.7 , medium-large effect size). Stool frequency and transit measures were non-significantly related to total QOL.

Conclusions Sensory symptoms (pain and bloating), not features of disturbed motility (stool frequency and transit), are the most predictive in determining overall symptom burden and QOL. Endpoints of clinical trials should focus on attenuating these symptom measures rather than merely changing bowel habit.

Values of effect sizes are in Cohen's d, wherein roughly a value of 0.2 equates to a small effect size (S^{es}), 0.5 a medium effect size (M^{es}) and 0.8 a large effect size (L^{es}). Abbreviations: ODS, obstructed defecation score.

Abstract OWE-14 Figure 1: Determinants of symptom burden and QOL in chronic constipation.