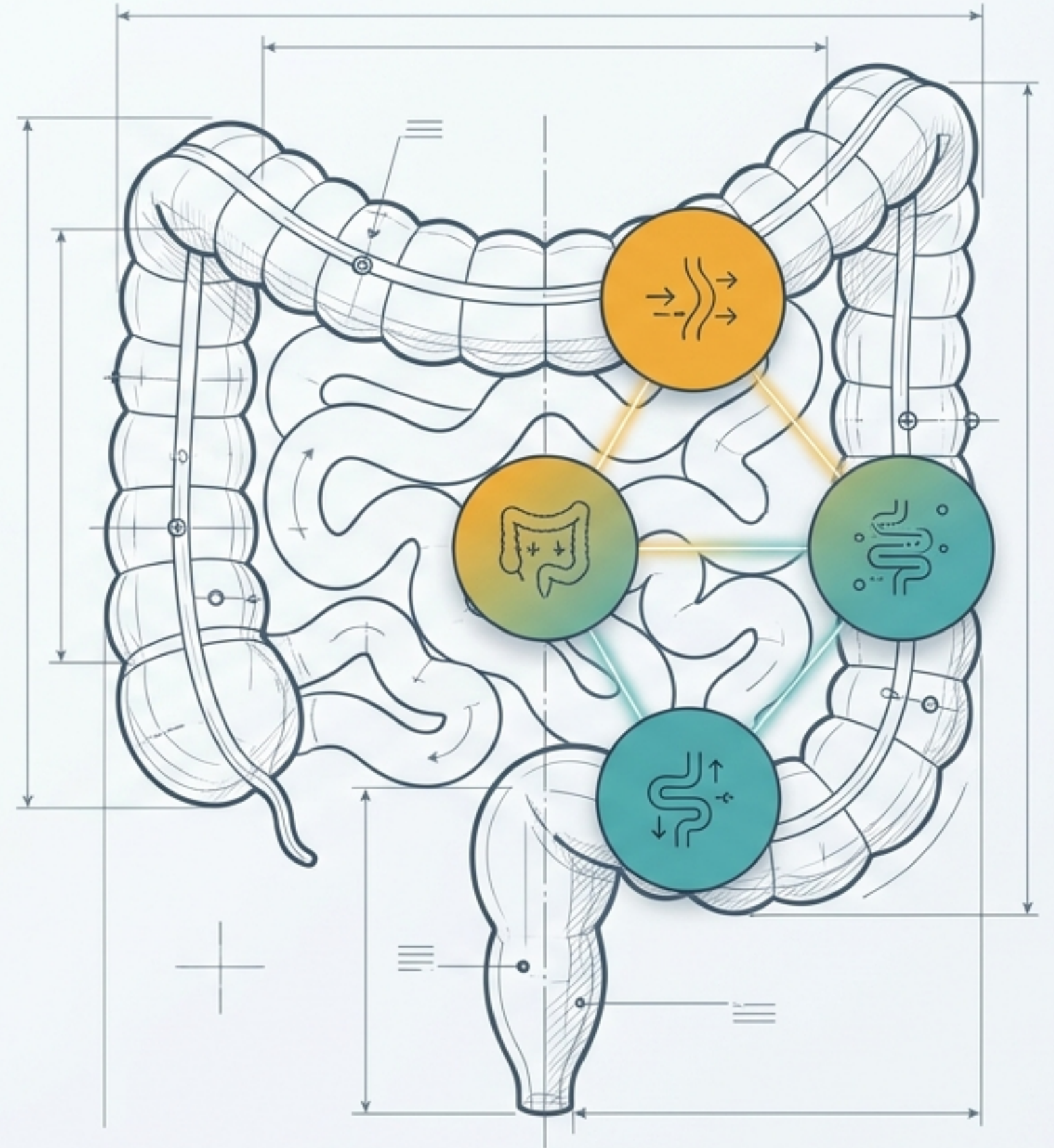
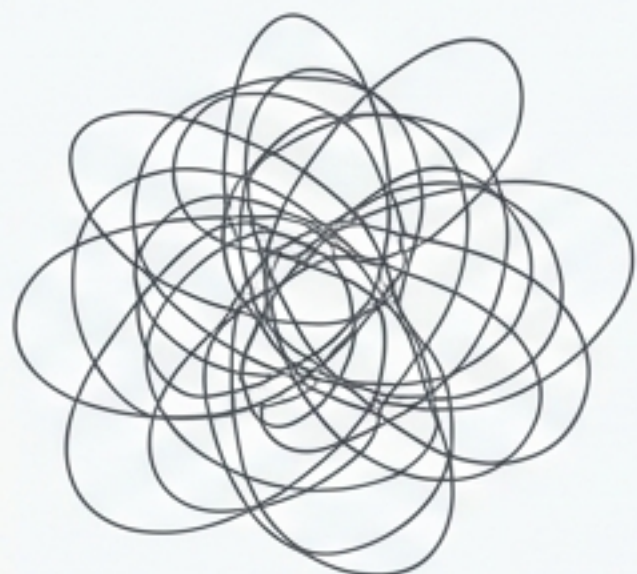


# Irritable Bowel Syndrome (IBS): A Clinical Blueprint

Evidence-Based Diagnosis,  
Subtyping, and Stepped-Care  
Management in Primary Care.



# The Paradigm Shift: From Exhaustion to Positive Diagnosis



## Diagnosis of Exclusion

**Focus:** Extensive, repeated exclusionary testing.

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**Result:** Increased health anxiety, delayed treatment, high systemic costs.



Discouraged



## Positive Symptom-Based Diagnosis

**Focus:** Symptom recognition via Rome IV criteria + limited baseline testing to rule out red flags.

**Result:** Validates patient experience (gut-brain interaction), enables immediate symptom management, high specificity (98%) for organic disease when alarm features are absent.



**RACGP Recommended**

# Australian Epidemiology & Systemic Burden

## Prevalence

**10–15%**

of Australians affected (Rome IV). AIHW 2022 notes ~12% of adults report functional GI symptoms. Peak onset ages 20–40.

## Demographics

**2:1**

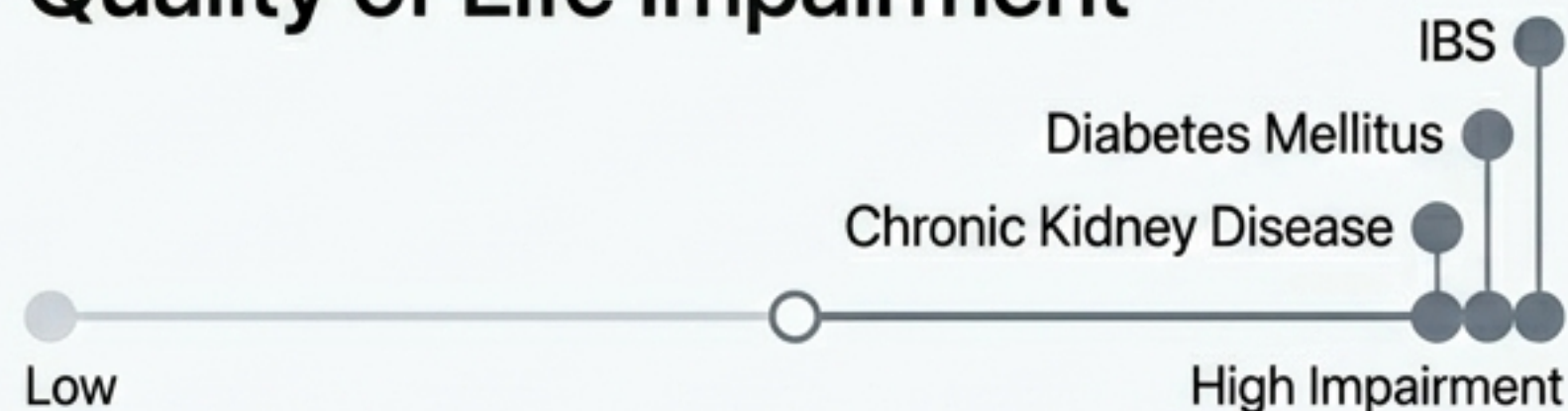
Female-to-Male ratio. Only 30% of affected individuals seek formal medical care.

## Economic Impact

**>\$1 Billion**

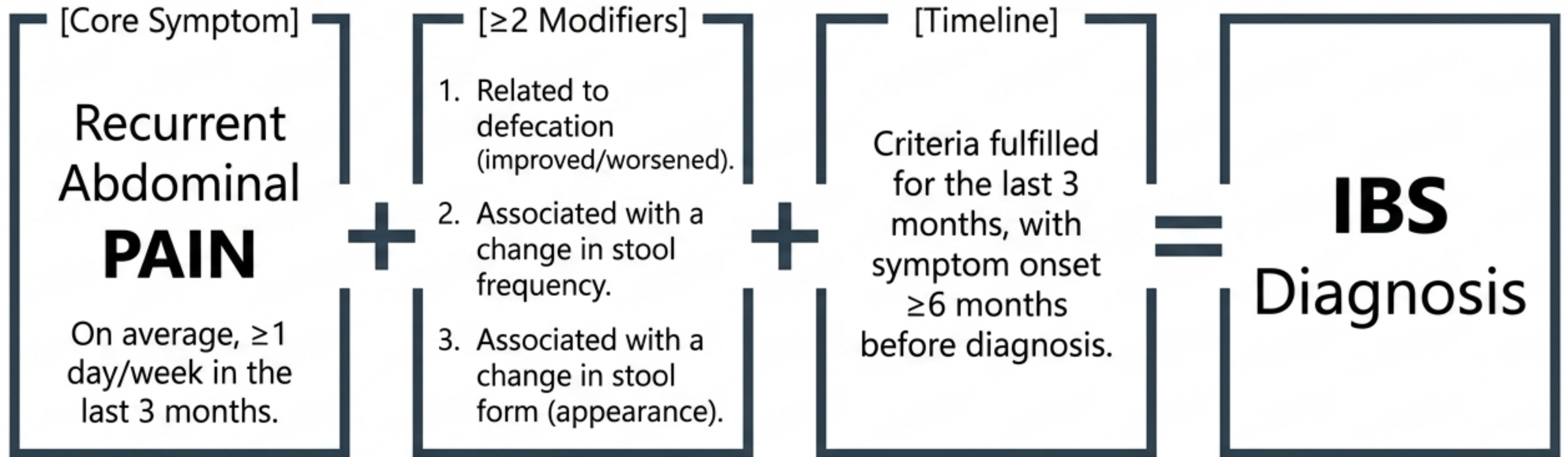
Annual direct and indirect costs (GP visits, investigations, medications, absenteeism).

## Quality of Life Impairment



Higher rates of impairment in individuals with high psychological distress.

# The Rome IV Diagnostic Criteria

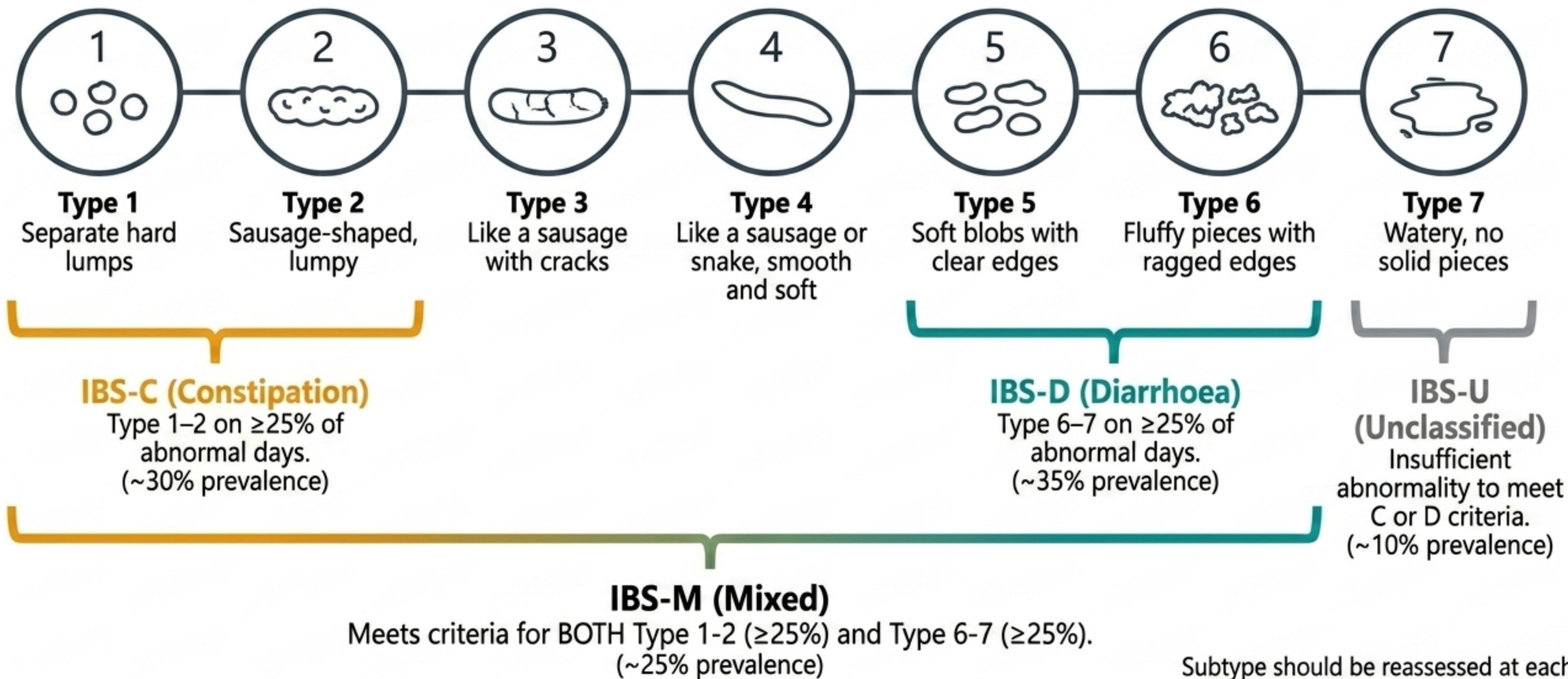


## Clinical Pearl: Differentiating FGIDs

Functional Constipation = difficult stools without pain.

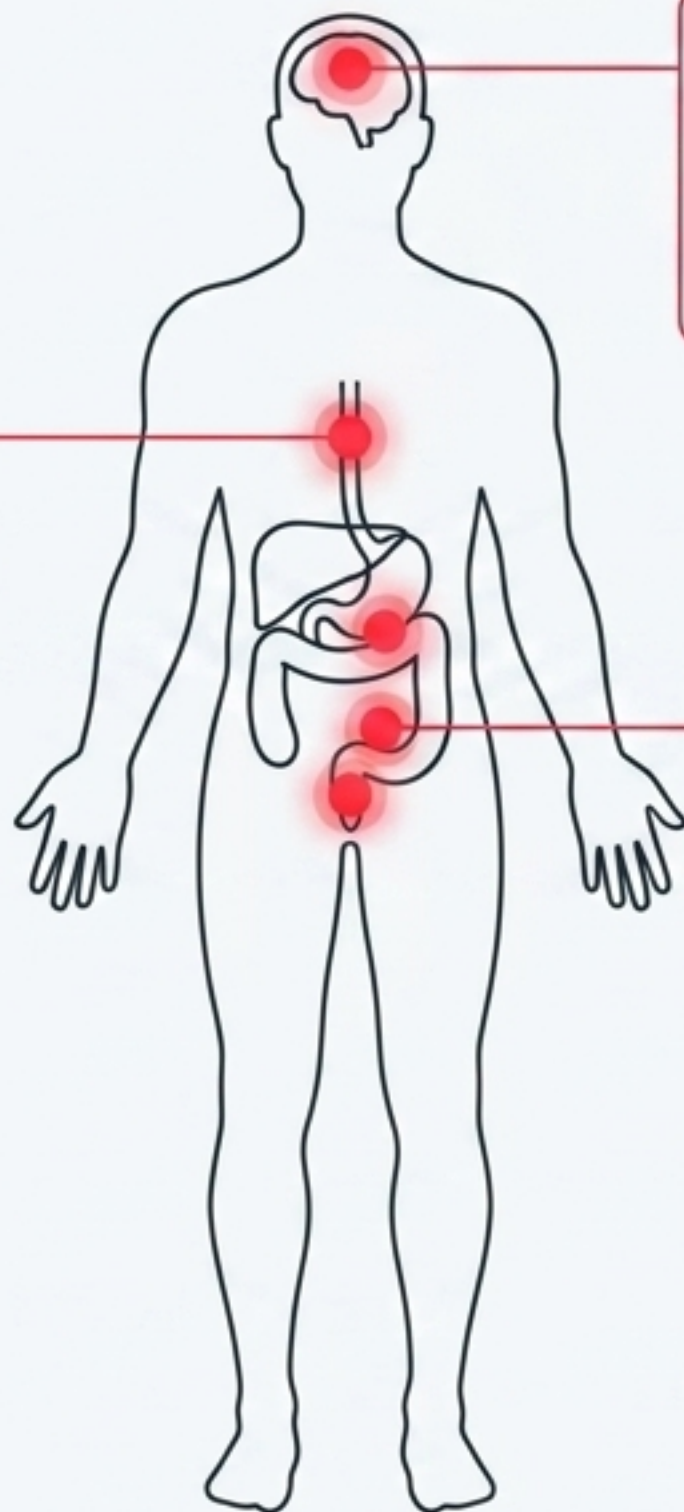
Functional Diarrhoea = loose stools without pain. Pain is the defining feature of IBS.

# Subtyping via the Bristol Stool Form Scale (BSFS)



Subtype should be reassessed at each clinical encounter as patterns fluctuate.

# The Diagnostic Dashboard: Alarm Features



## Systemic & Brain

- Nocturnal symptoms that wake the patient
- Progressive worsening over weeks/months
- Unintentional weight loss >5% over 6 months

## Blood & Vascular

- Iron-deficiency anaemia (ferritin <30 µg/L, low MCV)

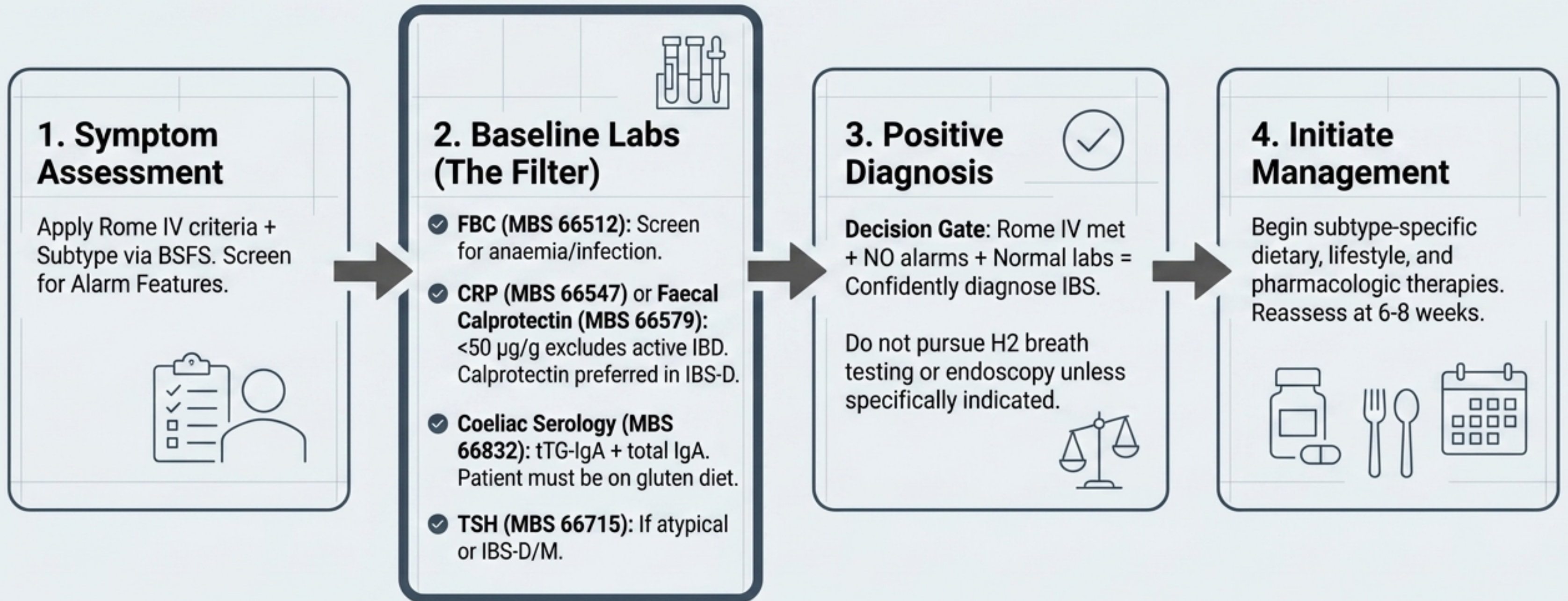
## GI & Abdominal

- Rectal bleeding or melaena (not haemorrhoidal)
- Palpable abdominal mass or lymphadenopathy

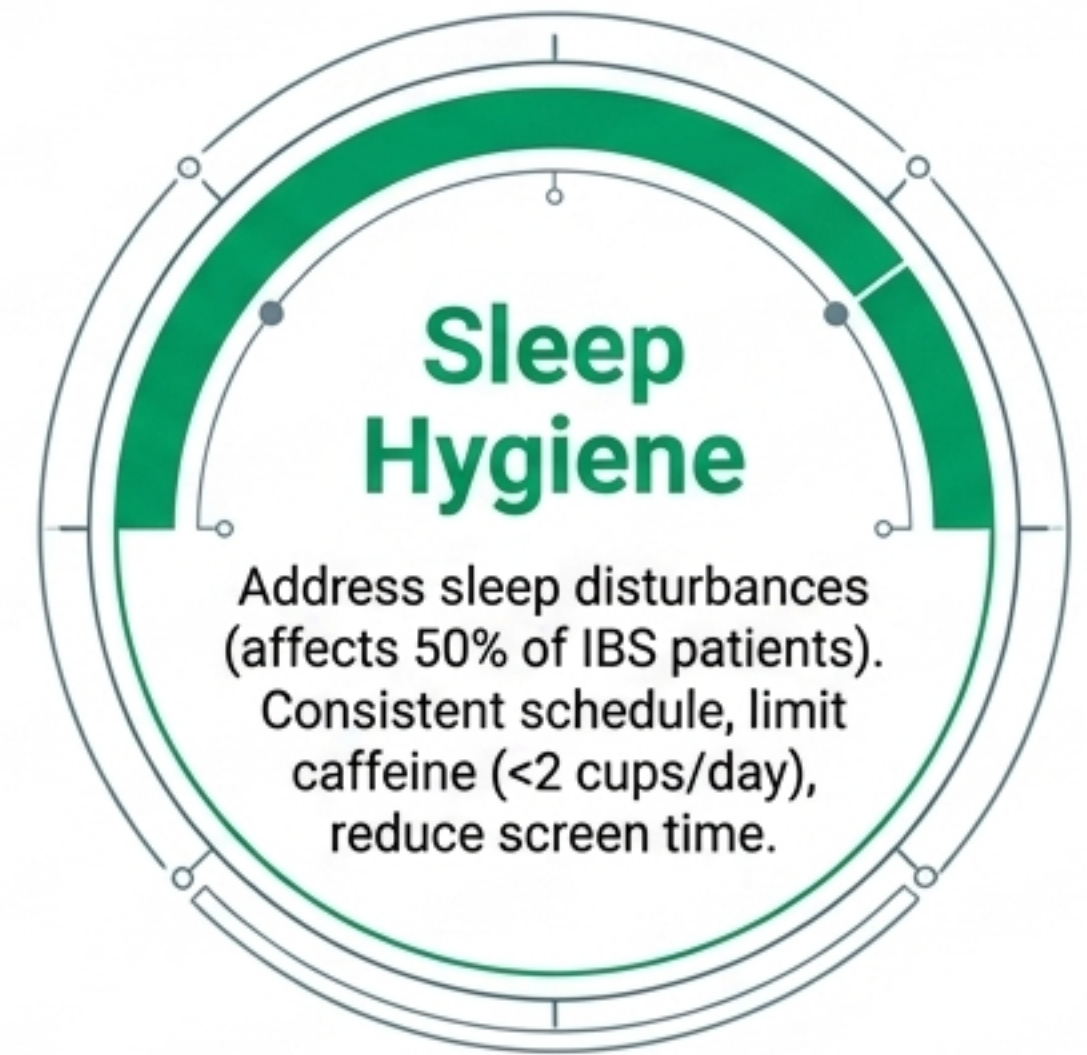
## Demographic & History

- New onset in patient aged ≥50 years
- Family history of colorectal cancer, coeliac disease, or IBD

# The 4-Step Positive Diagnosis Pathway




# Foundation Level A: Lifestyle Interventions



**Note on Probiotics:** Strain-specific evidence only (*B. infantis* 35624 and *L. plantarum* 299v).  
A 4-8 week trial is reasonable, but they are not PBS listed.

# Dietary Foundations: FODMAP Protocol & Fibre Matrix

## The Monash Low FODMAP Protocol

 Dietitian referral strongly recommended. Use Monash App.

### Phase 1: Elimination (2-6 Weeks)

Restrict all high-FODMAP foods.  
If no response by 6 weeks, stop.



### Phase 2: Reintroduction (6-8 Weeks)

Systematically reintroduce  
subgroups over 3 days each to  
find thresholds.



### Phase 3: Personalisation (Ongoing)

Liberalise to least restrictive diet.  
**WARNING:** Long-term strict  
restriction is NOT recommended.



## The Fibre Supplementation Matrix

### Recommended: Soluble Fibre



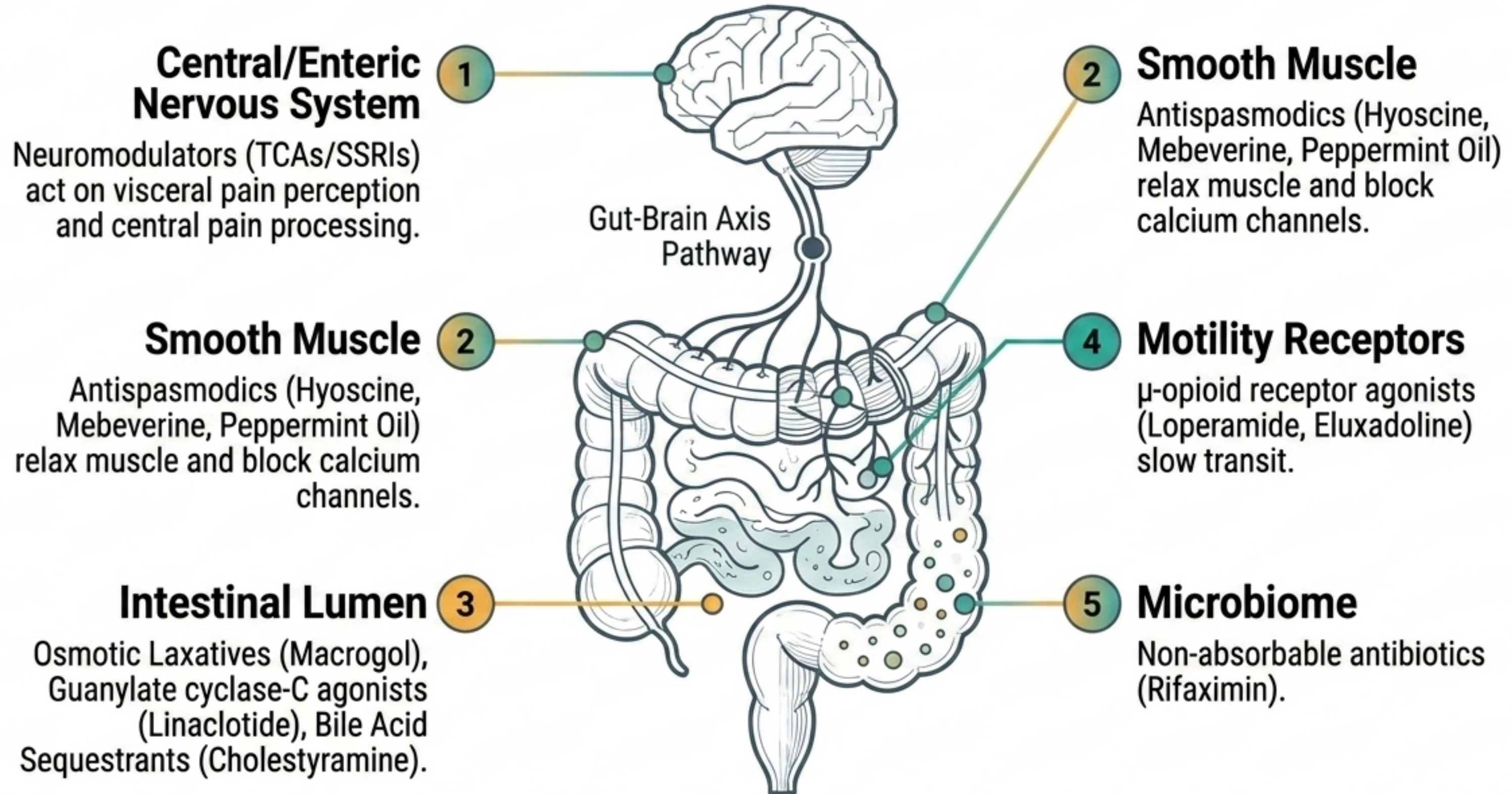
**Psyllium / ispaghula husk.** First line for all  
subtypes. Start 3-5g, titrate to 10-12g.  
Consider PHGG (Sunfiber) for IBS-C/M.

### Avoid: Insoluble Fibre







**Wheat bran.**  
May worsen bloating and  
abdominal pain.

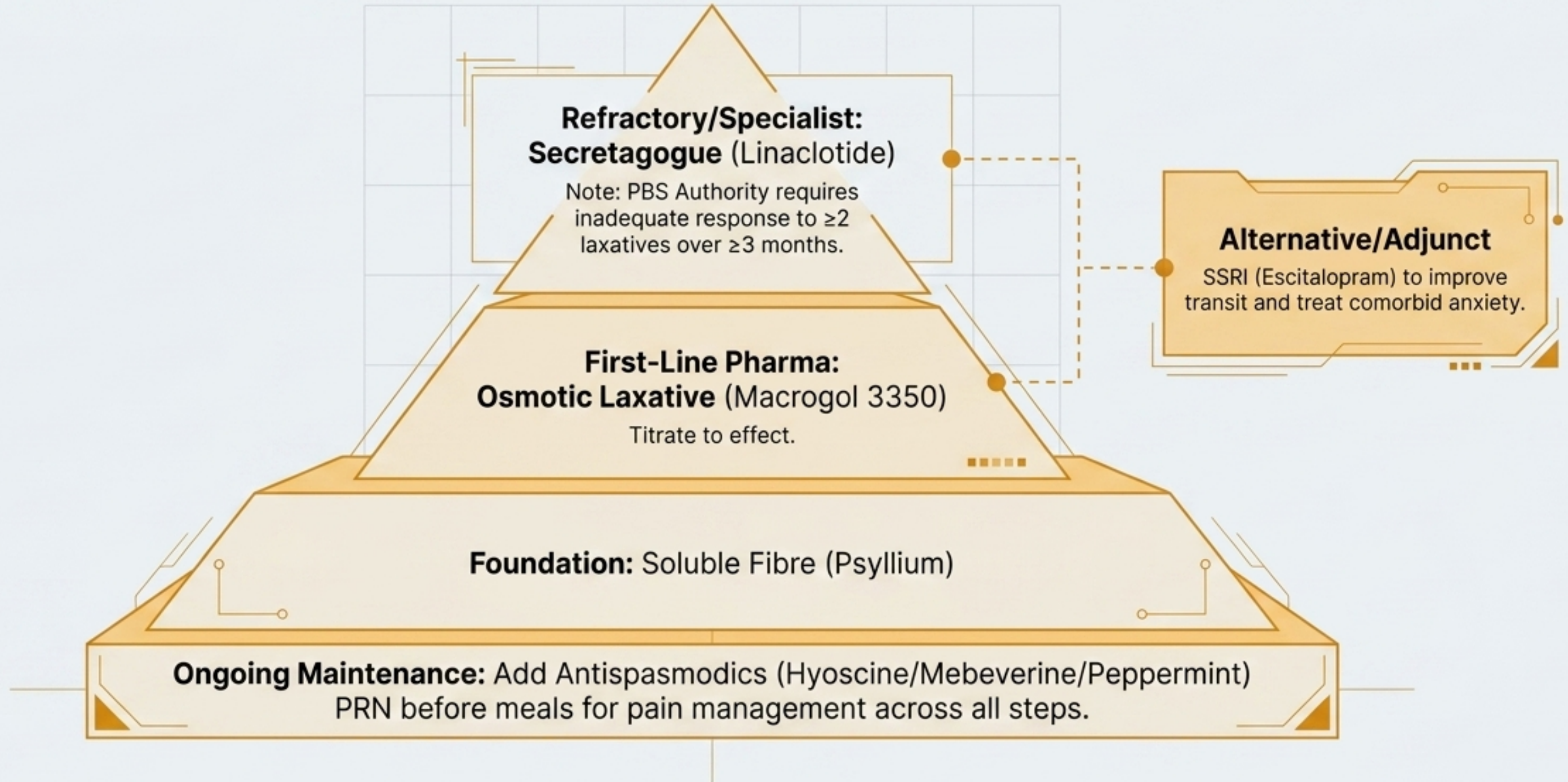
# Pharmacological Targeting: Mechanism of Action Map



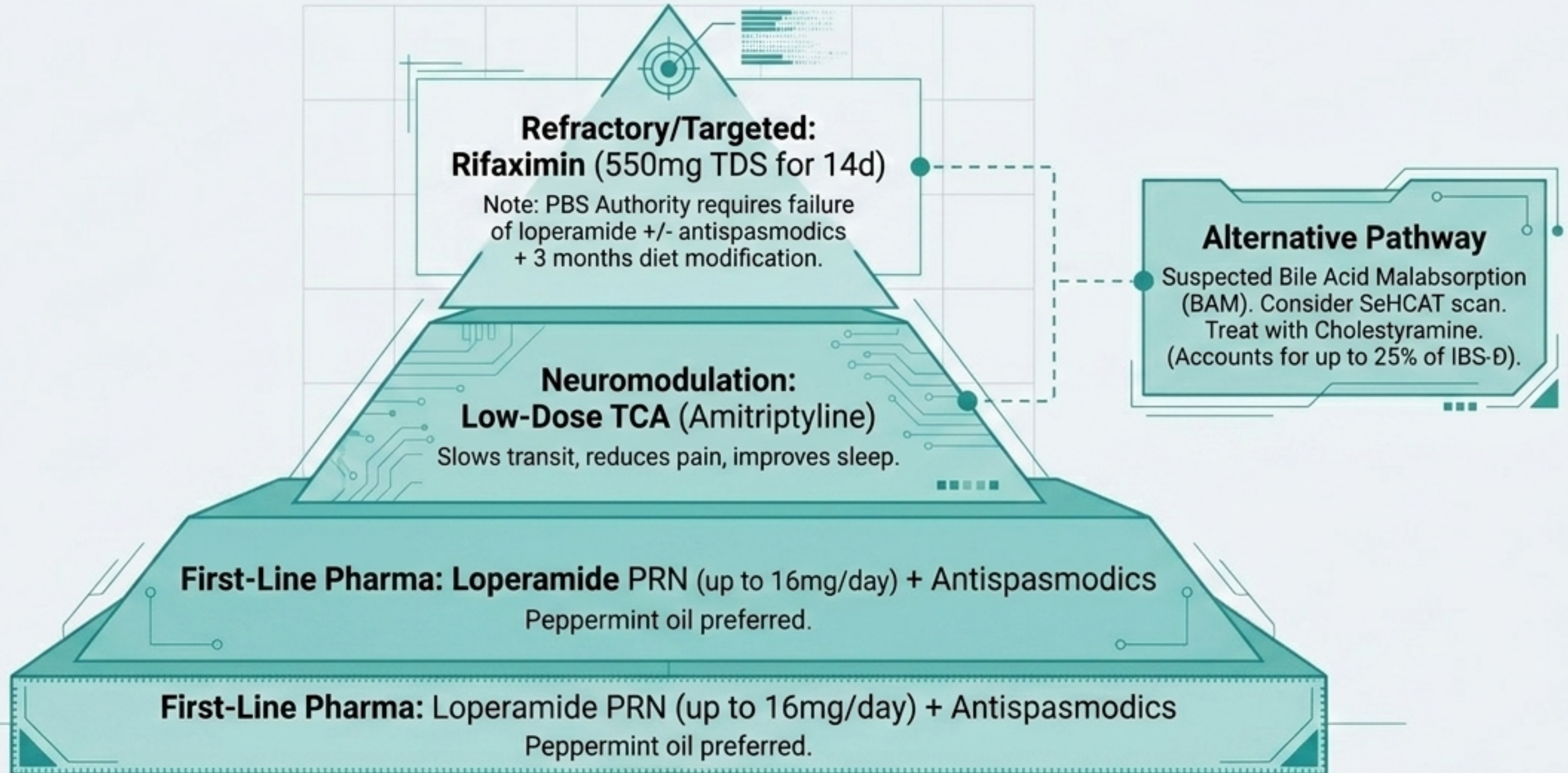
# Master Pharmacotherapy Reference Matrix

Drug Class & Name	Subtype Target	PBS Status & Dose	Key Warnings/Side Effects
<b>Antispasmodics:</b> Hyoscine (Buscopan), Mebeverine, Peppermint Oil	 All subtypes (Pain)	Hyoscine & Mebeverine: PBS Gen. Peppermint: OTC. PRN dosing.	Hyoscine: Anticholinergic SEs. Peppermint: Heartburn.
<b>Laxatives &amp; Secretagogues:</b> Macrogol 3350 (Movicol), Linaclotide (Constella)	 IBS-C	Macrogol: PBS Gen. Linaclotide: PBS Authority.	Macrogol: Renal caution. Linaclotide: Diarrhoea SE.
<b>Antidiarrhoeals &amp; Others:</b> Loperamide, Rifaximin, Eluxadoline, Cholestyramine	 IBS-D	Loperamide/Cholestyramine: PBS Gen. Rifaximin/Eluxadoline: PBS Auth.	Eluxadoline <b>contraindicated</b> if no gallbladder/pancreatitis history.
<b>Neuromodulators:</b> Amitriptyline (TCA), Escitalopram (SSRI)	 Refractory/Pain	PBS Gen. TCA: Start 5-10mg nocte. SSRI: Start 5mg.	TCA best for IBS-D, watch anticholinergic SEs. SSRI best for IBS-C.

# Subtype Management Pathway: IBS-C (Constipation)



# Subtype Management Pathway: IBS-D (Diarrhoea)



# Subtype Management Pathway: IBS-M (Mixed Bowel Habits)



## What to USE

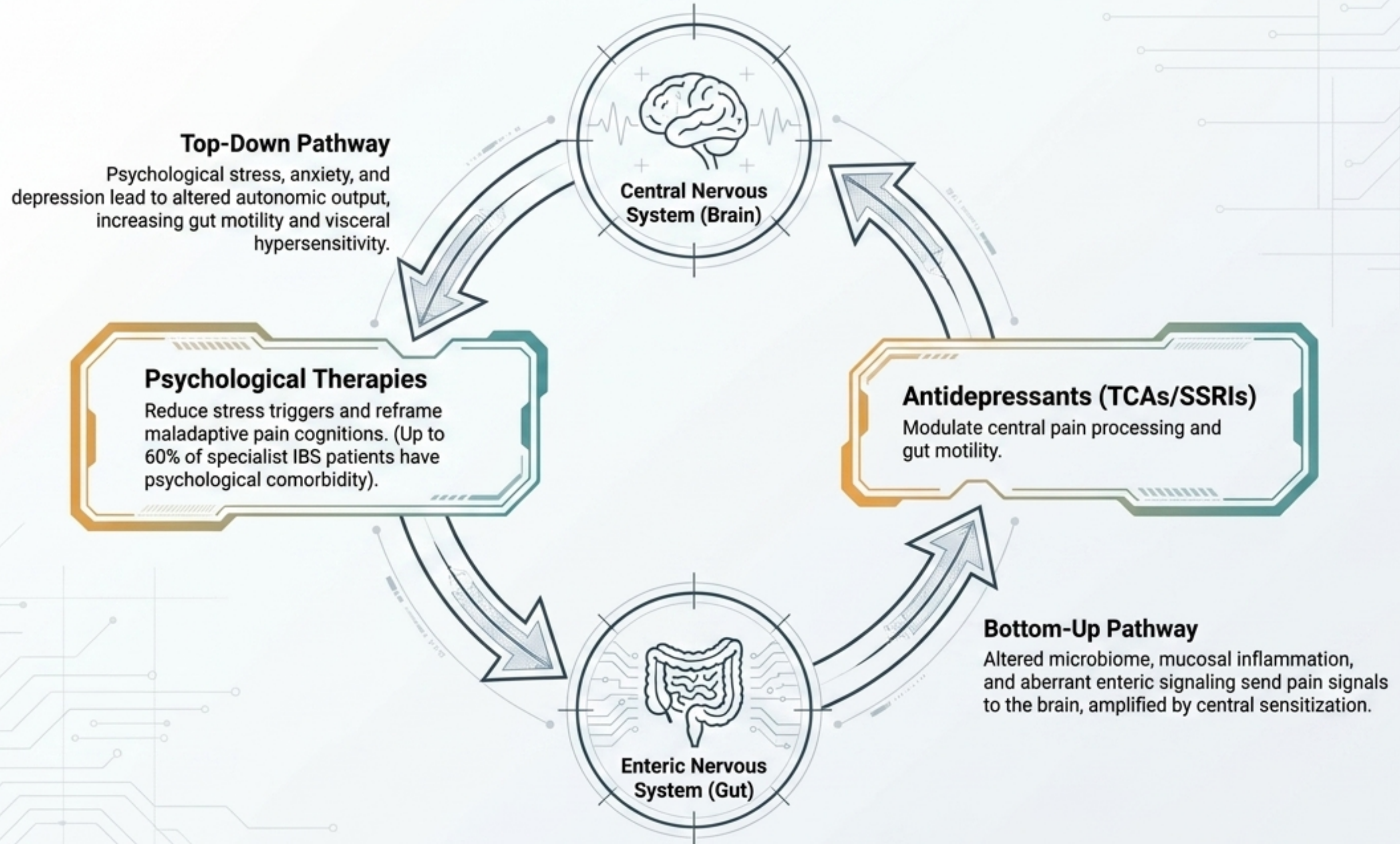
- **Soluble fibre** (Psyllium) normalises stool form in both directions.
- **Antispasmodics** address pain without altering bowel habits.
- **Low-dose TCAs** are often the single most useful medication for global symptoms in IBS-M.



## What to AVOID

- **Antidiarrhoeals** (trigger severe constipation phases).
- **Stimulant laxatives** (trigger severe diarrhoea phases).

# The Gut-Brain Axis: Rationale for Psychological Interventions



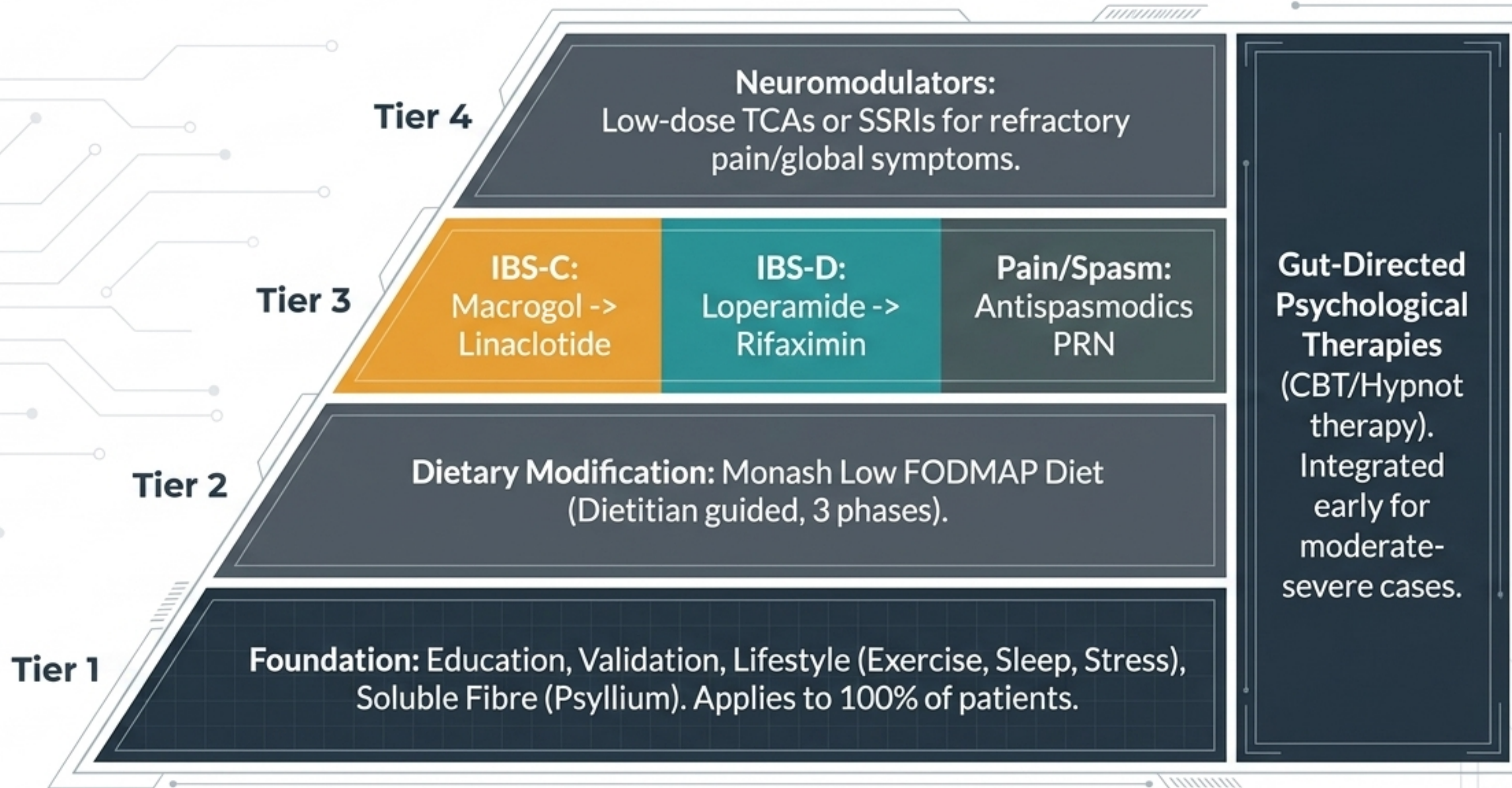
# Psychological Therapies: Modalities and Access

Therapy	Mechanism	Efficacy	Access/Cost
<b>Gut-Directed CBT</b>	<ul style="list-style-type: none"><li>• Targets maladaptive cognitions, catastrophising, avoidance.</li></ul>	<ul style="list-style-type: none"><li>• NNT ~4 (Strongest evidence, moderate-severe IBS).</li></ul>	<ul style="list-style-type: none"><li>• Psychologist via MHTP (MBS 721).</li><li>• Digital: Monash Mindgut telehealth.</li></ul>
<b>Gut-Directed Hypnotherapy</b>	<ul style="list-style-type: none"><li>• Targets visceral sensitivity via hypnotic suggestion/imagery (Manchester/NC protocols).</li></ul>	<ul style="list-style-type: none"><li>• 70-80% response rate.</li></ul>	<ul style="list-style-type: none"><li>• Tertiary GI centres.</li><li>• Digital: Nerva app (-\$120/6 weeks).</li></ul>
<b>Other (ACT/MBT)</b>	<ul style="list-style-type: none"><li>• Acceptance and Commitment Therapy, Mindfulness.</li></ul>	<ul style="list-style-type: none"><li>• Good evidence.</li></ul>	<ul style="list-style-type: none"><li>• Patient preference, local psychologist availability.</li></ul>



**Key Takeaway:** Psychological therapies are primary treatments for moderate-severe IBS, not a 'last resort' or suggestion that symptoms are 'all in the head'.

# The Master IBS Management Algorithm



# Aboriginal and Torres Strait Islander Health Considerations

<b>Prevalence &amp; Diagnosis</b>	<b>Dietary Access</b>
<ul style="list-style-type: none"><li>• 1.5x higher rate of functional GI symptoms. High index of suspicion needed for organic disease (Giardia, post-infectious IBS) in remote areas. Use CRP if faecal calprotectin is unavailable.</li></ul>	<ul style="list-style-type: none"><li>• Low FODMAP is often impractical in remote communities (food insecurity, cost). Focus on basic advice: increase soluble fibre, hydration, reduce processed fats. Utilise tele-dietitians via ACCHOs.</li></ul>
<b>Medication Access</b>	<b>Cultural Safety &amp; Psych</b>
<ul style="list-style-type: none"><li>• Utilise Closing the Gap (CTG) PBS Co-Payment (\$7.30/script). OTC peppermint oil may not be available in remote stores. Coordinate Authority scripts with Remote Area Aboriginal Health Services.</li></ul>	<ul style="list-style-type: none"><li>• Use a yarning-based approach. Involve Aboriginal Health Workers (AHWs). Align gut-brain explanations with Social and Emotional Wellbeing (SEW) holistic frameworks. Access telehealth (e-Mental Health in Practice).</li></ul>

# Navigating Special Populations

## Pregnancy & Breastfeeding



**Safe:** Psyllium, Macrogol.

**Use short-term/caution:** Loperamide, Hyoscine.

**Avoid:** Mebeverine, TCAs (1st trimester), Linaclotide, Rifaximin, Eluxadoline.

## Paediatrics



5-10% prevalence.

**First-line:** Diet/Fibre, reassurance, school attendance.

**Pharma:** Peppermint oil ( $\geq 8$  yrs) and Psyllium only.

**Avoid TCAs** without specialist guidance.

**Strong evidence** for psych interventions.

## Elderly ( $\geq 65$ yrs)



**Red flag:** New-onset symptoms mandate colonoscopy.

**Caution:** Anticholinergics (confusion/falls), TCAs (ECG required), Loperamide (megacolon risk).

Consider medication-induced GI symptoms.

## Renal/Hepatic Impairment



**Renal:** Caution with Macrogol in CKD (electrolytes).

**Hepatic:** **Avoid Rifaximin** in Child-Pugh C; **Eluxadoline absolutely contraindicated** in severe hepatic impairment.



# Gastroenterology Referral & The Therapeutic Relationship



## When to Refer

- Presence of any Alarm Features.
- Diagnostic uncertainty (atypical symptoms, abnormal baseline labs).
- Failure to respond to 6–12 months of optimised first/second-line management.
- IBS-M with predominant bloody diarrhoea (rule out microscopic colitis/BAM).
- Severe symptoms causing major functional impairment.



## Primary Care Continuity

- **Validation:** Explain pathophysiology explicitly (disordered gut-brain signaling, not ‘all in your head’).
- **Expectations:** Shift goal from ‘cure’ to ‘symptom management’.
- **Follow-up:** RACGP recommends regular GP review every 4–8 weeks during active management to reinforce strategies and adjust treatment.