Gastroenterology 2026;■:1–17

Recommendations for the Evaluation and Management of Inflammatory Bowel Disease With Irritable Bowel Syndrome–Like Symptoms: A Joint Rome Foundation and International Organization for the Study of IBD (IOIBD) Consensus

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BACKGROUND & AIMS: A substantial proportion of persons with inflammatory bowel disease (IBD) in remission continue to experience abdominal pain, altered bowel habits, and bloating that resemble irritable bowel syndrome (IBS). Lack of standardized definitions and evidence-based management strategies leads to diagnostic ambiguity and potentially unnecessary escalation of IBD therapy. A joint Rome Foundation/International Organization for the Study of Inflammatory Bowel Disease Working Team developed consensus recommendations on nomenclature, evaluation, and treatment of IBD with IBS-like symptoms. **METHODS:** A multidisciplinary international panel applied a modified RAND/UCLA Appropriateness Method. Systematic literature reviews informed statement generation across multiple domains: nomenclature, diagnostic and symptom assessment, dietary therapies, drugs, and brain-gut behavioral therapies. Panelists rated the appropriateness of candidate statements independently on a 9-point Likert scale, followed by anonymized feedback, discussion, and re-voting across 2 iterative rounds. **RESULTS:** Thirteen panelists reviewed 133 initial statements; 105 proceeded to final scoring. Of these, 86 were rated appropriate, 16 uncertain, and 3 inappropriate. The preferred term was "IBD with IBS-like symptoms," defined as abdominal pain, bowel habit change, and/or bloating not explained by active inflammation or structural disease. For clinical care, diagnosis should combine Rome clinical criteria with objective exclusion of inflammation. For research, candidate thresholds for endoscopic, histologic, biomarker, and imaging remission were endorsed. Appropriate therapies included psyllium (if no stricture), a short-term low fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAP) diet, targeted drugs, and brain-gut behavioral therapies. **CONCLUSIONS:** This first joint consensus provides standardized terminology, evaluation strategies, and treatment recommendations for IBD with IBS-like symptoms, supporting improved clinical management and guiding future mechanistic and therapeutic research.

Keywords: Inflammatory Bowel Disease; Ulcerative Colitis; Crohn's Disease; Irritable Bowel Syndrome.

Inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) are chronic gastrointestinal conditions that can present with similar symptoms but differ in

***Authors share co-first authorship; §Authors share co-senior authorship.**

Abbreviations used in this paper: **5-HT$_3$, 5-hydroxytryptamine type-3; 5-HT$_4$, serotonin type 4 receptor; BGBTs, brain-gut behavior therapies; CD, Crohn's disease; CRP, C-reactive protein; DGBI, disorder of gut-brain interaction; DI, disagreement index; FC, fecal calprotectin; FODMAP, fermentable oligosaccharides, disaccharides, monosaccharides, and polyols; IBD, inflammatory bowel disease; IBS, irritable bowel syndrome; IBS-SSS, IBS Severity Scoring System; IOIBD, International Organization for the Study of Inflammatory Bowel Disease; PROM, patient-reported outcome measure; QoL, quality of life; RAM, RAND/UCLA appropriateness method; RCT, randomized controlled trial; SES-CD, Simple Endoscopic Score for CD; SNRI, serotonin and norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant; UC, ulcerative colitis.**

0016-5085
https://doi.org/10.1053/j.gastro.2026.04.008

WHAT YOU NEED TO KNOW

BACKGROUND AND CONTEXT

Persons with inflammatory bowel disease frequently report persistent abdominal pain and bowel symptoms even after resolution of intestinal inflammation. The presence of these "irritable bowel syndrome–like" symptoms is common, but definitions, evaluation thresholds, and management approaches are lacking.

NEW FINDINGS

Consensus guidance by inflammatory bowel disease and irritable bowel syndrome experts define "inflammatory bowel disease with irritable bowel syndrome–like symptoms," which emphasizes using symptom-based irritable bowel syndrome criteria, combined with objective exclusion of active inflammation, proposes remission thresholds for research, and recommends dietary changes, neuromodulators, and other drugs for irritable bowel syndrome, and brain-gut behavioral therapies.

LIMITATIONS

Evidence is limited with few large, randomized controlled trials in inflammatory bowel disease with irritable bowel syndrome–like symptoms; remission definitions and symptom measures vary; and mechanistic phenotyping and treatment trials are limited. Appropriateness ratings reflect expert judgment and should be revisited as data evolve.

CLINICAL RESEARCH RELEVANCE

Provides standardized nomenclature and eligibility criteria (endoscopic, biomarker, histologic, and imaging remission) to enroll a homogeneous population of irritable bowel syndrome with irritable bowel syndrome–like symptoms; prioritizes development of a disease-specific activity measure that captures the multidimensional burden of inflammatory bowel disease with irritable bowel syndrome–like symptoms; development of a patient-reported outcome measure to prospectively measure symptom change and quality of life; and outlines multimodal intervention targets to enable robust, mechanism-informed randomized controlled trials and stepped-care implementation studies.

BASIC RESEARCH RELEVANCE

Highlights plausible mechanisms, including postinflammatory visceral hypersensitivity, low-grade immune activation, epithelial barrier dysfunction, bile acid disturbances, and dysbiosis, to guide biomarker discovery, mechanistic enrichment in trials, and translational studies linking microbial, metabolomic, and neurogastroenterology endpoints to symptom outcomes.

their pathogenesis and management.[1] IBS is a disorder of gut-brain interaction (DGBI) diagnosed by symptom-based criteria and classified by bowel habit subtypes: diarrhea-predominant, constipation-predominant, or mixed.[2] IBD includes Crohn's disease (CD) and ulcerative colitis (UC), chronic, immune-mediated conditions characterized by intestinal mucosal inflammation and progressive bowel damage.[3]

Ongoing IBD activity and/or mechanical bowel complications from inflammation drive symptoms requiring IBD-specific therapy or surgery. However, many individuals with IBD experience gastrointestinal symptoms despite no active inflammation or structural abnormalities, such as strictures.[1] This suggests potential shared pathophysiologic mechanisms underlying residual pain and bowel symptoms in IBD in remission and in IBS. A meta-analysis of 27 studies demonstrated that 1 in 3 individuals with IBD reported coexisting IBS, although estimates were heterogeneous and few studies objectively excluded active disease (11.2% to 63.6%).[1] Among those with endoscopic or histologic remission, 1 in 4 reported IBS-like symptoms.

Given the substantial variability in defining IBS-like symptoms in IBD in remission, accurate prevalence estimates are lacking. Standardized defining criteria are essential for both research and clinical practice. Clinicians must recognize when symptoms in persons with IBD are not associated with objective evidence of active inflammation to avoid unnecessary escalation of immunomodulators.[4] Individuals with IBD with IBS-like symptoms experience a substantial burden of unmet needs, including psychological distress, reduced quality of life (QoL), functional impairment, and increased health care utilization. Characterizing this phenotype may clarify its pathophysiologic mechanisms, including postinflammatory visceral hypersensitivity, dysfunctional microbiota, dysregulated gut-brain interactions, neural plasticity, increased intestinal permeability, immune activation, or bile acid disturbances (Figure 1).[5] Developing recommendations for appropriate evaluation and management of IBD with IBS-like symptoms, including dietary interventions, drugs, and brain-gut behavior therapies (BGBTs), will improve standards of care. Here, we report the first joint Rome Foundation and International Organization for the Study of Inflammatory Bowel Disease (IOIBD) Working Team Committee's consensus recommendations on addressing IBS-like symptoms in persons with IBD in remission.

Materials and Methods

RAND/UCLA Appropriateness Methods

A modified RAND/UCLA appropriateness method (RAM) was used to develop recommendations for nomenclature, assessment, and management of persons with IBD and IBS-like symptoms.[6] RAM is an evidence-based approach employing a modified Delphi panel with multiple iterative rounds of voting, group discussion, and feedback to determine appropriateness. The process incorporates both evidence from systematic reviews of the literature as well as expert opinion, particularly in areas where empiric data are lacking. Its iterative nature encourages discussion between experts and the opportunity to reflect on one's own judgment. RAM was selected a priori for its suitability in addressing clinical questions characterized by limited or heterogeneous evidence, where integrating available data with expert clinical judgment is required. Alternative approaches, including traditional Delphi methodology, were considered; however, RAM was chosen for its structured combination of evidence review, moderated discussion, and

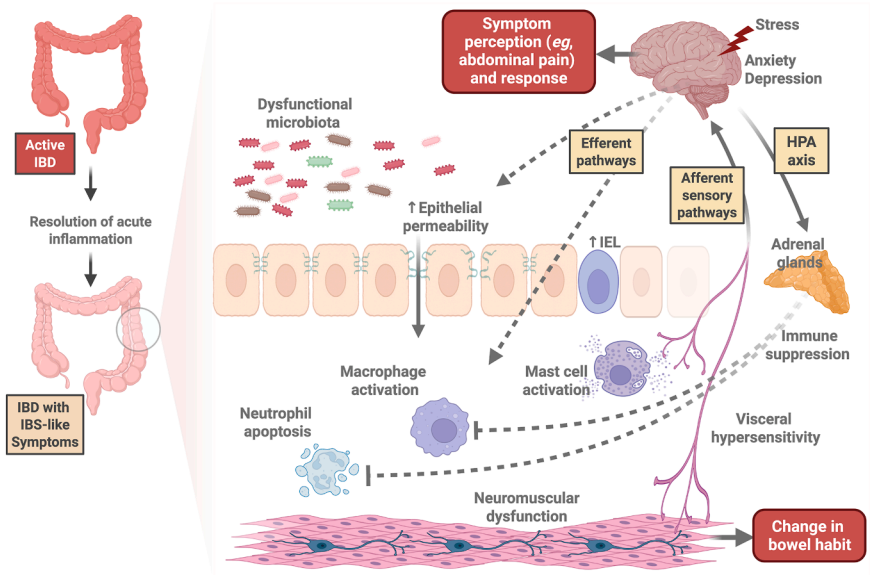

Figure 1. Proposed pathways underlying symptom development in IBD with IBS-like symptoms. Following resolution of acute inflammation in patients with IBS, IBS-like symptoms may develop. In these patients, dysfunctional microbiota (eg, reduced microbiota diversity and imbalance) contributes to changes in epithelial integrity, increased epithelial permeability, and neuromuscular dysfunction. Although acute inflammation is downregulated (ie, neutrophil apoptosis), mild immune activation may persist. Enhanced mast cell infiltration near enteric nerves is associated with visceral hypersensitivity and symptom perception. Increased numbers of intraepithelial lymphocytes (IELs) and macrophage activation is detected in subgroups of patients. Stress, anxiety, and depression activate brain-gut pathways, participating in gut structural and functional gut changes. The activation of the hypothalamic-pituitary-adrenal axis (HPA) is involved in the downregulation inflammation and immune activation.

formal appropriateness ratings. The RAM approach was discussed with panel members, who agreed with its use. Voting was anonymized to avoid any single dominant opinion biasing the group. Finally, although often used as a consensus-building method, voting focuses on statement appropriateness, rather than statistically forcing a consensus. Given the substantial heterogeneity in the literature and the relative paucity of large, well-conducted trials, the RAM process was the most appropriate method for informing clinically relevant recommendations and identifying future research priorities in IBD with IBS-like symptoms.

Panelists, Literature Review, and Statement Generation

A multidisciplinary, international panel of North American and European experts participated. Panelists were identified using predefined criteria to ensure multidisciplinary representation, including expertise in IBD and IBS, pediatric and adult clinical practice, psychogastroenterology, and experience with consensus methodology. Invitations were extended based on these criteria to achieve a balance of clinical and research perspectives across relevant domains. Because the evidence for "IBD with IBS-like symptoms" is limited and heterogeneous, priority was given to relevant expertise over geographical representation. Seven panelists were experts in IBD, and 6 were experts in IBS. A list of statements focusing on 4 major themes was generated: (1) nomenclature and clinical evaluation of persons with IBD with IBS-like symptoms; (2) dietary therapies for IBD with IBS-like symptoms; (3) drugs for IBD with IBS-like symptoms; and (4) BGBTs for IBD with IBS-like symptoms.

Systematic reviews of the literature were conducted evaluating each of these themes to inform the generation of consensus statements. MEDLINE, Embase, and the Cochrane CENTRAL Library were searched using terms capturing IBD, IBS, and related terms such as functional bowel disorders, as well as the treatments of interest. The search was completed January 16, 2025, by a single investigator (A.C.F.). Details of eligibility criteria and search strategies used are summarized in the Supplementary Material. Among identified studies, priority was given to meta-analyses and randomized controlled trials (RCTs) but, given the paucity of data relating to treatment of IBS-like symptoms in persons with IBD, observational studies were also considered. Working groups (see panelist assignments in Supplementary Table 1) evaluated the titles and abstracts of papers identified by the search for appropriateness, and all potentially relevant papers in detail, and prepared organized summaries of the data. Candidate statements were provided for consideration in the RAM. These statements were drafted and reviewed by each working group first, using specific instructions provided by a methods expert with experience in the RAM process (C.M.). These working group statements were then provided to the senior authors (B.E.S., L.C.) and methods expert for editing for consistency of formatting and clarity before being distributed to the larger group. The Cochrane risk of bias tool was used to assess risk of bias at the level of individual RCTs.[7]

RAND/UCLA Appropriateness Methods Meetings and Voting

Three moderated meetings were conducted by teleconference. In the first, the panelists met to review the study aims

and research methodology, agree on nomenclature, identify relevant themes for voting, and delegate responsibilities and working groups for reviewing the literature. After literature review and synthesis, an initial list of statements was shared with all panelists for feedback in a second meeting. These items were further revised for clarity and additional relevant concepts were added based on group discussion. This revised survey was circulated for all panelists to rate each statement on a 9-point Likert scale for appropriateness (1 = highly inappropriate, 9 = highly appropriate). After the first round of voting, anonymized group- and individual-level results were distributed for review. The panel met again to discuss their responses and amend statements to reflect the panel discussion. Revised statements were recirculated for a second round of voting, allowing panelists to consider their previous vote and panel feedback. To enhance rigor and mitigate potential bias, voting was conducted anonymously using predefined appropriateness scales, and disagreement thresholds were prespecified. Evidence summaries were provided to all panelists, and ratings and areas of disagreement were reviewed collectively. RAM voting was organized by a methodologist with experience in this process (C.M.), who also moderated the discussions and was a voting panelist. To mitigate the risk of impartiality, moderation was based on a preset discussion guide and slides. The moderator's role was principally to review the overall results, level of agreement, written feedback, areas of disagreement, and monitor timing. All surveys were completed using SurveyMonkey. All 13 panelists completed both rounds of voting.

Statistical Approach

Each statement was classified as "inappropriate," "uncertain," or "appropriate" according to the median panel rating and degree of disagreement. Appropriate statements were defined by a median panel rating of >6.5 to 9.0 without disagreement; inappropriate statements were defined by a median panel rating of 1.0 to <3.5 without disagreement. Uncertain statements included those with a median panel rating of 3.5 to 6.5 or any statements with disagreement. Disagreement was defined using both the "classical" definition (at least one-third of the ratings in each of the extreme 3-point ranges 1–3 or 6–9) and the disagreement index (DI), which compares the interpercentile range and the interpercentile range adjusted for symmetry to account for the distribution of voting.[6] Higher values of the DI indicate more variation in rating, with a threshold of DI >1 being indicative of disagreement. Data analysis was conducted by a single investigator (C.M.), although all results were distributed and available to all panelists.

Results

Summary of Statements

In the first round of voting, a total of 133 statements were evaluated. After revisions, 105 statements were assessed in the second round: 86 were considered appropriate, 3 inappropriate, and 16 uncertain. In the following text, we present recommendations based on panel voting, as well as a summary of the evidence within a broader framework of clinical and research relevance. Full results from earlier voting rounds are provided in Supplementary Table 2.

Nomenclature: Inflammatory Bowel Disease With Irritable Bowel Syndrome–Like Symptoms

Recommendations. The preferred terminology to describe the population of interest in both adults and children is "IBD with IBS-like symptoms" (Table 1). IBS-like symptoms can occur either preceding or after a diagnosis of IBD, and include abdominal pain or discomfort, diarrhea, constipation, mixed bowel habits, or abdominal bloating. Although bloating is not part of the Rome IV diagnostic criteria for IBS, it is a common accompanying symptom reported in patients with IBS and functional abdominal bloating and distension is recognized as a distinct DGBI that often fluctuates with IBS-like symptoms in persons with quiescent IBD. IBD with IBS-like symptoms should be considered in persons with an established diagnosis of CD or UC with symptoms that are either disproportionate to, or incompletely explained by, the degree of inflammation or structural bowel damage present. Structural bowel damage considered explanatory for symptoms included presence of a luminal stricture, short bowel syndrome, altered luminal anatomy or adhesions from prior surgery, or enteric/colonic fistula(s). Perianal fistulas were not considered explanatory for IBS-like symptoms. Many prior studies of IBS-like symptoms in IBD did not distinguish between complete absence of inflammation and minimal residual inflammatory activity, contributing to heterogeneity in definitions and outcomes. Accordingly, our current framework allowed for minimal inflammation, while emphasizing proportionality between objective findings and symptom burden, with longitudinal reassessment.

Evidence in context. We identified 1 meta-analysis of 27 observational studies reporting prevalence of symptoms compatible with DGBI in persons with IBD in remission according to various criteria.[1] Six observational studies were published subsequent to this, and incorporated for a total of 33 studies, including 4357 participants with IBD (Supplementary Table 3). The pooled prevalence of IBS-like symptoms in IBD was 30.3% (Supplementary Table 4) and varied according to criteria used to define remission (31.1% in studies using a validated disease activity index, 35.5% using physician global assessment, 35.1% using a fecal calprotectin [FC] <100 μg/g, 22.3% using endoscopic healing, and 25.8% using histological remission). Prevalence was similar in studies using Rome II or Rome III criteria (31.5% and 32.6%, respectively) to define IBS-like symptoms but lower in studies using Rome IV criteria (21.8%). Prevalence was higher in CD than UC (odds ratio, 1.68) (Supplementary Figure 1).

Evaluation of Persons With Inflammatory Bowel Disease and Irritable Bowel Syndrome–Like Symptoms

Recommendations. The evaluation of persons with IBD and IBS-like symptoms in clinical and research settings are distinct. In routine practice, the Rome clinical criteria,

Table 1. Nomenclature for Describing IBD With IBS-Like Symptoms

Statement	Median rating (IQR)	DI	Appropriateness
The preferred terminology to describe this population is IBD with IBS-like symptoms	8 (8,8.7)	0.09	Appropriate
IBS-like symptoms can occur either preceding or after a diagnosis of IBD	9 (8.3,9)	0.09	Appropriate
IBS-like symptoms should include			
Abdominal pain or discomfort	9 (9,9)	0.00	Appropriate
Diarrhea	9 (8,9)	0.13	Appropriate
Constipation	9 (8,9)	0.13	Appropriate
Mixed bowel habits	9 (8,9)	0.13	Appropriate
Abdominal bloating	8 (8,9)	0.13	Appropriate
Nausea	5 (3,6)	0.97	Uncertain
Vomiting	3.5 (2.3,5.4)	0.76	Inappropriate
Heartburn	2.5 (1.3,4.7)	0.64	Inappropriate
A diagnosis of IBD with IBS-like symptoms should be considered in persons with an established diagnosis of CD or UC who have symptoms that are disproportionate to or incompletely explained by either (1) the degree of inflammation or (2) the degree of structural bowel damage that is present	9 (8.3,9)	0.09	Appropriate
Currently, it is uncertain what threshold of objective inflammatory activity is directly correlated with IBD-related symptoms compared with IBS-like symptoms. In clinical care, this decision should be made individually, based on the correlation between burden of symptoms, degree of objective inflammation, and longitudinal follow-up of both symptomatic and inflammatory activity	9 (8,9)	0.13	Appropriate
Structural bowel damage that can result in IBS-like symptoms includes			
Luminal stricture	8 (8,9)	0.13	Appropriate
Short bowel syndrome	7.5 (5.3,9)	0.66	Appropriate
Altered luminal anatomy from prior surgery	8 (8,8.7)	0.09	Appropriate
Adhesions from prior surgery	8 (7.3,8.7)	0.20	Appropriate
Enteric or colonic fistula	7.5 (6,9)	0.49	Appropriate
Perianal fistula	2.5 (2,6.7)	1.41	Inappropriate

IQR, interquartile range.

with symptoms sufficiently bothersome to seek health care for at least the prior 8 weeks, in the setting of minimal inflammation or insufficient structural change to account for symptomatology, were felt sufficient for diagnostic and therapeutic purposes, provided other diagnoses have been excluded. Clinical symptoms and patient-reported outcome measures (PROMs), biomarkers, endoscopy (including small bowel endoscopy in CD), radiologic measures in CD, and histologic measures in UC, were all voted to be appropriate for supporting a diagnosis of IBD with IBS-like symptoms, recognizing that the specific threshold for the degree of inflammatory change or structural bowel damage sufficient to explain the symptoms remains a case-by-case decision in routine care (Figure 2).

Specific criteria were discussed for research settings, to identify a more homogenous population of persons with IBD with IBS-like symptoms. The current iteration of the Rome criteria should be used. Different thresholds for endoscopic remission (Simple Endoscopic Score for CD [SES-CD] <4 or absence of large >5-mm ulcers in CD, and Mayo endoscopy subscore of 0 or ≤ 1 in UC), biomarker remission (C-reactive protein [CRP] less than the upper limit of normal for the testing laboratory, FC <50–150 μg/g, or a combination of these measures), histologic remission (absence of mucosal neutrophilic inflammation, Robarts Histopathology Index ≤ 3 without lamina propria or epithelial neutrophils, or Nancy Index $= 0$), and radiologic remission in CD (resolution of both mural and extramural signs of active inflammation on imaging) were considered appropriate (Table 2). Currently, a disease activity measure specifically for IBD with IBS-like symptoms has not been validated and this remains a research priority. In the interim, instruments validated for adults or children with IBD or IBS may be appropriate.

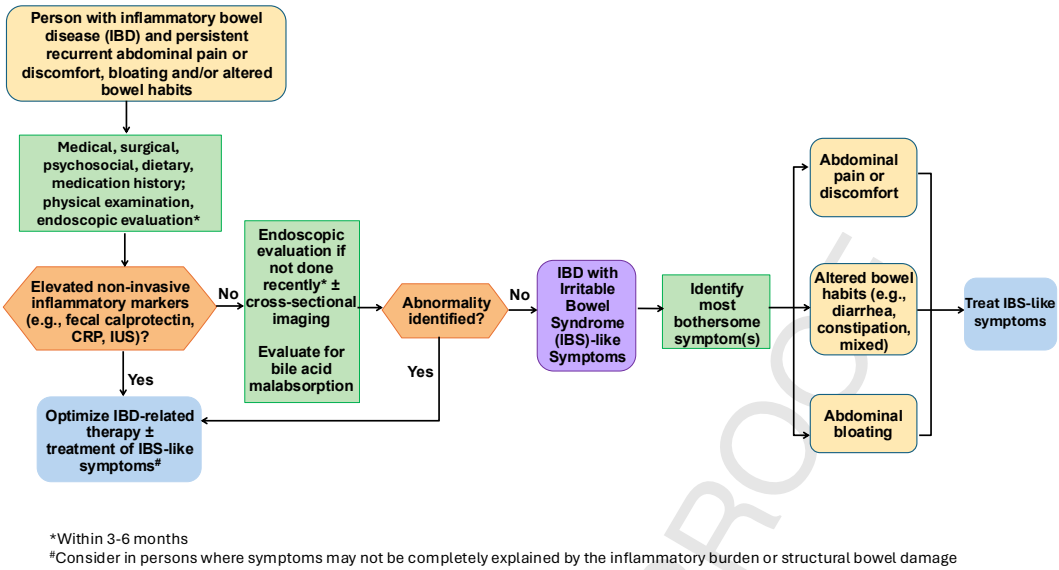

Figure 2. Diagnostic algorithm for IBD with IBS-like symptoms. IUS, intestinal ultrasound.

Evidence in context. Key symptoms in persons with IBD and IBS-like symptoms include diarrhea, constipation, abdominal pain, psychological symptoms (eg, anxiety, depression), and diminished QoL. These have been assessed in studies using both validated and nonvalidated scoring systems. Some symptom assessment tools have been validated specifically for IBD and often focus on signs and symptoms of the acute phase, which may not be present in persons with IBD in remission who experience chronic IBS-like symptoms. Examples of either symptom assessment or composite tools for IBD in adults[8–14] and children[15–18] are described elsewhere.

Tools have also been developed and validated for individuals with IBS including the IBS Severity Scoring System (IBS-SSS), the IBS Quality of Life Instrument, and the Visceral Sensitivity Index. Other tools are applicable across various conditions, including the Patient Health Questionnaire-9 for depression, Generalized Anxiety Disorder 7-Item Scale for anxiety, Hospital Anxiety and Depression Scale, and Patient-Reported Outcomes Measurement Information System Gastrointestinal Symptom Scales.[19–25]

Abdominal pain, bloating, and changes in bowel habits are common and represent the main treatment targets in persons with IBD and IBS-like symptoms. Pain is a multidimension symptom, including intensity, frequency, and constancy. The IBS-SSS is a widely used, psychometrically robust, multidomain questionnaire that is well suited to measure abdominal pain.[25] The Bristol Stool Form Scale is a validated and reliable instrument for assessing bowel habits, as it correlates with intestinal transit times[26] and allows categorization of bowel habit based on stool form.[2]

QoL is often impaired in persons with IBD and IBS-like symptoms.[27] It should be evaluated using validated instruments. In persons with IBD in long-term deep remission, those with IBS-like symptoms had more severe gastrointestinal symptoms, higher anxiety and depression scores, and reduced well-being than those without such symptoms. Anxiety and reduced vitality have been identified as independent predictors of IBS-like symptoms in persons with IBD in remission.[28]

Noninvasive inflammatory biomarkers can help identify active inflammation.[29] Studies have demonstrated that superior disease characterization and control can be achieved when combining multiple biomarkers rather than relying on symptoms alone, especially when biomarkers can be benchmarked against similarly timed endoscopic evaluation to better understand within-individual correlations between objective measures.[30] Serologic and fecal biomarkers can be combined, such as in the pediatric mucosal inflammation noninvasive index.[31] In addition, biomarkers should be interpreted within the context of endoscopic, histologic, or radiologic measures of inflammation.[32,33] An emerging noninvasive modality for objective disease activity assessment is point-of-care intestinal ultrasound, which has demonstrated correlation with endoscopy and other biomarkers.[34]

CRP is a cheap, widely available, sensitive serologic marker but lacks specificity for gastrointestinal inflammation. In addition, approximately 15% of individuals do not mount a CRP response despite active inflammation due to genetic polymorphisms.[35] FC is becoming more readily available in routine care and is more specific for IBD activity, although can be elevated in the setting of gastrointestinal infection, nonsteroidal anti-inflammatory drugs, proton pump inhibitors, and inflamed pseudopolyps.[36] Mild elevations also can be present in IBS.[37] An FC below 150 μg/g is considered normal, but persons with IBD with ongoing symptoms may require endoscopic evaluation even with a normal FC, especially in the setting of small bowel involvement or after surgery in CD.[38] Endoscopic evaluation remains the gold standard for evaluating disease activity in IBD and excluding competing diagnostic considerations. Validated endoscopic scoring systems such as

Table 2. Clinical and Research Measures for Evaluating IBD and IBS-like Symptoms

Statement	Median rating (IQR)	DI	Appropriateness
In clinical care, the diagnosis of persons with IBD with IBS-like symptoms is supported by evaluation with the following:			
Clinical measures (symptoms and PROMs)	9 (6.9,9)	0.31	Appropriate
Biomarker measures (including CRP and FC)	9 (9,9)	0.00	Appropriate
Endoscopic measures (including sigmoidoscopy, colonoscopy, or small bowel endoscopy)	9 (9,9)	0.00	Appropriate
Radiologic measures in UC	5.5 (4.3,7)	0.81	Uncertain
Radiologic measures in CD	8.5 (8,9)	0.13	Appropriate
Histologic measures in UC	8 (6.3,8)	0.30	Appropriate
In clinical care, the diagnosis of IBD with IBS-like symptoms can be supported using the Rome Clinical Diagnostic Criteria (having symptoms sufficiently bothersome to seek health care for at least the prior 8 weeks or when other conditions have been excluded).	8 (8,8.7)	0.09	Appropriate
In research settings, the Rome Criteria should be used to define potentially eligible study populations with IBD with IBS-like symptoms.	9 (8,9)	0.13	Appropriate
In research settings, the following endoscopic criteria should be used to define potentially eligible study populations with IBD with IBS-like symptoms			
Simple Endoscopic Score <4 in CD	7 (6.3,8)	0.30	Appropriate
Absence of any ulcer(s) on endoscopy in CD	6 (5.3,6.7)	0.36	Uncertain
Absence of any large ulcer(s) (>5 mm) on endoscopy in CD	8 (6.3,8.7)	0.39	Appropriate
Mayo endoscopy subscore of 0 for UC	8 (6.6,8)	0.24	Appropriate
Mayo endoscopy subscore of 0 or 1 for UC	7 (6.3,8)	0.30	Appropriate
In research settings, the following biomarker criteria should be used to define potentially eligible study populations with IBD with IBS-like symptoms:			
CRP <5 mg/L	7 (5.6,7.7)	0.44	Appropriate
CRP < upper limit of normal for the reference laboratory	7.5 (7,9)	0.29	Appropriate
FC <50 μg/g	7 (5,8.7)	0.72	Appropriate
FC <100 μg/g	6.5 (5,8)	0.65	Appropriate
FC <150 μg/g	7 (6.3,7)	0.15	Appropriate
FC <250 μg/g	5.5 (5,6)	0.32	Uncertain
Combination of FC <150 μg/g and CRP < upper limit of normal for the reference laboratory	7 (6,7)	0.22	Appropriate
In research settings, the following histologic criteria should be used to define potentially eligible study populations with IBD with IBS-like symptoms:			
Absence of mucosal neutrophilic inflammation	7 (7,7.7)	0.12	Appropriate
Geboes score ≤2B.0	6 (5,7)	0.52	Uncertain
Robarts Histopathology Index ≤3 (without lamina propria or epithelial neutrophils)	7 (6,8)	0.37	Appropriate
Nancy Index = 0 (no or mild chronic inflammatory infiltrate)	7 (6,8)	0.37	Appropriate
In research settings, resolution of both mural and extramural signs of active inflammation on cross-sectional imaging should be used to define potentially eligible study populations with IBD with IBS-like symptoms in			
CD	8.5 (7.3,9)	0.24	Appropriate
UC	5.5 (5,8.4)	0.69	Uncertain
In research settings, developing a validated disease-specific activity measure for persons with IBD with IBS-like symptoms is a priority. In the interim, using validated instruments to assess both IBD and IBS is appropriate.	9 (8,9)	0.13	Appropriate
In research settings, the following instruments that are currently appropriate for use include:			
The Crohn's Disease Activity Index for CD	7 (6.3,8)	0.30	Appropriate
The Harvey Bradshaw Index for CD	6.5 (6,7.7)	0.33	Appropriate

Table 2. Continued

Statement	Median rating (IQR)	DI	Appropriateness
The Modified Mayo Score for UC	7.5 (7,8)	0.16	Appropriate
The Simple Clinical Colitis Activity Index for UC	7 (6,8)	0.37	Appropriate
The IBD Questionnaire for quality of life	7 (7,8)	0.16	Appropriate
The IBS -SSS	7.5 (7,9)	0.29	Appropriate
The IBS Quality of Life Instrument	8 (7.3,9)	0.24	Appropriate
The Visceral Sensitivity Index (VSI)	7 (6.3,7.7)	0.26	Appropriate
The Patient Health Questionnaire-9 for depression	8 (7,8.7)	0.26	Appropriate
Generalized Anxiety Disorder 7-Item score for anxiety	7.5 (7,8)	0.16	Appropriate
The Hospital Anxiety and Depression Scale	7.5 (6.3,9)	0.43	Appropriate
The Patient-Reported Outcomes Measurement Information System Gastrointestinal Symptom Scales	8 (7.3,8)	0.11	Appropriate
In research settings involving children, the following instruments that are currently appropriate for use include:			
The Weighted Pediatric Crohn's disease Activity Index for CD	7 (5,8)	0.65	Appropriate
Pediatric Ulcerative Colitis Activity Index for UC	7 (6,8)	0.37	Appropriate
The TUMMY-UC for UC	7.5 (6.4,8)	0.28	Appropriate
IMPACT-III for QoL in pediatric IBD	7 (7,8)	0.16	Appropriate
The Patient Health Questionnaire-9A (modification for adolescents) for depression	7 (6,8)	0.37	Appropriate
The Children's Depression Inventory for depression	7 (6,8)	0.37	Appropriate
Generalized Anxiety Disorder 7-Item score (modification for children) for anxiety	8 (7,8)	0.16	Appropriate

IQR, interquartile range.

the SES-CD, Mayo endoscopic subscore, or UC Endoscopic Index of Severity, should be used whenever possible.[39,40] Although resolution of histologic disease activity for UC and radiologic evidence of transmural healing for CD remain ambitious goals, they could be considered additional markers of active disease.[41]

There are currently no validated algorithms to distinguish individuals with IBD and IBS-like symptoms from those with active inflammation. In clinical trials, participants are assessed using endoscopy to confirm IBD activity; older trials that enrolled participants using symptoms alone likely included participants with IBD and IBS-like symptoms who may be less likely to respond to anti-inflammatory treatment. In clinical practice, determining if active inflammation is present can guide decision making (Figure 2). This may include noninvasive biomarkers and possibly endoscopy and/or imaging. A relatively recent high-quality endoscopic evaluation (eg, within 6 months) can exclude other etiologies for gastrointestinal symptoms (eg, colon cancer). Those with diarrhea should additionally have stool studies for infectious etiologies.

Depending on the severity of symptoms and biomarker abnormalities, medical therapy for IBD can be optimized in individuals with active inflammation. Conversely, if the evaluation shows minimally active disease that should not be contributing to symptoms, treatment for IBS-like symptoms can be implemented, without the need to optimize/escalate IBD-related therapy. In these individuals, decisions about endoscopic evaluation, capsule endoscopy, and possibly cross-sectional imaging should be individualized.

Dietary Therapies for Inflammatory Bowel Disease With Irritable Bowel Syndrome–Like Symptoms

Recommendations. Dietary interventions are appropriate for the treatment of adults and children with IBD and IBS-like symptoms (Table 3). Psyllium is appropriate for improving IBS-like symptoms in participants with UC and those with CD, provided there is no clinically relevant stricture that could be worsened by fiber supplementation. A trial of a diet low in fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAP) is also appropriate for improving symptoms (Figure 3). There was uncertainty regarding the use of other dietary interventions for persons with IBD and IBS-like symptoms.

Evidence in context. In a crossover trial of 29 participants with quiescent UC and abnormal bowel habits, psyllium was significantly better than placebo in improving overall gastrointestinal symptoms.[42] Despite the fact that the trial was at unclear risk of bias, the use of psyllium in participants with IBD with IBS-like symptoms is appropriate in the absence of a clinically relevant stricture, given the low risk associated with fiber supplementation and supporting symptom efficacy data in participants with IBD.[42–46] Other types of fiber supplementation have limited data in IBS or IBD, and no data in participants with IBD with IBS-like symptoms, and should not be recommended in routine clinical care.[45,46]

Five trials have examined the efficacy of a low FODMAP diet in participants with IBD with IBS-like symptoms and a low FODMAP diet was superior for improving

Table 3. Recommendations for the Use of Dietary Interventions, Drugs, and Brain-Gut Behavioral Therapies in IBD and IBS-like Symptoms

Statement	Median Rating (IQR)	DI	Appropriateness
Dietary therapies			
Dietary interventions are appropriate in adult and pediatric persons with IBD and IBS-like symptoms	8.5 (8,9)	0.13	Appropriate
Psyllium is appropriate for improving IBS-like symptoms in persons with UC and in persons with CD provided there is no clinically relevant stricture	7.5 (7,8)	0.16	Appropriate
Fructo-oligosaccharide as a fiber supplement is appropriate for improving IBS-like symptoms in persons with IBD	5 (3.6,5.7)	0.73	Uncertain
Other kinds of fiber (oat bran, insoluble fiber) are appropriate for improving IBS-like symptoms in persons with IBD	6 (3.6,7)	1.21	Uncertain
A trial of a low FODMAP diet is appropriate for improving IBS-like symptoms in persons with IBD	8 (8,8)	0.00	Appropriate
A Mediterranean diet for improving IBS-like symptoms in persons with IBD	6 (5.3,7)	0.42	Uncertain
A low carbohydrate or low refined carbohydrate diet is for improving IBS-like symptoms in persons with IBD	5 (5,6)	0.32	Uncertain
Exclusive or partial enteral nutrition is appropriate for improving IBS-like symptoms in persons with IBD	5 (2.6,5)	0.58	Uncertain
Other elimination diets (carrageenan-free diet, low microparticle diet, immunoglobulin G–based elimination diet, symptom-based elimination diet) are appropriate for improving IBS-like symptoms in persons with IBD	5 (5,5)	0.00	Uncertain
Drugs			
Drugs are appropriate in adult and pediatric persons with IBD and IBS-like symptoms and should be tailored to the predominant IBS-like symptomatology	8 (8,8.7)	0.09	Appropriate
5-HT_3 receptor antagonists (eg, ramosetron) are appropriate for improving IBS-like symptoms in persons with IBD	7 (7,8)	0.16	Appropriate
Rifaximin is appropriate for improving IBS-like symptoms in persons with UC	6 (5.3,7)	0.42	Uncertain
Rifaximin is appropriate for improving IBS-like symptoms in persons with CD	7 (6.3,7)	0.15	Appropriate
Other antibiotics are appropriate for improving IBS-like symptoms in persons with IBD	5 (4.3,5)	0.24	Uncertain
TCAs are appropriate for improving IBS-like symptoms in persons with IBD	8 (7.3,8.7)	0.20	Appropriate
SSRIs are appropriate for improving IBS-like symptoms in persons with IBD	7 (5,7)	0.52	Appropriate
SNRIs are appropriate for improving IBS-like symptoms in persons with IBD	7 (6.3,7)	0.15	Appropriate
Antidiarrheals such as loperamide are appropriate for improving IBS-like symptoms in persons with IBD	7 (7,8)	0.16	Appropriate
Antispasmodics are appropriate for improving IBS-like symptoms in persons with IBD	6.5 (6,8)	0.37	Appropriate
Peppermint oil is appropriate for improving IBS-like symptoms in persons with IBD	7 (6.3,8)	0.30	Appropriate
Osmotic laxatives are appropriate for improving IBS-like symptoms in persons with IBD	7 (6.3,8)	0.30	Appropriate
Stimulant laxatives are appropriate for improving IBS-like symptoms in persons with IBD	6 (5.3,7)	0.42	Uncertain
Secretagogues are appropriate for improving IBS-like symptoms in persons with IBD	7 (6,7)	0.22	Appropriate
Sodium/hydrogen exchanger isoform 3 inhibitors are appropriate for improving IBS-like symptoms in persons with IBD	6 (5.3,6.7)	0.36	Uncertain

Table 3. Continued

Statement	Median Rating (IQR)	DI	Appropriateness
5-HT_4 receptor agonists are appropriate for improving IBS-like symptoms in persons with IBD (in the absence of a clinically significant stricture)	6.5 (6,7)	0.22	Appropriate
Antidiarrheals and laxatives are appropriate for improving persistent bowel symptoms but not abdominal symptoms	7 (7,8)	0.16	Appropriate
BGBTs			
BGBTs are appropriate in adults and children with IBD with IBS-like symptoms	9 (9,9)	0.00	Appropriate
A strong clinician-patient relationship that includes a patient-centered explanation of the role of the brain-gut axis in the maintenance of GI symptoms is required for improving the uptake of behavioral therapies in persons with IBD with IBS-like symptoms	9 (9,9)	0.00	Appropriate
Psychological interventions are appropriate for improving the following in persons with IBD and IBS-like symptoms:			
Satisfaction with treatment	9 (8.3,9)	0.09	Appropriate
QoL	9 (8.3,9)	0.09	Appropriate
Comorbid anxiety	9 (9,9)	0.00	Appropriate
Comorbid depression	9 (9,9)	0.00	Appropriate
Abdominal symptom improvement	7.5 (7,9)	0.29	Appropriate
GI-focused cognitive behavioral therapy is appropriate for improving IBS-like symptoms in persons with IBD	9 (8,9)	0.13	Appropriate
GI-focused cognitive behavioral therapy combined with mindfulness interventions are appropriate for persons with IBD and IBS-like symptoms to improve:			
Refractory abdominal pain or discomfort	8 (7.3,9)	0.24	Appropriate
Chronic stress	9 (8,9)	0.13	Appropriate
Mood disorders	8.5 (7.3,9)	0.24	Appropriate
Impaired health-related QoL	8 (7,9)	0.29	Appropriate
Other persistent bowel symptoms	7 (7,9)	0.29	Appropriate
Gut-directed hypnotherapy is appropriate for improving IBS-like symptoms in persons with IBD	8 (7,9)	0.29	Appropriate

GI, gastrointestinal; IQR, interquartile range.

gastrointestinal symptoms in all.[47–51] None of the 5 trials were at low risk of bias (Supplementary Table 5). Low FODMAP diet appears effective in both UC and CD. However, these trials only evaluated efficacy at 4 to 8 weeks, and all but one lacked a rigorous control arm. Nevertheless, given the preliminary evidence and its known efficacy in IBS, a low FODMAP diet is appropriate for IBD with IBS-like symptoms.[52] Other dietary interventions described in Table 3 have not been studied in IBD with IBS-like symptoms so the appropriateness of their use is uncertain. High-quality, adequately powered RCTs addressing the unique methodological complexities of dietary interventions have the potential to inform and improve clinical practice in this field.

Drugs for Inflammatory Bowel Disease With Irritable Bowel Syndrome–Like Symptoms

Recommendations. Drugs are appropriate in both adults and children with IBD and IBS-like symptoms; however, the specific treatment should be tailored to the predominant IBS-like symptom. Antidiarrheal or laxative therapies may be useful for diarrhea or constipation but may be less effective for abdominal pain. Additional treatments considered to be potentially appropriate for managing IBD and IBS-like symptoms included 5-hydroxytryptamine type-3 (5-HT_3) receptor antagonists, tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), antispasmodics, peppermint oil, secretagogues, or serotonin type 4 receptor (5-HT_4) agonists (Table 3, Figure 3). Although direct evidence supporting the use of osmotic laxatives, secretagogues, or antispasmodics in IBD and IBS-like symptoms is lacking, the panel agreed that their inclusion in clinical appropriateness is based on their established efficacy and safety in IBS. The panel voted that rifaximin may be appropriate in CD, but there was uncertainty in UC. The appropriateness of sodium/hydrogen exchanger isoform 3 inhibitors was also uncertain.

Evidence in context. *Ramosetron.* Ramosetron is available in Japan and some other Asian countries, but not the United States. One double-blind, placebo-controlled RCT evaluated the efficacy of ramosetron, a 5-HT_3

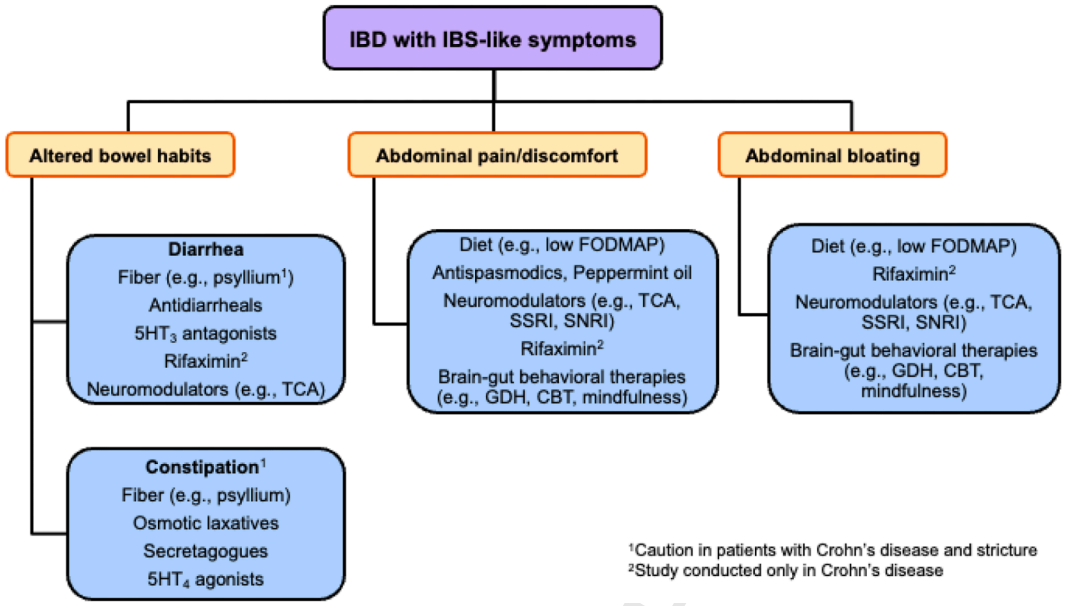

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Figure 3. Treatment algorithm for IBS with IBS-like symptoms. Dietary interventions, drugs, and brain-gut behavioral therapies that can be used to treat the predominant symptom (eg, diarrhea, constipation, abdominal pain, or bloating). Q10

antagonist, in participants with quiescent IBD (n = 56 CD [Crohn's disease activity index <150 and CRP <0.3 mg/dL], n = 10 UC [clinical activity index <4 and CRP <0.3mg/dL]) and Rome III–positive diarrhea-predominant IBS.[53] The trial was at high risk of bias due to incomplete outcomes data. Participants were randomized to ramosetron 5 μg/d or placebo. Responder rates for global relief were significantly higher with ramosetron compared with placebo (35.5% vs 11.4%, $P = .037$) and ramosetron was associated with a significantly higher responder rate for improvement of bowel habits (38.7% vs 14.2%, $P = .028$) and change in weekly average stool frequency score (−1.203 vs 0.313, $P = .044$) but not relief of abdominal discomfort/pain (29% vs 14.3%, $P = .12$). No significant adverse events were reported.

Rifaximin. An RCT compared repeated courses of rifaximin with antispasmodics as needed in 86 adult participants with CD in remission (FC <50 mg/g, CRP <0.5 mg/dL, and SES-CD <2) with Rome IV IBS symptoms of all subtypes.[54] The trial was at high risk of bias as it was open-label. Participants were randomized to 1200 mg/d rifaximin for 10 days per month over 3 months or trimebutine 300 mg as needed. At 3 months, rifaximin improved bloating (59.1% vs 19.0%, $P = 0.01$) and abdominal pain (54.5% vs 21.4%, $P = 0.04$) significantly compared with trimebutine. QoL scores also improved with rifaximin (70.4% vs 21.4% had a ≥30% improvement, $P < .001$). In addition, a greater proportion of participants treated with rifaximin experienced improvement in stool consistency, with a ≥1-point reduction in Bristol Stool Form Scale score (34.1% vs 14.2%, $P = .03$). No adverse events were reported. However, investigators were not blinded, and the total dose of antispasmodic used in the control group was not reported.

Neuromodulators. A retrospective single-center observational study evaluated the efficacy of TCA in 81 participants with IBD (58 CD, 23 UC) in clinical remission or with mild inflammation based on histologic, endoscopic, and/or radiographic evidence, but persistent gastrointestinal symptoms.[55] Symptom severity at TCA initiation was assessed using a 4-point Likert scale and treatment response was defined as a score of 2 or 3 and evaluated at follow-up using chart descriptors. TCAs used included amitriptyline, nortriptyline, desipramine, and doxepin. The median initial dose was 25 mg, with dose escalation occurring in 29 participants. There was no escalation of IBD-related therapy during the study. At the first follow-up, 59.3% of participants had at least a moderate symptom response. Overall, 52% of participants demonstrated at least moderate improvement. Response was better in UC than CD (83% vs 50%, $P = .01$). However, at a second follow-up, at least moderate symptom improvement was seen in 56% of participants with CD and 40% of participants with UC, which was not statistically significant ($P = .16$).

A more recent RCT compared 20 mg of the SSRI paroxetine with gabapentin titrated from 100 mg to 300 mg after the first month in 100 participants with quiescent UC and Rome IV IBS-like symptoms.[56] Disease quiescence was confirmed by normal CRP, FC, and endoscopic Mayo Score of 0. The primary endpoint was improvement in IBS-SSS. The trial was at high risk of bias as it was single-blind. Ninety-seven participants completed the study. The primary endpoint was improvement in IBS-SSS,[25] with secondary endpoints including changes in anxiety and depression symptoms, and QoL. Paroxetine showed significantly greater improvements across all measures compared with gabapentin ($P < .045$ for all endpoints). Within-group analysis showed that paroxetine improved

symptom severity, anxiety, depression, and QoL ($P < .001$ for all), whereas gabapentin only improved symptom severity ($P = .028$). Despite statistical significance, the absolute change in IBS-SSS in the gabapentin group was small. No participants relapsed during the 3-month trial, and adverse events were not reported.

Brain-Gut Behavioral Therapies for Inflammatory Bowel Disease With Irritable Bowel Syndrome–Like Symptoms

Recommendations. BGBTs are appropriate for both adults and children with IBD and IBS-like symptoms, and can improve satisfaction with treatment, QoL, comorbid psychological symptoms, abdominal pain, and bowel symptoms. Interventions voted to be appropriate included gastrointestinal-focused cognitive behavioral therapy, mindfulness-based interventions, and gut-directed hypnotherapy (Table 3). Improving access to these interventions could improve the quality of care for persons with IBD and IBS-like symptoms.

Evidence in context. BGBTs are clinician administered, skills-based interventions that focus on the modification of cognitive, affective, and behavioral factors influencing gastrointestinal symptom perception and response. There are robust data for their use in children and adults with IBS and other DGBIs.[57,58] Common drivers of altered symptom perception, and response along the gut-brain axis in both IBD and IBS, include pain catastrophizing, symptom hypervigilance, and avoidance behavior, which can in turn drive other symptoms, including reduced QoL, depression, anxiety, and fatigue.[29,58]

There is growing evidence for the use of BGBTs in IBD. A recent meta-analysis of 25 RCTs examining the efficacy of behavioral therapies for adults with IBD suggested a benefit for depression or anxiety symptoms, and improved disease-specific QoL, but there are limited data on disease parameters, such as remission status or biomarkers.[59] Only 4 of the 25 trials evaluated participants with active disease,[59] and none of the trials were at low risk of bias across all domains. To increase the uptake of BGBTs, a strong clinician-patient relationship and communication around the role of the gut-brain axis in the perpetuation of symptoms is necessary.[60]

In a recent meta-analysis of 42 RCTs of BGBTs for the management of abdominal pain in IBS, IBS-specific cognitive behavioral therapy and gut-directed hypnotherapy were associated with ~30% reductions in abdominal pain.[61] Interestingly, in IBD trials of BGBT, acceptance and mindfulness-based therapies, commonly known as third-wave behavior therapies, seemed to have the most significant impact on overall psychological well-being and symptoms like fatigue and pain.[59]

Discussion

This joint Rome Foundation-IOIBD Working Team used a modified RAM to address the highly prevalent but inconsistently defined problem of IBD with IBS-like symptoms. Studies estimate that 20% to 30% of individuals with IBD in remission report IBS-like symptoms.[1,62] Across 2 voting rounds, experts rated 105 statements, culminating in pragmatic recommendations on nomenclature, evaluation, and management. The panel endorsed the term "IBD with IBS-like symptoms" across adult and pediatric IBD, emphasized that these symptoms may precede or follow an IBD diagnosis, and specified a symptom cluster centered on abdominal pain/discomfort, bowel habit change (diarrhea, constipation, mixed), and bloating. For clinical care, the panel supported the diagnosis using Rome clinical criteria, alongside objective assessments to exclude active inflammation or explanatory structural damage. For research, the panel recommended candidate thresholds for endoscopic, biomarker, histologic, and imaging remission, and identified the urgent need for a disease-specific activity measure for IBD with IBS-like symptoms.

With respect to treatment, the panel judged dietary approaches (eg, psyllium when no stricture is suspected or a short-term low FODMAP diet) and targeted drugs (antidiarrheals or laxatives for bowel symptoms; 5-HT_3 antagonists, TCAs, SSRIs/SNRIs, antispasmodics, peppermint oil, secretagogues, and 5-HT_4 agonists in selected participants) to be appropriate but were uncertain regarding use of several other diets and some medications (eg, antibiotics or stimulant laxatives). Consistent with IBS treatment trials, BGBTs were universally endorsed for improving IBS-like symptoms in IBD. Clinicians should first secure objective evidence of active inflammation before escalating immunomodulatory therapy, which addresses a long-recognized gap in routine clinical practice and some previous RCTs. For example, trials that included participants only based on symptoms risked misclassification of active disease, dilution of anti-inflammatory therapeutic effects, and potential overtreatment of individuals without active inflammation. Simultaneous escalation of treatments targeted at the inflammatory burden and IBS-like symptoms can be considered in persons whose symptoms may not be completely explained by the inflammatory burden (Figure 2).

Pathophysiological Implications

IBD with IBS-like symptoms is not simply a continuation of prior inflammation but likely reflects multifactorial mechanisms, including visceral hypersensitivity, low-grade immune activation, impaired barrier function, and microbial dysbiosis. In UC in remission, rectal hypersensitivity is common, although mechanisms for this remain unclear.[63,64] Evidence supports that low-grade immune activation can occur without elevated FC: increased intraepithelial lymphocytes and mucosal tumor necrosis factor-α in quiescent IBD with IBS-like symptoms,[65] and correlations between mast cell density and visceral hypersensitivity. This parallels IBS, in which mast cells adjacent to nerves correlate with pain severity.[66] Concomitantly, mucosal barrier defects are implicated. Higher paracellular permeability and reduced Zonula Occludens-1/α-catenin expression in participants with quiescent IBD with IBS-like symptoms, mirror IBS.[65] More recent research highlights the role of

altered gut microbiota in IBD with IBS-like symptoms: in quiescent CD, increased dysbiosis indices and reduced α-diversity, and enrichment of sulfidogenic microbes/sulfur pathways in CD with IBS-like symptoms[67]; in IBD with fatigue and IBS-like symptoms, serum metabolite and fecal microbial alterations.[68] A deeper understanding of these mechanisms may inform the development of targeted, mechanism-based therapies to improve symptom management and QoL.

Clinical Implications

Using the term IBD with IBS-like symptoms provides a consistent and person-centered way to describe this clinical phenotype. It reduces ambiguity in communication, helps individuals understand that symptoms may persist despite remission, and may prevent unnecessary escalation of IBD-related therapy in the absence of objective evidence of active inflammation. The panel reinforces the pairing of symptoms and PROMs with biomarkers, endoscopy, histology, and/or cross-sectional imaging, when indicated. Although intestinal ultrasound is increasingly used to assess disease activity and monitor flares in UC, FC and/or endoscopy remain the reference standards for excluding active mucosal inflammation when evaluating IBS-like symptoms. Treatment should be directed toward the individual's predominant symptom (Figure 3). For bowel symptoms, antidiarrheals or laxatives may be appropriate, with consideration of 5-HT_3 antagonists in those with diarrhea and secretagogues or 5-HT_4 agonists in those with constipation, provided stricturing is not present due to risk of perforation. For abdominal pain and global symptoms, a time-limited low FODMAP trial with structured reintroduction, psyllium supplementation in the absence of strictures, and neuromodulators, particularly TCAs or, depending on stool pattern and comorbid mood or anxiety disorders, SSRIs or SNRIs may be beneficial. Finally, BGBTs should be incorporated earlier in management, rather than as a last resort, as these approaches target catastrophizing, hypervigilance toward gastrointestinal sensations, and maladaptive avoidance behaviors that can amplify symptom intensity and functional disability. Although beyond the scope of this review, practical guidance is available for integrating gastropsychologists and BGBT into gastroenterology practice,[69] as well as emerging frameworks for the appropriate clinical use of digital self-management tools alongside medical management.[70]

Research Priorities

Research priorities include developing a validated activity measure and PROMs to capture the multidimensional burden of IBD with IBS-like symptoms; conducting mechanism-based and predictive enrichment trials; performing longer-term RCTs of dietary interventions, drugs, and BGBTs; advancing stepped-care implementation models that address cost, access, and equity; and expanding pediatric studies with age-appropriate tools and tailored interventions.

Strengths and Limitations

Strengths of this study include a multidisciplinary, international panel, RAM methodology, a comprehensive literature review, and a transparent process integrating the best available evidence with expert judgment, while preserving anonymity to minimize dominance bias. The RAM approach was specifically selected, recognizing that limitations in the existing literature may need to be bridged by the incorporation of expert opinions, iterative feedback, and discussions. However, several limitations should be acknowledged. Panelists were recruited by invitation based on predefined expertise criteria rather than an open call, and some had prior professional relationships. Although recommendations are formalized through a structured voting process, they remain dependent on the panelists' experience, expertise, and potentially specialty bias. Voting is anonymized, but discussions that form a critical foundation for the recommendations may be influenced by more vocal panel members, and this setting is not always conducive to including patient partners. Accordingly, patients were not included in the formal consensus process, which is an important limitation. To incorporate patient perspectives, 4 individuals with IBD reviewed the near-final manuscript: 3 patients with IBD and IBS-like symptoms and 1 independent patient advocate. We acknowledge that 2 of the 3 patient reviewers had prior clinical relationships with members of the panel, which may introduce perceived bias and limit independence of feedback; however, patients were explicitly invited to provide honest and critical feedback, including identifying gaps in content, concerns regarding terminology and stigma, and priorities for patient-centered research. Feedback was obtained independently and incorporated in aggregate; however, this post hoc consultation does not substitute for direct participation in the consensus process and may not capture the full range of patient perspectives. Limitations in the existing literature were also consistently recognized during the voting process. These include but are not limited to heterogeneity in remission definitions and symptom criteria, relatively few large, well-controlled RCTs conducted in participants with IBD with IBS-like symptoms, short follow-up and limited mechanistic phenotyping, and potential regional differences in treatment availability (eg, ramosetron) that constrain generalizability. Appropriateness ratings do not equate to regulatory endorsement and should be revisited as evidence accumulates. This consensus did not address bile acid malabsorption specifically, which represents a distinct cause of diarrhea that should be evaluated and managed separately in patients with IBD when clinically suspected. There were also no RCTs evaluating bile acid sequestrants specifically in IBD with IBS-like symptoms. However, assessment for bile acid malabsorption has been incorporated into the diagnostic algorithm (Figure 2). An additional limitation is that, although the Rome Foundation and IOIBD have global membership, and reviewed and approved this working team consensus report, the panelists for this iteration were predominantly based in North America with limited

European representation and did not include experts from several world regions (eg, Asia, Latin America). Therefore, regional differences in health care infrastructure, access to endoscopy/imaging/biomarkers, sociocultural factors influencing symptom reporting, and regulatory approval/availability of therapies may limit generalizability. Accordingly, these recommendations should be adapted to local context, and future updates should incorporate broader geographic representation. As with most expert consensus statements, many panelists had prior industry interactions; however, anonymized voting, predefined scoring rules, and the absence of industry funding specific to the therapies under discussion were used to mitigate potential bias.

Patient Perspective

The perspectives of persons with IBD on this complex area are critical. After completion of the initial manuscript, we engaged 4 individuals with lived experience of IBD (3 with IBS-like symptoms and 1 with IBD who is a patient advocate for a Crohn's and colitis organization in Europe). Two are American, 1 is Canadian, and 1 is European. Their comments are summarized in Supplementary Table 6. Patient perspectives highlight the importance of clear communication and discussion of therapeutic options with rationales for use, and shared decision making when developing a diagnostic and management plan. Additional clinical and research implications have been incorporated. Future efforts should incorporate patient input earlier in the process, particularly to guide implementation strategies and ensure alignment with patient-centered priorities.

Conclusions

The Rome Foundation-IOIBD Working Team provides consensus, mechanism-informed guidance for the prevalent, burdensome, and historically underrecognized phenotype of IBD with IBS-like symptoms. By standardizing terminology, advocating objective exclusion of active inflammation, and endorsing multimodal management consisting of dietary interventions, drugs, and BGBTs, these recommendations aim to improve outcomes while refocusing treatment of quiescent IBD. Future research should prioritize validated activity measures, mechanism-enriched trials, and implementation strategies that broaden access to effective, person-centered care.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of Gastroenterology at www.gastrojournal.org, and at doi:10.1053/j.gastro.2026.04.008.

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Received November 18, 2025. Accepted April 6, 2026.

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Acknowledgments

Charles N. Bernstein, Anne M. Griffiths, Millie D. Long, and Bruce E. Sands are members of IOIBD. This work was conducted by the Endpoints Cluster of IOIBD. Lin Chang, Giovanni Barbara, Laurie Keefer, and Sam Nurko are members of the Rome Foundation Board of Directors. We would like to thank the persons with IBD, including Sandra Munroe, Rocio Castrillon, and Salvatore Leone (IBD patient advocate), who reviewed the manuscript and provided valuable comments.

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Conflicts of interest

These authors disclose the following: Christopher Ma has received consulting fees from AbbVie, Alimentiv, Amgen, Anaptys Bio, AVIR Pharma Inc, Bristol Myers Squibb, Celltrion, Domain Therapeutics, Eupraxia, Eli Lilly, Ferring, Forte Biosciences, Fresenius Kabi, Gilead, Janssen, McKesson, Mirador Therapeutics, Pendopharm, Pfizer, Prometheus Biosciences Inc., Roche, Sanofi, Takeda, and Tillotts Pharma; speaker's fees from AbbVie, Amgen, AVIR Pharma Inc, Alimentiv, Bristol Myers Squibb, Eli Lilly, Ferring, Fresenius Kabi, Janssen, Merck, Organon, Pendopharm, Pfizer, Sanofi, Takeda, and Tillotts Pharma; royalties from Springer Publishing; and research support from AbbVie, Eli Lilly, Ferring, and Pfizer. Jana G. Hashash served on an advisory board for Bristol Myers Squibb. Giovanni Barbara has consultancies, business interests, or sources of honoraria payments from Aboca, AB Biotics, Agave, Alfa Sigma, AGPharma, Bayer, Biocodex, Boeringer, Bromatech, Cadigroup, Danone, Diadema, Falk Pharma, GE Healthcare, Giuliani, Mayoly, Malesci, Sanofi, Sofar, and Yakult. Charles N. Bernstein is supported by the Bingham Chair in Gastroenterology and has served on advisory boards for AbbVie Canada, Amgen Canada, Celltrion, Eli Lilly Canada, Ferring Canada, Fresenius-Kabi Canada, Janssen Canada, Organon Canada, Pendopharm Canada, Sandoz Canada, Takeda Canada, and Pfizer Canada; educational grants from AbbVie Canada, Boston Scientific, Celltrion, Eli Lilly Canada, Ferring Canada, Fresenius Kabi Canada, Janssen Canada, Organon Canada, Pfizer Canada, and Takeda Canada; served on the speaker's panel for AbbVie Canada, Janssen Canada, Eli Lilly, Fresenius Kabi, and Takeda Canada; and received research funding from AbbVie Canada, Janssen Canada, Pfizer Canada, and Takeda Canada. Darren M. Brenner has been a speaker for Salix, AbbVie, and Ardelyx; has served as a consultant/advisor for Alnylam, Salix, AbbVie, Ardelyx, Bayer, Gemelli, Laborie, Vibrant, CinPhloro, Dr. Reddy, Bioamerica, Blueprint Meds, Owlstone, and SideBy Care; has unvested stock options in Owlstone and SideBy Care; and serves on the Board of Directors for IFFGD. Anne M. Griffiths has served on advisory boards for AbbVie, Alfasigma, Amgen, Janssen, and Lilly; has received speaker fees from AbbVie, Pfizer, and Takeda; and received investigator-initiated research support from AbbVie. Laurie Keefer has served as a consultant for AbbVie, Janssen, Lilly, Pfizer, and Reckitt; receives unrestricted research funding from Ardelyx; is an equity owner in Trellus Health; and is on the board of directors for the Rome Foundation. Millie D. Long has been a consultant for AbbVie, BMS, Celltrion, Genentech, Intercept, Janssen, Lilly, Merck, Pfizer, Prometheus, Roche, Roivant, Spyre, Takeda, and Target RWE and has received research support from Celltrion, Lilly, Pfizer, and Takeda. Samuel Nurko has served as a consultant for AbbVie, Ironwood, and Ardelyx and serves as a member of the Rome Foundation Board of Directors. Prashant Singh has served on the advisory board for GastroKnowMi and received research funding from Kiwi Biosciences. Bruce E. Sands reports consulting fees from AbbVie, Alimentiv, Adiso Therapeutics, Agomab, Amgen, AnaptysBio, AstraZeneca, Biolojic Design, Biora Therapeutics, Boehringer Ingelheim, Celltrion, Equillium, Ensho Therapeutics, Enthera, Enveda Biosciences, Evommune, Ferring, Fzata, Galapagos, Genentech (Roche), Gilead Sciences, GlaxoSmithKline, Gossamer Bio, Imhotex, Immunyx Therapeutics, Index Pharmaceuticals, Innovation Pharmaceuticals, Kaleido, Kallyope, Merck & Co., Microba, Microbiotica, Mirador Therapeutics, Mitsubishi Tanabe Pharma, Mobius Care, Morphic Therapeutics, MRM Health, Nexus Therapeutics, Nimbus Discovery, Odyssey Therapeutics, Palisade Bio, Prometheus Biosciences, Prometheus Laboratories, Protagonist Therapeutics, Q32 Bio, Rasayana Therapeutics, Recludix Therapeutics, Reistone Biotherapeutics, Sanofi, Sorriso Pharmaceuticals, Surrozen, Target RWE, Teva, TLL Pharmaceutical, TR1X, and Union Therapeutics; consulting and speaking fees from Abivax; consulting and speaking fees and other support from Lilly; research grants, consulting and speaking fees, and other support from Bristol Myers Squibb, Janssen/J & J Innovative Medicine, Pfizer, and Takeda; research grants and consulting fees from Theravance Biopharma; and consulting fees, stock, and stock options from Ventyx Biopharma. Lin Chang has served as a consultant for Ardelyx, Atmo, Food Marble, GlaxoSmithKline, Eli Lilly, Ironwood, Medscape, Nerva, and Vibrant; has been a speaker for Bausch Health; received research grants from AnX Robotica and Ironwood; serves as a member of the Rome Foundation Board of Directors; and has unvested stock options for Food Marble, ModifyHealth, PICO Health, and Trellus Health. The remaining author discloses no conflicts.

Funding

The Rome Foundation provided honoraria to members of the working team; no research funding was received for this project.

Data Availability

The data, analytic methods, and study materials that support the findings of this study are available from the corresponding author on reasonable request.