

Editorial
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Current Status of Diagnosis and Treatment of Irritable Bowel Syndrome in Korea

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► See the article “Survey-Based Analysis of the Clinical Treatment Status of Irritable Bowel Syndrome in Korea” in volume 38, number 16, e126.

Irritable bowel syndrome (IBS) is one of functional bowel disorders that are related with the patient's symptoms without any organic disease. It is a common gastrointestinal disorder, affecting 3.8-11.2% of the general population worldwide.^{1,2} The prevalence of IBS varies among countries and depends on the criteria used to diagnose it.¹ Diagnoses are made using the Rome criteria, which are based on symptoms. Since the Rome I consensus appeared in 1994, continuous efforts have been made to set stricter definitions of IBS. According to Rome IV criteria revised in 2016, the diagnostic criteria of IBS is defined as “recurrent abdominal pain, at least 1 day per week in the last 3 months, associated with two or more of the following criteria: related to defecation, associated with a change in frequency of stool and associated with a change in form of stool. Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.”³ The Rome IV criteria differ from the Rome III criteria by the deletion of the term “discomfort” and indicates clearly the “frequency of abdominal pain.”³ Owing to these more restrictive criteria, the prevalence of IBS is substantially lower using the Rome IV criteria than with the Rome III criteria.²

IBS involves a spectrum of symptoms including diarrhea, abdominal pain, and constipation. However, to aid the proper diagnosis and treatment of patients with IBS, it can be categorized into four subtypes: IBS with predominant constipation (IBS-C), IBS with predominant diarrhea (IBS-D), IBS with mixed bowel habits (IBS-M), and unclassified IBS (IBS-U).³ Clinicians treat IBS patients according to the predominant symptom type and severity. The Rome criteria are used for the diagnosis of IBS globally, however, the differences seen in symptom sets between Western and Asian countries due to many factors, including cultural differences and medical accessibility. Therefore, country-specific treatment guidelines for IBS have been developed. In line with this, “Korean guidelines for the treatment of IBS” were developed, with revision published in 2018.⁴

In this issue of the *Journal of Korean Medical Science*, Koo et al.⁵ conducted a survey-based study of doctors to evaluate the current status of IBS diagnosis and treatment in Korea. In particular, differences in treatment patterns between doctors in primary/secondary, and tertiary health care institutions (HCI) were investigated. The survey was conducted using a web-based platform with 37 questions on the general characteristics of the doctors, diagnosis of IBS, colonoscopy, and treatment of IBS. A total of 272 doctors responded, with the majority being internal medicine doctors (96.7%) who majored in gastroenterology or specialists of functional gastroenterology. The interesting results of the study showed that 82% of the

respondents diagnosed IBS according to the Rome IV criteria. The most common subtype of IBS was IBS-D (66%), followed by IBS-M (24%) and IBS-C (6%).

Colonoscopy is recommended in Korea for patients aged ≥ 50 years with change in bowel habits, in patients with alarm symptoms, or a family history of colorectal cancer.⁴ In this study, colonoscopy was performed more frequently in tertiary HCI than in primary/secondary HCI ($P < 0.001$). In addition, the purpose of performing colonoscopy differed between the HCIs.

IBS is treated with non-pharmacological interventions, such as diet modification, and with pharmacologic agents. A low FODMAP (fermentable oligosaccharides, disaccharides, monosaccharides, and polyols) diet was recommended to patients with IBS by 61% of respondents, resulting in improved abdominal distension (62%) and diarrhea (23%). Regarding pharmacologic treatment, a combination of two or three types of drugs was usually administered regardless of the type of HCI. Antispasmodics and probiotics were mainly prescribed to patients with IBS-D. Osmotic and bulk-forming laxatives were mostly prescribed to patients with IBS-C. However, doctors' preference for therapeutic agents showed significant differences between the HCI; for example, in the IBS-D subtype, the use of antispasmodics was higher in primary/secondary HCI than in tertiary HCI, while the use of serotonin type 3 receptor antagonists was higher in tertiary HCI than in primary/secondary HCI.

The strength of the current study is that it provides novel information regarding the diagnosis and treatment status of IBS in Korea. Most doctors used the Rome IV criteria for IBS diagnosis. However, in terms of performing colonoscopy and the treatment of IBS, doctors' perceptions differed according to the HCI. This difference may be due to the characteristics of the patients who seek medical care, as well as limitations of insurance coverage. Considering the lack of phenotypic markers or biochemical abnormalities to clearly define IBS and the fact that many diseases have symptoms that can mimic IBS, accurate and prompt diagnosis and proper treatment are challenging. Misdiagnosis of IBS may result in excessive consumption of medical resources and reduction in the quality of life of patients. Therefore, as authors commented, continuous update of guidelines for the diagnosis and treatment of IBS are needed, taking the perception of doctors into consideration.

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