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Irritable Bowel Syndrome (IBS): Diagnostic work-up at Kirurgen.dk

Irritable Bowel Syndrome, usually shortened to IBS, is one of the most common reasons adults live with persistent abdominal pain, bloating and unstable bowel habits. The condition is not dangerous, but the symptoms can be strong enough to shape daily life for years. The first step that actually matters is to find out whether the symptoms really are IBS, or whether something else is hiding underneath.

That diagnostic work-up is what we do at Kirurgen.dk. We see patients with bowel symptoms with or without a referral, perform the relevant tests on the same day, and give you a clear plan you can take back to your GP or dietitian.

When should bowel symptoms be investigated?

Some symptoms should never be labelled as IBS before serious disease has been ruled out. Contact your GP or us directly if you notice any of these:

- Blood in the stool or dark, tarry stools.
- Unexplained weight loss or persistent fever.
- First symptoms after the age of 50 without prior screening for bowel cancer.
- Diarrhoea that wakes you at night.
- A close relative with colorectal cancer, inflammatory bowel disease or coeliac disease.
- A sudden change in an otherwise stable bowel pattern.

These are called alarm symptoms. They do not rule out IBS, but they do mean the bowel needs a closer look before the diagnosis is settled.

How we investigate IBS

Our aim is a safe diagnosis with as few tests as possible. A typical visit includes:

1. Clinical interview. We go through your symptoms, how long they have lasted, your stool pattern, diet, medication and family history. The Bristol stool chart helps describe the consistency.
2. Physical examination. Abdominal palpation and a rectal examination pick up tenderness, masses or blood that are not visible from the outside.
3. Blood tests. CRP, haemoglobin, ferritin and coeliac serology (anti-tTG IgA plus total IgA) rule out inflammation, hidden bleeding, iron deficiency and gluten intolerance.
4. Stool test. Faecal calprotectin is the key test for separating IBS from inflammatory bowel disease (Crohn's disease and ulcerative colitis). A value below 50 µg/g argues strongly against active inflammation.
5. Endoscopy when indicated. If you have alarm symptoms, are over 50, or the blood tests point to inflammation, we offer colonoscopy or sigmoidoscopy on the same day. Both procedures are available without waiting lists and without a referral.

Once organic disease has been ruled out and the symptoms meet the international Rome criteria, the IBS diagnosis can be made with confidence. You leave with a written summary, and your GP receives a discharge letter.

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What is irritable bowel syndrome?

IBS is a functional bowel disorder. The gut looks normal on imaging and under the microscope, but it works differently than it should. Around one in ten adults has IBS symptoms in shorter or longer periods. The condition is more common in women than men, and it usually starts between the ages of 20 and 40.

Modern research describes IBS as a disturbance in the communication between brain and gut. That does not mean the symptoms are imaginary. They are real. But the nervous system in the bowel wall is over-sensitive, so signals most people never notice are perceived as pain, bloating or an urge to go to the toilet.

Several mechanisms are involved:

- Visceral hypersensitivity. The nerves in the bowel react strongly to normal stretching from food and gas.
- Altered motility. Food moves either too quickly or too slowly through the colon.
- Low-grade inflammation in the lining. Especially after a gastrointestinal infection, more active mast cells are often found close to the nerve endings of the bowel.
- Altered gut flora. The mix of bacteria often differs from normal, and gas production may be increased.
- Stress and psychological strain. The brain influences bowel movement through the autonomic nervous system and amplifies the experience of pain.

Subtypes: IBS-C, IBS-D, IBS-M and IBS-U

IBS is classified by the dominant stool consistency on symptomatic days:

- IBS-C (constipation) - mostly hard or lumpy stools.
- IBS-D (diarrhoea) - mostly loose or watery stools.
- IBS-M (mixed) - alternating between hard and loose.
- IBS-U (unclassified) - the pattern does not fit one group.

The subtype matters because diet and medication work differently from one to the next.

Typical symptoms

- Recurrent abdominal pain or discomfort, often relieved by passing stool.
- A bloated, distended abdomen, particularly later in the day.
- Fluctuating bowel habits without a clear pattern.
- Mucus in the stool (but never blood).
- A sense of incomplete emptying.
- Worsening with stress, menstruation or certain meals.

Many patients also experience fatigue, headache or poor sleep, because gut symptoms reach beyond the bowel itself.

What happens after the work-up?

Treatment of IBS is rarely surgical. It is mostly handled by your GP or a clinical dietitian, but you leave us with a plan based on the interventions with the best evidence:

- Diet. Psyllium husk (HUSK) regulates both hard and loose stools and is the first choice. The low-FODMAP diet has strong evidence but is complex and should be followed together with a dietitian. Many patients benefit from less insoluble fibre from wheat bran, less coffee, less alcohol and fewer artificial sweeteners.
- Exercise. 20-60 minutes of daily activity reduces both pain and bloating.
- Psychological treatment. Cognitive behavioural therapy and gut-directed hypnotherapy have evidence on par with medication for moderate to severe cases.
- Symptom-targeted medication.
- For constipation: an osmotic laxative (Magnesia, Movicol) or, in more severe cases, linaclotide.
- For diarrhoea: loperamid as needed and, in selected cases, a short course of rifaximin.
- For chronic abdominal pain: a low-dose tricyclic antidepressant (for example amitriptyline 10-25 mg at night) acts as a central pain modulator.

We are happy to see you again if new symptoms later require a fresh work-up. If blood, weight loss or a sudden change appears, please get in touch.

Outlook

IBS is chronic but not dangerous. It does not increase the risk of bowel cancer and does not shorten life expectancy. Most patients find that their symptoms settle once their triggers are mapped and their diet, sleep and stress level are in order.

Booking and referrals

You are welcome to contact us directly. Your GP can also send a referral through the public health system.

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