PATIENT INFORMATION

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. IBS is a disorder of the interaction between the gut and the brain. It is diagnosed as a positive clinical diagnosis based on the symptom pattern and a targeted assessment, not purely by exclusion. The condition is not life-threatening, but the symptoms can be strong enough to shape daily life for years.

That diagnostic work-up is what we do at Kirurgen.dk. We see patients with bowel symptoms, go through the history and agree which tests are needed. You get a written conclusion 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. Black, tarry stools can be a sign of bleeding higher up in the digestive tract and should be assessed the same day; call 112 if you feel dizzy, faint or generally unwell.
- 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

IBS is a clinical diagnosis. Our aim is a targeted work-up where relevant differential diagnoses and alarm symptoms are assessed individually, with no more tests than needed. 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 (an inflammation marker), haemoglobin (which shows the blood's oxygen-carrying capacity), ferritin (the body's iron store) and the coeliac test anti-tTG IgA, together with total IgA, are used to look for signs of inflammation, bleeding-related anaemia, iron deficiency or coeliac disease. Normal results cannot on their own exclude these conditions, and they are read together with the clinical picture.
4. **Stool test.** Faecal calprotectin is used to assess whether there are signs of inflammation in the bowel. A low value makes active inflammatory bowel disease less likely, but does not exclude it. The cut-off is set by the laboratory analysing the sample and is not the same everywhere. If clinical suspicion persists, the test is repeated or endoscopy is added.
5. **Endoscopy when indicated.** If you have alarm symptoms, are over 50, or the blood tests point to inflammation, colonoscopy or sigmoidoscopy may be relevant. Age is one part of the assessment alongside your symptom pattern and alarm features; there is no single age cut-off that applies to everyone. The appointment is arranged individually, and referral and payment arrangements are clarified when the appointment is booked.

Which investigations are relevant depends on your age, symptom pattern, alarm features and the differential diagnoses in play. Colonoscopy is not an automatic part of an IBS work-up. You leave with a written summary, and your GP receives a discharge letter.

Relevant differential diagnoses include coeliac disease, inflammatory bowel disease, microscopic colitis, bile acid diarrhoea, medication side effects, and defecation or pelvic floor dysfunction.

IBS is diagnosed positively from the typical symptom pattern: recurrent abdominal pain that is linked to bowel movements, together with a change in how often you go or the form of the stool. For this we use the international Rome V criteria alongside a clinical assessment and a check for alarm symptoms. The criteria are a tool for the doctor, not a self-test you can apply at home. If your symptoms do not fit the set exactly, that does not mean you do or do not have IBS; it calls for clinical judgement. A more detailed walk-through of the criteria, the subtypes and the Bristol scale is available at EndoCap: IBS assessment under the Rome V criteria.

What is irritable bowel syndrome?

IBS is a disorder of the interaction between gut and brain, previously called a functional bowel disorder. Investigations of the bowel can look normal, but a normal finding is neither universal nor a diagnostic criterion in itself. The bowel works differently than it should. It is common among adults, is seen more often in women than in men and usually starts in younger adulthood.

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.

No single established cause has been identified. Several mechanisms are described, and they carry different weight from person to person:

- **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 immune activation in the lining.** Described in some patients, particularly after a gastrointestinal infection, but the finding is not consistent and does not explain every case.
- **Altered gut flora.** Differences in the mix of gut bacteria have been described, but dysbiosis is a hypothesis under investigation rather than a proven cause of IBS.
- **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 can occur. Visible blood, however, should not be attributed to IBS without medical assessment.
- 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 best studied in IBS:

- **Diet.** Soluble fibre such as psyllium is often introduced early in dietary advice, as it can affect both hard and loose stools. The effect varies from person to person, and there is no fixed order that applies to everyone. The low-FODMAP diet has been studied in IBS, but it is complex, intended as a time-limited course with a planned reintroduction of foods so the diet does not stay unnecessarily narrow, and should be followed

together with a clinical dietitian. Some people benefit from less insoluble fibre from wheat bran, less coffee, less alcohol or fewer artificial sweeteners, but triggers differ from person to person.

- **Exercise.** Regular physical activity is part of most IBS treatment guidance. Some people find their symptoms ease, but there is no fixed dose or duration that suits everyone, and the effect varies from person to person.
- **Psychological treatment.** Cognitive behavioural therapy and gut-directed hypnotherapy have documented effect and are recommended particularly for moderate to severe cases, or when other treatment has not helped enough.
- **Symptom-targeted medication.**
  - For constipation: an osmotic laxative and, in selected cases, a secretagogue such as linaclotide. Choice and dose are agreed with the treating doctor.
  - For diarrhoea: loperamide as needed. Rifaximin has been studied in IBS-D but is not part of routine treatment in Denmark and can only be considered after individual medical assessment.
  - For persistent abdominal pain a neuromodulator, typically a low-dose tricyclic antidepressant, may be tried as a central pain modulator. The drug and dose are decided individually by the treating doctor and are not stated here.

Never stop or change prescribed medication without a specific agreement with the treating doctor.

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.

IBS does not in itself require an endoscopic examination. Where there are alarm features, or where the diagnosis is uncertain, colonoscopy can form part of the assessment, among other things to distinguish IBS from microscopic colitis and inflammatory bowel disease.

If symptoms change

IBS is a clinical diagnosis and does not in itself require an endoscopic examination. New symptoms such as blood in the stool, unintended weight loss, anaemia or fever should be assessed again, because they can point to a different condition.

Blood in stool · Changed bowel habits · Microscopic colitis · Chronic diarrhoea

Outlook

IBS is chronic but not dangerous. It does not increase the risk of bowel cancer and does not shorten life expectancy. The course varies from person to person. Some find their symptoms become more stable once possible triggers are mapped and diet, sleep and stress level are adjusted, while others continue to have fluctuating symptoms.

Booking and referrals

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

- Phone: +45 39 64 01 25 (Monday to Thursday, 09:00-12:00)
- Email: mail@kirurgen.dk
- Address: Hans Edvard Teglers Vej 9, 1st floor, 2920 Charlottenlund
- Provider number: 215430

Sources

- Corsetti M et al. *Bowel Disorders*. Gastroenterology 2026;170(6):1261-1282. doi:10.1053/j.gastro.2026.02.003 · Rome Foundation, Rome V overview
- BSG IBS guideline, Gut 2021;70:1214-1240, doi:10.1136/gutjnl-2021-324598