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EDITORIAL

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European guidelines on functional bowel disorders with diarrhoea: United European Gastroenterology (UEG) and European Society for neurogastroenterology and motility (ESNM) statements and recommendations

Although the functional bowel disorders (FBD) is a common reason for consulting a gastroenterologist, many still find diagnosis and treatment of these disorders challenging, particularly when diarrhoea is a prominent symptom.[1] This may lead to unnecessary investigations and suboptimal treatment including the information provided to the patient. Chronic diarrhoea in combination with various gastrointestinal and extraintestinal symptoms can also be due to other diseases,[2] which is a common concern in the patient-doctor relationship. Hence, a confident diagnosis and a treatment based on best evidence is essential to avoid unnecessary distress.

One step towards a structured management is to provide clinicians with specific guidance to a confident diagnosis and an easy-to-use overview of the treatment options that are at hand. In the current issue of UEG journal, 29 European key-opinion leaders provide us with this on the diagnosis and treatment of FBD with diarrhoea, more specifically irritable bowel syndrome with diarrhoea (IBS-D) and functional diarrhoea (FDr).[3] This guideline differs somewhat from what is most common, that a specific diagnostic entity within the disorders of gut-brain interaction (DGBI)[4] is covered but combining these two diarrhoea-dominated disorders fits well with the diagnostic overlap among the DGBI in general.[5] A core group of 6 experts started out by identifying 31 relevant statements related to the diagnosis and treatment of FBD with diarrhoea that was followed by a systematic review process including assessment of strength of evidence according to the GRADE methodology. After two rounds of voting consensus was met defined by at least 80% agreement on the statements. Finally, clinical recommendations including non-evidenced based aspects such as general consequences of strategies, also including health economy, was made. An obvious strength of this type of Delphi- process guidance is that also areas that involve knowledge gaps are dealt with in a way that is helpful to the clinician. Even if the strength of evidence is less good, which is the case for many areas of FDr, the grade of recommendation further guides how to use current knowledge.

The guideline endorses the overlap of IBS-D and FDr, but in clinical practice it can be difficult to separate all of the FBD from each other over time due to the tendency of alternating symptom profiles.[6] In fact, the Rome IV criteria advocate that all FBD, not only those with similar stool habits, could be seen as a continuum.[7] For example, diarrhoea can be a bothersome symptom also in other FBD, particularly in IBS with mixed stool habit and unsubtyped IBS. This means that in a patient that does not qualify for a FBD with diarrhoea, loose stool might still be the most bothersome symptom and therefore the most valuable to treat. The current guideline can be of some use also in that situation but with a more cautious approach.

What we find of particular importance for the reader to note in the diagnostics of a suspected FBD with diarrhoea is the recommendations to abstain from tests aiming at microbiota composition, small intestinal bacterial overgrowth (other in patients with presence of predisposing conditions), and breath tests intended for identification of carbohydrate malabsorption. The sensible arguments provided as motivations are good to have at hand when patients ask about them. In line with this, treatment with faecal microbiota transplantation (FMT) is not recommended due to the need to better understand efficacy, donor selection and best technique for administration. These are arguments emphasizing that FMT in gastroenterology should only be used as part of research projects outside of the established indication related to refractory of recurrent *clostridioides difficile* infection.[8] Among the pharmacologic treatment options, a problem to deal with for the clinician is the availability in parts of Europe when it comes to the antispasmodics, the 5-HT3 antagonist alosetrone, and eluxadoline with mixed opioid activity. We view this as an indicator of the low priority this large group of patients has in many healthcare systems, where consensus arguments provided in this guideline also can be useful in communications with national authorities.

To summarize, the current guideline provides recommendations for diagnosis and treatment of FBD with diarrhoea in an accessible way that includes a valuable background discussion for each statement. It comes with a potential for being a clinically helpful tool to provide best-practice based healthcare among a large group of patients.

CONFLICTS OF INTEREST

Navkiran T. Tornkvist is none. Hans Törnblom has served as advisory board member/consultant and/or speaker for Biocodex, Dr. Falk Pharma GmbH, Takeda, Tillotts and VIPUN Medical.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable.

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REFERENCES

1. Tornblom H, Goosey R, Wiseman G, Baker S, Emmanuel A. Understanding symptom burden and attitudes to irritable bowel syndrome with diarrhoea: results from patient and healthcare professional surveys. United Euro Gastroenterol J. 2018;6(9):1417–27.
2. Aziz I, Simren M. The overlap between irritable bowel syndrome and organic gastrointestinal diseases. Lancet Gastroenterol Hepatol. 2021;6(2):139–48.
3. Savarino E, Zingone F, Barberio B, Marasco G, Akyuz F, Akpinar H, et al. Functional bowel disorders with diarrhoea: clinical guidelines of the United European Gastroenterology and European Society for Neurogastroenterology and Motility. United Euro Gastroenterol J. 2022. https://doi.org/10.1002/ueg2.12259
4. Drossman DA, Hasler WL. Rome IV-functional GI disorders: disorders of gut-brain interaction. Gastroenterology. 2016;150(6):1257–61.
5. Sperber AD, Freud T, Aziz I, Palsson OS, Drossman DA, Dumitrascu DL, et al. Greater overlap of Rome IV disorders of gut-brain interactions leads to increased disease severity and poorer quality of life. Clin Gastroenterol Hepatol. 2022;20(5):e945–e56.
6. Barberio B, Houghton LA, Yiannakou Y, Savarino EV, Black CJ, Ford AC. Symptom stability in Rome IV vs Rome III irritable bowel syndrome. Am J Gastroenterol. 2021;116(2):362–71.
7. Lacy BE, Mearin F, Chang L, Chey WD, Lembo AJ, Simren M, et al. Bowel disorders. Gastroenterology. 2016;150:1393–407. https://doi.org/10.1053/j.gastro.2016.02.031
8. McDonald LC, Gerding DN, Johnson S, Bakken JS, Carroll KC, Coffin SE, et al. Clinical practice guidelines for clostridium difficile infection in adults and children: 2017 update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). Clin Infect Dis. 2018;66(7):987–94.