



## ROME III

### The Functional Gastrointestinal Disorders, Third Edition, 2006

**Rome III: The Functional Gastrointestinal Disorders, Third Edition. MacLean, VA: Degnon Associates, Inc., 2006.**

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Functional gastrointestinal disorders (FGIDs) are a group of disorders in clinical medicine that have often posed immense problems for patients to experience, for clinicians to diagnose and treat, and for researchers to study. The “road to Rome” began in Rome, Italy, in 1988 during the 12th International Congress of Gastroenterology, where a working team was set up chaired by W. Grant Thompson, MD to create guidelines for the management and study of irritable bowel syndrome (IBS). Later, a group of outstanding experts under the leadership of Dr. Douglas A. Drossman embarked on a mission to define, understand, study, diagnose, and treat all of the elusive FGIDs. After a 1990 publication outlining the classification system, several committees convened in Rome, Italy, throughout 1994 and began a process of review and analysis of the medical literature to improve the methodology for studying, diagnosing and treating about 21 FGID’s. The ultimate goal was to improve the lives of our patients and their families.

ROME I, the First Edition published in 1994, was a compilation of documents previously published in *Gastroenterology International* over a period of five years by 30 international investigators who categorized the FGIDs from esophagus to anus. The most striking result of this process was the creation of the Rome I symptom-based diagnostic criteria for FGIDs. These criteria began to change the diagnostic approach to FGIDs, no longer considered “diagnoses of exclusion” but rather “diagnoses of inclusion”. The Rome criteria enabled positive diagnoses without the need for extensive and unnecessary diagnostic studies to “rule out organic disease”. In addition, recommendations for the optimal design of research protocols were included, to ensure improved uniformity and quality in future clinical trials and investigations.

ROME II, the Second Edition published in 2000, resulted from the continual process of analyzing new scientific and clinical evidence in the study of FGIDs. Rome II diagnostic criteria for IBS were extended with a focus on frequency of symptoms occurring twelve weeks (not necessarily consecutive weeks) within twelve months. For the first time, pediatric FGIDs were categorized, and chapters highlighting physiology of motility, sensation, brain-gut interactions, and psychosocial aspects were included. Recommendations from the Clinical Outcomes Conference held in Vienna in 1998, a conference that initiated the collaborative process of Rome committees with international expert advisors, pharmaceutical companies and regulatory agencies, were also outlined.

ROME III, the Third Edition, published in September 2006, is a 1,048 page document written by a collaborative effort of 82 international experts. The book consists of seventeen chapters that contain the most recent information on the epidemiology, pathophysiology, diagnosis, and treatment of FGIDs. Diagnostic criteria for some of the FGIDs have been revised. “Red flag” symptoms and signs that warrant further diagnostic evaluation have been included. Suggestions for when to make a mental health referral have also been given. New chapters on pharmacology and pharmacokinetics, sociocultural perspectives related to gender, age, and cultural impact, and childhood FGIDs have been divided into two chapters, one for the neonate/toddler and the other for the child/adolescent. One chapter is also devoted to the development and validation of the Rome III Diagnostic Questionnaire. New appendices contain validated Rome III adult and pediatric questionnaires and a table comparing Rome II and Rome III diagnostic criteria. The most notable aspects of Rome III pertain to the following disorders:

*Irritable bowel syndrome (IBS) subtyping:* In Rome II, IBS with constipation (IBS-C) and IBS with Diarrhea (IBS-D) subtypes were based on frequency of bowel irregularities. In Rome III, stool consistency is emphasized. IBS-C is defined as having at least 25% of bowel movements (BMs) that are hard or lumpy; in IBS-D, loose or watery stools are present in at least 25% of BMs. A new category, IBS with mixed bowel habit pattern (IBS-M), is defined as having both hard, lumpy and loose, watery BMs, each 25% of the time. This is not to be confused with IBS with an alternating bowel pattern, in which constipation or diarrhea will alternate for a prolonged period of time. The recurring abdominal pain/discomfort in IBS has to be present for at least 3 days/month for the last 3 months, with symptom onset at least 6 months prior to diagnosis. It is important to recognize that bowel habit pattern subtypes are unstable over time, with a tendency of IBS-C to become IBS-D and IBS-C and IBS-M sharing similar characteristics.

*Functional dyspepsia classification:* Functional dyspepsia (FD) is a very difficult symptom complex to embrace. In the past, FD was categorized as ulcer-like or dysmotility-like. Based on recent physiologic, clinical and population studies, Rome III offers a new way of thinking about FD. It is described as an “umbrella” term for what appear to be two subsets that may overlap: (1) postprandial distress syndrome (PDS), consisting of dyspeptic symptoms induced by a meal, and (2) epigastric pain syndrome (EPS), in which epigastric pain is present regardless of meal ingestion.

*Functional disorders of the gallbladder and sphincter of Oddi:* Functional biliary tract disorders have been a challenging group of disorders to diagnose and treat. These disorders are of low prevalence in comparison to other FGIDs, but they tend to be investigated with invasive and risky studies, such as endoscopic retrograde pancreatography (ERCP) or sphincter of Oddi manometry, and treated with unnecessary endoscopic sphincterotomy and surgery. Rome III recommends more restrictive evaluation of these disorders. When diagnostic criteria are met, studies such as endoscopic ultrasound (EUS) and

magnetic resonance imaging (MRI) of the abdomen should be performed first, followed by a therapeutic trial of medications such as nifedipine or antidepressants. If these treatments are unsuccessful, it is recommended that more invasive studies and treatments be carried out in centers specifically dedicated to these disorders. This is in an effort to limit the number of unnecessary and potentially risky procedures and to identify a group of patients who are more likely to benefit from these interventions.

Rome III is the single most comprehensive and authoritative resource on the subject of FGIDs. It is readable, well organized, clearly labeled, and extensively referenced. The 82 experts who participated in the Rome III process have created an outstanding work from which clinicians, clinical investigators, basic scientists,

mental health providers, the pharmaceutical industry and, most of all, our patients with FGIDs will greatly benefit. There is something here for everyone! The Rome process continues to be a formidable process, but it has been based on a very solid foundation. I congratulate all who have participated in this “colossal” effort.

*Drossman DA, Corazziari E, Delvaux M, Spiller RC, Talley NJ, Thompson WG, Whitehead WE (Editors). Rome III: The Functional Gastrointestinal Disorders, Third Edition. McLean, VA: Degnon Associates, Inc., 2006.*

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