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Rome V Criteria for Adults: What's New and Why?

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ABSTRACT

The Rome V criteria, published in 2026, represent the culmination of a 7-year effort to refine and improve the diagnostic framework for disorders of gut–brain interaction. The revision incorporates the latest consensus guidelines and emerging research while moving away from stigmatizing language and toward a more personalized, patient-centered approach. It also more clearly distinguishes between clinical and research criteria, ensuring patients are diagnosed accurately and treated appropriately, and reinforces the roles of the multidimensional clinical profile and the biopsychosocial model in guiding personalized care. This paper reviews these changes and the rationale behind them.

1 | Introduction

Disorders of gut-brain interaction (DGBI) are highly prevalent and affect approximately 41% of people worldwide [1]. They substantially impair quality of life, and the burden increases with the number of coexisting DGBI [2]. Patients face stigma from providers, family, and colleagues with symptoms dismissed as "not real" or "all in their head", rather than recognized as arising from altered gut-brain interactions [3]. Frequent healthcare use makes their economic burden disproportionately high [4, 5], yet despite how often clinicians encounter DGBI, these disorders remain understudied and underrecognized in clinical practice, research, and medical education [6].

Established in the early 1990s to address these gaps, the Rome Foundation has fundamentally reshaped how DGBI are diagnosed and treated, convening experts to develop diagnostic criteria that legitimize these disorders through a positive diagnostic approach, while advancing research in this population [6]. Now in its fifth iteration, the current version refines definitions, adds new entities, de-stigmatizes language, integrates more objective testing, and updates the clinical approach [6]. This paper highlights the most important revisions, their rationale, and practical point-of-care implications.

2 | The Rome V Process and Philosophy

Rome V is built on six pillars designed to yield criteria for both clinical and research use. First, definitions were updated to keep criteria accurate and relevant. Second, our understanding of the pathophysiological mechanisms underlying DGBI has grown since Rome IV, offering insight into how biopsychosocial factors, pharmacogenomics, sex and gender, cross-cultural factors, diet, the gut microenvironment, and gut–brain interactions can each influence DGBI. Third, it shifts toward neutral, mechanism-based terminology that reflects altered gut-brain interactions, validating the biological complexity of these disorders. Fourth, Rome V adds diagnostic algorithms to support accurate and confident diagnoses. Fifth, it emphasizes the patient's illness experience within the sociocultural factors and social determinants of health that shape symptoms, healthcare access, diagnosis and treatment. Sixth, it updates therapeutic approaches to improve patient outcomes and provider comfort, all grounded in an evidence-based methodology [6].

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A patient-centered approach was also critical to the Rome V process. The Rome V process deliberately tested draft questionnaires early enough so that the results could be fed back to the criteria committees and Editorial Board, allowing changes to the criteria, questionnaire, or scoring rules before publication [7]. In addition, a US population sample of 2000 adults compared alternative response scales, and those data directly informed selection of the new 9-point frequency scale [7]. Furthermore, thirty thousand adults in 15 countries completed the questionnaire, specifically so that response patterns, prevalence, and understanding of questions could inform the final criteria and scoring algorithms [7]. Finally, during translation, patients with GI disorders in each country participated in cognitive debriefing to ensure that questions were understandable and culturally appropriate [7].

3 | New and Reorganized Diagnostic Entities

A major terminology shift is replacing "functional gastrointestinal disorders" with "disorders of gut-brain interaction," [6] Rome IV suggested this; Rome V abandons the term entirely [6]. Within the individual diagnoses, "functional" has likewise been removed, wherever suitable alternatives exist, while retaining it where a preferable term has not yet been established, such as functional dyspepsia. These changes emphasize that DGBI are genuine disorders with specific diagnostic criteria and recommended treatments [6]. Relatedly, "unspecified bowel disorders" becomes "unclassified bowel disorders," better conveying that these patients do not fit other diagnostic categories [6].

Rome V also adds several new diagnoses. Inability to belch syndrome, abdominal migraine, rectal hyposensitivity, and rectal hypersensitivity [6].

4 | Clinical Criteria

One major limitation Rome V aimed to address is the clinical relevance of the Rome diagnostic framework. Specifically, a large proportion of "subdiagnostic" patients do not meet the Rome criteria, yet still have significant, impactful GI symptoms. Like other DGBI, this group has higher healthcare utilization, greater work-life impairment, higher rates of anxiety and depression, and poorer quality of life [8]. DGBI also commonly overlap, and these patients have more severe quality of life and psychosocial impairment [9]. In response, Rome V introduces clinical criteria for these subdiagnostic or overlapping GI symptoms [6]. These emphasize excluding organic disease, where relevant, in a patient who meets the qualitative Rome V criteria and in whom both clinician and patient agree the symptoms are bothersome; here, frequency and duration thresholds need not be weighted as heavily [6]. Ultimately, this allows more patients to receive appropriate treatment and achieve better outcomes.

5 | Esophageal Disorders

Functional esophageal disorders are renamed esophageal DGBI. Rome V has adopted the Chicago Classification version 4.0 and Lyon Consensus 2.0, to exclude esophageal motility disorders and pathologic gastroesophageal reflux disease (GERD) [10–12]. Ineffective esophageal motility is not considered exclusionary for any esophageal DGBI, as it occurs in asymptomatic individuals [12]. For functional chest pain, Rome V no longer recommends routine esophageal biopsies but advises considering biopsy to exclude EoE when chest pain occurs during eating, as meal-triggered pain may be a surrogate for dysphagia [12]. Conclusive esophagogastric junction outflow obstruction (EGJOO) excludes a diagnosis of functional chest pain; an inconclusive manometric pattern of EGJOO does not, as it may reflect positional or technical artifacts [12]. For functional heartburn, biopsies are no longer required in patients without dysphagia, chest pain while eating, or endoscopic features of EoE, given their low yield [12, 13]. For reflux hypersensitivity, regurgitation, belching, rumination, supragastric belching, and inability to belch do not meet the criteria for reflux hypersensitivity, as they represent distinct pathophysiologic processes [12]. For globus, an inlet patch precludes a diagnosis, though its significance is de-emphasized given limited evidence that ablation is effective [12, 14]. For functional dysphagia, the authors caution that proton pump inhibitors may suppress the histological findings of EoE and recommend evaluation for other mucosal esophageal diseases (lichen planus, lymphocytic esophagitis, pemphigus, or pemphigoid) [12]. A normal barium esophagram and functional lumen imaging probe planimetry can further support the diagnosis [12]. Together, these updates (Table 1) streamline the diagnostic evaluation of esophageal DGBI, reducing unnecessary biopsies while reliably excluding organic mimics.

6 | Gastroduodenal Disorders

Within Rome V, although functional dyspepsia remains, postprandial distress syndrome (PDS) and epigastric pain syndrome (EPS) are now the preferred terms [15]. Rome IV led to substantial PDS-EPS overlap, since epigastric pain qualified as EPS, whether it occurred after meals or independently; Rome V reduces this by classifying postprandial epigastric pain under PDS when cardinal PDS symptoms are also present [15]. For PDS, the required frequency of bothersome postprandial fullness or early satiation is now 2 days/week, based on patient focus groups. Postprandial nausea may be included under PDS when it accompanies typical PDS symptoms, whereas predominant nausea or vomiting should prompt consideration for chronic nausea and vomiting syndrome (CNVS) or gastroparesis [15]. In the absence of PDS, EPS may be meal-related or meal-unrelated; provisional criteria are proposed for these potential subgroups, but further research is needed [15]. Upper endoscopy is not required to diagnose FD in patients without risk factors or alarm symptoms; however, normal findings are required for research purposes [15].

Rome V also refines the nausea and vomiting disorders. For CNVS, the threshold is now $\geq$ 2 days of nausea weekly, with or without $\geq$ 1 weekly vomiting episodes [15]. Because CNVS and PDS may overlap, patients evaluated for CNVS should be assessed for PDS; if predominant PDS symptoms are present, PDS is the primary diagnosis [15]. Cyclic vomiting syndrome (CVS) criteria now recognize that milder symptoms may occur between stereotypical vomiting episodes. Cannabinoid hyperemesis syndrome (CHS) criteria require prolonged cannabis for at least 1 year at a frequency of $\geq$ 4 days/week or $\geq$ 15 doses/week, with relief after cessation for $\geq$ 6 months or 3 typical emetic cycles [15]. CHS prevalence rose from 0.08% in Rome IV

TABLE 1 | Key changes from Rome IV to Rome V for esophageal and gastroduodenal disorders of gut-brain interaction.

Esophageal Disorders of Gut-Brain Interaction

Changes applicable to all esophageal disorders of gut-brain interaction

- Chicago Classification version 4.0 and Lyon Consensus 2.0 added to diagnostic criteria.
- Ineffective esophageal motility is not exclusionary.

Functional chest pain

- Added that symptoms must persist despite optimized 8-week course of antisecretory therapy.
- Added consideration for esophageal biopsies if chest pain occurs with meals.

Functional heartburn

- Added that symptoms must persist despite optimized 8-week course of antisecretory therapy.
- Routine esophageal biopsies are no longer required unless dysphagia, chest pain with eating, or endoscopic features raise suspicion for eosinophilic esophagitis.

Reflux hypersensitivity

- Added that symptoms must persist despite optimized 8-week course of antisecretory therapy.
- Specified that regurgitation and belching are not considered as reflux hypersensitivity.

Globus

- Added that symptoms must persist despite optimized 8-week course of antisecretory therapy.
- Clarified that gastric inlet patch is a mucosal abnormality and thus precludes a diagnosis of globus.

Functional dysphagia

- Added that a normal esophagram with a tablet/marshmallow, or normal functional lumen imaging probe planimetry may support a diagnosis.
- Added that a normal solid test meal during esophageal manometry may support a diagnosis.

Gastroduodenal disorders of gut-brain interaction

Functional dyspepsia

- Upper endoscopy is not required in routine clinical practice in the absence of alarm features or other risk factors, but is required to confirm functional dyspepsia for research.

Epigastric pain syndrome

- Specified that bothersome epigastric pain/burning can be precipitated/worsened postprandially or occur independently from eating.
- Specified that PDS criteria must not be fulfilled.
- Clarified that predominant nausea/persistent vomiting/both, excludes a diagnosis of EPS, suggests instead considering CNVS or gastroparesis.
- Specified that pain is limited to the central part of the abdomen above the navel.
- Added guidance to consider a bowel disorder when epigastric pain/burning/both are consistently relieved by bowel movements.
- Added provisional criteria for postprandial EPS: Epigastric pain/burning starts/worsens after meals $\geq$ 50% of the time.
- Added provisional criteria for meal-unrelated EPS: Epigastric pain/burning starts/worsens after meals $<$ 50% of the time.

Postprandial distress syndrome

- Specified symptoms must occur $\geq$ 2 days per week (changed from 3 days/week).
- Specified that in patients with either bothersome postprandial fullness/early satiation, other bothersome symptoms (i.e., postprandial epigastric pain/burning, postprandial nausea, postprandial upper abdominal bloating, or postprandial excessive belching) that are caused/worsened by food are part of PDS.
- Clarified that predominant nausea and/or persistent vomiting excludes a diagnosis of PDS. Suggested considering a diagnosis of CNVS or gastroparesis.
- Defined postprandial as symptoms triggered within 2 hours of a meal.

(Continues)

TABLE 1 | (Continued)

Chronic nausea and vomiting syndrome
• Changed the frequency of nausea from ≥ 1 day per week to ≥ 2 days per week and specified this can be with or without ≥ 1 vomiting episode per week.
• Clarified that symptoms predominantly due to PDS exclude CNVS.
• Specified if nausea/vomiting presents with delayed gastric emptying, the diagnosis is gastroparesis.
Cyclic vomiting syndrome
• Updated duration of episodes from < 1 week to up to 10 days.
• Added that milder symptoms, including nausea and isolated vomiting, may occur between cycles.
Cannabinoid hyperemesis syndrome
• Clarified duration (1 year) and type of cannabis use (≥ 4 days per week or ≥ 15 doses per week, or both).
• Added that relief of vomiting must be sustained ≥ 6 months or 3 typical emetic cycles after cannabis cessation.
Belching disorders (supragastric and gastric belching)
• Added that supragastric belching can be interrupted by maneuvers/distraction.
• Added intraluminal esophageal impedance measurement (+/− manometry) as a tool to allow for differentiation of gastric from supragastric belches.
Inability to belch syndrome
• New disorder defined by bothersome inability, or impaired ability to belch at least 3 days/week and no evidence of underlying esophageal disease/dysfunction to explain symptoms.
• Other common symptoms are chest pain, gurgling in the chest, bloating, flatulence, epigastric pain.
• Diagnosis can be supported on impedance manometry with air entrapment/oscillations and gas reflux episodes not followed by adequate UES relaxation.
• Criteria must be fulfilled for 3 months with symptom onset ≥ 6 months prior to diagnosis.
Rumination syndrome
• Regurgitation is not preceded by retching or nausea.
• Added that the presence of heartburn may help differentiate regurgitation in the context of gastroesophageal reflux disease.
• Added that manometry with impedance can establish a diagnosis.

Abbreviations: CNVS, Chronic Nausea and Vomiting Syndrome; EPS, Epigastric Pain Syndrome; PDS, Postprandial Distress Syndrome.

to 0.6% in Rome V, largely reflecting changes in questionnaire wording, although increasing cannabis use may also contribute (Figure 1) [1].

Inability to belch syndrome, is a new Rome V diagnosis presenting with bloating, excessive flatulence, gurgling chest noises, chest pain, and epigastric pain [7, 15]. Its inclusion in gastroduodenal disorders reflects the symptom-based organization of the Rome classification rather not that the underlying dysfunction being gastroduodenal in origin. It typically begins in childhood, though diagnosis is often delayed due to limited awareness [7, 15]. Botulinum toxin injection into the upper esophageal sphincter is the mainstay of treatment, relieving symptoms in over 90% of patients [16]. Its global prevalence is 1.4% [1].

Finally, for rumination syndrome, Rome V recognizes combined manometry and impedance monitoring as supportive tests that objectively confirm the diagnosis and distinguish rumination from other conditions. The absence of preceding nausea was changed from a supportive feature to a required criterion, reflecting its diagnostic importance [15].

These revisions (Table 1) sharpen the boundaries between overlapping gastroduodenal DGBI, incorporate patient-derived symptom thresholds, and formally recognize emerging disorders, collectively improving diagnostic precision and reducing misclassification.

7 | Bowel Disorders

Rome V substantially revised the criteria for irritable bowel syndrome (IBS). IBS prevalence fell markedly from Rome III to Rome IV, driven primarily by the higher abdominal pain frequency threshold and removal of abdominal discomfort [17, 18]. Because many patients with IBS report discomfort rather than pain, Rome V reinstates discomfort into the criteria [19, 20], and lowers the frequency threshold of pain or discomfort to ≥ 3 days per month [17]. To distinguish IBS from centrally mediated abdominal pain syndrome (CAPS), the IBS criteria require that abdominal pain not be continuous (present throughout the entire waking day, every day) [21]. A supportive criterion also specifies that symptoms should not relate exclusively to menses [17]. These changes increased IBS prevalence from 3.9% in Rome IV to 8.5% in Rome V, likely capturing a larger population with generally less severe symptoms (Figure 1) [1].

Rome V also updates the nomenclature of several bowel disorders. Functional constipation is replaced by chronic

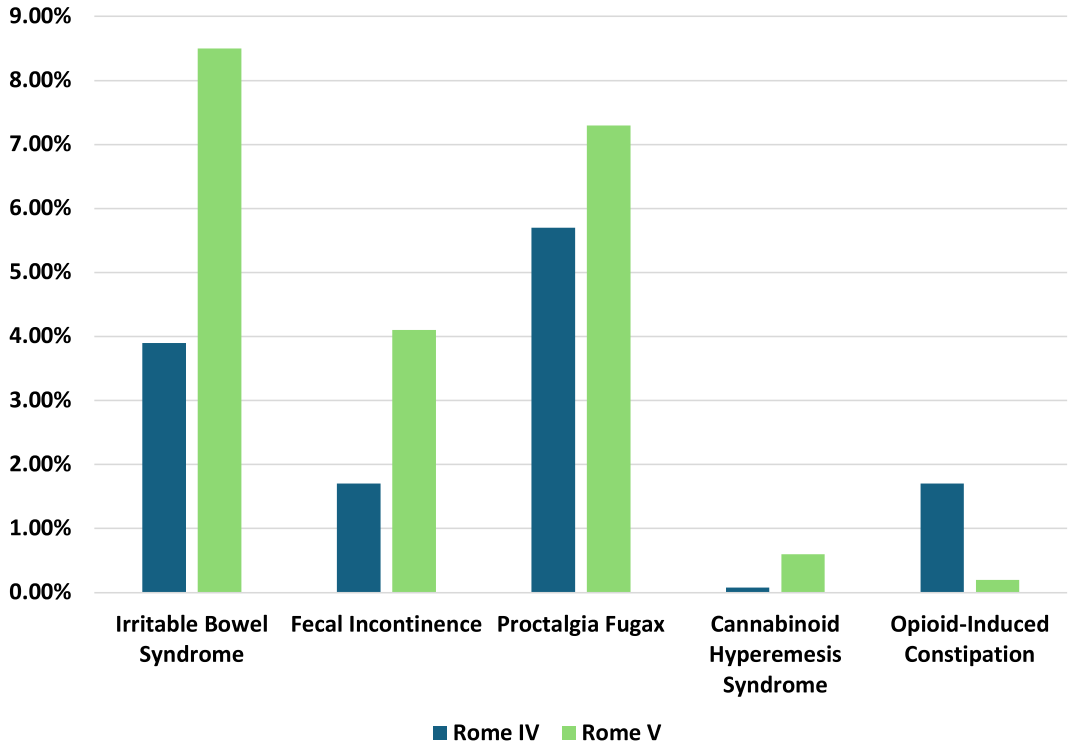


FIGURE 1 | Major prevalence shifts from Rome IV to Rome V utilizing data from the Rome V global epidemiology and validation survey. All data were based on internet surveys and directly compared the 15 countries in the Rome V survey to the same 15 countries in the internet group of the Rome IV foundation global epidemiology study [1].

constipation [17]. Functional abdominal bloating and distension removed "distension", as current evidence suggests, including distension adds no diagnostic value, despite the two being distinct phenomena [6]. Unspecified functional bowel disorders are renamed unclassified bowel disorders, better indicating that these patients have bothersome symptoms that do not meet other Rome classifications [17]. Finally, although diagnostic criteria for opioid-induced constipation changed little, its prevalence fell from 1.7% in Rome IV to 0.2% in Rome V (Figure 1) [1], likely because the Rome V questionnaire asks about opioid medications, rather than prescription pain medications [7]. Collectively, these changes (Table 2) aim to improve the diagnostic accuracy and classification of bowel disorders.

8 | Centrally Mediated Disorders of Gastrointestinal Pain

Rome V broadened the criteria for CAPS, which the committee felt were overly restrictive in Rome IV leading to underdiagnosis and leaving these patients unstudied and undertreated [22]. Under Rome IV, patients could be excluded when physiological events, such as eating, defecation, or menstruation, modified the pain [23], even when their clinical features otherwise matched the CAPS criteria. Rome V therefore created two CAPS categories: category A, in which pain is not associated with physiological events, and category B, in which pain has a variable association with physiological events [22]. Because categories A and B are otherwise similar, this subdivision primarily broadens phenotypic classification rather than defining distinct clinical syndromes. The authors also determined that only patients with continuous pain should be included, rather than the prior "continuous or nearly continuous," to better distinguish CAPS from other DGBI [22]. This temporal pattern distinguishes CAPS from IBS, in which pain is recurrent but not continuous [17]. Although IBS spans a spectrum of relatively peripheral- and central-predominant mechanisms, which may vary with symptom severity and comorbidities, CAPS represents the more centrally predominant end of this continuum, characterized by continuous, function-limiting pain. The prevalence of any centrally mediated disorder of GI pain rose from 0.01% using Rome IV criteria to 0.3% under Rome V criteria [1]. However, this may not be reflected in clinical practice, where clinicians may diagnose such patients with IBS despite continuous abdominal pain.

Abdominal migraine is a new Rome V diagnosis, an already established pediatric diagnosis, encountered clinically in adults but lacking a diagnostic standard. It is characterized by stereotypical episodes of intense abdominal pain separated by weeks or months, often with nausea, vomiting, pallor, headache, or photophobia [22]. Its adult prevalence was 5.1%, suggesting substantial prior underrecognition in adults [1].

Collectively, these revisions (Table 3) expand CAPS to include patients with continuous pain that varies with physiological events and formally recognize abdominal migraine as an adult disorder, improving the identification of patients not captured by Rome IV.

9 | Gallbladder and Sphincter of Oddi Disorders

The first major change was to define typical biliary pain, recognizing that pain is a symptom rather than a diagnosis [24]. The qualifier "typical" was added to convey that these

TABLE 2 | Key changes from Rome IV to Rome V for bowel and anorectal disorders of gut-brain interaction.

Bowel disorders of gut-brain interaction
Irritable bowel syndrome
• Clarified that abdominal pain should not be continuous, that is, present throughout the waking day, every day.
• Reintroduced abdominal discomfort alongside pain.
• Changed frequency of pain/discomfort from $\geq$ 1 day/week to $\geq$ 3 days per month.
• Added that abdominal pain/discomfort should not be only related to menses.
Chronic constipation
• Changed name from functional constipation to chronic constipation.
Functional diarrhea
• Clarified that hard stools are rarely present without medications that cause constipation.
Functional abdominal bloating
• Removed distension from name, although visible abdominal distension remains included in the disorder.
Unclassified bowel disorders
• Changed name from unspecified to unclassified.
Opioid-induced constipation
• No substantive changes to the diagnostic criteria
Anorectal disorders of gut-brain interaction
Fecal incontinence
• Changed recurrent to $\geq$ 2 episodes of FI.
• Added that the individual should report $\geq$ 1 episode of FI per month on a 4-week stool diary.
• For clinical purposes, "recurrent" was replaced by at least two episodes during the preceding 12 months; research criteria also require at least one episode per month documented by a 4-week stool diary.
Levator ani syndrome
• Added additional exclusions such as malignancy, fistula, and gynecologic causes of pelvic pain
Unexplained anorectal pain
• Clarified that no tenderness is seen during traction on the puborectalis muscles (no longer requires the specification of posterior traction).
Proctalgia fugax
• Removed maximum duration of episodes.
• Added malignancy and fistula as exclusions.
Dyssynergic defecation
• Added criteria that the patient must have $\geq$ 1 symptom suggestive of difficult defecation (excessive straining, use of digital maneuvers, sensation of anorectal blockage, and/or feeling of incomplete evacuation) in $\geq$ 25% of bowel movements.
• Now only require 1 of 3 abnormal tests (previously required 2).
• Abnormal testing can include abnormal anorectal manometry, balloon expulsion test, or impaired rectal evacuation with defecography.
• "Functional," type 3 dyssynergia (adequate rectal propulsive pressure during attempted defecation with absent or incomplete anal sphincter relaxation [$\leq$ 20%]), and electromyography were removed. Added that structural disorders may coexist with dyssynergic defecation.
Rectal hyposensitivity
• New diagnostic category introduced in Rome V.
• Must meet criteria for FI/dyssynergic defecation and demonstrate rectal hyposensitivity during rectal balloon distension sensory testing. Hyposensitivity defined as $\geq$ 2 threshold values of rectal sensation (first sensation, desire to defecate, urgency to defecate, or maximum tolerable sensation) $>$ 2 SDs of the upper limit of normal range using either a simple balloon (anorectal manometry) or rectal barostat.

(Continues)

TABLE 2 | (Continued)

- Cannot have evidence of a structural disease.
- Criteria must be fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.

Rectal hypersensitivity

- New diagnostic category introduced in Rome V.
- Must meet criteria for FI/dyssynergic defecation and exhibit rectal hypersensitivity with rectal balloon distention sensory testing. Hypersensitivity defined as ≥ 1 threshold values of rectal sensation (desire to defecate, urgency to defecate, maximum tolerable sensation, or pain) that are < 2 SDs of the lower limit of the normal range using either a simple balloon (anorectal manometry) or rectal barostat.
- Cannot have a history of rectal excision or evidence of structural disease.
- Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.
- Note that thresholds for first or constant sensation should not be used.

Abbreviations: FI, Fecal Incontinence; SD, standard deviation.

symptoms are most common in patients with true gallbladder or sphincter of Oddi dysfunction [24]. Typical biliary pain is episodic epigastric or right-upper-quadrant pain of acute onset that reaches a steady intensity, lasts at least 20 minutes up to several hours, and is severe enough to interrupt daily activities or prompt medical evaluation [24].

For dysfunctional gallbladder disorder, Rome V added persistence of symptoms during a nonoperative observation period as a supportive criterion, to minimize unnecessary cholecystectomy [24]. Gallbladder ejection fraction measured by cholescintigraphy was removed from the supportive criteria because findings are poorly reproducible and fail to predict the response to cholecystectomy; however, it may still aid surgical decision-making [24].

Rome V also simplifies the criteria for biliary sphincter of Oddi disorder (SOD), which now emphasize typical biliary pain with objective evidence of biliary obstruction, elevated liver tests, biliary ductal dilation, or both, in the absence of stones or other structural abnormalities [24]. The previous supportive criteria were removed, as were the requirements for normal amylase and lipase because pancreatic enzyme elevations can occur in biliary SOD [25]. The requirement for abnormal sphincter manometry was also eliminated owing to its poor reproducibility and sensitivity and inability to predict clinical outcomes, as was hepatobiliary scintigraphy, given the limited evidence that testing can predict treatment response [24, 26–28].

Finally, for pancreatic SOD, Rome V limits the diagnosis to patients with unexplained recurrent acute pancreatitis after excluding other causes. The requirement for a negative endoscopic ultrasound was removed, as excluding other etiologies already implied it [24]. As with biliary SOD, abnormal sphincter manometry was removed because of its limited sensitivity and reproducibility [26, 27].

Collectively, these revisions (Table 3) streamline the framework around typical biliary pain and objective evidence of obstruction or pancreatitis, adopt a more restrictive approach to invasive interventions, and remove diagnostic tests with poor reproducibility or predictive value, aligning Rome V with contemporary evidence and minimizing procedural harm.

10 | Anorectal Disorders

Rome V made several changes to the fecal incontinence (FI) criteria. Because "recurrent" was nonspecific, and even infrequent FI impairs quality of life and responds well to anorectal biofeedback, recurrent FI is now defined as ≥ 2 episodes of uncontrolled fecal passage within the preceding 12 months [29, 30]. The developmental age requirement was removed to focus on FI in adults [30], and the symptom duration was increased from 3 to 6 months to account for lifestyle and behavioral changes that may temporarily reduce episodes [30]. Under the revised criteria, the estimated prevalence of FI rose from 1.7% to 4.1% in Rome V (Figure 1) [1].

For anorectal pain disorders, the conditions were reordered to reflect real-world frequencies, and the term "functional" was removed. "Structural alterations" were replaced by "structural disorders," and "posterior traction" was eliminated, as traction in other quadrants can cause pain [30, 31]. Although the criteria for proctalgia fugax were largely unchanged, the Rome V diagnostic questionnaire specifically refers to anorectal "pain" rather than "aching, pain, or pressure" as described in the Rome IV questionnaire, increasing the prevalence from 5.7% to 7.3% (Figure 1) [1].

For dyssynergic defecation (DD), Rome V removed the term "functional" and broadened the symptom criteria to include patients with difficult evacuation who may not meet the criteria for chronic constipation or IBS [30]. In patients reporting difficult evacuation during $\geq 25\%$ of bowel movements, only one abnormal test (Table 2) is now sufficient to meet diagnostic criteria [30]. These changes reflect meaningful concordance between testing methods and reduce unnecessary testing [30, 32].

Finally, rectal hyposensitivity and rectal hypersensitivity were added as anorectal sensory dysfunction disorders [30]. These diagnoses require symptoms of FI or DD together with abnormal sensory thresholds on rectal balloon distension testing, recognizing the importance of normal rectal sensation for continence and defecation [30]. Taken together, these revisions (Table 2) improve diagnostic specificity, align the criteria with contemporary evidence, and reduce unnecessary testing.

TABLE 3 | Key changes from Rome IV to Rome V for centrally mediated disorders of gastrointestinal pain, gallbladder, and sphincter of oddi disorders.

Centrally mediated disorders of gastrointestinal pain

Centrally mediated abdominal pain syndrome

- Added that pain must be continuous (removes nearly continuous). Continuous refers to pain present during the waking state.
- Specified two categories of pain with physiological events: Category a has no association with physiological events and category B has variable association of pain with physiological events.
- Added a note that it is often associated with psychosocial comorbidities, but not a specific psychosocial profile.
- Defined physiological events as eating, defecation, menstruation, positioning, or other visceral/somatic activities.

Abdominal migraine

- Newly recognized diagnosis in adults.
- Individuals must have:
  1. Paroxysmal, stereotypical episodes of intense abdominal pain lasting $\geq$ 1 hour and up to several days.
  2. Episodes separated by weeks/months.
  3. Episodes occur $\geq$ 3 times per year and 2 times in the previous 6 months.
  4. Pain is incapacitating and interferes with daily activities.
  5. Pain is associated with $\geq$ 2 of the following:
     - History of migraine headaches
     - Family history of migraine headaches
     - Anorexia, nausea, or vomiting with episodes
     - Photophobia
     - Pallor
     - Aura or prodrome preceding the full episode
- Careful medical evaluation is required to exclude other causes.
- Criteria must be present for last 3 months, with symptom onset at 6 months before diagnosis.
- Compared to cyclic vomiting syndrome, pain is the main symptom in abdominal migraine, not vomiting, and the vomiting is not repetitive.

Narcotic bowel syndrome or opioid-induced gastrointestinal hyperalgesia

- No substantive changes

Gallbladder and sphincter of oddi disorders

Typical biliary pain

- Renamed "biliary pain" as "typical biliary pain" and replaced "criteria" with "definition", because pain is a symptom rather than a diagnosis.
- Changed duration of pain from lasting $\geq$ 30 minutes to $\geq$ 20 minutes.
- Clarified that symptoms should be unrelated to bowel movements and not relieved by acid suppression or positional changes. Previously the terminology used "not significantly" related to bowel movements/acid suppression.
- Added supportive criteria that pain occurs postprandially.

Dysfunctional gallbladder disorder

- Name changed from functional gallbladder disorder.
- Removed supportive criteria of a low ejection fraction on gallbladder scintigraphy.
- Added supportive criteria of persistent symptoms despite a trial of nonoperative therapy.

Biliary sphincter of oddi disorder

- Removed functional from name.
- Removed supportive criteria for a normal amylase/lipase, abnormal sphincter of oddi manometry, and hepatobiliary scintigraphy.

Pancreatic sphincter of oddi disorder

- Removed functional from name.
- Limited the diagnosis to unexplained recurrent acute pancreatitis after exclusion of other recognized causes.
- Removed requirement for a negative endoscopic ultrasound and abnormal sphincter manometry.

11 | The Multidimensional Clinical Profile and the Biopsychosocial Model of DGBI

Rome V retained the five domains of the multidimensional clinical profile (MDCP) (Figure 2): primary categorical DGBI diagnosis, clinical modifiers, impact on quality of life, psychosocial modifiers and comorbidities, and biomarkers [33]. The MDCP was developed because standard diagnostic algorithms, though effective at establishing a categorical diagnosis, often fail to capture the granular clinical, psychosocial, and physiologic factors that influence treatment decisions. By characterizing the patient across these domains, the MDCP aims to personalize treatment and improve patient outcomes [33]. Although its uptake in

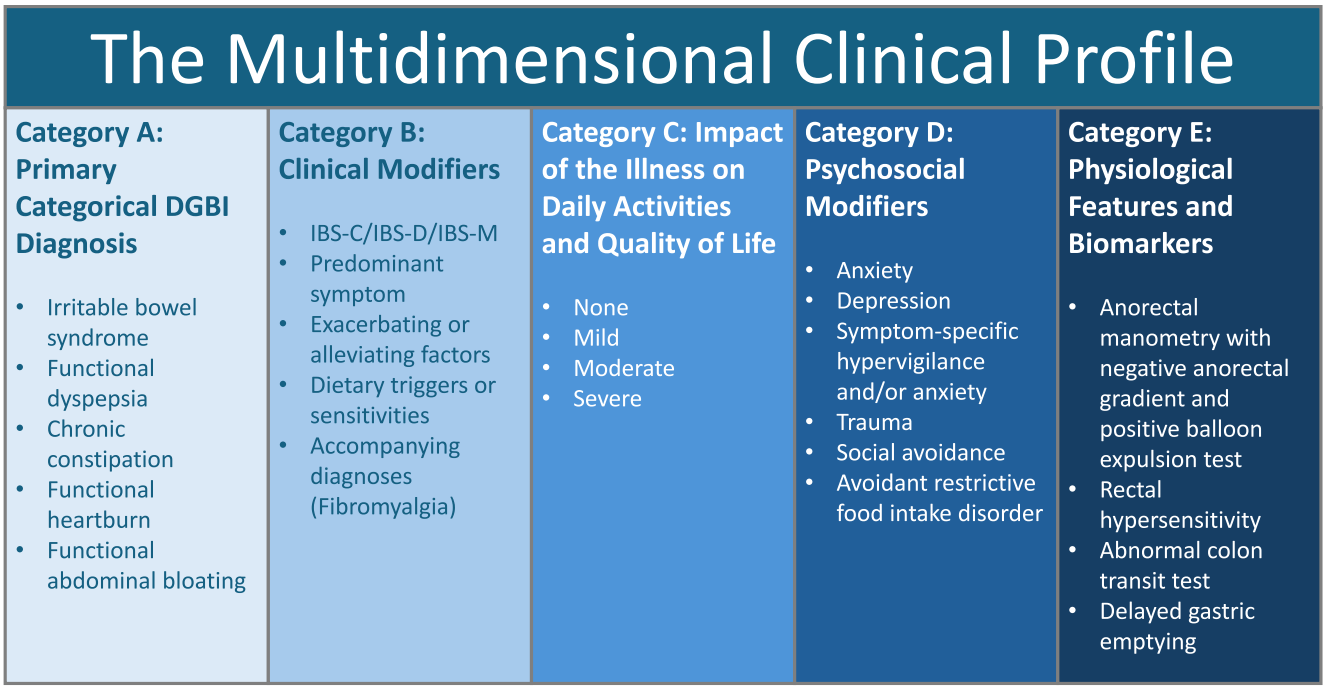


FIGURE 2 | The multidimensional clinical profile, outlining the five domains and examples for each category. To assess severity in category C, the healthcare provider should inquire how the disorder affects the patient's work, school, or social activities [33].

routine practice remains limited, broader implementation may be facilitated by greater integration into clinical management guidance, educational programs, and studies demonstrating its practical utility.

The MDCP is grounded in the biopsychosocial model of DGBI, which recognizes that biological processes, early-life experiences, psychological factors, and social context interact to influence symptom presentation, illness burden, and treatment outcomes [3]. The Rome V chapter on the biopsychosocial aspects of DGBI details this framework and provides practical guidance for biopsychosocial assessment and interpretation of treatment response. It also reviews evidence-based brain-gut behavior therapies and neuromodulation and offers recommendations for professional education and training [3]. Together, the MDCP and biopsychosocial model provide complementary frameworks for understanding the individual patient and guiding personalized care.

12 | Practical Clinical Perspectives and Conclusion

Rome V represents a major undertaking: a 7-year effort involving 144 investigators and clinicians across 27 countries and 25 committees, and an evidence-based recalibration of Rome IV with greater emphasis on patient-centered diagnosis, evaluation, and management [6]. Principal changes include updating the criteria to reflect current evidence and consensus guidance, thereby refining diagnostic frameworks to better inform management, and replacing potentially stigmatizing language with more neutral and accurate terminology. These revisions carry important clinical and epidemiological implications: by modifying certain overly restrictive criteria, Rome V is likely to capture broader, less severe populations, and consequently alter prevalence estimates, while the new clinical criteria add flexibility for diagnosing and treating patients with clinically meaningful symptoms who fall outside the more standardized research criteria. Of note, adult and pediatric Rome V classifications are not fully aligned, and some developmentally specific pediatric diagnoses, particularly feeding disorders, do not have direct adult counterparts. During transition to adult care, these patients should undergo reassessment of their current clinical phenotype and care needs rather than automatic diagnostic relabeling, with coordinated communication between pediatric and adult providers to maintain continuity of care [34]. Updated MDCP and biopsychosocial frameworks further support individualized assessment and treatment of patients with complex DGBI. Together, Rome V balances diagnostic standardization with real-world applicability, and its more inclusive, patient-centered framework is intended to improve recognition of DGBI, guide personalized care, and ultimately improve patient outcomes.

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Conflicts of Interest

A.K.: No disclosures. L.C.: Has served as a consultant for Alfasigma, Ardelyx, Atmo, Food Marble, GlaxoSmithKline, Eli Lilly, Nerva, Ono Pharmaceuticals, and Viscera Labs; has been a speaker for Bausch Health and Medscape; has received research grants from AnX Robotica and Ironwood; serves as a member of the Rome Foundation Board of

Directors and Senior Associate Editor of Rome V books; and has unvested stock options for Food Marble, ModifyHealth, PICO Health, Trellus Health.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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