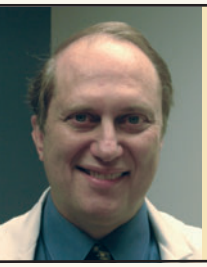
An Overview of the Rome Process and What is New in Rome III



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Functional gastrointestinal disorders (FGID) represent a common and important class of disorders within gastroenterology. The Rome committees serve as the nidus to modify and update information on these disorders for research and patient care. By necessity, the group develops criteria by consensus (via the "Delphi Approach") and the process has matured through three generations, producing a series of publications (Rome I, II and III), with an increased evidence-based approach to the recommendations.

Rome III Publications

Gastroenterology, Rome III Edition. The 13th edition of *Gastroenterology* is devoted entirely to Rome III. It contains 16 articles from 14 committees, each comprised of up to seven international experts. The introductory article sets the stage for what is to come and conceptualizes these functional disorders within a biopsychosocial context. The content-related articles that follow include new papers on Gender; Age; Society, Culture, and the Patient; and Pharmacological and Pharmacokinetics. They also include revised articles from the Rome II edition — Basic Science, Physiology, Psychosocial Factors and Design of Treatment Trials. These are followed by the seven criteria-related articles (as compared to five in Rome II) — Esophageal, Gastroduodenal, Gall Bladder/Biliary, Bowel, Functional Abdominal Pain, Anorectal and Pediatrics GI: Neonate/Toddler and Child Adolescent. The increase in criteria-related articles relates to the Functional Abdominal Pain committee being split off from the Bowel committee, and the Pediatric committee being expanded to two committees. The final article of the issue — "The Road to Rome" by Grant Thompson — traces the history of Rome committee work.

Rome III book. The book contains more than 1,000 pages and provides more comprehensive information than the Gastroenterology issue, including more graphics and hundreds of references in each chapter. In addition, there is a chapter that provides the validation data for the adult questionnaire. One of the highlights of the book is the set of appendices, which now contain:

- The new validated adult and pediatric Rome III questionnaires for diagnosis and their scoring algorithms
- "Red flag" questions to help exclude other diseases
- A set of psychological "red flag" questions to alert the clinician when mental health referral is suggested or urgently required
- A comparison table of Rome II and Rome III diagnostic criteria presented side by side, where the proximity of the two sets of criteria may assist clinical or industry investigators to reconcile differences in clinical trials
- A glossary, listing of the referees, and photo gallery of the contributors

Changes from Rome II to Rome III

The Rome III process is a conservative one, with changes made only where there is good evidence to do so. In that regard, the committees must remain responsive to new scientific data as it emerges. The following is a summary of the changes in criteria and other recommendations along with their justification.

1. **Time frame change for FGIDs.** The time frame for a diagnosis now originates at six months prior to clinical presentation and diagnosis and must be currently active (i.e., meet criteria) for three months. This time frame is less restrictive than Rome II (12 weeks of symptoms over 12 months) and is easier to understand in a questionnaire or for research and clinical practice.
2. **Changes in classification categories:**
   a. *Rumination syndrome has moved from being a functional esophageal (category A) to a functional gastroduodenal disorder (category B).* This reflects the evidence that symptoms originate from pressures generated in the stomach and abdominal musculature.
   b. *Removal of functional abdominal pain syndrome (FAPS) from functional bowel disorders (category C) into its own category (category D).* This is based on the growing evidence that FAPS relates more to CNS amplification of normal regulatory visceral signals rather than functional abnormalities per se within the GI tract. The committee members selected for this new category included psychologists, psychiatrists and gastroenterologists involved in brain gut interactions.
   c. *Creation of two pediatric categories.* The Rome II category of Childhood Functional GI Disorders is now classified as Childhood Functional GI Disorders: Neonate/Toddler (category G) and Childhood Functional GI Disorders: Child/Adolescent (category H). This reflects the different clinical conditions existing between the two categories relating to the growth and development of the child.
3. **Criteria changes:**
   a. *Functional Dyspepsia.* For Rome III, functional dyspepsia is deemphasized as an entity for research, due to its symptom heterogeneity. Instead, the gastroduodenal committee has recommended using an umbrella term — "dyspepsia symptom complex" — which is subclassified into two conditions that may overlap: (1) Postprandial Distress Syndrome, and (2) Epigastric Pain Syndrome. Although similar to the dysmotility-like and ulcer-like dyspepsia of Rome II, there now are several items for the criteria derived from factor analytic

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What Do You Think?

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Overview of the Rome Process

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studies and physiological support instead of being based on the single symptom of epigastric discomfort or pain. Further studies will be needed to validate this change.

b. *More restrictive criteria for functional disorders of the gallbladder and Sphincter of Oddi.* One of the more complex and controversial areas of the FGIDs relates to the diagnosis and treatment of patients with functional gallbladder and biliary tract disorders. In part, this relates to the low prevalence of these disorders relative to other FGIDs, making these conditions difficult to study, as well as the iatrogenic risk associated with diagnosing non-life threatening conditions with invasive assessments like ERCP and Sphincter of Oddi manometry, or treating them with unnecessary surgery or endoscopic sphincterotomy. Accordingly, Rome III has developed more specific criteria features and exclusions for symptom-based diagnosis. In doing so, the criteria reduce the patient population who then require invasive studies — like ERCP and manometry — to confirm the diagnosis and initiate treatment.

c. *Revision of IBS subtyping.* The Rome II subtype classification for IBS with constipation (IBS-C) and IBS with diarrhea (IBS-D) has been difficult to use in clinical practice. Furthermore, it is unclear how to classify patients who may not meet criteria for these two subtypes, yet still have IBS. In Rome III, the classification has been simplified so that diarrhea, constipation and mixed subtypes are based on the single classification of stool consistency (which can be determined by the Bristol Stool Scale Form). This criterion has a physiological linkage to intestinal transit rather than defecation difficulties. However, clinicians and investigators may also use the bowel Rome II subtyping scheme for IBS-D and IBS-C.

Further information about the Rome Foundation and the Rome III book can be found at www.romecriteria.org. ❖

Successful Return to the Match

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4. In terms of registering for the Match, only a few programs experienced problems in properly entering the Match, either through not ranking enough applicants or misunderstanding the "Match Quota." Based on individual training director feedback, it was noted that programs should rank as many applicants as they determine qualified to train at their program. This will serve to improve the odds of securing the top applicant(s) on their lists. The term "Match Quota" was also misunderstood; it refers to the number of positions a program is entering into the Match, not the number of positions a program has available. Even for those programs that commit all of their positions to the Match, please be reminded that the "quota" is the number of positions you are asking the National Resident Matching Program (NRMP) to match. The Match is legally binding; therefore, it is important that all data entered into the NRMP's registration system is reviewed for accuracy by each program.

As we move forward with registration for the GI Match 2007 for positions to begin July 1, 2008, let us again take this opportunity to congratulate the programs that participated and contributed to gastroenterology's successful return to the Match. The most important element to the success of the Match is your participation!

If there are questions or comments, please do not hesitate to contact us at GIMatch@gastro.org. ❖

By Ashley Lombard, AGA Institute Director of Education