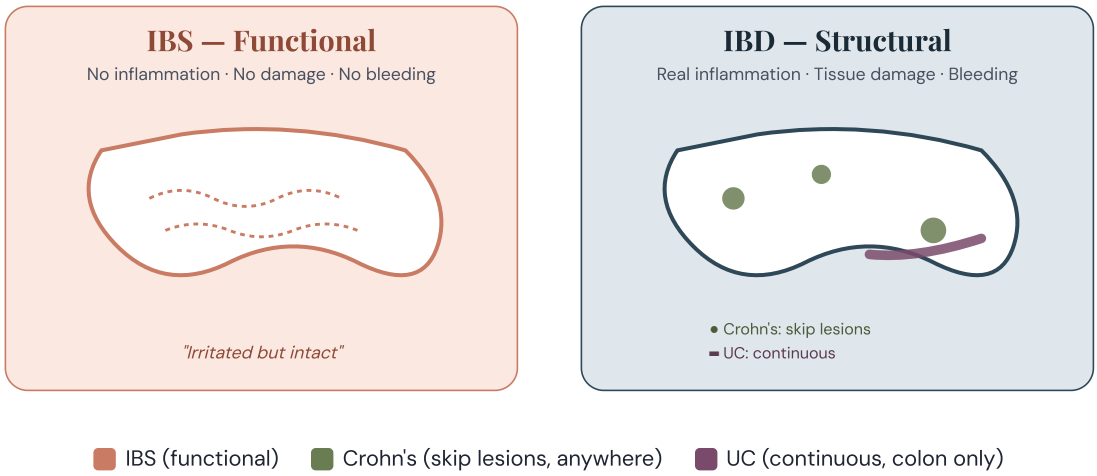
NGN NCLEX 2026 STUDY SERIES · GASTROINTESTINAL SYSTEM

IBS *vs.* IBD

Irritable Bowel Syndrome (functional) versus Inflammatory Bowel Disease (structural). Two diagnoses students confuse — but the NCLEX rewards the nurse who can tell them apart in seconds.

GI · Lower Tract | Clinical Judgment | NCJMM Integrated | High-Yield Compare

Where the Disease Lives — Quick Visual



1 Definition / Overview

WHAT IT IS · WHY IT MATTERS

IBS — Irritable Bowel Syndrome

A functional GI disorder — the gut is "irritated," not injured.

- **No structural damage**, no inflammation, no bleeding — labs and scopes look *normal*.
- **Diagnosis of exclusion** using **Rome IV criteria**: recurrent abdominal pain ≥1 day/week for 3 months, related to defecation.
- Subtypes: **IBS-D** (diarrhea), **IBS-C** (constipation), **IBS-M** (mixed).

IBD — Inflammatory Bowel Disease

Chronic, autoimmune inflammation that damages the bowel wall.

- Two distinct diseases: **Crohn's disease** and **ulcerative colitis (UC)**.
- **Real inflammation** with ulceration → bleeding, weight loss, fever, anemia, ↑ cancer risk.
- Lifelong with **flares and remissions**; treated with anti-inflammatories, immunosuppressants, biologics, sometimes surgery.

2 Pathophysiology (Simplified)

STEP-BY-STEP

IBS Mechanism

1. Brain–gut **signaling dysfunction** + visceral hypersensitivity
2. Triggers (stress, FODMAPs, hormones) → **altered gut motility**
3. Spasm + abnormal transit → **pain, bloating, altered bowel habits**
4. **Pain relieved by defecation** — bowel is irritable, not damaged ✓

IBD Mechanism

1. Genetic + environmental triggers → **autoimmune attack** on bowel mucosa
2. **Chronic inflammation** → ulceration of bowel wall
3. Crohn's: **transmural, skip lesions, mouth→anus**
   UC: **mucosa only, continuous, rectum→colon**
4. Bleeding, malabsorption, fistulas (Crohn's), megacolon (UC), **cancer risk** 🚨

3 Signs & Symptoms

SPOT THE DIFFERENCE

FEATURE	IBS	IBD (CROHN'S / UC)
Abdominal pain	Crampy, **relieved by defecation**	Persistent; Crohn's **RLQ**, UC **LLQ**
Stool	Diarrhea, constipation, or alternating · **NO blood**	**Bloody diarrhea** (UC classic) · mucus · pus 🚨
Weight loss	None / minimal	**Significant** (especially Crohn's — malabsorption)
Fever	Absent	**Present** during flares 🚨
Anemia	No	**Yes** — iron-deficiency & B12 (Crohn's terminal ileum)
Nocturnal symptoms	**Rare** — symptoms ease at night	**Common** — wakes patient up 🚨 (red flag clue)
Labs	All **normal**	↑ ESR, ↑ CRP, ↓ Hgb, ↓ albumin, + fecal calprotectin
Extra-intestinal	Anxiety, fatigue (mild)	Arthritis, uveitis, erythema nodosum, mouth ulcers
Onset age	Younger; **women > men**	15–35 (peak); also 50–70

⚙ Within IBD: Crohn's vs. Ulcerative Colitis

Crohn's Disease

"Cobblestone, skipping all the way through."

- **Location:** mouth → anus (terminal ileum most common)
- **Pattern: skip lesions** · **transmural** (all 4 layers)
- **Stool:** steatorrhea, non-bloody diarrhea (usually)
- **Complications:** **fistulas, strictures, abscesses, B12 deficiency**
- **Pain:** RLQ, cramping after meals

Ulcerative Colitis

"Continuous, bloody, colon only."

- **Location:** rectum → colon only (continuous, no skipping)
- **Pattern: mucosa & submucosa** only (not transmural)
- **Stool: bloody diarrhea** 10–20×/day, mucus, tenesmus
- **Complications:** **toxic megacolon, perforation, ↑↑ colon cancer**
- **Pain:** LLQ, cramping relieved by BM

4 Priority Nursing Interventions

ABCS · SAFETY · PRIORITIZATION

IBS — Comfort & Lifestyle Focus

- ✓ **Assess** trigger food/stress patterns — keep a symptom diary
- ✓ **Teach** low-FODMAP diet trial (low fermentable carbs)
- ✓ **Encourage** ↑ soluble fiber for IBS-C; **limit** caffeine, dairy, alcohol, gas-producing foods
- ✓ **Promote** stress management, regular exercise, adequate sleep
- ✓ **Administer** antispasmodics, loperamide (IBS-D), or osmotic laxatives (IBS-C) as ordered
- ✓ **Monitor** for red flags that signal something *worse* than IBS: blood, weight loss, fever → notify provider

IBD — Anti-inflammatory & Acute Care

- ✓ **Monitor** stools (count, blood, character) — **10+ bloody stools/day = severe flare** 🚨
- ✓ **Assess** for **perforation/toxic megacolon**: distended abdomen, absent bowel sounds, fever, tachycardia
- ✓ **Maintain** NPO during severe flares → **bowel rest**; advance to low-residue/low-fiber when tolerated
- ✓ **Administer** IV fluids, electrolytes, blood products, TPN as ordered
- ✓ **Give** 5-ASA, corticosteroids, immunomodulators, biologics — taper steroids slowly
- ✓ **Daily weights**, strict I&O, monitor Hgb/albumin/electrolytes
- ✓ **Skin/perianal care** — frequent stools cause breakdown; barrier cream
- ✓ **Prepare** for colonoscopy surveillance (cancer risk) and possible surgery (UC: colectomy is curative)

5 Pharmacology

DRUG · MECHANISM · SIDE EFFECTS · NURSING

IBS Medications

Dicyclomine (Bentyl)

ANTISPASMODIC / ANTICHOLINERGIC

MOA: relaxes smooth muscle of bowel → ↓ cramping

Nursing: watch for anticholinergic effects ("can't see, pee, spit, poop")

⚠ Dry mouth · constipation · urinary retention · blurred vision

Loperamide (Imodium)

ANTIDIARRHEAL · IBS-D

MOA: slows gut motility → firmer stools

Nursing: hold if fever or bloody stool (could mask infection)

⚠ Constipation · cardiac arrhythmias at high doses

Linaclotide / Lubiprostone

CHLORIDE CHANNEL ACTIVATORS · IBS-C

MOA: ↑ intestinal fluid → softer stool, ↑ transit

Nursing: take on empty stomach; not for <18 yr

⚠ Diarrhea · nausea · abdominal pain

Polyethylene Glycol (MiraLAX)

OSMOTIC LAXATIVE · IBS-C

MOA: draws water into bowel

Nursing: mix with 8 oz fluid; safe for long-term use

⚠ Bloating · electrolyte loss with overuse

IBD Medications

Sulfasalazine / Mesalamine (5-ASA)

ANTI-INFLAMMATORY · 1ST-LINE UC

MOA: topical anti-inflammatory in colon mucosa

Nursing: ↑ fluids · check for sulfa allergy · monitor CBC/LFTs · folic acid supplement

⚠ Photosensitivity · orange urine · agranulocytosis · crystalluria

Prednisone / Budesonide

CORTICOSTEROIDS · ACUTE FLARE

MOA: potent anti-inflammatory

Nursing: never stop abruptly — taper · take w/ food · monitor glucose, BP, infection signs

⚠ Hyperglycemia · ↑BP · osteoporosis · immunosuppression · Cushingoid · mood

Azathioprine / 6-MP / Methotrexate

IMMUNOMODULATORS · MAINTENANCE

MOA: suppress immune response

Nursing: monitor CBC, LFTs · infection precautions · avoid live vaccines · MTX → folic acid

⚠ Bone marrow suppression · hepatotoxicity · ↑ infection · ↑ malignancy risk

Infliximab / Adalimumab (Biologics)

TNF-A INHIBITORS · MODERATE–SEVERE

MOA: block tumor necrosis factor → ↓ inflammation

Nursing: screen for TB & hepatitis B before first dose · monitor for infusion reactions · no live vaccines

⚠ Reactivation of TB · serious infection · infusion reaction · ↑ lymphoma risk

6 NCLEX Test Traps

COMMON STUDENT MIX-UPS

✗ WRONG THINKING

"Patient has chronic abdominal pain and diarrhea — must be IBS." (Treat with diet changes.)

✓ RIGHT THINKING

Bloody stool, fever, weight loss, or nighttime symptoms = NOT IBS. Suspect IBD or other pathology → notify provider; IBS is a *diagnosis of exclusion*.

✗ WRONG THINKING

"Increase fiber for any patient with IBD diarrhea."

✓ RIGHT THINKING

IBD flare = **low-residue / low-fiber diet** + bowel rest. High fiber irritates inflamed mucosa. (High fiber is for IBS-C, not IBD flare.)

✗ WRONG THINKING

"UC and Crohn's are basically the same — both inflame the bowel."

✓ RIGHT THINKING

UC = colon only, continuous, mucosa, BLOODY stool, colectomy is curative.
Crohn's = mouth-to-anus, skip, transmural, FISTULAS, surgery is NOT curative.

✗ WRONG THINKING

"Stop the steroids — patient is feeling better."

✓ RIGHT THINKING

NEVER abruptly stop corticosteroids → adrenal crisis. Always taper as prescribed.

✗ WRONG THINKING

"Give loperamide for IBD flare diarrhea."

✓ RIGHT THINKING

Antidiarrheals in severe IBD flare can **precipitate toxic megacolon** 🚨 — avoid unless specifically ordered.

✗ WRONG THINKING

"Sulfasalazine causes orange urine — must be a kidney problem."

✓ RIGHT THINKING

Orange urine/skin = **expected, harmless** side effect of sulfasalazine. Reassure the patient.

7 Clinical Judgment Scenario (NCJMM)

RECOGNIZE · ANALYZE · PRIORITIZE · EVALUATE

> ***Scenario:*** *A 24-year-old with a known history of ulcerative colitis arrives at the ER reporting 15 bloody stools today. Vital signs: T 102.8°F, HR 128, BP 92/54, RR 24. The abdomen is markedly distended, tympanic, with absent bowel sounds. Hgb is 8.1 g/dL.*

① Recognize Cues

Fever, tachycardia, hypotension, distended/silent abdomen, bloody stools, anemia → severe UC flare with possible **toxic megacolon**.

② Analyze Cues

Cluster: SIRS criteria + ileus + GI bleed = life-threatening. Risk for perforation, sepsis, hypovolemic shock.

③ Prioritize Action

NPO + bowel rest, large-bore IV access, **aggressive fluid resuscitation**, type & cross for blood, IV corticosteroids, broad-spectrum antibiotics, NG decompression, **surgical consult STAT**.

④ Evaluate Outcomes

Goals: stabilize VS (MAP >65), abdominal girth ↓, return of bowel sounds, Hgb stable, no perforation on imaging. Reassess Q15min initially.

8 Patient Education

SELF-MANAGEMENT · SAFETY

For IBS Patients

- Keep a **food & symptom diary** to identify triggers
- Try a **low-FODMAP** diet under dietitian guidance
- Limit caffeine, alcohol, carbonated drinks, and high-fat meals
- Eat **small, regular meals**; chew slowly; ↑ soluble fiber slowly
- Manage stress: yoga, mindfulness, regular exercise, adequate sleep
- **Report immediately:** blood in stool, fever, weight loss, night-time pain — these are *not* IBS

For IBD Patients

- Take medications **exactly as prescribed**, even when feeling well — **do not stop steroids abruptly**
- During flares: **low-residue, low-fiber, low-fat, lactose-free** diet; small frequent meals
- Track stool frequency, blood, weight; report sudden ↑ in stools, severe pain, fever, or vomiting
- Stay **well hydrated**; replace electrolytes; **avoid NSAIDs** (trigger flares) and smoking (worsens Crohn's)
- Keep up with **colonoscopy surveillance** (↑ colon cancer risk after 8–10 yrs of disease)
- Get vaccines **before** starting biologics; avoid live vaccines after
- Report signs of infection promptly — immune suppression masks symptoms
- Connect with support groups (Crohn's & Colitis Foundation) and seek mental health support

9 Memory Boosters & Mnemonics

RETENTION ANCHORS

Crohn's Disease

CHRISTMAS

Cobblestone mucosa
High temperature (fever)
Reduced lumen (strictures)
Intestinal fistulas
Skip lesions
Transmural (all 4 layers)
Malabsorption / weight loss
Abdominal pain (RLQ)
Submucosal fibrosis

Ulcerative Colitis

U-C-CLOSEUP

Ulcers in colon
Continuous inflammation
Colon & rectum only
LLQ pain
Originates in the rectum
Severe bloody diarrhea
Excrement = blood + mucus
Unhealthy weight loss
Pseudo-polyps

IBS Diagnosis

"I.B.S."

Irritable, not Inflamed — labs are normal
Bowel habit altered (D, C, or both)
Stress + foods trigger; pain **relieved by defecation**
No blood, *no* fever, *no* weight loss = the "3 No's"

IBS vs IBD — Quick Tell

"BLOOD = BAD"

Blood in stool → **IBD**, never IBS
Labs normal → think **IBS**
Labs abnormal (↑ ESR, ↓ Hgb) → think **IBD**
Night-waking pain → IBD red flag
Pain **relieved by BM** → IBS