

Review

IBS-Related Faecal Incontinence: A Focused Narrative Review of Mechanisms, Evidence, and Conservative Care Considerations

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Abstract

Background: Faecal incontinence (FI) may occur in patients with irritable bowel syndrome (IBS), particularly when loose stool, urgency, reduced warning time, fluctuating bowel habits, or constipation with retention interferes with timely defaecation. However, IBS-related FI should be distinguished from FI caused primarily by structural sphincter injury, neurological disease, advanced frailty, or other organic gastrointestinal disorders. This focused narrative review examines IBS-specific mechanisms and conservative care considerations relevant to FI risk. **Methods:** This article is a focused narrative review rather than a systematic review, scoping review, clinical guideline, or formal GRADE assessment. PubMed and the Ichushi-Web/Japanese Medical Abstracts Society were searched for studies published from January 2000 to June 2026. Search terms were combined and included irritable bowel syndrome with faecal/fecal incontinence, urgency, diarrhoea/diarrhea, constipation, stool form, bowel diaries, diet, FODMAP, fibre/fiber, pelvic floor rehabilitation, biofeedback, skin care, absorbent products, ultrasound, and conservative management. Studies directly addressing IBS mechanisms or symptom management, FI assessment or conservative FI care, or implementation issues relevant to IBS-related FI were deemed eligible. **Results:** Direct studies of FI prevention in IBS patients are scarce. The most defensible IBS-specific targets are loose stool, urgency, reduced warning time, alternating bowel habits, constipation with retention or incomplete evacuation, diet- or medication-related triggers, stress-related exacerbation, and toilet access. Broader FI evidence supports supportive measures such as skin protection, absorbent products, pelvic floor rehabilitation, biofeedback, transanal irrigation, and referral, but these measures are not IBS-specific unless they are connected to IBS-related symptom pathways. **Synthesis:** Evidence was organized into three categories: direct IBS evidence, general FI evidence, and indirect implementation evidence from continence-care settings. No formal certainty ratings or recommendation strengths were assigned; statements are therefore framed as clinical considerations and areas for future study rather than guideline-level recommendations. **Conclusions:** IBS-related FI should be discussed as a symptom-risk pathway within IBS rather than as FI in general. Available evidence suggests the value of assessing IBS subtype, stool form, urgency, triggers, warning time, and toileting circumstances before applying general FI support. Because direct preventive trials are limited, conclusions should be interpreted as practice-informing clinical considerations rather than firm recommendations.



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1. Introduction

Irritable bowel syndrome (IBS) is a disorder of the gut–brain interaction and is characterized by recurrent abdominal pain associated with defaecation and/or changes in stool frequency or stool form [1–4]. Contemporary IBS care emphasizes positive diagnosis, assessment of alarm features, identification of symptom subtypes, and attention to diet, stress, bowel habits, and quality of life [3–6]. Faecal incontinence (FI) is not a defining diagnostic feature of IBS, but it may become clinically important when IBS-related diarrhoea, urgency, reduced warning time, mixed bowel patterns, or constipation with retention interferes with continence.

The scope of this review is deliberately narrower than FI in general. It focuses on situations in which IBS mechanisms plausibly increase leakage risk: loose stool and urgency in IBS-D, alternating stool form in IBS-M, retention or incomplete evacuation in IBS-C, and symptom exacerbation related to meals, stress, medications, or limited toilet access. Broader FI topics are included only when they clarify the differential diagnosis, elucidate the limitations of the evidence, or provide a conservative care context for patients whose IBS symptoms have led to leakage.

According to Rome IV, IBS is defined by recurrent abdominal pain associated with two or more of the following at least one day per week, on average, during the previous three months: defaecation, a change in stool frequency, or a change in stool form. Symptom onset should occur at least six months before diagnosis [3,4]. This wording is important because older descriptions that used abdominal discomfort or different frequency thresholds should not be presented as current Rome IV diagnostic criteria.

This review distinguishes IBS-specific assessment targets from general FI support. IBS-specific targets include stool consistency, urgency, reduced warning time, postprandial or stress-related symptom exacerbation, and alternation between constipation and diarrhoea. General FI measures, including skin protection, absorbent product selection, toileting assistance, pelvic floor rehabilitation, biofeedback, transanal irrigation, and specialist referral, are discussed only as supportive care when they are relevant to patients whose IBS symptoms are associated with leakage.

The review reorganizes IBS and FI evidence into an IBS-focused framework that separates (1) IBS-specific mechanisms that may precipitate leakage, (2) general FI support that may be needed after leakage occurs, and (3) evidence gaps requiring future IBS-specific studies. This approach aims to reduce overgeneralization from general FI literature to patients with IBS.

Accordingly, the review question is as follows: In patients with IBS, what symptom mechanisms may increase the risk of FI, and what conservative care considerations are supported by direct IBS evidence, general FI evidence, or indirect implementation evidence?

2. Materials and Methods

2.1. Review Design and Question

This article is a focused narrative review, not a systematic review, scoping review, evidence-based guideline, or formal evidence-certainty assessment. The review question is as follows: In patients with IBS, what IBS-specific symptom pathways may increase the risk of FI, and what conservative care considerations can be cautiously inferred from IBS literature and FI management literature?

The review was designed to synthesize clinically relevant concepts rather than to estimate pooled effects. No PRISMA flow diagram, meta-analysis, or formal risk-of-bias assessment was performed. To improve reproducibility within the limits of a narrative review, the databases, date limits, search concepts, eligibility criteria, exclusion criteria, screening approach, and evidence categories are stated below.

Search strategy: PubMed and the Ichushi-Web/Japanese Medical Abstracts Society were searched for studies published between January 2000 and June 2026. The principal PubMed search structure was as follows: (“irritable bowel syndrome” OR IBS) AND (“faecal incontinence” OR “fecal incontinence” OR “bowel urgency” OR urgency OR diarrhoea OR diarrhea OR constipation OR “stool form”) AND (“bowel diary” OR diet OR FODMAP OR fibre OR fiber OR “pelvic floor” OR biofeedback OR toileting OR “skin care” OR “absorbent product” OR ultrasound OR “conservative management”). Equivalent keyword combinations were used to search the Ichushi-Web where indexing permitted. Reference lists of relevant guidelines, consensus statements, systematic reviews, and major clinical reviews were checked to identify additional sources.

Screening and selection procedure: Titles and abstracts were screened for relevance to IBS, FI, urgency, stool form disturbance, or conservative continence care. Full texts were then reviewed when the abstract suggested relevance to the review question. Articles were retained if they reported at least one of the following: IBS-related leakage mechanisms, conservative IBS symptom management that could plausibly affect FI risk, general FI care applicable after leakage occurs, or limitations of transferring general FI evidence to IBS-related FI. Selection was based on clinical relevance and citation support for the focused synthesis; it was not intended to generate an exhaustive systematic evidence map.

Eligibility criteria: Sources were eligible if they addressed (1) IBS diagnostic concepts, subtype classification, stool form, urgency, transit, diet, soluble fibre, low-FODMAP therapy, or conservative IBS management; (2) FI assessment or conservative FI management relevant to daily care; or (3) implementation issues relevant to IBS-related FI, such as bowel diaries, toileting routines, skin protection, absorbent products, pelvic floor rehabilitation, biofeedback, transanal irrigation, objective assessment, or referral. Priority was given to guidelines, consensus statements, systematic reviews, randomized or comparative studies, and clinically relevant observational studies.

Exclusion criteria and scope control: Studies focused primarily on inflammatory bowel disease, microscopic colitis, radiation enteritis, malabsorption, spinal cord injury, obstetric sphincter injury, anorectal surgery, advanced neurological disease, severe frailty, diaper engineering, or product technology were excluded from the IBS-specific synthesis. They were considered only if they clarified differential diagnoses, contextualized general FI care, or illustrated why general FI evidence should not be uncritically applied to IBS.

Evidence interpretation: Included literature was grouped into three categories. Direct IBS evidence was used to discuss mechanisms such as diarrhoea, constipation, urgency, stool-form fluctuation, diet, and stress. General FI evidence was used to discuss supportive care after leakage occurred, including skin protection, absorbent products, pelvic floor rehabilitation, biofeedback, transanal irrigation, and referral. Indirect implementation evidence was used only to discuss feasibility in clinical or care settings. The lack of direct IBS-related FI evidence was noted as a limitation.

No formal GRADE or Evidence-to-Decision process was conducted. Accordingly, practical statements are worded as clinical considerations and should not be interpreted as guideline recommendations or as evidence that a specific intervention prevents FI in all patients with IBS.

Rationale for source use: Self-authored publications and tangentially related sources were not used as primary evidence for recommendations. They were retained only when they provided context directly related to IBS symptom mechanisms, diet, ultrasound, or prior conceptual work. Core clinical interpretations rely primarily on independent IBS guidelines, FI guidelines, systematic reviews, and comparative studies. Where evidence was contradictory, indirect, or limited, the text avoided directive wording and identified uncertainty.

2.2. Epidemiology and Clinical Relevance

Population studies have shown that FI is common, but estimates vary because definitions, survey methods, symptom duration, care setting, and age differ across studies [7–11]. These data demonstrate clinical relevance and underrecognition, but they do not provide precise prevalence estimates for IBS-related FI. The present review therefore uses epidemiological studies as background rather than as direct evidence of IBS-specific causation.

For an IBS-focused review, the epidemiological message is that clinicians should not assume that continence is preserved simply because the primary diagnosis is functional rather than structural. Patients with IBS may not disclose leakage, urgency, pad use, or fear of accidents because of embarrassment. A respectful and specific symptom history is therefore essential.

The available literature also indicates an important gap in evidence: many studies describe FI prevalence in general populations or care facilities, whereas fewer studies quantify FI directly attributable to IBS subtype, stool form, urgency, or mixed bowel patterns. This gap in evidence limits the strength of causal and preventive claims.

2.3. IBS-Specific Pathways and Differential Considerations

In IBS-related FI, the most relevant pathway is not necessarily permanent sphincter failure. Leakage risk may increase when loose stool, urgency, reduced warning time, postprandial bowel activity, stress-related exacerbation, or alternating diarrhoea and constipation overwhelm the patient's ability to reach the toilet. Constipation with retention or incomplete evacuation may also contribute to overflow-type leakage in select patients [3,4,12–20].

Other causes of loose stool or FI, including inflammatory bowel disease, microscopic colitis, radiation enteritis, drug-induced diarrhoea, malabsorption, neurological disease, or severe frailty, should be considered in clinical assessments when symptoms are atypical, severe, new in onset, or accompanied by alarm features. However, these disorders fall outside the primary scope of this IBS-focused review.

This distinction is important because general FI management can be useful without being IBS-specific. The synthesis below therefore labels each care component according to whether it mainly targets IBS mechanisms, general continence needs, or implementation issues in daily care.

3. Results and Discussion

3.1. IBS-Specific Mechanisms Leading to FI

IBS is associated with disordered gut–brain interactions, visceral sensitivity, motility disturbance, diet-related symptom triggering, stress responsiveness, and altered bowel habits [2–4,21–26]. These mechanisms become relevant to FI only when they produce immediate continence threats, such as watery stool, urgency, reduced warning time, rapid postprandial defaecation, incomplete evacuation, or alternating stool patterns.

IBS-D may increase FI risk through loose stool, urgency, and difficulty delaying defaecation. IBS-M may increase FI risk because bowel patterns change over time, making self-management unstable. IBS-C may contribute through retention, incomplete evacuation, or overflow-type leakage in some patients. These IBS-related pathways differ from those associated with FI caused primarily by sphincter disruption, neurological disease, or immobility, although more than one mechanism can coexist in an individual patient.

The main IBS-specific assessment targets are therefore stool consistency, urgency, timing of bowel movements, symptom triggers, medication effects, stress-related exacerbation, and toilet access. Skin care, pads, diapers, and specialist continence interventions remain supportive measures and should be integrated with, rather than substituted for, IBS assessment.

3.2. Bowel Habit Guidance as IBS-Specific Anticipatory Support

Bowel habit guidance should be presented cautiously because direct trials focusing on the prevention of IBS-related FI are limited. Its rationale is strongest when it is used to identify and anticipate IBS-specific risk patterns, such as postprandial urgency in IBS-D, alternating diarrhoea and constipation in IBS-M, or retention and incomplete evacuation in IBS-C.

A bowel diary can be used to record stool form, urgency, leakage episodes, abdominal pain, meals, fluids, caffeine, alcohol, medications, stress, toileting time, and circumstances in which the patient could not reach a toilet. For patients with IBS, this diary is not merely a tool for recording general continence; it can help link leakage risk to symptom fluctuation and modifiable triggers [3–6,27–40].

Evidence from general FI and nursing-home literature supports structured assessment and bowel routines in select settings, but the findings are not uniformly positive. Some interventions improve bowel movement frequency or care processes without clearly reducing FI frequency [27–30]. These mixed findings should prevent overstatement and indicate that toileting routines cannot be assumed to prevent IBS-related FI without IBS-specific evaluation.

For patients with IBS-D or IBS-M, care may focus on identifying high-risk times, planning toilet access, reviewing diet and medications, and addressing diarrhoeal urgency. For patients with IBS-C or mixed symptoms, care may focus on avoiding retention, recognizing incomplete evacuation, and preventing inappropriate long-term restriction or antidiarrhoeal use that could worsen constipation.

Recent FI guidelines support conservative management, bowel diaries, dietary and medical management, pelvic floor rehabilitation, biofeedback, transanal irrigation, and referral when conservative measures are insufficient [35–37,40,41]. In this manuscript, those sources are treated as general FI context. They are not presented as direct proof that all measures prevent FI in patients with IBS.

Thus, the IBS-specific value of bowel habit guidance lies mainly in pattern recognition and anticipatory planning. It may help clinicians and patients identify when leakage is most likely and select targeted actions before urgency becomes difficult to control (Table 1).

Table 1. Conservative care components relevant to IBS-related FI.

Care Component	Specific Considerations
Daily life and trigger support	Consider reviewing the patient's daily routine, meals, fluids, caffeine, alcohol, spicy foods, physical activity, sleep, stress, medications, and access to toilets. Identify patterns that worsen urgency or loose stool and agree on realistic changes rather than imposing broad restrictions.
Bowel habit and diary-based training	Consider a bowel diary to record stool form, urgency, leakage, meals, fluids, medications, and toileting times. Discuss prompt toilet use when urgency is present; when rectal sensation or cognition is reduced, scheduled toileting after meals and caregiver-assisted routines may be considered.
Skin protection and IAD prevention	When leakage occurs, assess the perineal and perianal skin regularly. Remove stool promptly, cleanse gently with a mild cleanser or suitable cleansing cloth, avoid rubbing and alkaline soap, dry carefully, moisturize when appropriate, and apply a barrier product to reduce exposure to stool, urine, moisture, and friction.
Pelvic floor rehabilitation and referral	If clinically appropriate, teach pelvic floor muscle contraction and relaxation only after confirming that the patient can identify the correct muscles. If symptoms persist, consider referral for supervised pelvic floor muscle training, biofeedback, transanal irrigation, medication review, or specialist continence assessment.

In summary, conservative care may reasonably begin with IBS subtype and symptom pattern, with general FI support added when leakage, dermatitis, functional limitation, or

persistent distress is present. This sequence avoids presenting general continence care as direct IBS-specific evidence.

3.3. General FI Supports Applicable to Patients with IBS-Related FI

When FI is persistent or recurrent, patients may benefit from support intended to reduce accidents, protect the skin, maintain social participation, and reduce anxiety. These goals are not unique to IBS, but they are relevant when IBS symptoms lead to leakage or fear of leakage.

Absorbent products and planned toileting should be interpreted as containment and safety strategies rather than as treatments for IBS itself. They may reduce visible contamination and distress, but they do not address stool-form fluctuation, urgency, abdominal pain, dietary triggers, or stress-related exacerbation. These IBS-specific factors still require assessment.

Product selection should consider stool consistency, leakage volume, the presence of urinary incontinence, mobility, ease of changing products, skin condition, odour concerns, cost, and patient preference [42–44]. Because IBS symptoms may alternate between diarrhoea and constipation, the most suitable product may change over time.

Skin protection is a general priority for FI. Prolonged exposure to stool, moisture, digestive enzymes, friction, and repeated cleansing can damage the perineal and perianal skin. When leakage occurs, gentle cleansing, moisturization, barrier protection, prompt product changes, and monitoring for incontinence-associated dermatitis can be considered in line with FI guidance [35–37,45–53].

These measures are best interpreted as supportive continence care. They may reduce skin injury, visible leakage, discomfort, or embarrassment, but they do not directly modify IBS mechanisms such as urgency, stool-form fluctuation, abdominal pain, or stress-related exacerbation. Documentation of leakage timing, stool form, triggers, product fit, skin condition, and patient discomfort can connect supportive FI care back to IBS-focused assessment.

Pelvic floor muscle training, biofeedback, transanal irrigation, device-aided therapy, and specialist referrals may be appropriate when conservative care is insufficient or when anorectal dysfunction, evacuation difficulty, or severe quality-of-life impairment is suspected [35–37,40,41,54]. Direct evidence for preventing FI specifically in patients with IBS remains limited; thus, referral decisions should be individualized.

3.4. Dietary Strategies for Stool Form and Urgency in IBS

Dietary management is one of the most IBS-specific areas of this review because food intake can influence abdominal pain, bloating, stool form, and urgency. General healthy eating advice, regular meals, adequate fluid intake, avoidance of overeating, and identification of patient-specific triggers are reasonable starting points [5,6,31,32,55–63].

Low-FODMAP therapy, soluble fibre such as psyllium, lactose restriction in lactose-intolerant patients, and individualized approaches have been shown to improve IBS symptoms in some patients [31–34,64–73]. However, most studies evaluate global IBS symptoms, abdominal pain, bloating, diarrhoea, constipation, or stool consistency rather than FI episodes as the primary outcome.

For IBS-related FI, the risk-reduction rationale is therefore indirect but clinically plausible: reducing watery stool and urgency may reduce situations in which leakage occurs. This inference is strongest for IBS-D and IBS-M and weaker when leakage is driven primarily by non-IBS factors such as sphincter injury, severe immobility, or neurological disease.

Dietary advice should not become an indefinite list of prohibited foods. Restrictive diets may reduce dietary variety, increase nutritional risk, worsen constipation in some patients, and increase social burden. Low-FODMAP approaches should generally include

reintroduction and personalization, and patients should be monitored for weight loss, nutritional inadequacy, constipation, diarrhoea, psychological burden, and satisfaction [31–34].

Soluble fibre may improve stool consistency and global IBS symptoms in select patients, whereas insoluble fibre may worsen bloating or abdominal pain in some patients [69–73]. Thus, fibre advice should distinguish soluble from insoluble fibre and should be adjusted to the patient's IBS subtype and stool pattern.

Evidence for diet as a method of preventing IBS-related FI should be described cautiously because diet is supported mainly as IBS symptom management. Its effect on FI prevention is inferred through changes in stool form and urgency rather than proven by direct IBS-related FI trials, making this an important area for future research.

3.5. Objective Assessment and Ultrasound: Adjunctive and Investigational Roles

Objective assessment may be useful when symptoms are difficult to describe, but ultrasound should not be presented as an established method for predicting IBS-related FI. Existing IBS ultrasound studies are limited, heterogeneous, and not designed primarily to evaluate FI prevention, leakage episodes, warning time, or continence-related quality of life [74–84].

Some studies suggest that ultrasound can evaluate gastrointestinal motility or colonic features in selected IBS contexts, and newer FI guidance discusses ultrasound techniques for selected diagnostic assessments [37,75–84]. These findings support ultrasound only as a possible adjunctive or investigational tool; they do not justify routine use for predicting IBS-related FI in routine clinical practice.

For the purposes of this review, ultrasound is relevant only as a potential adjunct when symptoms are difficult to describe or when further evaluation of constipation, faecal retention, diarrhoeal tendency, or bowel-content movement is required. At present, protocols, training requirements, reliability, thresholds, and outcome links remain insufficiently established.

Future studies should test whether ultrasound or other objective tools add value beyond bowel diaries, symptom questionnaires, physical assessments, and clinical judgement. Outcomes should be directly relevant to IBS-related FI, including urgency, warning time, leakage episodes, quality of life, feasibility, acceptability, and patient burden.

3.6. Research Gaps and Future Directions

The central gap in evidence is the lack of studies that use IBS-related FI as a primary outcome. Although many studies address IBS symptom control and many guidelines address FI management, few directly evaluate whether IBS-targeted interventions reduce leakage episodes, fear of accidents, pad use, or continence-related quality of life. This limits the reliability of strong preventive claims.

Future research should define IBS subtype, stool form, urgency, warning time, diet, medication use, psychological stress, toilet access, and comorbid anorectal dysfunction at baseline. This would allow investigators to distinguish leakage driven mainly by IBS symptom fluctuation from leakage driven mainly by general FI mechanisms.

Intervention studies should evaluate clinically meaningful outcomes such as leakage frequency, urgency severity, ability to defer defaecation, stool consistency, skin complications, social participation, patient embarrassment, and caregiver burden. Trials should also report the potential harms of restrictive diets, fibre supplementation, antidiarrhoeal treatment, or excessive scheduled toileting.

A coherent clinical pathway for IBS-related FI could begin with IBS diagnosis and subtype confirmation, screening for alarm features and alternative diagnoses, identifying stool-form and urgency patterns, addressing modifiable triggers, and then adding general

FI support such as skin protection, absorbent products, pelvic floor rehabilitation, or referral when needed.

This framework is intended to guide careful clinical thinking and future research, not to replace formal guidelines. It also limits product development, nursing home routines, spinal cord injury management, and technology-focused assessment to contextual roles unless they are directly connected to IBS-related FI mechanisms or outcomes.

3.7. Evidence Synthesis and Clinical Implications

Evidence published from 2016 to 2026 supports a narrower synthesis than a general review of FI. IBS guidelines clarify diagnosis and symptom-based management, whereas FI guidelines clarify assessment and conservative continence care [2–6,35–41,85,86]. The practical contribution of this review is to combine these two bodies of literature while explicitly stating which claims are direct, which are indirect, and which remain uncertain.

3.8. Evidence Sources for Clinical Considerations

The evidence base for preventing FI specifically in patients with IBS remains incomplete. Therefore, this review does not present formal recommendations or graded evidence statements. Table 2 summarizes how each care component relates to IBS-specific mechanisms, general FI evidence, and cautious practical interpretation.

Table 2. Evidence sources and cautious practical considerations relevant to IBS-related FI.

Care Component	IBS-Specific Evidence or Rationale	General FI Evidence or Rationale	Cautious Interpretation
Respectful screening and bowel diary	IBS symptoms fluctuate with stool form, abdominal pain, urgency, stress, meals, and subtype; diaries help reveal IBS-specific patterns [3,4,86].	FI guidelines support structured history, bowel diaries, symptom severity assessment, and quality-of-life assessment [35–37,40].	Consider bowel diaries to identify IBS-related patterns and guide individualized discussion; do not treat diary use as proof of prevention.
Diet, stool consistency, and urgency control	Low-FODMAP therapy, soluble fibre, and structured dietary advice can improve IBS symptoms or stool patterns in selected patients [5,6,31–34,55–73].	Conservative FI guidance emphasizes dietary and medical management, especially when loose stool contributes to leakage [35–37].	Consider diet and fibre strategies to target stool form and urgency, while avoiding unnecessary restriction and monitoring nutrition.
Bowel habit and toileting support	IBS-D and IBS-M may involve postprandial urgency and reduced warning time, whereas IBS-C may involve retention or incomplete evacuation [3,4,12–18].	Bowel training and prompted toileting have mixed evidence in nursing-home FI but can improve bowel movement frequency and care routines [27–30].	Consider toileting plans around the patient's IBS pattern rather than applying the same schedule to all patients.
Pelvic floor rehabilitation and referral	Pelvic floor dysfunction, urgency, and evacuation difficulty may coexist with IBS symptoms, but direct IBS-related FI prevention trials are limited [54].	Guidelines support pelvic floor muscle training, biofeedback, transanal irrigation, device-aided therapy, and specialist assessment when conservative care is insufficient [35–37,40,41].	Consider rehabilitation or referral when leakage persists or evacuation difficulty is suspected; direct IBS-related FI prevention evidence is limited.
Skin protection and absorbent products	IBS symptoms can alternate between loose stool and constipation, so product needs may change over time.	Evidence and guidance support gentle cleansing, moisturization, barrier protection, appropriate products, and IAD monitoring [35–37,42–53].	Consider as safety and dignity supports, not as substitutes for assessment of IBS triggers and stool patterns.
Ultrasound or objective assessment	IBS-related motility, stool retention, and bowel contents may be difficult to assess from symptoms alone in some patients [74–84].	Recent FI guidance includes ultrasound-based assessment in selected cases [37].	Consider ultrasound only as an adjunctive or investigational direction; routine use for IBS-related FI prediction is not yet established.

The most defensible IBS-specific clinical targets are loose stool, urgency, stool-form fluctuation, incomplete evacuation, dietary triggers, stress-related exacerbation, medication effects, and toilet access. General FI measures remain clinically important when leakage occurs, but they should be integrated with IBS assessment rather than presented as if all FI has the same cause.

4. Limitations

This review has several limitations. First, it is a focused narrative review rather than a systematic review or scoping review. Although the revised methods describe databases, date limits, search concepts, eligibility criteria, exclusion criteria, screening procedures, and synthesis categories, the search was not designed to identify every eligible study. No PRISMA flow diagram, duplicate screening, protocol registration, or formal risk-of-bias assessment was performed.

Second, direct evidence on the prevention of FI in patients with IBS is limited. Several conclusions are based on plausible pathways linking IBS symptom control to FI risk together with general FI management evidence. These inferences may be clinically useful but should be tested in IBS-specific studies before being treated as firm recommendations.

Third, the review excluded detailed discussions of organic gastrointestinal diseases, neurological disorders, spinal cord injury, obstetric sphincter injury, advanced frailty, and product engineering topics. These areas are clinically important but fall outside the revised scope.

Fourth, practical statements should be interpreted as clinical considerations in conjunction with existing IBS and FI guidelines, patient preferences, comorbidities, and local practice standards.

5. Conclusions

IBS-related FI should be defined and discussed more narrowly than FI in general. This review uses the Rome IV definition of IBS and avoids older diagnostic wording based on abdominal discomfort or different frequency thresholds.

The most relevant IBS-specific pathways to FI are loose stool, urgency, reduced warning time, stool-form fluctuation, incomplete evacuation, retention or overflow in select patients, diet- or medication-related symptom exacerbation, stress-related worsening, and limited toilet access. General FI measures such as skin protection, absorbent products, pelvic floor rehabilitation, biofeedback, transanal irrigation, and specialist referrals may be useful, but they should be clearly distinguished from IBS-specific mechanisms.

Because direct evidence on the prevention of IBS-related FI is limited, this review offers a cautious framework rather than guideline-level recommendations. Future studies should evaluate whether interventions that stabilize stool form, reduce urgency, improve warning time, and support timely toileting can reduce leakage episodes and improve quality of life in patients with IBS-D, IBS-M, and IBS-C with retention or incomplete evacuation.

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