MDForLives

THE GLOBAL PULSE OF HEALTHCARE · GASTROENTEROLOGY & HEPATOLOGY INSIGHT REPORT

IBS Management: Why Symptom Control Still Breaks Down

A clinician-level analysis of how GI specialists individualize treatment, respond when first-line management is not enough, integrate gut-brain care, and approach persistent or refractory IBS.

Phenotype & burden → First strategy → Reassessment → Gut-brain and multimodal care → Durable symptom control

40	5	90%	8974878
Survey records	Countries represented USA · UK · Italy · France · Germany	Completion rate	Survey ID

WHY THIS REPORT

IBS management becomes difficult when the diagnosis is familiar but the response to treatment is not.

Gastroenterologists rarely manage IBS through one decision. Bowel pattern matters, but so do abdominal pain or discomfort, bloating, symptom severity, diet, prior treatment response, quality-of-life impact, comorbidities, gut-brain factors, patient preferences, and access to therapies. A patient can fit a recognized IBS subtype and still require several different treatment domains before the pathway feels clinically settled.

That is why incomplete response is such an important point in the journey. The clinician may need to decide whether the treatment target was wrong, whether the dose or mechanism should change, whether adherence or intolerance is limiting the plan, whether overlapping symptoms need reassessment, and whether dietary, behavioral, neuromodulator, or multidisciplinary care should be added.

The MDForLives survey examines those decisions in practice: what GI clinicians prioritize when individualizing therapy, which approaches they currently use, which patients are hardest to manage, how practice has evolved, what happens after an inadequate response, how gut-brain interaction changes management, and what clinicians believe could improve refractory or difficult-to-control IBS.

> **Survey lens.** MDForLives survey SGID 8974878 includes 40 survey records with a 90% completion rate across 5 countries: USA · UK · Italy · France · Germany. Question-level response bases vary across clinical items. Multi-select questions are interpreted as option-level selections. Internal operational, required-text, after-survey, and honeypot fields are excluded from analysis.

CLINICAL CONTEXT

Current IBS guidance increasingly supports a positive diagnosis and a menu of treatments that can be matched to subtype, burden, and gut-brain features.

The American College of Gastroenterology clinical guideline describes IBS as a chronic disorder of gut-brain interaction and recommends a positive diagnostic strategy rather than prolonged exclusion in appropriate patients. It also supports accurate subtype classification, a limited low-FODMAP diet trial, subtype-relevant pharmacologic options, and gut-directed psychotherapy.

The AGA's guideline-based quality indicators for IBS similarly bring diagnosis, subtype-specific treatment, dietary counseling, and brain-gut behavioral therapy into the same quality framework. The AGA's clinical practice update on diet emphasizes that dietary intervention works best when it is structured and matched to the patient's ability to implement it.

The Rome V framework, available in 2026, continues to place IBS within disorders of gut-brain interaction and updates the clinical diagnostic framework to better reflect how symptoms present in practice. This makes the survey's emphasis on heterogeneity, gut-brain factors, and multimodal care particularly relevant to current specialist thinking.

Context for interpretation: External guidance provides the clinical frame. The MDForLives findings describe what respondents report prioritizing and doing in practice across five countries, including where symptom control remains difficult despite that expanding treatment toolkit.

EXECUTIVE SUMMARY

Six findings that show why IBS care increasingly depends on sequencing, reassessment, and multimodal treatment.

INSIGHT 01

Burden leads individualization

92.1% consider symptom severity, treatment response, and quality-of-life impact when individualizing treatment.

INSIGHT 02

Medication and diet are both core to current care

86.8% use symptom/subtype-specific pharmacologic treatment; 73.7% use dietary interventions and self-management.

INSIGHT 03

Inadequate response usually triggers a treatment change

81.6% optimize treatment or switch to a different mechanism after the initial strategy does not work well enough.

INSIGHT 04

Gut-brain care is integrated before the very end

37.8% prioritize gut-directed psychological therapy and 37.8% consider a neuromodulator or combined pharmacologic approach when gut-brain interaction is important.

INSIGHT 05

First-strategy control is often limited

56.8% estimate that only 25–49% of their IBS patients achieve satisfactory control with the first treatment strategy.

INSIGHT 06

Persistent symptoms define the sustained-control problem

70.3% identify persistent symptoms or limited response to available therapies as a leading barrier to sustained control.

01

INDIVIDUALIZING TREATMENT

Overall burden is the leading treatment lens, while subtype remains an important but not solitary guide

92.1% consider severity, treatment response, and quality-of-life impact; 76.3% consider IBS subtype and predominant symptoms.

CONTEXT

IBS treatment begins with a phenotype, but the phenotype is more than stool pattern. A specialist may need to weigh constipation or diarrhea alongside pain, bloating, previous response, functional impairment, diet, comorbidities, overlapping disorders, safety, and what the patient can realistically sustain.

WHAT THE DATA SHOWS

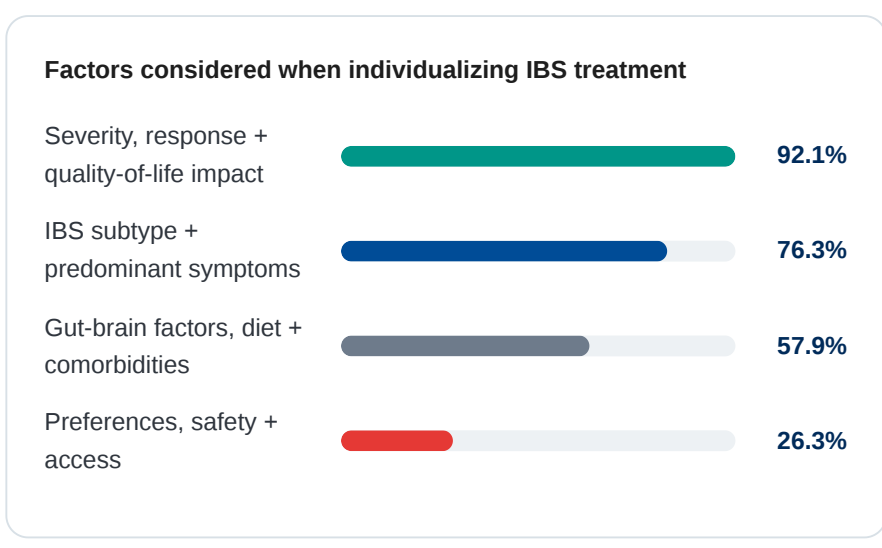
Symptom severity, treatment response, and quality-of-life impact is the most selected factor at 92.1%. IBS subtype and predominant symptoms follows at 76.3%. Gut-brain factors, diet, and comorbidities are selected by 57.9%, while patient preferences, safety, and treatment access are selected by 26.3%.

THE INSIGHT

The survey does not suggest subtype has become less clinically relevant. It suggests that subtype is being interpreted inside a wider burden-and-response framework. Two patients with IBS-C or IBS-D can still require very different sequencing if one has severe pain, a strong gut-brain component, dietary restriction, overlapping symptoms, or repeated treatment failure.

WHY IT MATTERS

A treatment plan that is technically subtype-appropriate can still fail if it does not address the factor that is actually driving disability. The practical task is to identify which problem the next intervention is meant to solve and how success will be judged.


Factors considered when individualizing IBS treatment

02

CURRENT TREATMENT MIX

Pharmacologic treatment leads current practice, but diet and gut-brain strategies are already part of the routine toolkit

86.8% use symptom/subtype-specific pharmacologic treatment; 73.7% use dietary interventions and self-management.

CONTEXT

The modern IBS toolkit spans several domains. Pharmacologic choices can be matched to constipation, diarrhea, pain, or other dominant symptoms. Dietary intervention may address meal-related symptom patterns. Neuromodulators and gut-directed psychological therapies can target pain processing, visceral sensitivity, stress-related amplification, or broader gut-brain interaction.

WHAT THE DATA SHOWS

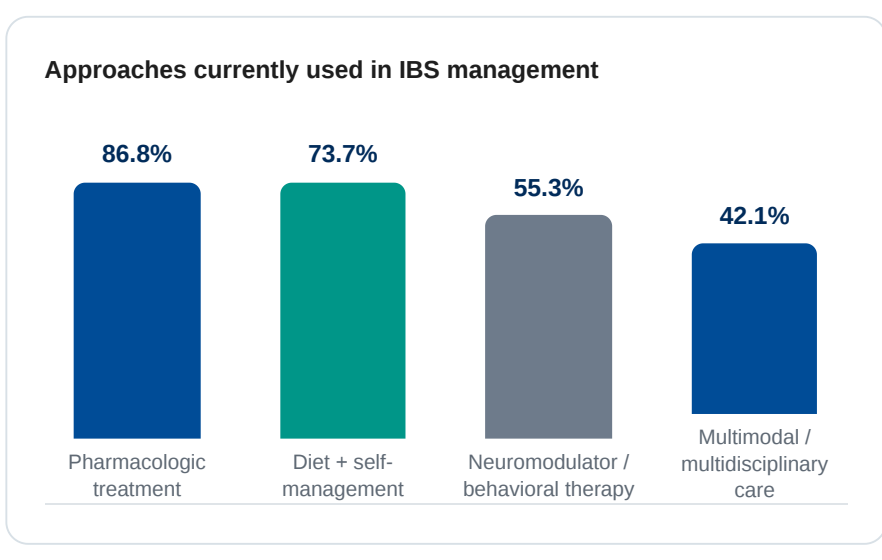
Symptom-directed or subtype-specific pharmacologic treatment is selected by 86.8%. Dietary interventions and patient self-management follow at 73.7%. Neuromodulators or gut-directed psychological or behavioral therapies are used by 55.3%, and combination, multimodal, or specialized multidisciplinary care by 42.1%.

THE INSIGHT

The data describe a layered care model, not a medication-versus-lifestyle split. Most clinicians are already using more than one treatment domain. The lower selection of formal multimodal or multidisciplinary care may reflect access, case selection, or the fact that clinicians can combine modalities without a formal multidisciplinary service.

WHY IT MATTERS

The ACG and AGA frameworks support both pharmacologic and non-pharmacologic strategies. The implementation question is therefore less about whether to use multiple domains and more about which patient needs which combination, in what sequence, with enough follow-up to know whether it is working.


Approaches currently used in IBS management

03

THE HARDEST IBS PATIENT

The most challenging cases are defined less by one subtype than by overlap, gut-brain complexity, and refractoriness

31.6% select IBS with significant gut-brain factors or overlapping symptoms as the most challenging patient type.

CONTEXT

A difficult IBS case is not always the patient with the most obvious bowel-pattern severity. The challenge can come from symptom overlap, discordant treatment targets, pain amplification, comorbid disorders, or a history of several reasonable treatments that did not produce durable control.

WHAT THE DATA SHOWS

IBS with significant gut-brain factors or overlapping symptoms leads at 31.6%. Refractory IBS after multiple treatment attempts follows at 26.3%. Persistent IBS-C, IBS-D, or IBS-M and pain- or bloating-predominant IBS are each selected by 21.1%.

THE INSIGHT

The distribution is relatively spread out, which is itself informative. There is no single difficult phenotype dominating practice. Complexity appears to arise from different combinations of persistent symptoms, gut-brain features, overlapping presentations, and treatment history.

WHY IT MATTERS

This is where a rigid treatment ladder can become less useful. Difficult-to-manage IBS often requires a fresh formulation of the case: what is persistent, what may be overlapping, what has actually been tried, what was not tolerated, and which treatment domain has not yet been addressed.

IBS patient type most challenging to manage

- **31.6%** Gut-brain factors or overlapping symptoms
- **26.3%** Refractory after multiple treatment attempts
- **21.1%** Persistent IBS-C / IBS-D / IBS-M
- **21.1%** Pain- or bloating-predominant IBS

04

HOW PRACTICE IS EVOLVING

The strongest recent influence is personalization beyond a single drug class

65.8% say individualized dietary, neuromodulator, or behavioral approaches have influenced IBS management over the past 3 years.

CONTEXT

IBS practice has expanded in several directions at once. Newer medicines have added subtype-specific options, while diet, neuromodulation, behavioral therapy, phenotype-based treatment, digital tools, and microbiome research have widened the conversation beyond one mechanism.

WHAT THE DATA SHOWS

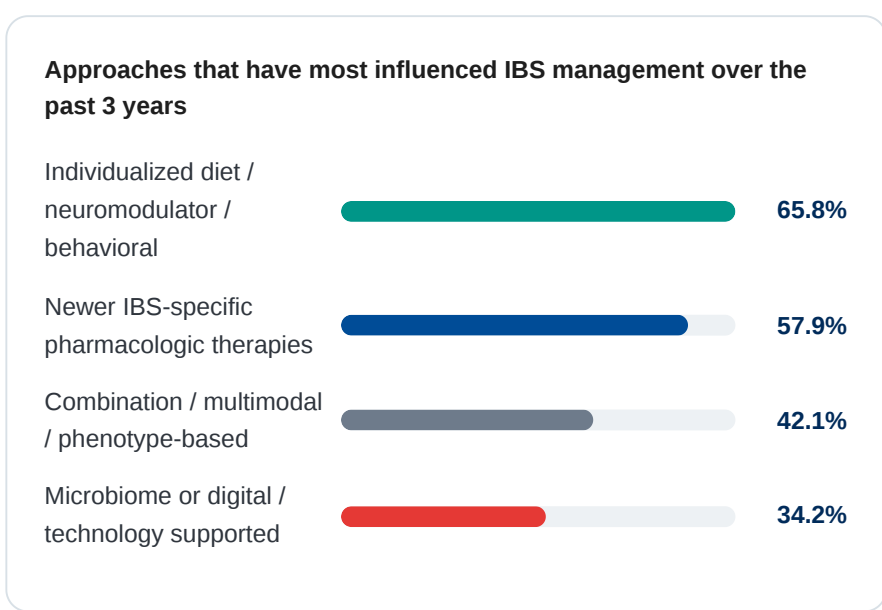
Individualized dietary, neuromodulator, or behavioral approaches lead at 65.8%. Newer IBS-specific pharmacological therapies are selected by 57.9%. Combination, multimodal, or phenotype-based treatment is selected by 42.1%, and microbiome-directed or digital/technology-supported approaches by 34.2%.

THE INSIGHT

The leading influence is not a single new therapy. It is the ability to match different treatment domains to the patient. That suggests personalization is becoming a practical management principle rather than a future concept.

WHY IT MATTERS

As the menu expands, decision quality becomes more important. More options can improve fit, but they can also create more sequencing decisions. The clinical advantage comes from knowing what to try next and why, not simply having a longer list of available interventions.


Approaches that have most influenced IBS management over the past 3 years

05

AFTER INADEQUATE RESPONSE

The first response to treatment failure is usually to optimize or switch, but reassessment remains part of the same decision

81.6% optimize treatment or switch to a different mechanism after an inadequate initial response.

CONTEXT

When symptoms remain inadequately controlled, the next step can look deceptively simple: change treatment. In practice, the clinician also has to ask whether the phenotype was correct, whether adherence or intolerance changed the exposure, whether another condition is overlapping, and whether a second treatment domain should be added rather than substituted.

WHAT THE DATA SHOWS

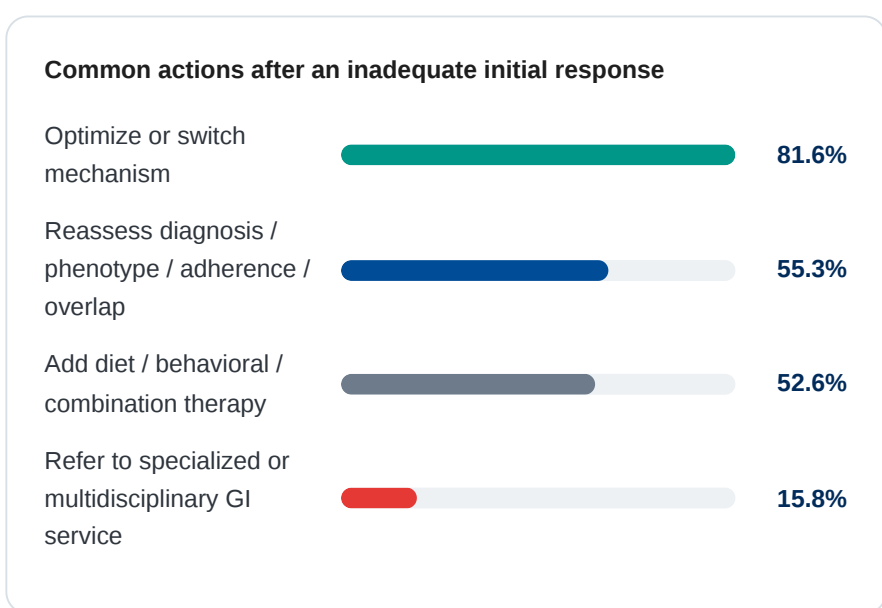
Optimization or switching mechanism is selected by 81.6%. Reassessing diagnosis, phenotype, adherence, or overlapping conditions is selected by 55.3%. Adding dietary, behavioral, or combination therapy is selected by 52.6%, while referral to a specialized or multidisciplinary GI service is selected by 15.8%.

THE INSIGHT

The dominant action is therapeutic change, but more than half also select reassessment and more than half select adding another treatment domain. That indicates that inadequate response is being treated as both a medication problem and a case-formulation problem.

WHY IT MATTERS

A change in mechanism is more useful when the reason for failure is understood. If the dominant issue is intolerance, adherence, overlapping symptoms, gut-brain amplification, or an incorrect target, simply moving to another drug may reproduce the same problem.


Common actions after an inadequate initial response

06

GUT-BRAIN MANAGEMENT

When gut-brain interaction matters, clinicians split evenly between behavioral and pharmacologic routes

37.8% prioritize gut-directed psychological therapy and 37.8% consider neuromodulator or combined pharmacologic treatment.

CONTEXT

IBS sits within disorders of gut-brain interaction, but recognizing that biology does not dictate one treatment. Some patients may benefit from gut-directed cognitive behavioral therapy, hypnotherapy, or another behavioral approach; others may need neuromodulation or a combined strategy alongside symptom-specific care.

WHAT THE DATA SHOWS

Gut-directed psychological or behavioral therapy and neuromodulator or combined pharmacologic treatment are tied at 37.8%. Patient education and symptom-management strategies account for 18.9%. Only 5.4% say they address gut-brain interaction mainly after conventional treatment has failed.

THE INSIGHT

The gut-brain decision is not one intervention versus another. It is a fork in the pathway that can lead to behavioral treatment, pharmacologic neuromodulation, or a combined plan. The very small share waiting until conventional treatment failure suggests many clinicians are integrating this dimension earlier.

WHY IT MATTERS

The ACG guideline and AGA quality framework both recognize brain-gut behavioral therapy as a legitimate treatment domain. Earlier identification of the patients most likely to benefit could reduce the tendency to repeat purely symptom-directed strategies when the clinical picture is broader.

How gut-brain interaction most commonly influences management

- **37.8%** Gut-directed psychological / behavioral therapy
- **37.8%** Neuromodulator or combined pharmacologic treatment
- **18.9%** Education and symptom-management strategies
- **5.4%** Mainly after conventional treatment fails

07

FIRST-STRATEGY CONTROL

For most respondents, satisfactory control with the first IBS strategy is achieved in fewer than half of patients

56.8% estimate that 25–49% of their IBS patients achieve satisfactory symptom control with the first strategy initiated.

CONTEXT

IBS care is often iterative because response is heterogeneous. A treatment can be evidence-based and appropriately chosen but still leave pain, bowel symptoms, bloating, dietary restriction, or quality-of-life burden insufficiently controlled.

WHAT THE DATA SHOWS

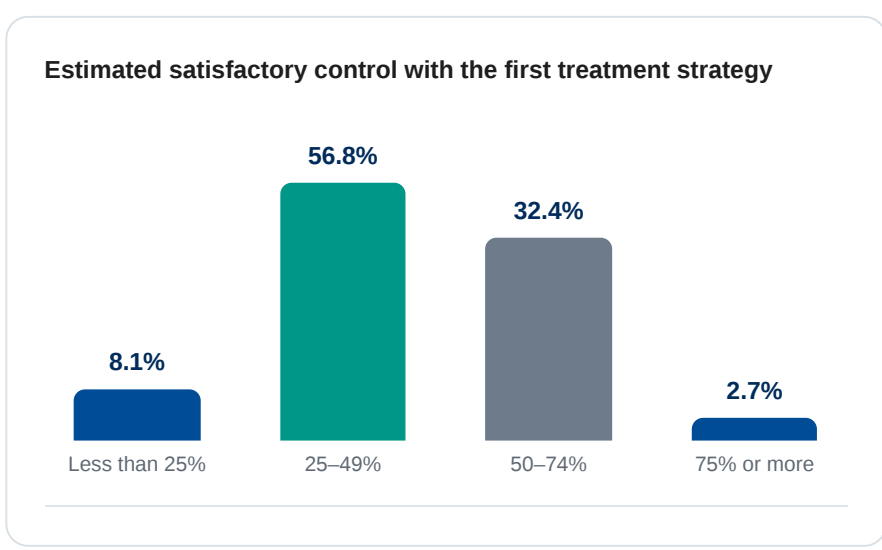
The largest group, 56.8%, estimates satisfactory control in 25–49% of patients after the first strategy. Another 32.4% estimate control in 50–74%. 8.1% estimate control in fewer than 25%, and only 2.7% estimate control in 75% or more.

THE INSIGHT

The distribution sets a realistic expectation for the pathway: a large proportion of patients will need reassessment or a second strategy. The clinical task is therefore not only choosing a good first treatment but also defining what constitutes inadequate response and what the next step will be.

WHY IT MATTERS

A planned review point can turn treatment iteration into a structured pathway rather than a sequence of disconnected trials. That is especially important when patients have already experienced several unsuccessful treatments or are losing confidence in the care plan.


Estimated satisfactory control with the first treatment strategy

08

SUSTAINED CONTROL

Persistent symptoms lead the long-term difficulty, but heterogeneity, adherence, and gut-brain factors add separate layers of friction

70.3% identify persistent symptoms or limited response to available therapies as a factor making sustained symptom control difficult.

CONTEXT

Short-term response and durable control are not the same outcome. Even after an initially reasonable improvement, IBS care can be destabilized by persistent symptoms, variable response, overlapping conditions, treatment intolerance, dietary complexity, changing expectations, or difficulty matching the plan to the patient.

WHAT THE DATA SHOWS

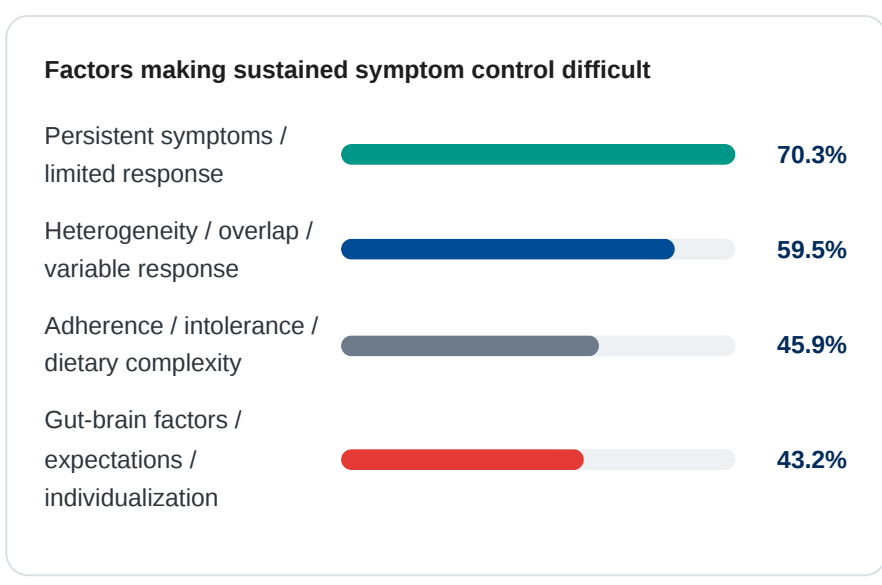
Persistent symptoms or limited response to available therapies leads at 70.3%. Heterogeneity, overlapping symptoms, or variable treatment response is selected by 59.5%. Treatment adherence, intolerance, or dietary complexity is selected by 45.9%, and gut-brain factors, expectations, or difficulty individualizing treatment by 43.2%.

THE INSIGHT

The leading barriers are not all solved by the same intervention. Persistent symptoms may require another mechanism; heterogeneity may require re-phenotyping; intolerance and adherence may require simplification; gut-brain or expectation issues may require a different type of conversation or treatment domain.

WHY IT MATTERS

Sustained control depends on matching the reason for instability to the response. A pathway that treats every recurrence as simple pharmacologic failure risks missing the factor that is actually preventing durability.


Factors making sustained symptom control difficult

09

THE NEXT 3–5 YEARS

Clinicians expect the next major gain to come from better refractory-IBS and multimodal strategies rather than one dominant new technology

37.8% select better approaches for refractory IBS and multimodal care as the development most likely to have the greatest impact.

CONTEXT

The future of IBS management is often discussed in terms of biomarkers, microbiome science, precision medicine, digital support, new drugs, and behavioral care. The survey asks clinicians to choose which development is most likely to matter most in the near term.

WHAT THE DATA SHOWS

Better approaches for refractory IBS and multimodal care leads at 37.8%. More targeted therapies and phenotype-based treatment selection is selected by 24.3%, matched by greater integration of gut-brain and personalized dietary approaches at 24.3%. Biomarker-, microbiome-, or AI-supported personalized management is selected by 13.5%.

THE INSIGHT

Respondents place the greatest weight on improving care for the patients who remain difficult despite existing options. That priority is pragmatic: the largest unmet need in the survey is not identifying another treatment category but making complex, refractory care more effective and coherent.

WHY IT MATTERS

The future pathway may combine better phenotype selection, easier access to behavioral and dietary expertise, more useful biomarkers, and more targeted therapies. The survey suggests those advances will matter most when they help clinicians solve the current problem of incomplete and unstable symptom control.

Development expected to have the greatest impact on IBS management

- **37.8%** Better approaches for refractory IBS + multimodal care
- **24.3%** More targeted therapies + phenotype-based selection
- **24.3%** More gut-brain + personalized dietary integration
- **13.5%** Biomarker / microbiome / AI-supported personalization

OPEN RESPONSE LENS

When clinicians describe what could improve difficult-to-manage IBS, they return to targeting, gut-brain care, microbiome options, and closer follow-up.

The open-ended item asked respondents to name one treatment strategy, emerging therapy, or clinical approach they believe could meaningfully improve outcomes for a patient with difficult-to-manage IBS. Responses were short and varied, so the themes below are qualitative rather than coded prevalence estimates.

The comments add texture to the quantitative data. Some clinicians want more precise treatment selection; others want earlier or more effective neuromodulation and psychological care; several mention microbiome-directed approaches; and others emphasize multidisciplinary follow-up, clearer targets, or treatments that produce longer-lasting relief.

Phenotype and target selection

Responses call for better differentiation of IBS subtypes, more specific phenotype-based treatment, clearer molecular targets, and therapies matched to the dominant clinical pattern.

Neuromodulation and psychological care

Comments include earlier neuromodulator use, neuropsychiatric approaches, psychiatric evaluation, SSRIs, and psychotherapy, reinforcing the survey's broader gut-brain signal.

Microbiome-directed care

Several respondents mention microbiome optimization, targeted probiotics, microbiome-specific treatment, or incorporating the microbiome into individual decision-making.

Multidisciplinary follow-up

One response explicitly calls for a multidisciplinary approach with close follow-up, while others point to better patient monitoring and earlier adjustment of treatment.

More durable pharmacologic relief

Some clinicians ask for medicines that provide longer-lasting relief, earlier use of appropriate medication, or combinations of active principles when single approaches are insufficient.

Diet remains part of the solution

A low-FODMAP diet appears in the comments, consistent with the survey's finding that dietary intervention is already a major component of current IBS management.

> **What the open responses add:** The quantitative survey identifies persistent symptoms, heterogeneity, and limited response as core obstacles. The comments show the directions clinicians hope will make care more precise: better targeting, stronger gut-brain integration, microbiome approaches, closer follow-up, and more durable treatment effects.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about IBS management.

How is IBS treatment individualized?

IBS treatment is usually individualized according to bowel pattern, predominant symptoms, symptom severity, previous treatment response, quality-of-life impact, comorbidities, patient preferences, and access to appropriate therapies. The mix of these factors differs from patient to patient.

What is refractory IBS?

Refractory IBS generally refers to persistent or difficult-to-control symptoms despite appropriate evaluation and more than one treatment approach. Before labeling symptoms refractory, clinicians may reassess the diagnosis, phenotype, adherence, overlapping conditions, and whether treatment targets the patient's dominant symptoms.

What is the gut-brain interaction in IBS?

IBS is classified as a disorder of gut-brain interaction. Symptoms can reflect bidirectional communication between the gastrointestinal tract and the nervous system, alongside factors such as motility, visceral sensitivity, diet, stress, and other biological or psychosocial influences.

Are diet and psychological therapies part of IBS management?

They can be. Guideline-supported IBS care may include structured dietary interventions and gut-directed psychological or behavioral therapies for appropriate patients, alongside pharmacologic treatment and other symptom-directed strategies.

What happens when the first IBS treatment does not work?

The next step depends on the clinical picture. Clinicians may reassess the diagnosis or phenotype, review adherence and overlapping conditions, optimize the current treatment, switch to a different mechanism, or add dietary, behavioral, or combination therapy.

Why can long-term IBS symptom control be difficult?

Long-term control can be complicated by persistent symptoms, variable response between patients, overlapping symptom patterns, treatment intolerance or adherence challenges, dietary complexity, gut-brain factors, and changing patient priorities over time.

GASTROENTEROLOGY IBS LENS

What this means at four decision points in the IBS pathway.

The survey suggests that effective IBS care depends on making the transition between phenotype, first treatment, inadequate response, and multimodal escalation explicit rather than treating each step as an isolated choice.

When choosing the first strategy

Phenotype lens. Start with bowel pattern, but also define symptom burden, quality-of-life impact, prior response, overlap, diet, comorbidities, and gut-brain features so the treatment target is clear.

When response is incomplete

Reassessment lens. Decide whether to optimize, switch mechanism, re-check the diagnosis or phenotype, address adherence or intolerance, or add another treatment domain.

When gut-brain interaction is prominent

Integration lens. Consider whether gut-directed behavioral therapy, neuromodulation, education, or a combined plan should enter earlier rather than after repeated conventional failure.

When symptoms remain refractory

Multimodal lens. Reconstruct the case around what remains uncontrolled, what has already failed, what overlaps, and which expertise or modality has not yet been meaningfully integrated.

CLOSING PERSPECTIVE

The next IBS management gain may come less from adding another option and more from making the sequence of care more precise.

The MDForLives findings describe gastroenterology practice in which IBS is already being treated as a heterogeneous, multidimensional condition. Clinicians are not relying on subtype alone. They are prioritizing symptom severity, prior response, quality-of-life impact, diet, gut-brain factors, comorbidities, and other patient-level considerations when they individualize treatment.

The treatment mix reflects the same breadth. Symptom-directed pharmacology is the most commonly used approach, but dietary intervention and self-management are also widely used, and more than half report neuromodulator or gut-directed psychological or behavioral therapies. The direction of travel is toward personalization across several domains rather than toward one dominant modality.

The strain appears when the first strategy is not enough. Most respondents optimize or switch treatment, but many also reassess diagnosis, phenotype, adherence, and overlap or add dietary and behavioral approaches. That combination is important because it separates simple drug failure from a more complex mismatch between treatment target and clinical phenotype.

Gut-brain care is also becoming part of that earlier reasoning. When gut-brain interaction is clinically important, respondents split evenly between gut-directed psychological or behavioral therapy and neuromodulator or combined pharmacologic treatment, while very few wait until conventional treatment has failed before addressing it. This is consistent with current frameworks that place IBS within disorders of gut-brain interaction rather than treating psychosocial or neural mechanisms as peripheral.

The clearest sign that the pathway still needs work is the first-strategy response estimate. The largest respondent group believes satisfactory control is achieved in only 25–49% of patients with the first approach. Persistent symptoms or limited response is then the leading barrier to sustained control, followed by heterogeneity and overlapping symptoms. The same clinical complexity is visible at both ends of the journey: it shapes the first treatment choice and later makes durable control difficult.

The future priorities are therefore pragmatic. Better approaches for refractory IBS and multimodal care lead the outlook, ahead of biomarker-, microbiome-, or AI-supported personalization. The open responses do not reject innovation, but they repeatedly translate it into clinical needs: clearer targeting, better subtype differentiation, earlier neuromodulation or psychological care, microbiome-directed strategies, closer multidisciplinary follow-up, and therapies with more durable effects.

The larger opportunity is to make IBS care more explicit as a sequence. Define the phenotype and burden. Choose the first strategy with a measurable target. Reassess before repeating. Decide whether the next move is a new mechanism, another treatment domain, or a broader reformulation of the case. Then build enough follow-up around the patient to know whether improvement is holding.

1 · Define the treatment target

Specify whether the dominant problem is bowel pattern, pain, bloating, functional impact, gut-brain amplification, or a combination before choosing the next intervention.

2 · Use subtype as a starting point, not the whole phenotype

Combine bowel pattern with severity, prior response, overlap, diet, comorbidities, patient context, and quality-of-life burden.

3 · Plan the reassessment point

Because first-strategy control is often incomplete, define when response will be reviewed and what would trigger optimization, switching, or augmentation.

4 · Bring gut-brain care into the pathway when the phenotype supports it

Use behavioral therapy, neuromodulation, education, or combined approaches as clinically appropriate rather than automatically reserving them for the end.

5 · Treat refractory IBS as a case-reformulation problem

Revisit diagnosis, phenotype, adherence, intolerance, overlap, and previously unaddressed treatment domains before simply adding another trial.

6 · Make multimodal care coherent

Dietary, pharmacologic, behavioral, and specialist inputs create more value when the patient understands how they fit together and who is responsible for follow-up.

Help future IBS insights reflect the decisions that make difficult cases different.

Join MDForLives to share clinical perspectives on phenotype, symptom control, gut-brain interaction, dietary care, refractory IBS, and multimodal treatment in real-world gastroenterology practice.

Join the Panel

REFERENCES AND DATA SOURCE

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