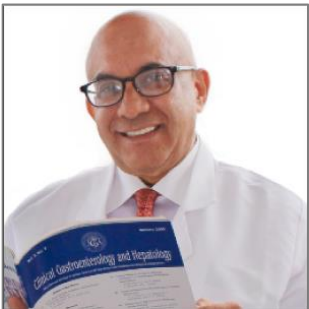


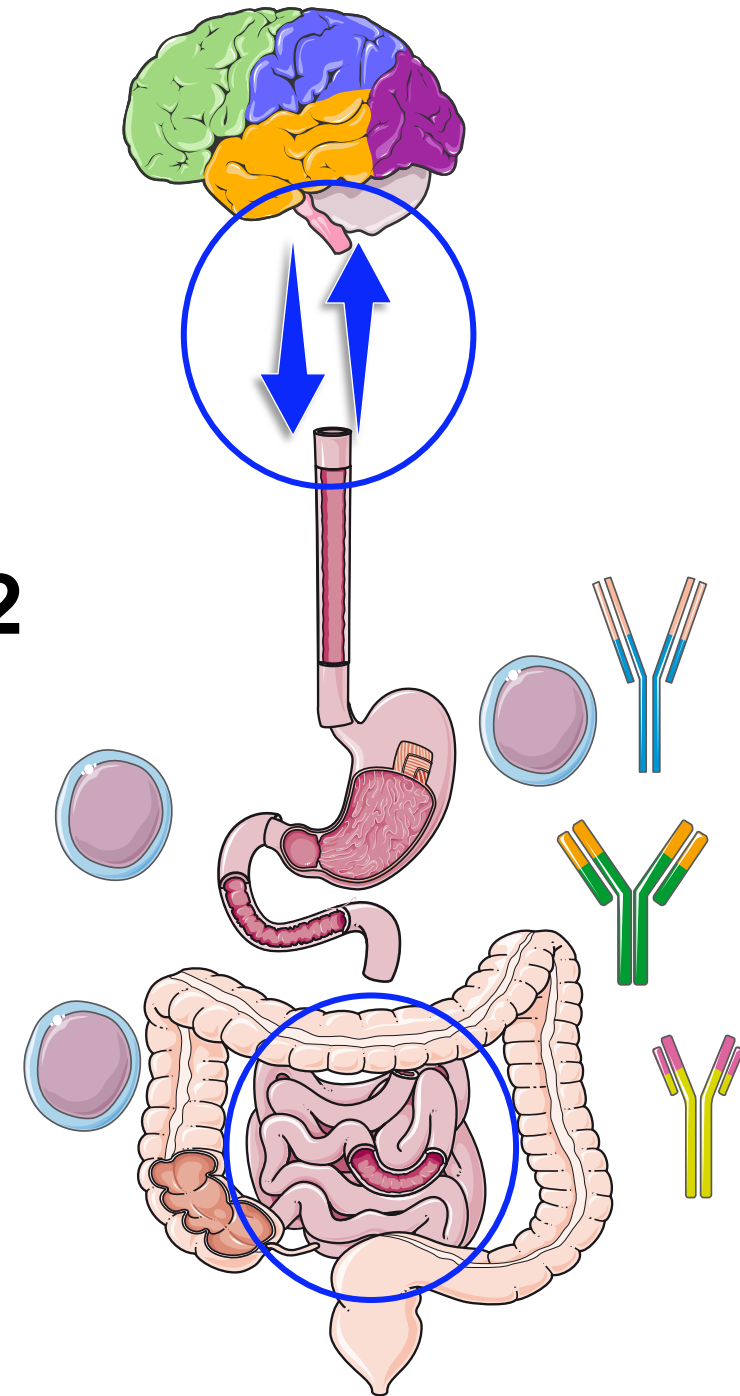
TQ / MK / AI Ritmo de la Medicina

Lo que Ud. no sabía de SII

Síndrome de intestino irritable Enfermedad orgánica con Múltiples Manifestaciones: Diagnóstico y Manejo 2022



William Otero MD FAGA, FACP
Profesor Titular de Medicina
Unidad de Gastroenterología
Universidad Nacional de Colombia
Hospital Universitario Nacional de Colombia



Prevalence of Rome IV Functional Bowel Disorders Among Adults in the United States, Canada, and the United Kingdom



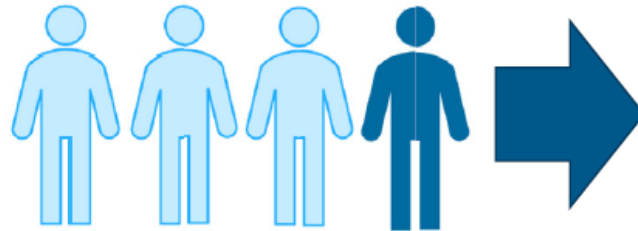
Olafur S. Palsson,¹ William Whitehead,¹ Hans Törnblom,² Ami D. Sperber,³ and Magnus Simren^{1,2}

¹Center for Functional GI & Motility Disorders, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina;

²Department of Internal Medicine and Clinical Nutrition, Institute of Medicine, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden; and ³Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel

Prevalence of Functional Bowel Disorders

More than **1 in every 4 adults** in the U.S., Canada and the U.K. has one of the six functional bowel disorders.

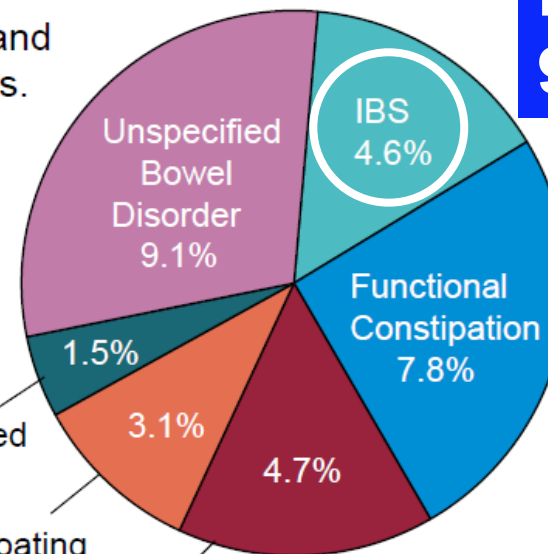


- ✓ Functional bowel disorders are more common in women than men
- ✓ They become less common after mid-life

Opioid-induced constipation

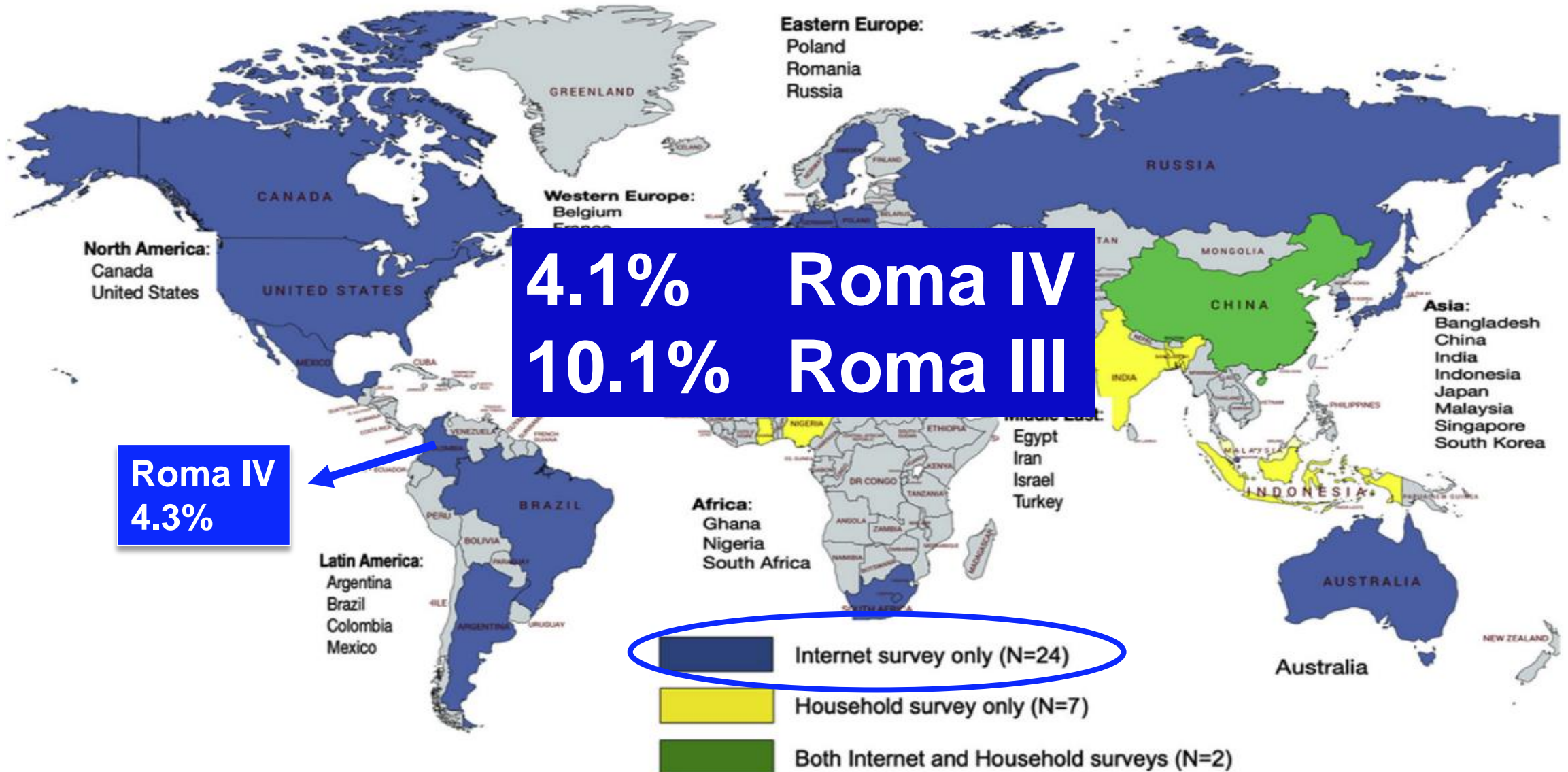
Functional Bloating

Functional Diarrhea



Gastroenterology

Worldwide Prevalence and Burden of Functional Gastrointestinal Disorders, Results of Rome Foundation Global Study

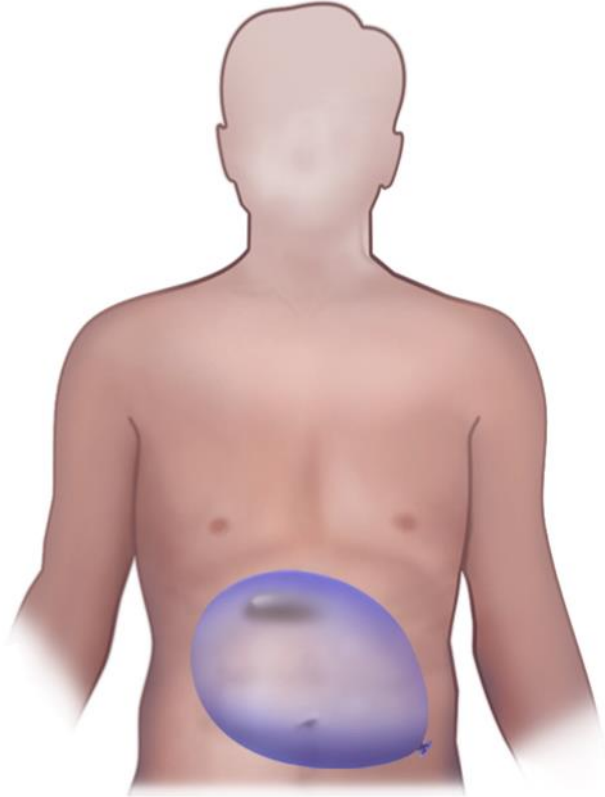


“Discomfort”
Palabra



**No todos los idiomas
Tienen “una palabra”
para “discomfort”**

“Bloating” y distensión abdominal



**Sensación subjetiva
De “inflación” y/o
Muchos gases**



**Aumento objetivo y
Medible de la circunferencia
abdominal**

ROME IV

The
Functional
Gastrointestinal
Disorders

FOURTH EDITION

Douglas A. Drossman, MD, Senior Editor

with Editors

Lin Chang, MD

William D. Chey, MD

John Kellow, MD

Jan Tack, MD, PhD

William E. Whitehead, PhD

and the Rome IV Committees

Trastorno funcional

Término obsoleto

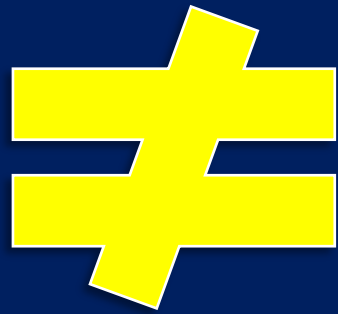
Estigmatiza
Al paciente

Enfermedad
No orgánica

Síntomas
por "estrés"

Sano:
"Enfermedad
imaginaria"

Síndrome de Intestino Irritable



Colon Irritable
Colon inflamado



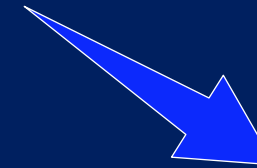
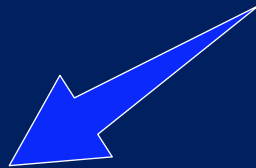
No
Existe!!

SII

Úlceras pépticas

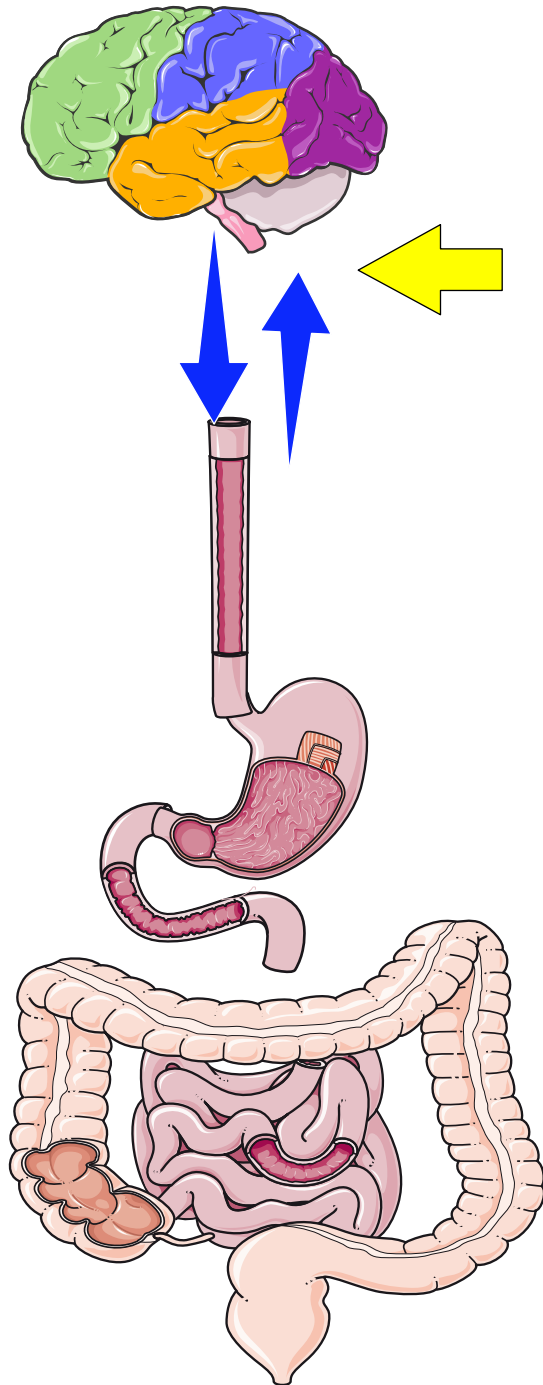


Enfermedad psicológica



***Enfermedad
Orgánica***

***Helicobacter pylori
AINES***



**Desórden
Interacción Eje
Intestino-cerebro**

**Síndrome
de Intestino
Irritable**

Más común

Impacto del SII

Principal Diagnóstico Gastroenterología 28%





Developing Valid and Reliable Health Utilities in Irritable Bowel Syndrome: Results From the IBS PROOF Cohort

Brennan Spiegel, MD, MSHS¹⁻⁵, Lucinda Harris, MD⁶, Susan Lucak, MD⁶, Emeran Mayer, MD^{2,3}, Bruce Naliboff, PhD¹⁻³, Roger Bolus, PhD^{2,3,5}, Eric Esrailian, MD, MPH^{2,5}, William D. Chey, MD⁷, Anthony Lembo, MD⁸, Hetal Karsan, MD^{9,10}, Kirsten Tillisch, MD^{2,3}, Gareth Dulai, MD, MSHS¹¹, Jennifer Talley, MSPH^{1,5} and Lin Chang, MD^{2,3,5}

**Pacientes cambiarían
10 -15 años de su vida**

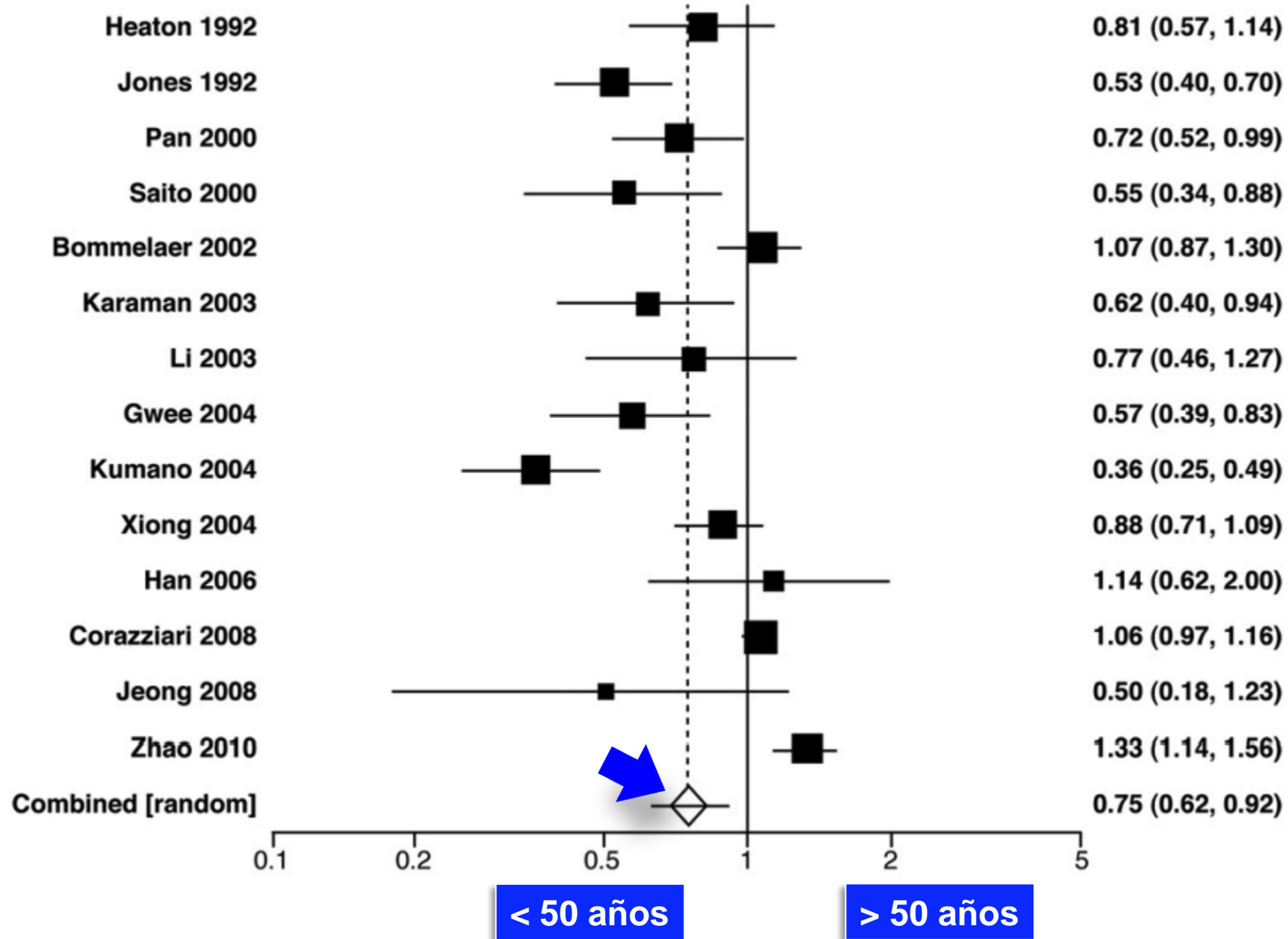


**Por un tratamiento
eficaz !!**

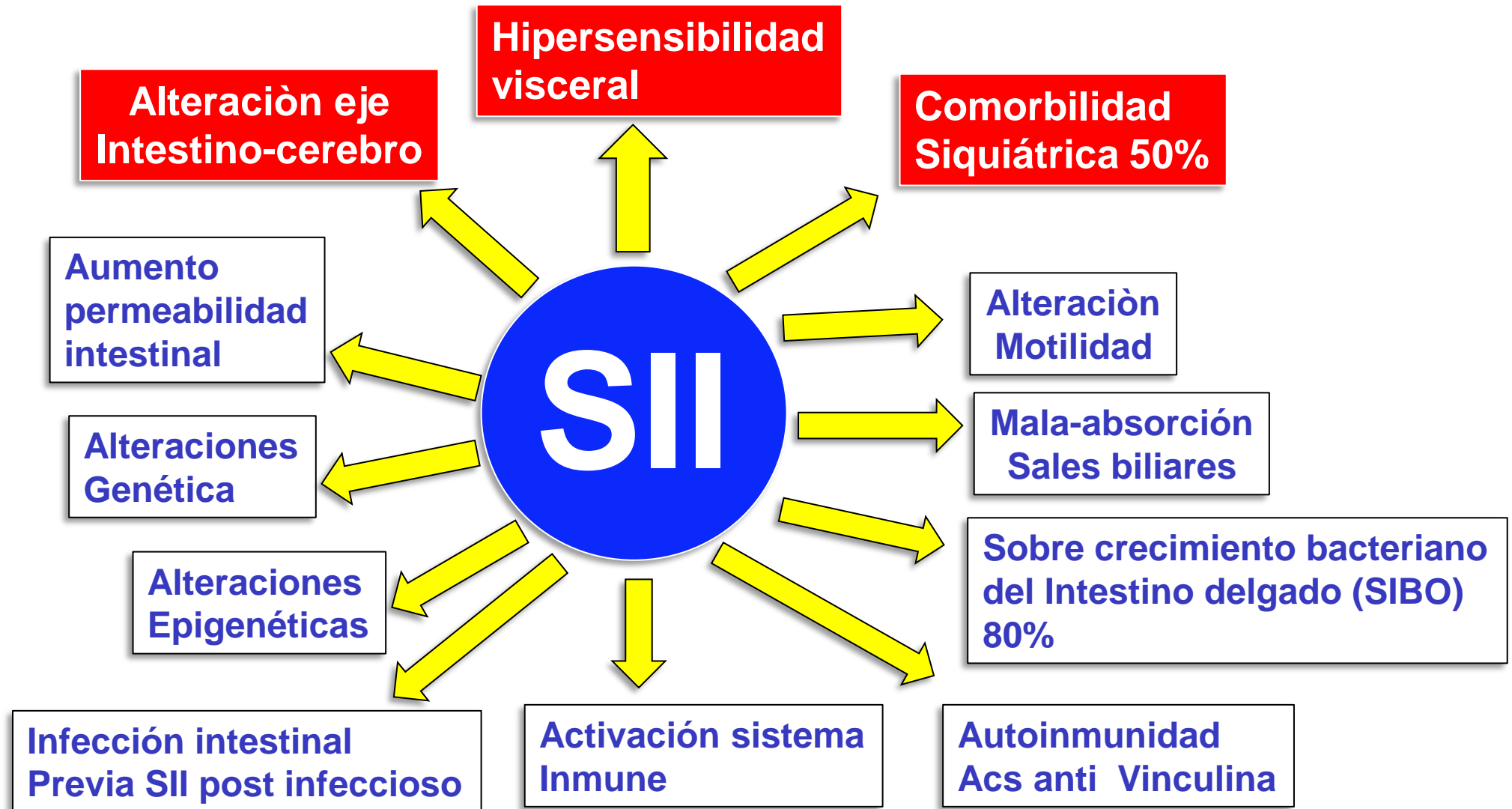
Síndrome de intestino irritable



Sperber AD, et al. Gut 2016; Jan 27, epub-ahead
Lacy MB, Scand J Gastroenterol 2009;26:34-9



SII -Fisiopatología



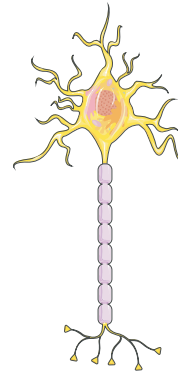
Autoimmunity Links Vinculin to the Pathophysiology of Chronic Functional Bowel Changes Following *Campylobacter jejuni* Infection in a Rat Model

Mark Pimentel · Walter Morales · Venkata Pokkunuri · Constantinos Brikos ·
Sun Moon Kim · Seong Eun Kim · Konstantinos Triantafyllou · Stacy Weitsman ·
Zachary Marsh · Emily Marsh · Kathleen S. Chua · Shanthi Srinivasan ·
Gillian M. Barlow · Christopher Chang

Anticuerpos Anti CdTB (Toxina citoletal distensionante)



Reacción cruzada
Vinculina en
Células Cajal
Ganglios mientéricos



Vinculina
Proteína Fundamental
Integridad estructural
Adhesion/migración
Neuronal

Alteración Motilidad
gastrointestinal

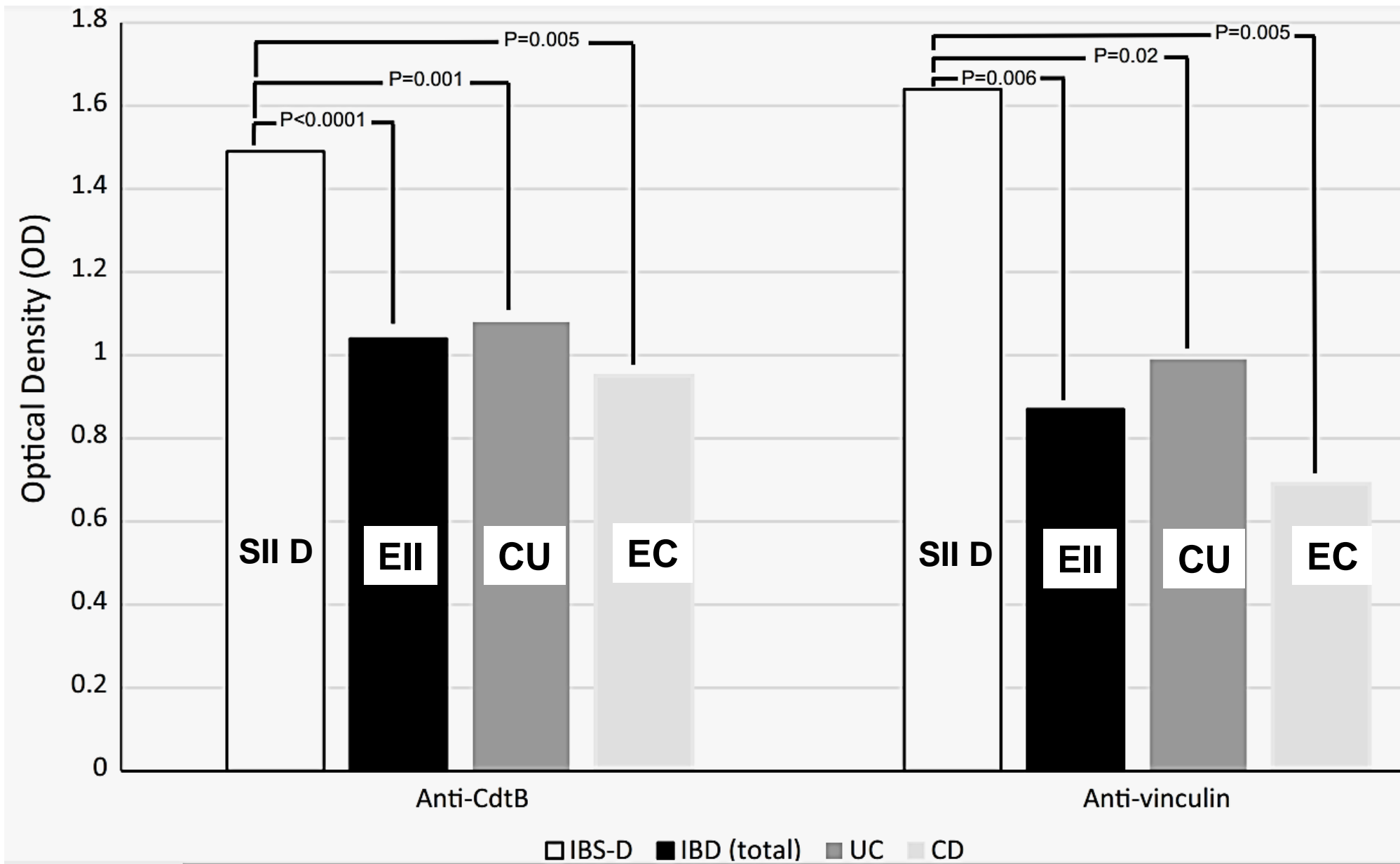


Dig Dis Sci. 2015;60:1195-205.

Second-Generation Biomarker Testing for Irritable Bowel Syndrome Using Plasma Anti-CdtB and Anti-Vinculin Levels

Walter Morales¹ · Ali Rezaie¹ · Gillian Barlow¹ · Mark Pimentel¹ 

Morales W, Dig Dis Sci. 2019;64:3115-21



Second-Generation Biomarker Testing for Irritable Bowel Syndrome Using Plasma Anti-CdtB and Anti-Vinculin Levels

Walter Morales¹ · Ali Rezaie¹ · Gillian Barlow¹ · Mark Pimentel¹ 

Test	Sensitivity	Specificity	PPV	NPV	LR+
Anti-CdtB (OD > 1.56)	43.0	93.5	95.6	33.7	6.7
Anti-vinculin (OD > 1.60)	52.0	90.9	96.3	29.4	5.7
Both antibodies positive	22	100	100	22	∞


Second-Generation Biomarker Testing for Irritable Bowel Syndrome Using Plasma Anti-CdtB and Anti-Vinculin Levels

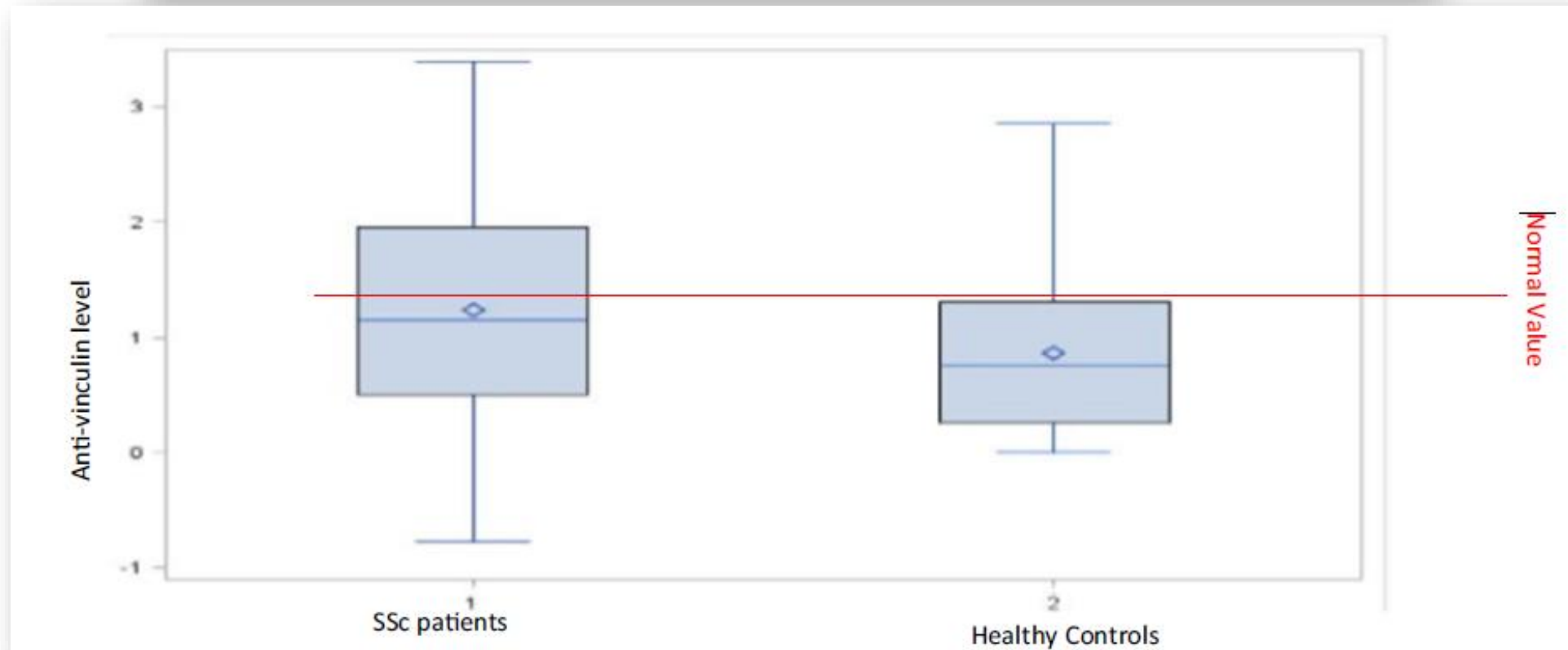
Walter Morales¹ · Ali Rezaie¹ · Gillian Barlow¹ · Mark Pimentel¹ 

Table 3 Posttest probability of IBS based on testing positive for one or both antibodies

Anti-CdtB	Anti-vinculin	Posttest probability of IBS (%)
No hay controles sanos		
+	-	89.9
-	+	88.3
+	+	98.1

Anti-vinculin antibodies in scleroderma (SSc): a potential link between autoimmunity and gastrointestinal system involvement in two SSc cohorts

Yossra Suliman^{1,2}  • Suzanne Kafaja¹ • Sunny J. Oh³ • Mohamed Alemam⁴ • Gianluca Bagnato⁵ • Giuseppina Abignano^{5,6} • Ram Raj Singh¹ • Gillian Barlow³ • Xiaochen Liu³ • Isela Valera¹ • Walter Morales³ • Ali Rezaie³ • Mark Pimentel³ • Francesco Del Galdo⁵ • Daniel E Furst^{1,7,8}



***Campylobacter* – SII Diarrea: Criterios de Bradford Hill**

Criterio	Significado	Calidad evidencia
<i>Analogía</i>	Exposiciones similares dan el efecto	Alta
<i>Gradiente biológico</i>	A mayor dosis > efecto	Moderada
<i>Coherencia</i>	El hallazgo no contradice lo demostrado	Moderada
<i>Especificidad</i>	Otras causas no están presentes	Baja
<u>Temporalidad</u>	Precede al efecto	Alta
<u>Fuerza de la Asociación</u>	Tamaño del OR, RR	Alta RR 5.6 SII vs Controles
<u>Consistencia</u>	Siempre se encuentra lo mismo	Moderada
<u>Plausibilidad biológica</u>	Fisiopatología	Alta
<u>Experimento clínico</u>	Evidencia definitiva	Moderada

SII: Diagnóstico

**Enfermedad orgánica
“Mientras se validan y llegan”
Marcadores Biológicos**



**Se hace con los “Criterios clínicos”
No es un diagnóstico de exclusión!**

SII, Criterios diagnósticos, Roma IV 2016

En ausencia de síntomas, o signos de alarma o Patologías que expliquen los síntomas

Asociado a la Defecación

Cambio en la Frecuencia heces

Cambio en la Apariencia heces

Síndrome de Intestino Irritable

SII con Diarrea
30%

Heces acuosas
>25% B/6-7
Duras <25% B1,2



SII con Estreñimiento

Heces duras
>25% B/1,2
Heces acuosas
<25%



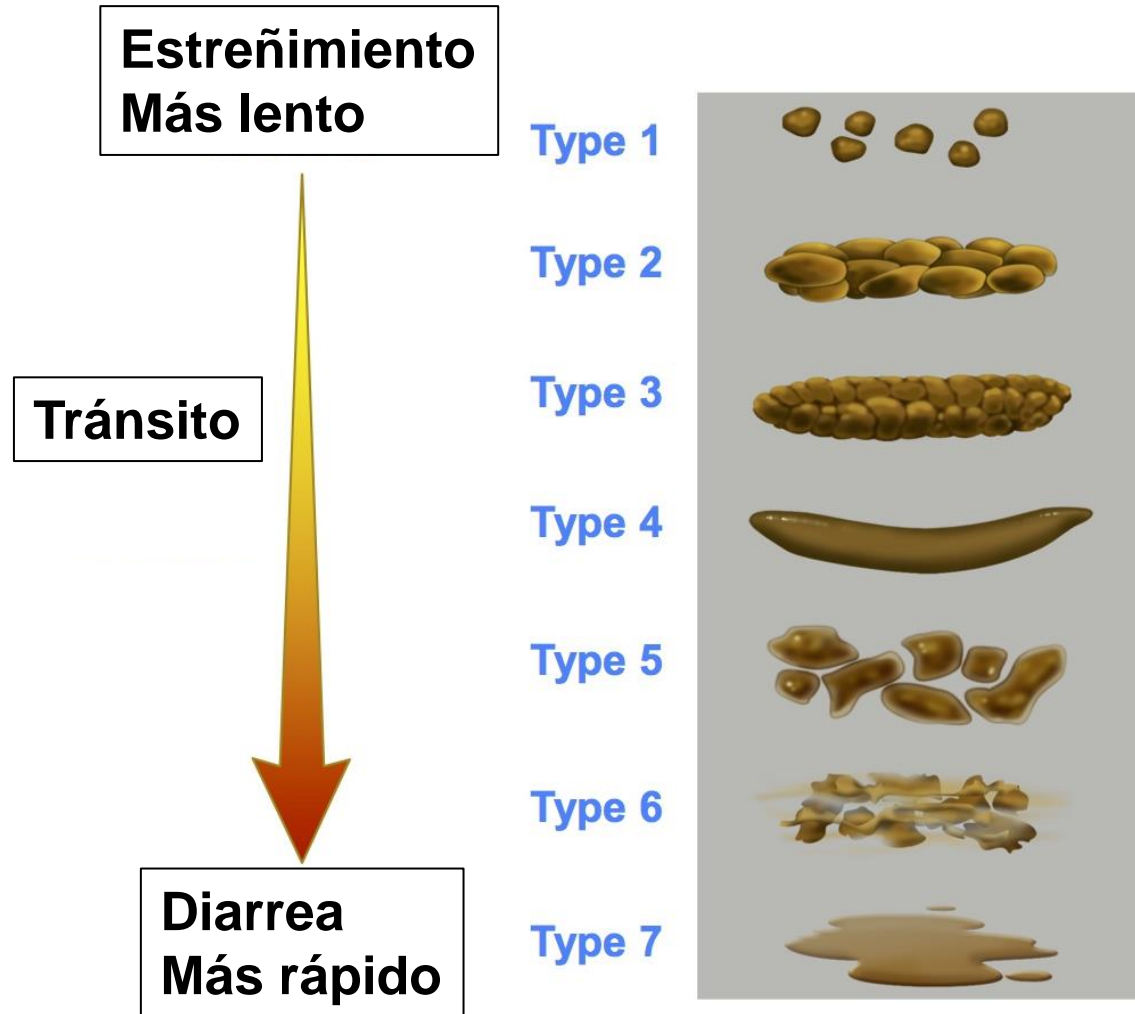
25%

Mixto

Heces duras
>25%
Heces acuosas
>25%

SII
Inclasificable
Cumple
criterios SII
heces
inclasificables

Bristol: Tiempo tránsito colónico y contenido de agua



Apoyan el diagnóstico

Dispepsia

Migraña

Cefalea

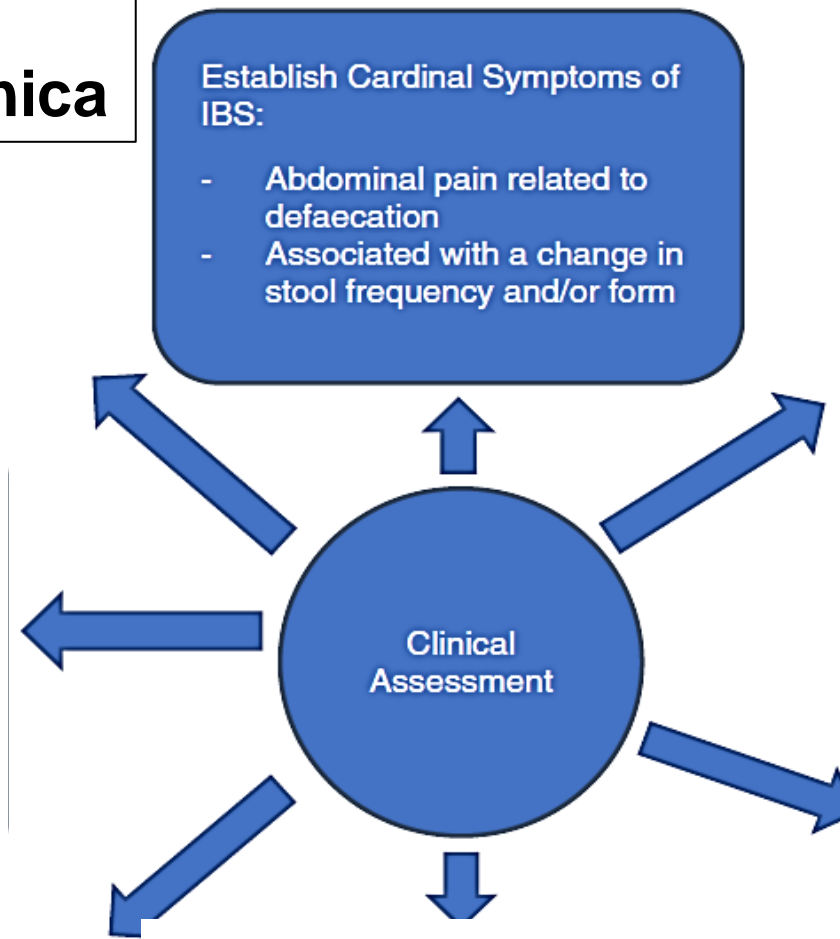
Fibromialgia

Cistitis intersticial

Dispareunia

SII diagnostico

Excelente Historia Clínica



SII Diagnóstico-Excelente historia clínica



≥ 40 años: Perdida peso, dolor abdominal
≥ 50 años: rectorragia
≥ 60 años: anemia, hábito intestinal
≤ 50 años: anemia, rectorragia, < peso

Examen físico

Masa abdominal, artropatía
Adenomegalias, ascitis
Hepato esplenomegalia
Carnett +

Lacy BE, Gastroenterology 2016;150:1393-1407

Goldstein R, Gastroenterol Clin nNorth Am 2021;50:547-63

Black CJ, Aliment Pharmacol Ther 2021;54 (Suppl.1):S33-S43

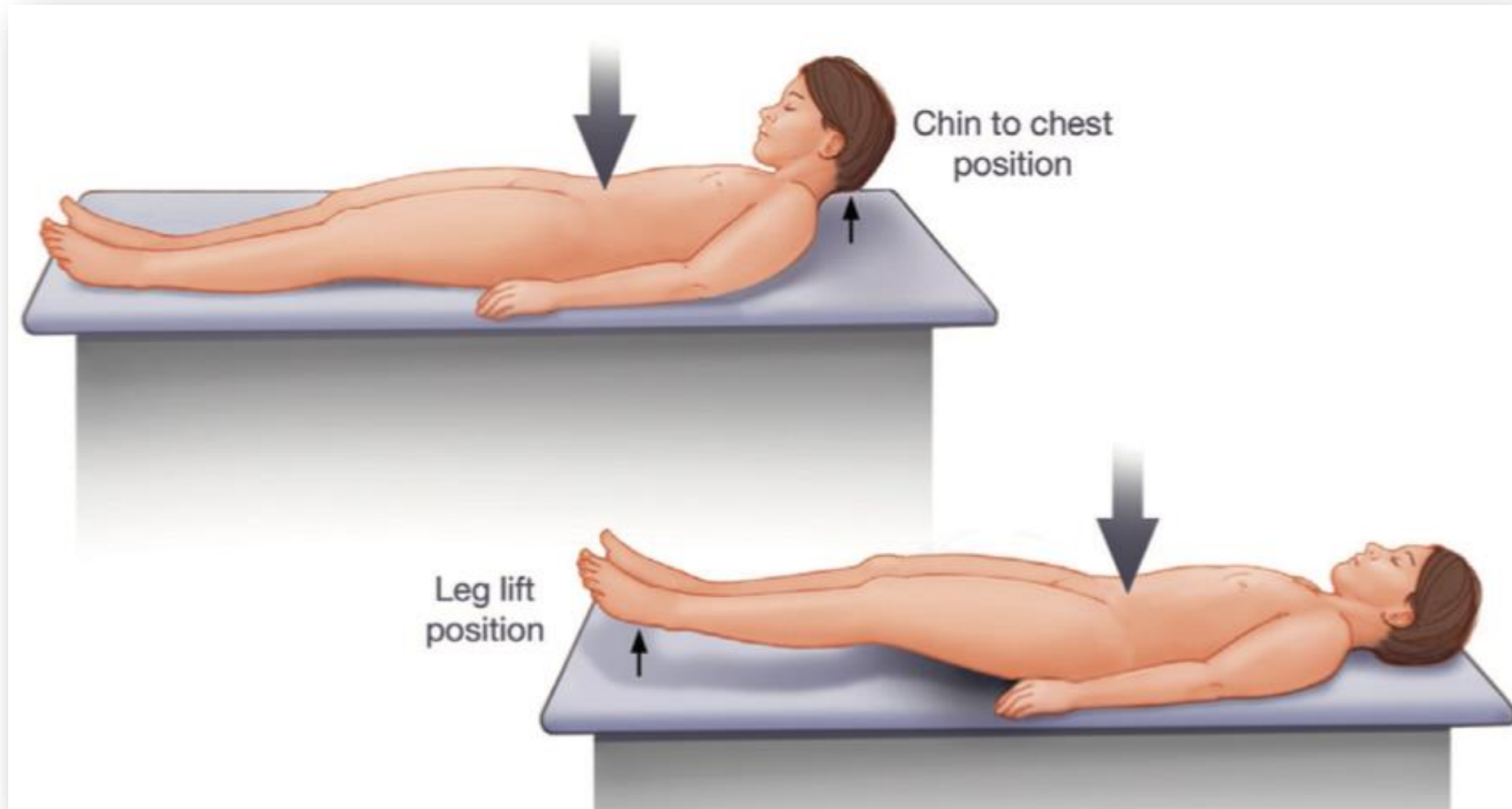
Carnett A



Carnett B



Signo de Carnett



RESEARCH

Evaluation of the clinical and cost-effectiveness of the York Faecal Calprotectin Care Pathway

James Turvill,¹ Daniel Turnock,² Hayden Holmes,³ Alison Jones,² Eleanor Mclaughlan,⁴ Victoria Hilton,⁵ Stacey Marriott⁶

< 100 mcg/gr

No alarma, Q.sanguínea

SII 98% Certeza

≥ 250 mcg/gr

Colonoscopia

Falsos (+): AINES, Obesidad, tumores

Turvill J, Frontline Gastroenterol. 2018;9:285-294

ACG Clinical Guideline: Management of Irritable Bowel Syndrome

Brian E. Lacy, PhD, MD, FACG¹, Mark Pimentel, MD, FACG², Darren M. Brenner, MD, FACG³, William D. Chey, MD, FACG⁴, Laurie A. Keefer, PhD⁵, Millie D. Long, MDMPH, FACG (GRADE Methodologist)⁶ and Baha Moshiree, MD, MSc, FACG⁷

Recommendation

We suggest that either fecal calprotectin¹ or fecal lactoferrin² and C-reactive protein¹ be checked in patients without alarm features and with suspected IBS and diarrhea symptoms to rule out inflammatory bowel disease.

¹Strong recommendation; moderate quality of evidence (CRP, fecal calprotectin).

²Strong recommendation; very low quality of evidence (fecal lactoferrin).

Colonoscopia: indicaciones

Edad >45 años

Diarrea persistente: colitis microscópica

Estreñimiento reciente en ancianos

Rectorragia, anemia, masa, Pérdida de peso

Ascitis, hepato esplenomegalia, fiebre

Masa Rectal, HF Ca de colon, EII

Roma IV

Lacy BE, Am J Gastroenterol 2021;116:17-44



Adultos mayores

Cáncer de colon

Isquemia colónica

E. Inflamatoria Intestinal

Colitis microscópica

Diverticulitis

Clostridioides difficile

Enf diverticular sintomática no complicada

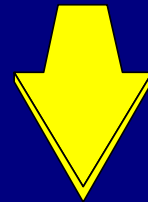
**SII como diagnóstico
de exclusión**

**Diagnóstico
Exclusión**

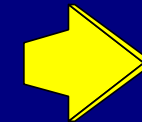


Antigüedad

**Cuadro hemático completo
PCR, Albumina, ALT, AST,
Bilirrubinas F. alcalina
TSH, Acs Transglutaminasa tisular
Test genético lactasa
Tres coprológicos,
Sigmoidoscopia con biopsias**



Todo negativo



**Síndrome
Intestino
irritable**

Diagnóstico positivo no de exclusión

***Laboratorios
Colonoscopia
Caso por caso***

***Examen
Físico***

***Historia
Clínica***

Roma IV

A Positive Diagnostic Strategy Is Noninferior to a Strategy of Exclusion for Patients With Irritable Bowel Syndrome

LUISE M. BEGTRUP,^{*,‡} ANNE LINE ENGSBRO,[§] JENS KJELDEN,^{*} PIA V. LARSEN,[‡]
OVE SCHAFFALITZKY DE MUCKADELL,^{*} PETER BYTZER,[§] and DORTE E. JARBØL[‡]

Aleatorizado, Cabeza a cabeza, Seguimiento un año




Costo anual US\$

Positivo
3.160
C. Hemático
PCR

Exclusión
5.075
Múltiples
Exámenes

A positive diagnostic strategy is safe and saves endoscopies in patients with irritable bowel syndrome: A five-year follow-up of a randomized controlled trial

Anne Line Engsbro^{1,2}  | Luise M. Begtrup^{3,4} | Peter Haastrup⁴ | Maria Munch Storsveen⁴ | Peter Bytzer¹ | Jens Kjeldsen⁵ | Ove Schaffalitzky De Muckadell⁵ | Dorte Ejg Jarbøl⁴

13 vs 23

Engsbro AL, Neurogastroenterol Motil. 2021;33:e14004

ACG Clinical Guideline: Management of Irritable Bowel Syndrome

Brian E. Lacy, PhD, MD, FACP¹, Mark Pimentel, MD, FACP², Darren M. Brenner, MD, FACP³, William D. Chey, MD, FACP⁴, Laurie A. Keefer, PhD⁵, Millie D. Long, MDMPH, FACP (GRADE Methodologist)⁶ and Baha Moshiree, MD, MSc, FACP⁷

Lacy BE, et al. Am J Gastroenterol 2021;116:17-44.

British Society of Gastroenterology guidelines on the management of irritable bowel syndrome

Dipesh H Vasant ,^{1,2} Peter A Paine,³ Christopher J Black ,⁴
Lesley A Houghton ,^{5,6} Hazel A Everitt,⁷ Maura Corsetti,⁸ Anurag Agrawal,⁹
Imran Aziz ,¹⁰ Adam D Farmer,^{11,12} Maria P Eugenicos,¹³ Rona Moss-Morris,¹⁴
Yan Yiannakou,¹⁵ Alexander C Ford ¹⁶

Vasant DH, et al. Gut. 2021 Jul;70(7):1214-1240

**Diagnóstico
Positivo**

Roma IV en 2022

ORIGINAL RESEARCH

Comparison of the Rome IV criteria with the Rome III criteria for the diagnosis of irritable bowel syndrome in secondary care

Christopher J Black ,^{1,2} Orla Craig,¹ David J Gracie ,¹ Alexander C Ford  ^{1,2}

Roma IV versus Roma II

	Specificity (95% CI)	Positive likelihood ratio (95% CI)	Positive predictive value (95% CI)
Rome IV criteria for IBS	82.9% (74.8% to 89.2%)	4.82 (3.30 to 7.28)	94.9% (92.3% to 96.9%)
Rome IV criteria for IBS with constipation	97.0% (84.2% to 99.9%)	25.7 (5.07 to 145)	98.9% (93.9% to 99.9%)
Rome IV criteria for IBS with diarrhoea	60.5% (44.4% to 75.0%)	2.07 (1.48 to 3.12)	88.4% (82.0% to 93.1%)
Rome IV criteria for IBS with mixed bowel habits	92.0% (74.0% to 99.0%)	10.6 (3.39 to 38.2)	98.6% (95.2% to 99.8%)
Rome III criteria for IBS	65.0% (54.6% to 74.4%)	2.45 (1.90 to 3.27)	90.4% (86.9% to 93.3%)

Enfermedad orgánica en pacientes con SII

	Met Rome IV criteria for IBS (n=395)	Met Rome III criteria for IBS (n=355)
Total with organic disease (%)	19 (4.8)	17 (4.8)
Small bowel Crohn's disease (%)	1 (0.3)	0 (0)
Microscopic colitis (%)	1 (0.3)	1 (0.3)
Bile acid diarrhoea (%)	14 (3.5)	13 (3.7)
Moderate (5.0%–9.9% retention)	9	9
Severe (<5.0% retention)	5	4
Exocrine pancreatic insufficiency (%)	3 (0.8)	3 (0.8)

Estar alerta en diarrea

Black CJ, et al. Gut 2021;70:1110-6

SII -Diarrea

Enfermedad
Celíaca

Diarrea Que
No mejora
Serología
EVDA
Otro DX

Colitis
Microscópica

SII

Mala-absorción
Sales biliares

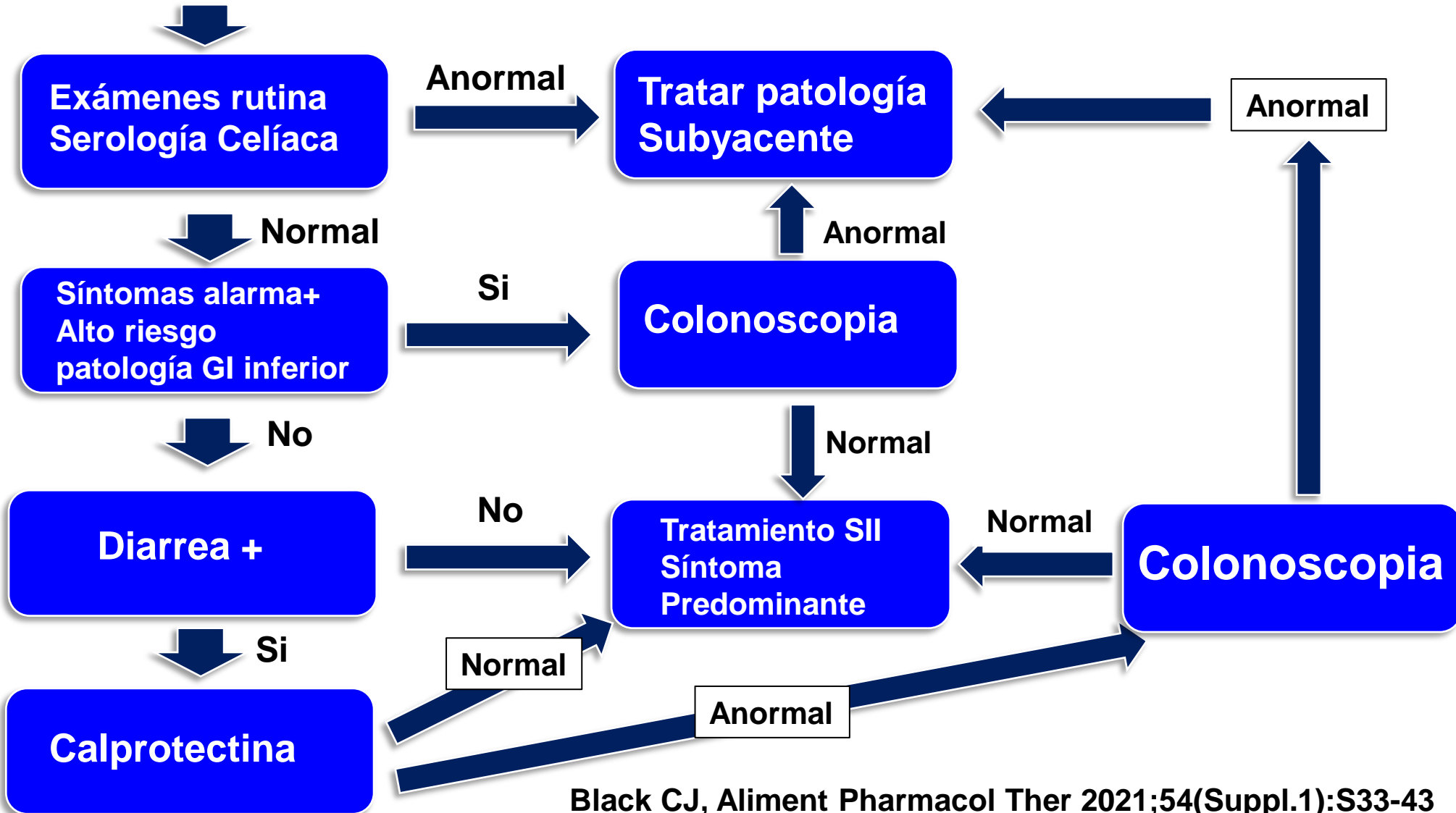
E. celíaca
Dolor,
distensión
Bloating
Diarrea

Enfermedad
Inflamatoria
Intestinal

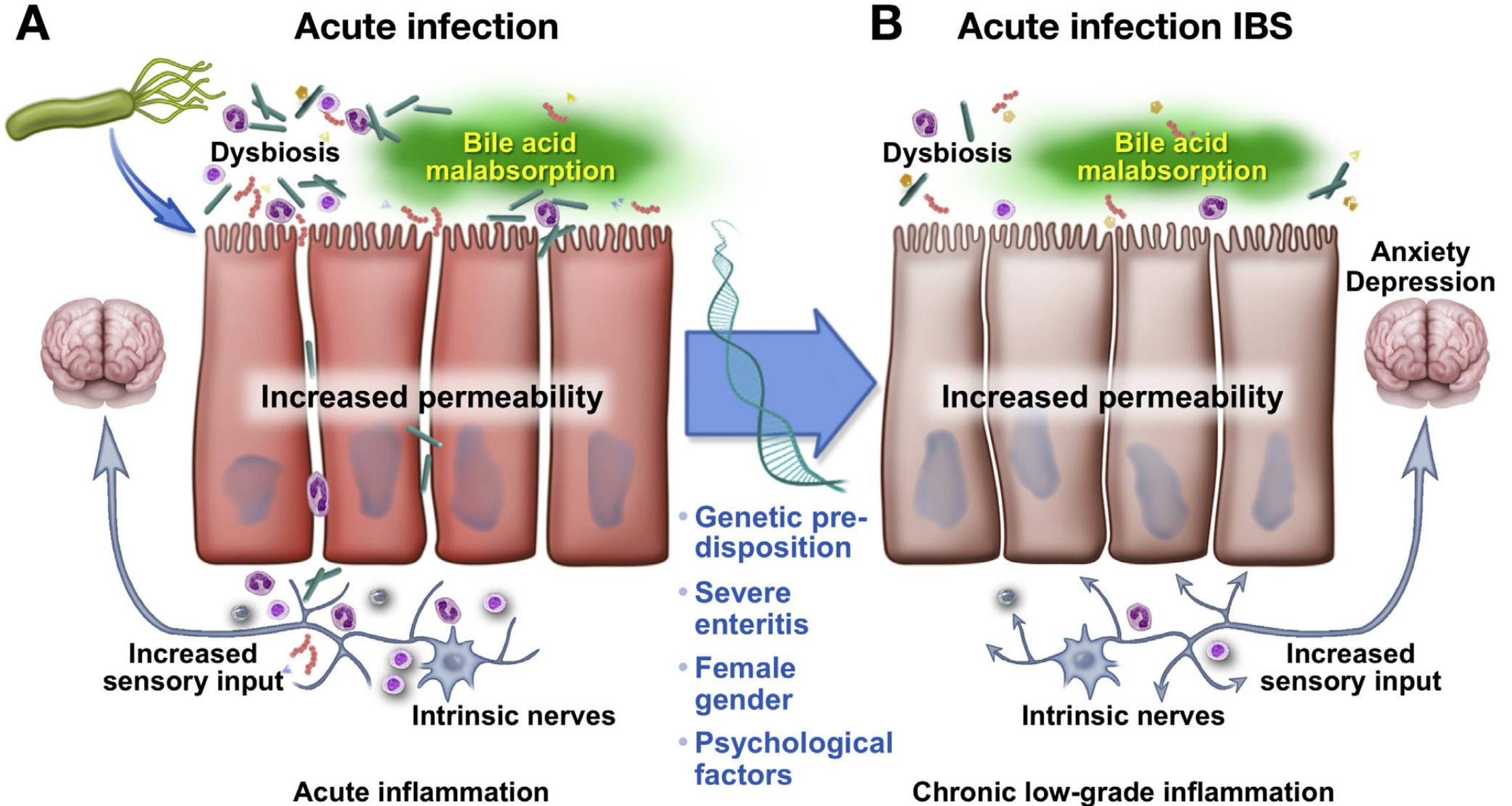
Roma IV

Sospecha De SII

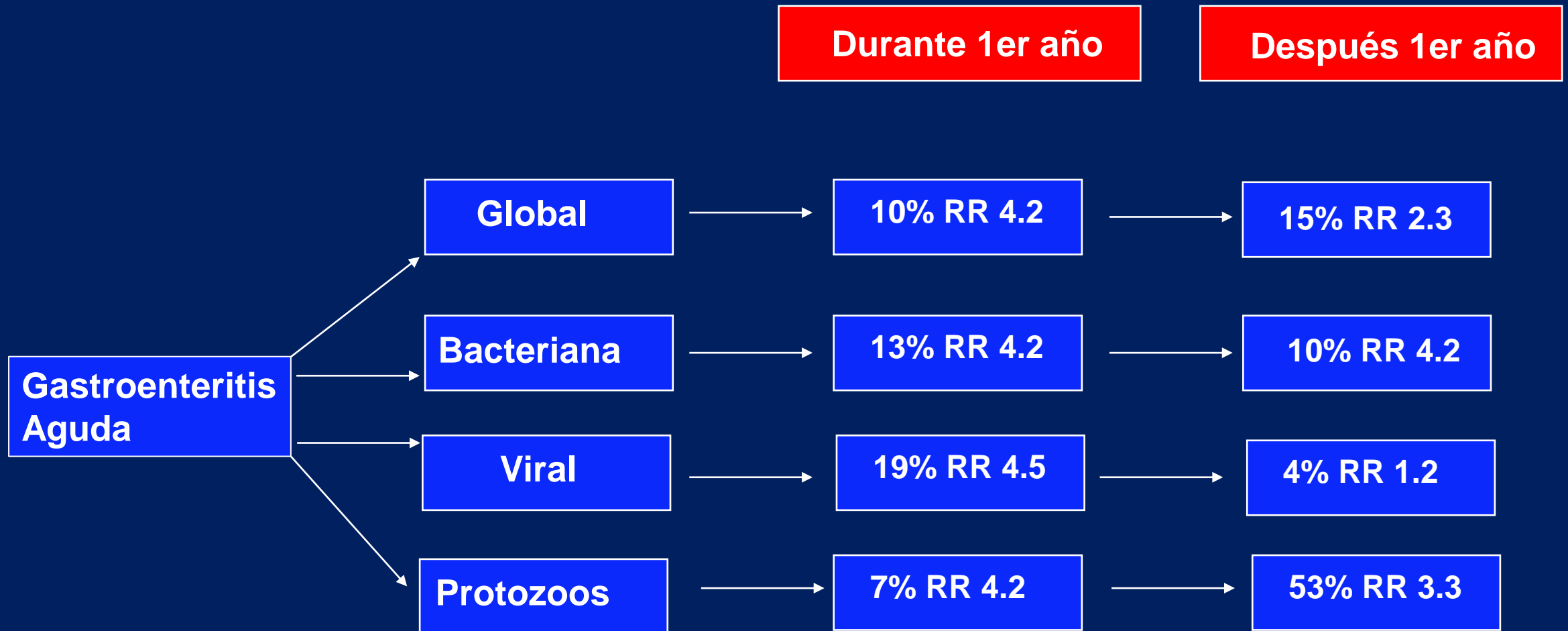
**Cuadro clínico
SII Roma IV**



Pos infeccioso: la mejor evidencia de organicidad



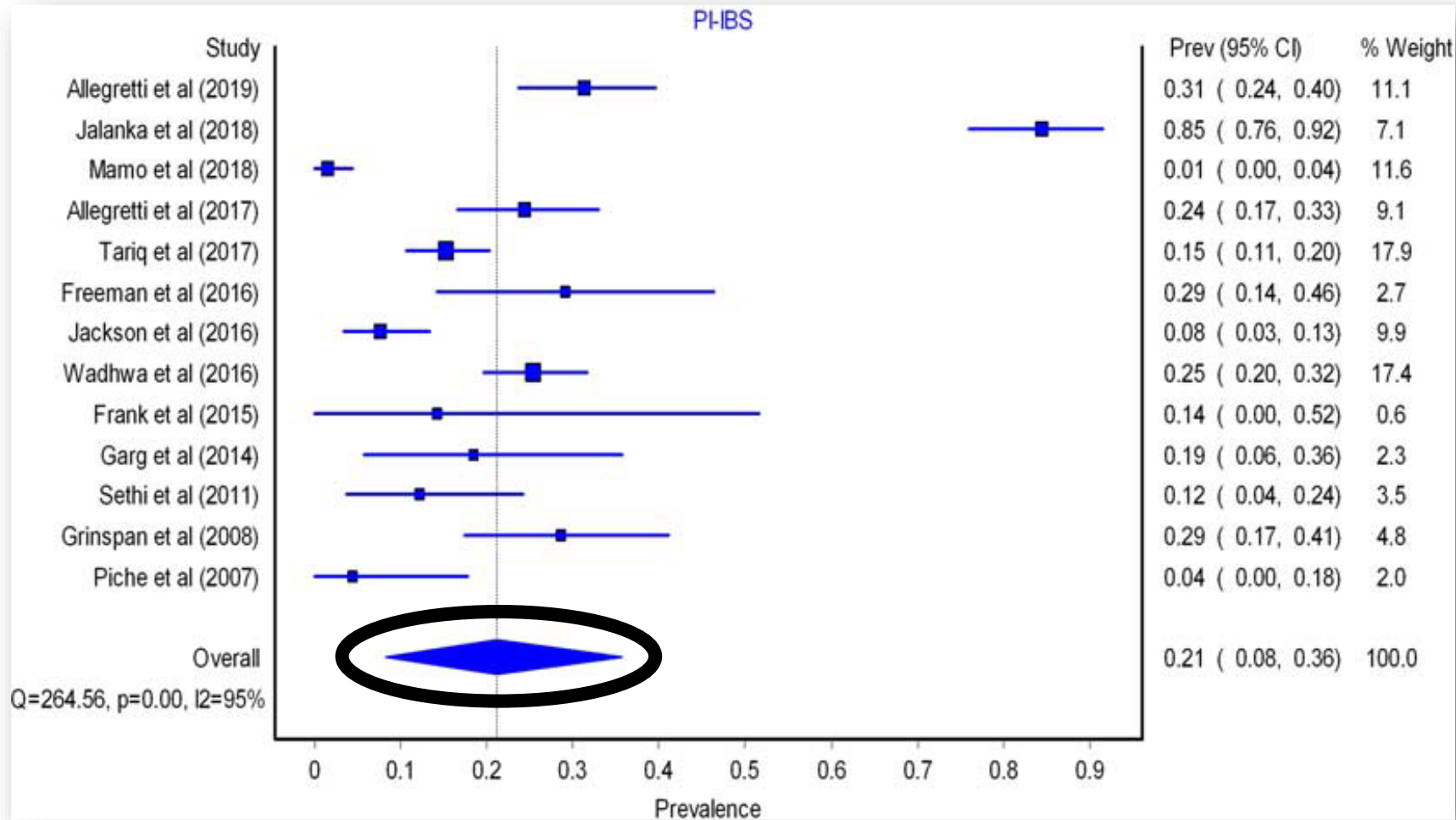
SII pos infeccioso



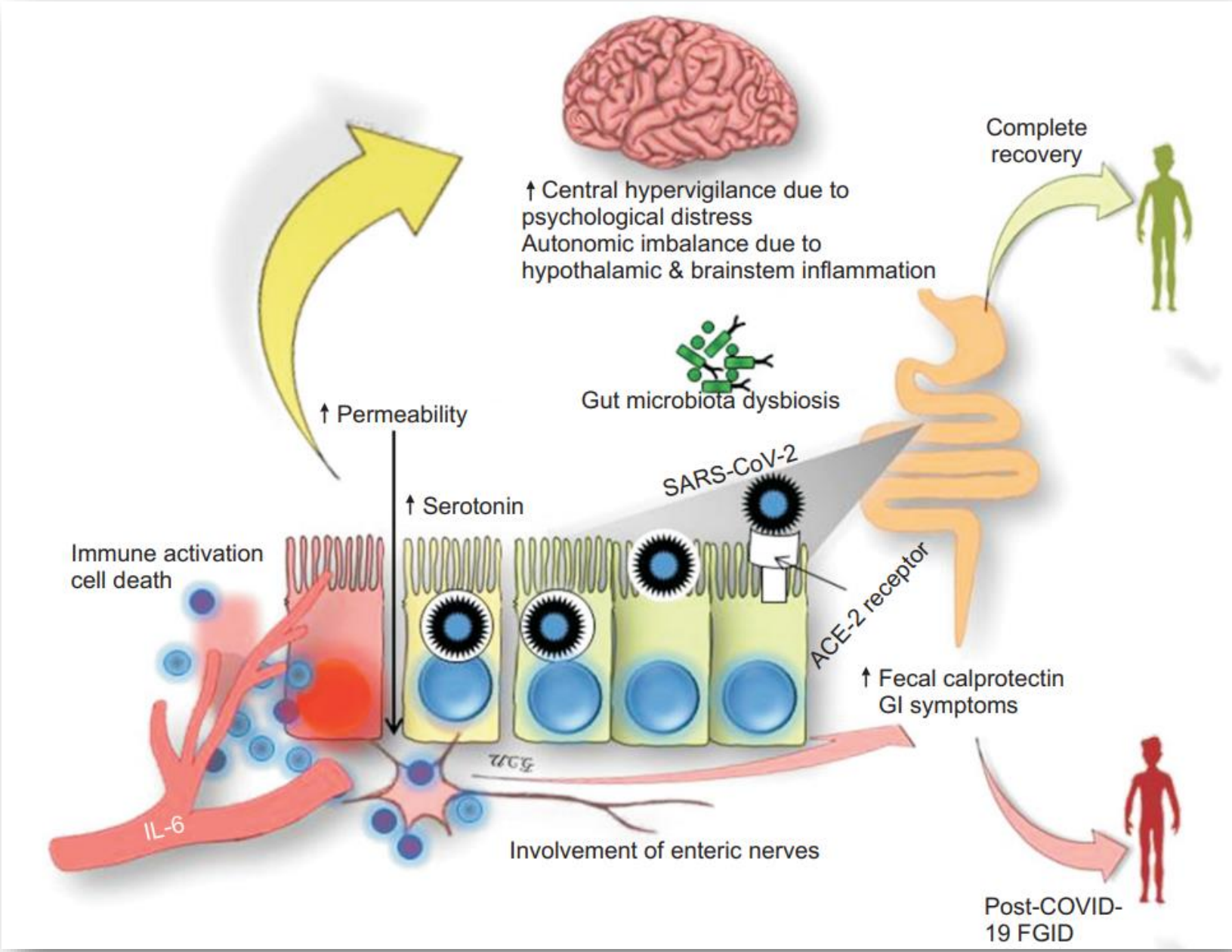
Postinfection Irritable Bowel Syndrome Following *Clostridioides difficile* Infection

A Systematic-review and Meta-analysis

Srishti Saha, MBBS, MD,* Kanika Sehgal, MBBS,*
Sumitabh Singh, MBBS, MD,† Madhusudan Grover, MBBS,*
Darrell Pardi, MD, MS,* and Sahil Khanna, MBBS, MS*



**SII
Pos COVID-19**



SII

Tratamiento

Medicamentos

Múltiples alteraciones orgánicas
Autoinmunidad, eje intestino cerebro



SII Médico Correcto



**SII: no es una
Enfermedad psicológica**

**SII: ES una
Enfermedad real**

**Profundo Impacto
Calidad vida**

**No predispone
Cáncer colon,
Colitis ulcerativa
E. De Crohn**

Ruddy J, Aliment Pharmacol Ther. 2021;54(Suppl. 1):S44–S52.



Subtipos SII y Tratamiento

Estreñimiento

Lubiprostone
Linaclotide
Psyllium ?
Polietilen glicol ?

Diarrea

Rifaximina
Eluxadoline
Loperamida ?
Ondansetron ?
Triciclicos ?
Baja FODMAP??

**No es
Un remedio
para el colon!**

**Alteración
función
intestinal**

**Dolor,
Malestar
abdominal**

**Bloating
Distensión
Abdominal**

Bromuro Pinaverio
Bromuro Otilonium
Menta oleosa ?
Triciclicos ?
ISRS ?

Rifaximina
Br Pinaverio
Br Otilonium
Dieta baja en FODMAP??
Probioticos ??

1ª línea

Antiespasmódicos

**Relajan músculo
liso intestinal**

**Black CJ, et al. Lancet Gastroenterol Hepatol 2020; 5:117-31.
Ford AC, et al. BMJ 2008;337:a2313**

Anti-Espasmódicos

Bromuro Pinaverio

Bromuro Otilonium

Menta oleosa

Masuy I, Minerva Gastroenterol Dietl 2020;66:136-50

Dolor

```
graph TD; Dolor[Dolor] --> AntiEspasmodicos[Anti-Espasmódicos]; Dolor --> Antibiotico[Antibiótico];
```

Trimebutina = Placebo

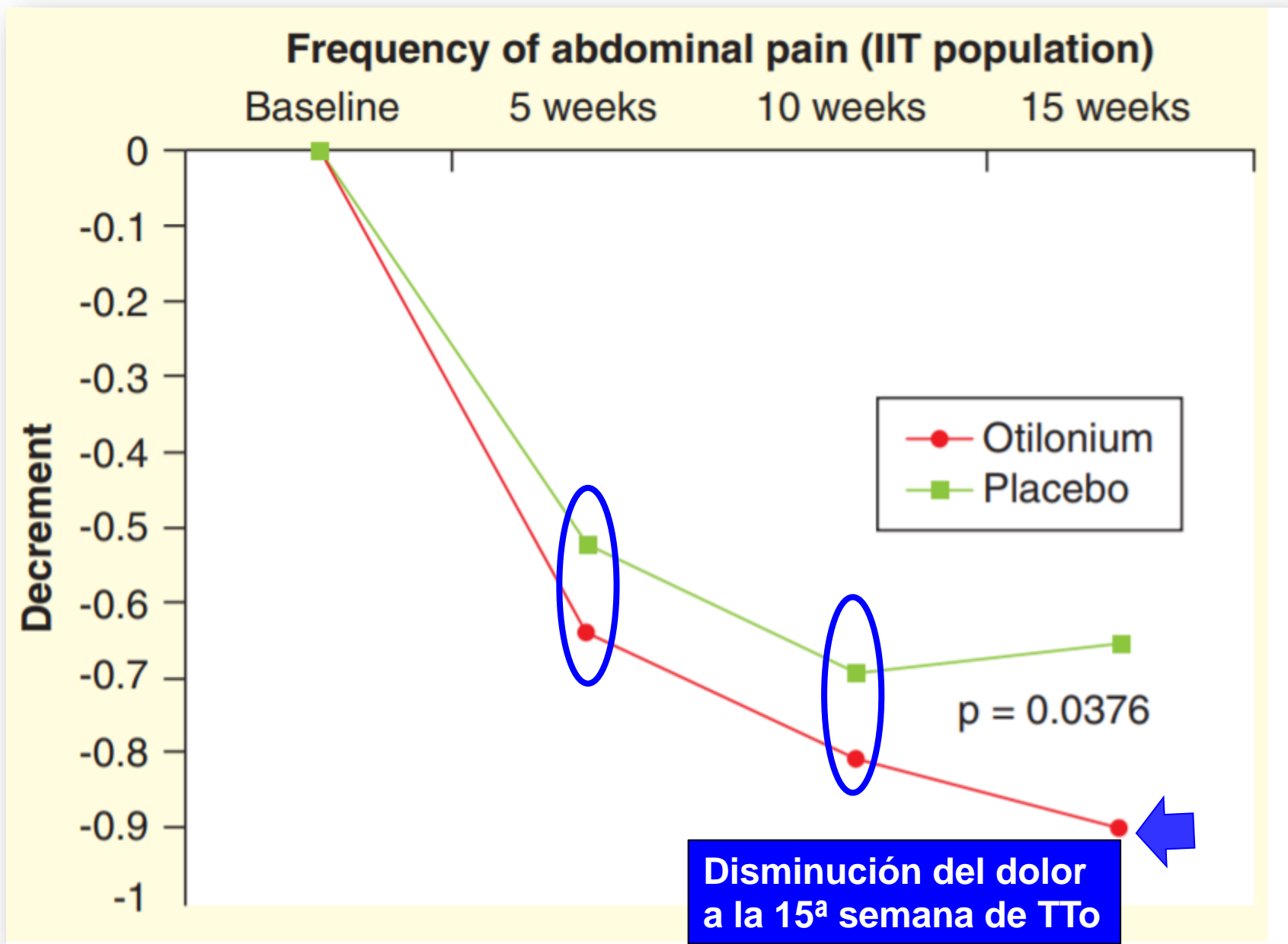
Mebeverina = Placebo

Antibiótico

Rifaximina

Poynard T, Aliment Pharmacol Ther 2001;15:355-61

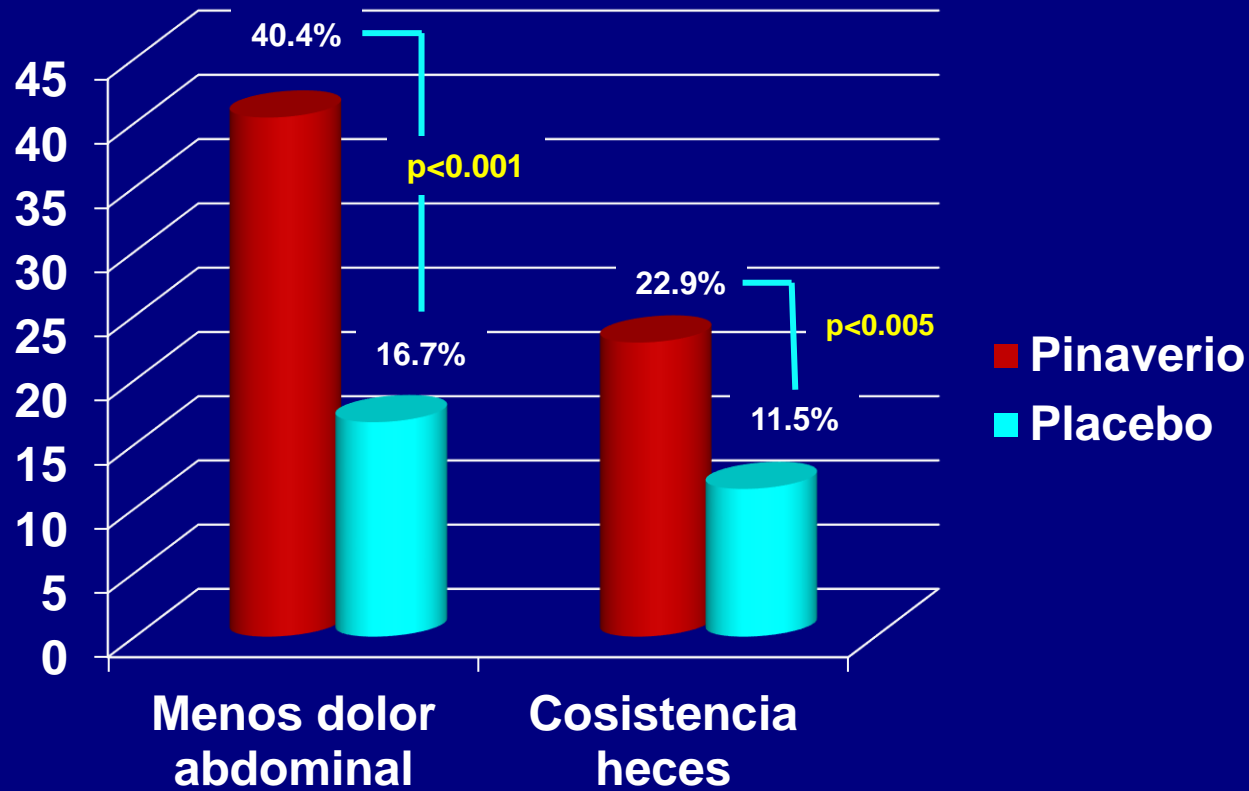
Bromuro De Otilonium



Pinaverium Reduces Symptoms of Irritable Bowel Syndrome in a Multicenter, Randomized, Controlled Trial

Liang Zheng,^{*} Yaoliang Lai,[‡] Weimin Lu,[§] Baiwen Li,^{||} Heng Fan,[¶] Zhixiang Yan,[#]

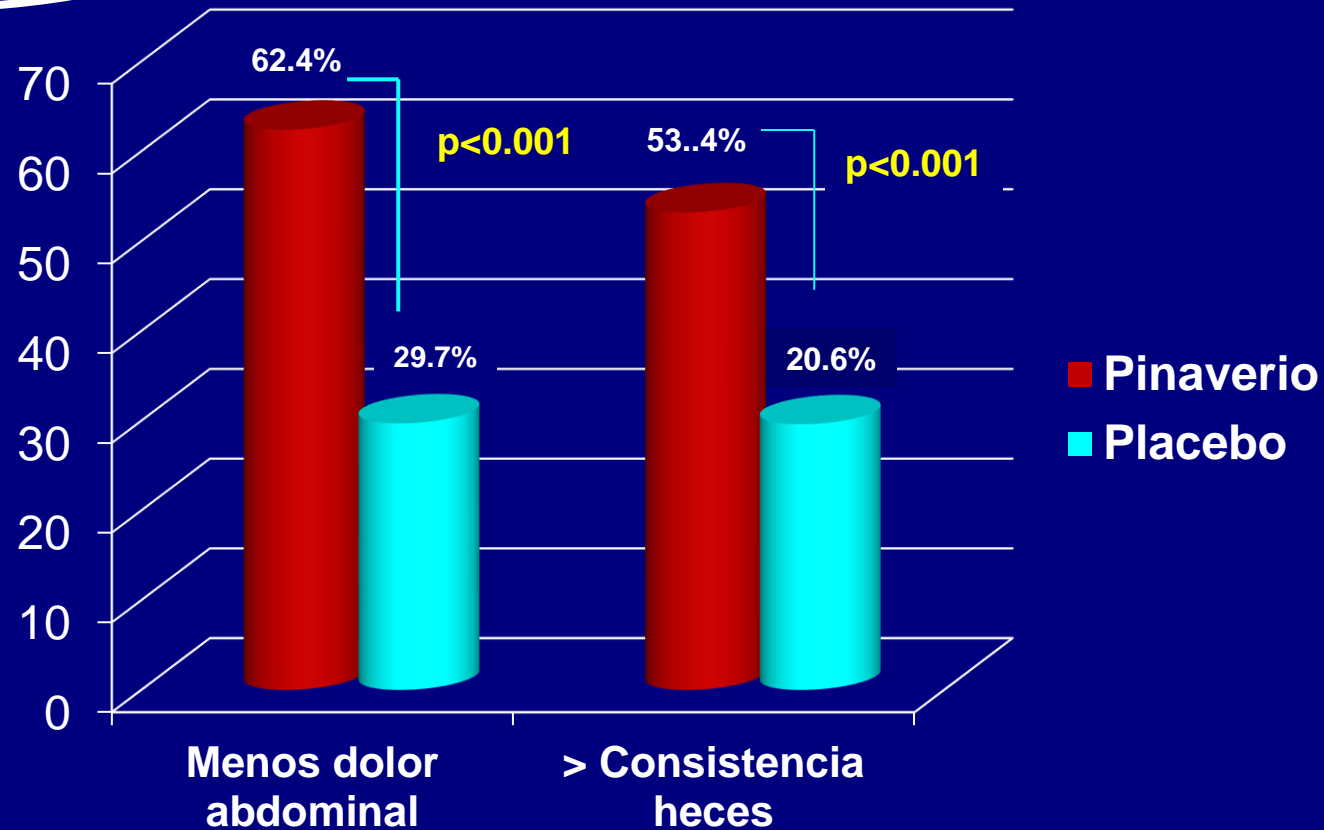
Dos semanas



Pinaverium Reduces Symptoms of Irritable Bowel Syndrome in a Multicenter, Randomized, Controlled Trial

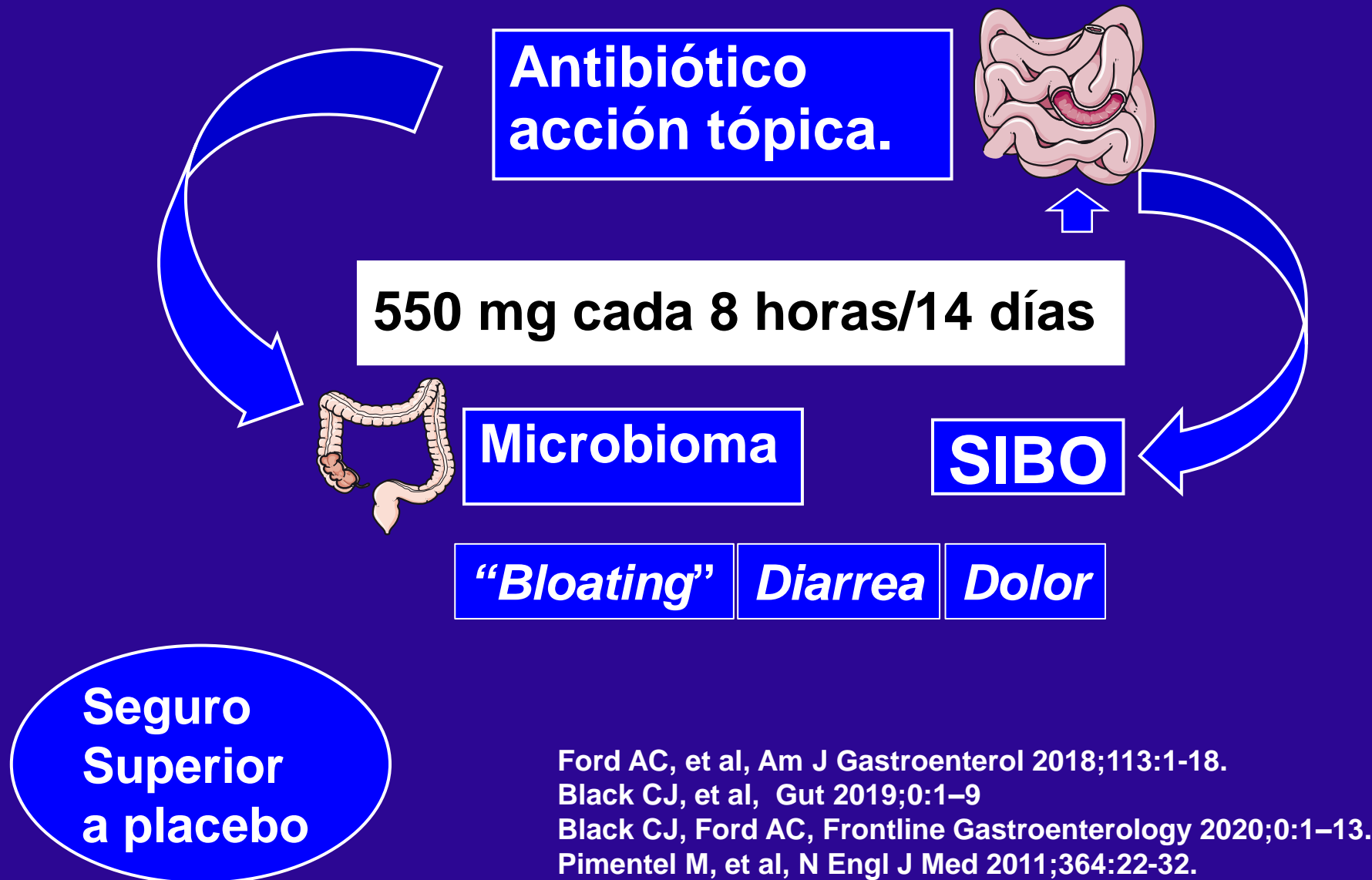
Liang Zheng,^{*} Yaoliang Lai,[‡] Weimin Lu,[§] Baiwen Li,^{||} Heng Fan,[¶] Zhixiang Yan,[#]

4 semanas



1ª línea SII

Rifaximina



SII Estreñimiento

ACG Clinical Guideline: Management of Irritable Bowel Syndrome

Brian E. Lacy, PhD, MD, FACP¹, Mark Pimentel, MD, FACP², Darren M. Brenner, MD, FACP³, William D. Chey, MD, FACP⁴, Laurie A. Keefer, PhD⁵, Millie D. Long, MDMPH, FACP (GRADE Methodologist)⁶ and Baha Moshiree, MD, MSc, FACP⁷

We recommend the use of chloride channel activators to treat global IBS-C symptoms.

Strong recommendation; moderate quality of evidence.

We recommend the use of guanylate cyclase activators to treat global IBS-C symptoms.

Strong recommendation; high quality of evidence.

We suggest that the 5-HT₄ agonist tegaserod be used to treat IBS-C symptoms in women younger than 65 years with ≤ 1 cardiovascular risk factors who have not adequately responded to secretagogues.

Conditional recommendation; low quality of evidence.

We suggest against the use of PEG products to relieve global IBS symptoms in those with IBS-C.

Conditional recommendation; low quality of evidence

SII Anti espasmodicos Rifaximina

Prucalopride
8mcg 2v/d
Plecanatide 3mg

Linacotide 290 mcg
Plecanatide 3mg

Tegaserod
6 mg 2v/día

**Insuficiente
Evidencia**

PEG Nosotros Si

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Recommendation

We suggest that anorectal physiology testing be performed in patients with IBS and symptoms suggestive of a pelvic floor disorder and/or refractory constipation not responsive to standard medical therapy.

Consensus recommendation; unable to assess using GRADE methodology

Estreñimiento-Síntoma

Estreñimiento Funcional

Disminución tránsito colónico
< Contracciones alta amplitud
Tránsito lento
Disinergia piso pélvico

*Microbiota
Metanogénica
Defecación
Disinérgica
Responden similar*

SII Estreñimiento

Hipersensibilidad visceral
Alodinia, hiperalgesia
> Permeabilidad
SIBO
Disinergia piso pélvico

Myths and Misconceptions About Constipation: A New View for the 2020s

Kyle Staller, MD, MPH¹ and Brooks D. Cash, MD²

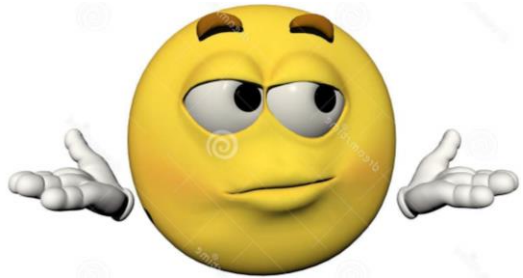
Mito #2:

El estreñimiento crónico funcional es diferente a SII-Estreñimiento

**SII con
Estreñimiento ?**



**Estreñimiento
Funcional ?**



**Tranquilo:
Mientras la ciencia lo descubre**

Los remedios son similares

El dolor requiere otros medicamentos

Mo1329 — 2020 AGA
RIFAXIMIN IS EFFICACIOUS FOR THE TREATMENT OF IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) IN ADULTS PREVIOUSLY TREATED WITH OTHER IBS MEDICATIONS

[View PDF \(497 Kb\)](#)

Stomach and Small Bowel Disorders
Irritable Bowel Syndrome: Clinical
 Presented on Monday, May 4, 2020 12:30 PM

**SII sin respuesta a
Otros tratamientos**

**SII que no
Responde a Nada
Responde a
Rifaximina**

Author(s): Satish S. Rao¹, Philip S. Schoenfeld^{2,5}, Alan D. Geibel³, Peter F. Lan⁴

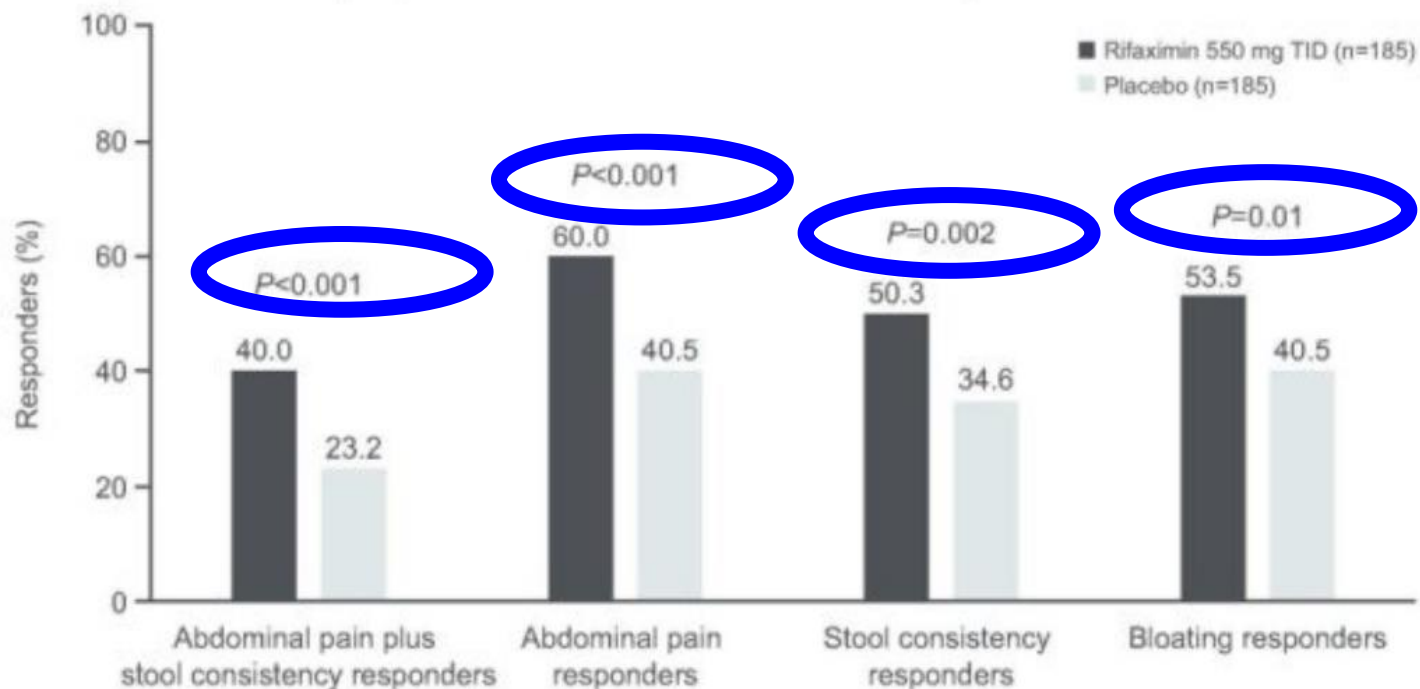
¹ Augusta University, Augusta, Georgia, United States
² Harborview Medical Center, Los Angeles, California, United States
³ Center, Detroit, Michigan, United States

Background: Antidiarrheals and antispasmodics are commonly used for the treatment of IBS. Rifaximin is indicated in the US for the treatment of IBS-D. This study assessed efficacy of two 2-week courses of rifaximin in patients with a history of prior IBS medication use. **Methods:** In a phase 3, randomized, double-blind, repeat-treatment phase of TARGET 3, patients were randomized to receive either open-label (OL) rifaximin 550 mg three times daily (TID) or placebo. The primary endpoint was the percentage of patients with a $\geq 30\%$ decrease from baseline in mean weekly Bristol Stool Scale type 6/7 stool during the 2-week treatment-free observation phase. Secondary endpoints included the percentage of patients with a composite response, individual component responses, and the percentage of patients with a medical history of IBS medication use. **Results:** In the OL population (n=2579), the percentage of patients with a composite response was 62.2% with rifaximin vs 48.1% with placebo. In the DB, repeat-treatment phase, the percentage of patients with a composite response was 62.2% with rifaximin vs 40.5% with placebo. **Conclusions:** Two-week courses of rifaximin are efficacious for the treatment of IBS-D in patients with a history of prior IBS medication use. Thus, rifaximin can be used as a first-line treatment for IBS-D in patients with a history of prior IBS medication use.

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Conclusions: Two-week courses of rifaximin are efficacious for the treatment of IBS-D in patients with a history of prior IBS medication use. Thus, rifaximin can be used as a first-line treatment for IBS-D in patients with a history of prior IBS medication use.

Figure. Response in Patients With History of Prior IBS Medication Use (Double-Blind, Repeat-Treatment Phase of TARGET 3)



IBS = irritable bowel syndrome; TARGET = Targeted, nonsystemic Antibiotic Rifaximin Gut-selective Evaluation of Treatment for IBS with diarrhea; TID = 3 times daily.

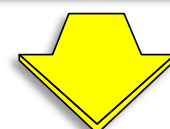
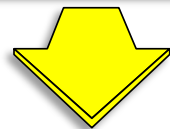
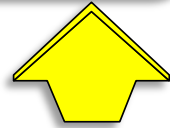
Antibióticos

**Dieta baja
en FODMAP**

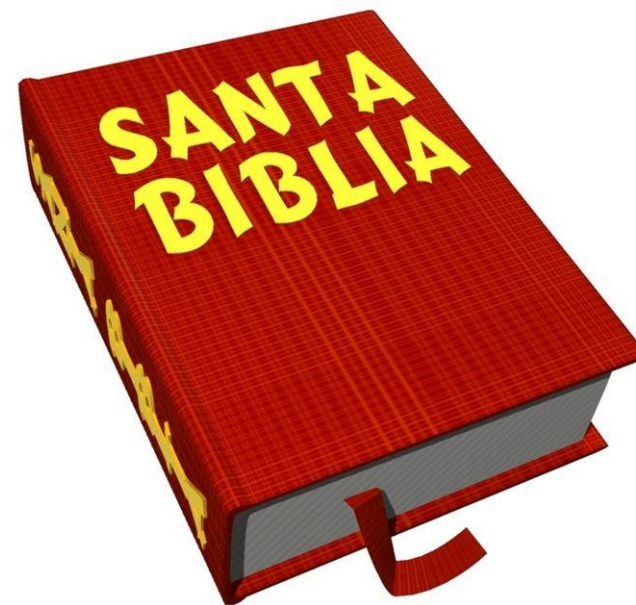
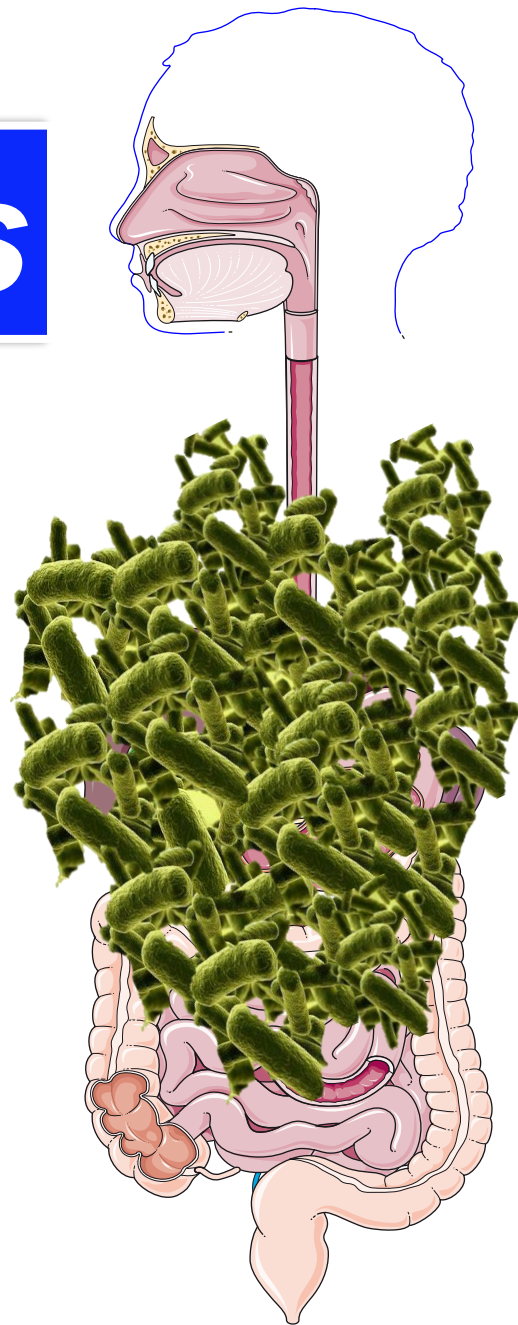
**Microbioma un
Blanco terapéutico**

**Trasplante
Fecal**

Probióticos



Probióticos



**“Mucha fe,
Pocas obras”**

AGA Technical Review on the Role of Probiotics in the Management of Gastrointestinal Disorders



Geoffrey A. Preidis,¹ Adam V. Weizman,² Purna C. Kashyap,³ and Rebecca L. Morgan⁴

¹Section of Gastroenterology, Hepatology and Nutrition, Department of Pediatrics, Baylor College of Medicine and Texas Children's Hospital, Houston, Texas; ²Division of Gastroenterology, Mount Sinai Hospital, Department of Medicine, University of Toronto, Toronto, Ontario, Canada; ³Enteric Neuroscience Program, Division of Gastroenterology and Hepatology, Mayo Clinic, Rochester, Minnesota; and ⁴Health Research Methods, Evidence and Impact, McMaster University, Hamilton, Ontario, Canada

The overall CoE across all critical outcomes for probiotics for the treatment of children and adults with IBS was Low.

Solamente en el contexto de ensayos clínicos

ACG Clinical Guideline: Management of Irritable Bowel Syndrome

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Recommendation

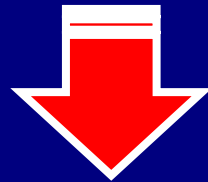
We suggest against probiotics for the treatment of global IBS symptoms.

Conditional recommendation; very low level of evidence.

SII Tratamiento



**Ningún tratamiento es eficaz
en todos los pacientes**



Tratamiento combinado
Anti-espasmódicos +
Anti diarrea o Anti estreñimiento

Mensajes para la casa

SII enfermedad orgánica

No es una enfermedad psicológica

Altera la calidad de vida

Se diagnostica con criterios de Roma IV

Tratamiento es personalizado

Bromuro de Pinaverio dolor, Bloating

Rifaximina dolor diarrea, “bloating”

¡ A la m...¡¡ SOY BATMAN!!!



**El Síndrome de Intestino irritable
Es colon inflamado**

¡ A la m!.....¡ Ya no SOY BATMAN!!!



**El Síndrome de Intestino irritable
Es más complejo! No es colon inflamado!**

En SII

**Los criterios de Roma IV
deben seguir siendo el
“Gold standard” en 2022**

Muchas gracias!