EXMI

BY PROCAPS GRUPO

¿CUAL ES EL IBP IDEAL?

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IBP ideal 2023

Seguro
Eficaz
Disponible
Rápida acción
Independiente de CYP2C19
Independiente de las comidas

Mossner J, Dtsch Artztebl Int 2016;113:477-83
Targownik L, Am J Gastroenterol 2018;113:519-28
Otero W, “El estómago” Aristizabal G (edit):2022:20-98

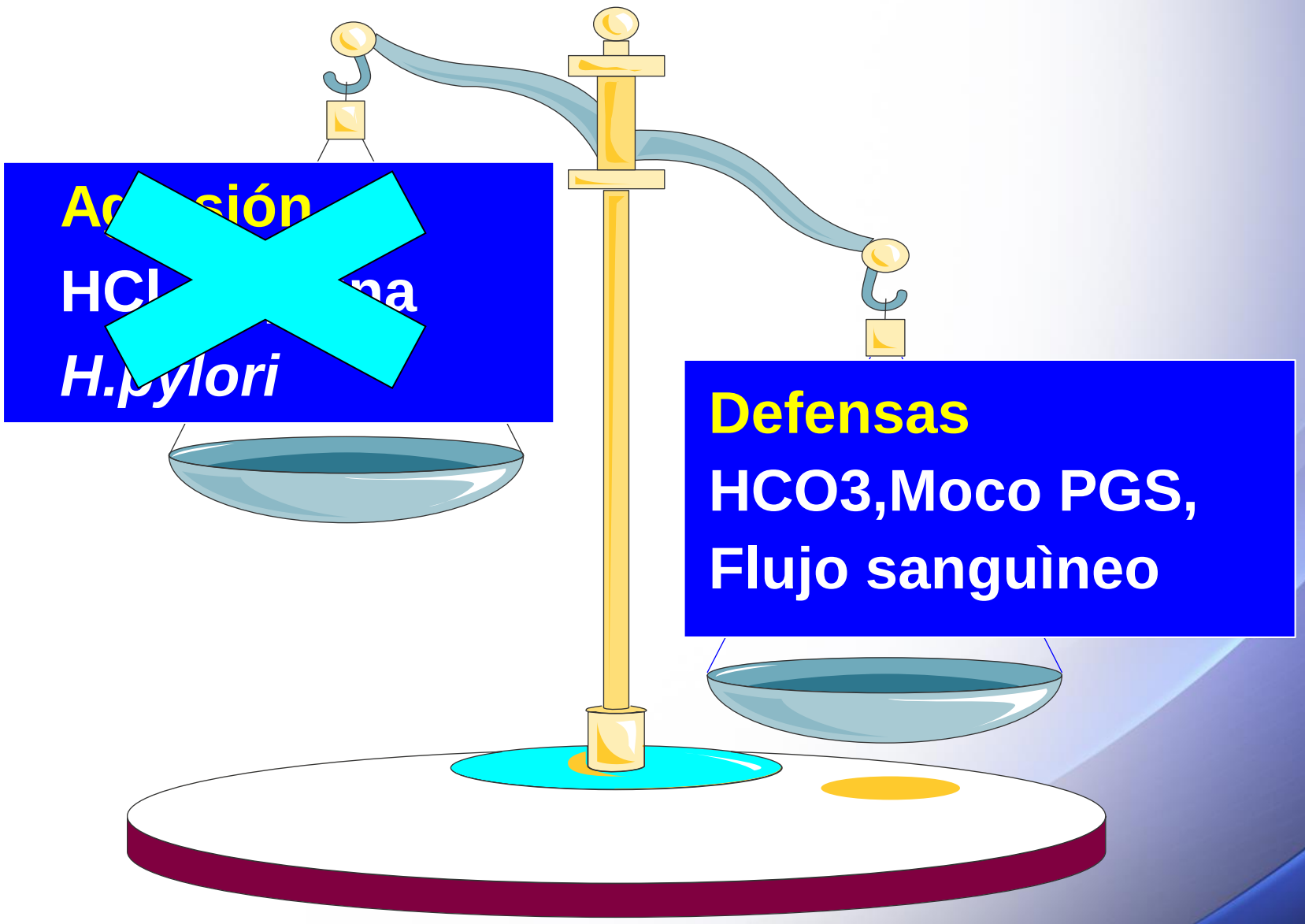
Enfermedad ácido péptica

Piedra angular

Disminuir HCl

IBP!

Enfermedad “acido péptica”



Los IBPs no son el antídoto para todas las enfermedades digestivas!

Indicaciones correctas de los IBPs

Por períodos Cortos <12 semanas

- Erradicación *H.pylori*
- Ulceras pépticas
- Ulcera péptica sangrante
- Profilaxis ulceras estrés
- Dispepsia funcional (“Gastritis”)
- Esofagitis eosinofílica sin respuesta

Por períodos Indefinidos

- Esofagitis C y D
- Esófago de Barrett
- Ulcera péptica idiopática
- Profilaxis AINES
- Profilaxis antiplaquetarios
- Esofagitis eosinofílica (+)
- Fibrosis Pulmonar
- Zollinger Ellison

Herszényi L, Dig Dis 2020;38:104-11
Targownik LE, Gastroenterology 2022;162:1334-42

63% Wang J, Hepatol Int. 2020; 14:385-98

IBP no indicados

Pancreatitis aguda o crónica
Cirrosis Descompensada
Hospitalizados en sala general
"Polimedicados"
Reflujo Faringo-laringeo

Herszényi L, Dig Dis 2020;38:104-11
Targownik LE, Gastroenterology 2022;162:1334-42

Use of proton pump inhibitors to treat persistent throat symptoms: multicentre, double blind, randomised, placebo controlled trial

James O'Hara,[1,2] Deborah D Stocken,[3] Gillian C Watson,[4] Tony Fouweather,[5] Julian McGlashan,[6] Kenneth MacKenzie,[7] Paul Carding,[8] Yakubu Karagama,[9] Ruth Wood,[4] Janet A Wilson[10]

O'Hara J, BMJ 2021;372:4903.

Table 2 | Questionnaire outcome scores for compliant intention-to-treat group

Questionnaires and intervention	No in group	Mean score at follow-up (95% CI)		
		Baseline	16 weeks*	12 months
RSI*: Índice de síntomas de reflujo				
Lansoprazole	102	22.0 (20.4 to 23.6)	17.4 (15.5 to 19.4)	16.0 (13.6 to 18.4)
Placebo	118	21.7 (20.5 to 23.0)	15.6 (13.8 to 17.3)	13.6 (11.7 to 15.5)
Difference†		0.3 (−1.7 to 2.3)	1.8 (−0.8 to 4.4)	2.4 (−0.6 to 5.4)
RSI-HB:				
Lansoprazole	102	20.3 (18.8 to 21.7)	16.3 (14.5 to 18.1)	14.7 (12.4 to 16.9)
Placebo	118	19.8 (18.6 to 21.0)	13.9 (12.2 to 15.5)	11.9 (10.1 to 13.7)
Difference†		0.5 (−1.4 to 2.4)	2.4 (−0.0 to 4.8)	2.8 (0.5 to 5.1)
CReSS:				
Lansoprazole	102	50.3 (44.9 to 55.7)	38.9 (33.4 to 44.3)	36.6 (29.8 to 43.5)
Placebo	118	51.1 (46.4 to 55.8)	34.7 (29.6 to 39.9)	31.8 (26.6 to 36.9)
Difference†		−0.8 (−7.9 to 6.3)	4.2 (−3.2 to 11.6)	4.8 (−3.5 to 13.1)
LPR-HRQL: Calidad de vida				
Lansoprazole	102	28.9 (24.5 to 33.3)	20.5 (16.1 to 25.0)	18.8 (13.7 to 23.8
Placebo	118	26.5 (22.5 to 30.5)	17.1 (13.3 to 21.0)	13.9 (10.0 to 17.8)
Difference†		2.4 (−3.5 to 8.3)	3.4 (−2.4 to 9.2)	4.9 (−1.3 to 11.1)

O'Hara J, BMJ 2021;372:4903.

Research Article

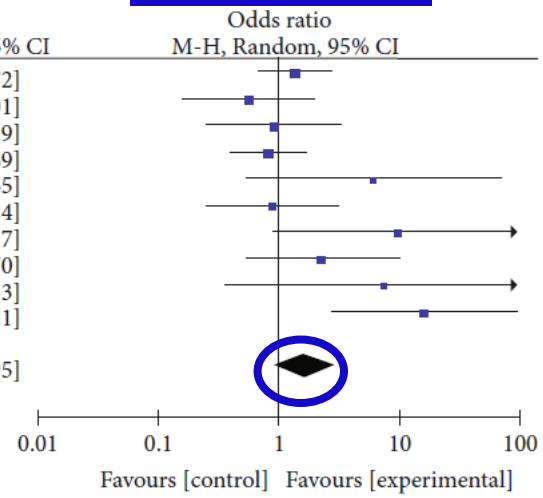
Meta-analysis of Proton Pump Inhibitors in the Treatment of Pharyngeal Reflux Disease

Xiulin Jin, Xufeng Zhou, Zongxian Fan, Yingchun Qin, and Junjie Zhan

Eficacia global

Study or Subgroup	Experimental Events	Total	Control Events	Total	Weight	Odds ratio M-H, Random, 95% CI
14.Chappity 2014	100	117	95	117	18.0%	1.36 [0.68, 2.72]
16.Fass 2009	8	24	8	17	11.4%	0.56 [0.16, 2.01]
19.Wo 2005	8	20	8	19	11.4%	0.92 [0.26, 3.29]
20.Vaezi 2006	40	83	23	43	17.4%	0.81 [0.39, 1.69]
21.Eherer 2003	9	10	6	10	4.8%	6.00 [0.53, 67.65]
22.Steward 2004	8	18	9	19	11.2%	0.89 [0.24, 3.24]
23.EL-Serag 2001	6	11	1	9	4.9%	9.60 [0.88, 105.17]
24.Noordzij 2001	9	15	6	15	9.8%	2.25 [0.52, 9.70]
25.Ours 1999	6	17	0	6	3.3%	7.35 [0.35, 152.53]
26.Langevin 2001	11	14	3	16	7.6%	15.89 [2.65, 95.21]
Total (95% CI)		329		271	100.0%	1.62 [0.89, 2.95]
Total events	205		159			

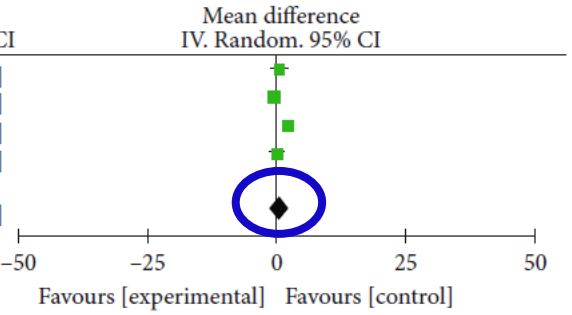
Heterogeneity: $Tau^2 = 0.39$; $Chi^2 = 17.50$, df = 9 (P = 0.04); $I^2 = 49\%$
Test for overall effect: Z = 1.59 (P = 0.11)



Puntaje sintomas

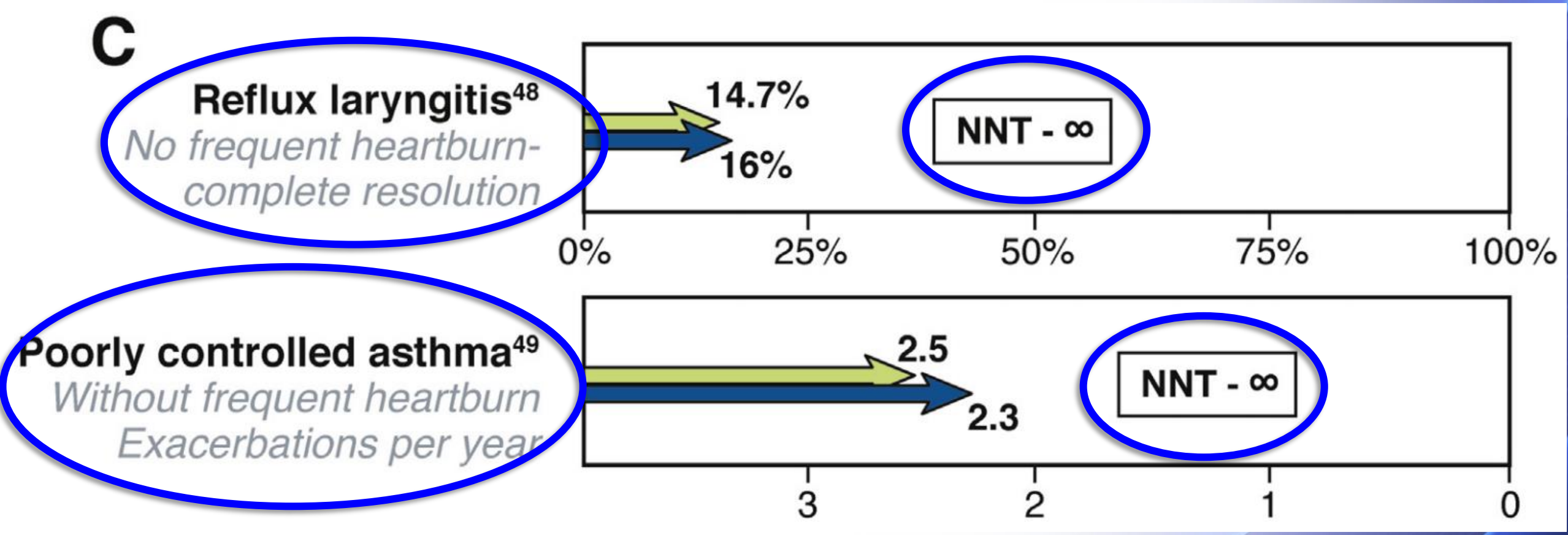
Study or Subgroup	Experimental Mean	SD	Total	Control Mean	SD	Total	Weight	Mean difference IV. Random. 95% CI
15.Shaheen 2010	0.6	2	22	0.1	2.9	18	22.7%	0.50 [−1.08, 2.08]
17.Lam 2010	2.21	0.64	42	2.75	0.5	40	26.8%	−0.54 [−0.79, −0.29]
18.Reichel 2008	4.6	0.63	30	2.32	0.76	28	26.7%	2.28 [1.92, 2.64]
22.Steward 2004	0.6	1.8	18	0.5	2.3	19	23.8%	0.10 [−1.23, 1.43]
Total (95% CI)			112			105	100.0%	0.60 [−1.28, 2.48]

Heterogeneity: $Tau^2 = 3.42$; $Chi^2 = 159.67$, df = 3 (P < 0.00001); $I^2 = 98\%$
Test for overall effect: Z = 0.63 (P = 0.53)



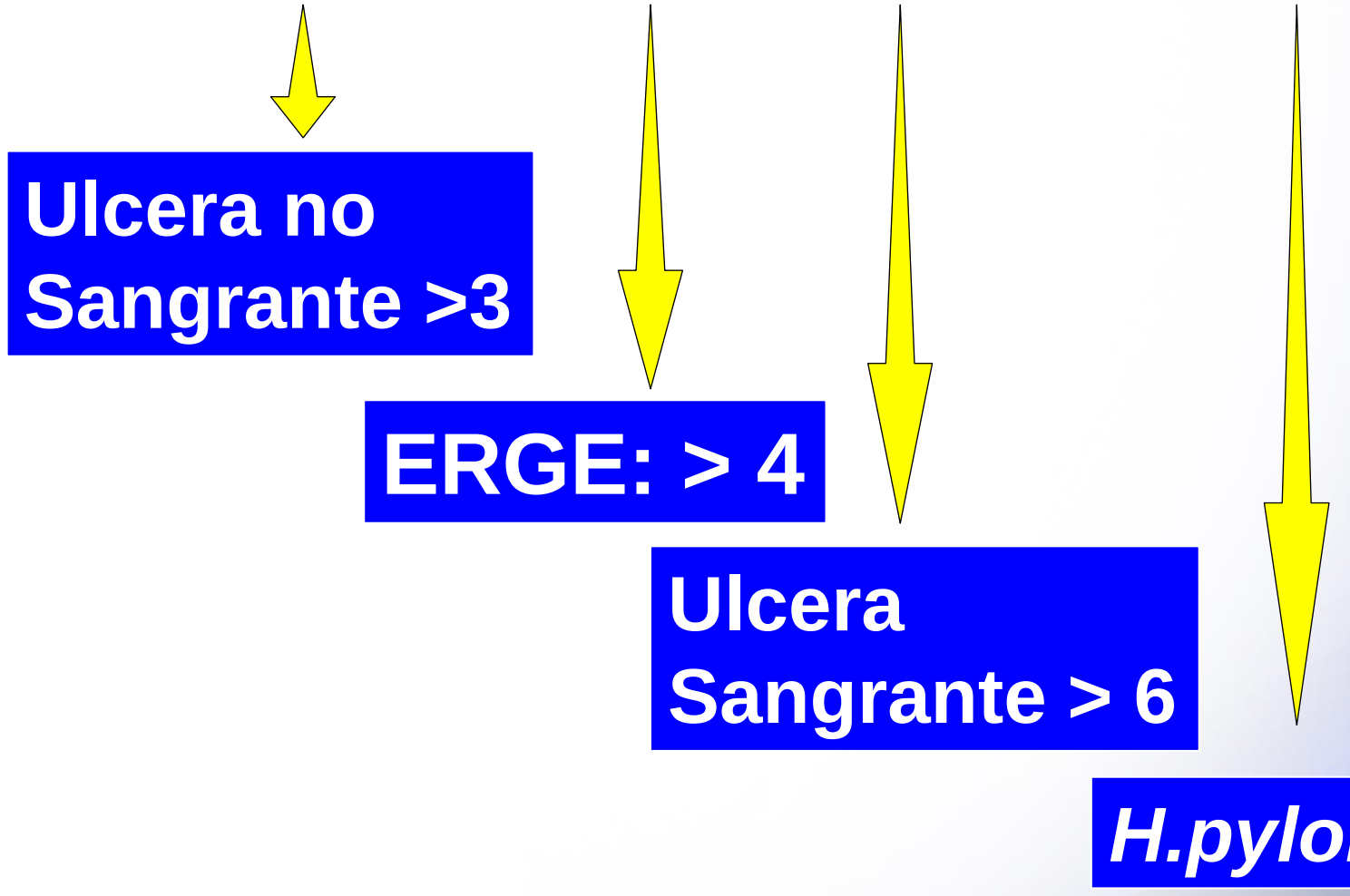
Jin X,et al. Comp Math Meth Med 2022;2022: Article ID 9105814, 9 pages

Síntomas extraesofágicos



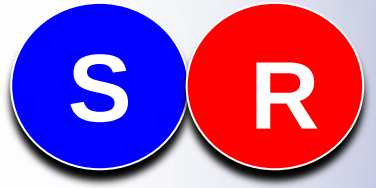
Katzka DA, Clin Gastroenterol Hepatol 2020;18:767-76

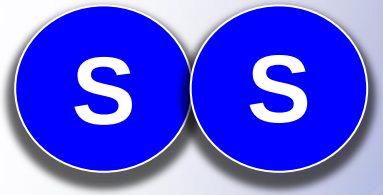
En indicaciones correctas
Para cada enfermedad un objetivo de pH



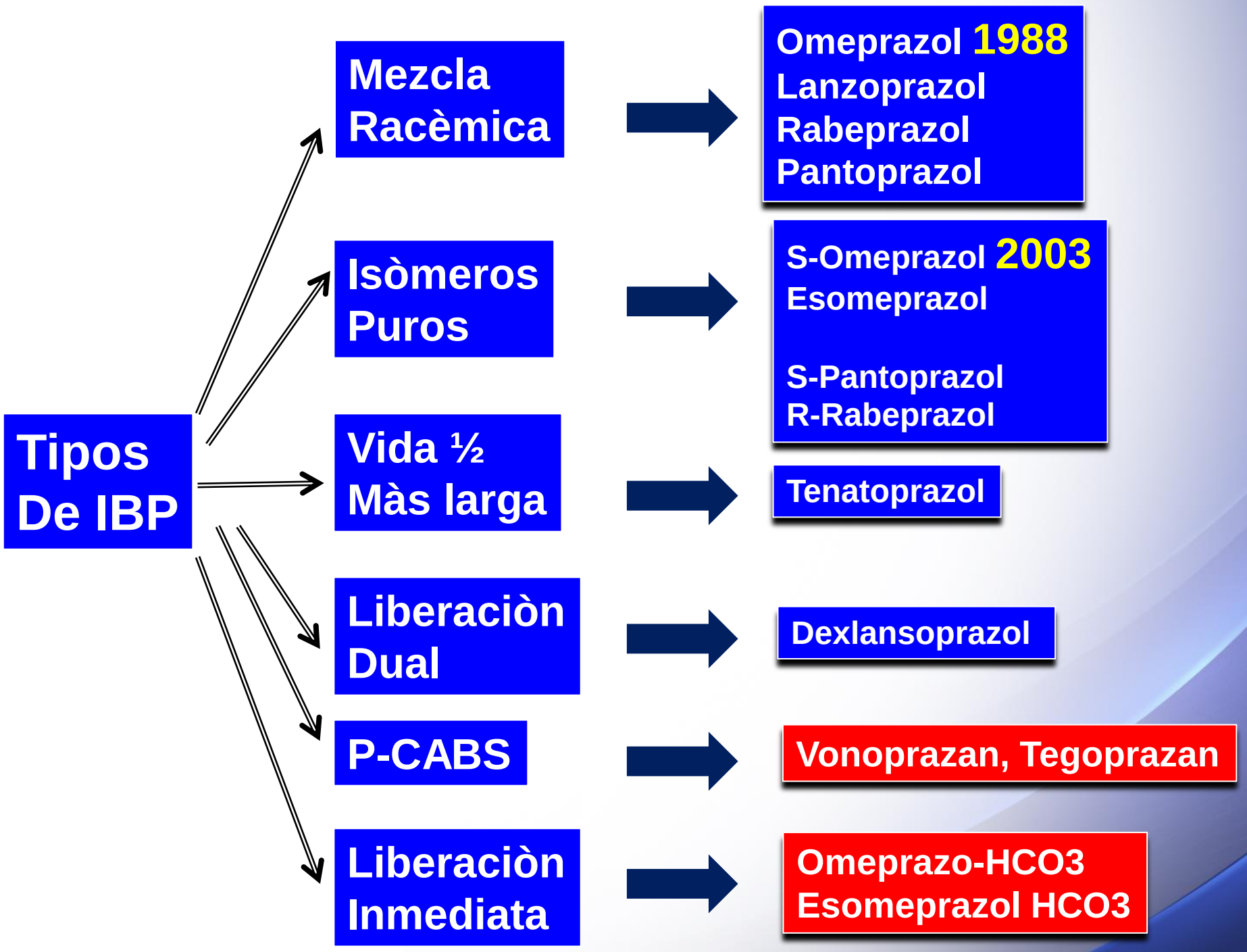
Omeprazol 1988

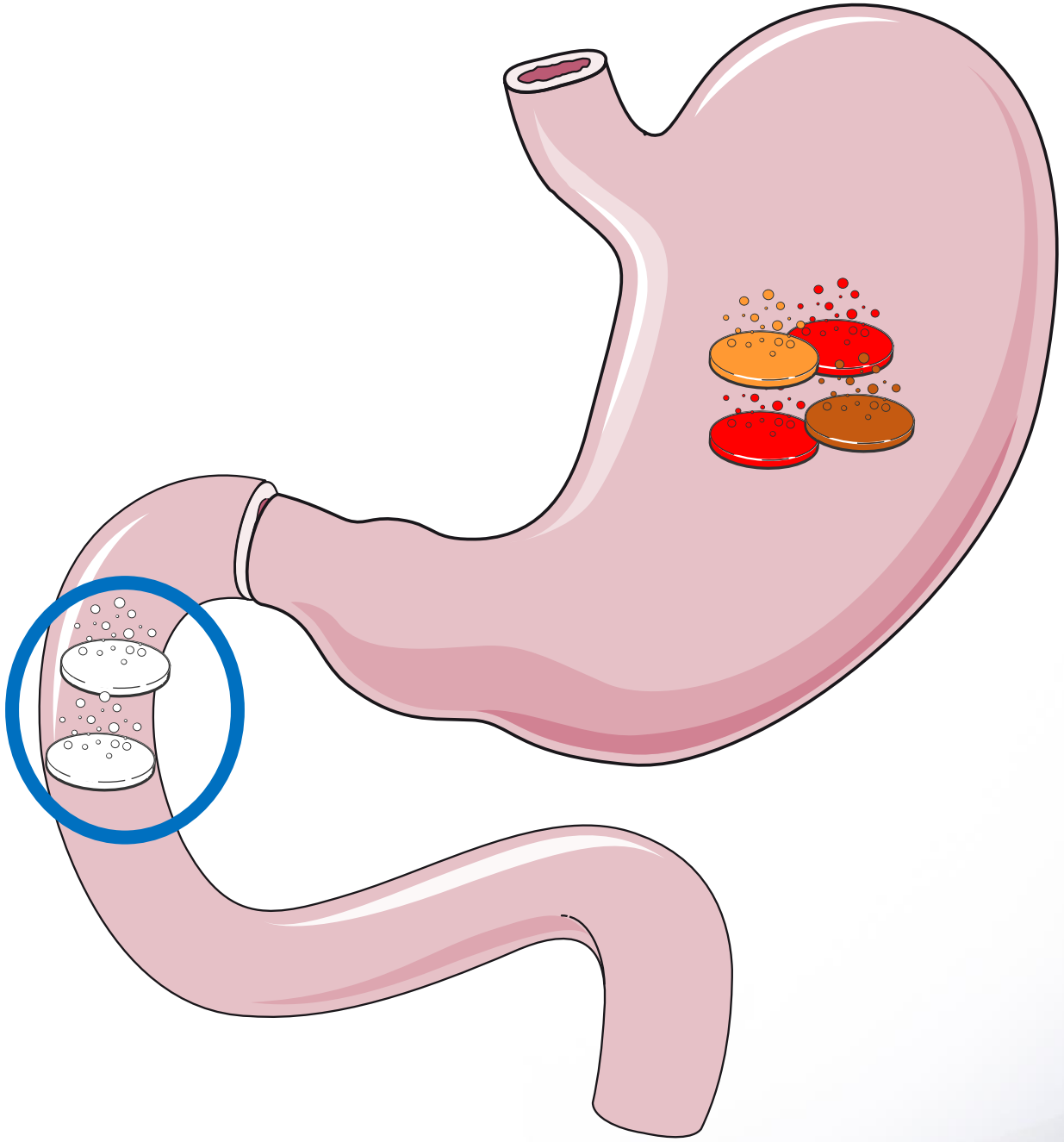
Esomeprazol 2003





Scarpignato C, Curr Opin Pharmacol 2008;8:677-84


Tipos De IBP
Mezcla Racèmica
Omeprazol 1988
Lanzoprazol
Rabeprazol
Pantoprazol
Isòmeros Puros
S-Omeprazol 2003
Esomeprazol
S-Pantoprazol
R-Rabeprazol
Vida ½ Màs larga
Tenatoprazol
Liberaciòn Dual
Dexlansoprazol
P-CABS
Vonoprazan, Tegoprazan
Liberaciòn Inmediata
Omeprazo-HCO3
Esomeprazol HCO3



Liberación Inmediata

IBP No son iguales

- Potencia
- Farmacognètica

Potencia de los IBPs comparados con omeprazol

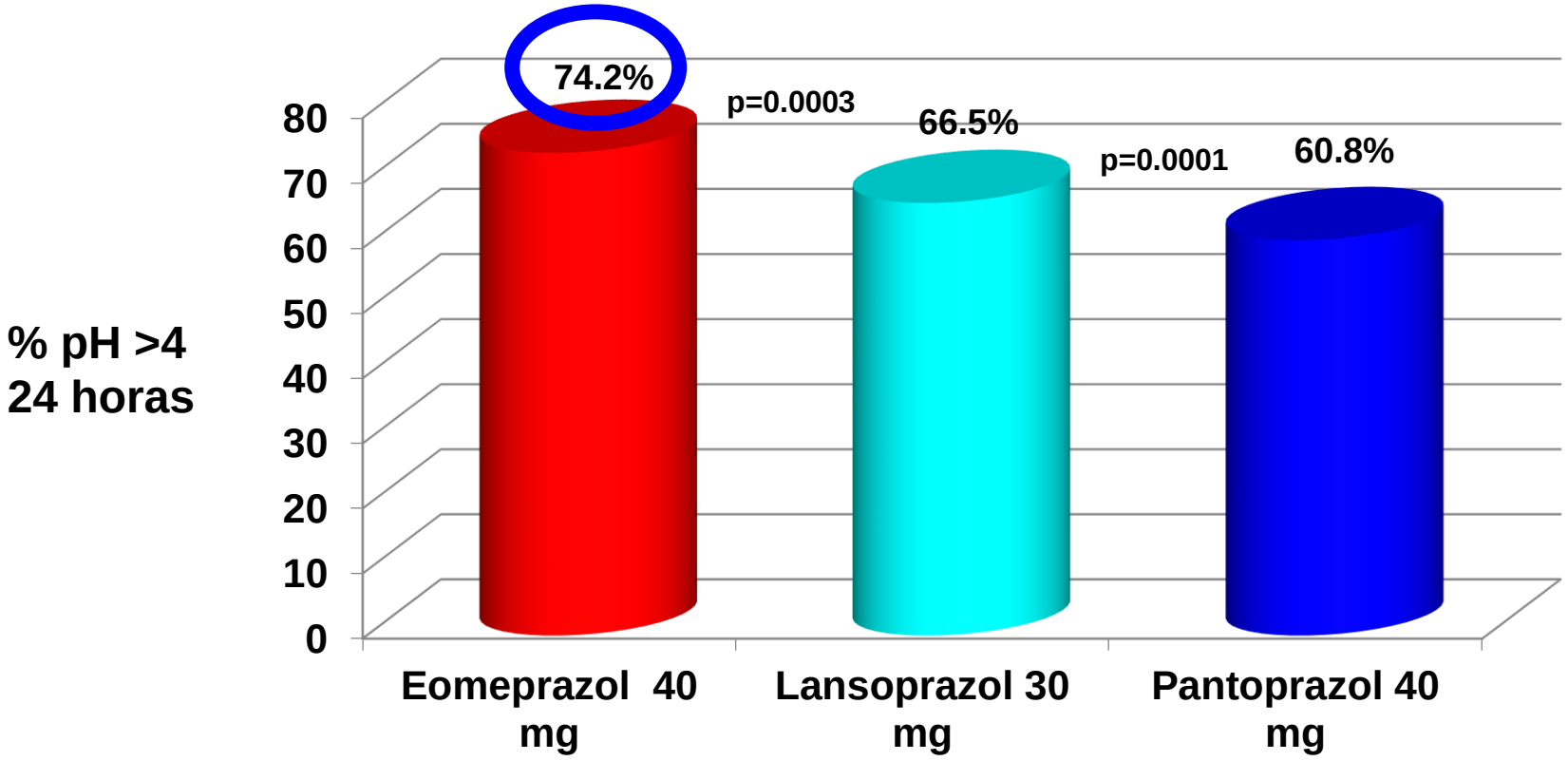
Diferentes IBPs		Omeprazol mg
Rabeprazol	20 mg	36 mg
Esomeprazol	20 mg	32 mg ***1.6 veces***
Omeprazol	20 mg	20 mg
Lansoprazol	20 mg	18 mg
Pantoprazol	20 mg	

Más potente

Menos potente

Graham DY, Clin Gastroenterol Hepatol. 2018;16:800-8

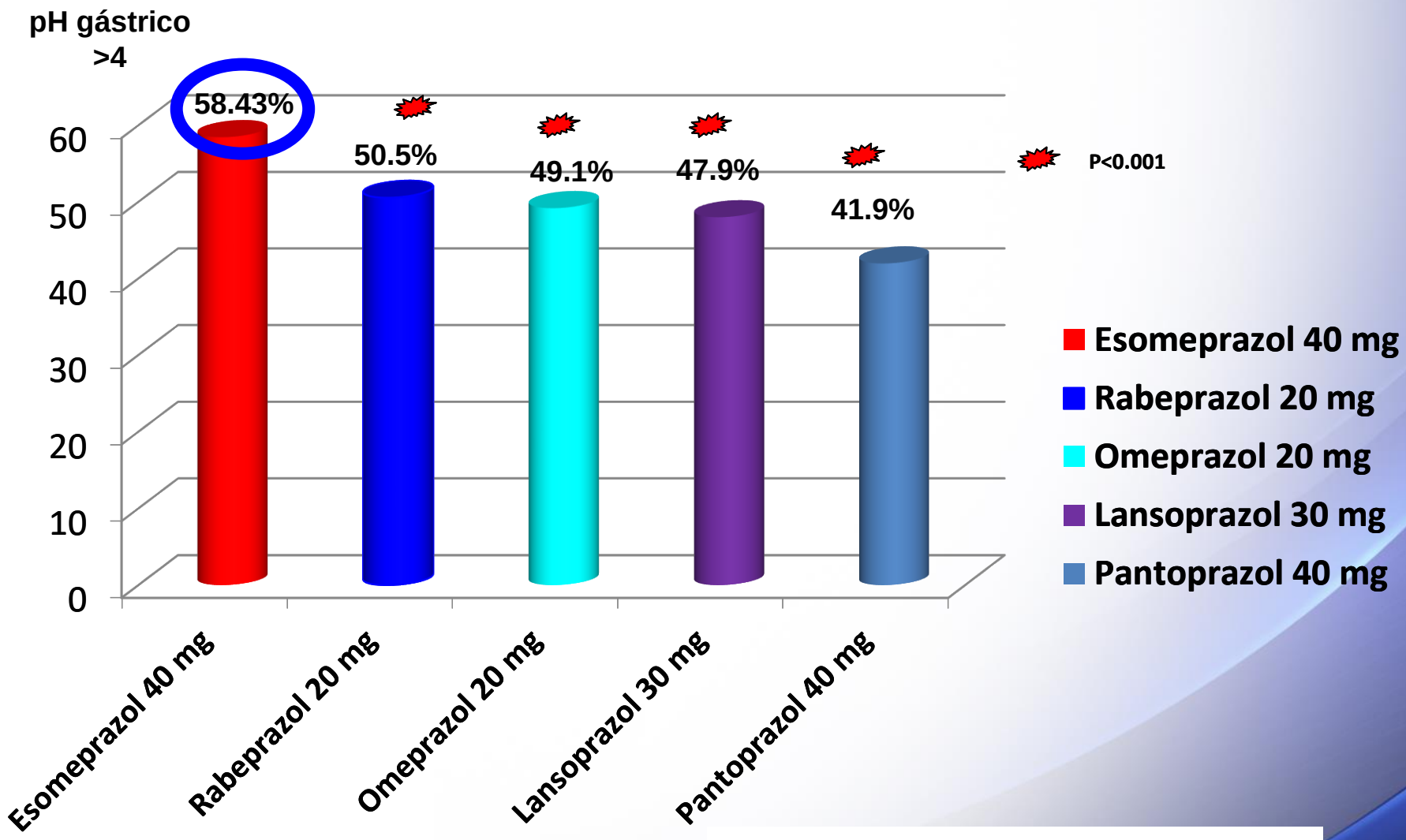
pH intragástrico > 4 consumidores AINES



Godstein JL, Aliment Pharmacol Ther 2006;23:1189-96

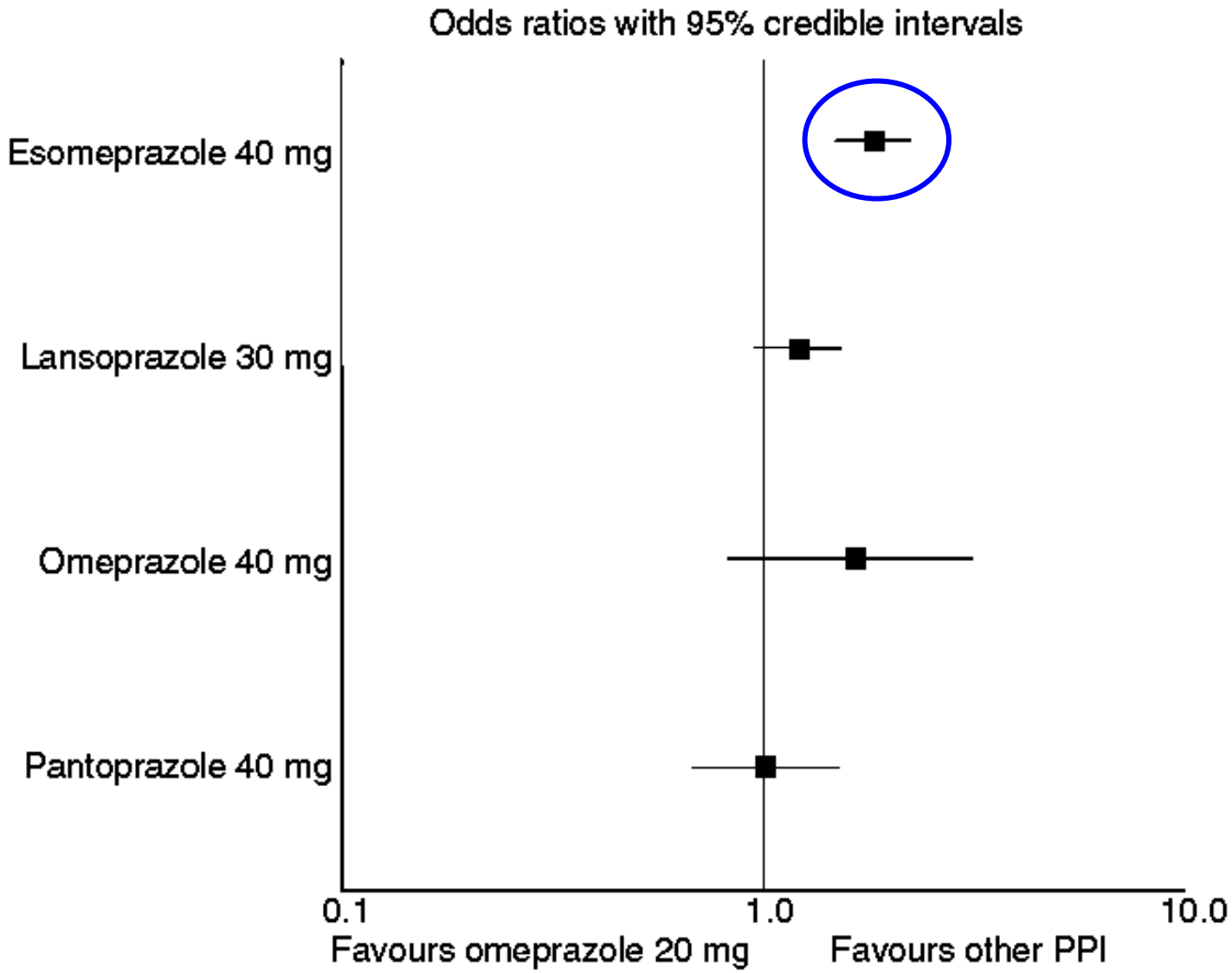
Gastric Acid Control With Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, and Rabeprazole: A Five-Way Crossover Study

Philip Miner, Jr., M.D., Philip O. Katz, M.D., Yusong Chen, Ph.D., and Mark Sostek, M.D.



Am J Gastroenterol 2003;98:2616-20

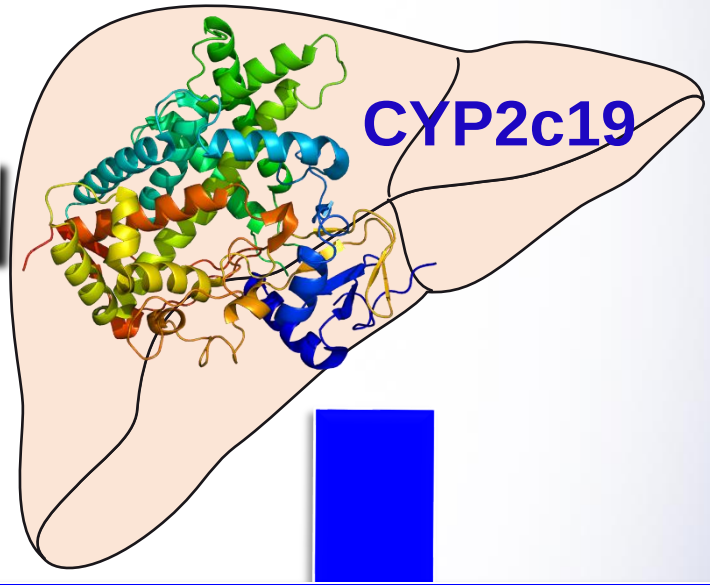
Edwards SJ, Aliment Pharmacol Ther 2009;30:547-56
Revisión sistemática



Farmacogenética

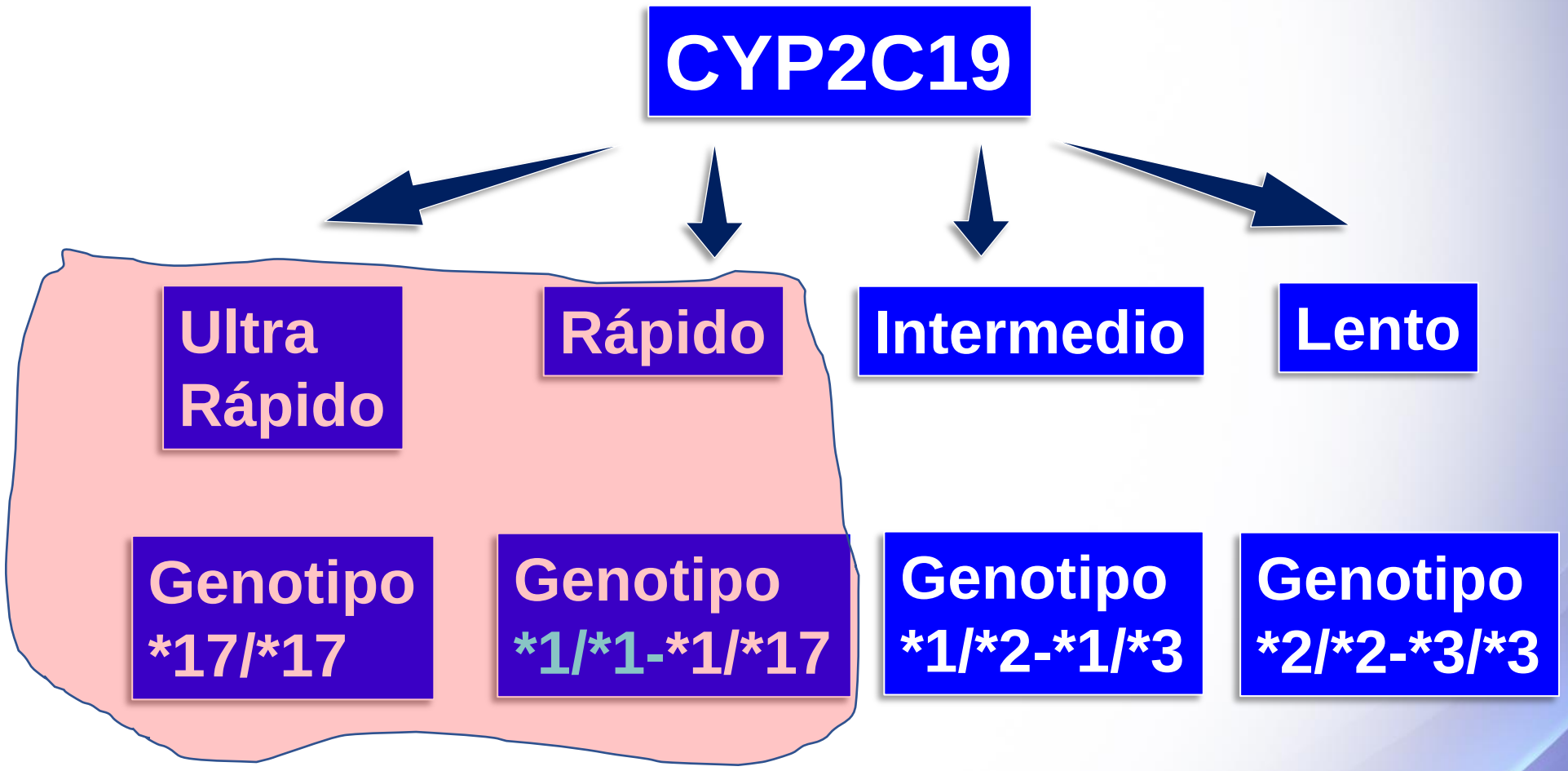
Primera Generación
Omeprazol
Lansoprazol
Pantoprazol

Dependientes



Menos dependientes

Segunda Generación
Esomeprazol
Rabeprazol



Arevalo A, Otero W, Trespalacios AA, et al. PLoS One 2021;16:e0245401

Cyp2C19

Rápido, Ultrarrápido
80-84%

Esomeprazol **Rabeprazol**
menos Influidos por el CYP
70% vs 90% OME

Isaza C, BMC Clin Pharmacol. 2007;7:6.
Arévalo A, Tresplacios A, Otero W, Helicobacter 2019;24:e12574
Arevalo A, Otero W PLoS One. 2021;16:e0245401

Impacto de la Farmacogenética

Host Genetic Determinants Associated With *Helicobacter pylori* Eradication Treatment Failure: A Systematic Review and Meta-analysis

Shailja C. Shah,[1,2,3,4] Adam Tepler,[5] Cecilia P. Chung,[6,7] Giovanni Suarez,[3] Richard M. Peek Jr,[3] Adriana Hung,[8,9] Christianne Roumie,[8,10] and Neeraj Narula[11]

57 estudios
Pacífico Asiático (Japón 24, Taiwan 6, Korea 5, Tailandia 1)
Europa (Alemania 3, Polonia 3, Italia 1)
Sur américa (Brazil 2)

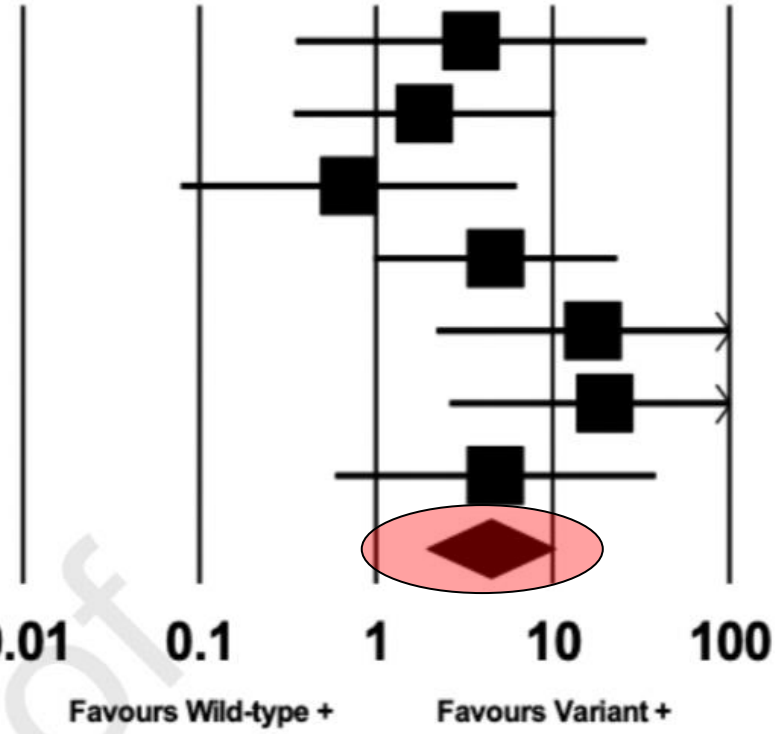
Gastroenterology 2021;161:1443–1459

Hpylori sensible a claritromicina o resistencia < 15% IBP Primera Generaciòn Lansoprazol, Omeprazol Pantoprazol Metabolizadores ràpidos

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	p-Value
Isomoto, 2003	3.438	0.352	33.612	1.061	0.289
Kawabata, 2004	1.875	0.342	10.269	0.725	0.469
Miki, 2003	0.700	0.079	6.224	-0.320	0.749
Sheu, 2005	4.742	0.975	23.062	1.929	0.054
Furuta, 2001	16.875	2.202	129.312	2.720	0.007
Furuta, 2004	19.753	2.617	149.103	2.893	0.004
Kang, 2008	4.738	0.589	38.140	1.462	0.144
	4.443	1.944	10.157	3.535	0.000

Statistics for each study

Odds ratio and 95% CI



Riesgo de Falla terapùtica

Shah SC, Gastroenterology 2021;161:1443–1459

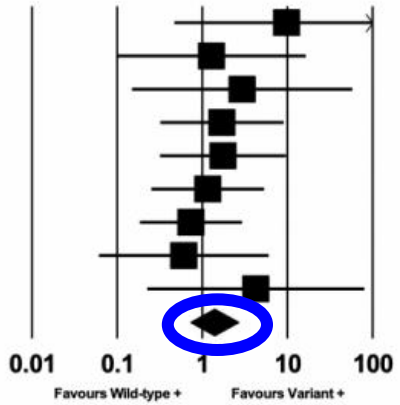
Ràpidos versus Pobres metabolizadors

Esomeprazol 9 estudios

Rabeprazol 18 estudios

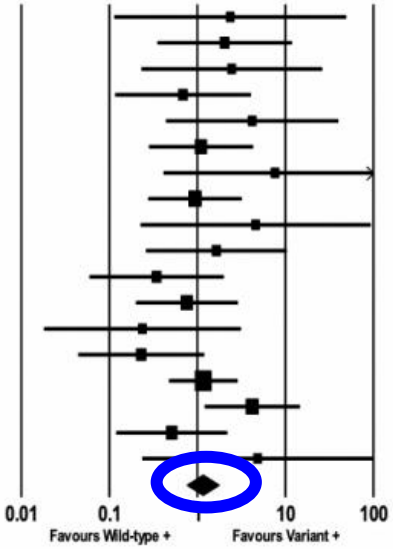
2B.

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	p-Value
Pan, 2010	9.783	0.473	202.374	1.475	0.140
Pan*, 2010	1.286	0.101	16.340	0.194	0.846
Miehlke, 2008	2.941	0.150	57.555	0.711	0.477
Sheu, 2005	1.705	0.323	9.007	0.628	0.530
Wu, 2011	1.750	0.321	9.554	0.646	0.518
Song, 2016	1.159	0.253	5.304	0.191	0.849
Okimoto, 2016	0.735	0.186	2.908	-0.438	0.661
Liou, 2011	0.606	0.061	5.985	-0.429	0.668
Kang, 2008	4.248	0.227	79.518	0.968	0.333
	1.387	0.723	2.662	0.984	0.325



2C.

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	p-Value
Isomoto*, 2003 - 7 days	2.368	0.114	49.041	0.558	0.577
Isomoto*, 2003 - 14 days	2.045	0.354	11.820	0.800	0.424
Yang, 2009	2.462	0.232	26.114	0.748	0.455
Pan, 2010	0.688	0.117	4.056	-0.414	0.679
Inaba, 2002	4.200	0.442	39.943	1.249	0.212
Miyoshi, 2001	1.100	0.283	4.282	0.137	0.891
Lay, 2010	7.638	0.414	140.829	1.367	0.172
Okimoto, 2016	0.942	0.278	3.189	-0.096	0.924
Lin, 2017	4.600	0.227	93.032	0.995	0.320
Dojo, 2001	1.647	0.262	10.359	0.532	0.595
Miki, 2003	0.345	0.060	1.993	-1.190	0.234
Lee, 2003	0.762	0.201	2.884	-0.400	0.689
Phiphatpatthamaamphan, 2016	0.238	0.018	3.121	-1.093	0.274
Kawabata, 2003	0.231	0.045	1.197	-1.746	0.081
Lee, 2010*	1.169	0.478	2.862	0.343	0.732
Kuwayama, 2007	4.211	1.216	14.585	2.268	0.023
Hokari, 2001	0.513	0.120	2.190	-0.902	0.367
Jiang, 2005	4.846	0.237	98.960	1.025	0.305
	1.153	0.761	1.748	0.674	0.501



Proof

Shah SC, Gastroenterology 2021;161:1443–1459

EXMI BY PROCAPS

Influence of *Cytochrome P450 2C19* Genotype on *Helicobacter pylori* Proton Pump Inhibitor-Amoxicillin-Clarithromycin Eradication Therapy: A Meta-Analysis

Yuko Morino[1], Mitsushige Sugimoto[2], Naoyoshi Nagata[2], Ryota Niikiura[2], Eri Iwata[2], Mariko Hamada[2], Yusuke Kawai[2], Tatsuhiro Fujimiya[3], Hironori Takeuchi[4], Sakae Unezaki[3] and Takashi Kawai[2]*

25 ensayos clínicos controlados aleatorizados

24 ASIA, 1 Suramérica (Colombia), 5318 pacientes, Tasa resistencia: Amoxi 8.9%, Claritromicina 13%

Morino Y, Front Pharmacol 2021;12:759240

Influence of *Cytochrome P450 2C19* Genotype on *Helicobacter pylori* Proton Pump Inhibitor-Amoxicillin-Clarithromycin Eradication Therapy: A Meta-Analysis

Yuko Morino[1], Mitsushige Sugimoto[2], Naoyoshi Nagata[2], Ryota Niikiura[2], Eri Iwata[2], Mariko Hamada[2], Yusuke Kawai[2], Tatsuhiro Fujimiya[3], Hironori Takeuchi[4], Sakae Unezaki[3] and Takashi Kawai[2]*

Extensos metabolizadores

Lansoprazol y omeprazol
Menor tasa erradicación

Esomeprazol y rapeprazol
No son influidos

Morino Y, Front Pharmacol 2021;12:759240

Gastroenterology 2021;160:1831–1841

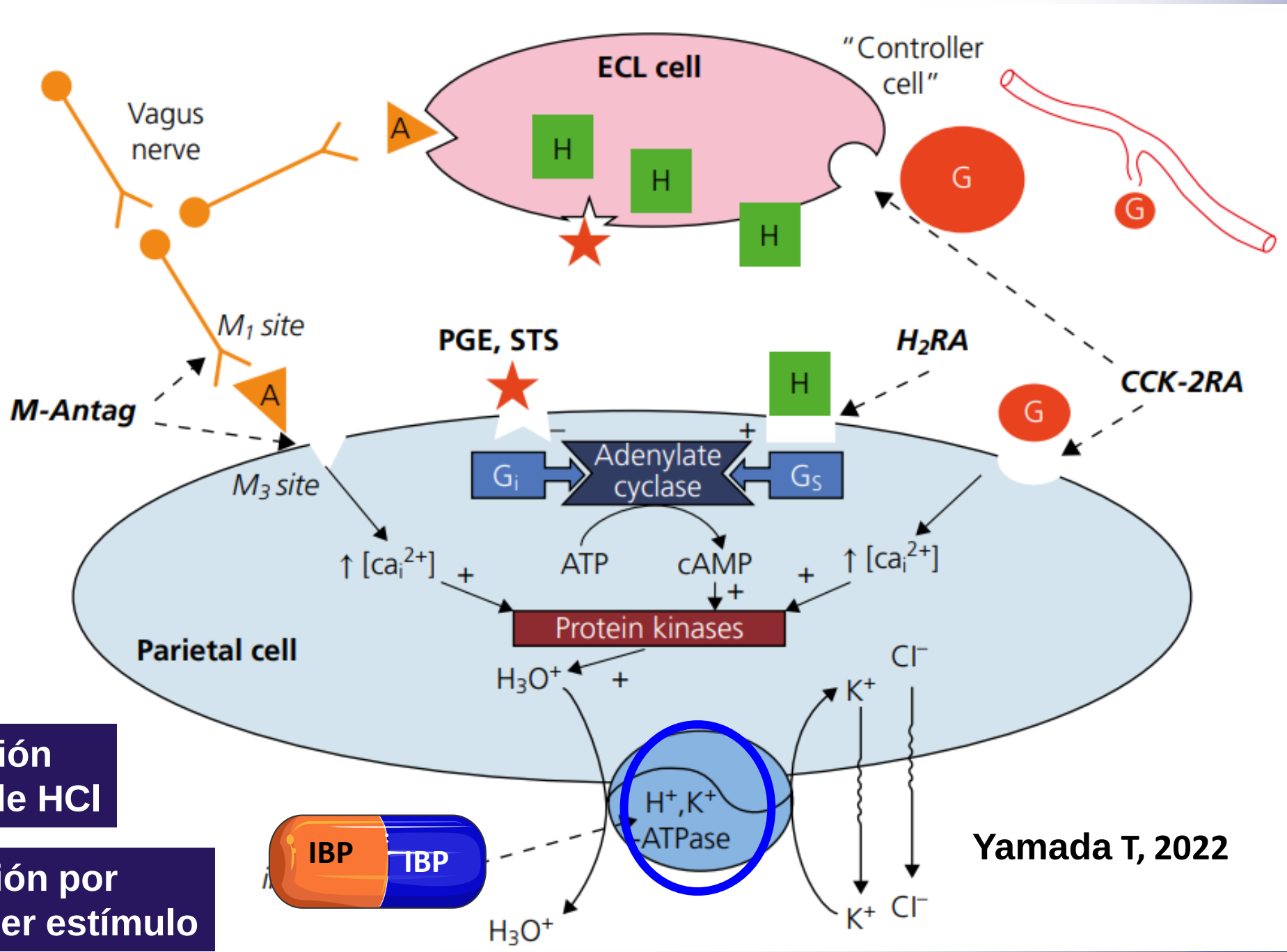
CLINICAL PRACTICE UPDATE

AGA Clinical Practice Update on the Management of Refractory *Helicobacter pylori* Infection: Expert Review

Shailja C. Shah,[1,2,3] Prasad G. Iyer,[4] and Steven F. Moss[5]

Best Practice Advice 7: Inadequate acid suppression is associated with *H pylori* eradication failure. The use of high-dose and more potent PPIs, PPIs not metabolized by *CYP2C19*, or potassium-competitive acid blockers, if available, should be considered in cases of refractory *H pylori* infection.

Opciòn Rabeprazol, Esomeprazol, Vonoprazan, Tegoprazan o aumentar dosis de IBP 1era generaciòn



Secreción Basal de HCl

Secreción por cualquier estímulo

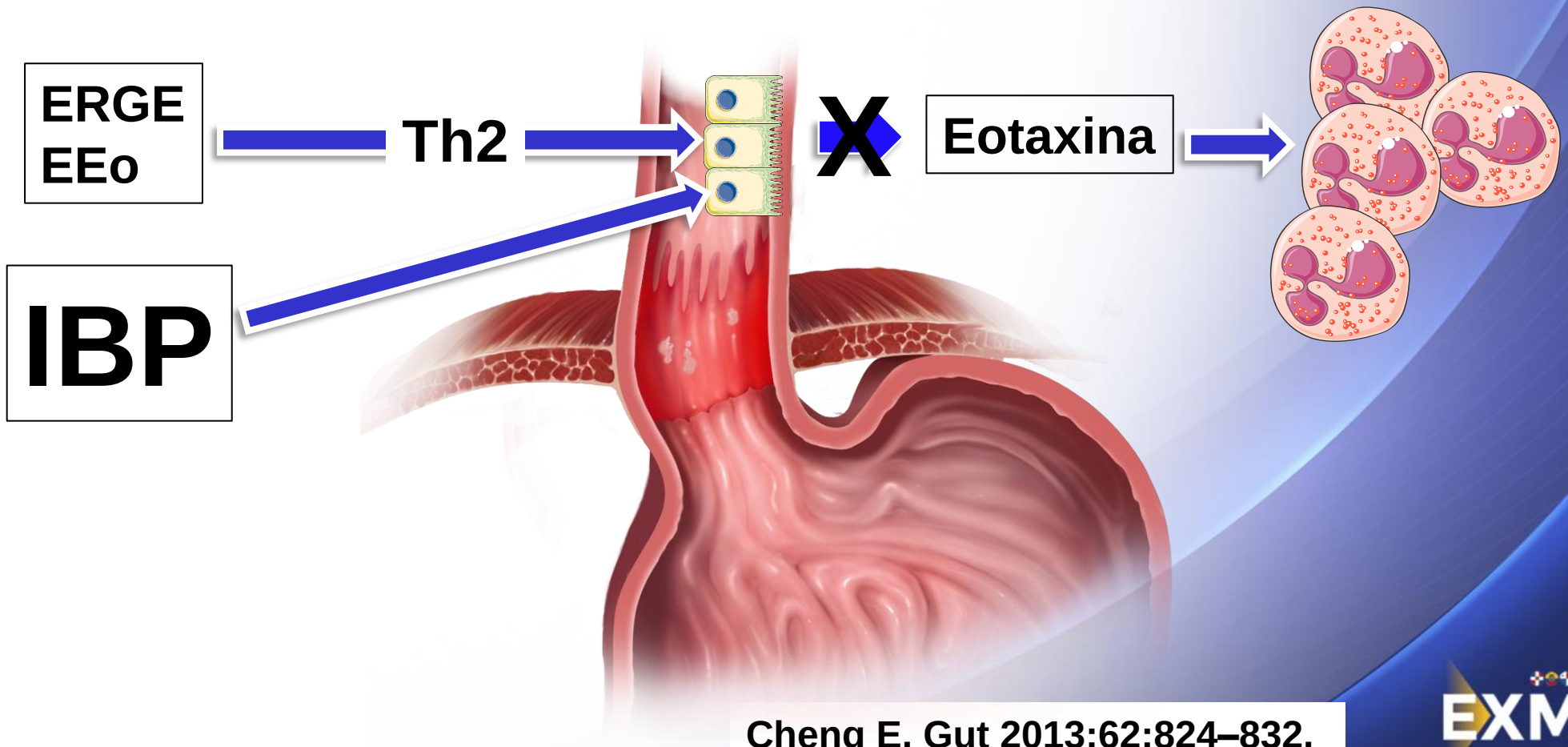
Yamada T, 2022

IBP

Efectos sistémicos anti inflamatorios

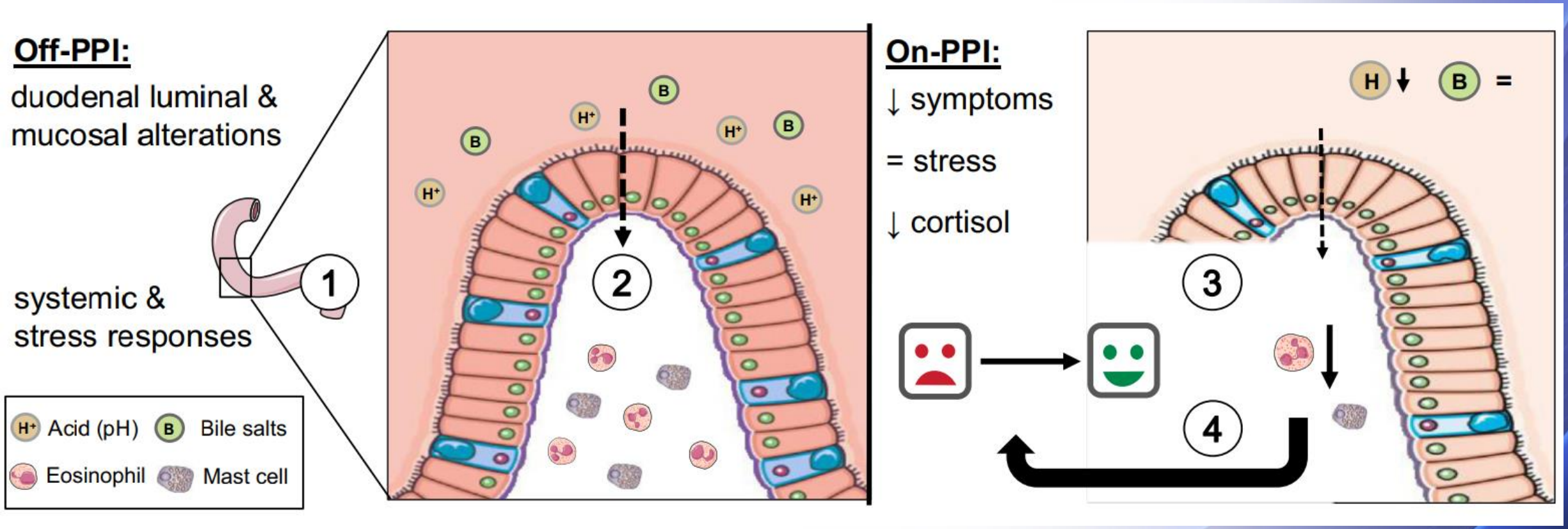
Omeprazole blocks eotaxin-3 expression by oesophageal squamous cells from patients with eosinophilic oesophagitis and GORD

Edaire Cheng,[1] Xi Zhang,[2] Xiaofang Huo,[2] Chunhua Yu,[2] Qiuyang Zhang,[2] David H Wang,[2] Stuart Jon Spechler,[2] Rhonda F Souza[2]

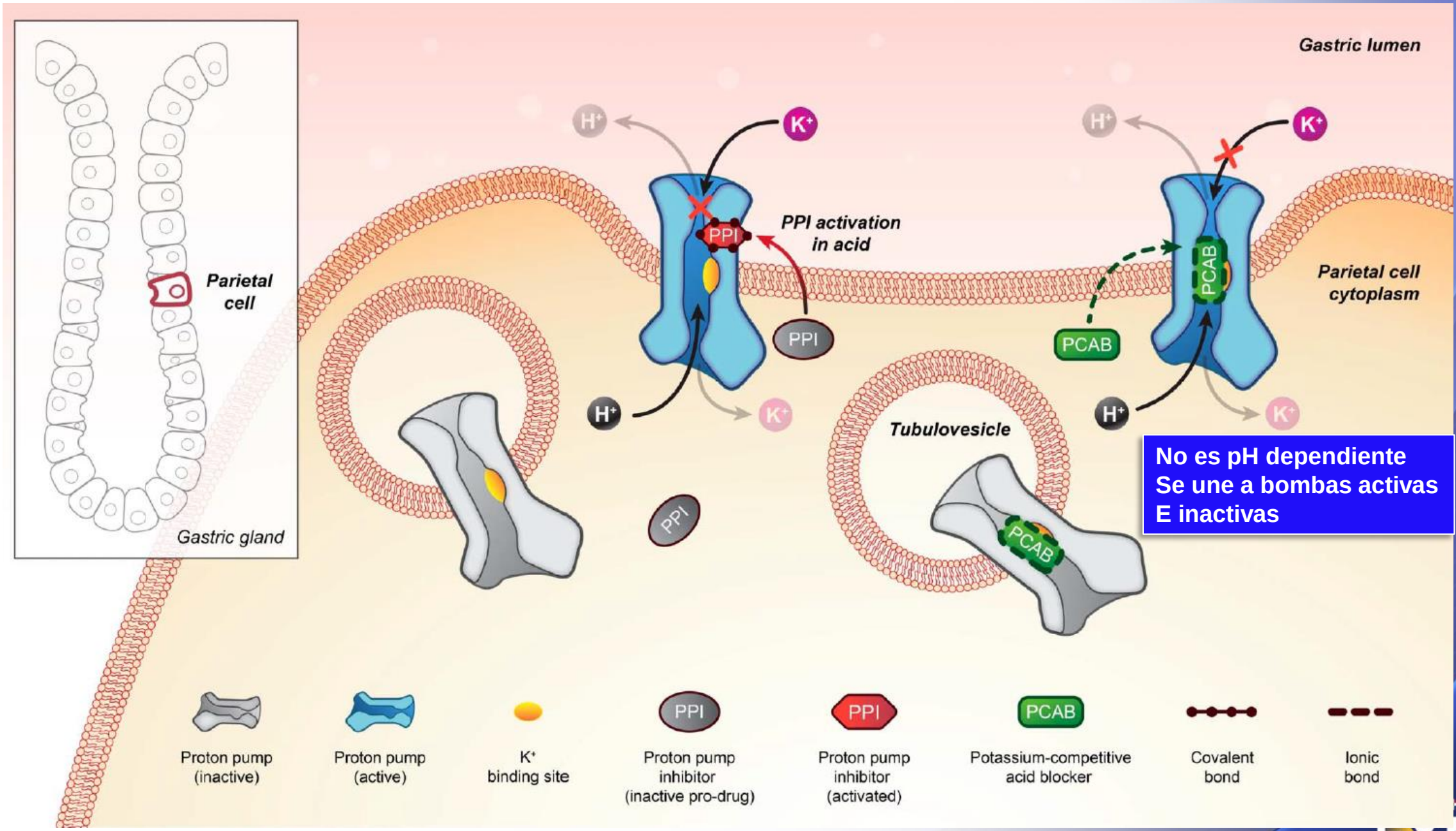


Cheng E, Gut 2013;62:824–832.

IBP y Dispepsia Funcional

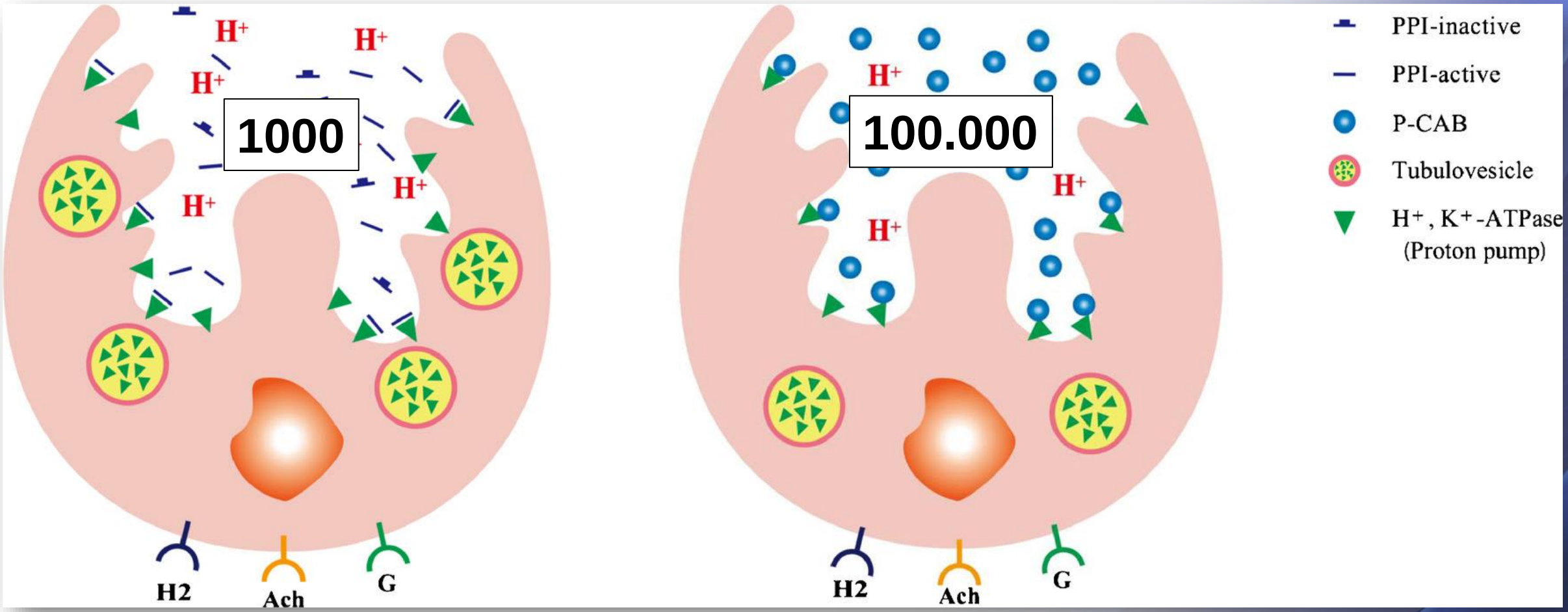


Wauters L, Gastroenterology 2021;160:1521-31

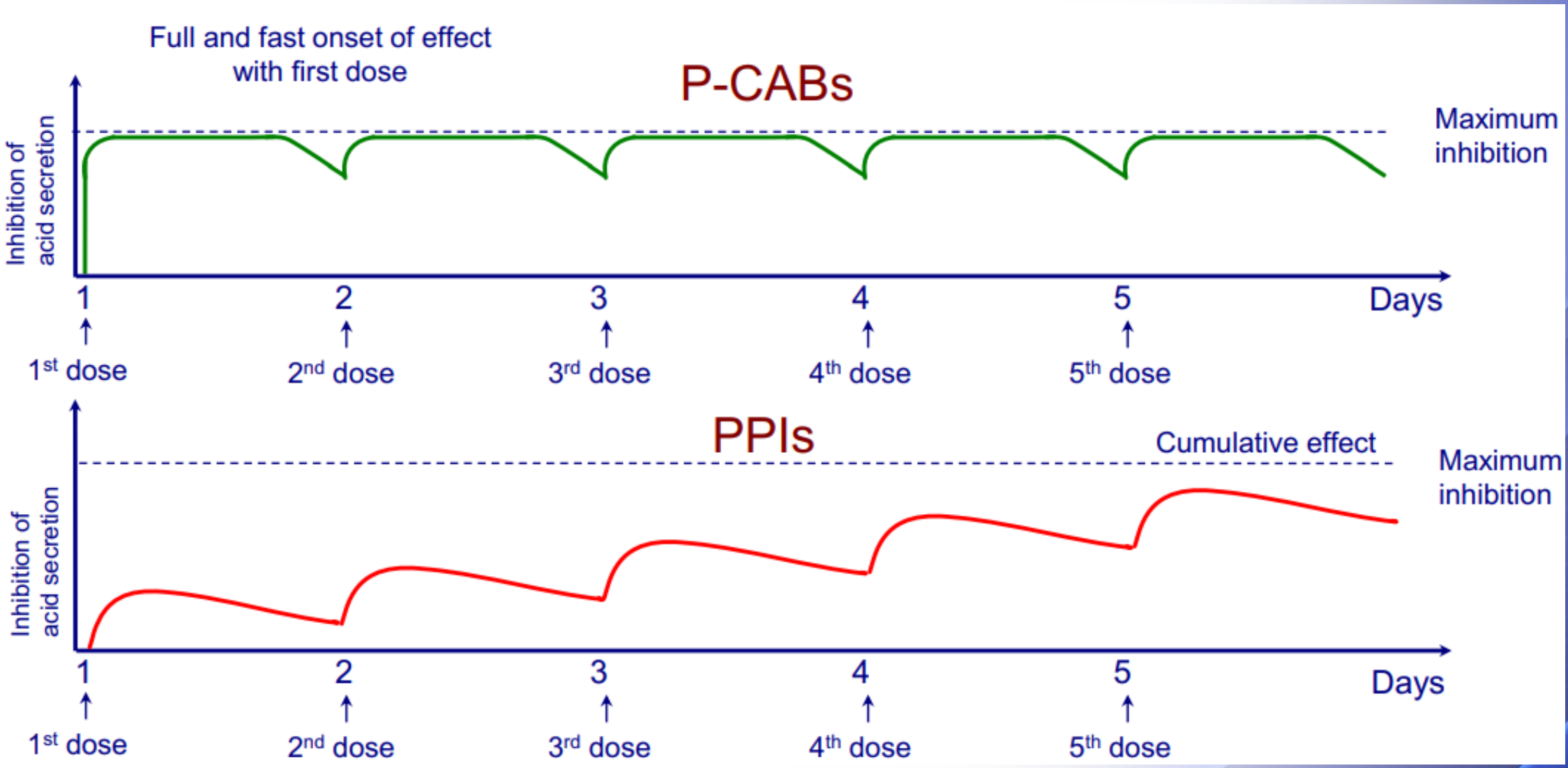


Laine L, Am J Gastroenterol 2022;117:1158-61

IBP 3ª Generación competitivos de K: *P-CABs*



Shibli F, Curr Gastroenterol Rep 2020; 22:16
Hunt RH, Curr Opt Treat Gastroenterol 2018;16:57-90



Hunt RH, Curr Opt Treat Gastroenterol 2018;16:57-90.

P-CAB

Vonoprazan

Tegoprazan

Japón
Filipinas
Singapur
Tailandia
Malasia

Corea del Sur

Estudio USA Europa 2021-2023

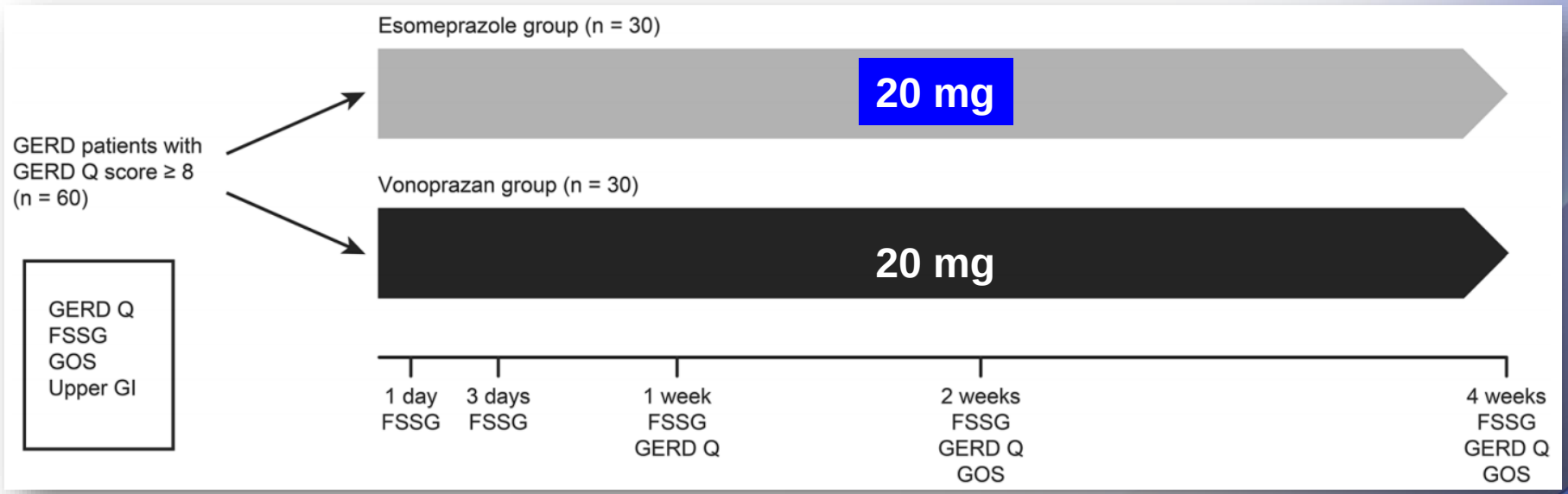
Oshima T, *J Neurogastroenterol Motil*. 2018;24:334–44.
Scarpignato C, *Aliment Pharmacol Ther*. 2019;50:960–62.

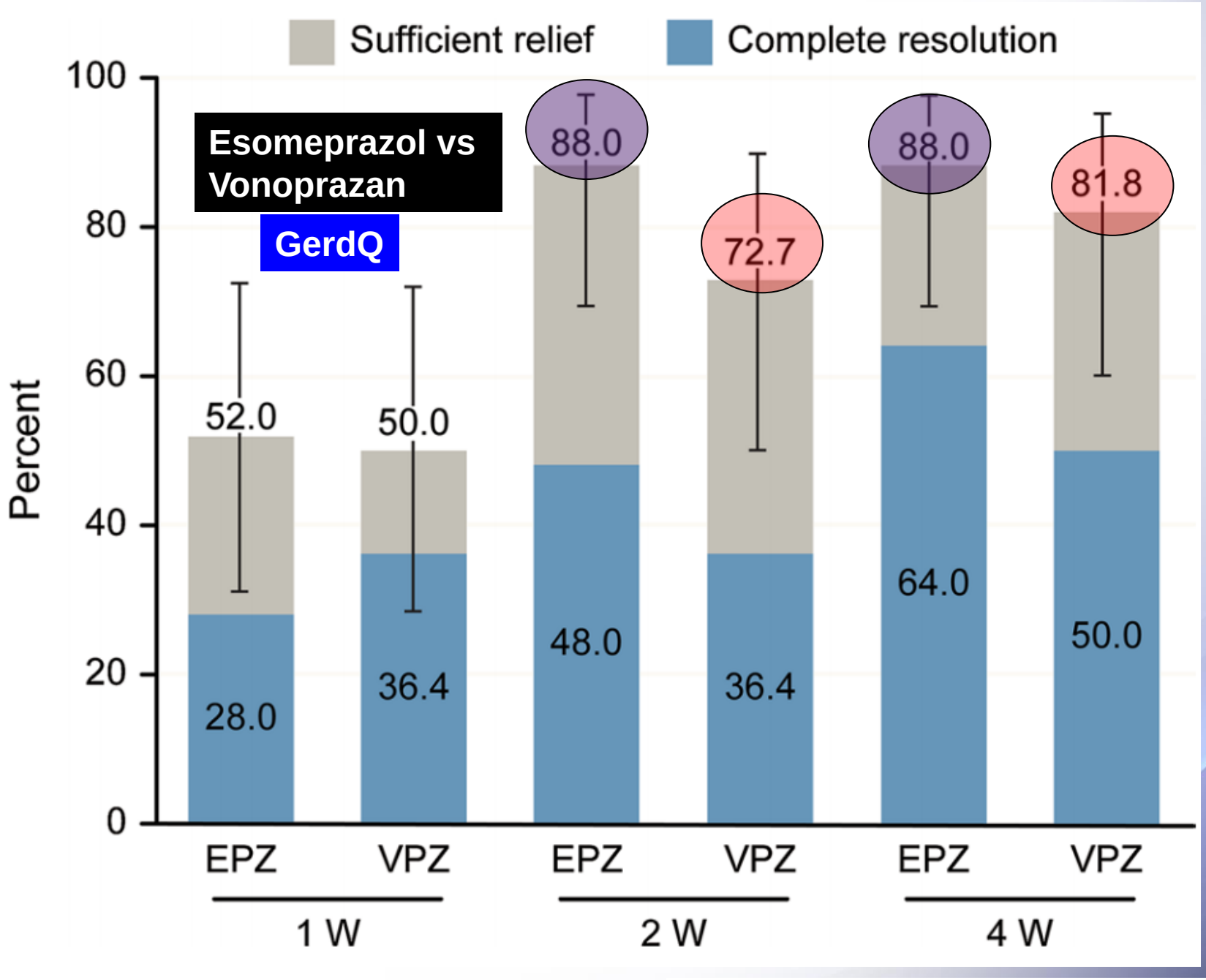
Digestive Diseases and Sciences (2019) 64:815–822
https://doi.org/10.1007/s10620-018-5365-0

ORIGINAL ARTICLE

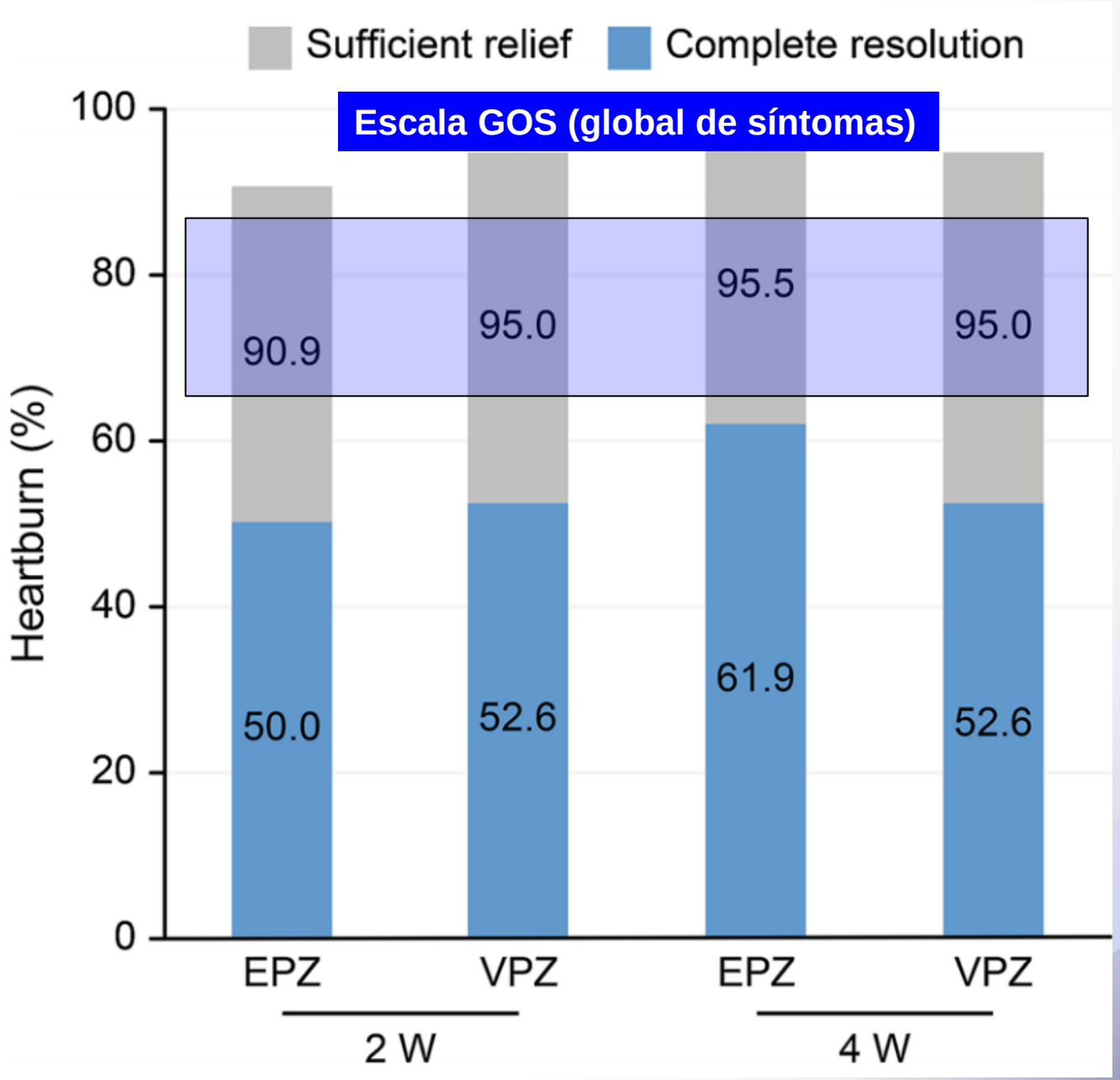
Short-Term Symptomatic Relief in Gastroesophageal Reflux Disease: A Comparative Study of Esomeprazole and Vonoprazan

Kouichi Sakurai[1] · Hiroko Suda[1] · Satomi Fujie[1] · Takayuki Takeichi[1] · Ayako Okuda[1] · Tetsuya Murao[1] · Kiwamu Hasuda[1] · Masahiro Hirano[2] · Kiyoharu Ito[3] · Katsuie Tsuruta[4] · Masahiro Hattori[1]

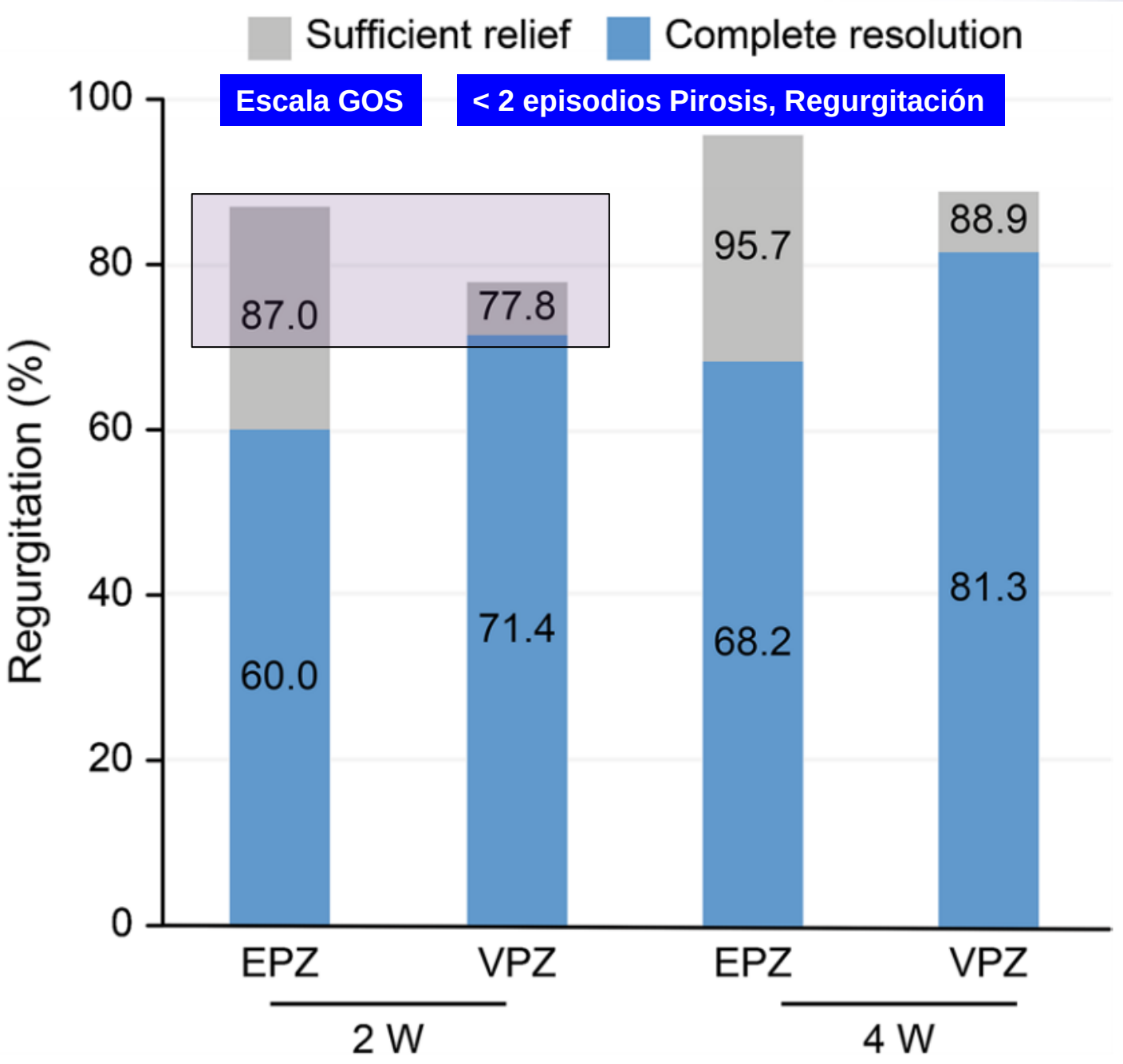




Sakurai K, Dig Dis Sci 2019; 64:815–22



Sakurai K, Dig Dis Sci 2019; 64:815–22



Sakurai K, Dig Dis Sci 2019; 64:815–22

ORIGINAL ARTICLE

Neurogastroenterology & Motility NGM WILEY

Randomized clinical trial: A double-blind, proof-of-concept, phase 2 study evaluating the efficacy and safety of vonoprazan 20 or 40 mg versus esomeprazole 40 mg in patients with symptomatic gastro-esophageal reflux disease and partial response to a healing dose of a proton-pump inhibitor

Jan Tack[1] | Borislav Vladimirov[2] | Ivo Horny[3] | Chui Fung Chong[4] | Jessica Eisner[5] | Richard Czerniak[6] | Yohei Takanami[6]

Conclusions: No statistically significant difference in efficacy and safety was observed among treatment groups, and vonoprazan was well tolerated. The trial is registered with the National Board of Health (EudraCT: 2015–001154-14) database.

Neurogastroenterol Motil 2023;35:e14468.

EXMI BY PROCAPS

ERGE Vonoprazan versus Esomeprazol

Esomeprazol Convencional

=

Vonoprazan

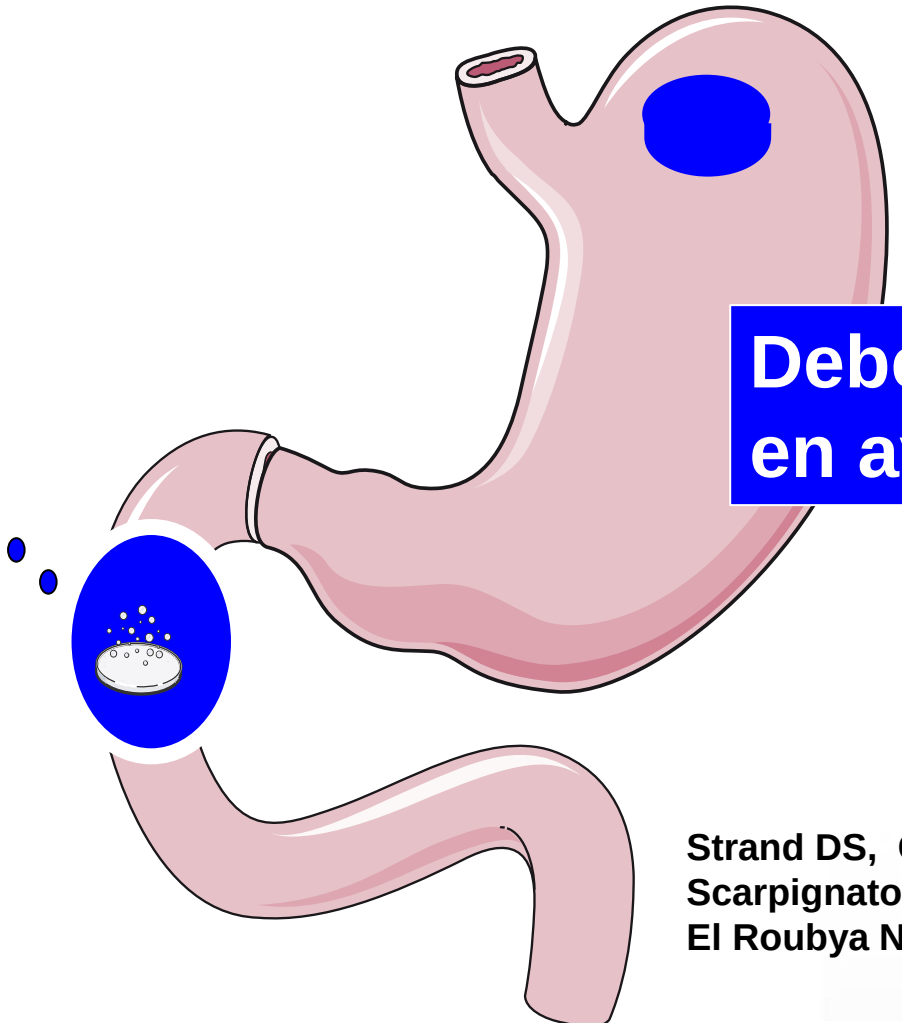
Esomeprazol Liberación inmediata ?

Novedad

IBP liberación
Inmediata
Varios países
Latinoamérica

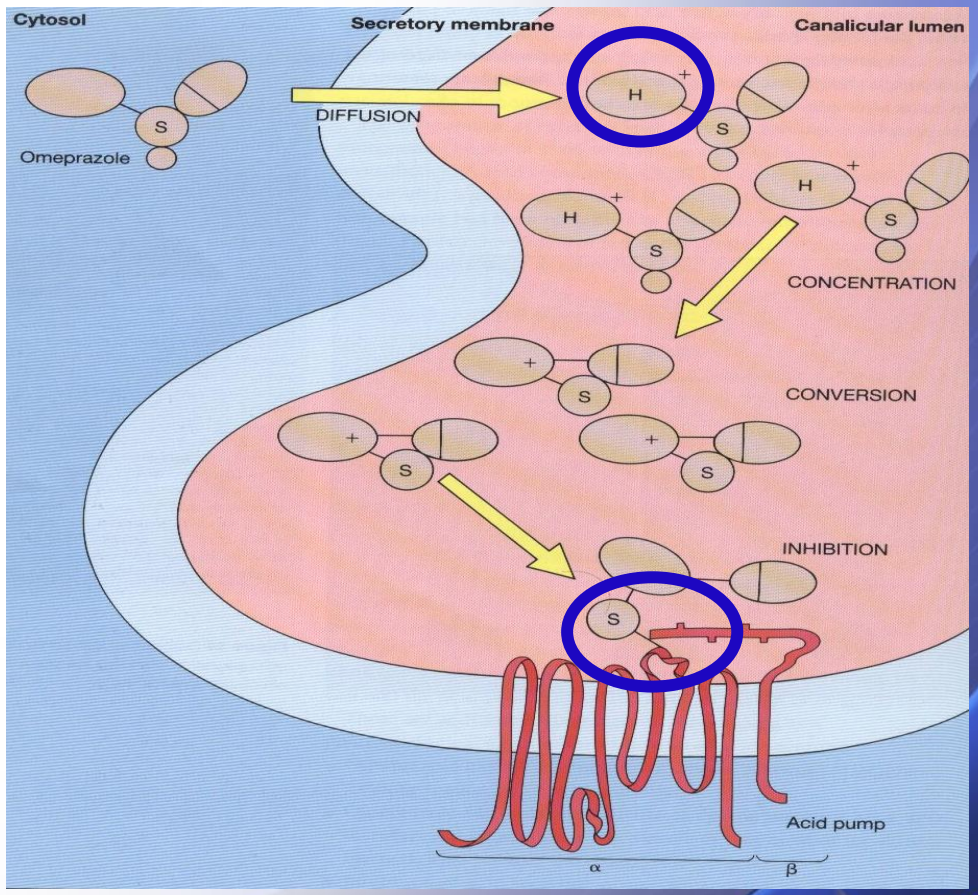
IBPs convencionales 1era y 2da Generación

Liberación Retardada



Deben darse en ayunas

Activación



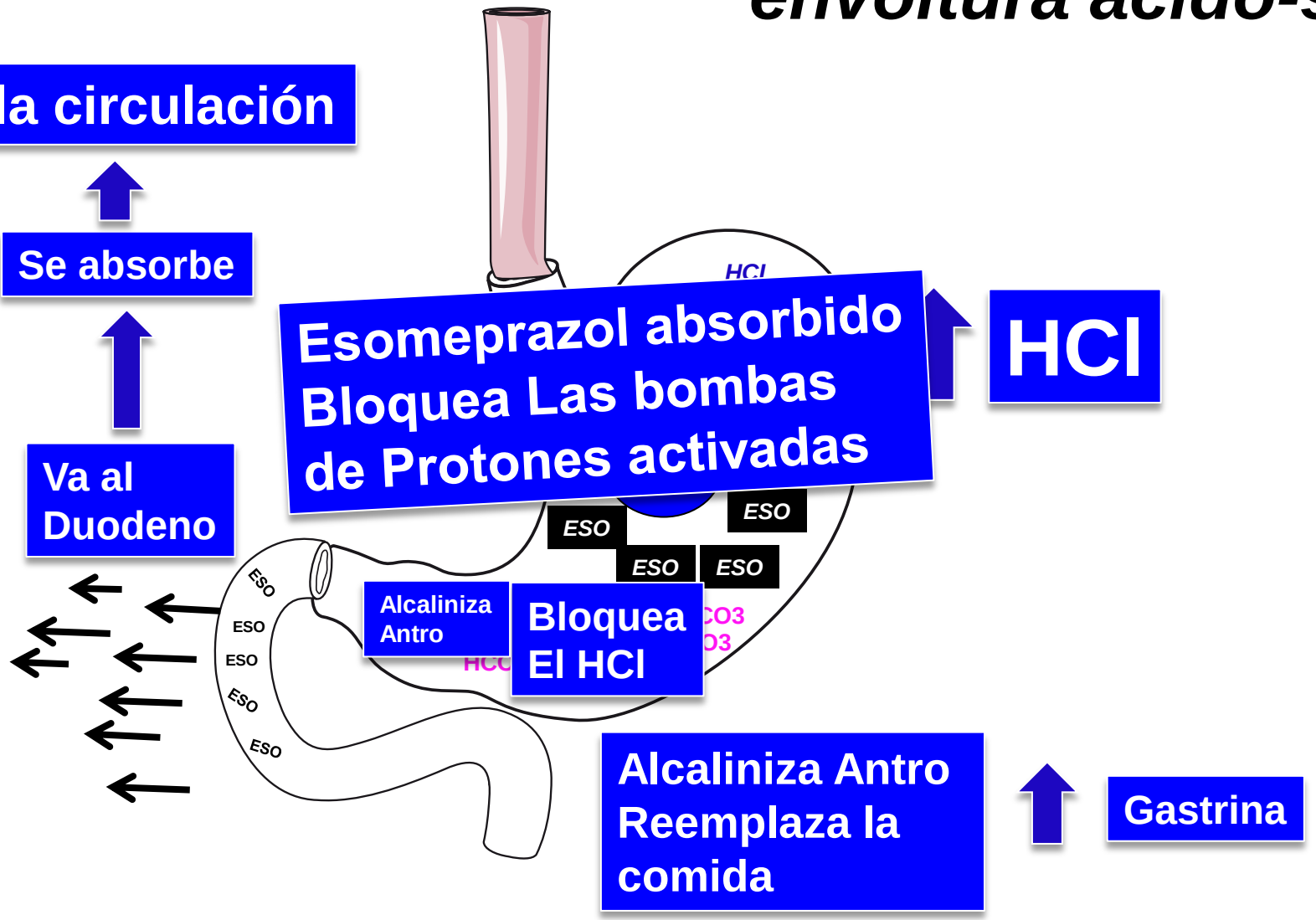
Strand DS, Gut Liver 2017;11:27-37
Scarpignato C, Curr Opin Pharmacol 2008;;8:677-84
El Roubya N, Exp Opin Drug Met Toxicol 2018;14:447–60

IBP Liberación Inmediata: envoltura ácido-sensible

Propósito

Agilizar la absorción

Superar Liberación Retardada



Adv Ther (2021) 38:1660–1676
https://doi.org/10.1007/s12325-021-01644-7

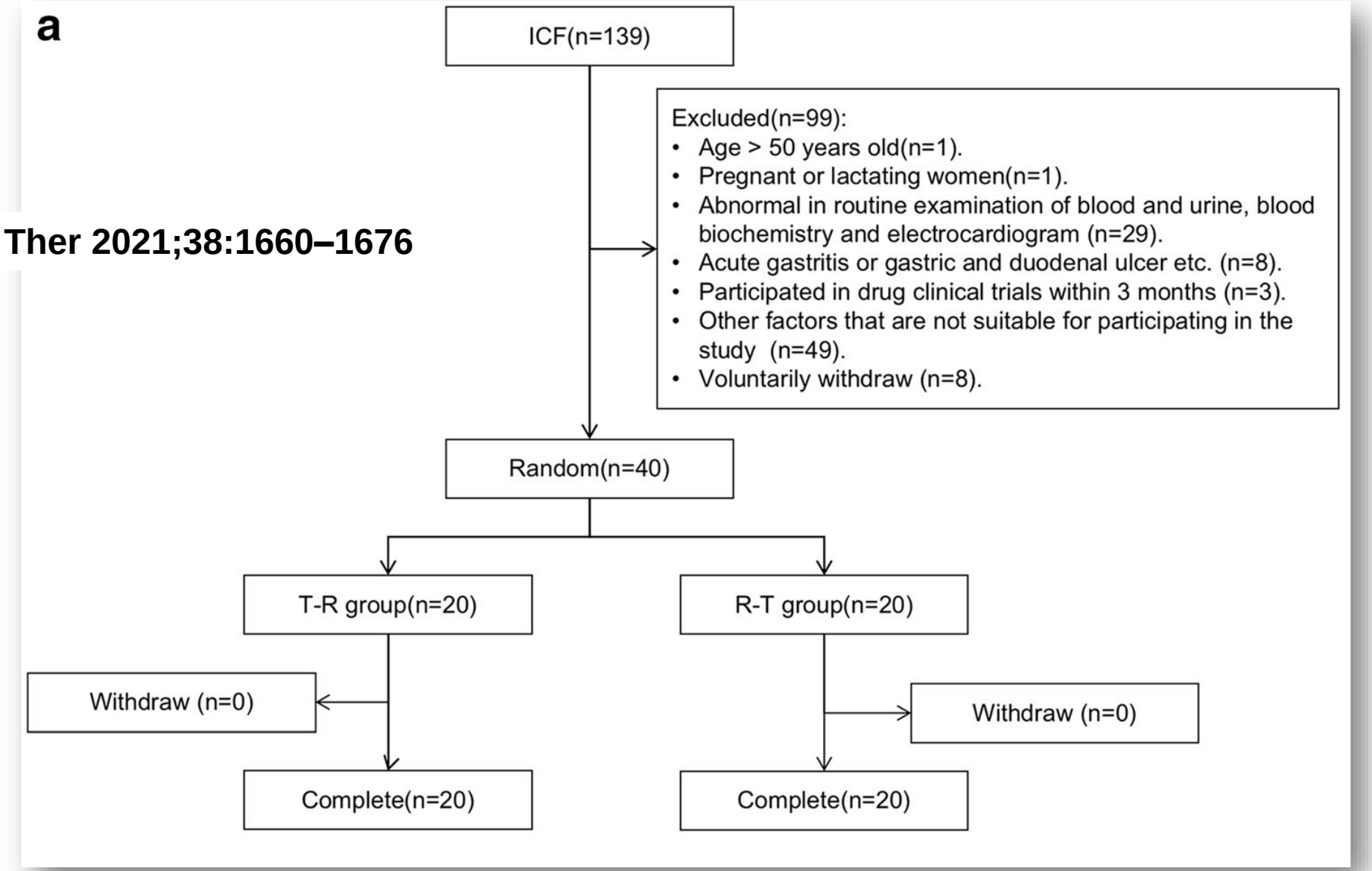
ORIGINAL RESEARCH

Changchun Haiyue Pharmaceutical have developed IR-ESO

Pharmacokinetics and Pharmacodynamics of Esomeprazole/Sodium Bicarbonate Immediate-Release Capsules in Healthy Chinese Volunteers: A Cross-Over, Randomized Controlled Trial

Shan Jing · Yue Zhu · Wenfang Liu · Kexu Yang · Lili Hu · Dan Deng · Chunyan Lu · Yang Lin

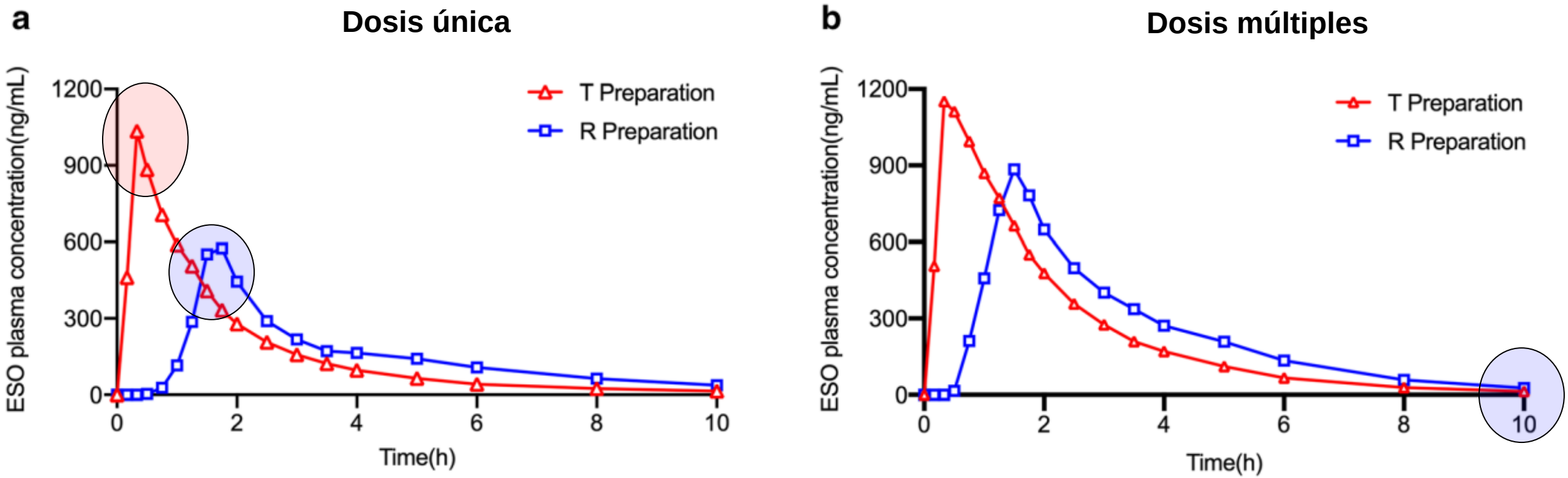
Jing S, Adv Ther 2021;38:1660–1676



ESO 20 mg + Sodium bicarbonate 1100 mg Changchun Haiyue Pharmaceutical

ESO 1 tableta 20 mg Astrazeneca (Nexium)

Esomeprazol liberación inmediata vs Liberación retardada



Jing S, Adv Ther 2021;38:1660-76

The safety, pharmacodynamics, and pharmacokinetics of immediate-release formulation containing esomeprazole 20 mg/sodium bicarbonate 800 mg in healthy adult male

40 voluntarios sanos

Dasohm Kim[1,2]
Min Soo Park[1,2]
Byung Won Yoo[2]
Taegon Hong[2]
Shin Jung Park[3]
Choon Ok Kim[2]

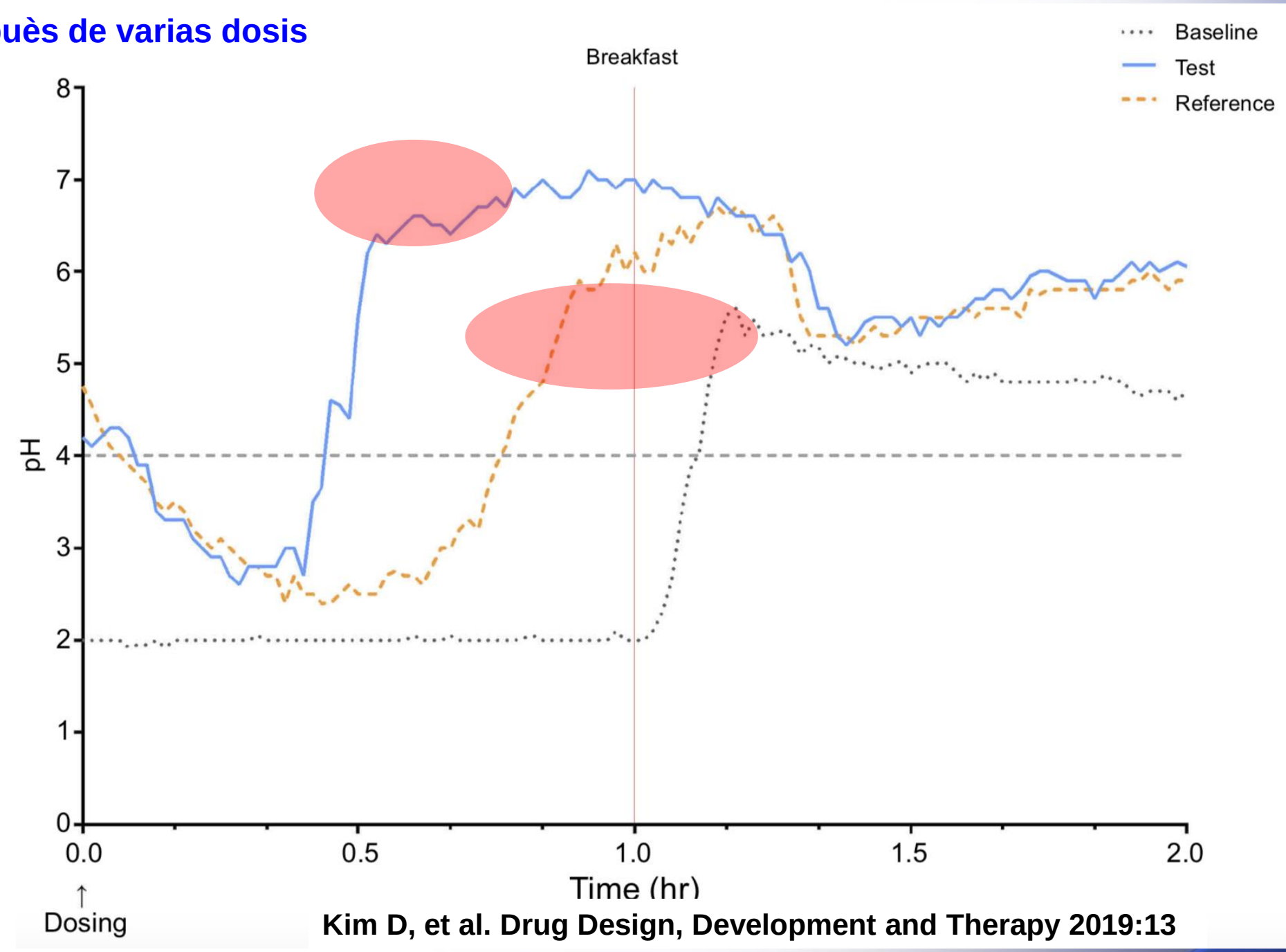
This article was published in the following Dove Press journal:
Drug Design, Development and Therapy

Background: Esomeprazole is the most effective treatment for acid-related disorders and is widely used with enteric coating due to rapid degradation in the acidic environment. However, the enteric-coated formulation delays absorption and onset of action. To overcome this limitation, an immediate-release formulation containing esomeprazole 20 mg and sodium bicarbonate 800 mg (IR-ESO) was developed.

Purpose: To evaluate the safety, pharmacokinetics (PK), and pharmacodynamics of IR-ESO compared to those of esomeprazole 20 mg (ESO)

Kim D, et al. Drug Design, Development and Therapy 2019:13

Dia 7, despuès de varias dosis



Kim D, et al. Drug Design, Development and Therapy 2019:13

GASTROENTEROLOGY

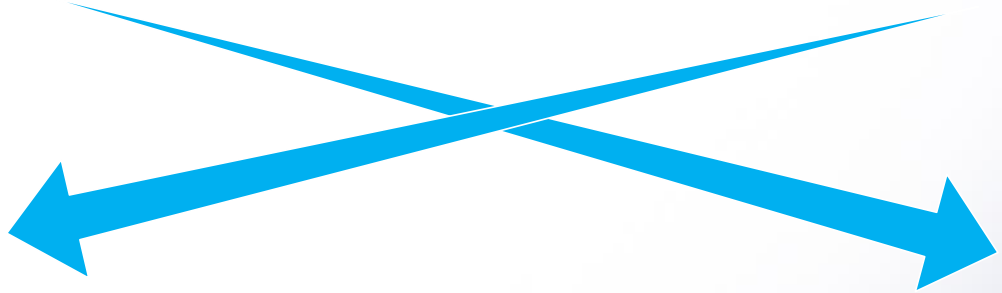
Oral buffered esomeprazole is superior to i.v. pantoprazole for rapid rise of intragastric pH: A wireless pH metry analysis

Rupa Banerjee,* D Nageshwar Reddy,* Nalini M Guda,† Rakesh Kalpala,* Swapna Mahurkar,* Santosh Darisetty* and G Venkat Rao*

10 Voluntarios sanos (8H, 2M), 31 años,IMC 21kg/m2, No anemia, *H.pylori* (-), perfil hepático normal. Dos dosis en 24 h *"washout"* 2 semanas Crossover

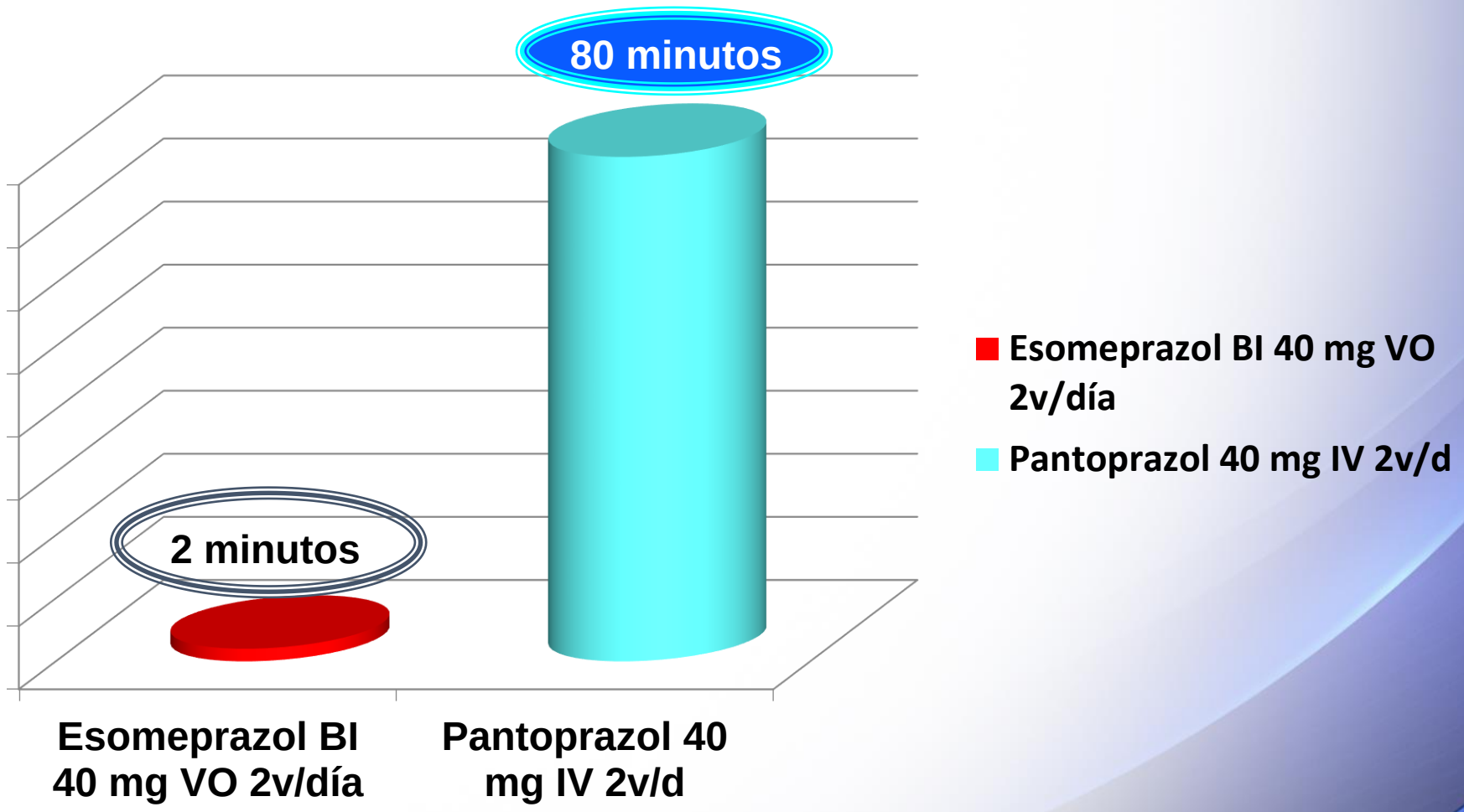
Esomeprazol BI 2v/dìa

Pantoprazol 40 mg IV 2v/dìa



Banerjee R, J Gastroenterol Hepatol 2010; 25: 43–47

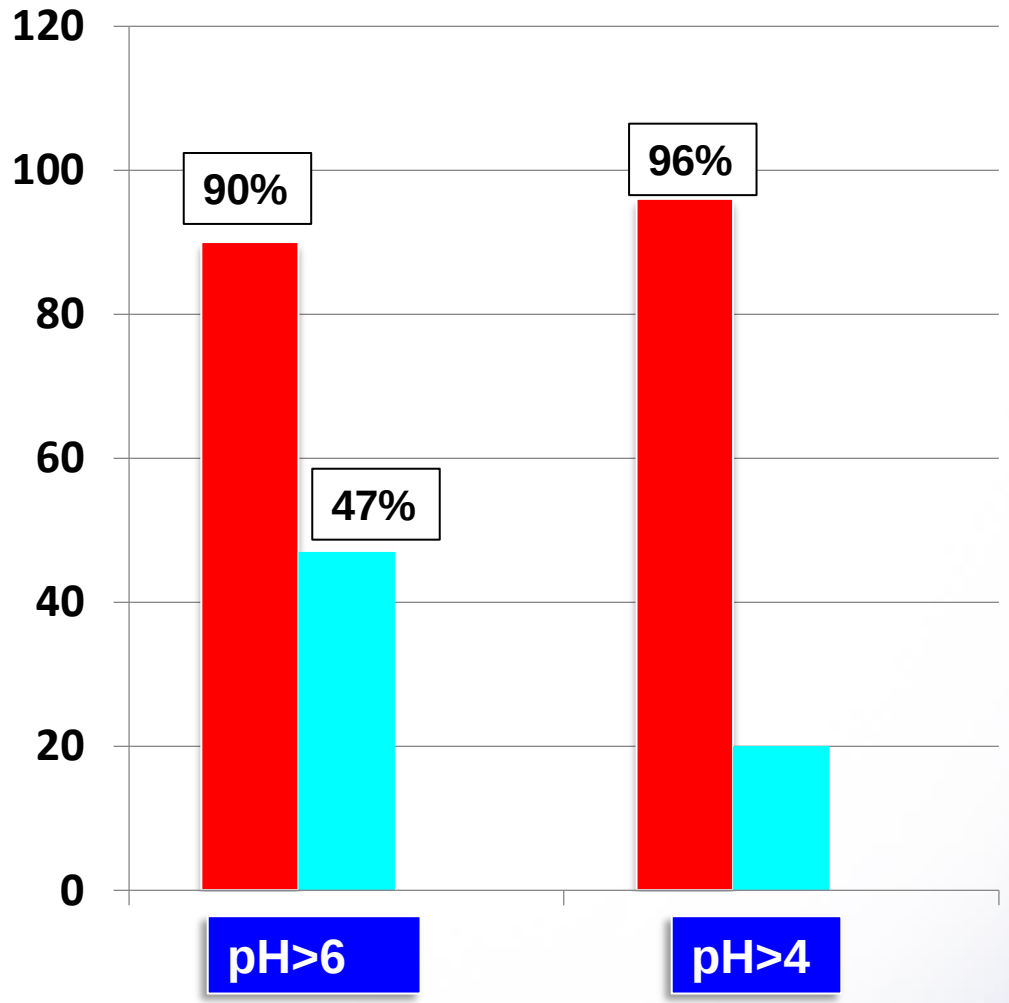
Tiempo para lograr pH > 6: Esomeprazol BI *vs* Pantoprazol IV/ 2v/dìa



Banerjee R, J Gastroenterol Hepatol 2010; 25: 43–47

% de 24 Horas con pH > 4 y >6
ESO BI 40 mg VO 2v/d VS Pantoprazol 40 mg IV/ 2v/dìa

pH
24 horas



La elevación del pH Persistió después de 6h de la 1era dosis: No es por efecto local del HCO3!

Banerjee R, J Gastroenterol Hepatol 2010; 25:43-47

Abstract

Background and Aims: A pH of more than 6 is required for clot stability and hemostasis. Intravenous proton pump inhibitors have a rapid onset of action compared to oral and have been preferred for management of non-variceal bleeding. Intravenous pantoprazole has

Por su rapidez de acción y Elevación de pH >6, Sería una excelente opción En en hemorragia por ulceras pépticas

tration. It was significantly superior to i.v. pantoprazole in equivalent dosing. This finding could have implications in the management of non-variceal bleed where a rapid and sustained pH of more than 6 is desirable.

Banerjee R, J Gastroenterol Hepatol 2010; 25: 43–47

A Randomized, Double-Blind, Active-Control, Noninferiority, Multicenter, Phase 4 Study to Evaluate the Efficacy and Safety of Esomeprazole/Sodium Bicarbonate 20/800 mg in Patients with Nonerosive Gastroesophageal Reflux Disease

Su Hyun Park[1], Kang Nyeong Lee[1], Oh Young Lee[1], Myung Gyu Choi[2], Jie-Hyun Kim[3], In-Kyung Sung[4], Jae Young Jang[5], Kyung Sik Park[6], Hoon Jai Chun[7], Eun Young Kim[8], Jun Kyu Lee[9], Jin Seok Jang[10], Gwang Ha Kim[11], Su Jin Hong[12], Yong Chan Lee[13], Suck-Chei Choi[14], Hyun Soo Kim[15], Tae Oh Kim[16], Gwang Ho Baik[17], and Yong Cheol Jeon[18]

Table 3. Proportions of Patients with Symptoms for More Than 3 Days among Those Patients with Complete Resolution of Heartburn at Week 4

Variable	Total (n=125)	Esoduo® group (n=62)	Nexium® group (n=63)	p-value*
Heartburn				
Daytime (>3 days)	25 (20.0)	17 (27.4)	8 (12.7)	0.040

Mas pacientes no tenían pirosis más de 3veces/día

Gut Liver 2023;17:226-233

Esomeprazol Liberación inmediata
Resuelve desventajas IBPs 1ª Generaciòn

Esomeprazol
Independiente Cyp2C19
Más potente > inhibición HCl

Acciòn Inmediata

Bicarbonato

No necesita darse Antes de comida

Supera actividad Esomeprazol original

CME

Katz PO, Am J Gastroenterol. 2022;117:27-56

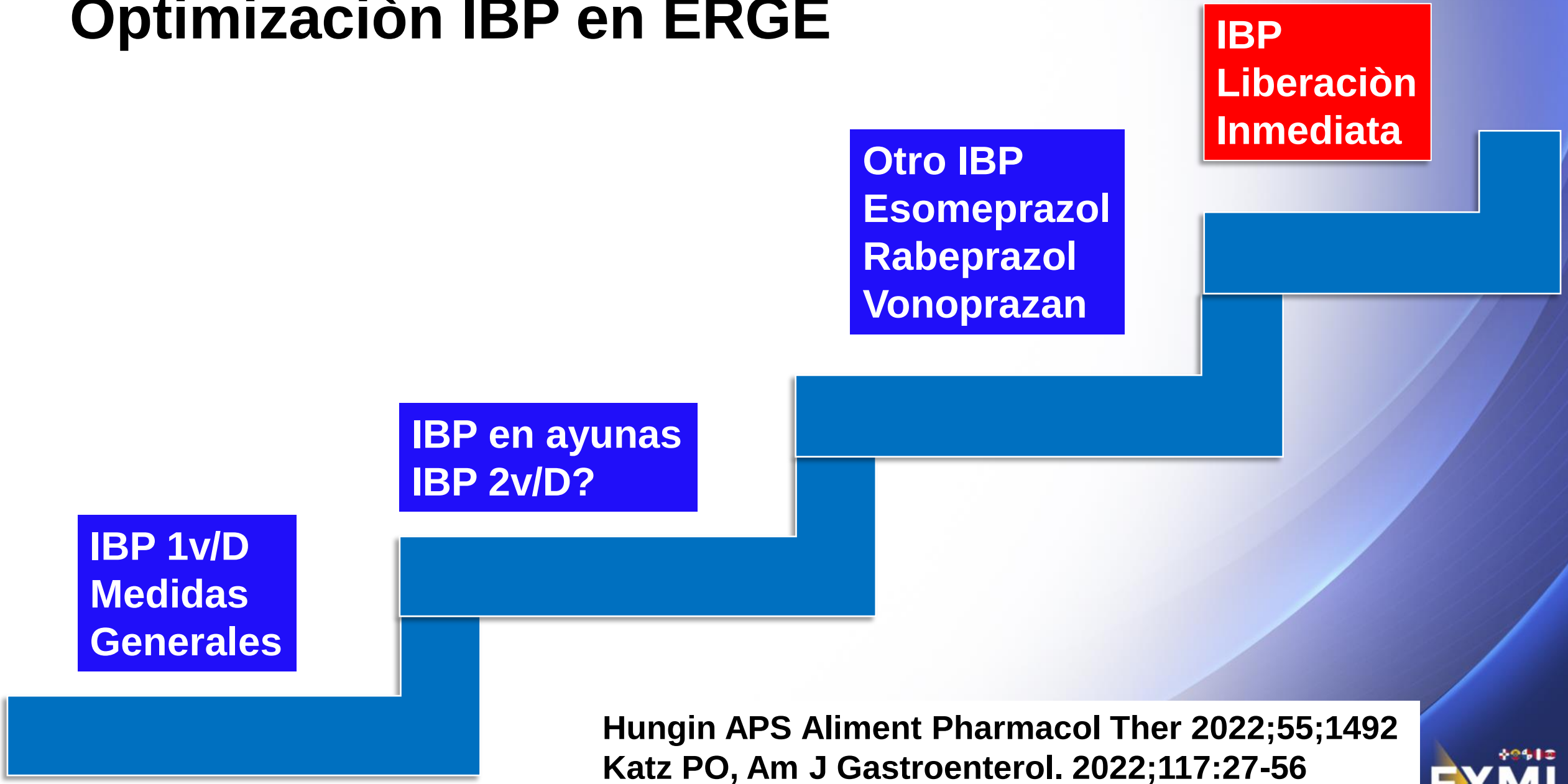
ACG Clinical Guideline for the Diagnosis and Management of Gastroesophageal Reflux Disease

Philip O. Katz, MD, MACG[1], Kerry B. Dunbar, MD, PhD[2,3], Felice H. Schnoll-Sussman, MD, FACG[1], Katarina B. Greer, MD, MS, FACG[4], Rena Yadlapati, MD, MSHS[5] and Stuart Jon Spechler, MD, FACG[6,7]

An omeprazole-sodium bicarbonate combination that is not enteric-coated provides good control of intragastric pH in the first 4 hours of sleep when dosed at bedtime (57).

There is little rationale for switching (almost all PPIs are similarly effective at equiactive antisecretory doses) unless the switch is toward a more effective antisecretory compound (e.g. esomeprazole,[15,16] rabeprazole[17,18]) or immediate release-omeprazole[20]).

Optimizaciòn IBP en ERGE



Hungin APS Aliment Pharmacol Ther 2022;55;1492
Katz PO, Am J Gastroenterol. 2022;117:27-56

Colombia, Serie de casos

68 pacientes síntomas nocturnos, ERGE 2-5 años,
28-60 años, 35 mujeres, Esofagitis B y C, IBP 2v/día

No mejoría, pirosis 3-4 v/semana

Esomeprazol-Bicarbonato 40 mg (Ezolium ®)
Por la mañana o al acostarse 8 semanas

Persistencia Síntomas 8%

Mejoría Síntomas 10%

No síntomas 80%

Otero W, manuscrito en preparación 2023

En ayunas

Con el estómago vacío

En la Tarde

A demanda

IBP ideal 2023

Seguro
Eficaz
Disponible
Rápida acción
Independiente de CYP2C19
Independiente de las comidas

Muchas gracias !