To the Editor: We read with great interest the exhaustive and updated review by Hachem and Shaheen (1) about the diagnostic workout and complex management of functional heartburn (FH). Diagnosis of FH is essentially achieved after having excluded other etiologies. Therefore, endoscopy has to be negative (i.e., no visible lesions), impedance-pH monitoring has to report physiological acid exposure and number of refluxes, further not related with the onset of symptoms, and manometry has not to recognize specific esophageal motility disorders. However, discrepancies between the latter negative findings and response to therapy, mainly proton pump inhibitors, is common and this suggests that current diagnostic procedures have important limitations for FH identification. In keeping, novel diagnostic modalities are desirable.

Recent data suggest that histologic evaluation, not only limited to dilated intercellular spaces (DIS) assessment, in patients with persistent symptoms despite optimal treatment might be of help to discriminate between FH and visceral hypersensitivity (2). Indeed, DIS has been considered the most important microscopic lesion related to reflux disease and symptom development (3). However, DIS are suggestive but not pathognomonic for gastroesophageal reflux disease (GERD), since its evaluation is subjective to high intra- and inter-observer assessment and, also for this reason, it has been found in other conditions (i.e., Candida infection, food allergy) and even in healthy subjects. Consequently, as acknowledged by the authors, this marker is not adequately sensitive or specific to recommend routinely esophageal biopsies. However, to partially increase the diagnostic accuracy of DIS, other histologic alterations related to GERD should be assessed, such as basal cell hyperplasia and papillary elongation. Recent studies have demonstrated that the evaluation of microscopic esophagitis achieved by adopting a histologic score resulting from the sum of all lesions assessed, rather than individually, guaranteed the best discrimination between non erosive reflux disease (NERD), FH, and controls (3–5).

With regard to impedance-pH monitoring, it is true that its diagnostic reliability, though good, is partially hampered by intra-individual variability and by the fact that symptoms recording is entrusted to patients’ compliance. However, during the past years, the diagnostic accuracy of this procedure has increased because of the development of new techniques such as baseline impedance and the post-reflux swallow-induced peristaltic wave (6,7). This latter has not been addressed in the review. We agree with the authors that these parameters are difficult to evaluate and so far they are used in specialized centers. Nevertheless, they seem to provide additional information helpful to better categorize patients with functional overlapping disorders or with incomplete response to treatment, which in turn should favor a tailored management.

In conclusion, since FH diagnosis is extremely challenging, we believe that all current diagnostic modalities should be considered in order to provide its correct identification and the best effective management.

CONFLICT OF INTEREST

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Microscopic Esophagitis, Baseline Impedance and Post-Reflux Swallow-Induced Peristaltic Wave in Functional Heartburn: Useful Diagnostic Tools

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It is Time to Re-Think the Role of Small Intestinal Bacterial Overgrowth in IBS Patients

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To the Editor: We read with great interest the debate on the use of breath testing to diagnose small intestinal bacterial overgrowth (SIBO) and the suggestion of treating this dysbiosis in irritable bowel syndrome (IBS) patients with antibiotics. Gupta and Chey (1) have emphasized the relevance of an accurate diagnosis of SIBO to maximize the benefits of rifaximin, and to minimize the dangerous overuse of antibiotics for wrong clinical indications. In fact, there are many investigations showing the better yield of glucose breath test (GBT) over lactulose breath test in detecting SIBO, when compared with jejunal aspiration, because the latter examination leads substantially to an overdiagnosis of this condition in IBS (2). On the other hand, Pimentel (3) proposes to treat empirically IBS patients with rifaximin, owing to the fact that at present there is no valid gold standard to validate breath testing.

However, all the above Authors continue to consider SIBO as one of the main causes of IBS, although many studies have strongly denied the very high prevalence (84%) found first by Pimentel et al in IBS and have questioned the role of SIBO in determining IBS symptoms (4). On the other hand, IBS is a common functional condition, which is characterized by abdominal pain and alterations in the consistency and frequency of stool movements, which are often associated with bloating. This clinical presentation is totally shared by SIBO and therefore it cannot be excluded that patients with this condition have only IBS-like symptoms, but do not pertain to the IBS realm. This difference can explain the good success of antibiotics in many clinical situations linked to SIBO, as we have shown in past studies (5–8), and their poor benefit in IBS (4), whose pathophysiological conditions are complex and not related to a unique mechanism. We suggest that GBT should be reserved to patients with bowel symptoms and predisposing conditions to the occurrence of SIBO, such as previous abdominal surgery (i.e., intestinal resections or cholecystectomy), prolonged acid suppressive therapy impairing the sterilizing power of acid, chronic use of antidepressant drugs capable to reduce intestinal motility, connective tissue disorders, or the existence of functional constipation. In these cases, normalization of GBT after rifaximin therapy provided significant improvement of intestinal symptoms as shown in the above-mentioned clinical trials (5–8), but this success is probably due to the fact that treatment is addressed against an evident etiologic factor, which is unfortunately lacking in IBS.

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