GI Reconnect NEWS

A Proceedings Snapshot for Gastroenterology Providers

As part of the 2025 GI ReConnect Conference, more than 80 gastroenterology providers convened to discuss current evidence and understanding of gastrointestinal (GI) therapeutics. Highlights of these discussions are summarized in this issue.

- Inflammatory bowel disease (IBD)
- Irritable bowel syndrome (IBS)
- Eosinophilic esophagitis (EoE)
- Gastroparesis, GERD, *Helicobacter pylori* infection
- Food intolerance
- *Clostridioides difficile* infection (CDI)

GI ReConnect

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Aurora, Colorado

GastroIntestinal Health Foundation

The 2025 ACG guidelines on IBD management emphasize the early introduction of

effective therapies, rapid steroid tapering, and continuous maintenance therapy with routine monitoring and treat-to-target follow-up.[1] Participants noted that the trend toward early use of advanced therapies continues to shape IBD management paradigms. Many experts are moving away from infliximab- and thiopurine-based regimens for initial therapy—except in acute severe ulcerative colitis— and are instead favoring earlier use of interleukin (IL)-23 or janus kinase (JAK) inhibitors. Despite restrictions limiting the use of JAK inhibitors to patients who have failed tumor necrosis factor (TNF) inhibitors, clinicians value these agents for their efficacy and rapid onset of action. In the absence of direct efficacy comparisons, practical considerations such as route of administration, convenience, and insurance reimbursement are key factors influencing treatment selection among these agents. Recognizing that contemporary biologics and small-molecule therapies are safer than long-term corticosteroids, the participants emphasized the importance of balancing therapy safety against the risks of inflammation-related damage resulting from undertreatment.

Despite initial resistance from both patients and providers, the use of biosimilars has become more widespread and is now considered a valuable cost-lowering tool that can improve access to advanced therapies. However, reimbursement for these therapies remains inconsistent. There is a strong interest in identifying combination advanced therapies for patients who have lost response to single advanced therapies. Despite promising efficacy, combination advanced therapies is a complex frontier that will require careful consideration for both safety and cost.

Great progress, but room for improvement.

The participants noted that a therapeutic ceiling appears to exist across all current IBD therapies, with most drugs demonstrating an efficacy plateau of approximately 30% to 40% in clinical trials. In other words, only about one-third of patients respond to any given therapy. This limitation may be due to immune escape mechanisms, similar to those observed with oncology therapeutics. The faculty suggested that as more is learned about these mechanisms, IBD therapies may eventually be primed and sequenced to direct certain cellular behavior, paralleling evolving strategies in oncology.

Managing comorbidities in IBD

With tthe prevalence of extraintestinal manifestations in IBD and the aging of the population, managing comorbidities has become an integral part of IBD care. Accordingly, coordinated care between gastroenterologists and other specialists who manage common comorbidities is essential for optimizing patient management. For example, GI clinicians often collaborate with rheumatologists and dermatologists to manage patients with immune-mediated diseases taht overlap with IBD, such as psoriasis, ankylosing spondylitis, and multiple sclerosis.

Recognizing IBD as a prothrombotic state, careful management is needed for patients with IBD and cardiovascular disease. The faculty noted that they frequently consult cardiologists and use strategies such as risk calculators, calcium scoring, and lipid monitoring to guide treatment decisions. Participants are also reported seeing more patients with IBD who have various cancers, noting that oncology treatments take priority while GI care adapts reactively. Vedolizumab and TNF inhibitors are commonly used for immune-related colitis, with prophylactic vedolizumab used in high-risk patients restarting immunotherapy.

1. Lichtenstein GR, Loftus EV, Afzali A, et al. ACT clinical guideline: management of Crohn's disease in adults. *Am J Gastroenterol.* 2025;120:1225-1264.
2. Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. ACG clinical guideline update: ulcerative colitis in adults. *Am J Gastroenterol.* 2025;120:1187-1224.

Looking ahead

The IBD pipeline is robust, with multiple therapies targeting various pathways currently under investigation. The TL1A inhibitors (eg, tulisokibart, duvakitug) are considered particularly promising given both their mechanism of action and their potential for biomarker-driven ability to predict response. TYK2 inhibitors (eg, deucravacitinib, ritelcitinib) have potential to achieve comparable efficacy of JAK inhibitors without the safety concerns that limit their use. Agents that combine 2 mechanisms may also be useful, such as an oral bispecific antibody that inhibits both TNF and IL-23. There is substantial interest in antifibrotic therapies that could potentially reverse fibrosis in IBD, although these agents are in very early stages of development.

Gastroenterologists are enthusiastic about the prospect of identifying biomarkers that can predict therapeutic response. Accordingly, companion diagnostics are anticipated to be increasingly important in IBD—paralleling their role in oncology—by facilitating targeted therapy and reducing time and cost spent on treatments that are unlikely to be effective for a given patient.

The widespread use of glucagon-like peptide 1 receptor agonists is increasingly influencing the IBD landscape. With recognition of their anti-inflammatory properties, these agents are being actively investigated in IBD, including a phase 3 study exploring a combination of mirikizumab and tirzepatide in one subcutaneous auto-injector.

Interest in modifying the microbiome—either directly or through dietary approaches—continues to grow, although this strategy has not yet translated into consistent clinical benefit. Despite hope for fecal microbiota transplant in this population, challeges with durable bacterial engraftment have limited the long-term efficacy of this approach. Nevertheless, interest in harnessing the microbiome continues to grow, with current research exploring ways to target specific bacterial subsets through bacterial phage therapy or other approaches that may be suitable for chronic use.

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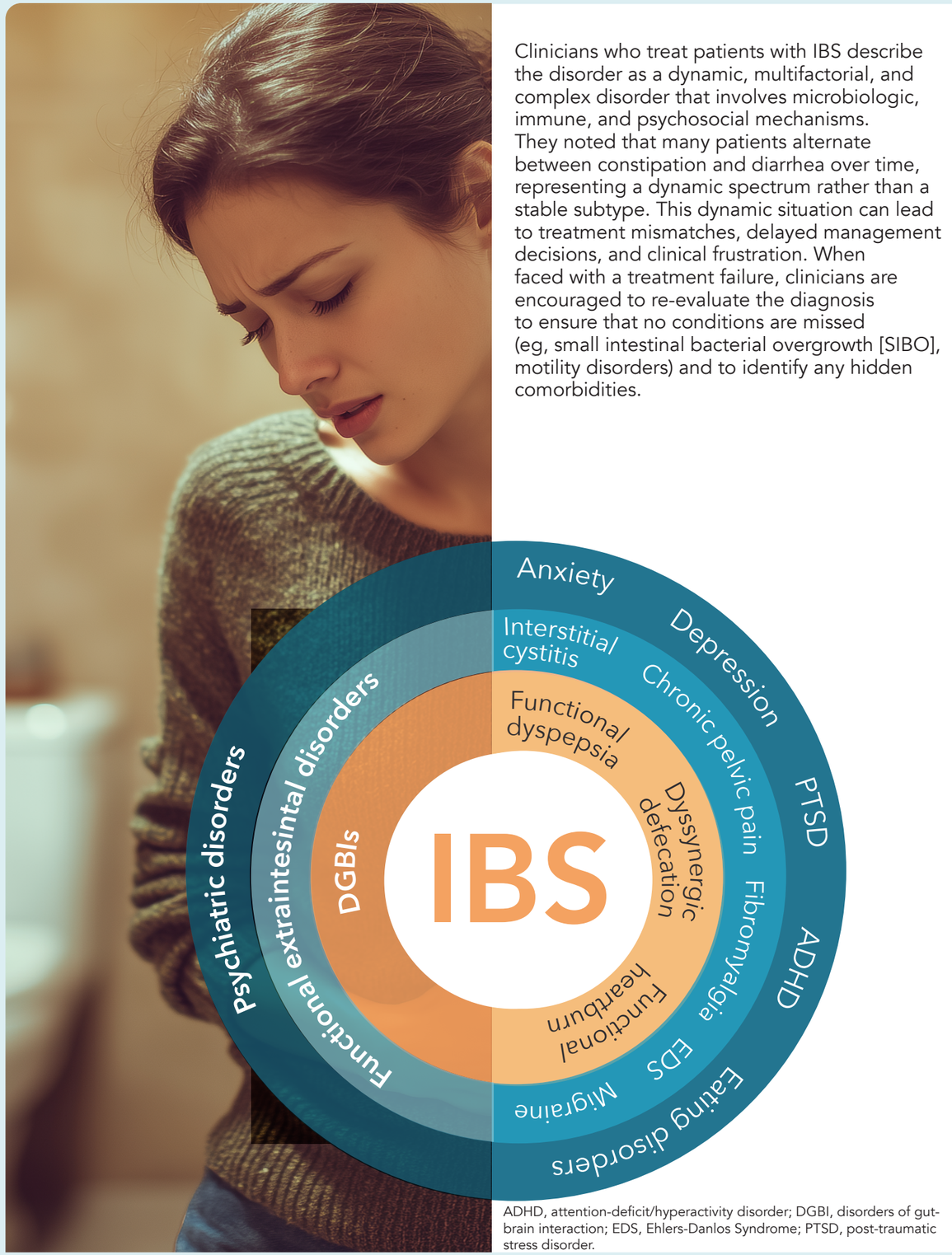

ADHD, attention-deficit/hyperactivity disorder; DGBI, disorders of gut-brain interaction; EDS, Ehlers-Danlos Syndrome; PTSD, post-traumatic stress disorder.

Clinicians who treat patients with IBS describe the disorder as a dynamic, multifactorial, and complex disorder that involves microbiologic, immune, and psychosocial mechanisms. They noted that many patients alternate between constipation and diarrhea over time, representing a dynamic spectrum rather than a stable subtype. This dynamic situation can lead to treatment mismatches, delayed management decisions, and clinical frustration. When faced with a treatment failure, clinicians are encouraged to re-evaluate the diagnosis to ensure that no conditions are missed (eg, small intestinal bacterial overgrowth [SIBO], motility disorders) and to identify any hidden comorbidities.

Comorbidities amplify the burden of IBS.

An essential component of IBS care is recognizing the many comorbidities and overlapping conditions that can occur in these patients. For example, one-third of patients with IBS are estimated to have another disorder of gut-brain interaction (DGBI), such as functional dyspepsia. Other broad types of comorbidities common to IBS include functional non-intestinal disorders with shared pain processing and serotonin-signaling pathways (eg, chronic pelvic pain, fibromyalgia, migraines), and psychiatric comorbidities.

The experts agreed that anxiety is the most prevalent comorbidity in patients with IBS, occurring in up to 60% of this population. They noted that anxiety can precede or follow an IBS diagnosis, and added that managing GI symptoms can often alleviate symptom-related anxiety. Although depression is common in this population, it tends to be less tightly linked to symptom severity than anxiety. Clinicians should be aware that trauma and post-traumatic stress disorder (PTSD) are major—and often undiagnosed—drivers of chronic pain and functional GI symptoms. Early-life trauma not only amplifies the severity of IBS but also predicts poor response to medications.

Up to 25% of patients with DGBIs may have comorbid attention deficit hyperactivity disorder (ADHD), and these patients tend to have worse anxiety and poorer outcomes than those without ADHD. Sleep dysfunction is also common in IBS and is strongly correlated with poor outcomes and heightened pain sensitivity.

Gynecologic conditions are common in women with IBS, with experts noting high rates of pelvic floor dysfunction, sexual dysfunction, and dyspareunia. It is important to identify and treat pelvic floor dysfunction appropriately with physiotherapy, as this can help alleviate IBS-related pain. They added that pelvic trauma and repeated in vitro fertilization (IVF) procedures can contribute to visceral hypersensitivity and chronic pelvic pain. Other pain-related comorbidities that may co-exist with IBS include Ehlers-Danlos Syndrome and joint hypermobility, both of which can increase the risk of regional pain syndromes post-surgery.

Disordered eating is an increasingly recognized comorbidity in patients with IBS, particularly in pediatric patients. Patients often self-restrict their diet excessively due to fear of symptom relapse, leading to nutritional deficiencies and social isolation. The experts described cases of "atypical anorexia nervosa," in which patients avoid specific foods due to fear of GI symptoms rather than body image. Often overlapping with avoidant/restrictive food intake disorder (ARFID), this type of restrictive eating can perpetuate a feedback loop of gut dysbiosis, symptom persistence, anxiety, and further avoidance. With this growing trend, the need for engaging dietitians in the care of patients with IBS is becoming increasingly important.

It takes a village

The high prevalence of comorbidities in this population highlights the need for a multidisciplinary approach to management. The participants emphasized that collaboration with psychologists, gynecologists, urologists, endocrinologists, dietitians, and other specialists, as appropriate, can be very helpful in confirming diagnoses of concomitant conditions and in determining treatment plans. Clinicians are strongly encouraged to engage GI psychologists when available, particularly for patients with a history of early-life trauma. Similarly, referral to a dietitian with relevant expertise is an essential component of care for patients with restrictive eating patterns.

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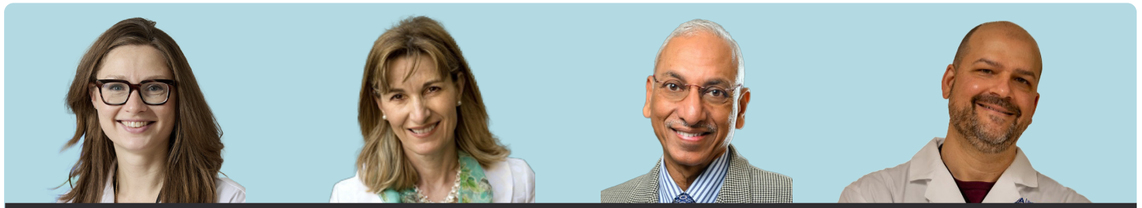

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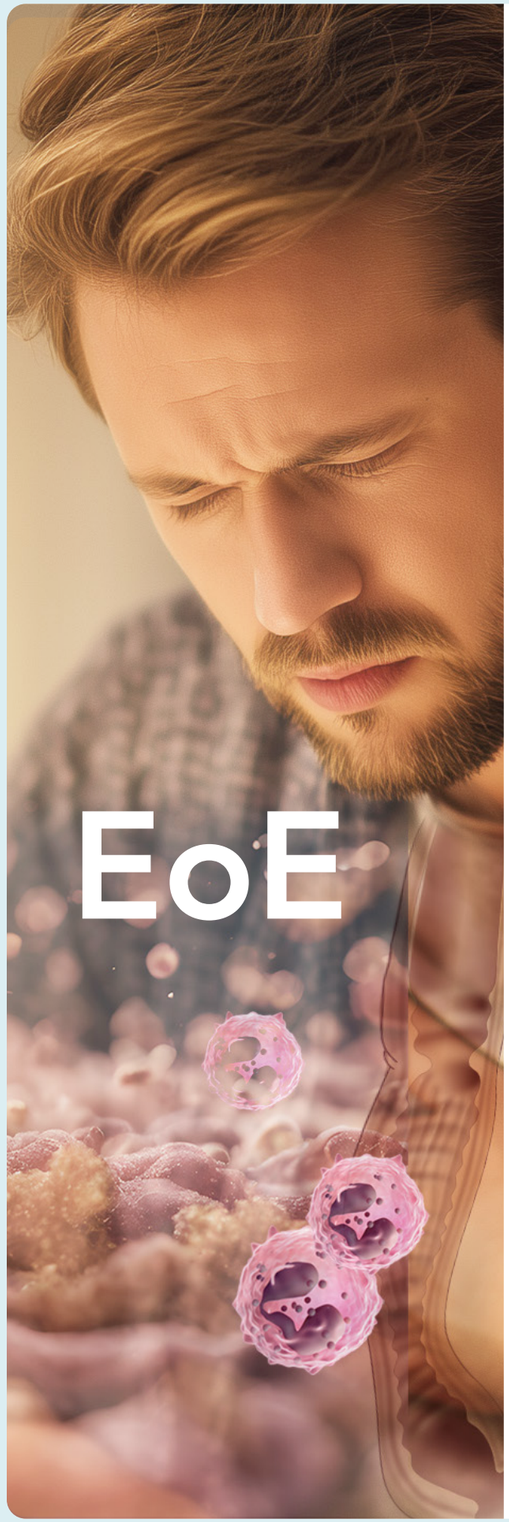


With the recent publication of updated EoE guidelines,[1] the participants discussed how these recommendations align with their own practices for diagnosing and managing EoE. The updated guidelines did not change the diagnostic criteria for EoE, whicih continue to emphasize symptoms suggestive of esophageal dysfunction, the presence of ≥15 eosinophils per high-power field (eos/hpf), and evaluation for non-EoE disorders that could cause or contribute to esophageal eosinophilia. While experts agree with the recommendation to obtain multiple (≥6) biopsies from different esophageal levels, their approaches vary regarding obtaining biopsies from the stomach and duodenum to assess for eosinophilic gastroenteritis, as recommended by the American Society for Gastrointestinal Endoscopy (ASGE).[2] Although some experts maintain a low threshold for biopsying the stomach in patients with EoE, the participants agreed that routine biopsies of the stomach and duodenum are unnecessary in the absence of clinical symptoms. However, when non-esophageal sites are biopsied, however, multiple biopsies should be obtained (4 bites in the antrum, 4 in the body, and ≥4 in the duodenum).

An important consideration is whether patients should be off therapy at the time of the index endoscopy. Because any therapy can influence endoscopic findings, the experts agreed that treatment should be discontinued before the index endoscopy whenever possible. They noted that patients should be off proton pump inhibitor (PPI) therapy for at least 2 weeks—and ideally for 6 to 8 weeks—before their first endoscopy to diagnose EoE.

The recommendation to quantify eosinophil counts on esophageal biopsies is an important change in the 2025 guidelines.[1] Although exceeding the 15 eos/hpf threshold is a key diagnostic criterion, the ability to evaluate trends in eosinophil count is needed to assess treatment response and guide therapy. Additionally, several experts noted that they are collaborating with pathologists at their institutions to template pathology reports in an effort to better capture certain ancillary features, such as micro abscesses and basal cell hyperplasia.

The experts advocate the use of standardized scoring systems to characterize and follow disease severity. The guidelines recommend routine use of the EoE Endoscopic Reference Score (EREFS) to assess and track endoscopic features of the disease. Additionally, the experts commonly use the Index of Severity in EoE (I-SEE), an app developed by the American Gastroenterological Association (AGA), to determine baseline disease severity and monitor patients' progress. This tool can be completed quickly and easily using information from the electronic medical record (EMR), and can help patients engage in their own care when completed during their visit.

Shared decision making allows you to get to know the patient better and the patient to get to know you, and that builds up a level of trust. Since this is a chronic disease, you're going to be following people over time, and that trust is so important.

Managing EoE

The therapeutic landscape of EoE includes multiple effective therapies that address the inflammatory and fibrotic aspects of the disease. Because there are no direct comparative trials of EoE therapies, treatment selection is driven by individual disease characteristics and patient preference using shared decision making. Patients should understand the benefits, limitations, and nuances of each treatment option. The experts agreed that the shared decision-making process is one of the most gratifying aspects of EoE care for both patients and clinicians.

Consistent with the updated guidelines,[1] most experts consider PPIs, topical steroids, and dietary elimination to be reasonable first-line options for treatment of EoE, with PPIs acknowledged as the most commonly used first-line option. With meta-analyses demonstrating that PPIs achieve histologic remission in about 45% of patients,[3] not all patients will respond to these agents. The guidelines recommend initiating PPIs at "high doses"—ie, double the approved doses for gastroesophageal reflux disease (GERD), such as omeprazole 40 mg once daily or 20 mg twice daily. Although guidelines recommend administering PPIs once daily or divided twice daily before meals, most experts favor twice-daily dosing, at least initially. Despite their good tolerability and widespread use, the widely-publicized concerns regarding the long-term safety of PPIs should be discussed with patients. Although most reported associations between PPIs and safety concerns are weak and the available data do not establish causality, it is reasonable to use the lowest effective disease that controls the disease and to routinely reassess treatment response.

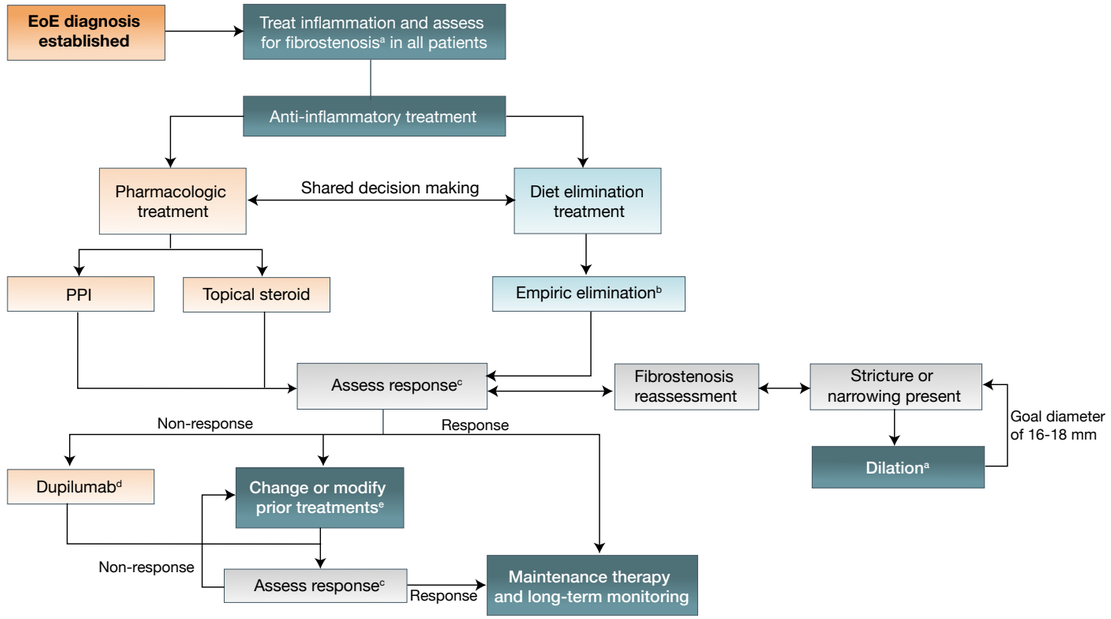
Topical steroids are used most commonly when patients fail to respond to PPIs or have more advanced disease. Key aspects of patient counseling regarding these agents include administration instructions—especially when off-label formulations are used—and reassurance for patients who are concerned about steroid-related side effects. Notably, experts expressed confidence in the safety of topical steroids, with concern for systemic adverse effects arising only when they are used concomitantly with other forms of steroids.

When discussing dietary elimination as a treatment option, patients should understand that these approaches require a significant initial investment on their part and are not intended for the "faint of heart." Although multiple dietary elimination regimens exist, many patients will respond to 1-food or 2-food elimination diets. Accordingly, some experts begin with a 2-food elimination diet and step up to 4- and 6-food elimination if needed. Practical challenges of dietary management include the need for repeated endoscopies after foods are reintroduced (eg, every 6 to 8 weeks), the need for dietitian support, and reliance on patient motivation and adherence for success. Although this type of commitment may not be sustainable for many patients, it may be reasonable for those who want to avoid using medications to treat their disease.

Esophageal dilation is an important adjunct therapy for patients with persistent dysphagia despite achieving endoscopic and histologic remission. Although dilation improves esophageal caliber and reduces symptoms of dysphagia, it must be combined with other treatments because it does not address esophageal inflammation.

Dupiliumab is often used as step-up therapy in patients who have failed PPIs or topical steroids and those who have failed or are unwilling to try dietary elimination. Earlier initiation of

ACG management algorithm for EoE.[1]



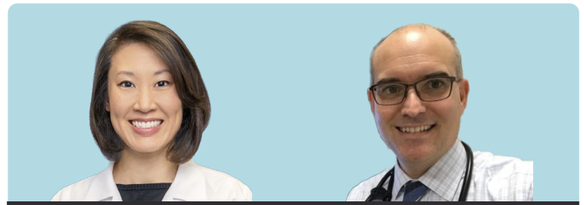
[a]Anti-inflammatory treatment is needed in all patients even if dilation is performed. Dilation can be considered prior to concomitant anti-inflammatory treatment if a critical stricture.
[b]Consider less restrictive diet elimination to start.
[c]Response should be assessed with symptoms, endoscopic findings with EREFS, and histologic features including quantified eosinophil count on esophageal biopsy.
[d]Patients receiving dupilumab generally should be PPI non-responders or intolerant to PPI; consider early use of dupilumab if moderate to severe asthma or eczema is present and after relevant subspecialist consultation.
[e]Could including changing medication, dose, or formulation, moving to a more restrictive diet, or considering a clinical trial.

dupilumab may be appropriate for patients with concomitant atopic conditions (eg, atopic dermatitis, asthma, chronic rhinosinusitis with nasal polpys) and potentially for younger patients with severe disease who are experiencing feeding difficulties and weight loss.

Current evidence suggests that patients do not "grow out of EoE," and that disease activity returns if treatment is discontinued. Recognizing that EoE follows a progressive, fibrostenotic course in most patients, the experts agree with guideline recommendations to continue maintenance therapy with dietary or pharmacologic treatments. However, the decision to continue maintenance therapy should be shared with patients, as some may not be willing to continue treatment once their symptoms resolve. It is also important to routinely follow up with patients, typically annually, to ensure continued treatment response. In the absence of data informing the optimal interval for endoscopy in patients in remission, the experts rely on their clinical judgement and patient-specific factors (eg, response, adherence) to determine when repeat endoscopies are appropriate.

1. Dellon ES, Muir AB, Katzka DA et al. ACG clinical guideline: diagnosis and management of eosinophilic esophagitis. *Am J Gastroenterol.* 2025;120(1):31-59.
2. Aceves SS, Alexander JA, Baron TH, et al. Endoscopic approach to eosinophilic esophagitis: American Society for Gastrointestinal Endoscopy Consensus Conference. *Gastrointest Endosc.* 2022;96(4):576-592.

EoE faculty chairs



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The epidemiology, diagnosis, and management landscape of CDI have evolved considerably over the past decade. Participants reported a plateau in the number of both hospital- and community-acquired cases of CDI in recent years, potentially due to stricter hospital testing policies and improved hygiene following the COVID pandemic. Recurrence rates of CDI appear to be lower, which may reflect the use of more refined treatment strategies. At the same time, management is shifting from tertiary care centers to community settings as primary care providers gain confidence in managing the infection.

Diagnostic algorithms for CDI are shifting from the historical reliance on polymerase chain reaction (PCR)-only testing, which cannot distinguish between colonization and true infection and may lead to overdiagnosis. Many institutions are now adopting multistep algorithms that begin with enzyme immunoassay (EIA) for glutamate dehydrogenase (GDH) and toxins A/B, followed by PCR testing if the results are discordant. The participants emphasized the need for clinical judgement when interpreting test results, stressing the importance of correlating test results with symptoms (eg, ≥3 loose stools in 24 hours) to avoid mismanagement or even iatrogenic CDI from unnecessary antibiotic treatment.

Approved live bacteriotherapeutic products[1,2]

	VOWST™	REBYOTA™
Description	Fecal microbiota spores, live-brpk	Fecal microbiota, live-jslm
FDA approval	2023	2022
Formulation	Oral capsules	Suspension for rectal use
Administration	**Prior to taking the first dose:** Complete antibacterial treatment for rCDI 2-4 days before initiating treatment with VOWST. Drink 296 mL magnesium citrate on the day before and ≥8 hours prior to taking the first dose of VOWST.	Enema administered by a healthcare provider 24 to 72 hours after the last dose of antibiotics for CDI.
Dosage	4 capsules daily, on an empty stomach prior to the first meal of the day, for 3 consecutive days	Single 150 mL-dose rectally
Most common adverse events	Abdominal distension (31.1%), fatigue (22.2%), constipation (14.4%), chills (11.1%), and diarrhea (10.0%)	Abdominal pain (8.9%), diarrhea (7.2%), abdominal distension (3.9%), flatulence (3.3%), nausea (3.3%)

Changes in product availability and accessibility are reshaping the therapeutic landscape of CDI.

Despite the demonstrated superiority of fidaxomicin in reducing recurrence, vancomycin continues to be used widely because of its affordability. However, the anticipated availability of generic fidaximicin may improve accessibility and facilitate its first-line use, as recommended in the IDSA/SHEA guidelines.[3] In 2024, the monoclonal antibody bezlotuxumab was discontinued, leaving a gap for first infections in high-risk and immunocompromised patients. Another significant change in 2024 was the FDA's decision to end enforcement discretion for OpenBiome, the nation's largest distributor of fecal microbiota therapy (FMT) products. With the closure of OpenBiome, the FDA-approved live microbiome products, Vowst and Rebyota, became the primary means of microbiota restoration. Clinical trials have demonstrated the safety and efficacy of both products in reducing CDI recurrence, although access remains inconsistent. Although currently recommended for use after second recurrence, emerging evidence supports earlier use of these products (ie, after first recurrence) in selected high-risk patients, such as those with IBD or cancer.

1. VOWST [prescribing information]. Aimmune Therapeutics, Inc. Bridgewater, NJ; 2025.
2. REBYOTA [prescribing information]. Ferring Pharmaceuticals; Roseville, MN; 2022.
3. Johnson S, Lavergne V, Skinner AM et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused update guidelines on management of *Clostridioides difficile* infection in adults. *Clin Infect Dis.* 2021ciab549.

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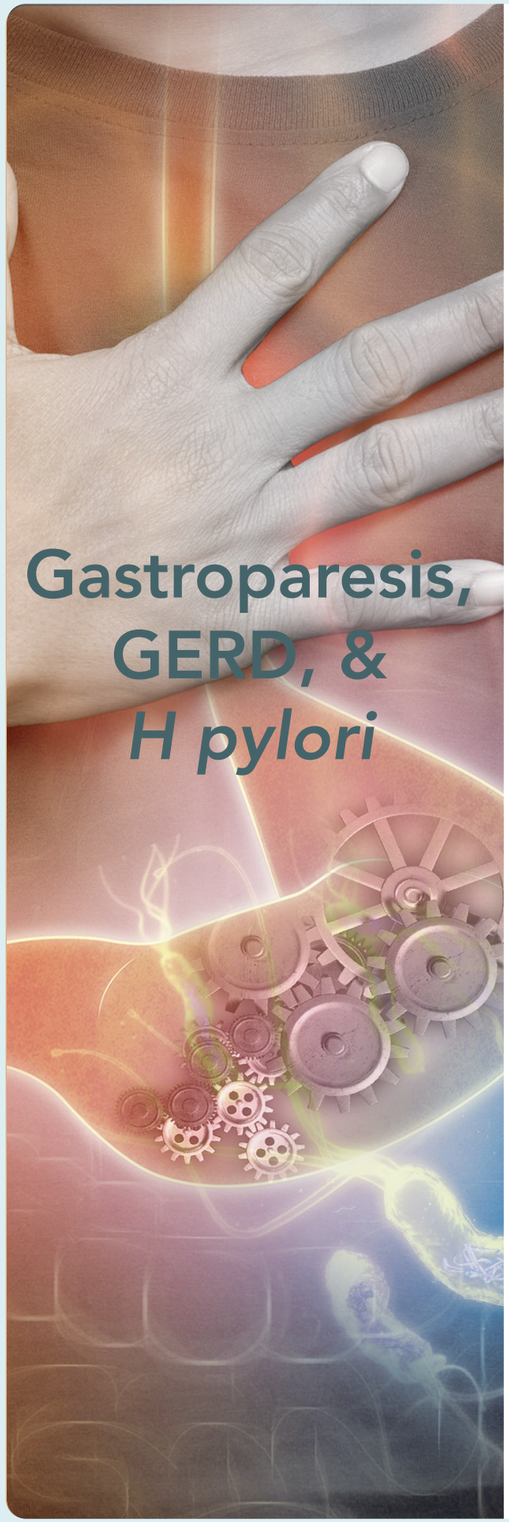


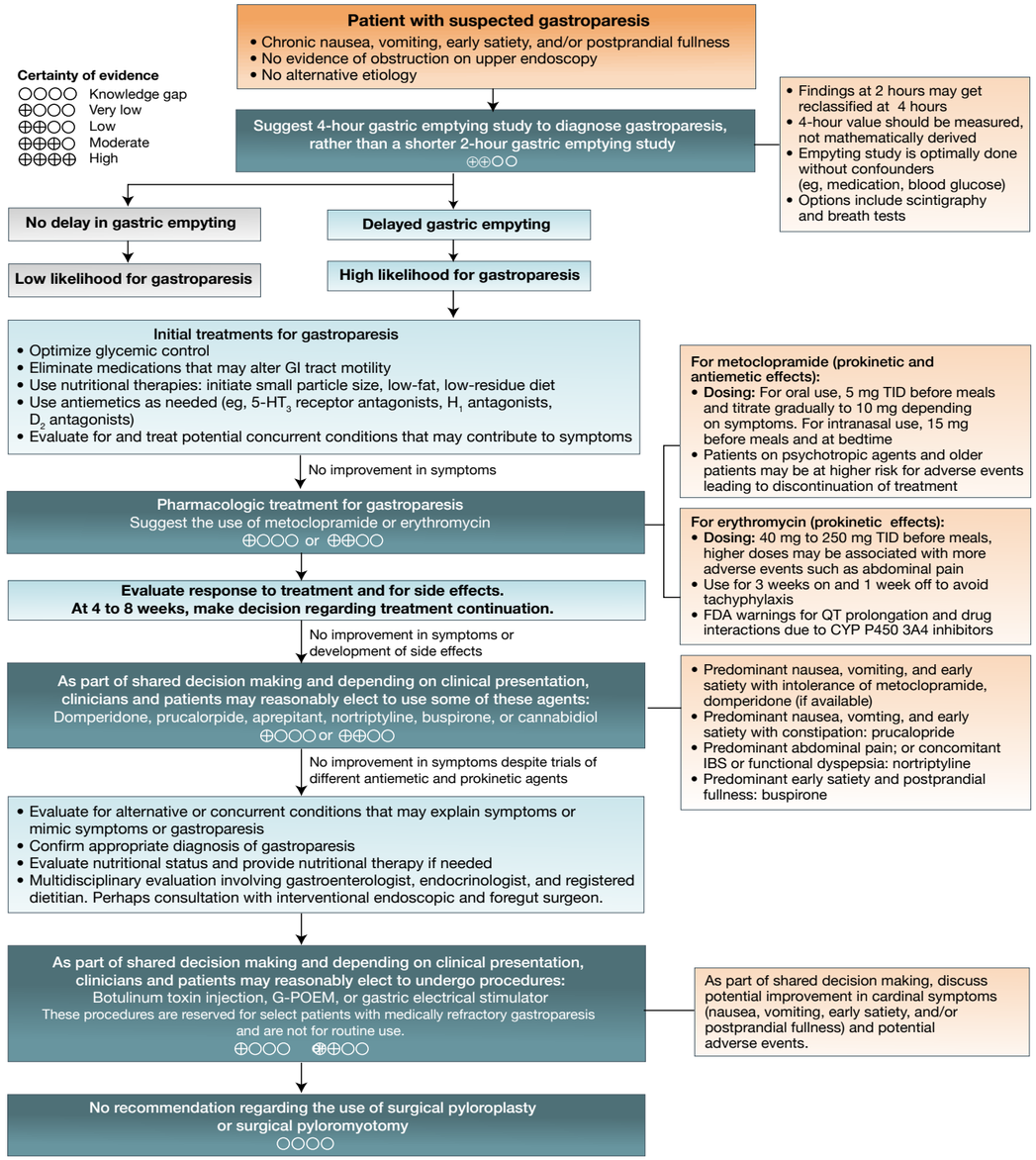
The discussion focused on the AGA gastroparesis guidelines published in September 2025.[1] As part of the guidelines committee, Dr Staller explained that the process was developed using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework and began with recruiting experts in the field and defining the key questions that the guidelines should address. The panel identified thresholds for minimally important difference (MID) to guide interpretation of the evaluated outcomes and the evidence assessment. This was followed by a rigorous literature review and meta-analysis of the current evidence relevant to each question.

The result of this rigorous, evidence-based methodology is a guideline consisting primarily of conditional recommendations supported by low or very low quality of evidence. Metoclopramide and erythromycin were the only 2 pharmacologic therapies that met the efficacy threshold defined by the guidelines committee. The lack of strong recommendations is a reflection of the limitations of the available evidence, which consists of heterogeneous clinical trials that are underpowered and poorly phenotyped.

The experts acknowledged that the tepid recommendations in the guidelines may give a pessimistic impression of the treatment options for gastroparesis for a population of patients who are suffering. However, they emphasized the need to interpret these recommendations with nuance in the clinical setting, understanding that a conditional recommendation reflects weak evidence rather than clinical uselessness. Therapies with conditional recommendations and low-quality evidence can be reasonable to use after appropriate risk-benefit analysis and discussion with the patient, and even therapies that are not recommended may be appropriate in the context of shared decision making with individual patients. Clinicians are also encouraged to read the implementation considerations accompanying the actual recommendations, as these are intended to provide more practical guidance than the evidence statements.

Among the available gastroparesis guidelines and expert reviews, the new AGA guidelines have been developed with the strictest methodology and interpretation of the data. While the experts support the rigor of this approach, they expressed concern that the field of gastroparesis is not ready for the GRADE approach, and that the AGA guidelines could actually limit care by discouraging clinicians from prescribing drugs the received only conditional recommendations. Guideline recommendations can also drive insurance coverage of therapies. With this in mind, the experts emphasized that these guidelines should be used as a call to action to advance the science in this field. This would include better characterizing the patient population and improving funding and research to develop more treatment options for patients with gastroparesis.

2025 AGA gastroparesis guideline: clinical decision support tool[1]



The introduction of the potassium-competitive acid blockers (P-CABs) as a welcome addition to the armamentarium for acid-peptic disorders. Although they may not dramatically improve the efficacy of acid suppression, their pharmacodynamic and pharmacokinetic differences from PPIs translate into a more rapid onset and a simpler dosing regimen, which should enhance patient adherence and be more forgiving of irregular dosing. Given the difficulty of taking PPIs in relation to meals twice daily, the ability to dose P-CABs irrespective of meals is an important practical advantage. Although P-CABs represent a welcome next step for patients with inadequate symptom control with PPIs, the experts acknowledged that many patients have symptoms driven by non-acid mechanisms, such as visceral hypersensitivity or functional heartburn. Accordingly, P-CABs will not be a "magic bullet" for these patients. However, because of their rapid onset, these agents may be useful in patients with episodic reflux, although data supporting their efficacy for on-demand symptom management are not yet available. The simplicity of P-CAB administration may also become an important advantage in *Helicobacter pylori* regimens, which are becoming increasingly cumbersome and poorly tolerated due to the need for quadruple therapy amid rising clarithromycin resistance rates.

Despite these advantages, the high cost of the P-CABs and variable insurance coverage are major barriers to their use. Further, the experts noted the lack of long-term data with these agents, and emphasized that these agents are not expected to offer any safety advantages over PPIs.

1. Staller K, Parkman HP, Greer KB, et al. AGA clinical practice guideline on management of gastroparesis. *Gastroenterology*. 2025;169(5):828-861.

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Food-DGBI news

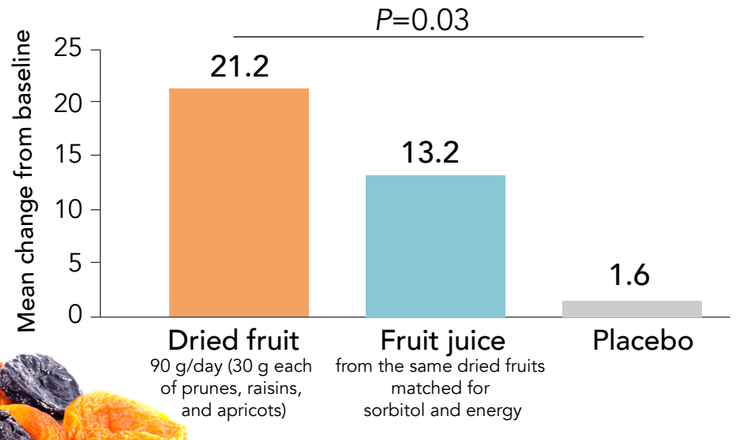
In this session, the participants reviewed interesting abstracts from Digestive Disease Week® 2025 relevant to the role of diet in managing DGBIs. Multiple studies explored various aspects of the low fermentable oligo-, di-, monosaccharides, and polyos (FODMAP) diet in patients with IBS. A real-world observational study of 272 patients with self-reported IBS demonstrated that using a FODMAP enzyme blend 1 to 7 times weekly was associated with clinically significant improvement in the IBS-Visual Analog Scale (-VAS) subscale of daily life disruption in 75.7% of patients.[1] Among the response 50 patients who continued the supplement through 24 weeks, this response increase, with significant improvement in observed in individual IBS symptoms and food-related quality of life. Another study demonstrated that the use of real-time dietary advice delivered via a chatbot with brief guidance reduced high-FODMAP intake, bloating severity, and improved dietary knowledge in 64 patients with DGBIs.[2] Other studies explored the practical aspects of implementing the FODMAP diet, with one reporting significant variability in practices for the reintroduction phase[3] and another exploring patient perspectives on the challenges in both the restriction and reintroduction phases.[4] Collectively, these studies highlight the need for simpler and more standardized approaches to the low FODMAP diet.

The participants reviewed 2 studies that explored the contribution of specific foods to constipation and/or their therapeutic potential in constipation. A cross-sectional study using data from the National Health and Nutrition Examination Survey explored the interaction between fiber intake, water intake, and consumption of ultra-processed foods, and how optimizing these factors may reduce the risk of constipation.[5] A randomized controlled study in 150 patients with Rome IV functional constipation found that dried fruits containing fiber and sorbitol (prunes, raisins, apricots) were more effective at increasing stool weight than fruit juices containing sorbitol alone, although improvement in complete and/or spontaneous bowel movements did not differ between groups.[6]

The group discussed several additional studies of interest, including one that identified distinct IBS subgroups based on eating patterns[7] and a retrospective chart review of patients from Australia indicating benefits of a low food-chemical diet on GI symptoms, but also noted the potential for prolonged dietary restriction and unintentional weight loss.[8]

1. Syed N, Eswaran LS, Singh P, Hachuel D, Wells J, Chey WD. 1225: Real world experience with a multi-enzyme supplement targeting key FODMAPs in patients with IBS. *Gastroenterology*. 2025;169(1, Suppl):S-300.
2. Somvanapanich P, Ipisuttithum P, Sirimongkolkasem J, Rattanchaisit P, Patcharatraul T, Gonalachanvit S. 465: The chatbot-assisted vs brief dietary advice in FODMAPs restriction phase in patients with bloating: randomized controlled trial. *Gastroenterology*. 2025;169(1, Suppl):S-116-117.
3. Lynett A, Bouwman J, Ponke M, Pelletier K. Tu 1983: FODMAP reintroduction in clinical practice: surveying the gaps and opportunities. *Gastroenterology*. 2025;169(1, Suppl):S-1582-S-1583.
4. Feldman J, Peng W, Pfenning, et al. Tu1982: Low FODMAP expounded: a new elucidation on patient attitudes, challenges and outcomes. *Gastroenterology*. 2025;169(1, Suppl):S-1582.
5. Lo JC, Martinez E, Zhao L, et al. Sa 1682: Modification of lifestyle factors and ultra-processed food consumption in relation to constipation in US adults. *Gastroenterology*. 2025;169(1, Suppl):S-503.
6. Farsi DN, Steenson S, Katsirma Z, et al. 1210: Dried fruit increases stool weight and stool frequency in CIC: a placebo-controlled randomized controlled trial. *Gastroenterology*. 2025;169(1, Suppl):S-295.
7. Katsumata R Identifying distinct IBS subgruops based on dietary data using Gaussian mixture model. *Gastroenterology*. 2025;169(1, Suppl):S-1584.
8. Cooke Z, Lynam K, Barnett J, Biesiekierski J, Trakman G, Tuck C. Tu 1987: Evaluation of the low food chemical diet on symptoms and identification of food triggers: a clinical audit. *Gastroenterology*. 2025;169(1, Suppl):S-1584.

Mean change in stool weight from baseline (primary endpoint[a]) in patients with Rome IV functional constipation (N=150)[6]



[a]The primary outcome was change in stool weight measured from 7-day total stool collection.

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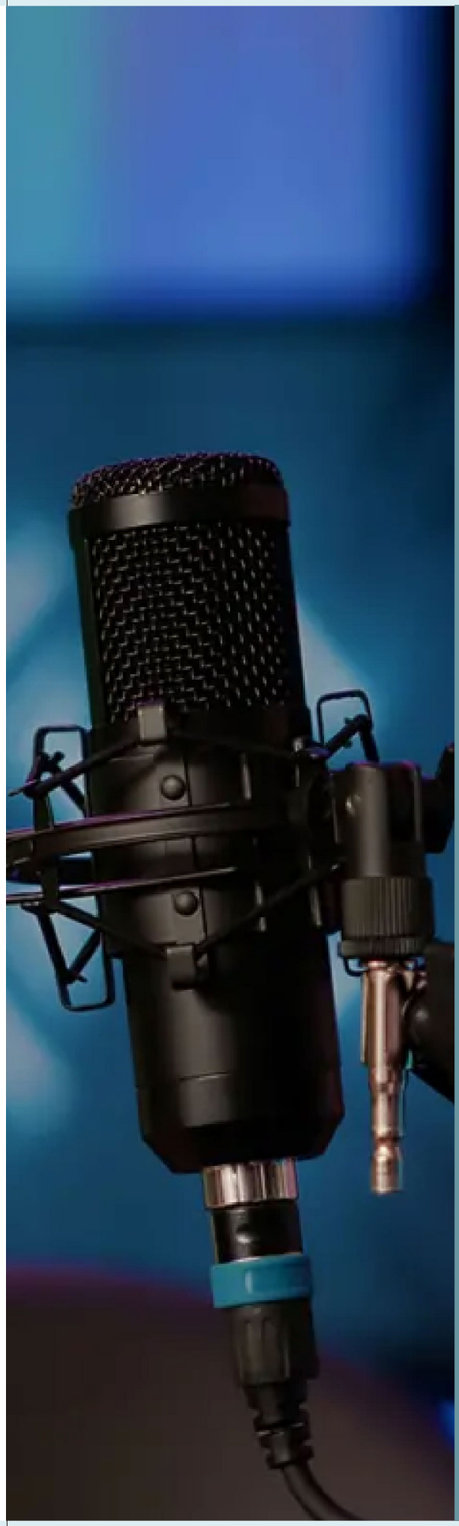

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