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Editorial

Rome V: A new outlook into the disorders of gut-brain interaction

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INTRODUCTION

The publication of Rome V represents a new chapter in the understanding of disorders of gut-brain interaction and provides an opportunity to reconsider how gastroenterologists conceptualize, diagnose, and manage a group of patients whose symptom burden and impairment in quality of life remain substantial. Ten years after Rome IV, this new classification incorporates accumulated advances in gastrointestinal physiology, visceral sensitivity, motility, mucosal and immune function, the microbiota, and central processing of gastrointestinal signals, while providing a clearer integration of dietary, biopsychosocial, gender-related, and sociocultural factors[(1)].

The most evident conceptual shift is the progressive abandonment of the term *functional gastrointestinal disorders* and the consolidation of the designation *disorders of gut-brain interaction*. This is not merely a semantic change. For years, the term *functional* could convey the erroneous notion that symptoms were less real, lacked a biological basis, or were essentially psychological in nature. Rome V instead proposes that these disorders be understood as conditions in which abnormalities of motility, visceral hypersensitivity, mucosal and immune function, the microbiota, autonomic regulation, and cerebral processing of gastrointestinal stimuli may interact[(1)].

This perspective is particularly relevant to clinical practice. A diagnosis of a disorder of gut-brain interaction should not be interpreted as a diagnosis of exclusion reached only after all possible organic diseases have been ruled out. Rome V moves toward a positive diagnostic model based on a structured medical record, recognition of symptom patterns, and identification of predominant pathophysiological mechanisms.

This shift may enhance the rigor with which physicians determine the need for diagnostic testing, reduce repetitive interventions, and, above all, improve communication with patients, who have often endured a protracted diagnostic journey involving multiple consultations without receiving a satisfactory explanation for their symptoms.

ESOPHAGEAL DISORDERS OF GUT-BRAIN INTERACTION

Esophageal disorders represent one of the clearest examples of the transition from an anatomical interpretation of symptoms to a neurobiological understanding of their underlying mechanisms. Rome V retains functional chest pain, functional heartburn, reflux hypersensitivity, globus, and functional dysphagia within this group. These conditions are characterized by esophageal symptoms that cannot be adequately explained

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by structural disease, a major esophageal motor disorder, or pathological exposure to gastroesophageal reflux.

The principal clinical challenge lies in distinguishing these disorders from gastroesophageal reflux disease and esophageal motor disorders. Rome V reinforces the need for objective evaluation aligned with advances in the Chicago Classification and contemporary recommendations for the diagnosis of reflux disease. In selected patients, endoscopy, ambulatory reflux monitoring, and high-resolution esophageal manometry are no longer merely confirmatory investigations; rather, they play a fundamental role in establishing a positive diagnosis and avoiding treatments directed at mechanisms that do not account for the patient's symptoms[2].

In functional heartburn, for example, patients experience a retrosternal burning sensation without sufficient evidence of reflux disease to account for the intensity or persistence of symptoms. In reflux hypersensitivity, by contrast, there is an association between reflux episodes—which may occur within the physiological range—and symptom perception. This distinction has important therapeutic implications: indefinitely escalating acid suppression in a patient whose predominant abnormality is visceral hypersensitivity or altered central processing of gastrointestinal signals is unlikely to provide substantial benefit[2].

These perspectives have a far-reaching practical implication: the goal should not be to demonstrate to patients that "nothing is wrong," but rather to explain what condition they have and why they may experience genuine symptoms even when structural investigations are normal. Diagnostic communication thus becomes a therapeutic intervention in its own right.

GASTRODUODENAL DISORDERS: TOWARD MORE PRECISE CHARACTERIZATION

Gastroduodenal disorders represent one of the clinical settings in which Rome V offers a particularly relevant characterization. Functional dyspepsia remains a central entity, but its clinical presentation is more precisely organized around two principal phenotypes: postprandial distress syndrome, characterized predominantly by postprandial fullness and early satiation, and epigastric pain syndrome, defined by pain or burning localized to the epigastrium[3].

This distinction is not merely descriptive; it also makes it possible to recognize that different mechanisms may coexist under the designation of *dyspepsia*, including impaired gastric accommodation, visceral hypersensitivity, abnormalities of gastroduodenal motility, and alterations in the central processing of gastrointestinal signals. Rome V also establishes clearer distinctions from conditions such as chronic nausea and vomiting syndrome, gastroparesis, cyclic vomiting syndrome, cannabinoid hyperemesis syndrome, and rumination syndrome[3].

A particularly noteworthy aspect is the recognition of inability to belch as a gastroduodenal disorder. The inclusion of this condition reflects an essential feature of Rome V: the recognition of clinical phenomena that may have been regarded for years as minor symptoms, provided that sufficient evidence exists to establish a reproducible clinical entity. For gastroenterologists, this entails more careful attention to patients' symptom descriptions and avoiding the automatic attribution of apparently isolated symptoms to dyspepsia or anxiety.

CENTRALLY MEDIATED GASTROINTESTINAL PAIN: BEYOND THE SEARCH FOR A LESION

One of the greatest challenges in modern gastroenterology is likely to be the management of patients with persistent gastrointestinal pain for which no structural explanation proportional to symptom severity can be identified. Rome V devotes a specific chapter to centrally mediated gastrointestinal pain disorders and recognizes three principal entities: centrally mediated abdominal pain syndrome, abdominal migraine in adults, and narcotic bowel syndrome, or opioid-induced gastrointestinal hyperalgesia[4].

In centrally mediated abdominal pain syndrome, pain processing within spinal and cerebral networks assumes a predominant role. Pain may have little or no relationship to physiological events such as food intake or defecation, and its persistence may be explained by central sensitization and impaired modulation of visceral signals. The incorporation of abdominal migraine in adults also represents an important acknowledgment that certain patterns of gastrointestinal pain may share mechanisms with other neurological pain syndromes[4].

This model requires abandoning a dichotomy that has been detrimental for far too long: organic pain versus psychological pain. Pain is a neurobiological experience involving peripheral and central mechanisms, cognitive, emotional, and social factors, as well as the physician-patient relationship. Accordingly, the management of these patients may require a combination of pharmacological interventions, behavioral therapies targeting the gut-brain axis, and neuromodulatory strategies[4].

THE CHALLENGE FOR GASTROENTEROLOGISTS

Rome V emerges at a time when gastroenterology must move beyond a model of medicine focused exclusively on individual organs toward one capable of integrating systems

and mechanisms while remaining centered on the person. The gut and brain constitute a bidirectional network in which neural, endocrine, immune, metabolic, and microbial signals converge. The ultimate clinical expression of this interaction results from multiple mechanisms that cannot be reduced to the presence or absence of a structural lesion.

For Colombia and Latin America, Rome V represents an opportunity for education, research, and transformation of clinical practice. Greater emphasis should be placed on the teaching of neurogastroenterology; multidisciplinary programs incorporating nutrition and therapies targeting the gut-brain axis should be developed; rational access to gastrointestinal physiology testing should be improved; and, particularly, Latin American evidence should be generated to assess the applicability of these criteria to our population.

The success of Rome V, therefore, will not depend on how many criteria are memorized, but on the ability to use them as a tool to improve diagnostic accuracy, pursue more rational investigation, tailor treatment to predominant mechanisms, and listen to patients differently. The shift from "functional disorder" to "disorder of gut-brain interaction" ultimately represents far more than a terminological modification: it is an invitation to recognize that gastrointestinal symptoms are real, complex, and multidimensional.

In this issue, the work of Latin American leaders and experts in neurogastrointestinal motility is presented. These specialists have participated in the *Rome Foundation* across various academic and research settings and provide an interpretation of these criteria adapted to our own context, with the aim of enabling readers to deliver more precise, comprehensive, and patient-centered care.

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