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Colitis: An Unknown Truth

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ABSTRACT

Introduction: colitis is an increasingly common condition in patients, where the mucosa of the colon becomes acutely or chronically inflamed. Histological evaluation is crucial to understanding the structural integrity of the colon, as it provides direct evidence of tissue damage, inflammation, and healing after therapeutic intervention. Objective: to report the experience of the different colitis diagnosed through medical practice in the Colon and Rectal Surgery service. Methods: multicenter study with a retrospective, longitudinal, observational and descriptive design. Reporting disease activity in colon and rectal anatomy, medical treatment lines with or without colon and rectal surgery, morbidity and mortality. Results: with a total of 297 patients: 154 women representing 51.17% and 143 men representing 48.14%. The age range was 18 to 89 years, with an average age of 43 years. Patients who had a follow-up of more than one year, since their diagnosis confirmed histopathologically, with clinical, laboratory and colonoscopy congruence. Treatment and management are determinant of the diagnosis according to each case. Discussion: the diagnoses of colitis and its variety make the veracity complex but demandingly convincing for a coherent and effective treatment: ranging from ulcerative colitis, ischemic colitis, collagenous colitis, lymphocytic colitis, eosinophilic colitis, neutropenic colitis, amoebic colitis and more. Conclusions: there is a lack of knowledge about colitis tacitly both for functional digestive disorders and for anatomical disorders or only stigmatized by the medical vulgar. The current fashion called "consensus" by "experts" (a true empiricism); discarding scientific methodology, the pillar of the essence of a science, trembling its veracity, forcefulness and effectiveness.

Keywords: Colitis, Colon, Colonoscopy. Ischemic Colitis, Collagenous Colitis, Lymphocytic colitis, Eosinophilic colitis, Neutropenic colitis, Amoebic colitis.

INTRODUCTION

In today's medicine, colitis is an increasingly common condition in patients, where the lining of the colon becomes acutely or chronically inflamed. This study reviews colitis and focuses on the etiology, epidemiology, pathophysiology, assessment, management, and complications of colitis, and highlights the role of the Colon and Rectum surgeon in improving health care outcomes. **[1]** The gut-liver axis is a critical interface that influences the immune system, inflammation, and autophagy, thereby impacting gut and liver health, assessing the severity of colitis and colonic pathology, while the expression of autophagy-related genes was analyzed by quantitative polymerase chain reaction in real-time, Native probiotics and para-probiotics have the potential to effectively mitigate inflammation in both the gut and liver by affecting the autophagy signaling pathway. **[2]** The etiology of the vast majority of colitis occurs with an unknown pathophysiological scenario, however, there are environmental factors that trigger it, causing an exaggerated immune response in the intestinal mucosa and the immune system, reacting to intestinal microbial antigens. **[3]**

The gut flora has been recognized as another significant contributor to the maintenance of intact intestinal hemostasis comprising billions of bacteria that possess metabolic, trophic and immune functions crucial to the well-being of the body. **[4]** cAMP is a protective mediator by

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regulating the gut/liver axis with citrullination by peptidyl arginine deiminases, converting arginine residues into protein peptide chains in citrulline. **[5]** Colitis is one of the diseases that involves chronic inflammation from the rectum to the cecum, characterized by constantly elevated reactive oxygen species. The pathogenesis is again believed to be multifactorial, including dysregulated immune responses, genetic predisposition, gut flora disorder, epithelial barrier damage, and environmental issues, are responsible. **[6]** By implication, if corticosteroids inhibit protein synthesis and transcription, ultimately decreasing the regulation of inflammatory cytokines such as NF-kappa B, TNF-α, interleukin-1, and interleukin-6, treatment for colitis is stigmatized accordingly. **[7]** The aim is to restore the intestinal microbial balance and improve the function of the intestinal barrier, preventing colitis or inflammation of the colon, through the production of metabolites such as short-chain fatty acids, equated with an integrity of the intestinal barrier, oxidative stress and the composition of the microbiota. **[8]**

Further analyses reveal significant differences in key inflammatory biomarkers. Myeloperoxidase levels, indicating neutrophil infiltration and tissue inflammation, in the colon resulting in colitis. Histological evaluation is crucial to understanding the structural integrity of the colon, as it provides direct evidence of tissue damage, inflammation, and healing after therapeutic intervention. **[9]** Colitis is accompanied by a reduction in the number of goblet cells and a significant decrease in the secretion of mucins and glycoproteins, which are essential components of the mucus layer that protects the intestinal epithelium. In parallel, the expression of tightly bound proteins such as ZO-1 and claudin-1 is markedly downregulated, leading to increased epithelial permeability and impaired barrier integrity. **[10]** Colitis is a chronic and recurrent gastrointestinal inflammatory disorder, the underlying mechanisms of which remain unknown to date. New modalities of cell death, such as ferroptosis and pyro ptosis, are involved in its pathogenesis or failing that, genes/proteins/pathways that highlight the importance of necroptosis should be sought. **[11]** In addition, patients with chronic colitis report concerns about being judged, body image issues, relationship difficulties, and discrimination in the workplace. However, represented and internal stigma is reported less frequently. Greater disease complexity and symptom frequency are associated with higher levels of perceived stigma, coupled with low public awareness and awareness. This leads to psychological impacts such as anxiety and depression, social isolation, and healthcare challenges, including lower adherence to treatment, ultimately reducing quality of life. **[12]**

Colitis is a pathology that involves chronic inflammation of the gastrointestinal tract and presents heterogeneity in terms of symptoms, which mainly include abdominal pain and diarrhea associated with malabsorption, weight loss, and fever. The incidence generally occurs around the third decade of life, but 25% of cases begin during childhood and adolescence with an average age of 20 to 40 years. **[13]** The prevalence of ulcerative colitis was 37.5 to 248.6 per 100,000 in North America and 4.9 to 505 per 100,000 in Europe. For Crohn's disease, the incidence ranged from 0 to 20.2 per 100,000 in North America and from 0.3 to 12.7 per 100,000 in Europe. **[14, 15]** In Latin America, these data differ considerably, but have a much lower prevalence, reporting 0.99 to 44.3 per 100,000 population for ulcerative colitis and 0.24 to 16.7 per 100,000 population for Crohn's disease. **[16, 17]**

OBJECTIVE

To report the experience of the different colitis diagnosed through medical practice in the Colon and Rectal Surgery service in a multicenter study.

METHOD

It is a study with a retrospective, longitudinal, observational and descriptive design. In the Colon and Rectal Surgery Services, second and third level of public and private health care, in five hospitals in Mexico City. In a study period that spanned from May 2015 to May 2025 based on clinical records, colonoscopy reports, histopathological reports. The following were documented: age, sex, clinical picture, location of disease activity in the anatomy of the colon and rectum, lines of treatment or behaviors of the colon and rectum. In addition, an analysis of the research of the national and international medical literature on what is described in relation to colitis is carried out.

RESULTS

The records of patients diagnosed with a report of pathology such as colitis in all its variants were reviewed; with a total of 297 patients: 154 women representing 51.17% and 143 men representing 48.14%. The age range was 18 to 89 years, with an average age of 43 years.

Patients who had a follow-up of more than one year from their histopathological confirmed diagnosis, with clinical, laboratory and colonoscopy congruence, were included in this study. The diagnosed colitis and its follow-up are detailed below in **Table 1**.

Table 1: Patients With An Objective Diagnosis By Histopathology/Laboratory Of Colitis Expressed In Number And Percentage In A Ten-Year Multicenter Study In The Colon And Rectal Surgery Service.

Type of Colitis	Number/Percentage
Pseudomembranosa Colitis	4 / 1.64
Actinic Colitis	16 / 5.38
Colytis Fulminans	4 / 1.34
Non-Specific Colitis	2 /0.67
Bacterial Colitis	32/10.77
Dysenteric Colitis	19/6.39
Neutropenic Colitis	11/3.70
Eosinophilic Colitis	27/9.09
Ulcerative Colitis	81/27.27
Post-Referral Colitis	49/16.29
Crohn's Disease	2/0.67
Ischemic Colitis	22/7.40
Lymphocytic Colitis	13/.37
Colegenous Colitis	6/2.02
Tuberculous Colitis	1/0.33
Cytomegalovirus Colitis	3/1.01
Amebic Colitis	5/1.68
Total	297

The colitis that was most diagnosed in the specialty of the Colon and Rectal Surgery service, since they arrived at the subspecialty outpatient clinic or referred by other hospitals or who come to the emergency department sent by the third levels public/private or mixed system (due to lack of resources of the patients), was ulcerative colitis or also called chronic non-specific ulcerative colitis. With a detailed expression in percentage of 27.27%, in second place the finding of post-referral colitis is determined in 49 cases with a percentage of 16.29%, in

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third place bacterial colitis is quantified with 32 cases that are 10.77%, immediately as a cause and not far from the mean eosinophilic colitis is reported representing 9.09%. As is evident, the variety of diagnoses is highly dependent on the equipment, infrastructure, resources, skills of the staff, mode of study or protocol, etc.

It is crucial to rule out irritable bowel syndrome, toxic bowel syndrome or patients who have colon perforation due to any of these pathologies that evoke or cause a surgical intervention, or such as the two patients with Wegener's disease or pneumatosis coli, among others. In short, there is so much variety that they cause chronic symptomatic colitis, which are merely anecdotal, with very limited power to point out the causal of it. To be able to issue an objective and conclusive diagnosis without failure and with the certainty of adequate treatment.

The most frequent colorectal anatomical condition is the rectum and secondly sigmoid, perhaps due to two situations that must be reflected, the first is the accessibility of the diagnosis and the second the fear of invasive studies, for the same reason, the taking of biopsies with acute inflammatory processes with risk of perforation, as well as the search at great intensity for an inflammatory bowel disease as a fashionable disease and even with the aim of obtaining certain benefits by the doctor. The third most frequent incidence is in the entire colon or pancolonic condition. Colonoscopies are the ideal diagnostic and discarding instrument, with the consequent pathology report that is correct and conclusive. **Table 2** specifies the most affected anatomical sites of the colon and rectum.

Table 2: Affected Anatomical Segment of the Colon/Rectum in Patients with Colitis in Multicenter Study, Expressed in Number and Percentage, as Well as the Diseases with the Highest Incidence.

Anatomical portion	Number	%	Illness
Right colon	31	10.43	Ischemic, Amebic, Crohn's, Neutropenic
Rectum	140	47.13	UC (Ulcerative Colitis), Actinic, Post-Referral
Rectum/Sigmoid	69	23.23	UC, Post-Referral, Collagenose
Segmental or isolated	11	3.70	Cytomegalovirus, Ischemic, Bacterial
Pancolonic	20	6.73	Pseudomembranous, UC, Eosinophilic
Transverse	26	8.75	Nonspecific, tuberculous, cytomegalovirus
Total	297	100	

Pancolonic involvement is less common in chronic nonspecific ulcerative colitis, while it occurs in pseudomembranous colitis, toxic colon colitis, and eosinophilic colitis. Its treatment is varied, however, the decision to require emergency, priority or scheduled surgical management is potential and its indication is only decided by a surgeon. Proctitis after radiotherapy requires very specific management, where the main sign and symptom is hemorrhage with its respective hemodynamic considerations. They consist of management with diet, psyllium, 5-aminosalicylic acid, thermal electro-cautery, with argon diode laser, neodymium: YAG (Nd: YAG) and colmium, or even formaldehyde with local action; and if it is impossible to remit the bleeding due to the inflammatory process, it goes to the extreme of even a loop colostomy, or even a protectomy, with the aim of saving the patient's life. **[18]**

The transverse colon is an anatomical site where there is no special convergence of diseases, since most colonoscopic studies are incomplete due to the impossibility or lack of competence

of the operators and the special anatomical condition of the splenic angle with the blind maneuver of reaching the transverse portion, which is why the lack of diagnosis and therefore of complete protocols. Correct and consequently the incidence drops radically. **[19]**

As far as treatment is concerned, management is determinant of the diagnosis, which will be specific to what each case merits. Strict management should be converged and determine if there is more benefit or better opportunity with surgical management. There are colitis that are potentially surgical at some point in the natural history of the disease. In other colitis, it is decisive to make the decision of an imminent surgery and an appropriate or correct technique, depending on the patient's specific presentation, since his life depends on it. **See Figure 1.**

Figure 1: Surgical Specimen Of The Colon And Rectum. Due To Fulminant Colitis With Multiple Perforations Throughout The Colon Due To Amoebiasis. Image extracted from: Mendoza-Pineda, N., García-Sánchez, M. A., De la Fuente González, M., Estrada-Rodríguez, M. I., Terán-Estrella, M. L., Urbina-Cabello, J. J., Jiménez-Bonola, Y., Herrera-Medina, J. M., Castillo-García, G., Flores-Pazos, M. I., Méndez-Barrón, G., Zapien-Rangel, M. A., Li-Gómez, H. B., Bocanegra-Eugenio, H. N., Hernández-Ordóñez, J. C., Ramírez-López, V. K., & Valle-Nava, L. E. (2023). Fulminating Colitis Multiple Drilling: Case Report. British Journal of Healthcare and Medical Research, Vol - 10(6). 01-09. [20]

It is decisive to make an adequate diagnosis since this leads to a successful treatment and to give the best possibility of a greater option of cure to the patient or control in a better quality of life. Regarding UC, management was always medical with a success rate of much higher than 91.54%, and only with monotherapy with oral mesalazine (Salofalk) at the maximum dose, in a dosage of 4-3-4 tablets per day every 8 hours orally of 500 mg each, 5 g in 24 hours and suppositories of 250 mg 2 every 12 hours rectally. and in case of relapse, steroids are used, temporarily. No patient was managed with a biological. In patients with moderate/severe dysplasia, radical surgery is planned. were performed in a single surgical time. Three restorative

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proctocolectomies with ileonal J-pouch were performed in three patients for severe dysplasia, colorectal cancer, and refractoriness to medical management. There were 2 cases of toxic colon, two of which responded to surgical management with the technique Turnbull-Blowhole. **[21]** Patients with pseudomembranous colitis were given intensive medical treatment with antibiotics within 15 days with continuous monitoring for aggravation by intestinal perforation. The response was adequate to therapy with metronidazole and vancomycin, both medications administered orally, leaving surgery as a last resort. Post-shunt colitis, which in most patients is asymptomatic, resolves at the time of intestinal restitution. In patients with symptoms, local management with mesalazine with suppositories/enemas is initiated. Or a preventive resource is that of a loop stoma at the level of the transverse colon or sigmoid colon, thus avoiding inflammation of the colon/rectum. **See Figure 2.**

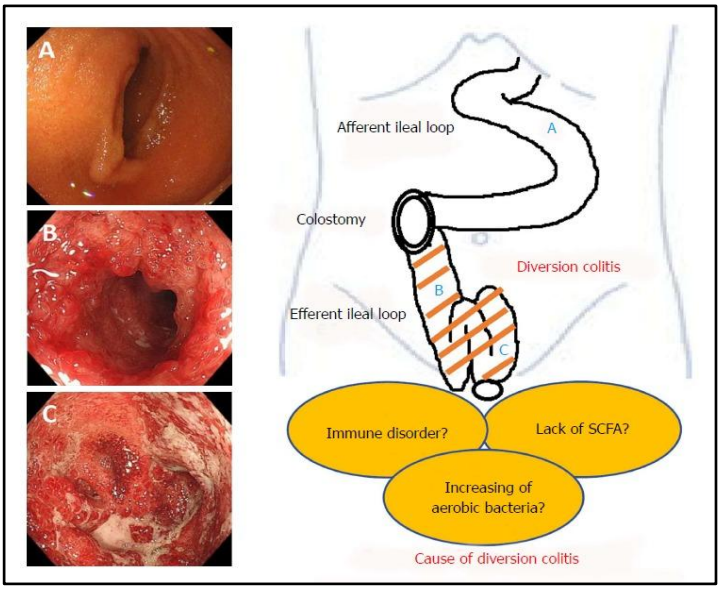
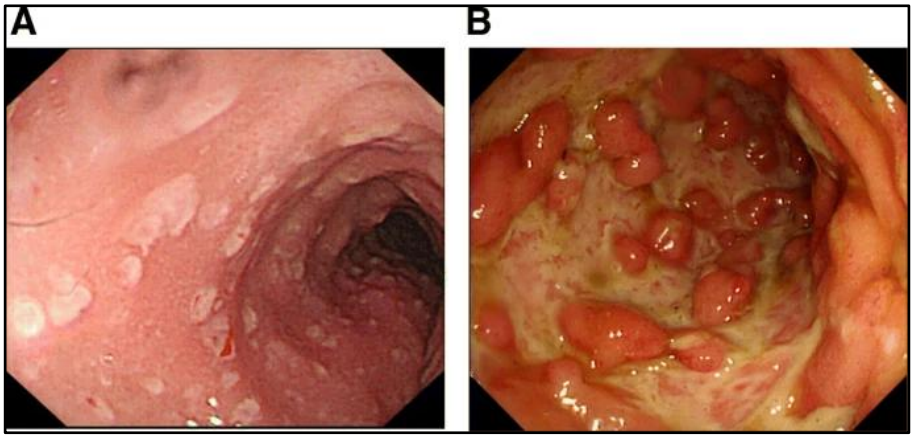


Figure 2: Schematic presentation of shunt colitis and pouchitis. It is extracted from: Tominaga K, Kamimura K, Takahashi K, Yokoyama J, Yamagiwa S, Terai S. Diversion colitis and pouchitis: A mini review. World J Gastroenterol. 2018 Apr 28; 24(16):1734-1747. DOI: 10.3748/WJG. v24.i16.1734. [22]

In ischemic colitis, segmental management is surgical, since revascularization or implementation of local anticoagulant after catheter is in the case of only a massive mesenteric venous thrombosis of the superior mesenteric artery that includes the right colon. In the case of exclusive ischemic colitis of the colon diagnosed transoperatively by infusion of indocyanine green or fluorescein detected with ultraviolet or black light, or by selective arteriography preoperatively. Otherwise, if it is only segmental of the colon due to a history of previous surgery and there is no objective improvement, its resection is imminent. The remaining colitis requires some expertise in what represents a decisive management, in neutropenic colitis very common in patients with HIV without prior medical control, which were resolved medically or in case of perforation with right hemicolectomy, however, its decrease has changed in the last 10 years with an incidence of a clear decrease.

In contrast, the new publications, clinical practice guidelines/consensus that encourage the use of biologics has unfortunately seen that Crohn's disease is misdiagnosed indiscriminately in a

"clinical way" without conclusive pathological evidence, since in most cases the origin is different, not to mention cases with expected evolution in an intestinal anastomosis, in a massive resection or short bowel syndrome, in an intestinal reservoir or even post-shunt colitis mistakenly becoming Crohn's disease. In this study, only one case was presented that was corroborated by pathology reports. **[21]** And cases of colitis have been documented, such as that derived from Wegener's disease, with colon involvement and with symptoms very similar or emulating to nonspecific colitis. **[23] See figures 3.**



Figures 3: Colonoscopy of patients with chronic nonspecific colitis (A) Severe colonoscopy appearance of a patient with pseudomembranous colitis and chronic nonspecific ulcerative colitis, (B). Extracted from: Yang TM, Lu FT, Yen HH, Chen YY. Prevalence and association testing of antinuclear antibodies and inflammatory bowel disease in Taiwan. Peer J. 2025 Nov 28; 13: e20474. doi: 10.7717/peerj.20474 [24]

Regarding morbidity, the sequelae of post-surgical events led to an increase in their incidence that in some cases was alarming, with the sole objective of saving the patient's life and glimpsing an acceptable or viable prognosis. Its incidence is detailed in **Table 3.**

Table 3: Morbidity in Patients with Colitis Treated in a Multicenter Study Expressed in Number and Percentage.

Morbidity	Number/%
Healthcare-Associated Pneumonia	7 /02.35
Severe Anemia	18 /06.06
Malnutrition	24 /08.08
Urinary Tract Infection	5 /01.68
Anal Fissure	6 /02.02
Chronic Diarrhea	16 /05.38
Seroma	3 /01.01
Surgical Wound Infection	10 /03.36
Hernia	4 /01.34
Upper Gastrointestinal Bleeding	3 /01.01
Avitaminosis/Hydroelectrolytic Imbalance	11 /03.70
Total	107 /36.02

An overall morbidity of 36% is documented with 107 different events, however, it should be noted that the same patient may have more than one morbidity event. The most frequent

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scenario is exacerbated chronic malnutrition that merited management with special mixed nutrition in some cases and/or with total parenteral nutrition. The second place, severe anemia, was the second morbidity factor that was treated with blood transfusion, intravenous iron, and intensive management of colitis, preventing further bleeding. Like chronic diarrhea after surgery and/or outside the underlying pathology, control is achieved with a special combined treatment of loperamide at maximum dose and butylhioscine, due to the lack of intestinal adaptation, achieving control in 72 hours later. Vitamin deficiency and hydroelectrolyte imbalance were managed assertively, especially substituting each vitamin factor and/or mineral element. The report of surgical wound infection was 3%, which was resolved with dressings and antibiotic therapy, in response to surgical patients. It should be clarified that morbidity is mostly typical of the underlying disease "colitis" and the adjusted morbidity in the study is manifested in 9%. No mortality was reported in this group of patients.

DISCUSSION

Inflammatory bowel disease is a “fashionable pathology”, more so because of the economic impact of biologics and millions of dollars in profits for pharmaceutical emporiums/benefits for their indication that they generate for these doctors: it includes Crohn's disease and ulcerative colitis, which is characterized by chronic inflammation of the gastrointestinal tract. **[21]** In order to support the above, indirect conclusions such as inti-nuclear antibodies are indiscriminately made, where only 15.7% of the population studied with these two inflammatory bowel diseases were present, complementing advanced age at the time of diagnosis of the disease and statistically significant risk factors. **[24]** Ulcerative colitis, on the other hand, is characterized by chronic mucosal inflammation, recurrent epithelial injury, and impaired wound healing of the colonic mucosa, but the mechanisms of these abnormalities remain unclear. Although single-nucleus RNA-sequential multi-ohmics have been studied and analyzed. Without being able to evidence the mechanism of this disease. **[25]** In Crohn's disease, the therapeutic arsenal is mostly surgical, and when it occurs, ileocolic resections are carried out as the most common, in 24.7% early surgical recurrence is documented at less than 12 months. In the multivariate analysis, smoking, positive microscopic margins, and granulomas were associated with recurrence, however, prophylactic treatment and a younger age at diagnosis were protective. **[26]**

The etiology of other colitis, such as intestinal Behçet's disease, tuberculosis, and primary intestinal lymphoma, should be considered, and are frequently found in clinical practice. Both intestinal tuberculosis colitis and Crohn's disease are chronic granulomatous intestinal diseases; however, with misdiagnosis rates they are high. **[27]** In addition, celiac disease, gastritis, peptic ulcer, gastroesophageal reflux disease, and rare syndromes such as Peutz-Jeghers, Gardner, Cowden, and Plummer-Vinson can cause some degree of colitis clinically and even endoscopically. **[28]**

Pseudomembranous colitis caused by Clostridium difficile is a common cause of infectious diarrhea and is spread by the fecal-oral route and often through contact with spores on contaminated surfaces. Most people can develop an effective immune response, but older populations, immunocompromised people, and those taking antibiotics are at higher risk of being colonized by C. difficile. **[29]**

This microorganism Clostridium difficile gram-positive, obligate anaerobic and spore-forming, present in the gastrointestinal tract in 3% of healthy people and 40% of babies during their first year without causing symptoms; exposure to broad-spectrum antibiotics and elderly patients are the two most important risk factors for developing symptomatic infection resulting in various clinical manifestations ranging from mild diarrhea to pseudomembranous colitis, toxic megacolon and death. **[30]** With increasing trends in incidence and mortality rates. The epidemiological situation in medical institutions is even worse, with approximately 453,000 cases of pseudomembranous colitis occurring annually in the United States. These cases result in about 29,000 deaths and impose $1.5 billion in health care costs. **[31, 32]**Vancomycin and fidaxomicin are the first-line treatments, in combination with parenteral metronidazole for fulminant colitis. **[33]**

Eosinophilic colitis is an inflammatory disease caused by the infiltration of eosinophils into the mucosa of the colon, ruling out other possible causes with the histopathological definition as the presence of more than 20-35 eosinophils/100 epithelial cells per field in any of the segments and not uniform. Importantly, colonic eosinophilia is not the same as eosinophilic colitis. Detection of eosinophils in different gastrointestinal segments is common. The presence of eosinophils in the lamina propria of the colon is a normal finding. **[34]** There is a tendency toward eosinophilia in allergic disorders, but it can also be induced by drugs, parasitic infections, or autoimmune diseases. Eosinophils are part of hypereosinophilic smalignancies and in inflammatory bowel disease and hematologic malignancies and are part of the histopathological spectrum of gluten-induced enteropathy, as well as other entities associated with intestinal lymphoma. **[35]** Treatment is not protocolized, and there has been a good response with management with a gluten-free diet, steroids such as prednisone, budesonide, immunomodulators (azathioprine), montelukast leukotriene receptor antagonists, ketotifen antihistamines, mast cell stabilizers cromoglycate disodium, and biological agents such as omalizumab, mepolizumab. **[36]**

Collagenous colitis was discovered in 1976 by Lindström, with histological criteria as follows: a) presence of a subepithelial collagenous band with a thickness > 10 μm, which encompasses superficial capillaries and presents an irregular and scalloped appearance on its lower border. b) existence of a chronic inflammatory infiltrate in the lamina propria consisting of plasma cells, lymphocytes and some eosinophils. c) presence of surface epithelial lesion, with flattening and vacuolization of epithelial cells d) increase in intraepithelial lymphocytes, in general, above 20 lymphocytes per 100 epithelial cells. **[37]** Inflammatory changes in collagenous colitis were "patchy," were more severe in the right colon and up to 40% absent in the rectum, and treatment is primarily empirical. In this sense, anti-inflammatory drugs such as salazopyrine, 5-ASA derivatives and oral corticosteroids have excellent results. **[38]**

Neutropenic colitis is a syndrome that manifests in patients with levels less than 1500 neutrophils per mm^3, and in those patients who receive treatment for hematological neoplasms, such as leukemia, lymphoma, multiple myeloma, aplastic anemia; it can also manifest in cases of HIV/AIDS, thalassemia minor, systemic lupus erythematosus, chemotherapy against solid tumors and in post-transplant patients. **[39]**

With a mortality rate of up to 50%, secondary to intestinal perforation and sepsis, the cecum is the portion of the large intestine where it is affected, followed by the ascending colon; fever and

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abdominal pain concomitant with neutropenia are indicators of pathogenesis, pain is frequently reproducible on palpation of the right lower quadrant (cecum and ascending colon). **[40]** The administration of granulocyte-leukocyte colony-stimulating factors has been indicated; however, surgical intervention is determined in cases of intestinal perforation or hemodynamic instability secondary to gastrointestinal bleeding. **[41]** Colitis due to cytomegalovirus infection is a rare disease that is detected in immunocompromised people with high rates of morbidity and mortality, ranging from asymptomatic to chronic diarrhea with severe lower gastrointestinal bleeding. **[42]** The colon is the predominant location causing various symptoms, histological confirmation by visualizing viral inclusions, or the use of immunohistochemistry techniques. The viral load in the blood has a low sensitivity. **[43]** The treatment of choice is antiviral therapy with valganciclovir or ganciclovir. **[44]**

Intestinal amebiasis is a parasitic infection caused by Entamoeba histolytica. It is common in developing countries with poor hygiene. A rare and life-threatening complication of amebiasis is fulminant necrotizing amoebic colitis, histopathological examination confirmed the diagnosis, the treatment is metronidazole, which should be administered as quickly as possible to avoid emergency surgical management. **[20, 45]** On the other hand, it should be noted that there is chronic iatrogenic diarrhea, because there is a malabsorption disorder that is associated regardless of the resected intestinal length, secondary to repeated ileal resection surgeries (40.8%, 20/49) or by right hemicolectomies for various causes, as the most frequent causes. In a published study, a total of 228 patients were registered for follow-up for intestinal failure of any etiology, 89 patients (39.5%) who at the end of the day, ironically, were identified with Crohn's disease. **[46]** The goal is early achievement of enteral autonomy, however, there is the concept of short bowel syndrome that is divided into anatomical by length (less than 100 cm) and/or physiological short bowel syndrome than by length (less than 200 cm). **[47]** Gut adaptation becomes both a morphological and functional mechanism in three phases:

1. **Phase I:** from 2 weeks postoperative to 2 months. Equalizing the hydroelectrolyte imbalance.
2. **Phase II:** lasts from 2 months to 2 years, with mixed feeding both enteral and parenteral.
3. **Phase III:** nutritional and metabolic stability is achieved. More than 2 years until normalization with nutritional self-sufficiency or with minimal supplementation by oral intake. **[48]**

Most gastroenterologists classify short bowel syndrome as colitis and even some surgeons, "in some cases despite the surgical absence of the colon" and even indicate high-cost biologics, the authors of this paper do not know the reason. **[49]** The use of biologics in the treatment of so-called "colitis" with anti-TNF drugs (Infliximab, Adalimumab, Certoluzimab Pegol and Golimumab), anti-integrin drugs (Vedolizumab), inhibitors of interleukins 12 and 23 (ustekinumab), in a third line of management, is in many scenarios a therapeutic even absurd. **[50, 51]** On the other hand, facilitating bowel adaptation in short bowel syndrome remains an important focus of research. Emerging data supports the role of the gut microbiome in modulating disease progression. **[52]** The human microbiome is composed of bacteria, archaea, viruses, and microbes. Healthy adult humans typically have more than 1000 species of bacteria, among their known functions include digestion, vitamin production, regulation of the immune response through their metabolites. **[53]** Emerging data also supports the use of fecal microbiota transplantation as a therapeutic strategy for short bowel syndrome with varying success. **[54, 55]**

Finally, the term colitis is applied indiscriminately in a large majority of physicians, stigmatized to patients with diverse, non-specific abdominal pain or of another etiology that is not colonic, together with the "so-called" clinical criteria *"Rome Criteria"* **[56, 57]** with the identity of irritable bowel syndrome. scenario where discarding: through multiple studies or a complete meticulous protocol that is the critical essence of the diagnosis of this pathology. **[58]**

CONCLUSIONS

Unfortunately, there is a huge lack of knowledge about colitis in a tacit and punctual way, both functional digestive disorders and anatomical disorders or those that are really or only stigmatized by the medical vulgar, leaving an exorbitant and incalculable trail of overdiagnosis and high costs, due to a lack of expertise or expertise on the subject and much less treated correctly. The proof of this is that this void is only filled by absurd, subjective classifications with minimal evidence, the current fashion in Medicine pitifully called "consensus" by "experts" (a true empiricism); discarding scientific methodology, the pillar of the essence of a science as a matter, trembling its veracity, forcefulness and effectiveness.

Conflict of Interest

The authors stated that they had no potential conflicts of interest regarding the research, authorship, and/or publication of this article.

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