

Dijabetička gastropareza - od dijagnoze do električne stimulacije želuca

Klobučar Majanović, Sanja; Zelić, Marko; Belančić, Andrej; Giroto, Neva; Licul, Vanja; Štimac, Davor

Source / Izvornik: **Medicina Fluminensis : Medicina Fluminensis, 2017, 53, 50 - 55**

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

https://doi.org/10.21860/medflum2017_173380

Permanent link / Trajna poveznica: <https://urn.nsk.hr/urn:nbn:hr:184:274592>

Rights / Prava: [In copyright](#)/[Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2024-11-09**



Repository / Repozitorij:

[Repository of the University of Rijeka, Faculty of Medicine - FMRI Repository](#)



Diabetic gastroparesis – from diagnosis to gastric electrical stimulation treatment

Dijabetička gastropareza – od dijagnoze do električne stimulacije želuca

Sanja Klobučar Majanović^{1*}, Marko Zelić², Andrej Belančić³, Neva Giroto⁴, Vanja Licul⁵, Davor Štimac⁵

¹Department of Endocrinology, Diabetes and Metabolic Diseases, Clinical Hospital Centre Rijeka, Faculty of Medicine, University of Rijeka, Rijeka

²Department of Abdominal Surgery, Clinical Hospital Centre Rijeka, Faculty of Medicine, University of Rijeka, Rijeka

³Faculty of Medicine, University of Rijeka, Rijeka

⁴Clinical Department of Nuclear Medicine, Clinical Hospital Centre Rijeka, Faculty of Medicine, University of Rijeka, Rijeka

⁵Department of Gastroenterology, Clinical Hospital Centre Rijeka, Faculty of Medicine, University of Rijeka, Rijeka

Abstract. The most common known underlying cause of gastroparesis is diabetes mellitus. General symptoms and signs include nausea, vomiting, bloating and early satiety. The diagnosis of diabetic gastroparesis (DGP) is closely made based on clinical history, exclusion of gastrointestinal obstruction by endoscopy and abdominal ultrasound, and confirmation of delay in gastric emptying by gastric emptying scintigraphy. First-line interventions for DGP are dietary modifications and prokinetic-antiemetic therapy. In cases resistant to maximal medical therapy, gastric electrical stimulation is indicated. The aim is to alleviate both the severity and frequency of symptoms, improve gastric emptying, ameliorate patient's nutritional status and to optimize glycemic control.

Key words: diabetes mellitus; electrical stimulation therapy; gastroparesis; scintigraphy

Sažetak. Šećerna bolest je najučestaliji poznati uzrok gastropareze. Uobičajeni simptomi su mučnina, povraćanje, nadutost i rano postizanje sitosti. Postavljanje dijagnoze dijabetičke gastropareze (DGP) temelji se na kliničkoj prezentaciji bolesti, otklanjanju mogućnosti opstrukcije endoskopskim ili ultrazvučnim pregledom te na potvrdu usporenog pražnjenja želučanog sadržaja uz pomoć nalaza scintigrafije pražnjenja želuca. Prve terapijske odrednice za DGP su dijetoterapija te uvođenje prokinetika i antiemetika u kroničnu terapiju. Električna stimulacija želuca indicirana je u slučajevima rezistentnim na maksimalnu medikamentoznu terapiju. Cilj je ublažiti intenzitet i učestalost simptoma, poboljšati pražnjenje želuca i nutritivni status pacijenta te optimizirati kontrolu glikemije.

Ključne riječi: električna stimulacija; gastropareza; scintigrafija; šećerna bolest

***Corresponding author:**

Asst. Prof. Sanja Klobučar Majanović,
MD, PhD
Department of Endocrinology, Diabetes
and Metabolic Diseases
Clinical Hospital Centre Rijeka
Krešimirova 42, 51000 Rijeka
e-mail: sanja.klobucarm@gmail.com

<http://hrcak.srce.hr/medicina>

ABBREVIATIONS

DGP – diabetic gastroparesis; DTPA – diethyltri-amino pentaacetic acid; FDA – Food and Drug Administration; GCSI – Gastroparesis Cardinal Symptom Index; GEMS – Gastric Electrical Mechanical Stimulation Study; GES – gastric electrical stimulation; IGF-1 – insulin-like growth factor 1; LEHR – low-energy high-resolution; MBq – milibecquerel; ^{99m}Tc – technetium-99m; USA – United States of America; WAVESS – Worldwide Anti-Vomiting Electrical Stimulation Study

INTRODUCTION

Gastroparesis is defined as a chronic motility disorder characterised by objectively delayed gastric emptying in the absence of any mechanical obstruction. The average time it takes the healthy stomach to empty half of its contents into the small intestine is approximately 60 to 100 minutes, while patients with gastroparesis have emptying times with a half-life from just over 100 to >500 minutes¹. Hence, patients who suffer from this disease often report a significant reduction of their life quality². The incidence of gastroparesis is not known precisely, but it is estimated to affect about 4 %–5 % of the entire population³.

ETIOPATHOGENESIS OF GASTROPARESIS

Idiopathic (36 %), diabetic (29 %) and postsurgical (13 %) etiologies include the majority of all gastroparesis cases^{4,5}. Idiopathic gastroparesis, as the most common form of gastroparesis, refers to a symptomatic patient from delayed gastric emptying with no detectable primary underlying abnormality. The pathogenesis of postsurgical gastroparesis is known and it is based on vagal nerve disruption or interference⁶⁻⁸. On the contrary, the exact mechanism of diabetic gastroparesis (DGP) is unknown, but several contributing factors have been suggested: hyperglycemia, vagal dysfunction, loss of neural nitric oxide synthase expression in the myenteric plexus, oxidative stress with loss of upregulation of protective enzymes, loss of interstitial cells of Cajal with resultant gastric arrhythmia and delay in gastric emptying, smooth muscle atrophy and loss of insulin-like growth factor 1 (IGF-1), and

last but not least, loss of macrophages expressing heme oxygenase-1⁹. Rare causes of gastroparesis also could be Chagas disease, hypothyroidism, hyperparathyroidism, hypoparathyroidism, collagen vascular diseases, some neurological conditions like Parkinsonism or medication^{4,10}.

DIABETIC GASTROPARESIS

Diabetic gastroparesis, as the complication of diabetes, was first reported in 1958¹¹. Typically, it

Diabetic gastroparesis can cause a wide variety of symptoms. Early in the course of the disease symptoms may be minimal, but as the dysfunction upwards they become more common. General symptoms and signs include nausea, vomiting, bloating, postprandial fullness, upper abdominal pain and finally weight reduction.

develops after at least 10 years of previously diagnosed diabetes mellitus, and this group of patients in most cases already has evidences of autonomic dysfunction^{12,13}. Nevertheless, at the population level 5 % of type 1 and 1 % of type 2 diabetes patients have both a delay in gastric emptying and the presence of typical DGP symptoms^{10,13}. The disease affects females more than males in approximate 4:1 ratio^{8,13}. There are two possible explanations for the gender differences. One explanation is the fact that gastric emptying in female gender is on average slower than in males¹². The other possible explanation is based on recent animal data which pointed that the effect of diabetes mellitus on the enteric nervous system is more expressed in females^{14,15}.

Clinical manifestations and diagnosis

In order to exclude other disorders that may mimic DGP (rumination syndrome, superior mesenteric artery syndrome, cyclic vomiting syndrome and bulimia nervosa), the diagnosis of gastroparesis is closely made based on typical clinical history, exclusion of gastrointestinal obstruction by endoscopy and abdominal ultrasound, and confirmation of delay in gastric emptying^{13,16}. DGP can cause a wide variety of symptoms^{13,17}. Early in the course of the disease

Table 1. Review of gastroparesis cardinal symptoms index (GCSI) (Adapted from reference 20)

	None	Very mild	Mild	Moderate	Severe	Very severe
1. Nausea	0	1	2	3	4	5
2. Retching	0	1	2	3	4	5
3. Vomiting	0	1	2	3	4	5
4. Stomach fullness	0	1	2	3	4	5
5. Not able to finish a normal-sized meal	0	1	2	3	4	5
6. Feeling excessively full after meals	0	1	2	3	4	5
7. Loss of appetite	0	1	2	3	4	5
8. Bloating	0	1	2	3	4	5
9. Stomach or belly visibly larger	0	1	2	3	4	5

**Figure 1.** Gastric emptying scintigraphy – the gold standard for measuring gastric emptying

symptoms may be minimal, but as the dysfunction upwards they become more common. However, several symptoms do not always correlate to measures of gastric emptying¹⁸. General symptoms and signs include nausea, vomiting, bloating, postprandial fullness, upper abdominal pain and finally weight reduction¹⁹. There is a variety

of scoring systems for symptoms of gastroparesis, but the most commonly used system is the Gastroparesis Cardinal Symptom Index (GCSI), which is a validated scoring system. The GCSI consists of nine symptom severity items that cover the following domains: nausea/vomiting (3 items); fullness/early satiety (4 items); and bloat-

ing (2 items). Symptoms are rated by the patients among the choices: none (0), very mild (1), mild (2), moderate (3), severe (4) and very severe (5) (Table 1). The GCSI total score equals the sum of the nausea/vomiting, bloating and fullness/early satiety subscales divided by 3²⁰. After gastrointestinal obstruction is ruled out by endoscopy and abdominal ultrasound, gastric emptying scintigraphy – gold standard for measuring gastric emptying, is performed²¹. In our Clinical Hospital Centre gastric emptying study (Figure 1) is usually performed after labelling the liquid meal, Alitraq® (Abbot, USA) with 74 MBq 99mTc DTPA (diethyltriamino pentaacetic acid) radiopharmaceutical. Content of one Alitraq® package is dissolved in 250 ml of water, resulting in the volume of 300 ml. One third of the content, 100 ml is used per patient and mixed with 74 MBq of DTPA prepared earlier according to the manufacturer's instruction. Patients are asked to drink the glass containing labelled meal with the straw, taking care to avoid possible contamination. Immediately after that, patients are positioned in semi recumbent position with the gamma camera detector placed over the region of abdomen, parallel to the surface of the body. Images are collected during 120 minutes, 60 s per frame in a matrix 128 × 128, zoom 1.0, with one detector Siemens Diacam gamma camera equipped with low-energy high-resolution (LEHR) collimator. Acquired images are firstly inspected visually, and then analyzed with Siemens Icon software package for Gastric emptying, with region of interest drawn over the gastric activity. Generated time activity curves are analyzed for the time needed for complete emptying or the estimate; emptying half time and time delay until emptying begins (retention time).

Therapeutic options

The aim of DGP treatment is to alleviate both the severity and frequency of symptoms, improve gastric emptying level, ameliorate the patient's nutritional status and to optimize glycemic control. First-line interventions for DGP are dietary modifications accompanied with or without medical therapy¹⁸. According to nutrition guidelines 4-5 small, low-fat, low-fiber meals a day are recommended, since both fat and fiber can lead to

delay in gastric emptying. Small meal size is preferred, because stomach may only empty up to 2 kcal/min⁵. In diabetics, normal glycemic control with diet and hypoglycemic drugs are of high importance, as improvement of hyperglycemia can accelerate gastric emptying. DGP medical therapy may include several medication classes-prokinetics, antiemetics and pain modulation therapies¹³. Mostly used prokinetic agents in DGP treatment are: antidopaminergic prokinetics (metoclopramide, domperidone) and motilin receptor ago-

Gastric emptying scintigraphy has been considered as gold standard in gastric emptying measurement due to its physiologic, quantitative and non-invasive nature.

nists which include the macrolide antibiotics, with erythromycin as the classic agent used. Of the prokinetic agents, only metoclopramide is USA Food and Drug Administration (FDA) approved medication for the treatment of gastroparesis for no longer than a 12-week period¹⁸. Nevertheless, since DGP is a chronic disease, it is often prescribed indefinitely on 'as required' basis. Motilin agonist-erythromycin is usually not used as a first-choice prokinetic due to antibiotic resistance and tachyphylaxis¹³. To conclude, there is a little evidence that prokinetic agents may improve glycemic control through improved gastric emptying²². In drug-resistant cases, mechanical steps in therapy such as endoscopic pyloric botulinum toxin injection, gastric electrical stimulation (GES), gastrectomy and gastrostomy or jejunostomy may need to be considered^{5,23}.

GASTRIC ELECTRICAL STIMULATION

When it comes to gastric electrical stimulation, three principal methods are currently available: low-frequency/high energy GES with long pulse stimulation, high-frequency/low energy GES with short pulse stimulation and neural sequential GES. Low frequency/high energy GES is currently not suitable for implantation, because of heavy batteries and variable effect of gastroparesis symptoms, while neural sequential GES is not even used in humans at the moment²⁴. Finally, high frequency/low energy GES, also known as

Enterra (Medtronic, Minneapolis, MN, USA) Therapy, is currently the only GES principal method suitable for human implantation²⁵. It delivers impulses at high frequency/low energy (short pulses) at around 12 pulses per minute through pacemaker and consequently stimulates the gastric emptying. The exact mechanism is not well understood yet, but initial studies suggest that it may induce descending noxious inhibitory control by the brain via vagal afferent nerves from the stomach^{13,26}.

Enterra Therapy implantable system consists of two unipolar intramuscular leads and a neurostimulator that uses mild electrical stimulation of the lower stomach (antrum) to reduce drug-resistant nausea and vomiting associated with gastroparesis of diabetic or idiopathic origin.

The Enterra system consists of a neurostimulator implanted beneath the skin, usually in the lower abdominal region and two leads. The leads are implanted via laparotomy or laparoscopy into the stomach wall muscle layer 1-2 cm apart at greater curvature of the stomach, 10 cm proximal to the pylorus²⁷. An upper endoscopy is performed to ensure that there is no penetration of the wires through the mucosa into the stomach lumen. The neurostimulator is programmed to specific parameters established on earlier canine and human studies^{28,29}. It delivers low-energy, high frequency stimuli and has a battery life of 5-10 years, depending on the pulse parameters used³⁰. When the battery life is over, the pulse generator is replaced by local intervention.

The experience of gastric pacing was obtained through 2 multicenter trials, the Gastric Electrical Mechanical Stimulation Study (GEMS)³¹ and the Worldwide Anti-Vomiting Electrical Stimulation Study (WAVESS)³². GEMS was an open-labeled which has documented improvement in both specific and global gastroparesis symptoms and gastric emptying, while WAVESS was a controlled double-blind sham stimulation trial that reaffirmed the efficacy of GES⁴. Afterwards, GES has been approved by the FDA (Enterra Therapy, Medtronic, Minneapolis, MN, USA) for patients

with diabetic or idiopathic gastroparesis resistant to drug therapy.

About 10 % of patients develop GES complications: infections, electrode dislodgement, wire breakage, penetration of the stomach and intestinal obstruction. Due to complications surgical intervention with removal of the device needs to be performed³³. However, GES does seem to offer significant improvement in life quality and in the severity and frequency of symptoms to a subset of patients. Still, more multicenter long-term controlled studies will be necessary for GES to be ready for its prime time.

CONCLUSION

The rising rates of diabetes mellitus will inevitably result in increasing the incidence of diabetic complications, including gastroparesis. Most therapeutic options available to treat DGP are less than ideal and patients usually require their combination depending on the severity of their condition. Hence, further research is needed for better understanding of the pathogenesis of DGP, which may lead to improved treatment options. However, gastric electrical stimulation with Enterra system is at this point definitely the most efficient therapeutic solution, when dietary modifications accompanied with medical prokinetic and antiemetic agents fail to show satisfying results.

Conflicts of interest statement: The authors report no conflicts of interest.

REFERENCES

1. Ross J, Masrur M, Gonzalez Heredia R, Elli EF. Effectiveness of Gastric Neurostimulation in Patients With Gastroparesis. *JSL* 2014;18:1-6.
2. Talley NJ, Locke GR, Lahr BD, Zinsmeister AR, Tougas G, Ligozio G et al. Functional dyspepsia, delayed gastric emptying and impaired quality of life. *Gut* 2006;55:933-9.
3. Hasler WL. Gastroparesis: symptoms, evaluation and treatment. *Gastroenterol Clin North Am* 2007;36:619-47.
4. Gumaste V, Baum J. Treatment of Gastroparesis: An Update. *Digestion* 2008;78:173-9.
5. Camilleri M, Parkman HP, Shafi MA, Abell TL, Gerson L. Clinical Guideline: Management of Gastroparesis. *Am J Gastroenterol* 2013;108:18-38.
6. Jung HK, Choung RS, Locke GR, Schleck CD, Zinsmeister AR, Szarka LA et al. The incidence, prevalence and outcomes of patients with gastroparesis in Olmsted County, Minnesota from 1996 to 2006. *Gastroenterology* 2009;136:1225-33.

7. McCallum R, Lin Z, Wetzel P, Sarosiek J, Forster J. Clinical response to gastric electrical stimulation in patients with postsurgical gastroparesis. *Clin Gastroenterol Hepatol* 2005;3:49-54.
8. Timratana P, El-Hayek K, Shimizu H, Kroh M, Chand B. Laparoscopic Gastric Electrical Stimulation for Medically Refractory Diabetic and Idiopathic Gastroparesis. *J Gastrointest Surg* 2013;17:461-70.
9. Kashyap P, Farrugia G. Diabetic Gastroparesis: what we have learned and had to unlearn in the past 5 years. *Gut* 2010;59:1716-26.
10. Parkman HP, Camilleri M, Farrugia G, McCallum RW, Bharucha AE, Mayer EA et al. Gastroparesis and functional dyspepsia: excerpts from AGA/ANMS meeting. *Neurogastroenterol Motil* 2010;22:113-33.
11. Kassander P. Asymptomatic gastric retention in diabetics (gastroparesis diabeticorum). *Ann Intern Med* 1958;48:797-812.
12. Bharucha AE, Camilleri M, Forstrom LA, Zinsmeister AR. Relationship between clinical features and gastric emptying disturbances in diabetes mellitus. *Clin Endocrinol (Oxf)* 2009;70:415-20.
13. Vanormelingen C, Tack J, Andrews CN. Diabetic gastroparesis. *British Medical Bulletin* 2013;105:213-30.
14. Gangula PR, Maner WL, Micci MA, Garfield RE, Pasricha PJ. Diabetes induces sex-dependent changes in neuronal nitric oxide synthase dimerization and function in the rat gastric antrum. *Am J Physiol Gastrointest Liver Physiol* 2007;292:725-33.
15. Gangula PR, Sekhar KR, Mukhopadhyay S. Gender bias in gastroparesis: is nitric oxide the answer? *Dig Dis Sci* 2011;56:2520-27.
16. Fukami N, Anderson MA, Khan K, Harrison ME, Appalaneni V, Ben-Menachem T et al. The role of endoscopy in gastroduodenal obstruction and gastroparesis. *Gastrointest Endosc* 2011;74:13-21.
17. Parkman HP, Yates K, Hasler WL, Nguyen L, Pasricha PJ, Snape WJ et al. Clinical features of idiopathic gastroparesis vary with sex, body mass, symptom onset, delay in gastric emptying, and gastroparesis severity. *Gastroenterology* 2011;140:101-15.
18. Alam U, Asghar O, Malik RA. Diabetic Gastroparesis: Therapeutic Options. *Diabetes Ther* 2010;1:32-43.
19. Camilleri M, Bharucha AE, Farrugia G. Epidemiology, mechanisms and management of diabetic gastroparesis. *Clin Gastroenterol Hepatol* 2011;9:5-12.
20. Revicki DA, Rentz AM, Dubois D, Kahrilas P, Stanghellini V, Talley NJ et al. Development and validation of patient-assessed gastroparesis symptom severity measure: the Gastroparesis Cardinal Symptom Index. *Aliment Pharmacol Ther* 2003;18:263-83.
21. Abell TL, Camilleri M, Donohoe K, Hasler WL, Lin HC, Maurer AH et al. Consensus recommendations for gastric emptying scintigraphy: a joint report of the American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine. *Am J Gastroenterol* 2008;103:753-63.
22. Intagliata N, Koch KL. Gastroparesis in type 2 diabetes mellitus: prevalence, etiology, diagnosis and treatment. *Curr Gastroenterol Rep* 2007;9:270-79.
23. Camilleri M. Clinical practice. Diabetic gastroparesis. *N Engl J Med* 2007;356:820-9.
24. Bortolotti M. Gastric electrical stimulation for gastroparesis: a goal greatly pursued, but not yet attained. *World Journal of Gastroenterology* 2011;17:273-82.
25. Lal N, Livemore S, Dunne D, Khan I. Gastric Electrical Stimulation with the Enterra System: A Systematic Review. *Gastroenterol Res Pract* 2015; Forthcoming.
26. Hasler WL. Methods of gastric electrical stimulation and pacing: a review of their benefits and mechanisms of action in gastroparesis and obesity. *Neurogastroenterol Motil* 2009;21:229-43.
27. Soffer E. Gastric Electrical Stimulation for Gastroparesis. *J Neurogastroenterol Motil* 2012;18:131-7.
28. Familoni BO, Abell TL, Nemoto D, Voeller G, Johnson B. Efficacy of electrical stimulation at frequencies higher than basal rate in canine stomach. *Dig Dis Sci* 1997;42:892-7.
29. Familoni BO, Abell TL, Voeller G, Salem A, Gaber O. Electrical stimulation at a frequency higher than basal rate in human stomach. *Dig Dis Sci* 1997;42:885-91.
30. McKenna D, Beverstein G, Reichelderfer M, Gaumnitz E, Gould J. Gastric electrical stimulation is an effective and safe treatment for medically refractory gastroparesis. *Surgery* 2008;144:566-74.
31. Abell T, Van Cutsem E, Abrahamsson H, Huizinga JD, Konturek JW, Galmiche JP et al. Gastric electrical stimulation in the tractable symptomatic gastroparesis. *Digestion* 2002;66:204-12.
32. Abell T, McCallum R, Hocking M, Koch K, Abrahamsson H, Leblanc I et al. Gastric electrical stimulation for medically refractory gastroparesis. *Gastroenterology* 2003;125:421-8.
33. Maranki J, Parkman HP. Gastric electrical stimulation for the treatment of gastroparesis. *Curr Gastroenterol Rep* 2007;9:286-94.