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Assessing Gastroparesis & Functional Dyspepsia: Should We Use Gastric Emptying Tests?

Dr. Buch:
In spite of the fact that gastroparesis and functional dyspepsia are considered separate conditions, they are often confused with one another. But when it comes to assessing patients with symptoms, is it time to discard gastric emptying tests?

Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. Joining us today to discuss this topic is Dr. Reena Chokshi. Dr. Chokshi is an assistant professor at Baylor College of Medicine and author of an editorial on this topic published in Clinical Gastroenterology and Hepatology May 2021.

Welcome to the program, Dr. Chokshi.

Dr. Chokshi:
Thank you so much for having me. I'm really excited to be here and discuss this important topic with you.

Dr. Buch:
Thank you. Dr. Chokshi, let's start by looking at the relationship between functional dyspepsia and gastroparesis. Where do these two conditions overlap?

Dr. Chokshi:
So this is a really important question because when you talk about symptoms of functional dyspepsia and symptoms of gastroparesis, clinically, they can often appear the same. Patients can have such symptoms as nausea, abdominal discomfort especially postprandially, and so, what the thought process is now is potentially these disorders exist on a continuum. Traditionally, functional dyspepsia is thought of as a disorder of gut/brain interaction and gastroparesis is thought of more of—thought more as a motility disorder. However, there is a significant overlap in their symptoms, and we know that epidemiologically speaking that you can have patients who meet the criteria, the ROME criteria for functional dyspepsia, but also have delayed gastric emptying. And conversely, a lot of patients who we find to have gastroparesis do still fit the criteria for functional dyspepsia, and that's where the concern and the confusion can come in.

Dr. Buch:
Thank you. And considering that there is so much clinical overlap between functional dyspepsia and gastroparesis, why do we define them separately?

Dr. Chokshi:
It's it's a good point. The question, inherently becomes pathologically speaking or pathophysiologically speaking, Where are their differences? And they do have some overlap here. Things like impaired fundic accommodation potential electrical dysthymias of the stomach, abnormal visceral sensitivity, those have been proposed in both disorders. So the problems come in though with, How do we treat these patients? What might be some of those differences? For example, delayed gastric emptying in patients with functional dyspepsia has been associated with worse symptom scoring, potentially worse nausea in various studies, and so we try to see is there a reason we should be potentially be treating them differently. However, we know that patients can go between functional dyspepsia and gastroparesis over time, and so it becomes even more complicated.

Dr. Buch:
Thank you. How often do the symptoms of functional dyspepsia and gastroparesis transition between the two?

Dr. Chokshi:
Yeah. So there was an important study that came out that looked at exactly this question and noted that the categorization between gastroparesis and functional dyspepsia and vice versa can occur in approximately 40 percent within the course of one year, so you may actually do a gastric emptying test in a patient this year and then it can be completely different next year. And knowing that really supports, again, that these two entities probably exist on some sort of continuum.

Dr. Buch:
That's a really shocking statistic.

Dr. Chokshi:
Absolutely.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Reena Chokshi on the use of gastric emptying tests in patients with symptoms of gastroparesis and functional dyspepsia.

Dr. Chokshi, what should we know about the association between constipation and gastroparesis?

Dr. Chokshi:
Yeah, this is an important topic, and it can be really helpful in my opinion in terms of how we treat patients. But what we found in a study with the Gastroparesis Consortium was that patients who have symptoms of gastroparesis, in those patients you see moderate to severe symptom reporting of constipation in about 58 percent. There was another study that also showed an increased risk of slow transit constipation in gastroparesis patients. So, when patients come in and we focus on their upper gut symptoms, we may be doing them a disservice by not also addressing their constipation. For me, this has become really key in my treatment regimen. I really try and think about asking those questions related to their bowels also and potentially treating them.

One of the more recent medications that was approved for chronic idiopathic constipation is prucalopride, and prucalopride is important because it's a 5HT4 agonist, and that is how it works for constipation. However, we have those same receptors in our stomachs, and there have been studies that show that prucalopride also accelerates gastric emptying time and can improve symptoms in patients with gastroparesis symptoms, so it begs the question, should we consider in those patients who have concomitant constipation and gastroparesis—should we preferentially be using prucalopride to treat them?

Dr. Buch:
And again, prucalopride, it's not FDA approved for gastric emptying, but certainly, it is for chronic constipation.

Dr. Chokshi:
It would have to be in a patient who has constipation, but as I kind of tell my patients, it's a nice side effect that it might accelerate your gastric emptying also.

Dr. Buch:
So, here's the issue of today. Should we still be performing gastric emptying tests?

Dr. Chokshi:
It's such a great question. Where does it become useful, and who are the right patients in whom we should be obtaining this in our clinical practice? I do think that it can offer some benefit, currently chronic upper GI symptoms in patients who are, are failing to improve with initial therapy, often times things like diet or initial medications. I do think that gastric emptying time can be a helpful adjunct test. Right now it's our main measure. That's how we really define gastroparesis, but I do think that the more and more we learn about gastroparesis, the more adjunct tests we may have. But for right now, it's the one that helps dictate, you know, what potential interventions our patients can get into, things like that, so from that perspective, I do feel like it's helpful. I definitely feel like it's helpful in those patients who really have nausea, knowing that that worst symptom of nausea and vomiting can really pinpoint patients who may respond better to some of our therapies.

Dr. Buch:
And just for review for some of our audience members, what can affect gastric emptying? So, what should we know about before we even do this test?

Dr. Chokshi:
Great. So, the big thing to remember before you do this test is that opiates are the big culprit. There are other medications, but when it comes to actually measuring gastric emptying and doing things like scintigraphy, etc., we want our patients to be off of opiates before that test occurs.

Dr. Buch:
Thank you. So, moving on to this topic, do you think that some failures of gastric electrical stimulation for gastroparesis may actually be due to the fact that they really have functional dyspepsia?

Dr. Chokshi:
Yeah, I do think that that's a really interesting topic. So, gastric electrical stimulation, just to review, it uses high-frequency, low-energy stimuli, and it really is primarily for the treatment of the refractory nausea and vomiting due to gastroparesis. What we know is that the patients often times have improvements in symptoms, but it's not really associated with improved gastric emptying, so it, again, feeds into this concern that there really is a little bit more of a complex pathophysiology in gastroparesis. There may be some areas where we're helping with some things, some interventions that help with other things. So, for sure I think one thing to consider in those refractory gastroparesis patients is what is their dominant symptom. For patients with nausea and vomiting, things like gastric electrical stimulation and, G-POEM, gastric peroral endoscopic myotomy, may be a potential choice. For patients who have abdominal pain as their primary symptom, perhaps we should be treating this more as we do functional dyspepsia with things like neuromodulators, cognitive behavioral and hypnotherapy.

Dr. Buch:
Thank you for that. And before we conclude, is there anything else you would like to share with our audience today?

Dr. Chokshi:
You know, I think one thing that we discuss all the time is that I feel like gastroparesis can sometimes be a little bit overwhelming to the clinician, how to deal with these patients, what to do, and a lot of them have a lot of concerning features about their care. A few things to remember: one is that our initial treatment, especially for primary care physicians, is still symptom-based, low fat low diet with small frequent meals, initial medications, but when it gets to the time where you feel like this is something where I need some help, a place with multidisciplinary care is very helpful. Just the gastroenterologist can do some things, but a gastroenterologist who also has access to interventions, who also has access to dietitians and psychologists can really make a huge difference for the patient. The other thing I think that we should consider in this time is that we do notice a post viral type of gastroparesis as well and now that we are seeing more patients who are post-COVID, that's something to consider in those patients who are having upper gut symptoms, who have other symptoms of long COVID.

Dr. Buch:
This was an important discussion on gastroparesis, functional dyspepsia and gastric emptying tests. I want to thank my guest, Dr. Reena Chokshi, for sharing her insights. Dr. Chokshi, it was a pleasure having you on the program.

Dr. Chokshi:
Thank you so much. Thank you for having me. I really enjoyed it.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GI-Insights where you can be Part of the Knowledge. Thanks for listening and see you next time.