

Gastroparesis

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1 Gastroparesis is more common in women

Gastroparesis is defined by delayed gastric emptying without mechanical obstruction, causing epigastric symptoms.¹ Prevalence in the United States is 9.6 cases per 100 000 person-years for men and 37.8 cases per 100 000 person-years for women.²

2 Consider gastroparesis in patients with chronic nausea and vomiting

Gastroparesis presents with nausea, vomiting and dyspeptic symptoms (e.g., postprandial fullness, early satiety, epigastric pain and bloating).¹ The pathophysiology includes impairment in gastric neuromuscular function.² Risk factors for gastroparesis include diabetes, upper abdominal surgery, neurological diseases (e.g., Parkinson disease), connective tissue diseases and medications that delay gastric emptying (e.g., opioids, anticholinergic medications, glucagon-like peptide-1 receptor agonists [e.g., semaglutide]).¹ Most cases are idiopathic.² The differential diagnosis includes functional dyspepsia, cyclic vomiting syndrome and rumination syndrome.²

3 A gastric emptying study is required to diagnose gastroparesis

Patients with suspected gastroparesis should be referred for an upper gastrointestinal endoscopy to exclude an obstruction.¹ Evidence of delayed gastric emptying is required to establish the diagnosis.¹ The scintigraphic emptying test provides a reliable assessment of gastric emptying; more than 10% meal retention at 4 hours is abnormal.

4 Treatments include dietary modifications and prokinetic agents

Patients should follow a low-fat, low-fibre diet and eat small, frequent meals to manage symptoms.² Prokinetic agents, such as first-line dopamine-2 antagonists (e.g., domperidone) or 5-hydroxytryptamine 4 receptor agonists (e.g., prucalopride), should be used.¹ Medications that delay gastric emptying should be avoided.³ Therapies can be trialled before endoscopy if the suspicion of gastroparesis is high; they should be held before scintigraphy.

5 Refer patients with persistent symptoms to gastroenterology

Second-line pharmacological therapies include antiemetics (e.g., 5-hydroxytryptamine 3 receptor antagonists and neurokinin-1 receptor antagonists), prokinetic agents (e.g., macrolide antibiotics) or antidepressants (e.g., tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors or tetracyclics).⁴ Enteral nutrition may be required in patients with refractory symptoms.⁴

References

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