Step-Down Tx Helpful in Refractory Gastroparesis

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SOUTH LAKE TAHOE, CALIF. — Treating refractory gastroparesis aggressively with a combination of prokinetic medications in high doses and then slowly reducing the doses over time works much better than does a stepped-up dosing strategy, Dr. Amar Al-Juburi said.

Gastroparesis is a challenging problem that greatly decreases the quality of life, often in young patients. Most commonly it develops as an idiopathic disorder, or after surgery, or in association with diabetes.

Slow movement of food out of the stomach leads to nausea, vomiting, regurgitation, fullness, and bloating, Dr. Al-Juburi said at a meeting on gastroenterology and hepatology sponsored by the University of California, Davis.

Drug therapy can include antiemetics, prokinetic agents, and proton pump inhibitors to limit acid, which slows gastric emptying.

Dietary modification may help by reducing intake of fat and fiber, avoiding alcohol and smoking, and offering a liquid diet supplemented with vitamins and minerals if the patient can't tolerate solid foods, said Dr. Al-Juburi of the division of gastroenterology at the university.

Drug therapy can include antiemetics, prokinetic agents, and proton pump inhibitors to limit acid, which slows gastric emptying. Dr. Al-Juburi said he has no relationships with the companies that manufacture the drugs and devices that he discussed.

Among antiemetics, Dr. Al-Juburi may start with a dopamine receptor antagonist such as promethazine (Phenergan) with or without a serotonin receptor antagonist. Benzodiazepines can be helpful as short-term antiemetics for gastroparesis associated with chemotherapy or surgery but shouldn't be used long term.

The main prokinetic agent, metoclopramide, works much better in liquid form than in pill form, he said. "Providers forget that it comes in many formulations—pill, liquid, [intravenous, intramuscular], and subcutaneous," he said. Subcutaneous metoclopramide is useful to treat some patients at home who otherwise would be hospitalized, and the intravenous form may be useful for some inpatients.

Domperidone is an excellent alternative to metoclopramide and is being used but is an experimental agent that's not yet approved for use in the United States, he added.

The drug has fewer CNS side effects because it does not cross the blood-brain barrier, as metoclopramide does.

Intravenous erythromycin—but not oral erythromycin—is a prokinetic agent that's helpful in acute situations for hospitalized patients, at a dosage of 250 mg every 8 hours. "It kick-starts the gastric motility," he said. Side effects from chronic therapy keep this a short-term treatment.

Data are scarce on the best strategy for treating refractory gastroparesis, but Dr. Al-Juburi advised using an aggressive step-down approach with a combination of prokinetics.

"You have to break the cycle of the exacerbation of the nausea and vomiting," he said. Don't limit patients to small doses p.r.n., he advised. "We've had people use a Phenergan pump," perhaps in combination with intravenous erythromycin and oral tegaserod.

The dose of tegaserod is higher than that used for chronic constipation. Refractory gastroparesis usually requires about 18 mg (6 mg t.i.d.) of tegaserod. Keep in mind that tegaserod does not have antiemetic effects, and consider adding an antiemetic agent as well, he said.

For patients who fail these strategies, injections of pyloric botulinum toxin (Botox) may help, pilot studies suggest, but the drug is expensive and effects last for only a few months.

Clinicians may resort to enteral feeding for patients who require intensive nutritional rehabilitation, but this may not alleviate the symptoms of gastroparesis.

Dr. Al-Juburi said he would choose jejunostomy over gastrostomy.

Jejunostomy frequently causes complications and impairs quality of life, but it can usually maintain patients for months or years. ■