

Motility Evaluation in the Patient with Inflammatory Bowel Disease



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KEYWORDS

- Functional bowel disease • Motility disorders • Gastroparesis
- Gastroesophageal reflux disease • Irritable bowel syndrome
- Dyssynergic defecation • Fecal incontinence • Small bowel bacterial overgrowth

KEY POINTS

- Patients with inflammatory bowel diseases (IBD) suffer frequently from functional bowel diseases (FBD) and motility disorders.
- Complete evaluation of ongoing symptoms not related to an inflammatory flare in patients with IBD should be prompt with consideration of these motility disorders for which diagnostic studies are now available.
- Management of FBD and motility disorders in IBD combined with continued treatment of a patient's IBD symptoms will likely lead to better clinical outcomes and improve the patient's quality of life.

INTRODUCTION

Patients with inflammatory bowel disease (IBD) have significantly higher rates of functional bowel diseases (FBD) as compared with healthy controls^{1,2} and often require motility evaluation for ongoing symptoms not thought to be related to an IBD flare. In fact, 66% of patients with IBD in one study met Rome III criteria for at least one FBD and the number of FBD symptoms correlated positively with anxiety/depression scores and negatively with health-related quality-of-life scores.¹ Given the high

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prevalence of motility disorders in patients with IBD resulting in diminished quality of life and sometimes narcotics use, it is important for physicians to recognize and treat comorbid motility disorders and FBD. The goals of this review were to summarize the most recent literature on motility disturbances in patients with IBD and to give a brief overview of the ranges of motility disturbances, from reflux disease to anorectal disorders, and discuss their diagnosis and specific management.

GASTROESOPHAGEAL REFLUX DISEASE IN INFLAMMATORY BOWEL DISEASE

Gastroesophageal reflux disease (GERD) is a widely spread condition, with a reported prevalence of up to 27.8% of the US population.³ IBD and GERD share upper gastrointestinal (GI) symptoms, such as heartburn, chest pain, and regurgitation. In more advanced upper GI involvement in IBD, patients may even present with dysphagia, odynophagia, worsening reflux symptoms, or obstructive symptoms, such as early satiety, postprandial vomiting, and weight loss.⁴ GERD is encountered more frequently in patients with IBD than in the general population. In one study of more than 450 patients with IBD, the prevalence of GERD was 62% in ulcerative colitis (UC) and 72% in Crohn's disease (CD), and having a diagnosis of GERD was associated with reduced quality of life.² Although the esophagus is the least common location to be affected by CD in the GI tract,⁴ it is likely underdiagnosed in adults due to lack of endoscopic biopsies of the esophagus.⁴ The involvement of upper GI tract in IBD is increasingly becoming recognized, however, due to the now more frequent utilization of upper GI endoscopy in the assessment of patients with IBD.

GERD can be diagnosed clinically by improvement of typical symptoms with proton pump inhibitor (PPI) therapy and/or endoscopically by an upper endoscopy with biopsies showing esophagitis, or objectively by measuring acidity and duration of acid reflux episodes using a 24-hour ambulatory esophageal pH monitoring system. The diagnosis of CD esophagitis is more challenging due to the similarity of its manifestations to those of more common entities (eg, GERD).⁵

The prevalence of esophageal CD ranges from 0.2% to 11.2% in adults and up to 43.0% in children.^{6,7} The prevalence of macroscopic upper GI tract inflammation in CD on endoscopy ranges from 30% to 64% of patients with CD in pediatric literature,^{8,9} whereas microscopic inflammation had been reported to be present in 70% of patients.^{10,11} Consensus among gastroenterologists regarding the definition of what qualifies to be significant upper GI involvement in IBD is yet to be established.¹² Although most of the literature links upper GI tract involvement to CD, the once widespread notion that UC is never associated with upper GI tract involvement is no longer considered valid.¹² Albeit used to be considered a separate entity that may not coexist with more distal disease in the 1998 Vienna classification of IBD,¹³ upper GI involvement in CD has been accepted to accompany distal disease in the 2005 Montreal classification of CD.¹⁴

Endoscopically, GERD esophagitis has 3 stages: active, healing, and scarring,^{15,16} based on the degree of presence of redness, necrotic debris, regenerating epithelium, and epithelial staining with Lugol iodine. The endoscopic findings in CD esophagitis are similar to those of colonic disease, and usually manifest as areas of inflammation, linear ulcerations, or, in more advanced disease, mucosal nodularity, cobblestone appearance, fistulas, fibrosis, stenosis, and/or strictures.^{4-6,17} Histologically, CD esophagitis shows segmental, focal inflammatory infiltration of the lamina propria, extending between the muscle fibers of the muscularis mucosa, consisting mainly of lymphocytes, and associated with edema, dilated lymphatics, and epithelioid granulomas in the lamina propria, and may be associated with focally enhanced gastritis.¹⁷

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