



Management options for functional dyspepsia

Role of new prokinetic agent mosapride citrate

The ROME II criteria for functional GI disorders (FGIDs) distinguish functional dyspepsia from upper-abdominal complaints related to irritable bowel syndrome (IBS) by the absence of any change in defecation frequency or kind of stool and the failure of defecation to ease epigastric symptoms. ROME II also classifies functional dyspepsia into three types according to subjective symptoms: ulcer-like, dysmotility-like, and nonspecific.

“The ulcer-like type is anchored on night pain and abdominal discomfort in the upper abdomen. Dysmotility-like is anchored on early satiety and distention, while the worst type is a mix of ulcer and dysmotility types,” said Dr. Jose Sollano, professor of medicine at the University of Santo Tomas. Speaking in a symposium organized by HI-Eisai Pharmaceutical Inc. during the joint annual convention of the Philippine Society of Gastroenterology, Philippine Society of Digestive Endoscopy, and Hepatology Society of the Philippines, Sollano also cited studies differences in prevalence between Caucasians and Asians.

A systematic review of 22 Western studies placed the prevalence of functional dyspepsia at 11.5 to 14.7 percent among Caucasians and that of uninvestigated dyspepsia (upper-abdominal discomfort, which includes symptoms of heartburn or acid regurgitation, at 10 to 40 percent. On the other hand, functional dyspepsia with reflux-disease symptoms was less common among Southeast Asians. Instead, belching symptoms after epigastric pain were found to be more common among them.

Endoscopy also showed that 25 percent of Caucasians had erosive esophagitis while 22 percent of Asians had had only mild erosive gastritis. Pointed out Sollano: “Maybe in Asia we have more epigastric pain while in the West there is more reflux disease, with esophagitis ... as part of their dyspeptic syndrome. The other glaring difference ... is the incidence and prevalence of peptic-ulcer disease among Southeast Asian patients.”

New findings led to the reclassification of functional dyspepsia into epigastric-pain syndrome (EPS) and postprandial-pain syndrome (PPS) under ROME III, with a smaller group of patients subclassified further into those with co-existent heartburn or IBS, cyclic-vomiting syndrome, and chronic idiopathic nausea. ROME III thus recognized epigastric pain as an important and integral part of the diagnosis.

Role of PPIs and prokinetics

Several multicenter trials have proved that suppressing acid secretion with proton-pump inhibitors (PPIs) helps treat func-

tional dyspepsia. A metaanalysis of 22 studies showed that 10- to 20-percent more patients on PPIs experienced relief from symptoms than those on placebo, weak H₂ blockers, or prokinetic agents. El-Serag and Talley (2004) estimated that with PPIs, 50 percent of patients will have “total relief” of symptoms. Another metaanalysis (van Pinxteren et al., 2008) validated the distinct advantage of PPIs over prokinetics among 400 patients. With H₂-receptor antagonists, relief of symptoms was minimal. Relief from early satiety, regurgitation, heartburn, epigastric tenderness, and distention was shown by Mundo-Gallardo et al. (2000) with 20-mg rabeprazole once daily.

Acid hypersecretion is one problem functional-dyspepsia patients experience, with such symptoms as bloating, nausea and belching, heartburn, and epigastric pain. Using PPIs, however, may not yield satisfactory results. Prof. Hiroto Miwa, head of the division of upper gastroenterology at Japan’s Hyogo College of Medicine, pointed out that patients who report complete symptom relief using 20-mg omeprazole will go down to around 40 percent of total patients—around the same rate as placebo’s.

Meanwhile, a Canadian metaanalysis showed that as high as 40 percent of patients did not respond to prokinetics while 60 percent did not respond to percent, making prokinetic 20 percent more efficacious. However, greater efficacy was seen only as the data became smaller, and among the 14 studies in the metaanalysis, six did not show any significant statistical difference.

Mosapride

Miwa cited the new prokinetic agent mosapride citrate, a serotonin 5-HT₄-receptor agonist known to activate GI-tract motility. It is relatively safe, since it has no known effect on the cardiovascular system. In abdominal ultrasonography following a meal, mosapride was seen to affect a part of the proximal stomach. This, reported Kusunoki et al. (2004), helped to significantly increase and facilitate

accommodation reflux. In rats, mosapride reduced the pain evoked by balloon distention of the stomach. In patients with reflux disease, mosapride citrate was shown effective in relieving symptoms.

A four-week randomized, placebo-controlled study involving 200 patients compared 10-mg omeprazole plus 15-mg mosapride with omeprazole alone. The primary end point was the ratio of cured patients and relief of symptoms based on the visual analog scale. The study revealed that omeprazole-mosapride resulted in statistically significant relief of symptoms versus omeprazole alone. **M**

