Chronic intestinal pseudo-obstruction in children and adults: diagnosis and therapeutic options

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Abstract

Background: Chronic intestinal pseudo-obstruction (CIPO) represents the most severe form of gastrointestinal dysmotility with debilitating and potentially lethal consequences. Symptoms can be non-specific, and result in this condition being diagnosed incorrectly or too late with consequences for morbidity and even mortality.

Purpose: The present article aims to provide pediatric and adult gastroenterologists with an up to date review about clinical features, diagnosis and therapeutic options for CIPO. Although pediatric and adult CIPO share many clinical aspects distinctive features can be identified. There is no single diagnostic test or pathognomonic finding of CIPO, thus a stepwise approach including radiology, endoscopy, laboratory, manometry, and histopathology should be considered in the diagnostic work-up. Treatment of patients with CIPO is challenging and requires a multidisciplinary effort with participation of appropriately experienced gastroenterologists, pathologists, dieticians, surgeons, psychologists, and other subspecialists based on the presence of comorbidities. Current treatment options invariably involve surgery and specialized nutritional support, especially in children. Medical therapies are mainly aimed to avoid complications such as sepsis or intestinal bacterial overgrowth and, where possible, restore intestinal propulsion. More efficacious therapeutic options are eagerly awaited for such difficult patients.

Keywords
chronic intestinal pseudo-obstruction, clinical manifestations, histopathology, manometry, nutritional therapy

1 | INTRODUCTION

Chronic intestinal pseudo-obstruction (CIPO) is a rare condition characterized by a severe impairment of gastrointestinal (GI) propulsion, which results in symptoms suggestive of partial or complete intestinal obstruction in the absence of any lesion restricting or occluding the intestinal lumen.¹⁻⁵ Chronic intestinal pseudo-obstruction can involve any segment of the GI tract (although the small bowel and colon are mainly affected) and represents the most severe form of GI dysmotility with potentially lethal consequences.²,⁴ Symptoms can be non-specific with CIPO mistaken for other diseases and consequently not diagnosed for long periods of time.⁶,⁷ The chronicity of the severe digestive symptoms, the inability to maintain an adequate nutritional status without specialist support, the suboptimal efficacy of medical treatments, and the limited knowledge of the syndrome by physicians constitute some of the main factors contributing to the poor quality of life and the high morbidity and mortality rate of patients with CIPO.⁶⁻¹⁰

Much like other rare diseases with poorly defined diagnostic criteria, CIPO has a largely unknown prevalence and incidence.² One nationwide survey in the U.S. reported that about 100 infants were born with CIPO every year.¹¹ A more recent nationwide survey in Japan found a prevalence of 3.7 in one million children (1 in 270 000 children younger than 15 years of age) with equal sex incidence.¹²

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TABLE 1 Etiology and classification of CIPO

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
<th>Familial forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No demonstrable etiopathogenetic causes</td>
<td>• Neurological disorders</td>
<td>• Autosomal dominant</td>
</tr>
<tr>
<td></td>
<td>• Metabolic diseases</td>
<td>o SOX10*</td>
</tr>
<tr>
<td></td>
<td>• Paraneoplastic syndromes</td>
<td>• Autosomal recessive</td>
</tr>
<tr>
<td></td>
<td>• Neurotropic viruses</td>
<td>o RAD21*</td>
</tr>
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<td></td>
<td>• Autoimmune disorders</td>
<td>o TYMP*</td>
</tr>
<tr>
<td></td>
<td>• Celiac disease</td>
<td>o POLG*</td>
</tr>
<tr>
<td></td>
<td>• Neuro-muscular disorders</td>
<td>• X-Linked</td>
</tr>
<tr>
<td></td>
<td>• Radiation enteritis</td>
<td>o FLNA*</td>
</tr>
<tr>
<td></td>
<td>• Endocrinological disorders</td>
<td>o L1CAM*</td>
</tr>
<tr>
<td></td>
<td>• Drugs</td>
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</tbody>
</table>

*Mutation(s) to the indicated genes.
FLNA, filamin; L1CAM, L1 cell adhesion molecule; POLG, polymerase DNA gamma; RAD21, cohesin complex component; SGOL1, shugoshin-like 1; SOX10, SRY-BOX 10; TYMP, thymidine phosphorylase; CIPO, chronic intestinal pseudo-obstruction.

These studies most likely underestimate the true number of new cases per year, as they do not include patients who develop symptoms of CIPO later in life. In another survey of 378 institutions belonging to the Japanese Society of Gastroenterology, CIPO prevalence in adult patients was estimated to be 1.0 and 0.8 cases per 100 000 males and females respectively. The incidence in the same population was 0.21 and 0.24 cases per 100 000 males and females respectively.13

The purpose of this article is to provide a broad review of CIPO ranging from pediatric to adult age highlighting selectively the main clinical aspects such as symptoms/signs, diagnosis and therapeutic options in the different age groups. Deliberately, we did not address the putative mechanisms underlying severe gut dysfunction and the attendant histopathological features and the reader is referred to published comprehensive articles on these topics (references 14–57). In Table 1 we have summarized the classification of CIPO in relation to etiopathogenetic factors.

2 | DISEASE SPECTRUM

Chronic intestinal pseudo-obstruction is not a single clinical entity, rather an umbrella term for a range of different diseases leading to severe, end-stage gut motor failure. The most severe cases of the CIPO spectrum are those involving pediatric patients with antenatal (in utero) evidence of multivisceral dilation of the hollow viscera (e.g. digestive and urinary systems), often characterized by inability to tolerate enteral feeding and poor prognosis (Fig. 1A and B).8,58–60 This clinical subset represents the most common group of pediatric CIPO patients with diffuse involvement of the GI tract. In these cases, the neuromuscular abnormalities (either genetic or acquired) of the GI tract do not preclude birth, but can be severe enough to generate the onset of symptoms in the early newborn period with reported mortality rates ranging from 10% to 32%.8,58,59

More rarely, some cases appear to be acquired after birth being characterized by a variable period of normality followed by progression to intestinal failure with bowel (and often urinary tract) dilatation. In some of the most aggressive forms of acquired CIPO, the histopathological analysis may detect a massive inflammatory (mainly lymphocytic) neuro-muscular infiltrate, reminiscent of the autoimmune pancreatic “insulitis” underlying insulin-dependent diabetes mellitus of the childhood25 (Fig. 1C and D). These cases of CIPO may respond to an immunosuppressive treatment if the immune-mediated insult has not completely damaged regulatory cells, i.e. enteric nerves, interstitial cells of Cajal (ICC), and smooth muscle.34–39

Other cases of pediatric and adult CIPO may occur in patients who experience more insidious mild and non-specific symptoms (either “irritable bowel syndrome” - or “dyspepsia” - like) thought not to carry a risk to evolve into severe dysmotility. Nonetheless, some of these patients do progress on to a classic CIPO phenotype over time (Fig. 1E and G). We consider them the “dark-side” of adult CIPO spectrum, i.e. cases in which a number of factors, including an altered gut microbiota, intestinal epithelial barrier dysfunction, immune dysregulation, and other poorly defined mechanisms may operate, individually or in concert, to impair the neuro-muscular homeostasis.6 Patients with acute onset of CIPO after abdominal surgery, i.e. mimicking a prolonged postoperative ileus, remain a largely unexplained subset. Other striking examples are those cases occurring after ileal bypass performed to treat morbid obesity, suggesting that surgical manipulation may by itself evoke neuro-myoelectrical abnormalities in predisposed alimentary tracts.61 A synoptic view of this section is reported in Fig. 1.

3 | CLINICAL FINDINGS

Chronic intestinal pseudo-obstruction may involve any segment of the GI tract and therefore symptoms can vary from patient to patient based on the location and the extent of the gut segment involved. In addition, extra-intestinal manifestations and malnutrition contribute to the clinical features.5,7,15,62–64 Prenatal signs are only detected in about 20% of cases, whereas 50–70% of patients show clinical signs perinatally (i.e. within the first month of age). Most patients
Di NarDo et al. (80%) show clinical manifestations by the first year of age, while the remaining 20% have sporadic onset during the first two decades of life. One study indicated that the median age of symptom onset in adults is 17 years. Both pediatric and adult CIPO share many clinical aspects, although distinctive features can be identified (Table 2). In any age group, the clinical picture tends to be dominated by abdominal pain and distension (80%), which are particularly severe during acute episodes of pseudo-obstruction. Associated symptoms include nausea and vomiting (75%), constipation (40%), and diarrhea (20%). Between acute episodes, patients can be minimally symptomatic, or continue to experience severe proximal (anorexia, early satiety, nausea and vomiting) and distal digestive symptoms (constipation, diffuse abdominal pain and/or distension). Prevalence and severity of acute episodes that recur at irregular intervals vary from patient to patient. Malnutrition is another significant clinical aspect in any patient with CIPO. This is due to both the limited oral intake, because ingestion of food generally aggravates symptoms, and the intestinal malabsorption related to the altered gut transit, often associated with dilated bowel loops. In about 30% of CIPO patients, small intestinal bacterial overgrowth (SIBO) occurs as a result of intestinal stasis and can cause diarrhea and steatorrhea. Gastroparesis and urinary bladder dysfunction (with or without megacystis and megaureter) are co-morbidities likely sharing similar pathophysiological mechanisms with those underlying CIPO. In addition, because of the frustrating ineffectiveness of most therapeutic interventions, patients with CIPO may develop depression or other psychological disorders.

In children, there is a higher risk of colonic and small bowel volvulus secondary to severe dysmotility and gut dilatation, congenital adhesions or concurrent malrotation. Urological involvement...
TABLE 2  Main similarities and differences in CIPO in children and adults

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adults</th>
</tr>
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<tbody>
<tr>
<td><strong>Etiology</strong></td>
<td>Mainly idiopathic</td>
<td>Half of cases are secondary to acquired diseases</td>
</tr>
<tr>
<td><strong>Histopathology</strong></td>
<td>Myopathies and neuropathies</td>
<td>Mainly neuropathies</td>
</tr>
<tr>
<td><strong>Symptom onset</strong></td>
<td>In utero, from birth or early infancy with 65–80% of patients symptomatic by 12 months of age</td>
<td>Median age of onset at 17 years</td>
</tr>
<tr>
<td><strong>Clinical features</strong></td>
<td>Occlusive symptoms at birth and/or chronic symptoms without free intervals</td>
<td>Chronic abdominal pain and distension with superimposed acute episodes of pseudo-obstruction Urinary bladder involvement not so often reported</td>
</tr>
<tr>
<td><strong>Natural history</strong></td>
<td>Myopathic CIPO, urinary involvement and concurrent intestinal malrotation are poor prognostic factors</td>
<td>The ability to restore oral feeding and the presence of symptoms &lt;20 years of age is associated with a low mortality; while, systemic sclerosis and severe/diffuse esophageal and intestinal dysmotility are associated with a high mortality</td>
</tr>
<tr>
<td><strong>Diagnostic approach</strong></td>
<td>Specialized tests (e.g. intestinal manometry) often difficult to perform; non-invasive, radiation-free imaging tests are warranted</td>
<td>Various methodological approaches usually starting from endoscopy and radiological tests up to more sophisticated functional exams</td>
</tr>
<tr>
<td><strong>Nutritional therapy</strong></td>
<td>To ensure normal growth extensively hydrolyzed and elemental formulas are often empirically used to facilitate intestinal absorption</td>
<td>To improve nutritional status and prevent malnutrition</td>
</tr>
<tr>
<td><strong>Pharmacological therapy</strong></td>
<td>Small number/sample size controlled trials</td>
<td>Small number/sample size controlled trials; few conclusions can be drawn for most drugs</td>
</tr>
<tr>
<td><strong>Surgical therapy</strong></td>
<td>Venting ostomies (although characterized by high complication rates) possibly helpful; surgery as a “bridge” to transplantation may be indicated in highly selected cases</td>
<td>Venting ostomies can be helpful; resective surgery may be indicated in accurately selected patients (i.e. cases with proven segmental gut dysfunction)</td>
</tr>
</tbody>
</table>

is commonly identified in patients with familial and congenital forms of CIPO, particularly in the myopathic subgroup, ranging from 36% to 100%.8,70–73 Findings include urinary retention secondary to bladder atony, hydronephrosis, vesicoureteral reflux, and recurrent urinary tract infections. Megacystis on antenatal ultrasound has been reported in up to 59% of CIPO and this finding may require cesarean delivery.72,73 The megacystis can be associated with a microcolon, a phenotype referred to as megacystis-microcolon-intestinal-hypoperistalsis syndrome.6 Other syndromic form of CIPO are represented by the mitochondrial disorders which in a large adult series account for 19% of all CIPO patients. They are characterized by severe intestinal dysmotility, poor nutritional status, and neurological manifestations, e.g. peripheral neuropathy (with mild to moderate hypeaesthesia), proprioceptive ataxia, progressive external ophthalmoplegia with ptosis, and hearing loss.7 Gastrointestinal manifestations are common at presentation and positive family history together with the progressive neurological and nutritional deterioration should alert clinicians to search for mitochondrial disorders.42,43,74,75

Secondary systemic forms (i.e. related to underlying conditions) of CIPO are more common in adult patients in whom they occur at much older age.2 A proximal muscle weakness may indicate the presence of polymyositis and dermatomyositis. Scleroderma is usually associated with skin abnormalities, while the suspicion of a paraneoplastic syndrome should prompt investigations aimed at uncovering an occult malignancy of the lung, ovary, and breast. Finally, forms of CIPO associated with Chagas' disease are common in Latin America and are characterized by combination of dysphagia and cardiomyopathy.6,7,11,25,26,32,33,76

4  | DIAGNOSIS

The diagnosis of CIPO is mainly clinical. The diagnostic work up of both children and adults with suspected CIPO has the following goals: (i) rule out mechanical causes of bowel obstruction. This can be achieved by abdominal computed tomography (CT) or plain X-ray; (ii) identify any underlying diseases by an accurate laboratory test profile; (iii) evaluate the possibility of a drug-induced CIPO-like presentation (e.g. opioids, tricyclic antidepressants, anti-cholinergic agents, anti-Parkinsonian agents, phenothiazines); and (iv) understand the pathophysiological features which may direct management or bear prognostic information in selected cases (particularly by performing GI manometry in cases without bowel dilation). Thus, a stepwise approach (as outlined above) is commonly recommended in CIPO and includes radiology, endoscopy, laboratory, manometry, and histopathology.

4.1  | Radiology

A plain radiograph of the abdomen usually identifies the typical signs of intestinal obstruction, i.e. air-fluid levels and dilated bowel
Air-fluid levels are better visualized in the upright position, but lateral views can be useful. In symptomatic patients without these radiographic findings, other conditions (e.g. chronic constipation, irritable bowel syndrome and functional dyspepsia) should be considered.

Fluoroscopic studies should be performed using water-soluble contrast solutions in order to avoid complications related to barium concretions and, at the same time, enhance hydration and transit of intestinal contents. Upper GI series with small bowel follow-through can reveal dilated bowel loops (often involving the stomach and duodenum) with very slow transit, although the latter finding may not be detectable in some pediatric cases. Intestinal malrotation may be identified in up to a third of children with CIPO. Less common findings include diverticulosis of the small intestine (in 53% of patients with mitochondrial neurogastrointestinal encephalomyopathy [MNGIE], and 42% of scleroderma), and intestinal pneumatosis.

Contrast medium radiological tests have been recently superseded by dedicated enterography with high-resolution CT or MRI, which more accurately detect mechanical obstruction and intestinal adhesions. Cine-MRI is emerging as a non-invasive, radiation-free method for assessing and monitoring GI motility particularly in the pediatric population.

Excretory urograms should be performed in patients with urinary symptoms, since neuro-mydopathies may affect both the GI tract and urinary system. A chest CT may be necessary to exclude small cell lung cancer in adult patients with suspected paraneoplastic CIPO. Finally, imaging of the brain can identify leukoencephalopathy in CIPO related to MNGIE.

### 4.2 Endoscopy

Upper GI endoscopy may be useful to exclude a mechanical occlusion of the proximal small intestine and to collect duodenal biopsies in cases where celiac disease or eosinophilic gastroenteropathy are suspected. Colonoscopy can be used to rule out mechanical obstruction and decompress the large intestine, although this maneuver rarely provides long-term satisfactory results. The wireless motility capsule measures intraluminal pH, temperature, and pressure; however, the role of this technique in the diagnosis of CIPO has not been established yet and its use is thought to be possibly hazardous when a mechanical obstruction has not been definitely ruled out.

### 4.3 Laboratory tests

Laboratory exams are aimed to uncover secondary causes of CIPO. Blood tests for diabetes mellitus (i.e. hemoglobin A1C and/or post-prandial blood glucose concentration), celiac disease (antitissue transglutaminase IgA and antideamidated gliadin peptides IgG), connective tissue and skeletal muscle disorders (antinuclear antibody, anti-double-stranded DNA and SCL-70, creatine phosphokinase, aldolase), and hypothyroidism should be performed. Other tests include serology for Chagas’ disease, urinary catecholamines for pheochromocytoma, and enteric neuronal autoantibodies (anti-Hu or type 1 antineuronal nuclear antibodies) in patients with suspected paraneoplastic syndrome. Urinary porphyrins should be assayed in patients with severe, otherwise unexplained abdominal pain. A complete blood cell count, electrolytes, albumin, liver enzymes, vitamin B12, fasting cortisol, inflammatory indexes (C-reactive protein and erythrocyte sedimentation rate) are useful in all cases. Patients receiving parenteral nutrition (PN) should be carefully monitored with particular attention to fluid, electrolytes, and circulating levels of trace elements. In patients with symptoms and signs suggestive of an underlying mitochondrial disorder, serum lactate and thymidine phosphorylase (TYMP) activities should be performed. If TYMP activity is markedly reduced/absent and nucleosides are increased, then TYMP (in MNGIE), and polymerase DNA-gamma (POLG) (in sensory ataxic neuropathy dysarthria and ophthalmoparesis) gene mutations should be tested.

### 4.4 Manometry

Intestinal manometry can be useful to define the pathophysiologic (neuro-muscular) mechanisms involved in CIPO (e.g. neuropathy or myopathy), although it has a low diagnostic specificity and in most pediatric and adult patients does not influence treatment. Nonetheless, intestinal manometry can differentiate mechanical from functional forms of sub-occlusion, provided that the organic cause is at an early stage. The presence of postprandial, prolonged, high pressure, non-propagated contractions is a pattern suggestive of a recently occurred mechanical obstruction. A neuropathy is characterized by contractions showing a normal amplitude, although with uncoordinated pattern (neuro-muscular) mechanisms involved in CIPO (e.g. neuropathy or myopathy). Notably, only esophageal motor disorders had a significantly negative predictive value in terms of survival, home PN requirement, and inability to maintain sufficient oral feeding. In children with chronic symptoms suggestive of CIPO, a normal manometry essentially excludes CIPO and should lead to the consideration of emotional or factitious disorders (e.g. Munchausen syndrome by proxy).

Amiot et al. have identified abnormal esophageal manometry in 73% (51% with severe ineffective dysmotility) adult CIPO cases. Similar findings have been also documented in pediatric cases of CIPO. Notably, only esophageal motor disorders had a significantly negative predictive value in terms of survival, home PN requirement, and inability to maintain sufficient oral feeding, suggesting the presence of a more generalized disease. In addition, esophageal manometry may have diagnostic value in CIPO associated with scleroderma. Anorectal manometry is indicated when the clinical picture is characterized by intractable constipation and marked colonic dilatation, suggestive of Hirschsprung’s disease. A careful manometric assessment of the entire GI tract, including the colon, has been deemed helpful in helping to plan for an isolated or a multivisceral transplantation in the most severe forms of pediatric CIPO.
Collection of gut full-thickness biopsies is aimed at providing clinicians with a histopathological correlate which may unravel abnormalities related to: (i) extrinsic and/or intrinsic neurons controlling gut functions; (ii) the ICC networks; and (iii) enteric smooth muscle cells. Changes affecting these cellular systems are tightly linked to the pathophysiology of CIPO and may have prognostic and sometimes
therapeutic implications. Minimally invasive procedures, e.g., laparoscopic surgery or very recently - endoscopic approaches (for example natural-orifice transluminal endoscopic surgery), have shown a high diagnostic yield and safety. In addition, guidelines proposed by the Gastro 2009 International Working Group have helped to find consensus about technical aspects (including tissue collection and processing) and histopathological reporting of results in a variety of gut neuro-muscular disorders, including CIPO.

In the absence of clinical guidelines, we suggest that ideal CIPO patients who should be referred to laparoscopic surgery for full-thickness biopsies fall into these two major categories: (i) idiopathic cases characterized by an acute onset likely of post-infectious origin; (ii) patients with progressive, rapidly evolving forms of CIPO who are not under treatment with opioids and do not respond to any therapeutic options. In contrast, CIPO patients with severe pain, not uncommonly treated with opioids, should not undergo any therapeutic options. In those cases it is advisable to taper down opioids and change with other non-opioidergic analgesic compounds. This measure is directed to avoid useless and often misleading histopathological analysis. In CIPO cases with a clear origin (i.e. secondary forms of CIPO), tissue sampling may be less clinically meaningful as many systemic diseases are known to affect the gut neuro-muscular layer.

5 | NATURAL HISTORY

A severe clinical course can be expected for both pediatric and adult patients with CIPO when an underlying treatable disease is not identified. In a single-center study of 59 adult patients with idiopathic CIPO followed up for a long time (13 years), it was demonstrated that the average time between the first sub-occlusive episode and the diagnosis of CIPO was 8 years, with 88% of patients undergoing an average of 3 unnecessary surgical procedures. Similar rates of questionable surgery are seen in the pediatric setting. The digestive symptoms worsened over time with abdominal pain becoming intractable or responsive only to major analgesics (e.g. opioids - always used parsimoniously and with extreme caution in our own experience) in approximately 25% of cases. Most patients had oral feeding restrictions, while 30–50% of patients needed long-term PN. A study by Amiot et al., which examined all patients with CIPO on PN at home, revealed that the lowest mortality was associated with the ability to restore oral feeding and with the presence of symptoms before 20 years of age, while an increased mortality was associated with the presence of scleroderma.

Manometric parameters, such as inadequate or absent motor response to meals, absence of migrating motor complex (MMC) during fasting, and generalized hypomotility have been shown to be predictive of poor outcome in patients with CIPO. Finally, detection of esophageal dysmotility in CIPO seems to have negative prognostic implications in terms of mortality and need for home PN. In children with CIPO, a myopathic etiology, coexisting urinary involvement, and concurrent intestinal malrotation are poor prognostic factors. In both adults and children, the risk of death is increased by the absence of a specialist team and in the early phases after the diagnosis of intestinal failure has been established.

6 | THERAPY

Treatment of patients with CIPO is challenging and requires a multidisciplinary effort. The management of both children and adults with CIPO should be directed to avoid unnecessary surgery, restore fluid and electrolyte balance, maintain an adequate caloric intake, promote coordinated intestinal motility, and treat complications e.g. sepsis, SIBO and associated symptoms. In general, current therapeutc approaches are not very effective; however, recent advancement in nutritional, pharmacological, and surgical treatment has helped to improve the management of patients with CIPO.

6.1 | Nutritional support

Patients with CIPO are often malnourished, due to malabsorption and insufficient food intake. Patients with sufficient intestinal absorption capacity should be encouraged to take small, frequent meals (5–6 per day), with an emphasis on liquid calories and protein intake, while avoiding high-fat and high-residue (fiber containing) foods. Carbohydrate containing foods, rich in lactose and fructose, may worsen abdominal bloating and discomfort. Vitamin levels, i.e. A, D, E, and K and B12 and folic acid, should be supplemented when needed. In cases of inadequate oral intake, enteral nutrition with standard non-elemental formula may be considered. In children, extensively hydrolyzed and elemental formulas are often empirically used to facilitate intestinal transit and absorption. Before a permanent feeding tube is placed, a trial with a nasogastric or nasojejunal feeding tube should be attempted using an enteral formula at a rate sufficient to provide an adequate caloric support. When delayed gastric emptying is present, bypassing the stomach and directing the feeding into the small intestine is generally preferred. Jejunal feeding tubes were tolerated in all patients with manometrically detectable MMC vs 33% of those without. Enteral nutrition should be started with a slow infusion given continuously or, preferably, in a cyclical manner (during the night).

In the most severe cases, PN is necessary to maintain nutritional support and an adequate level of hydration. If patients are exclusively dependent on PN, they should receive approximately 25 kcal/kg/day, and lipids should approximately supply 30% of total parenteral calories with 1.0–1.5 g/kg/day of proteins and dextrose covering the remaining caloric amount. Complications of PN, including liver failure, pancreatitis, glomerulonephritis, thrombosis, and sepsis, are frequent causes of morbidity and mortality in any form of pediatric and adult CIPO. Individualized PN formulations with minimal amount of intravenous lipids can help reducing metabolic complications. A long-term PN does not seem to be associated with a significant increase in morbidity and mortality in CIPO. A retrospective analysis of 51 adult patients receiving PN for an average of 8.3 years showed 180 episodes of catheter-related sepsis, 9 of acute pancreatitis, 5...
encephalopathy, and 4 patients progressing to cirrhosis. Oral intake was a major independent factor associated with better survival; thus, patients receiving PN should be allowed and encouraged to maximize oral intake as tolerated.93,95

6.2 | Pharmacological therapy

The main aim of pharmacological treatment in patients with CIPO is to promote GI propulsive activity, thereby improving oral feeding, decreasing symptom severity, and minimizing SIBO.2–4

The efficacy and main features related to various drugs, such as erythromycin, metoclopramide, domperidone, somatostatin analogues (octreotide and lanreotide), cholinesterases inhibitors (neostigmine and pyridostigmine), serotoninergic agents (such as 5-hydroxytryptamine receptor 4 · 5-HT₄ · agonists, e.g. prucalopride), prostaglandins and gonadotropin-releasing hormone analogues (leuprolide), have been reported in a number of pediatric and adult CIPO studies (Table 3).96–112

Erythromycin is a macrolide antibiotic mimicking the prokinetic hormone motilin that induces phase III of the MMC. It has shown to be effective (at a dose of 1.5–2 g/day in adults or 3–5 mg/kg/dose in children) in accelerating gastric emptying and improving symptoms of CIPO in case reports.4,96 Metoclopramide and domperidone are two orthopramides which exert their prokinetic effects via type 2 dopamine receptor antagonism and increasing acetylcholine release from myenteric neurons. Although widely used in patients with functional gut disorders,7 there are no clinical data regarding their use in CIPO. In addition, metoclopramide has a boxed warning by the Food and Drug Administration due to the risk of tardive dyskinesia.97 Octreotide, a long-acting analogue of somatostatin, is known to evoke phase III of the MMC in the small intestine of patients with scleroderma-related CIPO.98 Subcutaneous octreotide at a dose of 50 µg/day resulted in a significant beneficial effect by relieving bacterial overgrowth in those patients.98 Further studies confirmed its efficacy showing reduction in nausea, vomiting, bloating, and abdominal pain, in a subset

<table>
<thead>
<tr>
<th>Drug and study</th>
<th>Type of study</th>
<th>Number and type of patients</th>
<th>Dose and period of treatment</th>
<th>Results</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythromycin</td>
<td>Emmanuel et al. APT 2004</td>
<td>Retrospective case series</td>
<td>15 adults</td>
<td>1.5–2 g/day, oral or i.v.</td>
<td>6 responders (4 myopathy)</td>
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<td>Metoclopramide</td>
<td>No reported studies</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<tr>
<td>Domperidone</td>
<td>No reported studies</td>
<td>–</td>
<td>–</td>
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<td>–</td>
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<tr>
<td>Octreotide</td>
<td>Soudah et al. N Eng J Med 1991</td>
<td>Case series</td>
<td>5 adults with scleroderma related CIPO and SIBO</td>
<td>100 µg/day sc</td>
<td>Reduces SIBO and improved symptoms</td>
</tr>
<tr>
<td>Verne et al. Dig Dis Sci 1995</td>
<td>Prospective case series</td>
<td>14 adults</td>
<td>50 µg/day sc, 20–33 weeks in association with erythromycin</td>
<td>5 responders</td>
<td>Not reported</td>
</tr>
<tr>
<td>Neostigmine</td>
<td>Calvet et al. Am J Gastroenterol 2003</td>
<td>Case report</td>
<td>1 adult with chronic colonic pseudo-obstruction with autonomic paraneoplastic neuropathy</td>
<td>2 mg i.v. every 6 hours</td>
<td>Improvement of abdominal distension and discomfort and enteral diet could be resumed</td>
</tr>
<tr>
<td>Pyridostigmine</td>
<td>O’Dea et al. Colorectal Dis 2010</td>
<td>Case series</td>
<td>7 adults</td>
<td>10 mg b.i.d. and increased if required (max 30 mg) orally</td>
<td>7 responders</td>
</tr>
<tr>
<td>Prucalopride</td>
<td>Emmanuel et al. APT 2012</td>
<td>RCT cross-over trial</td>
<td>4 adults</td>
<td>2–4 mg</td>
<td>3 responders</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>No reported studies</td>
<td>–</td>
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<td>Non-narcotic pain modulators</td>
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of idiopathic CIPO. The acetycholinesterase inhibitor neostigmine has proven efficacy in colonic decompression in adult and pediatric acute colonic pseudo-obstruction. Repeated use was successful in an adult patient with colonic pseudo-obstruction, although chronic use in children with CIPO has not been reported. The longer acting pyridostigmine has also been used with success in adult patients with CIPO. Among the newly discovered highly selective 5-HT₄ receptor agonists, prucalopride has shown high bioavailability and lack of major interactions with other drugs as it is not metabolized by the cytochrome P3A4. Prucalopride exerts a significant enterokinetic effects and a recent randomized, controlled trial on CIPO patients (three patients had visceral myopathy; one had visceral neuropathy; all are treated with 2–4 mg once daily and followed up for 48 weeks), showed beneficial symptomatic effects and lower use of analgesic drugs. Although the sample size was very small, the results of this study lend support to future multicenter controlled trials.

Small intestinal bacterial overgrowth is known to cause mucosal inflammation, which further impairs GI motility thereby contributing to nausea, bloating, and abdominal distension. Various antibiotic regimens have been recommended. The treatment of choice usually involves the use of non-absorbable antibiotics, such as rifaximin. Nonetheless, most clinicians use 1- to 2-week rotation of broad-spectrum antibiotics such as amoxicillin and clavulanic acid, gentamicin, and metronidazole, often combined with an antifungal compound (e.g., nystatin or fluconazole) followed by antibiotic-free periods. Notably, amoxicillin-clavulanate has been shown to combine antibiotic and enterokinetic properties in children.

Non-narcotic pain modulators, such as tricyclic antidepressants and serotonin-norepinephrine reuptake inhibitors, should be used with caution in CIPO patients due to their significant side effects (i.e. constipation and/or drowsiness). Starting with low doses followed by gradual increase is advisable to optimize the beneficial/side effect ratio. Gabapentinoids (gabapentin and pregabalin) and peripherally acting μ-opioid receptor antagonists may represent promising alternatives to antidepressants; however, studies in patients with CIPO are lacking. If visceral pain is untreatable, an extremely careful and cautionary use of opiates may be attempted. In children with CIPO and significant abdominal pain, transdermal buprenorphine (5 μg/h), a μ- partial agonist and κ- and δ-opioid receptor antagonist, has shown adequate pain relief in 3 of 4 patients.

In CIPO characterized by histopathological signs of marked inflammation/immune response within myenteric ganglia or throughout the neuromuscular tract, immunosuppressive drugs (e.g., steroids and azathioprine), might be an effective therapeutic option. Treatment of secondary forms of CIPO is mainly directed toward the underlying diseases (e.g., scleroderma, paraneoplastic syndrome, endocrine related disorders, and many others) in addition to gut-directed therapy such as antibiotics, prokinetics, and laxatives.

6.3 | Endoscopic and surgical therapy

Decompression of distended GI segments via intermittent nasogastric suction, rectal tubes, or endoscopy in both adults and children is an important therapeutic target. In some cases a "venting" enterostomy, typically placed endoscopically in the intestine, may be necessary. Recently, repetitive colonoscopic decompression has been successfully used as a bridge therapy before surgery in a pregnant woman with CIPO. In adult patients needing multiple endoscopic decompression, percutaneous endoscopic colostomy has been recently proposed as a feasible therapeutic option as it leads to durable symptom relief without risk of surgical intervention.

The role of surgery in CIPO has been debated over the years. Although its use may be indicated as a tool to collect gut biopsy specimens for histopathology, the need for surgical therapy is sometimes required in emergency situations (massive bowel distension and perforation/ischemia). In a retrospective study on 63 adult patients there was an overall postoperative mortality rate of 7.9%, while CIPO-related re-operation rate was 66% at 5 years. In children palliative procedures such as feeding/venting gastrostomies and jejunostomies are mainly used to relieve symptoms in half of the patients. It is important to keep in mind that when a surgical procedure is performed in a CIPO patient, full-thickness biopsies should be obtained and processed in dedicated centers.

6.4 | Transplantation

Intestinal transplantation (isolated or multivisceral) is thought a reasonable therapeutic alternative for patients with CIPO who experience serious complications of PN (e.g. liver failure or recurrent sepsis arising from a central venous catheter). Other indications to transplantation are the inability to obtain venous access for PN and a poor quality of life while on PN. Patients with CIPO account for approximately 9% of the total intestinal transplants in both adults and children. Patients with CIPO should be evaluated for urological abnormalities and antibiotic prophylaxis for urinary tract infections is often required following transplant in these patients.

The development of new immunosuppressive agents such as tacrolimus and novel induction agents (basiliximab, alemtuzumab, daclizumab, and antilymphocyte globulins) have been associated with an increased overall survival rate and reduced graft rejection rate. Complications include acute rejection, opportunistic infections, e.g. cytomegalovirus and Epstein–Barr virus, and surgical morbidity including wound infections, stoma-related complications, graft ischemia, intestinal perforations, delayed gastric emptying, intestinal obstruction, and biliary tract dilatation.

In the presence of gastric involvement, modified multivisceral transplantation (stomach-duodenum-pancreas plus small bowel) should be performed, even though some reports described the possibility to overcome this issue by transplanting the bowel and modifying surgically the stomach in order to facilitate gastric emptying. In children, PN-related liver failure represents an indication for combined transplant (liver and bowel), but a full multivisceral transplantation (modified multivisceral graft plus liver) is rarely required. While isolated small bowel and liver-bowel transplantation have reasonable long-term results, multivisceral transplant should be performed only in very selected cases and in experienced centers. A study by the University of Miami
including 98 adult patients undergoing multivisceral transplantation showed patient and graft survival rates of 49% and 47%, respectively, at a 5-year follow-up. Italian experiences in adult patients with CIPO showed that isolated intestinal transplantation performed with different surgical approaches (in order to reduce the delayed postsurgical gastric emptying) had patient survival rates of 70% at 5 years. These results are comparable to those of intestinal transplant in patients with underlying diseases distinct from CIPO. The same data have been reported by the United Network for Organ Sharing in children transplanted for CIPO with a 5-year survival rate of 57%, which is comparable to the overall survival rates for intestinal transplant. These data were also recently confirmed by an Italian study with a reported survival rate for recipient of intestinal grafts, in any combination, of 75% at 2-year follow-up. Notably, the catch-up growth seen in children following liver transplantation has not been demonstrated in children with intestinal transplantation. This is probably related to the severity of the illness at the time of presentation and the use of intense immunosuppression, including long-term corticosteroids.

Concerning extra-digestive organ transplant, the allogeneic hematopoietic stem cell transplantation (AH SCT) can be used to restore TYMP enzyme function which is the key biochemical deficit in patients with MNGIE. However, so far the results of AH SCT at a 10-year follow-up show that only about 30% of transplanted MNGIE patients are alive. This finding prompted research to focus on alternative tissue source of TYMP. Based on recent data displaying that the liver has high TYMP expression, we have recently transplanted a MNGIE patient with promising results.

7 | CONCLUSIONS

Chronic intestinal pseudo-obstruction is a rare and severe condition resulting in a marked impairment of GI motility with the appearance of a mechanical obstruction, without any detectable mechanical cause. Although still a challenge for most clinicians and surgeons, the future of CIPO may be more promising than one would expect thanks to a number of important achievements. Firstly, less invasive diagnostic tests, such as cine-MRI and even endoscopic approaches for full thickness biopsy sampling are novel tools that are expected to facilitate identification and investigation of CIPO patients. Secondly, the classification of enteric neuro-ICC-myopathies and guidelines for tissue processing and analysis represents a hallmark for tissues analysis aimed to identify novel targeted therapeutic options. Thirdly, many prokinetic agents are in the pharma pipeline ready to be tested in clinical trials. Fourthly, intestinal transplantation is improving as confirmed by recently published studies. In conclusion, the advancements so far obtained and those expected in the next years are likely to shed light on CIPO patients, their management, and related therapeutic options.

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