

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Gastric Emptying Abnormalities in Diabetes Mellitus

Raj K. Goyal, M.D.

From the Division of Gastroenterology, Department of Medicine, Veterans Affairs Boston Healthcare System, West Roxbury, and the Division of Gastroenterology, Hepatology, and Endoscopy, Department of Medicine, Beth Israel Deaconess Medical Center and Harvard Medical School, Boston — both in Massachusetts. Address reprint requests to Dr. Goyal at the Division of Gastroenterology, Department of Medicine, Veterans Affairs Boston Healthcare System, 2B101 OREA Bldg., 1400 VFW Pkwy., West Roxbury, MA 02132, or at raj_goyal@hms.harvard.edu.

N Engl J Med 2021;384:1742-51.

DOI: 10.1056/NEJMra2020927

Copyright © 2021 Massachusetts Medical Society.

DIABETES MELLITUS IS ASSOCIATED WITH A SPECTRUM OF GASTRIC EMPTYING abnormalities, including transient slow gastric emptying, transient fast gastric emptying, persistent slow or delayed gastric emptying (gastroparesis), and persistent fast gastric emptying. Transient changes in gastric emptying are counterregulatory responses and do not require treatment. Delayed gastric emptying has been associated with abdominal symptoms and is considered to be a cause of severe illness. However, rapid gastric emptying is associated with similar symptoms. Whereas delayed gastric emptying may cause difficulty in glucose control in patients receiving insulin therapy, rapid gastric emptying plays an important role in the genesis and progression of type 2 diabetes mellitus. Treatment of rapid gastric emptying is emerging as an important target for the management of postprandial hyperglycemia.

The gastric emptying rate represents a highly regulated output of nutrients into the intestine. The stomach discharges 1 to 4 kcal of homogenized food per minute, regardless of the carbohydrate, protein, and fat composition, into the duodenum.¹ This remarkable feat is achieved through integrated motor activities of different parts of the stomach, regulated by intricate neurohumoral mechanisms² (for details, see the Supplementary Appendix, available with the full text of this article at NEJM.org).

Diabetes leads to patterns of abnormal gastric emptying by altering the motor activities of various segments of the stomach. These changes are mediated by dysfunction of vagovagal neural circuits, through interstitial cells of Cajal and smooth muscle (see the Supplementary Appendix). Sudden changes in blood sugar levels affect glucose-stimulated or glucose-inhibited neurons in the gastric inhibitory and gastric excitatory vagal circuits and lead to altered gastric emptying. Persistent hyperglycemia affects the molecular elements of neurons, smooth-muscle cells, and interstitial cells of Cajal through oxidative stress and products of the polarized M1 (proinflammatory) and M2 (prohealing, or repair) macrophages. These metabolites may have complex effects on cellular functions. They may induce transcriptional changes in proteins and in microRNA (miRNA), with consequent alteration of the cellular phenotype to hypercontractile or hypocontractile smooth-muscle cells.

Upper abdominal symptoms resembling functional dyspepsia were thought to be due to underlying delayed gastric emptying. However, similar symptoms are associated with rapid gastric emptying, suggesting that gastroparesis may not be the cause of the symptoms. The symptoms may instead be due to parallel activation of sensory receptors induced by inflammatory changes in the gastric wall. Therefore, maneuvers to accelerate gastric emptying may not provide symptomatic relief and may worsen hyperglycemia.

This review summarizes the pathophysiology of gastric emptying abnormalities

in diabetes mellitus and the rationale for their management. The current practice of treating symptomatic gastroparesis is extensively covered in recent reviews.³⁻⁵

METABOLIC CHANGES THAT AFFECT GASTRIC EMPTYING

Glucose enters cells mainly through the glucose transporter (GLUT) and the sodium–glucose cotransporter (SGLT).⁶ Glucokinase converts intracellular glucose to glucose-6-phosphate, which undergoes glycolysis, a process that leads to the production of ATP and reactive oxygen species in mitochondria.^{7,8} Mild oxidative stress causes transcriptional up-regulation of the enzyme NADPH oxidase 4 (NOX4), leading to moderate oxidative stress.⁹ In addition, moderate oxidative stress, along with products of lipid oxidation, advanced glycation end-products, and reactive carbonyls, alters the proteins of the extracellular matrix and increases macrophage adhesion and activation. Depending on specific local signals, macrophages¹⁰ undergo polarization to M1^{11,12} or M2 macrophages, producing a number of cytokines. Oxidative stress and cytokines may act through transcriptional factors to modify signaling proteins directly or through regulation of miRNAs.^{13,14} These noncoding RNAs are critical post-transcriptional regulators of gene expression. They can bind to their target messenger RNAs to suppress the translation into cellular proteins and lead to marked changes in the cellular phenotype.^{9,15,16} Consequently, miRNAs are emerging as important therapeutic targets.¹⁷

Different metabolic changes each produce specific cellular alterations that result in distinct gastric emptying abnormalities. Immediate changes in the plasma glucose level activate vagal motor circuits, resulting in transient gastric emptying abnormalities. Chronic hyperglycemia in association with oxidative stress and macrophage polarization has distinctive effects on neuromuscular transmission, interstitial cells of Cajal, and smooth muscle, depending on the type of macrophage polarization and the degree of oxidative and inflammatory stress. Moderate oxidative stress disrupts neuromuscular transmission, causes a gain in the number of interstitial cells of Cajal, and converts smooth muscle to the hypercontractile phenotype. In addition, moderate oxidative stress promotes macrophage polar-

ization to the M2 or M1 type. Polarization to M2 macrophages suppresses M1 macrophages and their inflammatory responses and results in severe loss of neurotransmission, loss of interstitial cells of Cajal, and conversion of smooth muscle to the hypocontractile phenotype (see the Supplementary Appendix).

TRANSIENT SLOW GASTRIC EMPTYING

Postprandial hyperglycemia is characteristic of glucose intolerance in diabetes mellitus. Acute hyperglycemia slows gastric emptying of digestible food during the digestive period and indigestible food residues in the fasting period. Deceleration of gastric emptying suppresses postprandial hyperglycemia and serves as a negative feedback loop. Slowing of gastric emptying is due to a reduction in the tone of the proximal stomach and suppression of antral contractions.¹⁸ Hyperglycemia also suppresses powerful contractions of the interdigestive migrating motor complex,¹⁹ resulting in slow gastric emptying during both digestive and interdigestive (fasting) periods.

As shown in Figure 1, hyperglycemia stimulates glucose-sensitive neurons in the vagal afferents by suppressing ATP-sensitive potassium (K_{ATP}) channels.²⁰ Stimulation of the gastric inhibitory vagal motor circuit may affect electrical slow waves, as well as smooth muscle. Acute hyperglycemia may disrupt the slow waves by affecting myenteric interstitial cells of Cajal, leading to isolated tachygastria (an increase in the cyclic electrical activity in the stomach, with a frequency of >3.6 cycles per minute [cpm]),²¹ although high glucose levels do not directly affect interstitial cells of Cajal.²² Tachygastria and other slow-wave abnormalities have been thought to cause reduced antral contractions; however, slow waves do not correlate with mechanical contractions.¹⁸ High glucose levels stimulate the gastric inhibitory vagal motor circuit; such stimulation inhibits contractions and overcomes the hyperglycemia-mediated contraction of the isolated smooth muscle.²³ Transient slow gastric emptying due to acute hyperglycemia is a counterregulatory phenomenon and does not require treatment. The transient nature of the effects of hyperglycemia is attributed to the down-regulation of glucokinase.²⁴

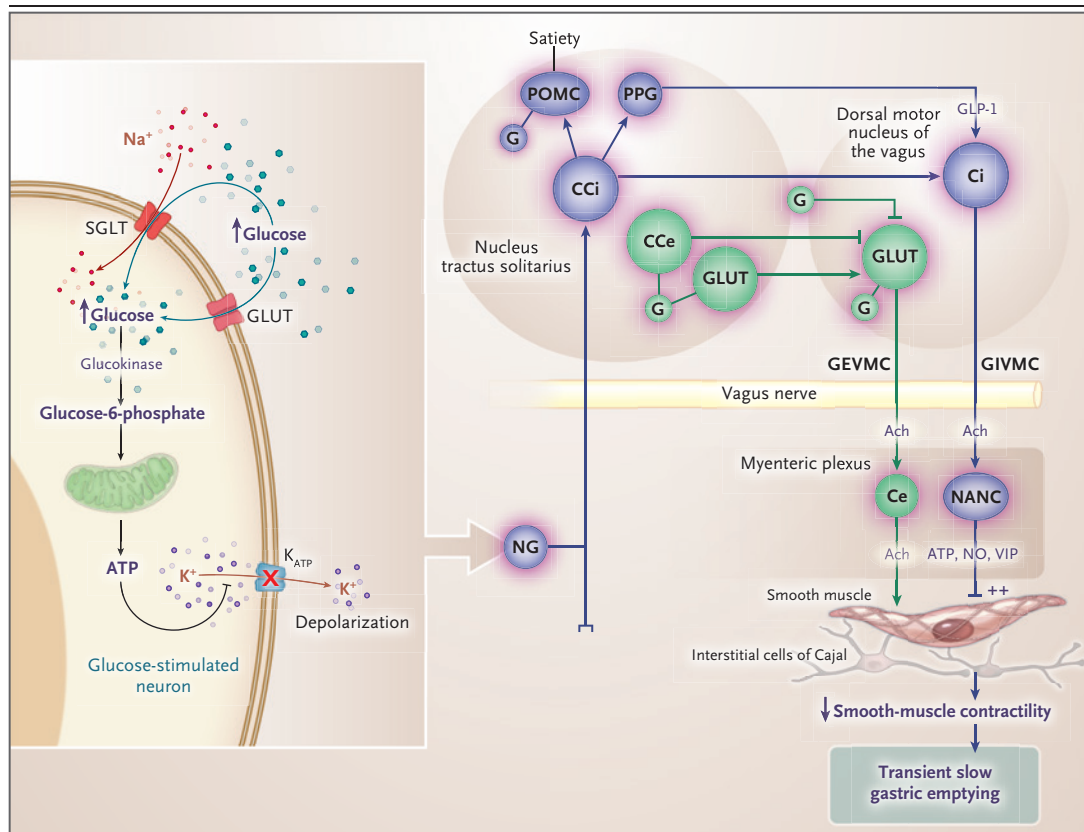


Figure 1. Acute Hyperglycemia Causing Slow Gastric Emptying.

Acute hyperglycemia triggers glucose-stimulated neurons of vagal afferents in the nodose ganglion (NG) and the nucleus tractus solitarius, which are part of the gastric inhibitory vagal motor circuit (GIVMC). They bear the glucose transporter (GLUT, type undefined) and sodium–glucose transporter (SGLT). Hyperglycemia results in a rapid increase in intracellular glucose levels. Glucokinase converts glucose to glucose-6-phosphate, which undergoes glycolysis to produce pyruvic acid, leading to the production of ATP in mitochondria. ATP inhibits ATP-sensitive potassium (K_{ATP}) channels, causes depolarization, and triggers afferent neurons to stimulate the GIVMC. However, the stimulatory effect of hyperglycemia is terminated because hyperglycemia also causes down-regulation of glucokinase. Activation of the GIVMC releases inhibitory transmitters (nitric oxide [NO], ATP, and vasoactive intestinal peptide [VIP]), which decrease smooth-muscle contractility and cause dysfunction of interstitial cells of Cajal, with resulting slow-wave abnormalities. ACh denotes acetylcholine, CCE catecholaminergic neuron of the excitatory pathway, CCI catecholaminergic neuron of the inhibitory pathway, Ce cholinergic neuron of the excitatory pathway, Ci cholinergic neuron of the inhibitory pathway, dorsal motor nucleus of the vagus, G γ -aminobutyric acid–producing (GABAergic) neuron, GEVMC gastric excitatory vagal motor circuit, NANC nonadrenergic noncholinergic neuron, POMC proopiomelanocortin neuron, and PPG preproglucagon neuron.

TRANSIENT RAPID GASTRIC EMPTYING

Acute hypoglycemia causes fast gastric emptying. Iatrogenic hypoglycemia is a common and serious complication of insulin treatment. Acute hypoglycemia causes activation of the gastric excitatory vagal motor circuit (GEVMC), which provides cholinergic excitatory innervation to the gastric smooth muscle, enhancing contractile ac-

tivity and thus leading to rapid gastric emptying. The GEVMC is also connected to glucagon-secreting alpha cells, to orexigenic (appetite-stimulating) neurons, to the sympathoadrenal pathway, and to hypothalamic neurons involved in the counter-regulatory responses to hypoglycemia. A blood glucose level below the normal range induces parasympathetic activity and glucagon secretion. Further reduction of glucose levels triggers sympathetic activity.²⁵

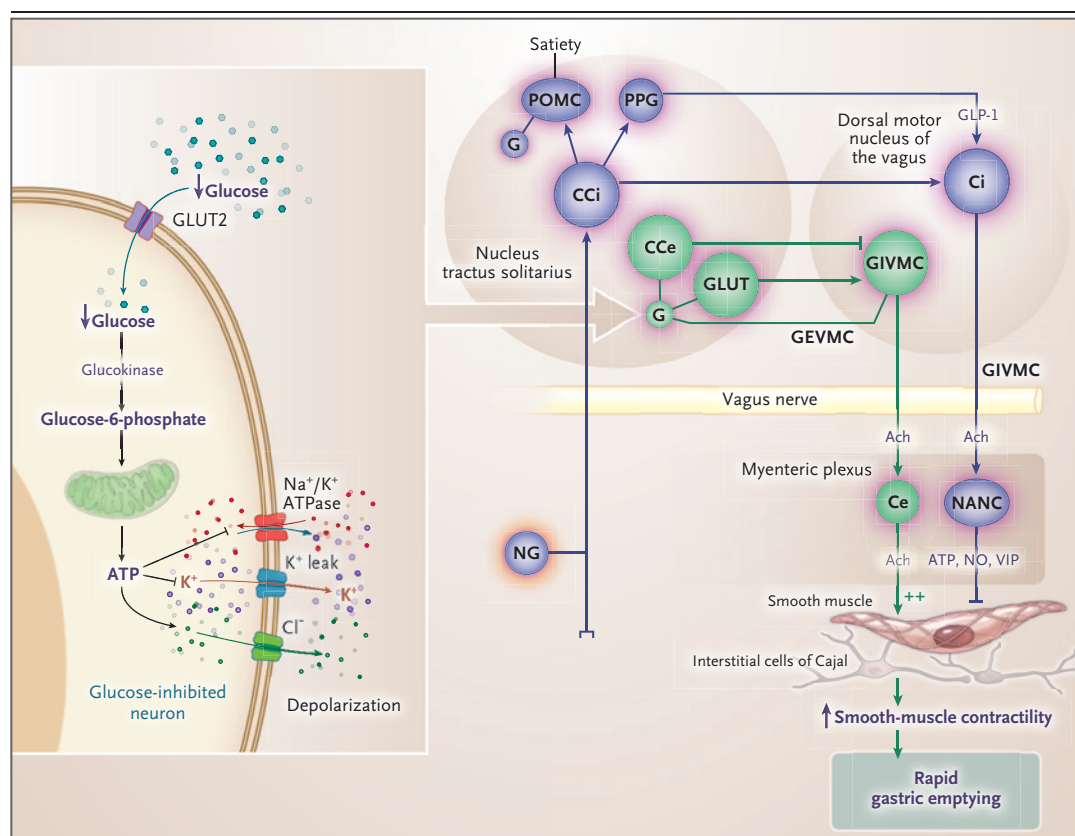


Figure 2. Acute Hypoglycemia Causing Rapid Gastric Emptying.

GABAergic interneurons (G) in the GEVMC are very sensitive to glucose deprivation. Hypoglycemia causes loss of mitochondrial glycolysis and a decrease in ATP production. This leads to inhibition of Na^+/K^+ ATPase, blockade of the K^+ leak channel, and, probably, opening of chloride channels, with resulting depolarization. Stimulation of GABAergic neurons leads to stimulation of the GEVMC, with release of acetylcholine at the neuromuscular junction, excitation of smooth muscle, and rapid gastric emptying. A recurring episode of hypoglycemia may lead to up-regulation of glucokinase and up-regulation of alternative sources of energy, bypassing the signals of hypoglycemia.

The activation of GEVMC is due to stimulation of GLUT2-expressing, γ -aminobutyric acid-producing (GABAergic) neurons in the nucleus tractus solitarius. Hypoglycemia leads to a decrease in intracellular glucose and lowers intracellular ATP levels, causing reduced Na^+/K^+ ATPase activity and membrane depolarization²⁶ (Fig. 2). Responses to acute hypoglycemia are transient because of the rapid up-regulation of glucokinase and the use of energy sources other than glucose. Transient rapid gastric emptying is part of the counterregulatory response and should not be treated. In recurrent hypoglycemia, these changes may serve as protective mechanisms against hypoglycemia-associated autonomic failure and impaired awareness of hypoglycemia, which are potentially life-threatening conditions.^{26,27}

PERSISTENT RAPID GASTRIC EMPTYING

Formerly, persistent rapid gastric emptying was not seriously considered as a complication of diabetes mellitus. Almost 20% of patients with poorly controlled, long-standing, type 1 or type 2 diabetes mellitus, regardless of the presence or absence of upper abdominal symptoms, have rapid gastric emptying even in late stages of the disease.²⁸⁻³⁰ Dumping syndrome, with symptoms of postprandial nausea, bloating, light-headedness, flushing, palpitation, abdominal pain, cramps, borborygmi, and diarrhea, occurs after gastric-bypass surgery.³¹ However, such symptoms do not occur in patients with an intact stomach. Upper abdominal symptoms are indistinguishable from

Table 1. Prevalence of Normal, Rapid, and Delayed Gastric Emptying among Patients with Diabetes.*

Gastric Emptying	Prevalence among Patients with or with- out Upper Abdominal Symptoms	Prevalence among Patients with Upper Abdominal Symptoms	Effect on Postprandial Hyperglycemia
	percent		
Normal	33–46	43–52	No effect
Rapid	20–22	20–37	Accentuates early postprandial hyperglycemic peak
Delayed (diabetic gastro- paresis)	40–47	19–28	Delays early postprandial hyper- glycemic peak

* Patients with diabetes and upper abdominal symptoms have normal, rapid, or delayed gastric emptying; there is no specific relationship between the presence of symptoms and delayed gastric emptying. Patients who have diabetes with or without upper abdominal symptoms have similar distributions of gastric emptying abnormalities. Rapid gastric emptying may worsen postprandial hyperglycemia, whereas delayed gastric emptying postpones the hyperglycemic peak. Data for patients with or without upper abdominal symptoms are from Bharucha et al.^{28,29} Data for patients with upper abdominal symptoms are from Park et al.³² and Chedid et al.³³

those of functional dyspepsia or gastroparesis. Approximately 20 to 37% of patients with diabetes and upper abdominal symptoms have rapid gastric emptying.^{32,33} This rate is similar to that among patients with long-standing diabetes, whether or not they have upper abdominal symptoms²⁸⁻³⁰ (Table 1), which suggests that upper abdominal symptoms are not specifically related to rapid gastric emptying. The disorder may respond to intensive insulin therapy in patients with type 1 diabetes.^{29,34}

Rapid gastric emptying has a profound effect on glucose intolerance,³⁵ and it has been implicated in the genesis and propagation of type 2 diabetes mellitus.³⁶ Correction of rapid gastric emptying by means of dietary manipulations and pharmacologic therapy is central to the management of postprandial hyperglycemia.³⁷ Amylin or leptin deficiency is associated with chronic hyperglycemia and rapid gastric emptying.^{38,39} Agents such as metformin, amylin analogues, and short-acting glucagon-like peptide 1 agonists decelerate gastric emptying.^{34,40-42}

Rapid gastric emptying is associated with reduced relaxation and increased contractility of the fundus as a result of impaired inhibitory transmission and enhanced smooth-muscle contractility. Antral peristaltic contractions are augmented because of increased smooth-muscle contractility and possibly because of an increase in the number of myenteric interstitial cells of Cajal.⁴³

As shown in Figure 3, moderate oxidative

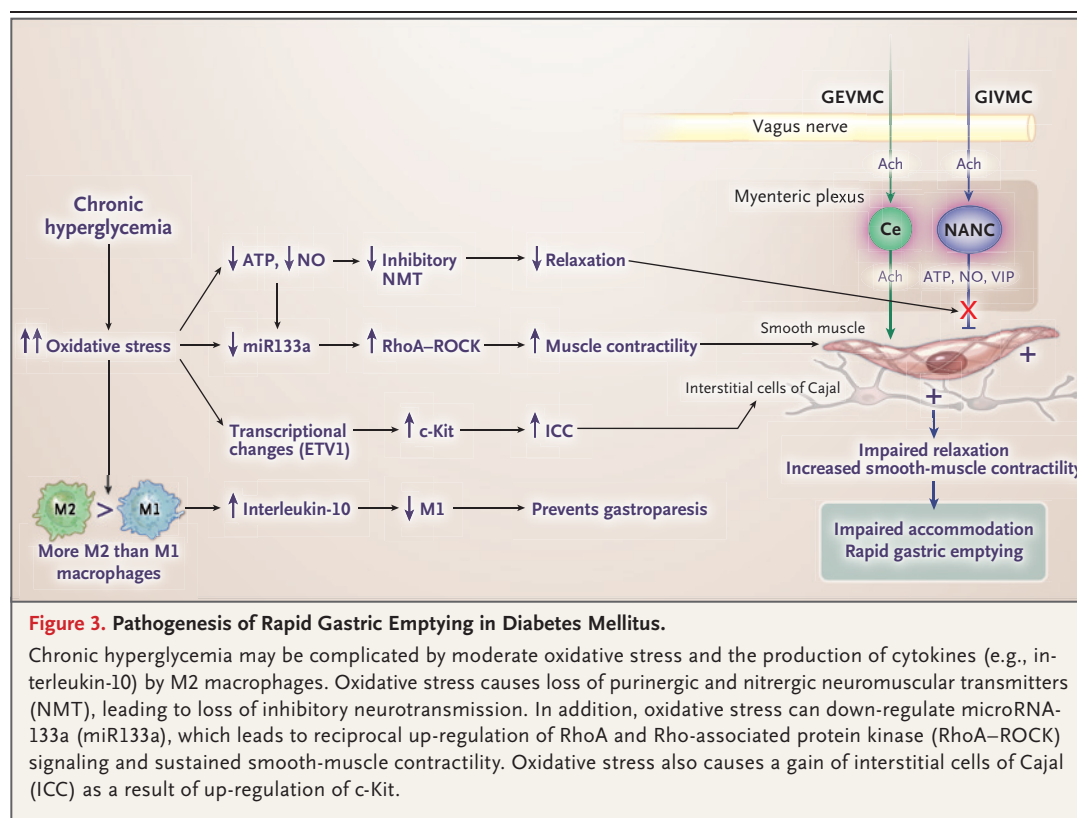
stress leads to loss of inhibitory neuromuscular transmission, a transcriptional increase in c-Kit, and an increased number of interstitial cells of Cajal.³⁹ Oxidative stress also causes transcriptional down-regulation of miRNA-133a, leading to up-regulation of the small guanosine triphosphatase protein RhoA and Rho-associated protein kinase (RhoA–ROCK) signaling.^{44,45} These changes result in impaired gastric accommodation and increased contractility, promoting rapid gastric emptying.⁴⁶ Products of M2 macrophages such as interleukin-10 and the enzyme heme oxygenase suppress M1 macrophages and prevent gastroparesis. Increased smooth-muscle contractility in other parts of the gut may involve other signaling pathways⁴⁷ (see the Supplementary Appendix for details).

GASTROPARESIS

Diabetic gastroparesis is the most talked-about gastric complication of diabetes mellitus. Simply stated, diabetic gastroparesis is a gastric motility complication of diabetes characterized by persistent delayed gastric emptying. Mechanical outlet obstruction and other coexisting conditions that affect gastric emptying must be ruled out to establish the diagnosis.

MOTOR ABNORMALITY

The prevalence of delayed gastric emptying in untreated cases is 40 to 47% among patients with type 1 diabetes mellitus and 32 to 47% among



those with type 2 diabetes.²⁸⁻³⁰ Diabetic gastroparesis does not change over time,^{29,48} and it occurs with both liquids and digestible solids, as well as with indigestible food residues. However, impaired gastric emptying of indigestible solids may be an earlier abnormality.⁴⁹

Delayed gastric emptying may have a beneficial effect in type 2 diabetes, since it postpones the postprandial hyperglycemic peak. In patients receiving insulin therapy for diabetes, however, such a delay may result in episodes of early postprandial hypoglycemia unless careful adjustments are made in the dose of insulin and the timing of administration. Treatment to hasten gastric emptying may even worsen glycemic control.⁵⁰

Diabetic gastroparesis is associated with motor abnormalities in various components of the stomach, including defects in smooth muscles, interstitial cells of Cajal, and neurotransmission. The gastric fundus is characterized by loss of relaxation due to suppression of inhibitory neurotransmission, as well as reduced tonic contraction because of impaired muscle contractility. There are no phasic contractions or slow waves in the fundus. Reduced relaxation results in re-

duced accommodation, and poor tonic contraction impairs gastric emptying.

A decrease in the propulsive contractions in the gastric antrum leads to poor grinding and mixing of food and ejection into the duodenum. These changes involve loss of cholinergic excitatory neuromuscular transmission and weakness of the smooth muscle. In addition, abnormalities of slow waves may contribute to contractile weakness. The gastric antrum may have periods of rapid slow-wave activity. Normally, the rate of slow-wave activity varies between 2.4 cpm and 3.6 cpm. Tachygastria indicates a slow-wave rate greater than 3.6 cpm, and bradygastria indicates a rate less than 2.4 cpm. Abnormalities in the rate of slow waves may contribute to contractile weakness. However, the slow-wave abnormalities correlate with symptoms of nausea rather than weakness of the contraction and may serve as the electrical marker of nausea.⁵¹ Diabetic gastroparesis is characterized by abnormal initiation and conduction of slow waves on high-resolution electrical mapping. These abnormalities may contribute to disordered propagation of contractions and slow gastric emptying.⁵²

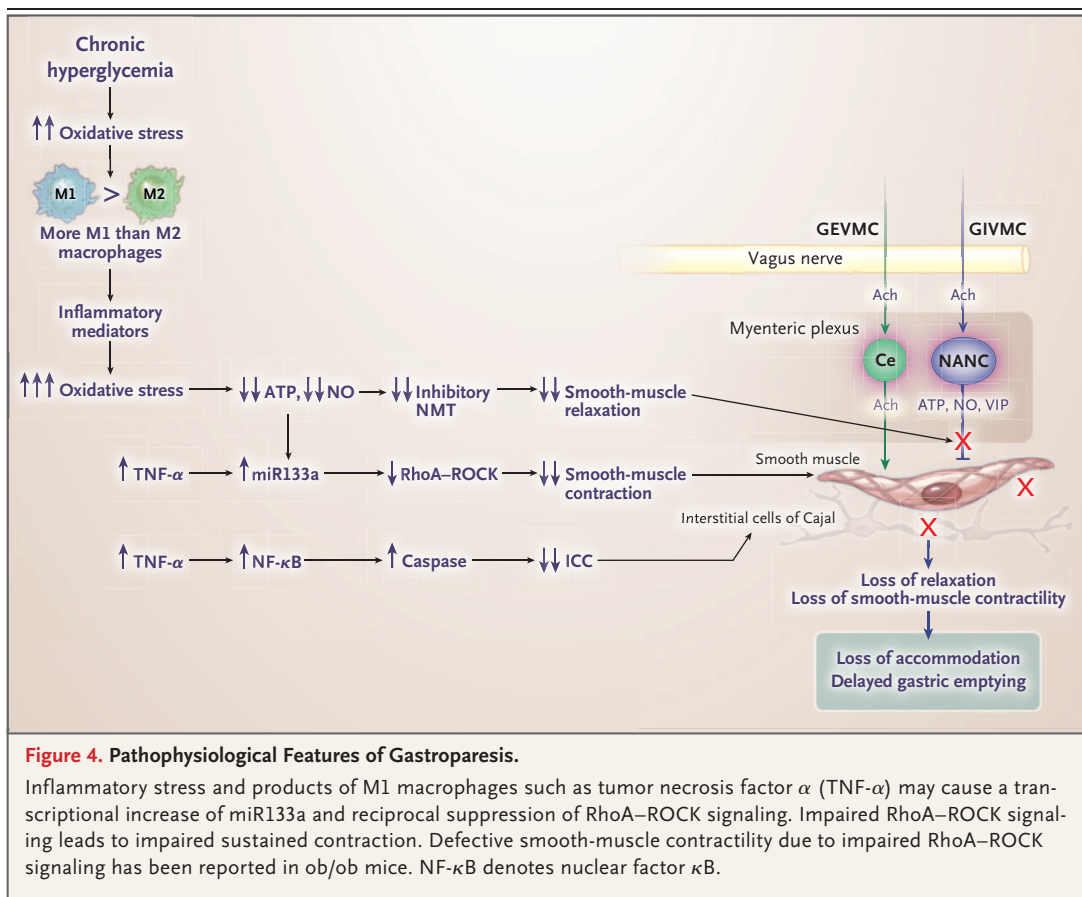
Although smooth muscle appears morphologically normal in most cases of diabetic gastroparesis, in very advanced cases, smooth-muscle degeneration, fibrosis, collagen deposits, and eosinophilic inclusion bodies are observed.⁵³ However, functional studies show that the contractility of smooth muscle is impaired in diabetic gastroparesis. Augmentation of antral contractions is one of the main mechanisms of action of the gastric prokinetic agents used to enhance gastric emptying.^{3,4,54}

In diabetic gastroparesis, pyloric and duodenal relaxation may be impaired, resulting in outflow obstruction. Loss of pyloric relaxation and antroduodenal coordination is caused by the loss of inhibitory neuromuscular transmission.^{55,56} In mice that lack neuronal nitric oxide synthase isoform α (nNOS α $-/-$), the failure of inhibitory neuromuscular transmission has been associated with functional outlet obstruction. However, in diabetic gastroparesis, impaired smooth-muscle contractility may weaken the outlet obstruction.

In some cases, clinically significant pyloric obstruction may be documented with the use of techniques such as Endoflip impedance planimetry. Sham-controlled trials are needed to establish the usefulness of pyloric interventions to promote gastric emptying in specifically defined cases of gastroparesis.³ It is known that placement of a wide cannula in the pylorus does not accelerate gastric emptying in the absence of efficient antral contractions.

As shown in Figure 4, diabetic gastroparesis is associated with M1 macrophage polarization and release of inflammatory products. These products cause severe oxidative stress, leading to loss of inhibitory neurotransmission through the uncoupling of nNOS α and scavenging of the released neurotransmitter, nitric oxide. Severe oxidative stress also causes loss of purinergic inhibitory transmission.⁴⁶

The loss of interstitial cells of Cajal is due to tumor necrosis factor (TNF) or TNF- α and transcriptional up-regulation of caspase.⁵⁷ Interstitial



cells of Cajal are very fragile and can be reduced through other pathways, including reduced insulin and insulin-like growth factor signaling,²² myopathy of smooth muscle and subsequent loss of the stem-cell factor,⁵⁸ and loss of nitric oxide.⁵⁹

Reduced muscle contractility may be due to M1 macrophage polarization, with release of TNF, interleukin-6, and other inflammatory cytokines.⁶⁰ TNF is known to cause up-regulation of miRNA-133a through the transcription factor nuclear factor κ B, with an associated decrease in RhoA–ROCK signaling in gastrointestinal smooth muscles.⁴⁴ Severe oxidative stress may lead to reduced muscle contractility.⁴⁵ Reduced RhoA–ROCK signaling associated with hypocontractile smooth muscle has been reported in diabetic gastroparesis.⁶¹ These observations from studies carried out in experimental models resemble transcriptomic signatures of immune dysregulation in human gastroparesis.^{54,62}

UPPER ABDOMINAL SYMPTOMS

Diabetic gastroparesis was originally described in 1958 by Kassander⁶³ in a group of patients with diabetes who had irreversible delayed gastric emptying and gastric stasis without mechanical obstruction (gastroparesis diabeticorum), which was thought to be due to an abnormality of gastric motility. Later, patients with diabetic gastroparesis were found to have upper gastrointestinal symptoms. *Merriam-Webster's Medical Dictionary* defines gastroparesis as “partial paralysis of the stomach” and, citing G.F. Cahill et al., notes that “diabetic gastroparesis is characterized by a triad of postprandial symptoms: nausea, vomiting, and abdominal distension.” Diabetic gastroparesis with upper abdominal symptoms has been called “clinical or symptomatic gastroparesis.” Other symptoms, including severe upper abdominal pain, have been added to the definition of gastroparesis, resulting in ever-changing definitions.^{3-5,64}

To identify symptoms of diabetic gastroparesis that are distinct from those of functional dyspepsia, the Gastroparesis Cardinal Symptom Index (GCSI) and the Patient Assessment of Gastrointestinal Disorders Symptom Severity Index (PAGI-SYM) were developed. Cardinal symptoms of gastroparesis included postprandial fullness, early satiety, nausea, vomiting, and bloating, which did not distinguish between functional dyspepsia and clinical gastroparesis.⁶⁵ Therefore, clinical gastroparesis is considered to be part of functional

dyspepsia. Upper abdominal symptoms suggestive of functional dyspepsia occur in up to 10% of the general population.⁶⁶ Delayed gastric emptying is reported in 19 to 28% of patients with diabetes who have upper abdominal symptoms^{32,33} (Table 1). Cherian et al., in their study of symptoms of diabetic gastroparesis, included patients with coexisting medical conditions who were receiving treatment with opiates or psychotherapeutic agents that may produce symptoms unrelated to diabetic gastroparesis.⁶⁷ A revised GCSI with a daily diary score for symptoms was developed to quantitate the severity of the symptoms. No significant correlation was found between the symptom score and gastric emptying.⁶⁷

The available studies do not support a causal relationship between motor abnormalities and symptoms in diabetic gastroparesis. The most telling argument against gastric motor abnormalities in diabetic gastroparesis is the fact that patients with diabetes and upper abdominal symptoms have normal, delayed, or rapid gastric emptying^{32,33} (Table 1). The frequency of reduced gastric accommodation is not higher among patients with gastroparesis than among those with normal or accelerated gastric emptying.³³ Moreover, the normalization of gastric emptying does not ameliorate symptoms with any consistency,⁶⁸⁻⁷¹ nor does the amelioration of symptoms result in improved gastric emptying.⁷²

In recognizing that there is no causal relationship between motor abnormalities and symptoms, some clinicians wondered whether gastroparesis is a separate entity or simply part of dyspepsia.⁷³ Moreover, the use of invasive maneuvers to target gastric emptying for the relief of symptoms has been discouraged.⁷⁴ The observation that acceleration of gastric emptying may worsen hyperglycemia⁵⁰ further arouses concern about the indiscriminate use of such interventions. It appears that functional dyspepsia-like symptoms in gastroparesis may arise not through motility changes but rather through the parallel effects of oxidative stress and inflammation on nociceptors and on other afferents that produce the symptoms.⁷⁵ Recent concepts of the mechanism of functional dyspepsia suggest the involvement of low-grade inflammation and noxious mediators in symptoms related to functional dyspepsia.⁷⁶ The effective treatment of symptoms in diabetic gastroparesis may be similar to the treatment of functional dyspepsia.

CONCLUSIONS

The recent development of easy-to-use, reproducible tests (gastric scintigraphy or a stable-isotope ^{13}C breath test) has helped to identify different gastric emptying abnormalities, particularly rapid gastric emptying. Recent studies have shown that symptoms attributed to gastroparesis are not specific but can also be seen in rapid or normal gastric emptying. Rapid gastric emptying is now emerg-

ing as an important mechanism in postprandial hyperglycemia. Studies in animals have shown that vagus nerves may control gastric emptying through vagovagal circuits and that metabolic products associated with hyperglycemia may have distinct effects on gastric motility. An understanding of the mechanisms of these complications may help to identify new targets for rational treatment.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

REFERENCES

- Watson LE, Xie C, Wang X, et al. Gastric emptying in patients with well-controlled type 2 diabetes compared with young and older control subjects without diabetes. *J Clin Endocrinol Metab* 2019;104:3311-19.
- Goyal RK, Guo Y, Mashimo H. Advances in the physiology of gastric emptying. *Neurogastroenterol Motil* 2019;31:e13546.
- Camilleri M, Chedid V, Ford AC, et al. Gastroparesis. *Nat Rev Dis Primers* 2018;4:41.
- Krishnasamy S, Abell TL. Diabetic gastroparesis: principles and current trends in management. *Diabetes Ther* 2018;9: Suppl 1:1-42.
- Grover M, Farrugia G, Stanghellini V. Gastroparesis: a turning point in understanding and treatment. *Gut* 2019;68: 2238-50.
- Chen LQ, Cheung LS, Feng L, Tanner W, Frommer WB. Transport of sugars. *Annu Rev Biochem* 2015;84:865-94.
- Polì G, Leonarduzzi G, Biasi F, Chiarotto E. Oxidative stress and cell signaling. *Curr Med Chem* 2004;11:1163-82.
- Brownlee M. The pathobiology of diabetic complications: a unifying mechanism. *Diabetes* 2005;54:1615-25.
- Mahavadi S, Sriwari W, Manion O, Grider JR, Murthy KS. Diabetes-induced oxidative stress mediates upregulation of RhoA/Rho kinase pathway and hypercontractility of gastric smooth muscle. *PLoS One* 2017;12:e0178574.
- Shapouri-Moghaddam A, Mohammadian S, Vazini H, et al. Macrophage plasticity, polarization, and function in health and disease. *J Cell Physiol* 2018;233:6425-40.
- Varol C, Mildner A, Jung S. Macrophages: development and tissue specialization. *Annu Rev Immunol* 2015;33:643-75.
- Kirkham P. Oxidative stress and macrophage function: a failure to resolve the inflammatory response. *Biochem Soc Trans* 2007;35:284-7.
- Solway J, Forsythe SM, Halayko AJ, Vieira JE, Hershenon MB, Camoretti-Mercado B. Transcriptional regulation of smooth muscle contractile apparatus expression. *Am J Respir Crit Care Med* 1998; 158:S100-S108.
- Joshi SR, Comer BS, McLendon JM, Gerthoffer WT. MicroRNA regulation of smooth muscle phenotype. *Mol Cell Pharmacol* 2012;4:1-16.
- Neshatian L, Gibbons SJ, Farrugia G. Macrophages in diabetic gastroparesis — the missing link? *Neurogastroenterol Motil* 2015;27:7-18.
- Cai Y, Yu X, Hu S, Yu J. A brief review on the mechanisms of miRNA regulation. *Genomics Proteomics Bioinformatics* 2009; 7:147-54.
- Chiba Y, Misawa M. MicroRNAs and their therapeutic potential for human diseases: MiR-133a and bronchial smooth muscle hyperresponsiveness in asthma. *J Pharmacol Sci* 2010;114:264-8.
- Hasler WL, Soudah HC, Dulai G, Owyang C. Mediation of hyperglycemia-evoked gastric slow-wave dysrhythmias by endogenous prostaglandins. *Gastroenterology* 1995;108:727-36.
- Barnett JL, Owyang C. Serum glucose concentration as a modulator of interdigestive gastric motility. *Gastroenterology* 1988;94:739-44.
- Zhou SY, Lu Y, Song I, Owyang C. Inhibition of gastric motility by hyperglycemia is mediated by nodose ganglia KATP channels. *Am J Physiol Gastrointest Liver Physiol* 2011;300:G394-G400.
- Coleski R, Hasler WL. Coupling and propagation of normal and dysrhythmic gastric slow waves during acute hyperglycemia in healthy humans. *Neurogastroenterol Motil* 2009;21(5):492-9.
- Horváth VJ, Vital H, Ordög T. Reduced insulin and IGF-I signaling, not hyperglycemia, underlies the diabetes-associated depletion of interstitial cells of Cajal in the murine stomach. *Diabetes* 2005;54:1528-33.
- Hien TT, Turczyńska KM, Dahan D, et al. Elevated glucose levels promote contractile and cytoskeletal gene expression in vascular smooth muscle via Rho/protein kinase C and actin polymerization. *J Biol Chem* 2016;291:3552-68.
- Halmos KC, Gyarmati P, Xu H, et al. Molecular and functional changes in glucokinase expression in the brainstem dorsal vagal complex in a murine model of type 1 diabetes. *Neuroscience* 2015;306: 115-22.
- Taborsky GJ Jr, Mundinger TO. Mini-review: the role of the autonomic nervous system in mediating the glucagon response to hypoglycemia. *Endocrinology* 2012;153: 1055-62.
- Lamy CM, Sanno H, Labouëbe G, et al. Hypoglycemia-activated GLUT2 neurons of the nucleus tractus solitarius stimulate vagal activity and glucagon secretion. *Cell Metab* 2014;19:527-38.
- Litvin M, Clark AL, Fisher SJ. Recurrent hypoglycemia: boosting the brain's metabolic flexibility. *J Clin Invest* 2013; 123:1922-4.
- Bharucha AE, Camilleri M, Forstrom LA, Zinsmeister AR. Relationship between clinical features and gastric emptying disturbances in diabetes mellitus. *Clin Endocrinol (Oxf)* 2009;70:415-20.
- Bharucha AE, Batey-Schaefer B, Cleary PA, et al. Delayed gastric emptying is associated with early and long-term hyperglycemia in type 1 diabetes mellitus. *Gastroenterology* 2015;149:330-9.
- Bharucha AE, Kudva Y, Basu A, et al. Relationship between glycemic control and gastric emptying in poorly controlled type 2 diabetes. *Clin Gastroenterol Hepatol* 2015;13(3):466-476.e1.
- Berg P, McCallum R. Dumping syndrome: a review of the current concepts of pathophysiology, diagnosis, and treatment. *Dig Dis Sci* 2016;61:11-8.
- Park SY, Acosta A, Camilleri M, et al. Gastric motor dysfunction in patients with functional gastroduodenal symptoms. *Am J Gastroenterol* 2017;112:1689-99.
- Chedid V, Brandler J, Vijayvargiya P, Park SY, Szarka LA, Camilleri M. Characterization of upper gastrointestinal symptoms, gastric motor functions, and associations in patients with diabetes at a referral center. *Am J Gastroenterol* 2019; 114:143-54.
- Goyal RK, Cristofaro V, Sullivan MP. Rapid gastric emptying in diabetes mellitus: pathophysiology and clinical importance. *J Diabetes Complications* 2019;33: 107414.
- Holst JJ, Gribble F, Horowitz M, Ray-

- ner CK. Roles of the gut in glucose homeostasis. *Diabetes Care* 2016;39:884-92.
36. Marathe CS, Horowitz M, Trahair LG, et al. Relationships of early and late glycemic responses with gastric emptying during an oral glucose tolerance test. *J Clin Endocrinol Metab* 2015;100:3565-71.
 37. Lupoli R, Pisano F, Capaldo B. Postprandial glucose control in type 1 diabetes: importance of the gastric emptying rate. *Nutrients* 2019;11:1559.
 38. Lutz TA, Coester B, Whiting L, et al. Amylin selectively signals onto POMC neurons in the arcuate nucleus of the hypothalamus. *Diabetes* 2018;67:805-17.
 39. Hayashi Y, Toyomasu Y, Saravanas-perumal SA, et al. Hyperglycemia increases interstitial cells of Cajal via MAPK1 and MAPK3 signaling to ETV1 and KIT, leading to rapid gastric emptying. *Gastroenterology* 2017;153:521-535.e20.
 40. Riddle MC. Basal glucose can be controlled, but the prandial problem persists — it's the next target! *Diabetes Care* 2017;40:291-300.
 41. Borg MJ, Bound M, Grivell J, et al. Comparative effects of proximal and distal small intestinal administration of metformin on plasma glucose and glucagon-like peptide-1, and gastric emptying after oral glucose, in type 2 diabetes. *Diabetes Obes Metab* 2019;21:640-7.
 42. Meier JJ, Rosenstock J, Hincelin-Méry A, et al. Contrasting effects of lixisenatide and liraglutide on postprandial glycemic control, gastric emptying, and safety parameters in patients with type 2 diabetes on optimized insulin glargine with or without metformin: a randomized, open-label trial. *Diabetes Care* 2015;38:1263-73.
 43. Frank JW, Saslow SB, Camilleri M, Thomforde GM, Dinneen S, Rizza RA. Mechanism of accelerated gastric emptying of liquids and hyperglycemia in patients with type II diabetes mellitus. *Gastroenterology* 1995;109:755-65.
 44. Singh J, Boopathi E, Addya S, et al. Aging-associated changes in microRNA expression profile of internal anal sphincter smooth muscle: role of microRNA-133a. *Am J Physiol Gastrointest Liver Physiol* 2016;311:G964-G973.
 45. Singh J, Kumar S, Rattan S. Bimodal effect of oxidative stress in internal anal sphincter smooth muscle. *Am J Physiol Gastrointest Liver Physiol* 2015;309:G292-G300.
 46. He XD, Guo YM, Goyal RK. Effect of hyperglycemia on purinergic and nitrergic inhibitory neuromuscular transmission in the antrum of the stomach: implications for fast gastric emptying. *Front Med (Lausanne)* 2018;5:1.
 47. Anthony RM, Rutitzky LI, Urban JF Jr, Stadecker MJ, Gause WC. Protective immune mechanisms in helminth infection. *Nat Rev Immunol* 2007;7:975-87.
 48. Chang J, Rayner CK, Jones KL, Horowitz M. Prognosis of diabetic gastroparesis — a 25-year evaluation. *Diabet Med* 2013;30:e185-e188.
 49. Feldman M, Smith HJ, Simon TR. Gastric emptying of solid radiopaque markers: studies in healthy subjects and diabetic patients. *Gastroenterology* 1984;87:895-902.
 50. Camilleri M, McCallum RW, Tack J, Spence SC, Gottesdiener K, Fiedorek FT. Efficacy and safety of relamorelin in diabetes with symptoms of gastroparesis: a randomized, placebo-controlled study. *Gastroenterology* 2017;153(5):1240-1250.e2.
 51. Koch KL. Gastric dysrhythmias: a potential objective measure of nausea. *Exp Brain Res* 2014;232:2553-61.
 52. O'Grady G, Angeli TR, Du P, et al. Abnormal initiation and conduction of slow-wave activity in gastroparesis, defined by high-resolution electrical mapping. *Gastroenterology* 2012;143:589-598.e3.
 53. Grover M, Farrugia G, Lurken MS, et al. Cellular changes in diabetic and idiopathic gastroparesis. *Gastroenterology* 2011;140(5):1575-1585.e8.
 54. Grover M, Gibbons SJ, Nair AA, et al. Transcriptomic signatures reveal immune dysregulation in human diabetic and idiopathic gastroparesis. *BMC Med Genomics* 2018;11:62.
 55. Kumar A, Attaluri A, Hashmi S, Schulze KS, Rao SS. Visceral hypersensitivity and impaired accommodation in refractory diabetic gastroparesis. *Neurogastroenterol Motil* 2008;20:635-42.
 56. Mashimo H, Kjellin A, Goyal RK. Gastric stasis in neuronal nitric oxide synthase-deficient knockout mice. *Gastroenterology* 2000;119:766-73.
 57. Eisenman ST, Gibbons SJ, Verhulst PJ, Cipriani G, Saur D, Farrugia G. Tumor necrosis factor alpha derived from classically activated "M1" macrophages reduces interstitial cell of Cajal numbers. *Neurogastroenterol Motil* 2017;29:1-24.
 58. Horváth VJ, Vittal H, Lörincz A, et al. Reduced stem cell factor links smooth myopathy and loss of interstitial cells of Cajal in murine diabetic gastroparesis. *Gastroenterology* 2006;130:759-70.
 59. Choi KM, Gibbons SJ, Roeder JL, et al. Regulation of interstitial cells of Cajal in the mouse gastric body by neuronal nitric oxide. *Neurogastroenterol Motil* 2007;19:585-95.
 60. Cipriani G, Gibbons SJ, Miller KE, et al. Change in populations of macrophages promotes development of delayed gastric emptying in mice. *Gastroenterology* 2018;154:2122-2136.e12.
 61. Bhetwal BP, An C, Baker SA, Lyon KL, Perrino BA. Impaired contractile responses and altered expression and phosphorylation of Ca(2+) sensitization proteins in gastric antrum smooth muscles from ob/ob mice. *J Muscle Res Cell Motil* 2013;34:137-49.
 62. Bernard CE, Gibbons SJ, Mann IS, et al. Association of low numbers of CD206-positive cells with loss of ICC in the gastric body of patients with diabetic gastroparesis. *Neurogastroenterol Motil* 2014;26:1275-84.
 63. Kassander P. Asymptomatic gastric retention in diabetics (gastroparesis diabeticorum). *Ann Intern Med* 1958;48:797-812.
 64. Pasricha PJ, Parkman HP. Gastroparesis: definitions and diagnosis. *Gastroenterol Clin North Am* 2015;44:1-7.
 65. Revicki DA, Camilleri M, Kuo B, Szarka LA, McCormack J, Parkman HP. Evaluating symptom outcomes in gastroparesis clinical trials: validity and responsiveness of the Gastroparesis Cardinal Symptom Index-Daily Diary (GCSI-DD). *Neurogastroenterol Motil* 2012;24(5):456-63.
 66. Talley NJ, Ford AC. Functional dyspepsia. *N Engl J Med* 2015;373:1853-63.
 67. Cherian D, Sachdeva P, Fisher RS, Parkman HP. Abdominal pain is a frequent symptom of gastroparesis. *Clin Gastroenterol Hepatol* 2010;8:676-81.
 68. Janssen P, Harris MS, Jones M, et al. The relation between symptom improvement and gastric emptying in the treatment of diabetic and idiopathic gastroparesis. *Am J Gastroenterol* 2013;108:1382-91.
 69. Rayner CK, Jones KL, Horowitz M. Is making the stomach pump better the answer to gastroparesis? *Gastroenterology* 2019;156:1555-7.
 70. Tack J, Goelen N, Carbone F, et al. Prokinetic effects and symptom relief in the pharmacotherapy of gastroparesis. *Gastroenterology* 2020;158:1841-2.
 71. Vijayvargiya P, Camilleri M, Chedid V, Mandawat A, Erwin PJ, Murad MH. Effects of promotility agents on gastric emptying and symptoms: a systematic review and meta-analysis. *Gastroenterology* 2019;156:1650-60.
 72. Lacy BE, Saito YA, Camilleri M, et al. Effects of antidepressants on gastric function in patients with functional dyspepsia. *Am J Gastroenterol* 2018;113:216-24.
 73. Stanghellini V, Tack J. Gastroparesis: separate entity or just a part of dyspepsia? *Gut* 2014;63:1972-8.
 74. Fosso CL, Quigley EMM. A critical review of the current clinical landscape of gastroparesis. *Gastroenterol Hepatol (N Y)* 2018;14:140-5.
 75. Addula M, Wilson VED, Reddymasu S, Agrawal DK. Immunopathological and molecular basis of functional dyspepsia and current therapeutic approaches. *Expert Rev Clin Immunol* 2018;14:831-40.
 76. Wauters L, Talley NJ, Walker MM, Tack J, Vanuytsel T. Novel concepts in the pathophysiology and treatment of functional dyspepsia. *Gut* 2020;69:591-600.

Copyright © 2021 Massachusetts Medical Society.