**Name of Journal:** *World Journal of Gastrointestinal Pharmacology and Therapeutics*

**Manuscript No:** 53832

**Manuscript Type:**ORIGINAL ARTICLE

***Case Control Study***

**Gastrointestinal symptoms in acromegaly: A case control study**

Inayet N *et al*. Acromegaly and gastrointestinal symptoms

Nashiz Inayet, Jamal Hayat, Gul Bano, Andrew Poullis

**Nashiz Inayet, Jamal Hayat, Andrew Poullis,** Department of Gastroenterology, St Georges Hospital and St Georges, University of London, London SW17 0QT, United Kingdom

**Gul Bano,** Department of Endocrinology, St Georges Hospital and St Georges, University of London, London SW17 0QT, United Kingdom

**Author contributions:** Poullis A and Hayat J designed the project and reviewed the statistics and the manuscript; Bano G identified the cases and reviewed the manuscript; Inayet N collected the data, carried out the statistical analysis and wrote the manuscript.

**Corresponding author: Nashiz Inayet, BSc, CCST, MBBS, MD, MRCP, Doctor,** **Senior Lecturer,** Department of Gastroenterology, St Georges Hospital and St Georges, University of London, Blackshaw Road, Tooting, London SW17 0QT, United Kingdom. n.inayet@nhs.net

**Received:** December 31, 2019

**Revised:** April 25, 2020

**Accepted:** May 29, 2020

**Published online:** June 9, 2020

Abstract

BACKGROUND

Acromegaly is a chronic disease caused by a pituitary somatotroph adenoma resulting in excess secretion of growth hormone, which leads to excess secretion of Insulin like growth factor 1 from the liver, causing abnormal soft tissue growth. There is increasing awareness that diseases affecting connective tissue are associated with an increase in functional gastrointestinal symptoms. Data was collected from patients with a confirmed diagnosis of acromegaly to evaluate the intensity, variety and impact of abdominal symptoms in comparison with a control group who were healthy participants recruited from the local fracture clinic.

AIM

To evaluate the frequency type and burden of abdominal symptoms in acromegaly in comparison with a control group.

METHODS

Medical documentation of patients with a diagnosis of acromegaly treated in one tertiary medical centre between 2010 and 2017 has been analysed. Data was collected from patients with confirmed acromegaly, using the Short Form Health Survey (SF36) and Rome IV Diagnostic questionnaire for Functional Gastrointestinal Disorders in Adults (R4DQ) and compared to a sex- and age-matched control group, to assess the burden of abdominal symptoms. Microsoft Excel and IBM SPSS v 25 were used for data analysis.

RESULTS

Fifty patients with acromegaly (24 male and 26 females; age range 23-64 years, mean 43) and 200 controls (96 male and 104 females; age range 18-84, mean 42.4) were recruited. 92% (46 out of 50) of patients with acromegaly reported abdominal symptoms and 78% (39 out of 50) had at least one functional gastrointestinal disorder according to the Rome IV diagnostic criteria, compared to 16% of controls (OR > 1, *P* < 0.0001). The most commonly reported symptom was constipation (69% acromegaly *vs* 21% of controls OR > 1, *P* < 0.0001, 95%CI: 4.4–15.8). 34 out of 50 (68%) respondents met the criteria for functional constipation according to Rome IV. Upper gastrointestinal disorders were also more prevalent in the acromegaly group. There was no statistically significant difference in the prevalence of biliary and anorectal symptoms between the two groups. Patients in acromegaly group scored lower on the mean scores of the eight parameters of SF36 Quality of Life questionnaire (mean scores 60.04 *vs* 71.23, 95%CI: -13.6829 to -8.6971, OR > 1, *P* < 0.001) as compared to the control group.

CONCLUSION

Upper and lower functional gastrointestinal tract disorders (defined by Rome IV diagnostic criteria) are significantly more prevalent in patients with acromegaly compared with healthy age and sex matched controls in our study. Functional constipation is the most commonly reported problem. Poorer quality of life may in part be attributable to the increased prevalence of abdominal symptoms.

**Key words:** Functional gastrointestinal disorders; Acromegaly; Constipation; Irritable bowel syndrome; Somatostatin; Pituitary

**Citation:** Inayet N, Hayat J, Bano G, Poullis A. Gastrointestinal symptoms in acromegaly: A case control study. *World J Gastrointest Pharmacol Ther* 2020; 11(2): 17-24

URL: <https://www.wjgnet.com/2150-5349/full/v11/i2/17.htm>

DOI: <https://dx.doi.org/10.4292/wjgpt.v11.i2.17>

**Core tip:** Irritable bowel syndrome is the commonest cause of gastrointestinal symptoms. The aetiology is thought to be multi-factorial but remains incompletely understood. Our group has previously identified that patients with connective tissue disorders have an increased incidence of functional gastrointestinal symptoms. Investigating for these symptoms in patients with acromegaly may give further insight into the pathogenesis of functional disorders and irritable bowel syndrome.

**INTRODUCTION**

Acromegaly is caused by a pituitary somatotroph adenoma and characterised by excessive secretion of growth hormone (GH)[1,2]. GH stimulates the liver to produce Insulin like growth factor 1 (IGF-1). In addition to the insulin-like effects, IGF-1 can also regulate cellular DNA synthesis and is an important signalling molecule with regards to cancer cell transformation and proliferation, including mitogenesis and apoptosis inhibition[3].

A variety of complications have been reported in patients with acromegaly including cardiovascular diseases, such as hypertrophic cardiomyopathy, heart failure, hypertension, diabetes mellitus or respiratory disorders, obstructive sleep apnoea[4] as well as increased risk of benign and malignant neoplasms including colon cancer[5].

The organic gastrointestinal pathology associated with acromegaly such as increased risk of colonic cancer and an increased risk of cholelithiasis has been studied in detail[6], however the issue of overall burden of gastrointestinal symptoms, particularly the functional disorders in acromegaly and the gastrointestinal effects of its treatment have not been well studied. We have previously identified how changes in connective tissue in hypermobility (in Marfan and Ehlers Danlos) are associated with an increase in functional gastrointestinal symptoms[7]. The impact of soft tissue changes associated with over secretion of GH and gastrointestinal symptoms has not previously been studied.

Somatostatin analogues used in the treatment of acromegaly are also associated with a wide range of abdominal symptoms. Due to the higher risk of colon cancer, acromegaly patients are offered screening colonoscopy during which standard preparation for colonoscopy is often found inadequate, indicating functional and structural change[5,8,9].

Our aim was to evaluate gastro-intestinal symptoms in a cohort of acromegaly patients. We assessed the frequency, character, severity and burden of abdominal symptoms in patients with acromegaly in comparison with a control group.

**MATERIALS AND METHODS**

***Patients***

Medical documentation of patients with acromegaly treated in one medical centre (Department of Endocrinology, St George’s Hospital, London) between 2010 and June 2017 have been analysed in order to find the information about their diagnosis, treatment and presence of abdominal symptoms. Treatment information including Somatostatin analogues and other medicines with significant gastrointestinal effects were obtained from patients and controls. Selected patients were then asked to fill out Rome IV Diagnostic questionnaire for Functional Gastrointestinal Disorders in Adults (R4DQ) and SF36 questionnaire and were included as cases. Results were compared with sex- and age-matched group of controls.

***Controls***

Participants in the control group were recruited from people who were being discharged from fracture clinic who were otherwise healthy and did not report any other medical problems. Details of treatment history including drugs affecting the gastrointestinal system were obtained.

***Statistical analysis***

Microsoft Excel and IBM SPSS v 25 were used to analyse the data. A case-control ratio of 4:1 was used. Fisher’s exact test was used to analyse the results of R4DQ and one-tailed Independent sample t test was used to analyse the mean scores of SF36. A *P*-value under 0.05 was considered statistically significant.

***Screening protocol***

All patients had a confirmed diagnosis of acromegaly and were either post treatment or undergoing treatment.

***Ethics***

The study protocol was approved by the South West-Central Bristol Research Ethics Committee and NHS Health Research Authority United Kingdom.

RESULTS

Fifty patients with acromegaly (24 male and 26 females; age range 23-64 years, mean 43) and 200 controls (96 male and 104 females; age range 18-84, mean 42.4) were recruited in a 1:4 Case:Control ratio. The mean age at diagnosis of acromegaly was 32.44 years and on average participants had their diagnosis confirmed 11.8 years prior to this study. All patients had trans-sphenoidal surgery and 21 (42%) had pituitary radiotherapy in addition. Thirty-seven (74%) patients were using somatostatin analogues (Table 1).

Ninety-two percent (46 out of 50) of patients with acromegaly reported abdominal symptoms (abdominal pain, diarrhoea or constipation) and 78% (39 out of 50) had at least one functional gastrointestinal disorder (FGID) according to the Rome IV diagnostic criteria, compared to 16% of controls (OR > 1, *P* < 0.0001). All female patients with acromegaly reported suffering from at least some abdominal symptoms as compared to 87% of male patients with acromegaly, however there was no statistically significant gender difference observed in the frequency and intensity of symptoms. The use of medicines (antacids, **histamine receptor antagonists**, proton pump inhibitors, laxatives) used to alleviate gastrointestinal symptoms was also higher and statistically significant in the acromegaly group (Table 2).

A few patients with acromegaly reported multiple abdominal symptoms and qualified for more than one FGID. The most commonly reported symptom was constipation (68% acromegaly group *vs* 7.5% of controls OR > 1, *P* < 0.0001, 95%CI: 4.4-15.8) followed by abdominal pain (22% acromegaly group *vs* 9.5% of controls OR > 1, *P* < 0.0001, 95%CI: 2.5-9.3). Thirty-four out of 50 (68%) respondents met the criteria for functional constipation according to Rome IV. The prevalence of constipation increased with increasing age and was often associated with bloating. All bowel symptoms showed statistically significant prevalence in the acromegaly group. Some oesophageal and gastroduodenal conditions such as functional heartburn, functional dysphagia and functional dyspepsia also showed statistically significant prevalence in acromegaly group. There was no statistically significant difference of prevalence of biliary and anorectal symptoms between the acromegaly group and controls (Table 3).

Acromegaly patients scored lower than controls on the mean scores of all eight parameters measured by the SF36 quality of life index. These parameters include physical functioning levels, role limitations due to physical health, role limitations due to emotional health, energy/fatigue levels, emotional wellbeing, social functioning levels, perception of pain and general health (mean scores 60.04 *vs* 71.23, 95%CI: -13.6829 to -8.6971, OR > 1, *P* < 0.001) (Table 4).

**DISCUSSION**

Acromegaly is a rare and unique disease associated with abnormal soft tissue growth[4] with a prevalence that is estimated at 40 per million in United Kingdom and an annual incidence rate ranging between 2 and 11 cases per million per year, with an equal distribution between genders[10].

Acromegaly is associated with gastrointestinal complications, such as constipation, higher prevalence of colorectal polyps and cancer[11] and higher prevalence of gallstones in patients treated with Somatostatin analogues[12]. Somatostatin analogues used in the management of acromegaly are also associated with a wide range of abdominal symptoms in addition to the known association with gallstones.

The higher prevalence of lower gastrointestinal symptoms in acromegaly could partly be due to slow intestinal motility. Slow intestinal and colonic transit times have been attributed to both acromegaly and its treatment with Somatostatin analogues. Disease related slow gut motility may be worsened because of treatment with Somatostatin. Resmini *et al*[13] demonstrated that patients with acromegaly have a prolonged small intestinal transit time and a prolonged colon transit time. The small bowel transit time calculated by standardized 10 g lactulose hydrogen breath test showed significantly slower oro-caecal transit in patients than in controls, without significant differences between patients treated with Somatostatin and untreated patients. These data suggest that acromegaly itself may cause motility alteration. However Thomas *et al*[14] performed radiological tests to investigate colonic transit and found an increased transit time of colon (66% longer) in patients with acromegaly compared with controls, and it was even more increased during octreotide treatment. This may predispose to small intestinal bacterial overgrowth, which in turn can cause symptoms[13]. Autonomic intestinal impairment due to vagal hypertonia, similar to that demonstrated previously in the cardiovascular system, has been proposed as a pathogenic mechanism[15]. Another proposed pathogenic mechanism could be related to hormonal imbalance which can be influenced by the complex interaction between GH and ghrelin, as shown by Arosio *et al*[16].These gut motility disturbances in acromegaly increase circulating levels of IGF-1, which is a known mitogen[17] that may stimulate the proliferation of intestinal epithelial cells by autocrine and paracrine actions[11].

Our study has also showed a higher prevalence of upper gastrointestinal symptoms (functional heartburn, functional dysphagia and functional dyspepsia) in the acromegaly group. Sisman *et al*[18] showed that the prevalence of gastritis, duodenitis, peptic ulcers or intestinal metaplasia were higher in patients with acromegaly than in healthy subjects; while the prevalence of hiatal hernia was lower. Ilhan *et al*[19] demonstrated oesophageal dysmotility manifesting as profound reduction in the amplitude and duration of lower oesophageal sphincter relaxation even in acromegaly patients without any significant gastrointestinal symptoms. George *et al*[20] described a rare case of megaduodenum without any distal obstruction in a patient with acromegaly. Somatostatin analogues inhibitory effect on gut motility, particularly antral contractility may also produce or worsen symptoms in patients with delayed gastric emptying[21].

Despite our study not showing any statistically significant difference in the prevalence of biliary symptoms in the two groups, other studies have shown an increased risk of gall stones in acromegaly[22-24]. The increased risk of faecal anaerobic bacteria overgrowth associated with slow gut transit times, with the additional increased risk of impairment of bile acid metabolism may be responsible in part for gallstone development[14]. Ultrasound studies have found increased gall bladder volume in both fasting and postprandial states in acromegaly. These are associated with profound suppression of released cholecystokinin, which is associated with Somatostatin administration. The incomplete gall bladder emptying may be the reason for higher incidence of gall bladder calculi in patients with acromegaly treated with Somatostatin[12].

This study is the first study in our knowledge that looks into the prevalence of various abdominal symptoms in acromegaly. The burden of non-organic gastrointestinal symptoms, particularly the functional disorders in acromegaly and the gastrointestinal effects of its treatment have not been well studied. This study, along with our previous studies on Marfan and Ehlers Danlos[7] gives insight into the possible link between connective tissue abnormalities and irritable bowel syndrome (IBS). IBS is the commonest final diagnosis in patients presenting with gastrointestinal symptoms. The aetiology is multifactorial. This study gives further evidence to the suggestion that connective tissue abnormalities may be the underlying pathology in some individuals with IBS.

The strengths of this study are that for a very rare condition this is a large patient cohort being looked after in one tertiary hospital, with a large control group for comparison. A weakness of this study is that cases were not clinically reviewed to ensure that symptoms had been fully investigated to ensure that the symptom complex was truly functional. Also, it was not possible to analyse for disease duration prior to diagnosis, treatment administered historically, on-going treatment and time since diagnosis were not possible.

The presence of FGIDs affecting both upper and lower gastrointestinal tract in patients with acromegaly is substantially higher than the controls in our study. The lower mean scores on quality of life indicators in the acromegaly group reflect the overall burden of disease on quality of life. The high prevalence of abdominal symptoms may in part explain this. This is likely to be multifactorial and factors such as delayed small intestinal and colonic transit times, treatment with Somatostatin analogues, increased bowel length may all play a part in this. A larger follow up international multi-centre study on the presence of abdominal symptoms in acromegaly and future clinical research focussing on the association of abdominal symptoms with connective tissue abnormalities may further help our understanding of IBS and other FGIDs.

**ARTICLE HIGHLIGHTS**

***Research background***

Acromegaly results from an excess of growth hormone, which leads to excess secretion of Insulin like growth factor 1 from the liver, causing abnormal soft tissue growth. This is associated with an increase in a number of organic diseases. There is increasing awareness that diseases affecting connective tissue are associated with an increase in functional gastrointestinal symptoms. We are not aware of any other study that has looked into the burden of abdominal symptoms in acromegaly and the impact they have on patient’s quality of life as a result of this.

***Research motivation***

This study is part of a larger study that is assessing the role and significance of connective tissue involvement in abdominal symptoms. We have previously described an increase in functional gastrointestinal symptoms in other diseases affecting connective tissue (Marfan and Ehlers Danlos). In this study we evaluate the frequency of abdominal symptoms in patients with acromegaly.

***Research objectives***

The main objective of this study was to evaluate if patients with acromegaly had more frequent and intense abdominal symptoms, as described by the Rome criteria, than controls and thus, as a result of this had poorer quality of life. Furthermore, other factors such as use of Somatostatin analogues, which in itself can cause abdominal symptoms, had to be taken into account. The next step in our research would be to carry out objective gastrointestinal physiological studies in larger groups of patients and controls to see if the presence of symptoms reflects actual physiological variations across different groups.

***Research methods***

Patients with acromegaly were identified from a clinical database at one tertiary medical centre (Department of Endocrinology, St George’s Hospital, London). Identified patients were then asked to fill out previously validated questionnaires and results were compared with sex- and age-matched group of controls (recruited from fracture clinic who were otherwise healthy and did not report any other medical problems).

***Research results***

The results of this study showed that the presence of abdominal symptoms in acromegaly is significantly higher than controls. The results also show that the presence of these symptoms has an overall detrimental effect on quality of life or well being of the patient. This study also supports the increasing awareness in the scientific world regarding the association of connective tissue abnormalities and gastrointestinal or abdominal symptoms. It is yet to be seen if gastrointestinal physiological studies in these patients will be reflective of these results.

***Research conclusions***

The presence of abdominal symptoms is significantly higher in patients with acromegaly compared to controls and this may have a significant impact on their quality of life. Connective tissue abnormalities are associated with abdominal symptoms as has been shown by this study and other studies and may be one of the underlying reasons behind functional gastrointestinal disorders (FGIDs). Other studies have shown similar results in Ehlers-Danlos and Marfan syndromes and abnormalities of connective tissue such as elastin may be common to these disease processes. This needs to be studied further to see if minor variations in gut connective tissue the cause of FGIDs could be.

***Research perspectives***

Future research in this area will have to be pursued in an international and multicentre study as it is difficult for one centre to recruit a large number of patients in rare diseases. Gastrointestinal physiological studies would help to see if the variance in symptoms is reflected in physiological variance.

**ACKNOWLEDGEMENTS**

Thank you to the patients and controls who gave up their time to participate in this study.

**REFERENCES**

1 **Melmed S**. Medical progress: Acromegaly. *N Engl J Med* 2006; **355**: 2558-2573 [PMID: 17167139 DOI: 10.1056/NEJMra062453]

2 **Nabarro JD**. Acromegaly. *Clin Endocrinol (Oxf)* 1987; **26**: 481-512 [PMID: 3308190 DOI: 10.1111/j.1365-2265.1987.tb00805.x]

3 **Baserga R**, Peruzzi F, Reiss K. The IGF-1 receptor in cancer biology. *Int J Cancer* 2003; **107**: 873-877 [PMID: 14601044 DOI: 10.1002/ijc.11487]

4 **Colao A**, Ferone D, Marzullo P, Lombardi G. Systemic complications of acromegaly: epidemiology, pathogenesis, and management. *Endocr Rev* 2004; **25**: 102-152 [PMID: 14769829 DOI: 10.1210/er.2002-0022]

5 **Dworakowska D**, Grossman AB. Colonic Cancer and Acromegaly. *Front Endocrinol (Lausanne)* 2019; **10**: 390 [PMID: 31293513 DOI: 10.3389/fendo.2019.00390]

6 **Ezzat S**. Hepatobiliary and gastrointestinal manifestations of acromegaly. *Dig Dis* 1992; **10**: 173-180 [PMID: 1611713 DOI: 10.1159/000171355]

7 **Inayet N**, Hayat JO, Kaul A, Tome M, Child A, Poullis A. Gastrointestinal Symptoms in Marfan Syndrome and Hypermobile Ehlers-Danlos Syndrome. *Gastroenterol Res Pract* 2018; **2018**: 4854701 [PMID: 30151001 DOI: 10.1155/2018/4854701]

8 **Renehan AG**, Painter JE, Bell GD, Rowland RS, O'Dwyer ST, Shalet SM. Determination of large bowel length and loop complexity in patients with acromegaly undergoing screening colonoscopy. *Clin Endocrinol (Oxf)* 2005; **62**: 323-330 [PMID: 15730414 DOI: 10.1111/j.1365-2265.2005.02217.x]

9 **Jenkins PJ**, Fairclough PD, Richards T, Lowe DG, Monson J, Grossman A, Wass JA, Besser M. Acromegaly, colonic polyps and carcinoma. *Clin Endocrinol (Oxf)* 1997; **47**: 17-22 [PMID: 9302367 DOI: 10.1046/j.1365-2265.1997.1911029.x]

10 **Lavrentaki A**, Paluzzi A, Wass JA, Karavitaki N. Epidemiology of acromegaly: review of population studies. *Pituitary* 2017; **20**: 4-9 [PMID: 27743174 DOI: 10.1007/s11102-016-0754-x]

11 **Rokkas T**, Pistiolas D, Sechopoulos P, Margantinis G, Koukoulis G. Risk of colorectal neoplasm in patients with acromegaly: a meta-analysis. *World J Gastroenterol* 2008; **14**: 3484-3489 [PMID: 18567075 DOI: 10.3748/wjg.14.3484]

12 **Attanasio R**, Mainolfi A, Grimaldi F, Cozzi R, Montini M, Carzaniga C, Grottoli S, Cortesi L, Albizzi M, Testa RM, Fatti L, De Giorgio D, Scaroni C, Cavagnini F, Loli P, Pagani G, Ghigo E. Somatostatin analogs and gallstones: a retrospective survey on a large series of acromegalic patients. *J Endocrinol Invest* 2008; **31**: 704-710 [PMID: 18852531 DOI: 10.1007/BF03346419]

13 **Resmini E**, Parodi A, Savarino V, Greco A, Rebora A, Minuto F, Ferone D. Evidence of prolonged orocecal transit time and small intestinal bacterial overgrowth in acromegalic patients. *J Clin Endocrinol Metab* 2007; **92**: 2119-2124 [PMID: 17405840 DOI: 10.1210/jc.2006-2509]

14 **Thomas LA**, Veysey MJ, Murphy GM, Russell-Jones D, French GL, Wass JA, Dowling RH. Octreotide induced prolongation of colonic transit increases faecal anaerobic bacteria, bile acid metabolising enzymes, and serum deoxycholic acid in patients with acromegaly. *Gut* 2005; **54**: 630-635 [PMID: 15831907 DOI: 10.1136/gut.2003.028431]

15 **Resmini E**, Casu M, Patrone V, Murialdo G, Bianchi F, Giusti M, Ferone D, Minuto F. Sympathovagal imbalance in acromegalic patients. *J Clin Endocrinol Metab* 2006; **91**: 115-120 [PMID: 16263819 DOI: 10.1210/jc.2005-1506]

16 **Arosio M**, Ronchi CL, Gebbia C, Pizzinelli S, Conte D, Cappiello V, Epaminonda P, Cesana BM, Beck-Peccoz P, Peracchi M. Ghrelin administration affects circulating pituitary and gastro-entero-pancreatic hormones in acromegaly. *Eur J Endocrinol* 2004; **150**: 27-32 [PMID: 14713276 DOI: 10.1530/eje.0.1500027]

17 **Benito M**, Valverde AM, Lorenzo M. IGF-I: a mitogen also involved in differentiation processes in mammalian cells. *Int J Biochem Cell Biol* 1996; **28**: 499-510 [PMID: 8697095 DOI: 10.1016/1357-2725(95)00168-9]

18 **Sisman P**, Pekgoz M, Bayrakci I, Sisman M, Cander S, Oz Gul O, Erturk E, Ersoy C. Evaluation of upper gastrointestinal system in acromegaly. *Ann Endocrinol (Paris)* 2019; **80**: 196-201 [PMID: 31227172 DOI: 10.1016/j.ando.2019.03.001]

19 **Ilhan M**, Danalioglu A, Turgut S, Karaman O, Arabaci E, Tasan E. Acromegaly can be associated with impairment of LES relaxation in the oesophagus. *Endokrynol Pol* 2015; **66**: 308-312 [PMID: 26323467 DOI: 10.5603/EP.2015.0039]

20 **George B**, Vinay D, Moolechery J, Mathew V, Anantharaman R, Ayyar V, Bantwal G. Megaduodenum in a patient with acromegaly. *Indian J Endocrinol Metab* 2012; **16**: S324-S325 [PMID: 23565414]

21 **Edmunds MC**, Chen JD, Soykan I, Lin Z, McCallum RW. Effect of octreotide on gastric and small bowel motility in patients with gastroparesis. *Aliment Pharmacol Ther* 1998; **12**: 167-174 [PMID: 9692691 DOI: 10.1046/j.1365-2036.1998.00289.x]

22 **Rhodes M**, James RA, Bird M, Clayton B, Kendall-Taylor P, Lennard TW. Gallbladder function in acromegalic patients taking long-term octreotide: evidence of rebound hypermotility on cessation of treatment. *Scand J Gastroenterol* 1992; **27**: 115-118 [PMID: 1561523 DOI: 10.3109/00365529209165429]

23 **Annamalai AK**, Gayton EL, Webb A, Halsall DJ, Rice C, Ibram F, Chaudhry AN, Simpson HL, Berman L, Gurnell M. Increased prevalence of gallbladder polyps in acromegaly. *J Clin Endocrinol Metab* 2011; **96**: E1120-E1125 [PMID: 21543430 DOI: 10.1210/jc.2010-2669]

24 **Chakravarty AA**, Ajmani A, Manchanda S, Kulshreshtha B, Chopra S. Incidence of gall stone formation in acromegalic patients on octreotide therapy. *Indian J Endocrinol Metab* 2012; **16**: 406-408 [PMID: 22629508 DOI: 10.4103/2230-8210.95683]

**Footnotes**

**Institutional review board statement:** The study protocol was approved by the South West-Central Bristol Research Ethics Committee and NHS Health Research Authority United Kingdom.

**Informed consent statement:** All patients had given informed consent for this study.

**Conflict-of-interest statement:** The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

**Data sharing statement:** The questionnaire data used to support the findings of this study are available from the corresponding author upon request.

**STROBE Statement:** The authors have read the STROBE Statement-checklist of items, and the manuscript was prepared and revised according to the STROBE Statement-checklist of items.

**Open-Access:** This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

**Manuscript source:** Invited manuscript

**Peer-review started:** December 31, 2019

**First decision:** January 19, 2020

**Article in press:** May 29, 2020

**Specialty type:** Gastroenterology and hepatology

**Country/Territory of origin:** United Kingdom

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): 0

Grade C (Good): C

Grade D (Fair): D

Grade E (Poor): 0

**P-Reviewer:** Mari A, Wu KL **S-Editor:** Dou Y **L-Editor:** A **E-Editor:** Qi LL

**Table 1** **Acromegaly demographic and treatment data**

|  |  |  |
| --- | --- | --- |
|  | **Controls** | **Acromegaly patients** |
| *n* | 200 | 50 |
| M:F  | 96:104 | 24:26 |
| Age at diagnosis (mean, yr) | 33 | 32.44 |
| Years since diagnosis (mean, yr) | - | 11.8 yr |
| Transsphenoidal surgery | - | 50 (100%) |
| Pituitary radiotherapy | - | 21 (42%) |
| Somatostatin analogue | - | 37 (74%) |

**Table 2 Acromegaly abdominal symptoms and medicine use**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Controls (*n* = 200)** | **Acromegaly patients (*n* = 50)** | ***P* value (Fisher’s exact test)** |
| Gastrointestinal symptoms |  | 32 (16%) | 46 (92%) |  |
|  | Abdominal pain | 19 (9.5%) | 11(22%) | 0.4905 |
|  | Diarrhoea | 8 (4%) | 4 (8%) | 0.2652 |
|  | Constipation | 15 (7.5%) | 34 (68%) | < 0.00001b |
| Medicines |  |  |  |  |
|  | Regular use of anti-secretory (PPI/H2RA)/antacids | 11 (6.5%) | 31 (62%) | < 0.00001b |
|  | Regular use of laxatives | 6 (3%) | 46 (92%) | < 0.00001b |
|  | Regular use of opioid analgesics | 11 (6.5%) | 2 (4%) | Not statistically significant |
|  | Somatostatin analogues | - | 37 (74%) |  |

b*P* < 0.01, statistically significant. PPI: Proton pump inhibitor; H2RA: Histamine H2 receptor antagonists.

**Table 3 Gastrointestinal symptoms in acromegaly patients compared with controls**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Controls, *n* = 200 (%)** | **Acromegaly patients, *n* = 50 (%)** | ***P* value (Fisher’s exact test)** |
| Oesophageal disorders |  |  |  |  |
|  | Functional chest pain | 2 (1%) | 3 (6%) | 0.0561 |
|  | Functional heartburn | 22 (11%) | 15(30%) | 0.0016b |
|  | Globus | 2 (1%) | 2 (4%) | 0.1796 |
|  | Functional dysphagia | 4 (2%) | 6 (12%) | 0.0053b |
| Gastroduodenal disorders |  |  |  |  |
|  | Functional dyspepsia  | 14 (7%) | 12 (24%) | 0.0013b |
|  | Belching disorders | 8 (4%) | 5 (10%) | 0.1441 |
|  | Nausea and vomiting disorders | 2 (1%) | 2 (4%) | 0.1796 |
|  | Rumination syndrome | 2 (1%) | 1 (2%) | 0.4895 |
| Bowel disorders |  |  |  |  |
|  | Irritable bowel syndrome | 12 (6%) | 10 (20%) | 0.0041b |
|  | Functional constipation | 22 (11%) | 34 (68%) | 0.0006b |
|  | Functional diarrhoea | 10 (5%) | 9 (18%) | 0.0048b |
|  | Functional abdominal bloating/distension | 12 (6%) | 11 (22%) | 0.0015b |
|  | Unspecified functional bowel disorder | 44 (22%) | 25 (50%) | 0.0002b |
| Centrally mediated Abdominal pain syndrome |  | 6 (3%) | 4 (8%) | 0.1165 |
| Functional Biliary pain |  | 1 (0.5%) | 3 (6%) | 0.0261a |
| Anorectal disorders |  |  |  |  |
|  | Faecal incontinence | 1 (0.5%) | 2 (4%) | 0.1028 |
|  | Functional anorectal pain | 2 (1%) | 4 (8%) | 0.0157a |

a*P* < 0.05, b*P* < 0.01, statistically significant.

**Table 4** **Quality of life scores in acromegaly patients**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Controls (mean scores)** | **Acromegaly (mean scores)** | **Independent sample *t* test**  |
| Physical functioning | 100.0 | 80.0 | 0.80516 |
| Role limitations due to physical health | 100.0 | 50.0 | 0.001053b |
| Role limitations due to emotional problems | 100.0 | 100.0 | 1 |
| Level of energy/fatigue | 95.0 | 45.0 | 0.001053b |
| Emotional wellbeing | 100.0 | 68.0 | 0.002175b |
| Social functioning | 87.5 | 50.0 | < 0.000076b |
| Pain | 77.5 | 67.5 | 0.1732 |
| General health | 100 | 30.0 | < 0.0001b |

b*P* < 0.01, statistically significant.