



Sacral nerve stimulation in patients with slow transit constipation

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Dear Sir

We read with great interest the recent article “Sacral nerve stimulation for constipation: long term outcomes” by Gortazar de las Casas et al. [1], in which they eloquently report their experience in treating this often challenging group of patients. Although the aetiology of slow transit constipation (STC) is complex and multifactorial, medication usage is a recognised risk factor [2, 3]. Opioid analgesics in particular are known to cause a significant reduction in colonic motility and hence are associated with a marked risk of constipation. Most patients in this group are unwilling or unable to alter their medication and this necessity for continued use of constipation-inducing analgesics produces a significant challenge in the treatment of STC. We have, therefore, previously investigated whether the success of sacral neuromodulation (SNM) in STC is influenced by the concurrent use of opioids and other constipation-inducing agents.

In our patient cohort of STC patients undergoing SNM over a 9 year period, we identified 32 patients (30 female, 2 male; median age [range] 50 [21–70] years) who had a temporary SNM trial. Of these 32 patients, 5 (16%) patients were opioid users (defined by the usage of 2 or more opioid drugs at the time of SNM implantation) and 27 (84%) patients were non-opioid users. Overall, 20 (63%) of these patients had a successful temporary SNM trial. We observed no difference in the outcome of the temporary SNM trial between opioid- and non-opioid users (successful outcome in 3/5 [60%] opioid users and 17/27 [63%] non-opioid-users; $p=1.00$, Fisher’s exact test).

Due to the low numbers of patients ($n=5$) classed as opioid users, other recognised constipating analgesics were included in a further analysis. We identified gabapentin, amitriptyline, and imipramine as the commonest used

medications known to cause constipation used by this patient cohort. When grouped together with the opioids, patients classed as taking constipating medications ($n=12$ [38%]) were just as likely to have a successful temporary SNM trial as patients ($n=20$ [72%]) who were not taking constipating medications (temporary SNM success in 6/12 [50%] medication users and 14/20 [70%] non-medication users; $p=0.29$; Fisher’s exact test).

Of the 20 patients who had a successful SNM trial, 15 (3 opioid users and 12 non-opioid users) progressed to permanent SNM implantation. At a median follow-up of 18 months (range 7 months–5 years), 8/15 (53%) remained with the permanent stimulator still implanted and had continued effective symptom control. Seven patients had a suboptimal result, of which 3 patients were undergoing stimulator reprogramming, 3 had progressed to other treatments, and 1 underwent SNM implant removal due to infection resulting from pilonidal disease. The use of opioid medications did not affect the continued success of permanent SNM (success in 1/3 [33%] opioid-users and 7/12 [58%] non-opioid-users; $p=0.57$; Fisher’s exact test). Success of the permanent SNM was also not affected by the use of additional constipating agents (2/5 [40%] medication users versus 6/10 [60%] non-medication-users; $p=0.56$, Fisher’s exact test).

STC can cause significant physical and psychological distress, and SNM represents a potential therapeutic avenue in those who have failed treatment with conservative therapies. The results reported by Gortazar de las Casas et al. [1] are an important step forward in highlighting the usefulness of SNM in a strictly defined cohort of individuals. We would suggest that the use of opioid medication or other constipating agents should not dissuade the practitioner from utilising SNM in this patient group.

Yours sincerely

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in the study involving human participants were in accordance with the ethical standards of the Trust and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent For this type of study formal consent is not required.

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