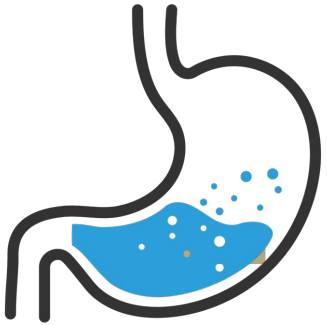
Dyspepsia

case



A 25 yo female patient, single, presented with recurrent episodes of ***dyspepsia*** described as pain mainly, sometimes related to food. Her pain started 1 year ago but became frequent (2-3 times a week) in the last 4 months.

History

Dyspepsia : is a general term describing upper abdominal non specific symptoms such as indigestion, bloating, discomfort, pain….

-Functional dyspepsia features:

Postprandial fullness

Early satiety

Epigastric pain

Epigastric burning

Symptoms for 3 months

-Onset , progression, duration, site, radiation, relieving and exacerbating factors

-Bowel motion

-Fever, chills and rigors

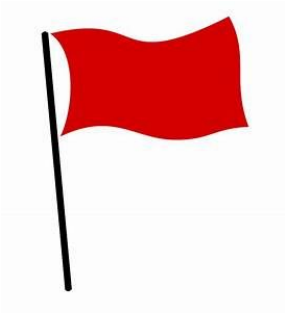
-Pregnancy , missed period if married

-Medications ; NSAIDS…

-Chest pain, sweating, SOB; cardiac?..

History

-Alcohol intake, history of gallbladder stones
-Past medical and surgical hx
-smoking
-Red flags?



History

When to refer for endoscopy ?

Alarm features (Red Flags) that may necessitate endoscopy include:

– Unintended weight loss
– Progressive dysphagia
– Odynophagia
– Persistent vomiting
– GI bleeding
– Family history of upper GI cancer
– Age ≥60 years; some references >50
- IDA
- Abdominal mass

Physical

-Document weight status and vital signs.
-Examine for signs of systemic illness
– Murphy sign for cholecystitis
– Rebound and guarding for ulcer perforation
- Abdominal masses
– Palpation during muscle contraction for abdominal wall pain
– Jaundice
– Thyroid enlargement

Differential diagnosis

Functional dyspepsia : accounts for 70% of dyspepsia the most common cause of dyspepsia.

Peptic ulcer disease

Gastroesophageal reflux disease

Cholecystitis; choledocholithiasis

Gastric or esophageal cancer

Esophageal spasm

Malabsorption syndromes; celiac disease

Pancreatic cancer; pancreatitis

Inflammatory bowel disease

Malabsorption

gastroparesis

Ischemic bowel disease

Intestinal parasites

Irritable bowel syndrome

Ischemic heart disease

Diabetes mellitus; Thyroid disease(masquerades)

Connective tissue disorders

Conversion disorder

Medication effects

Investigations

-If red flags present >> refer for upper endoscopy

-If not >> Order labs based on clinical Suspicion.

-Test for H. pylori (stool antigen or urea breath test) in areas of high H. pylori prevalence

-CBC (if anemia or infection are suspected)

-Liver-associated enzymes

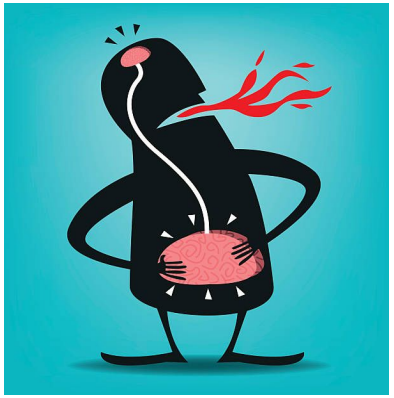
-right upper quadrant ultrasound (if hepatobiliary disease is suspected)

-Pancreatic enzymes (if pancreatic disease is suspected)

Esophageal manometry or gastric accommodation studies are rarely needed

Motility studies are unnecessary, unless gastroparesis is strongly suspected

Functional dyspepsia



A group of epigastric symptoms classified based on presenting symptoms:
The presence of bothersome postprandial fullness, early satiety, or epigastric pain/burning in the absence of causative structural disease (to include normal upper endoscopy) for at least 1 to 3 days per week for the preceding 3 months, with initial symptom onset at least 6 months prior to diagnosis **(Rome IV criteria)**

Rome IV criteria divide patients into two subtypes:

– Postprandial distress syndrome (PDS); mainly postprandial symptoms; early satiety, discomfort, nosea….

– Epigastric pain syndrome (EPS); mainly pain not related to food intake

Management

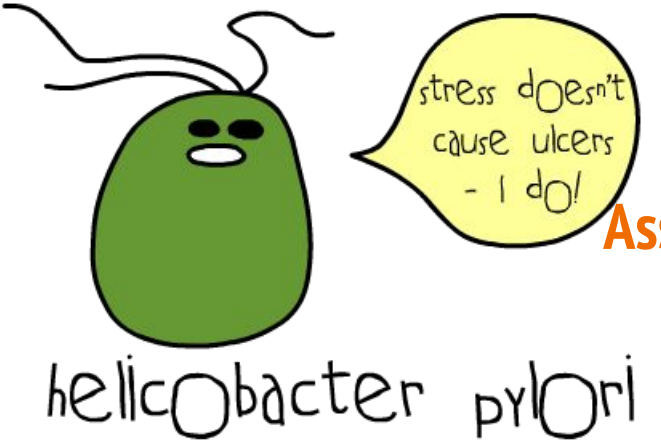
-Exclude red flags

-Reassurance and physician support are helpful

-Treatment is based on presumed etiologies.

-Discontinue offending medications

-**Test H.pylori and treat if positive (eradication therapy)**



If H.pylori is negative :
Assess predominant symptoms;

OR

– Postprandial distress syndrome (PDS)

-Trial of prokinetics, motility agents; *metoclopramide, domperidone*

-if improved continue for 3 months

-if not improved;

Try acid suppression

– Epigastric pain syndrome (EPS)

-Trial of acid suppression; *PPIs, H2 blockers.*

-if improved continue for 3 months

-if not improved; trial of Tricyclic Antidepressants (TCAs)

If not improved;

Try combination therapy; psychological measures

Refer

-Change medications if no difference in symptoms after 4 weeks

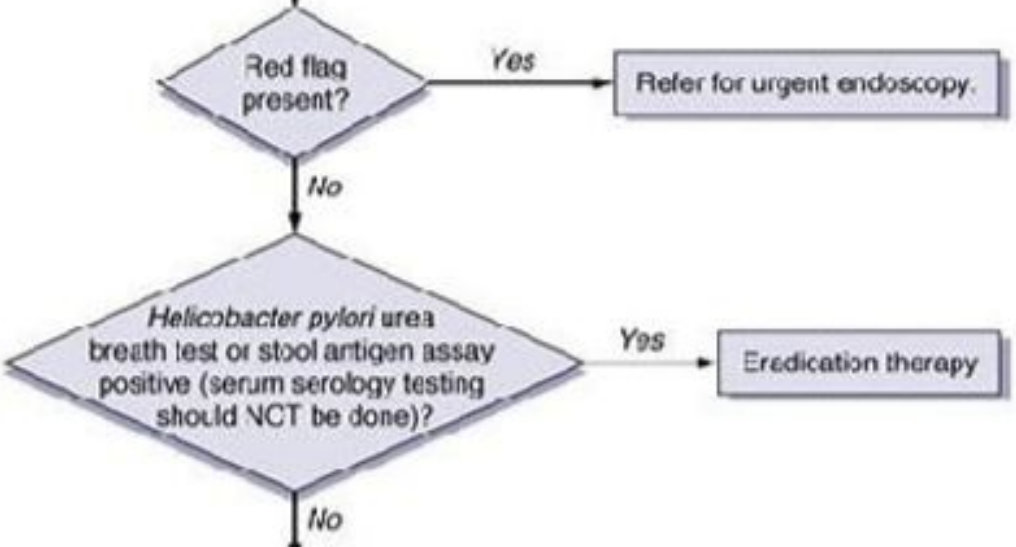
-Prokinetics should be prescribed at the lowest effective dose to avoid potential side effects; Use with caution in elderly patients due to side effects of tardive dyskinesia and parkinsonian symptom.

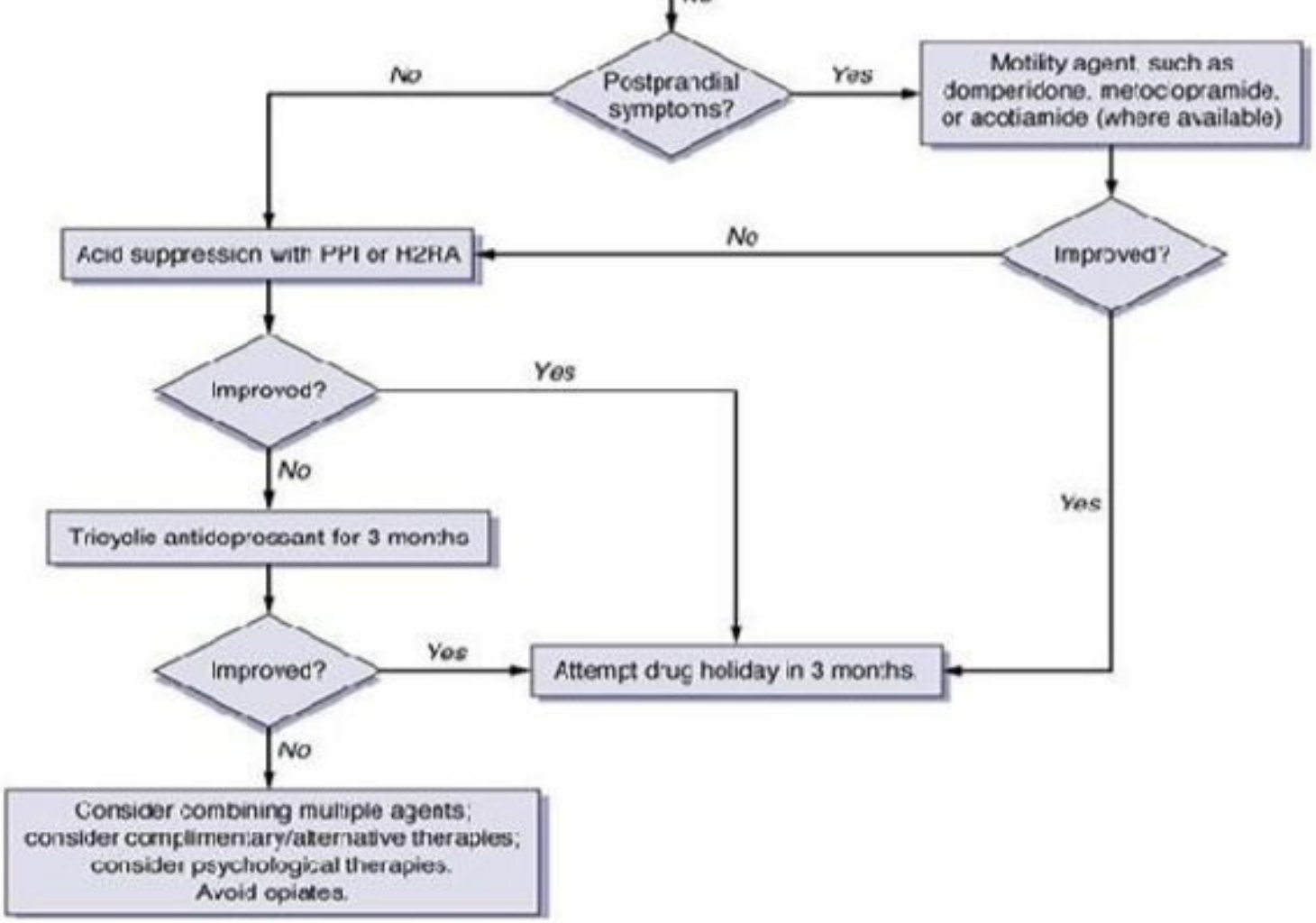
DYSPEPSIA

Common causes: peptic ulcer (<10%), gastroesophageal cancer (<1%), gastroparesis, functional dyspepsia (>70%)

Main forms of functional dyspepsia: **epigastric pain syndrome** (intermittent pain/burning in epigastrium at least weekly) and **postprandial distress syndrome** (at least several episodes weekly of bothersome fullness after meals or early satiety). The two syndromes may both be present in the same patient.

GI red flags: onset at age 55 years or later (lower threshold in areas where gastric cancer is common, e.g., Southeast Asia); overt GI bleeding; dysphagia; persistent vomiting; unintentional weight loss; family hx gastric or esophageal cancer; palpable abdominal/epigastric mass; abnormal adenopathy; iron deficiency anemia





Jennifer L. Hamilton, MD, PhD, FAAFP

Management

-Additional therapies

-Avoid foods that exacerbate symptoms: wheat and cow milk proteins, pepper or spices, coffee, tea, and alcohol

-Stress reduction

-Psychotherapy effective in some patients

-Patients should be given a positive diagnosis and reassured of benign Prognosis

-Alternative medicine approaches need further study and are not currently recommended

-Probiotics have theoretical benefit but few controlled trials

-Hypnotherapy may help

-Transcutaneous electroacupuncture may help

Thank you!