

# Approach to Patients with Epigastric Pain



Patrick Robinson, MD<sup>a,\*</sup>, John C. Perkins Jr, MD<sup>b</sup>

## KEYWORDS

- Epigastric pain • Dyspepsia • Esophagitis • Boerhaave syndrome
- Acute pancreatitis • Food bolus impaction

## KEY POINTS

- Emergency medicine providers must consider upper-gastrointestinal bleeding in patients presenting with epigastric pain and dyspepsia.
- Empirical trials of proton pump inhibitor therapy in patients with uncomplicated peptic ulcer disease have been shown to improve symptoms and increase the rate of ulcer healing.
- Patients with sudden onset of dysphagia, odynophagia, chest pain, and sialorrhea should be considered to have food bolus impaction and require involvement of gastrointestinal specialists to help determine the most appropriate management.
- Emergency medicine providers should maintain a high index of suspicion for more serious disorders of esophagitis in immunocompromised patients presenting with dyspepsia, odynophagia, and/or dysphagia.
- It is important to consider the broad differential diagnosis of an increased serum lipase level other than acute pancreatitis.
- Acute pancreatitis can have a wide spectrum of mortality and emergency medicine providers should use a Sequential Organ Failure Assessment score or BISAP (blood urea nitrogen, impaired mental status, systemic inflammatory response syndrome criteria, age, pleural effusion) criteria for appropriate disposition.

## INTRODUCTION

Abdominal pain is the most frequent presenting complaint in emergency departments (EDs) across the country and the emergency medicine provider (EMP) must be skilled at differentiating and managing this presentation.<sup>1</sup> Approximately 6% of chief complaints involve abdominal pain and, of these, 25% present with epigastric pain.<sup>2</sup>

---

Disclosure: The authors have nothing to disclose.

<sup>a</sup> Virginia Tech Carilion Emergency Medicine Residency, Department of Emergency Medicine, 1 Riverside Circle, 4th Floor, Roanoke, VA 24016, USA; <sup>b</sup> Virginia Tech Carilion Emergency Medicine Residency, Department of Emergency Medicine, Virginia Tech Carilion School of Medicine, 1 Riverside Circle, 4th Floor, Roanoke, VA 24016, USA

\* Corresponding author.

E-mail address: [Perobinson@carilionclinic.org](mailto:Perobinson@carilionclinic.org)

Emerg Med Clin N Am 34 (2016) 191–210  
<http://dx.doi.org/10.1016/j.emc.2015.12.012>

[emed.theclinics.com](http://emed.theclinics.com)

0733-8627/16/\$ – see front matter © 2016 Elsevier Inc. All rights reserved.

Abdominal complaints, including epigastric discomfort, can be complicated. A general understanding of visceral pain in the epigastric region with its distinct features can help ED providers understand the appropriate work-up for this complaint type.<sup>1</sup> Abdominal organs communicate stretch, ischemia, and nondescript pain via nociceptors that transmit signals via afferent receptors to the spinal cord.<sup>1</sup> Organs derived from the embryonic foregut, such as the esophagus, stomach, pancreas, biliary system, and proximal duodenum, can all produce pain located in the midline epigastric region.<sup>1</sup> Chest pain as the result of gastroesophageal reflux disease (GERD) and dysphagia are notoriously difficult to distinguish from cardiac disorders because esophageal disease can cause chest pain, but this diagnostic quandary is discussed in further detail elsewhere in this article.<sup>3</sup> This article discusses noncardiac emergency disorders associated with epigastric discomfort. Clinical features and diagnostic and therapeutic options are presented for EMPs trying to appropriately and efficiently evaluate and treat patients with epigastric discomfort, which has a large differential involving both severe and benign disorders.<sup>3</sup>

### ***Peptic Ulcer Disease/Gastritis***

Dyspepsia is any symptom of the upper gastrointestinal (GI) tract, including epigastric pain, heartburn, reflux, nausea, vomiting, or discomfort lasting greater than 4 weeks.<sup>4</sup> It is a common presentation thought to afflict 25% to 40% of the population every year.<sup>4,5</sup> This presentation should not be taken lightly, because some studies have shown the incidence of upper-GI bleed secondary to peptic ulcer disease (PUD) to be as high as 41 persons in 100,000 with an 8.7% risk of mortality.<sup>6</sup> One-quarter of those with dyspepsia are thought to have an underlying organic cause, whereas the other 75% have no identifiable disorder after further evaluation.<sup>5</sup> There has been a common notion that many lifestyle variables, such as smoking, coffee, alcohol, chocolate, obesity, and fat intake, precipitate dyspepsia but evidence does not support this notion.<sup>4</sup> EMPs should recognize that there is a subset of patients presenting with dyspepsia or epigastric pain associated with unique features listed in **Box 1** who should have stool guaiac testing in the ED.<sup>7</sup> A normal hemoglobin test and hematocrit can also be supportive evidence that the dyspepsia is not associated with a GI bleed.

#### **Box 1**

##### **Indications for stool guaiac testing**

- Symptoms of acute or chronic GI bleeding
- Physical signs of anemia (eg, pallor)
- New anemia on complete blood count
- Report of greater than 2 kg (4.5 lb) of weight loss in past 6 months
- Signs of enteric illness (eg, fever and diarrhea)
- Tenesmus
- History of GI malignancy
- Change in bowel habits
- Use of anticoagulants
- Significant use of nonsteroidal antiinflammatory drugs
- History of esophageal varices

Download English Version:

<https://daneshyari.com/en/article/3236598>

Download Persian Version:

<https://daneshyari.com/article/3236598>

[Daneshyari.com](https://daneshyari.com)