

Symptoms and signs of upper gastrointestinal disease

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Abstract

Patients with upper gastrointestinal (GI) disease present with diverse symptoms, which are linked to significant morbidity and relatively few reliable signs. Upper GI pathology may present as an acute abdomen, when clinical diagnostic accuracy is approximately 50%. The aim of this article is to provide a systematic approach for formulating a differential diagnosis in patients with common symptoms and signs of upper GI disease, highlighting red flags for serious pathology.

Keywords belching; chest pain; dyspepsia; dysphagia; gastro-oesophageal reflux; hiccups; nausea; upper abdominal pain; vomiting

Introduction

Upper gastrointestinal (GI) disease presents with a variety of symptoms. It is essential that clinicians are able to formulate a differential diagnosis, investigate appropriately and rule out serious pathology urgently. This article will highlight important differential diagnoses, and aims to give guidance on the assessment of patients presenting with diverse symptom complexes.

Swallowing difficulties (dysphagia, odynophagia)

Dysphagia can be divided into two distinct groups: oropharyngeal and true oesophageal dysphagia. Identification of the type of dysphagia is important as the likely pathology, investigations and treatment pathways are different.

Oropharyngeal dysphagia

The voluntary, oropharyngeal swallow requires activation of a complex neurological pathway, damage to any part of which can lead to impairment. Clues in the history might be difficulty initiating a swallow, choking, coughing or nasal regurgitation of food. On examination, there may be delayed swallowing, coughing, or a wet voice, due to pooling in the pharynx. Dysarthria and cognitive impairment may point to an underlying

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What's new?

- Eosinophilic oesophagitis (EO) is a condition that is fast emerging as an important cause of dysphagia and may be present in up to 15% of patients referred for upper gastrointestinal investigation of this symptom¹
- In patients with gastroparesis refractory to medical treatment, a gastric pacemaker can be inserted in selected patients. This has been shown to improve symptoms and reduce the need for nutritional support

neurological cause (see below). If a patient repeatedly chews food and spits it out before swallowing, consider dementia or an underlying psychiatric condition.

Oesophageal dysphagia

Impairment of the involuntary, oesophageal swallow leads to compromised function and disorganized coordination of the oesophageal musculature. This can occur as a result of mechanical obstruction or narrowing (stricture), achalasia with a hypertonic lower oesophageal sphincter, oesophageal body dysmotility, or systemic disorders including connective tissue disorders such as systemic sclerosis; the latter may be evident on systemic examination of the patient.

Oesophageal dysphagia can be progressive or acute. Complete acute dysphagia, where a patient is unable to swallow their saliva, is a medical emergency requiring hospital admission. Food bolus impaction is the most common cause of the sudden onset of complete or partial dysphagia and an oesophagogastroduodenoscopy (OGD), with bolus removal, should be performed within 24 hours.² Prolonged food bolus impaction can result in oesophageal ulceration and potential perforation. A chest X-ray is indicated if history suggests ingestion of a sharp object, or if there are concerns of pharyngeal perforation.

In young patients with atopy or recurrent food bolus obstruction, consider eosinophilic oesophagitis (EO). Long-standing EO may present with oesophageal stricturing. Biopsies from the mid- and distal oesophagus support the diagnosis and treatments include topical corticosteroids (i.e. swallowing a metered dose of corticosteroid aerosol).

Dysphagia to solids, particularly if restricted to certain foods, is likely to indicate an obstructive lesion. However, if dysphagia is equal to liquids and solids, or intermittent, consider dysmotility or inflammatory causes (see below). Progressive dysphagia is a red-flag symptom, often indicating a worsening obstructive lesion, usually a peptic stricture or oesophageal carcinoma. Ask patients about the presence or absence of reflux symptoms, the duration of symptoms and regurgitation of undigested food after the initial swallow. Do not forget systemic symptoms such as weight loss, anorexia and change of taste, which may indicate underlying malignancy.

Globus sensation is a diagnosis of exclusion where patients describe a 'lump' in their throat, like a 'boiled sweet'. This is usually not related to food ingestion, but may occur on swallowing saliva. This can be intermittent and may occur during times of stress.

Odynophagia

Odynophagia (painful swallowing) is often mistaken for dysphagia. If odynophagia is sudden in onset, consider ingested (caustic) substances and foreign bodies. An emergency OGD may be required to assess mucosal damage to the upper GI tract, which aids prognostication, assessment of the development of strictures and possible therapy (removal of foreign bodies).

The leading cause of odynophagia is candidiasis. Odynophagia may be preceded by other symptoms that may point to the aetiology of the pain (e.g. heartburn may indicate reflux oesophagitis). A drug history is essential (e.g. corticosteroids leading to oesophageal candidiasis or bisphosphonates causing oesophageal ulceration/stricturing) (Table 1).

Investigation pathway

Patients with oropharyngeal dysphagia should undergo a thorough neurological examination and assessment from the speech and language team. They are then investigated with video-fluoroscopy and may need referral to a neurologist for consideration of further investigations, as appropriate.

All patients with oesophageal dysphagia should be urgently investigated, usually with an OGD under the 2-week wait rule, if malignancy is suspected. If dysmotility is the suspected diagnosis, patients should have a barium swallow examination and be considered for oesophageal manometry. Patients with reflux often describe the sensation of difficulty with swallowing.

Differential diagnosis of swallowing problems

Category	Differential
Extrinsic compression	Thyroid mass, thoracic aortic aneurysm, osteophytes and skeletal abnormalities, enlarged left atrium, nodal mass, lung cancer
Obstructive	Pouch, diverticulum, web, Schatzki ring, benign stricture, radiation stricture, oesophageal cancer, food bolus
Inflammatory	Eosinophilic oesophagitis, chemical ingestion, gastro-oesophageal reflux disease, pill oesophagitis
Infective	CMV, HSV, candida
Motility	Achalasia, oesophageal dysmotility, scleroderma, connective tissue disorders
Neuromuscular	Dementia, cerebral trauma, stroke, Guillain–Barré syndrome, movement disorders (e.g. Huntington's chorea), multiple sclerosis, encephalopathy, motor neurone disease, brainstem tumours
Psychological	Anxiety, depression, globus sensation
Other	Xerostomia
Odynophagia	Candida, viral oesophagitis (HSV, CMV), ingestion of corrosive substance, foreign body, dissecting intramural oesophageal haematoma (rare)

CMV, cytomegalovirus; HSV, herpes simplex virus.

Table 1

Around 10% of referrals with dysphagia/dyspepsia under the 2-week wait for upper GI cancer are found to have a malignant diagnosis.³ The presence of candidiasis without obvious cause should raise the possibility of HIV or occult underlying malignancy.⁴

Dyspepsia and reflux

Dyspepsia is common; around 40% of adults experience this symptom annually.⁵ It is defined as pain or discomfort in the upper abdomen and may be associated with other symptoms, such as early satiety, bloating, borborygmi or heartburn. A clear description is helpful in the history as patients may have very different ideas of 'indigestion pain' than those ascribed to dyspepsia by the medical profession. It is important to establish the nature and site of the pain, exacerbating and relieving factors, relation to food and the benefit of medications such as proton pump inhibitors. Pain may be nocturnal, periodic or radiating through to the back, sometimes with post-prandial exacerbation. Associated symptoms such as vomiting, nausea, weight loss, reflux and belching should be part of direct questioning. A drug history may also support diagnosis, for example in patients taking non-steroidal anti-inflammatory drugs.

If a patient complains of worsening pain, early satiety, persistent vomiting and systemic features, such as anaemia and unintentional weight loss, they should be investigated urgently. Abnormal laboratory findings, such as anaemia, or a raised platelet count or serum C-reactive protein, increase the likelihood of organic pathology such as malignancy, inflammatory disease or bleeding peptic ulcer disease.

Investigation pathway

In certain circumstances, dyspepsia can be a red-flag symptom and warrant urgent investigation. If patients present with dyspepsia and upper GI bleeding, they should be referred urgently, on the same day, to a gastroenterologist.⁶

In patients who do not meet the criteria for urgent referral, testing for *Helicobacter pylori* and eradication, if positive, followed by a trial of proton pump inhibitor is an appropriate management strategy. Recent guidelines state that patients of any age with gastro-oesophageal symptoms that are unexplained or do not respond to treatment should be referred to a gastroenterologist and considered for an OGD.⁶ Endoscopy may reveal a hiatus hernia, reflux oesophagitis, Barrett's oesophagus, peptic ulcer disease or an underlying malignancy.

In patients with a normal endoscopic examination, especially those whose dyspepsia is associated with other systemic features, such as weight loss or diarrhoea, rarer causes should be considered; these include coeliac disease, pancreatic pathology, 'intestinal angina' (mesenteric ischaemia) and metabolic causes (e.g. hypercalcaemia). Infiltrative conditions (e.g. sarcoid, Crohn's disease) may be detected on biopsy of the gastric mucosa, or occasionally have a recognizable macroscopic appearance at endoscopy (e.g. 'bamboo stomach' in Crohn's disease of the upper GI tract).

Non-ulcer dyspepsia is a diagnosis of exclusion and should be diagnosed according to the Rome III criteria for functional GI conditions.⁷ *H. pylori* status should be checked as around 7% of patients will respond to eradication therapy.^{8,9}

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