PRESENTING PROBLEMS IN GASTROINTESTINAL DISEASE

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Dysphagia

Dysphagia is defined as difficulty in swallowing. It may coexist with heartburn or vomiting

odynophagia (pain during swallowing, usually from gastro-oesophageal reflux or candidiasis).

Dysphagia can occur due to

Oropharyngeal disorders affect the initiation of swallowing at the pharynx and upper oesophageal sphincter. The patient has difficulty initiating swallowing and complains of choking, nasal regurgitation or tracheal aspiration. Drooling, dysarthria, hoarseness and cranial nerve or other neurological signs may be present.

Oesophageal disorders cause dysphagia by obstructing the lumen or by affecting motility. Patients with oesophageal disease complain of food ‘sticking’ after swallowing, although the level at which this is felt correlates poorly with the true site of obstruction. Swallowing of liquids is normal until strictures become extreme.

8.7 Causes of dysphagia

Oral

- Tonsillitis, glandular fever, pharyngitis, peritonsillar abscess
- Painful mouth ulcers

Neurological

- Bulbar or pseudobulbar palsy
- Cerebrovascular accident

Neuromuscular

- Achalasia
- Pharyngeal pouch
- Myasthenia gravis
- Oesophageal dysmotility

Mechanical

- Oesophageal cancer
- Peptic oesophagitis
- Other benign strictures, e.g. after prolonged nasogastric intubation
- Extrinsic compression, e.g. lung cancer
- Systemic sclerosis

8.8 Symptom checklist in dysphagia

- Is dysphagia painful or painless?
- Is dysphagia intermittent or progressive?
- How long is the history of dysphagia?
- Is there a previous history of dysphagia or heartburn?
- Is the dysphagia for solids or liquids or both?
- At what level does food stick?
- Is there complete obstruction with regurgitation?

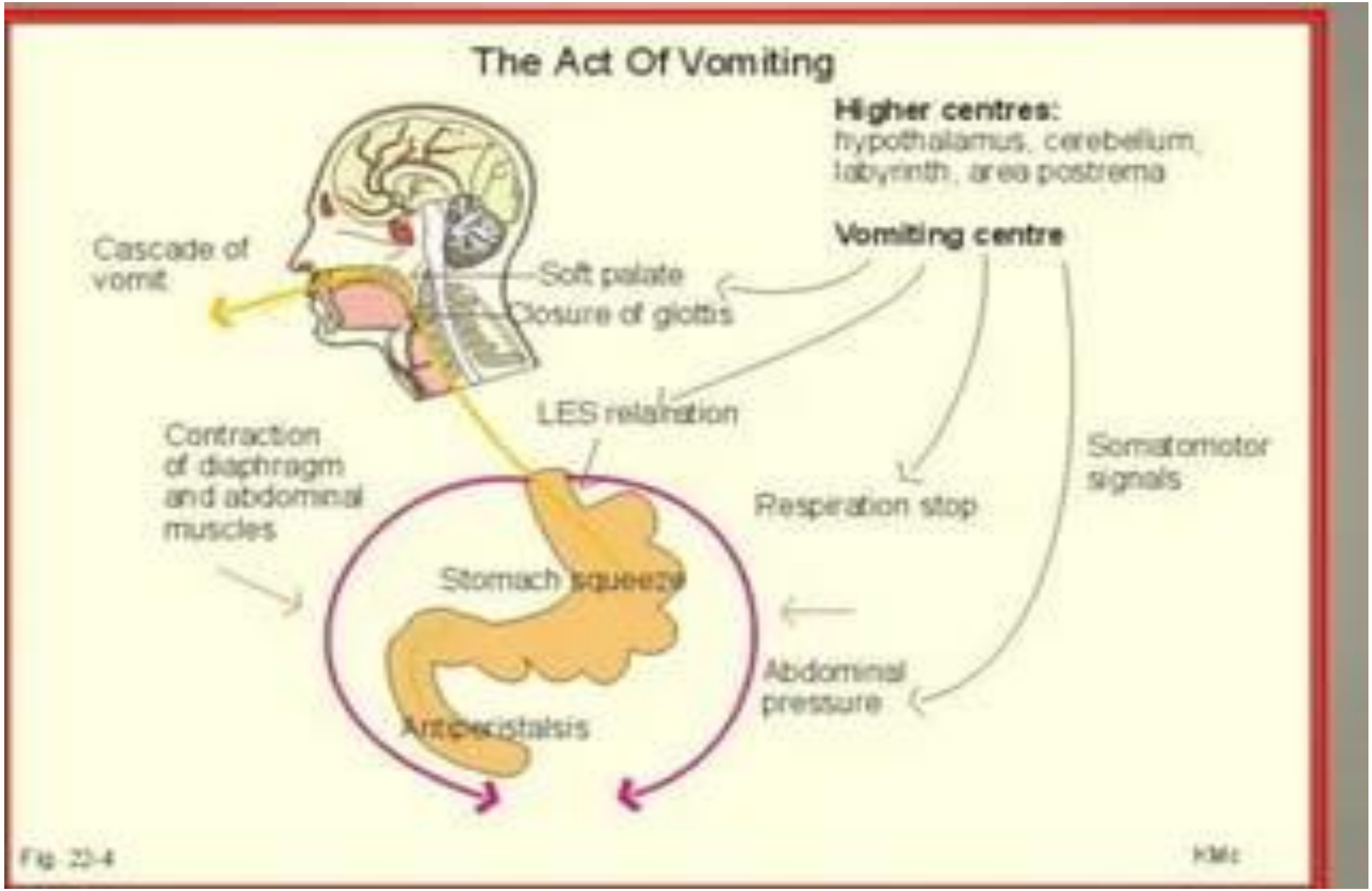
Nausea and vomiting

Nausea is the sensation of feeling sick.
Vomiting is the expulsion of gastric contents via the mouth.

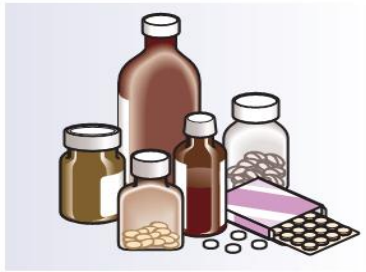
Both are associated with pallor, sweating and hyperventilation. Nausea and vomiting, particularly with abdominal pain or discomfort, suggest upper gastrointestinal disorders.

Remember to consider non-gastrointestinal causes of nausea and vomiting, especially adverse drug effects, pregnancy and vestibular disorders

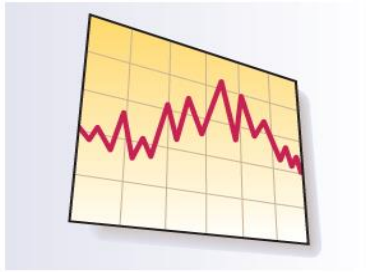
Vomiting is a complex reflex involving both autonomic and somatic neural pathways. Synchronous contraction of the diaphragm, intercostal muscles and abdominal muscles raises intra-abdominal pressure and, combined with relaxation of the lower oesophageal sphincter, results in forcible ejection of gastric contents.


The Act Of Vomiting
Higher centres:
hypothalamus, cerebellum,
labyrinth, area postrema
Vomiting centre
Cascade of vomit
Soft palate
Closure of glottis
LES relaxation
Contraction of diaphragm and abdominal muscles
Resperation stop
Somatomotor signals
Stomach squeeze
Abdominal pressure
Antiperistalsis
Fig. 22-4

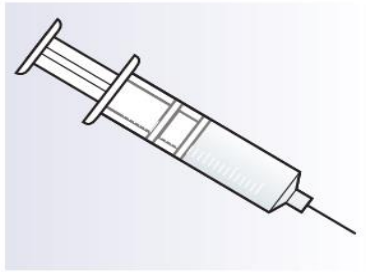
Alcoholism



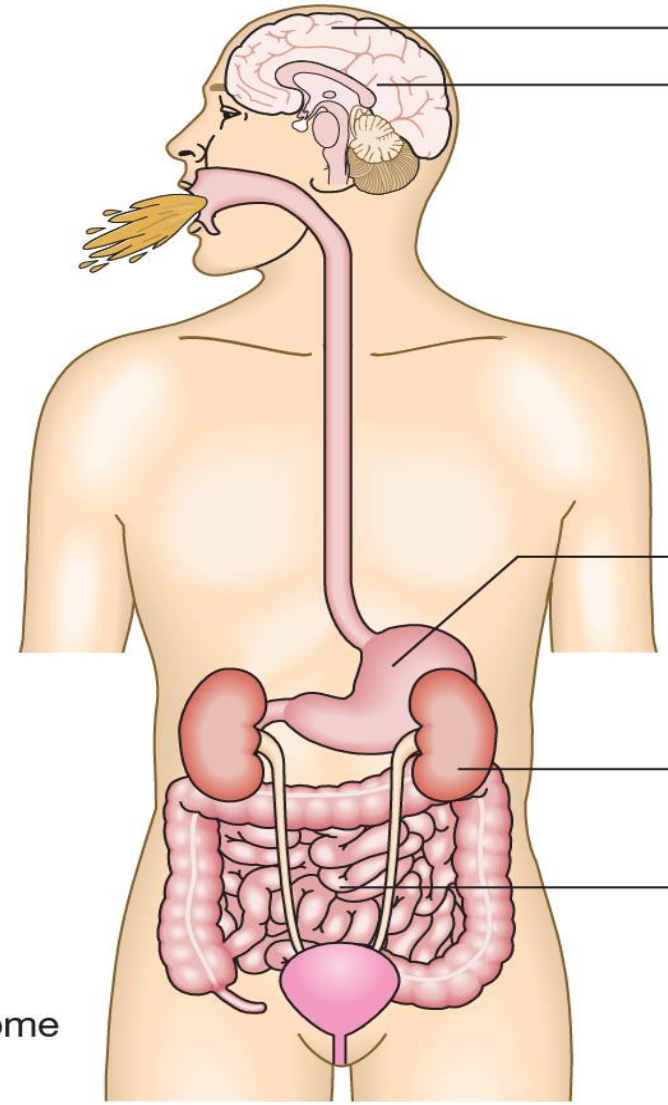
Drugs
- NSAIDs
- Opiates
- Digoxin
- Antibiotics
- Cytotoxins



Infections
- Hepatitis
- Gastroenteritis
- Urinary tract infection



Metabolic
- Diabetic ketoacidosis
- Addison's disease
- Cyclical vomiting syndrome



Psychogenic

CNS disorders
- Vestibular neuronitis
- Migraine
- Raised intracranial pressure
- Meningitis

Gastroduodenal
- Peptic ulcer disease
- Gastric cancer
- Gastroparesis

Uraemia

The acute abdomen
- Appendicitis
- Cholecystitis
- Pancreatitis
- Intestinal obstruction

Fig. 22.17 Causes of vomiting.

8.10 Symptom checklist in vomiting

- What medications has the patient been taking?
- Is vomiting:
  - heralded by nausea or occurring without warning?
  - associated with dyspepsia or abdominal pain?
  - relieving dyspepsia or abdominal pain?
  - related to mealtimes, early morning or late evening?
  - bile-stained, blood-stained or faeculent?

Diarrhoea

Diarrhoea is also subjective, but the regular passage of more than three stools per day, or the passage of a large amount of stool (more than 200 gm per day) can certainly be called diarrhoea.

Diarrhoea is the frequent passage of loose stools.

Normal bowel movement frequency ranges from three times daily to once every 3 days. The most severe symptom in many patients is urgency of defecation, and faecal incontinence is a common event in acute and chronic diarrhoeal illnesses.

Acute diarrhoea is common as a result of dietary indiscretion or from viral or bacterial infection.

Chronic diarrhoea should raise the possibility of inflammatory bowel disease or malabsorption with steatorrhoea.

Steatorrhoea is the passage of pale, bulky stools containing excess fats that commonly float in water and are difficult to flush away. Steatorrhoea is diarrhoea associated with fat malabsorption.

8.13 Causes of diarrhoea

Acute

- Infective gastroenteritis, e.g. *Clostridium difficile*
- Drugs (especially antibiotics)

Chronic (>4 weeks)

- Irritable bowel syndrome
- Inflammatory bowel disease
- Parasitic infestations, e.g. *Giardia lamblia*, amoebiasis, *Cryptosporidium* spp.
- Colorectal cancer
- Autonomic neuropathy (especially diabetic)
- Laxative abuse and other drug therapies
- Hyperthyroidism
- Constipation and faecal impaction (overflow)
- Small-bowel or right colonic resection
- Malabsorption, e.g. lactose deficiency, coeliac disease

8.14 Symptom checklist in patients with diarrhoeal disorders

- Is diarrhoea acute, chronic or intermittent?
- Is there tenesmus, urgency or incontinence?
- Is the stool:
  - watery, unformed or semisolid?
  - large-volume and not excessively frequent, suggesting small-bowel disease?
  - small-volume and excessively frequent, suggesting large-bowel disease?
  - associated with blood, mucus or pus?
- Is sleep disturbed by diarrhoea, suggesting organic disease?
- Is there a history of:
  - contact with diarrhoea or of travel abroad?
  - relevant sexual contact ('gay bowel syndrome', human immunodeficiency virus (HIV))?
  - alcohol abuse or relevant drug therapy?
  - gastrointestinal surgery, gastrointestinal disease or inflammatory bowel disease?
  - family history of gastrointestinal disorder, e.g. gluten enteropathy, Crohn's?
  - any other gastrointestinal symptom, e.g. abdominal pain and vomiting?
  - systemic disease suggested by other symptoms, e.g. rigors or arthralgia?

Constipation

Constipation is the infrequent passage of hard stools and may be due to impaired colonic motility, physical obstruction, impaired rectal sensation or anorectal dysfunction causing anismus (impaired process of evacuation)

Absolute constipation (no gas or bowel movements) suggests intestinal obstruction and is likely to be associated with pain, vomiting and distension.

Tenesmus, the sensation of needing to defecate although the rectum is empty, suggests rectal inflammation or tumour

8.16 Symptom checklist in patients with constipation

- Has constipation been lifelong or is it of recent onset?
- How often do the bowels empty each week?
- How much time is spent straining at stool?
- Is there associated abdominal pain, anal pain on defecation or rectal bleeding?
- Has the shape of the stool changed, e.g. become pellet-like?
- Has there been any change in drug therapy?

8.17 Causes of constipation

- Lack of fibre in diet
- Irritable bowel syndrome
- Intestinal obstruction (cancer)
- Drugs (opioids, iron)
- Metabolic/endocrine (hypothyroidism, hypercalcaemia)
- Immobility (stroke, Parkinson's disease)

- THANK YOU