CHRONIC EPIGASTRIC & NON-CARDIAC CHEST PAIN

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Peptic ulcer
Case 1

- 65 yrs old lady
- HT, DM, IHD with PTCA 6 yrs ago
- On multiple medication include aspirin
- Heavy smoker
- Epigastric pain x 6 mths with weight loss
- Pain: dull & cramping
- Onset: 15 mins to 30 mins after diet
- Association: vomiting & Diarrhoea
- Subsided spontaneously
- No physical sign in abdomen
- Sign of PVD +
- Investigation:
• Blood: no anaemia
• OGD: no ulcer
• USG: no gallstone
• CT: no mass lesion found, pancreas normal
- Worrying symptom
- Nothing found ?!
CTA found stenosis of celiac & SMA origin

Chronic Mesenteric ischemia / bowel angina
PTCS done
Characteristic Features of the Pain of Abdominal Angina

The 7 characteristics of the patient's pain provide the most valuable clues for recognition of abdominal angina. These are the same characteristics appropriate for recognizing angina pectoris, but have substantially different features for abdominal angina.

1. Location of the pain is poorly localized around the umbilicus or in the epigastrium.

2. Radiation may occur at back but radiation is frequently absent.

3. Quality of the pain varies from a dull ache in some patients to a colicky pain in others. Lack of associated tenderness is characteristic but is present in most other painful conditions.

4. Intensity is usually sufficient severe to discourage eating and to lead to severe loss of weight. It is greater than one might expect with the limited physical findings.

5. Duration varies from few minutes to an hour or more and correlates with intestinal function. It gradually increases, reaches a plateau, and then decreases several hours after eating.

6. Fluctuation and periodicity are characteristic and pain-free intervals separate the attacks that are ordinarily correlated with eating and lead to food avoidance behavior and weight loss.

7. Circumstances surrounding the occurrence and subsidence of the pain are correlated with intestinal function. Ordinarily, it begins 15-30 minutes after meals, but may be delayed by as much as 2 hours if gastric emptying is delayed. The patient often prefers hunger to pain, eats infrequently in small amounts (the "small meal" syndrome [3]). Mideau not invariably present: atherosclerosis elsewhere, weight loss, assuming some relief from prone or squatting position, sitophobia, fear of eating, functional bowel disturbance with fatty stools.
Case 2

- 25 yrs lady
- Good past health
- Un-employed
- Smoker
- Repeated attack of epigastric pain for 2 yrs
- No systemic symptom
- No physical sign
- Tattoo found
Investigation:
- Blood
- OGD
- USG
- All normal
- No effect to antacid & anti-spasmodic drug
- Admission as drug overdose after ketamine abuse
- Refer to psychiatry for drug cessation programme
- Symptom improved
A retrospective survey on the clinical presentation of ketamine abusers in a Hong Kong emergency department

目的：在香港我們發現，對於中毒者的临床表现，我們需要了解他們和中毒者求診時的臨床表現形式。方法：這是一個回顧性的研究。研究對象是氯胺酮中毒者。他們是由急症科以外的地方轉介來的。對照組是由急症室內的病人隨機選擇出來的。我們審閱和分析了過去三年（2004年4月1日至2007年3月31日）氯胺酮中毒者和對照組的電子記錄病歷。結果：研究中包括91人（氯胺酮中毒組有48人，對照組有43人）。氯胺酮中毒組和對照組的平均年齡分別為21和22.2。大多數（97.9%）病人不會告訴我們有氯胺酮中毒的可能。氯胺酮中毒組和對照組的平均3年就診率分別為2.38和0.907，有1.47的差別（95%信心區間為0.54-2.41，p=0.003）。大多數病人的診斷是上腹痛（25%），接下來就是上呼吸道感染（18.8%），頭外傷（10.4%）和尿道感染（10.4%）。氯胺酮中毒者患胃病的風險與對照組比較具有明顯的上升。（勝算比143，p<0.001）。結論：大多數年輕氯胺酮中毒者當他們到急症室求診時都不會告訴別人他們中毒的背景。他們傾向有較多的求診率。大多數求診的原因與胃腸道有關。
Upper gastrointestinal problems in inhalational ketamine abusers.

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Abstract

OBJECTIVE: To study the association between upper gastrointestinal (GI) problems and inhalational ketamine abuse.

METHODS: This is a retrospective study of 64 ketamine abusers treated from 2001 to 2008. Variables studied included clinical presentations, findings of upper GI endoscopy, abstinence from ketamine and relief of epigastric pain.

RESULTS: The following patients with (i) a previous history of upper GI problem; (ii) a history of non-steroidal anti-inflammatory drug (NSAID), aspirin or other substance abuse; and (iii) a known history of Helicobacter pylori (H. pylori) infection were excluded. The study group thus consisted of 37 ketamine abusers, of whom 28 had upper GI symptoms. Overall 14 of these patients had an upper endoscopy performed. The endoscopic diagnoses were: 12 (85.7%) with gastritis, one (7.1%) with gastroduodenitis, and one (7.1%) normal finding. Test for H. pylori, infection was negative. Abstinence from ketamine was found to be associated significantly with relief of symptoms (P= 0.027). Logistic regression showed the odds ratio of symptomatic relief for abstinence versus continued use of ketamine is 12.5 (95% CI[1.20, 130.6], P= 0.035). In patients whom an upper GI endoscopy was performed, H. pylori negative gastritis was the commonest histopathological finding (78.6%). Despite the use of medications, symptoms are commonly not relieved and that is associated with the continued abuse of ketamine.

CONCLUSION: Ketamine abusers frequently presented with upper GI symptoms, the commonest of which is epigastric pain (73% of abusers). Abstinence from ketamine abuse can lead to the relief of symptoms, which is an important message for ketamine abusers.
Case 3

- 50 yrs old lady
- Obese
- Smoker
- IHD on aspirin & TNG
- Coro done: no significant stenosis requiring intervention
- Dull retro-sternal chest discomfort for 2 years
- Some angina-like attack with radiation to jaw & back
- Also with heart burn symptom & occasional non-progressive dysphagia
- Angina symptom not well controlled by the usual medication
- New onset of GERD
- +/- progressive IHD
- Refer to cardiologist to rule out worsening condition of IHD
- Work up for GERD
Reflux esophagitis
- Proton pump inhibitor given
- Symptom partially improve
- Occasional dysphagia same
Cardiologist reply:
Coro: no new lesion found, stenosis same
What next?
Barium swallow
Manometry

Diffuse esophageal spasm

WS

Simultaneous contraction

Peristaltic contraction

Prox

Mid

Distal
- Well control of GERD
- Diet modification- cold/ hot food & drink
- Calcium channel blocker
- Anti-depressant
- Endoscopic treatment
- Surgery
Case 4

- 80 yrs old lady
- IHD with CABG done, HT
- GERD symptom
- Increase in retrosternal chest discomfort after meal in recent 1 year
- Nausea & vomiting of undigested food recently
Investigation:
OGD:
CT thorax:
Hiatal hernia with gastric volvulus
- With visceral rotation – can lead to gastric volvulus & subsequent strangulation of stomach (33%)
- Surgical emergency due to potential ischaemia
- Borchardt’s triad: Pain, retching without vomiting, inability to pass NG tube (in 70% of patient with strangulation)
- Surgical treatment: Laparoscopic repair of hiatal hernia with fundoplication
Conclusion

- Organ-specific
- Vascular
- Drug/substance abuse
- Psychological /social
Conclusion

- Join-specialty input for complex cases