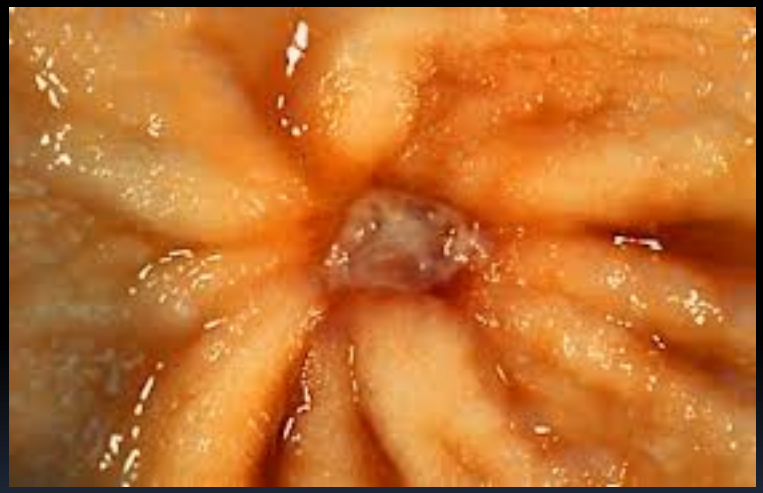
CHRONIC EPIGASTRIC & NON-CARDIAC CHEST PAIN

Dr. Tsang Shiu Hei
Department of Surgery
United Christian Hospital

Peptic ulcer



Case 1

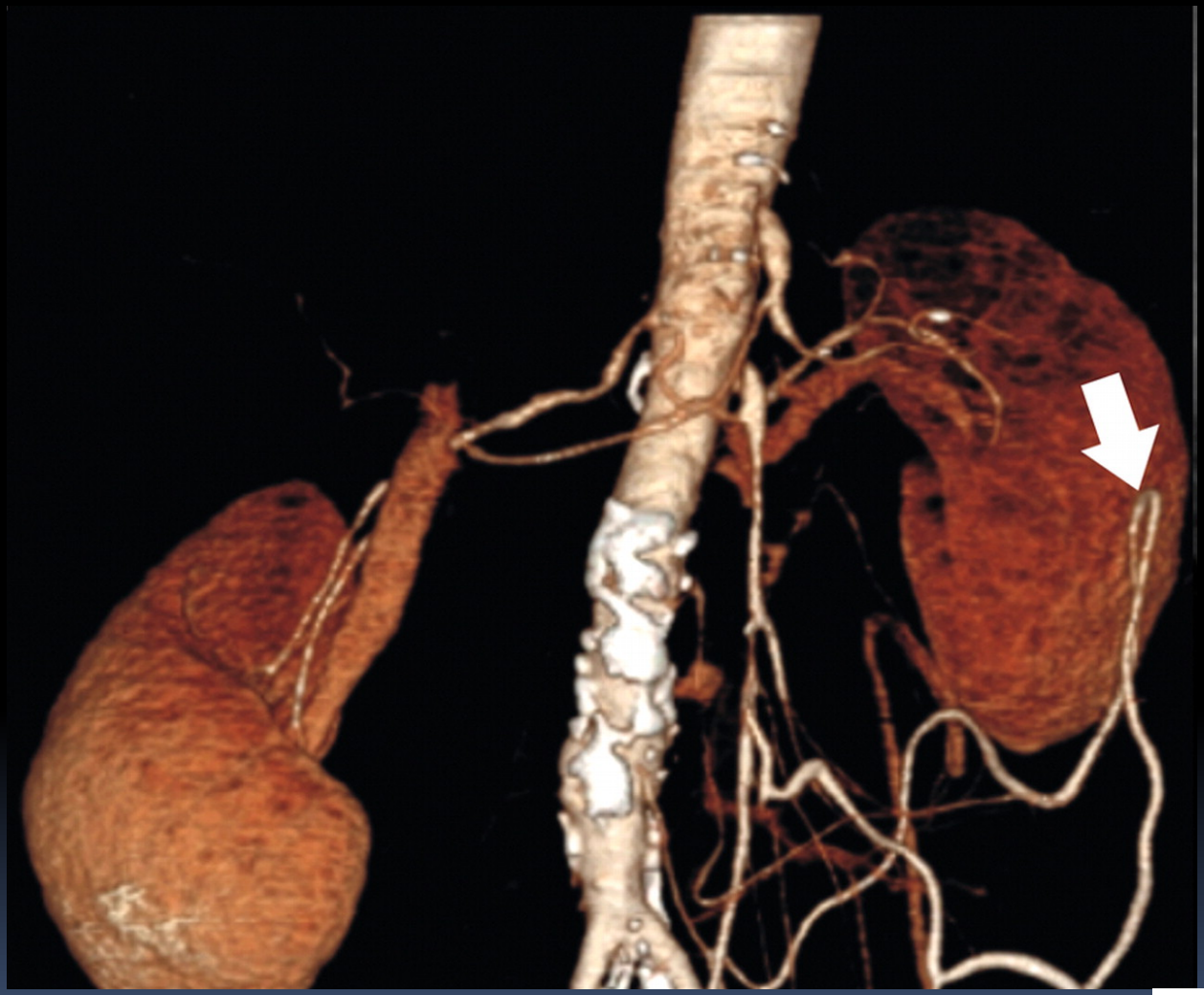
- 65 yrs old lady
- HT, DM, IHD with PTCA 6 yrs ago
- On multiple medication include aspirin
- Heavy smoker

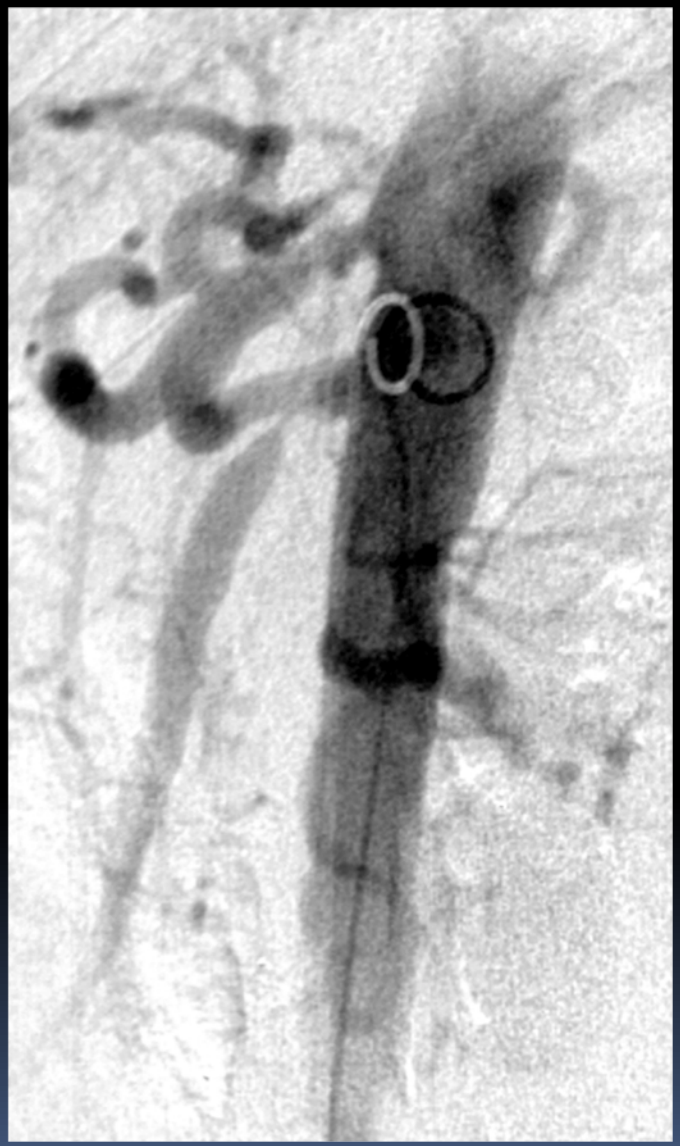
- Epigastric pain x 6 mths with weight loss
- Pain: dull & cramping
- Onset: 15 mins to 30 mins after diet
- Association: vomiting & Diarrhoea
- Subsided spontaneously

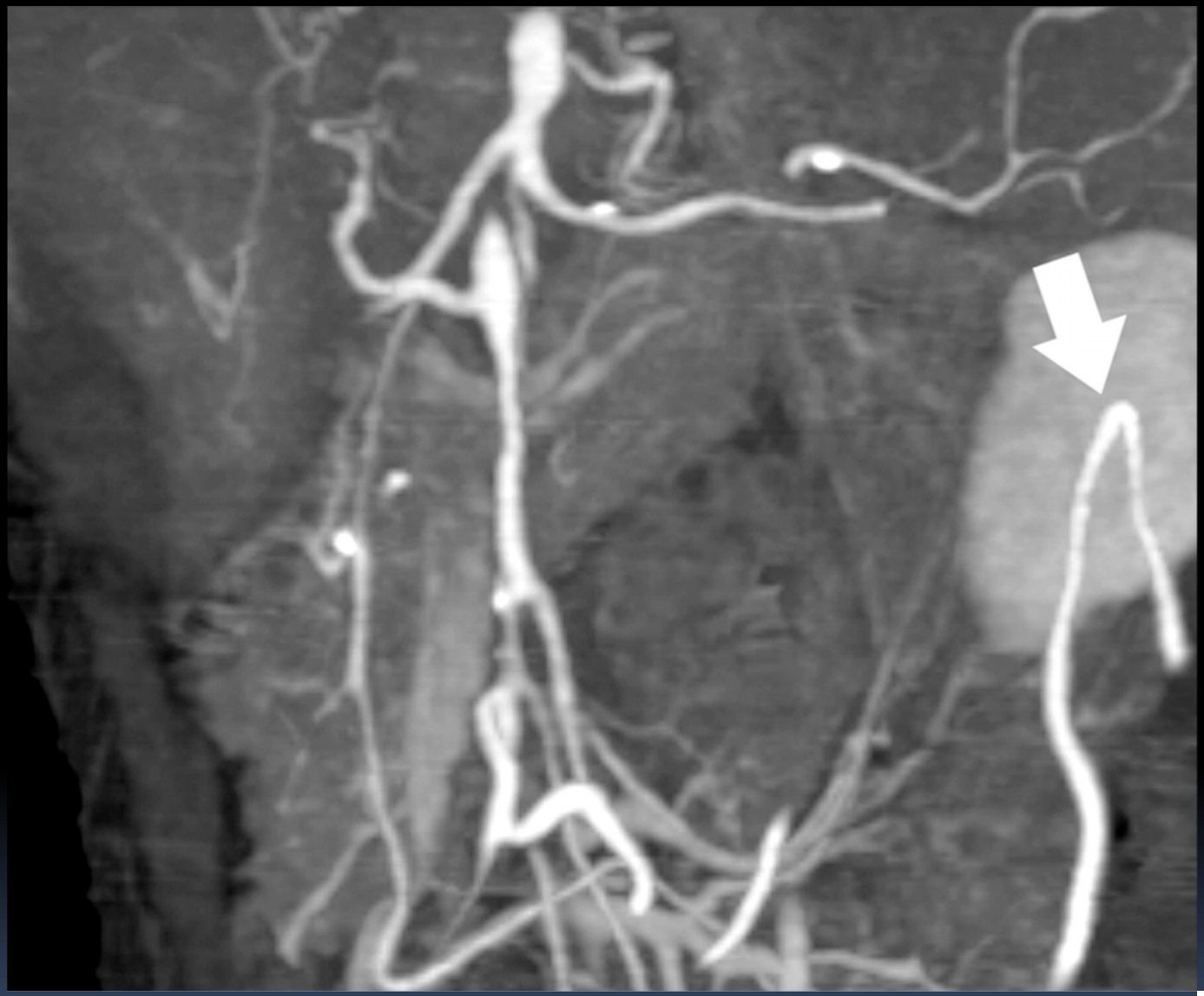
- No physical sign in abdomen
- Sign of PVD +
- Investigation:

- Blood: no anaemia
- OGD: no ulcer
- USG: no gallstone
- CT: no mass lesion found, pancreas normal

- Worrying symptom
- Nothing found ?!



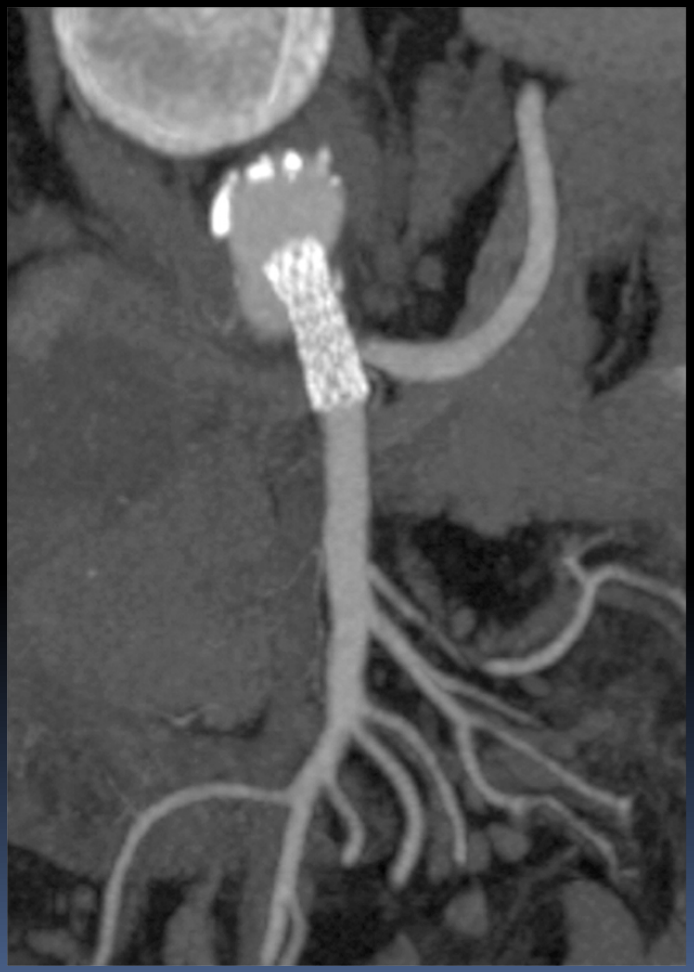




- CTA found stenosis of celiac & SMA origin

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 the pain, eats infrequently in small amounts (the "small meal" syndrome [3]). Mileau 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

Hong Kong Journal of Emergency Medicine

A retrospective survey on the clinical presentation of ketamine abusers in a Hong Kong emergency department

一個香港急症科有關 ketamine（氯氨酮）濫藥者臨床表現的回顧性研究

HKH Lee 李家慶, HW Ng 吳漢華, ML Tse 謝嵩里, FL Lau 劉飛龍

Objective: Ketamine is one of the commonest abusing agents in Hong Kong. Our study aims to identify their clinical pattern of presentations to emergency departments. ***Method:*** This is a retrospective survey study. The studied group was ketamine abusers being referred to us from a source out of emergency department (ED). Control group was randomly selected from patients attending our ED. The electronic records of the ketamine abusers and the controls in the past 3 years (1st April 2004-31st March 2007) were reviewed and analysed. ***Results:*** Total 91 subjects (48 in ketamine group, 43 in control group) were included. The mean age of ketamine abusers and control group are 21 and 22.2 year-old respectively. Most of them (97.9%) did not declare their background of ketamine abuse. The mean 3-year attendance rate for the ketamine group was 2.38 and for control group was 0.91, with a difference of 1.47 (95% CI 0.54-2.41, p=0.003). Most of their illnesses were diagnosed as epigastric pain (25%), followed by upper respiratory tract infection (18.8%), head injury (10.4%) and urinary tract infection (10.4%). Significantly higher number of ketamine abusers presented with epigastric pain compared with control group (odds ratio 143, p<0.001). ***Conclusion:*** Most teenage ketamine abusers do not declare their background of drug abuse when they present to emergency departments. They tend to have a higher frequency of attendances. Most of their presenting problems are related to gastrointestinal system. (Hong Kong j.emerg.med. 2011;18:210-216)

目的：在香港氯氨酮是最常見的濫用藥物之一。我們研究的目的是要了解他們在急症室求診時的臨床表現形式。**方法**：這是一個回顧性的研究。研究對像是氯氨酮濫藥者。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）氯氨酮濫藥者和對照組的電子記錄病歷。**結果**：研究中包括 91 人（氯氨酮濫藥組有 48 個人，對照組有 43 個人）。氯氨酮濫藥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氨酮濫藥的背景。氯氨酮濫藥組和對照組的平均 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%）。氯氨酮濫藥者患上腹痛的人數與對照組比較具有明顯的上升。（勝算比 143 ， p<0.001 ）。**結論**：大多數年輕氯氨酮濫藥者當他們到急症室求診時都不會告訴別人他們濫藥的背景。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。

J Dig Dis. 2010 Apr;11(2):106-10. doi: 10.1111/j.1751-2980.2010.00424.x.

Upper gastrointestinal problems in inhalational ketamine abusers.

Poon TL, Wong KF, Chan MY, Fung KW, Chu SK, Man CW, Yiu MK, Leung SK.

Department of Surgery, Tuen Mun Hospital, Hong Kong SAR, China.

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.

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KETALAR
Injection
KETALAR
Injection 100 mg/ml
Ketamine Hydrochloride Ph Eur
10 ml Single-dose Vial
POM
Active: Ketamine hydrochloride
equivalent to: 100 mg per ml
ketamine
Inactives: Benzethonium chloride
1:10,000 as preservative
water for injection

Case 3

- 50 yrs old lady
- Obese
- Smoker
- IHD on aspirin & TNG
- Coro done: no significant stenosis requiring intervention

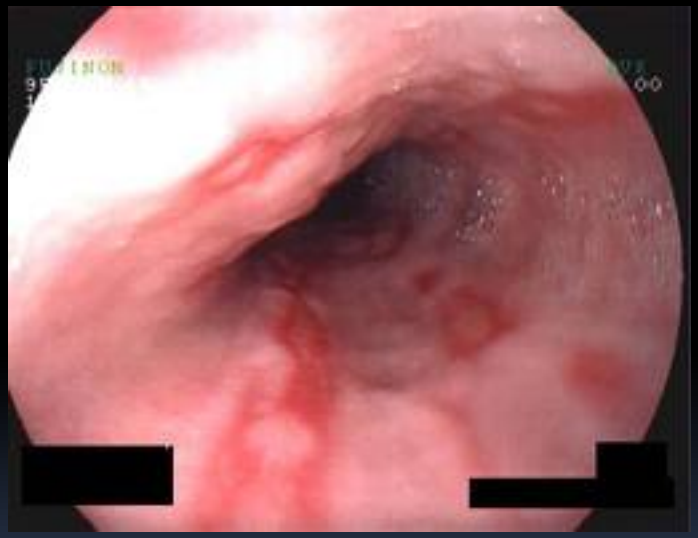
- Dull retro-sternal chest discomfort for 2 year
- Some angina-like attack with radiation to jaw & back
- Also with heart burn symptom & occasional non-progressive dysphagia

- Angina symptom not well controlled by the 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

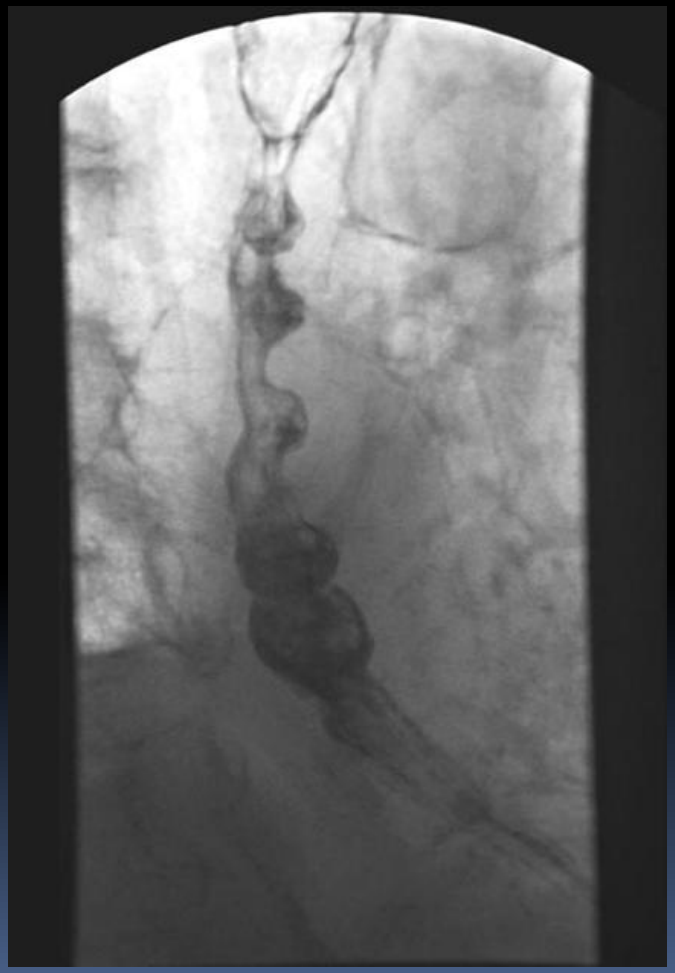


- Proton pump inhibitor given
- Symptom partially improve
- Occasional dysphagia same

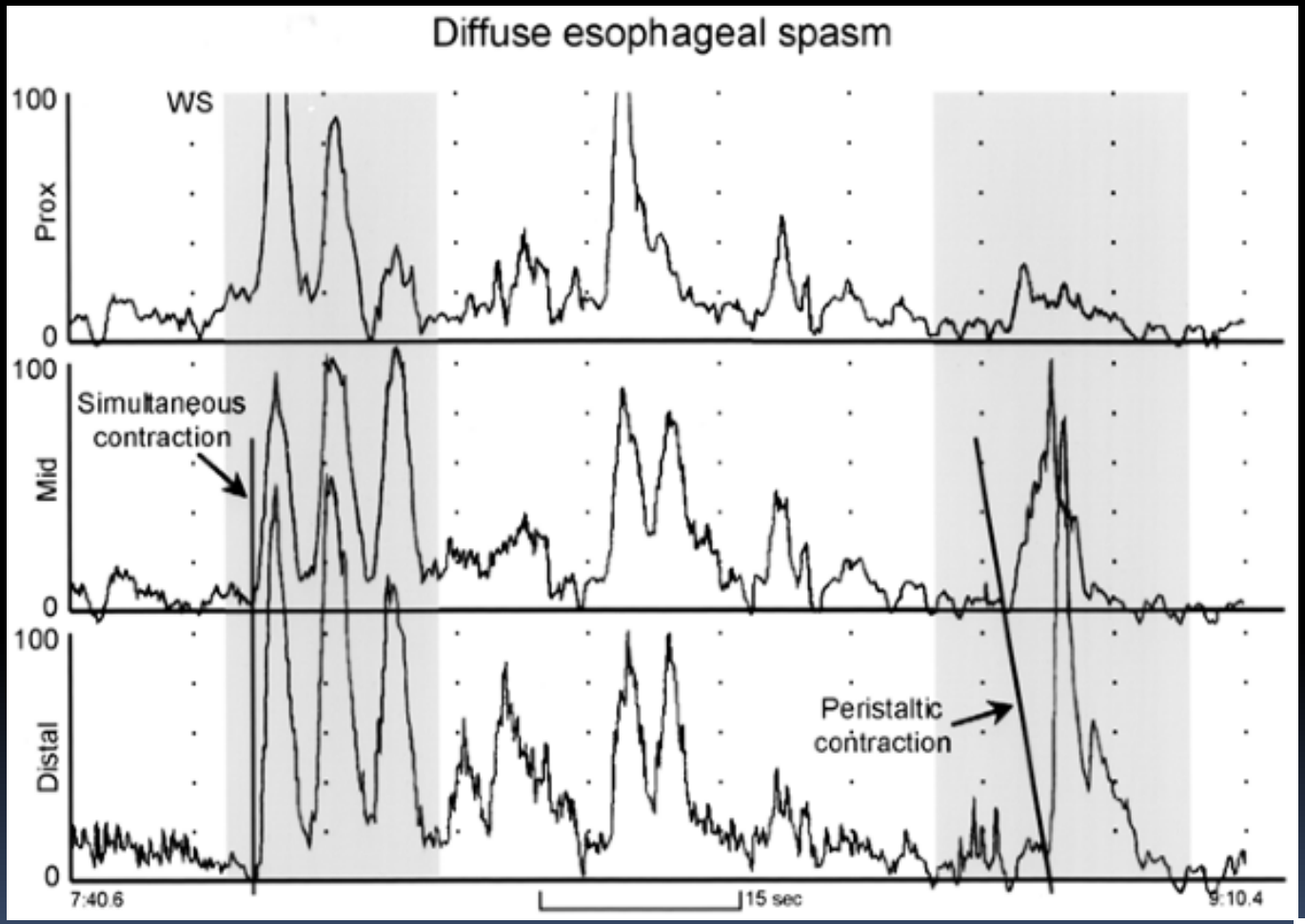
- Cardiologist reply:
- Coro: no new lesion found, stenosis same

- What next ?

Barium swallow



Manometry


Diffuse esophageal spasm
WS
100
Prox
0
100
Mid
Simultaneous contraction
0
100
Distal
Peristaltic contraction
0
7:40.6
15 sec
9:10.4

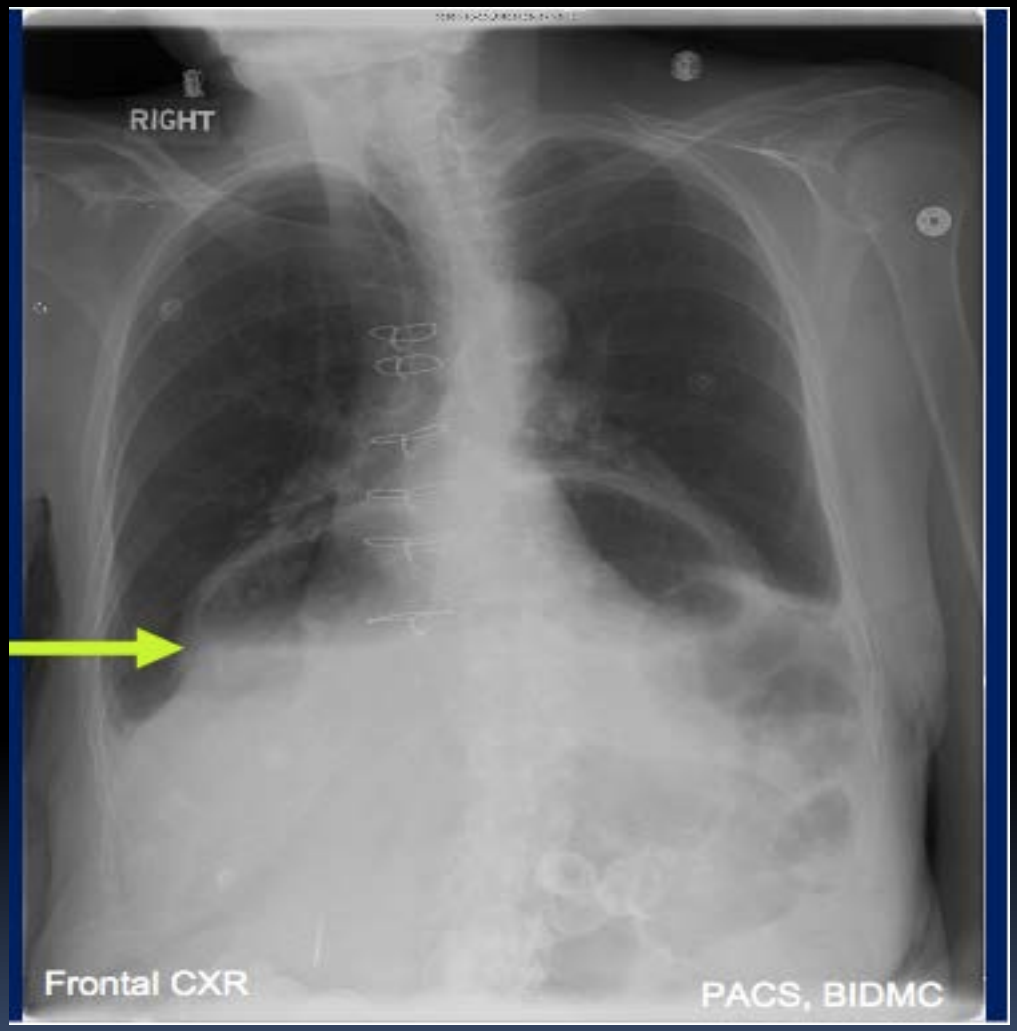
- Well control of GERD
- Diet modification- cold/ hot food & drink
- Calcium channel blocker
- Anti-depressant
- Endoscopic treatment
- Surgery

Case 4

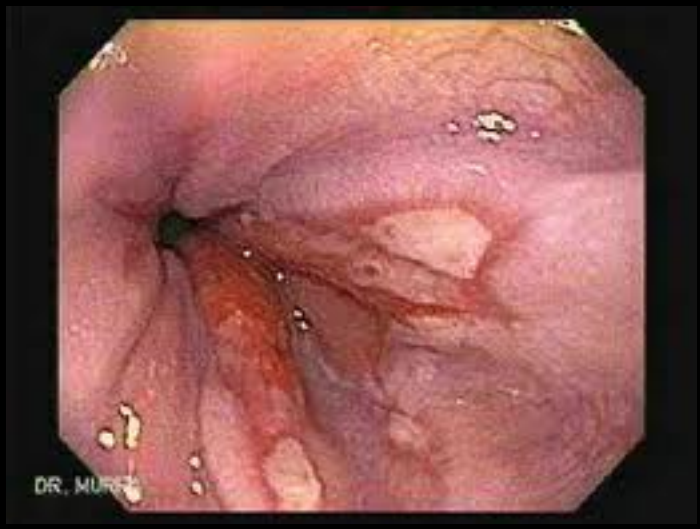
- 80 yrs old lady
- IHD with CABG done, HT
- GERD symptom
- Increase in retrosternal chest discomfort after meal in recent 1 year
- Nausea & vomiting of undigested food recently

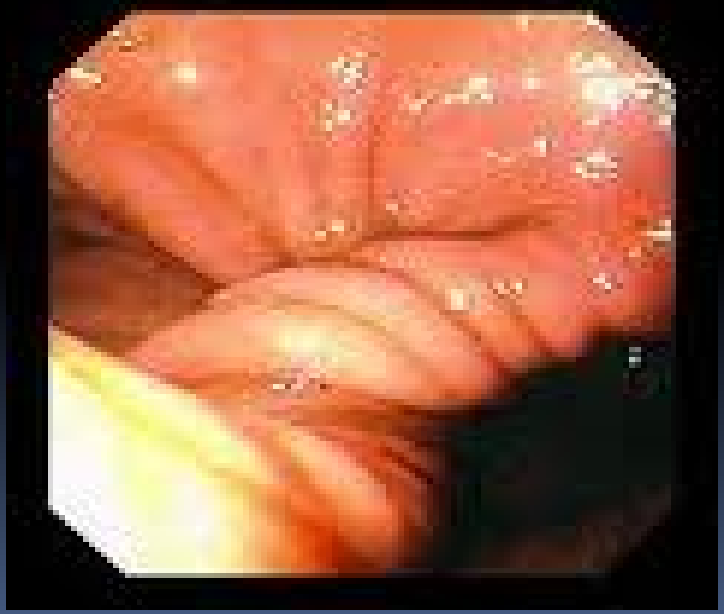
- Investigation:

CXR:

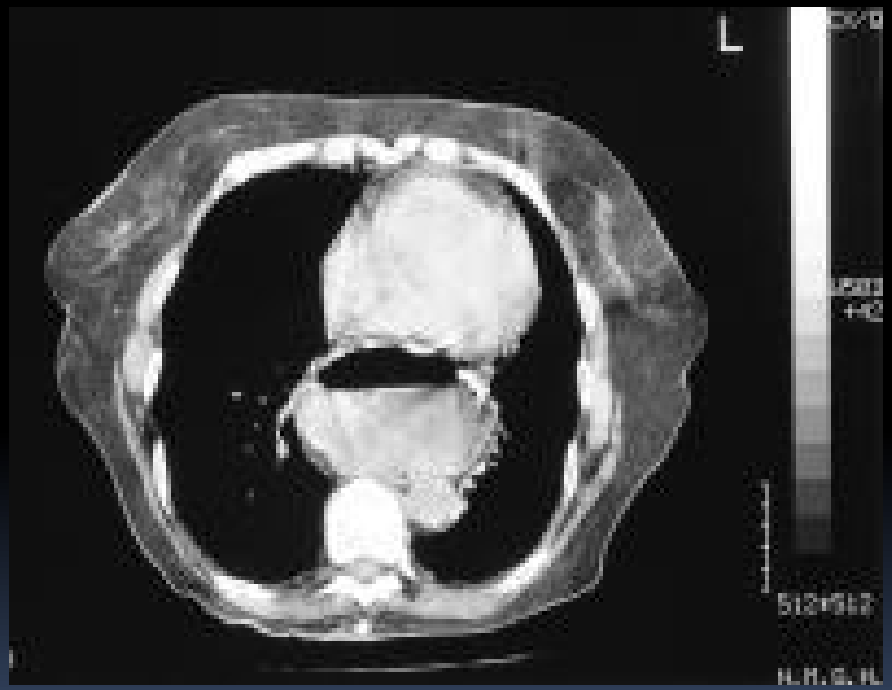


OGD:

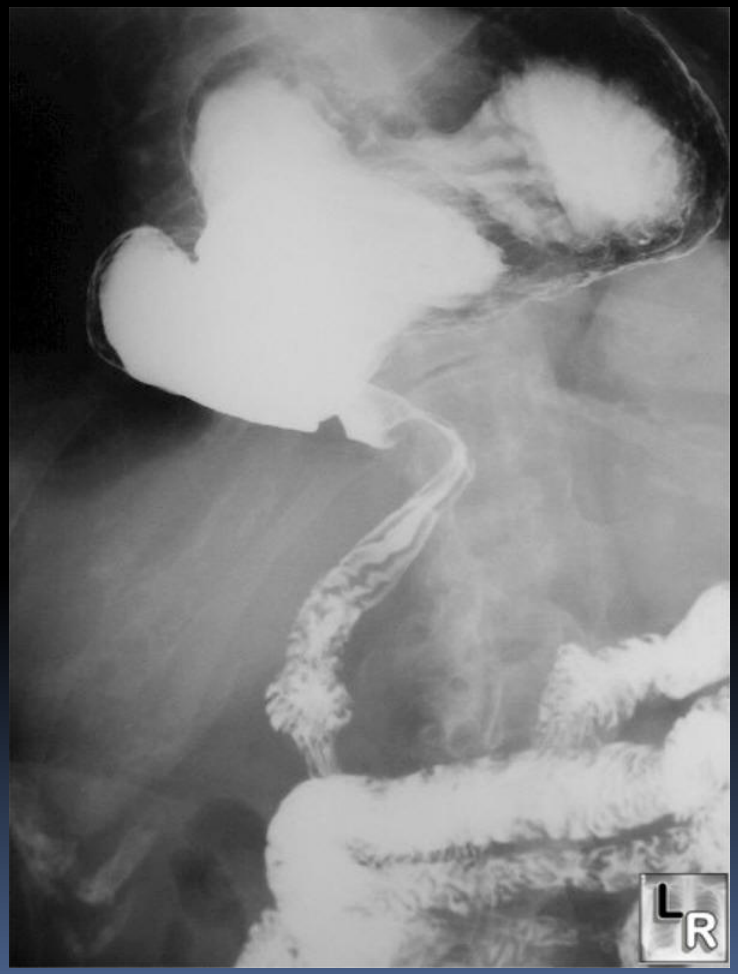




CT thorax:



Hiatal hernia with gastric volvulus



- With visceral rotation – can lead to gastirc 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