Show Notes: Episode 5 In the clinic – Chest Pain

Questions discussed in the podcast:

1) Assuming a gastrointestinal cause, which features suggest dyspepsia
    a) Epigastric discomfort/pain
    b) Heartburn
    c) Postprandial fullness or bloating (upper abdominal)
    d) Early Satiety
    e) Regurgitation

It can be challenging to sort out Dyspepsia from GERD as the symptoms overlap considerably. Many guidelines talk about "predominant symptoms."

GERD: Predominantly heartburn +/- regurgitation

Dyspepsia: Predominantly epigastric pain/discomfort/burning; Post-prandial fullness / upper abdominal bloating; Early satiety (in most guidelines)

Although the initial complaint was 'chest pain,' there were no real cardiac features and the story was much more in keeping with gastrointestinal.

2) Which of the following is **not** included among the list of alarm features;

a) Age >60 (or 50/55) with new and persistent symptoms	b) First degree relative with history of esophageal or gastric cancer
c) GI Bleeding (melena or hematemesis) or anemia	d) Persistent vomiting (not associated with cannabis)
e) Personal history of peptic ulcer disease	**f) Recurrent or persistent diarrhea.**
g) Unintended weight loss (≥5% over 6 months)	h) Odynophagia (pain with swallowing)
i) Progressive dysphagia	j) Abdominal mass

Alarm features: Age >60 (some say 50 or 55) with new and persistent symptoms (>3 months); First degree relative with esophageal or gastric cancer; GI Bleeding (melena or hematemesis) or anemia; Persistent vomiting (not associated with cannabis); Personal history of peptic ulcer disease; Unintended weight loss (≥5% over 6 months); Odynophagia (pain with swallowing); Progressive dysphagia; Abdominal mass.

The 2017 America College of Gastroenterology and Canadian Association of Gastroenterologists state: "We do not suggest endoscopy to investigate alarm features for dyspepsia patients under the age of 60 to exclude upper GI neoplasia" due to the poor predictive power of alarm features in younger patients. However, they qualify that "Alarm features should not automatically precipitate endoscopy in younger patients but this should be considered on a case-by-case basis."

3) With the working diagnosis of Dyspepsia, what is your top priority in the management of Lamis (assume you can pick only one).

    a) Prescribe 30 days of proton pump inhibitors (PPI)

    b) Refer for Gastroenterology and scope

    c) Abdominal ultrasound

    d) **Test for H. pylori (treat if positive)**

    e) Barium swallow and upper GI Series

    f) Labs like Liver function tests, CBC, ferritin, lipase, & celiac serology

The proportion of patients who still had dyspeptic symptoms at the end of the year was 73-74% managed with Test & Treat, 77% with endoscopy and 78% with PPI patients (not statistically different).

Although, 25% of studied Test & Treat patients inevitably required endoscopy, a test and Treat approach (without alarm features) saved an average ~$402 vs to prompt endoscopy. Test and Treat was also trending to be ~$50 less than empirical acid suppression approach.

Compared to no intervention, Test & Treat resulted in less patients with dyspeptic symptoms with a Number Needed to Treat of 7.

A randomized trial in primary care confirms Test & Treat as good or better (with less endopscopy and sick days) than PPI alone.

Plan:

Discuss with Lamis the most likely diagnosis of dyspepsia

You send her for H pylori testing and ask her to do it as soon as possible

You offer her a script for a PPI (Pantoprazole 40mg once a day for 30 days) but stress she cannot start the medication until AFTER her H pylori testing

You advise of alarm features to watch for and then have her book follow-up in 2 weeks time.

References & Links:

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