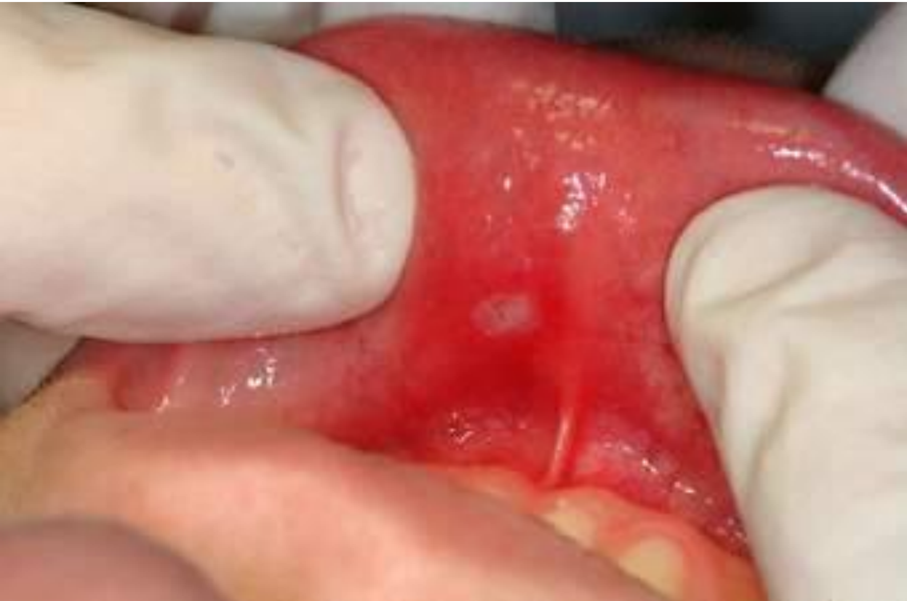
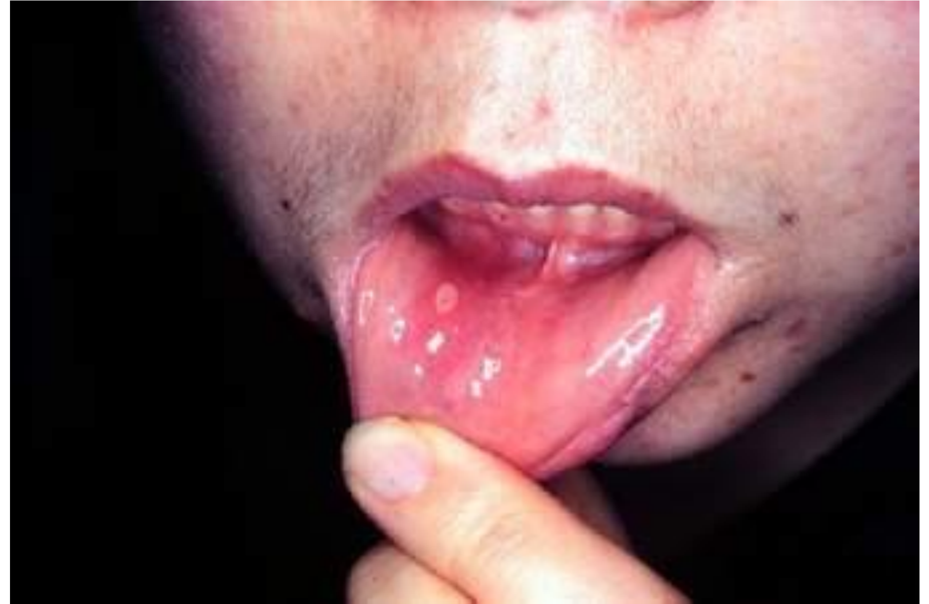
GIT symptoms د.احمد مدب

Aphthous ulcers

20% of us get these shallow, painful ulcers on the tongue or oral mucosa that heal without scarring

Treatment is difficult: •

1-hydrocortisone lozenges • held on the ulcer may help,

2-Prednisolone •

3-as may tetracycline • mouthwash. â–

4-¶Biopsy •

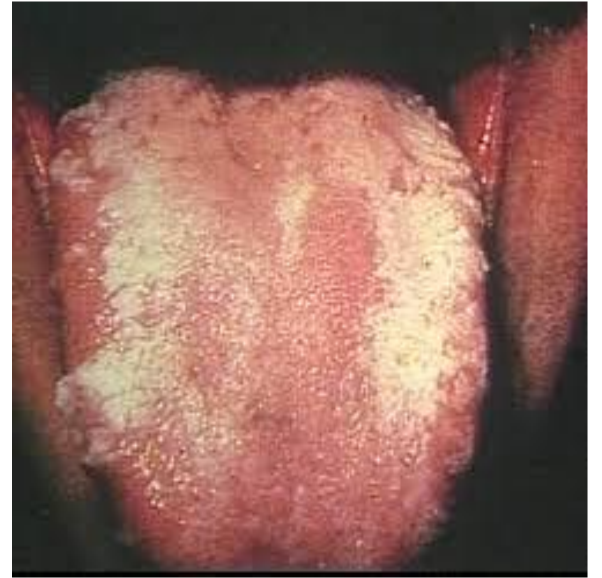
any ulcer not healing after 3 • weeks to exclude malignancy

Other Causes of severe ulcers: •

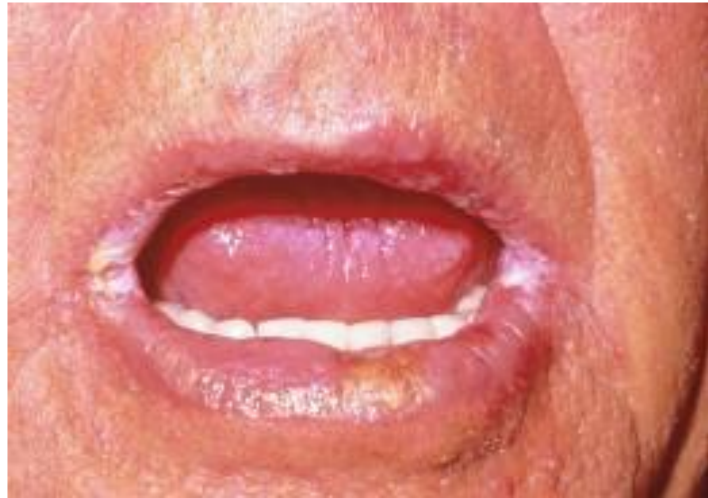
Crohn's & coeliac disease; Behcet's •
trauma ; erythema multiforme; lichen planus; pemphigus; pemphigoid; infections (herpes simplex, syphilis, Vincent's angina

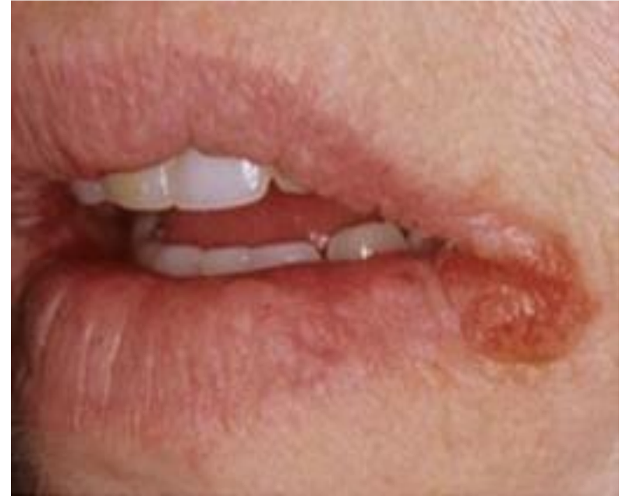
White intra-oral lesions •

- Carcinoma •
- Leucoplakia •
- Lichen planus •
- Lupus erythematosus •
- Poor dental hygiene •
- Smoking •
- Candidiasis •
- Aphthous stomatitis •
- Squamous papilloma •
- Secondary syphilis •



- Cheilitis (angular stomatitis)
- Fissuring of the mouth's corners is caused by
- 1-denture problems,
- 2-candidiasis
- 3- deficiency of iron or riboflavin (vitamin B2).
- 4-allergic dermdtitis





Gingivitis

Gum inflammation ± hypertrophy •

1-occurs with poor oral hygiene,

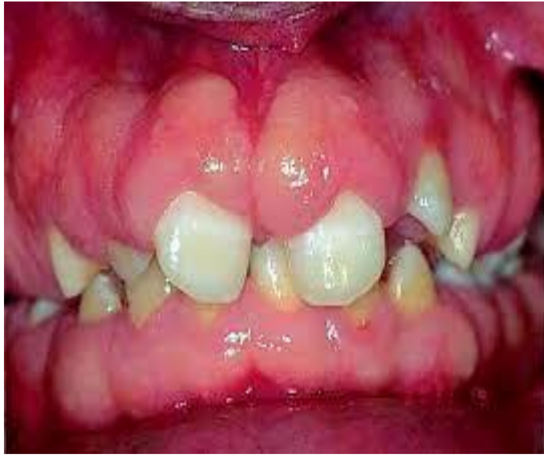
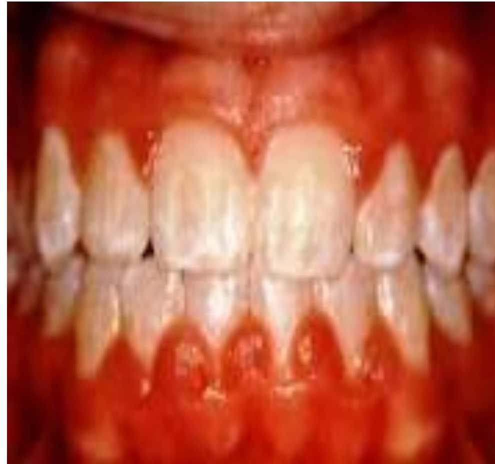
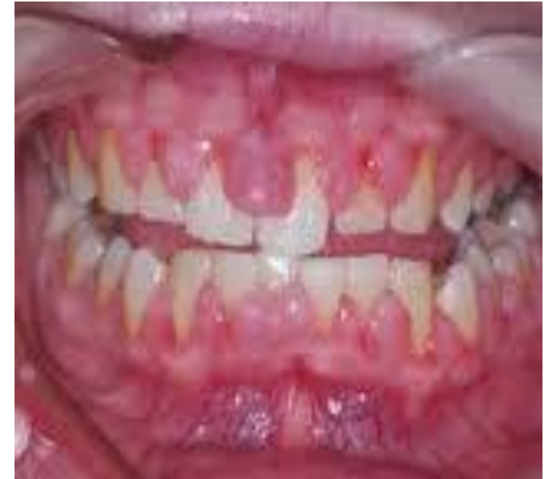
2- drugs (phenytoin, ciclosporin, nifedipine),

3-pregnancy,

4-vitamin C deficiency (scurvy,),

5- acute myeloid leukaemia, or

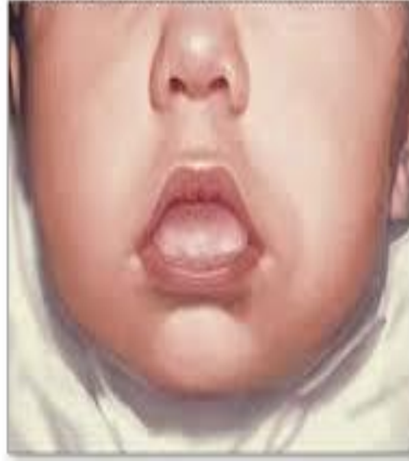
6- Vincent's angina

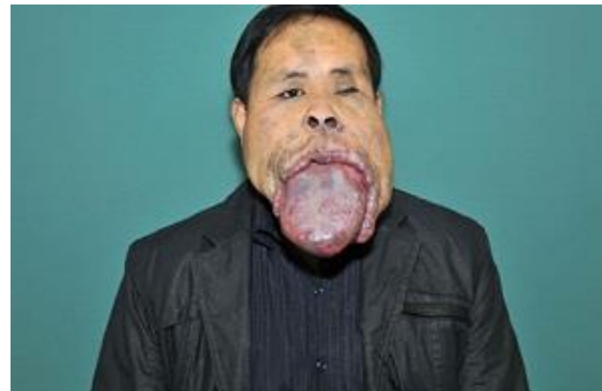
Tongue

- This may be furred or dry (xerostomia) in 1-dehydration2-drugs tricyclics,hyoscine etc.,3-after radiotherapy, 4-in Crohn's disease, 5-Sjogren's 6-mouth breathing
- **Glossitis**
- means a smooth, red, sore tongue, eg caused by iron, folate, or B12 deficiency
- **Macroglossia:** The tongue is too big. Causes: myxoedema; acromegaly; amyloid.,cancer ,downs syndrum

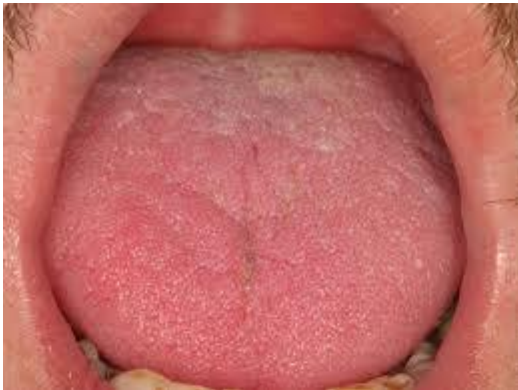
Macroglossia (abnormally large tongue)

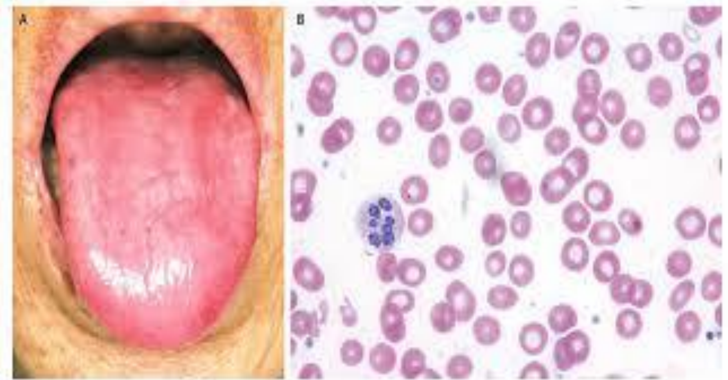


ADAM.



Stomatitis





Dysphagia

- Dysphagia is difficulty in swallowing and always needs investigating to exclude malignancy. If symptoms are progressive or prolonged then urgent investigation is required.
- Causes of dysphagia

1-Mechanical disorders

- 1-Malignant stricture
  - Oesophageal cancer
  - Gastric cancer
  - Pharyngeal cancer
- 2-Benign strictures
  - -Oesophageal web or ring
  - -Peptic stricture
- 3-Extrinsic pressure
  - Lung cancer
  - Mediastinal lymph nodes
  - Retrosternal goitre
  - Aortic aneurysm
  - Left atrial enlargement
- 4-Pharyngeal pouch

2-Motility disorders

- Achalasia
- Diffuse oesophageal spasm
- Systemic sclerosis
- Myasthenia gravis
- Bulbar palsy
- Pseudobulbar palsy
- Syringobulbia
- Bulbar poliomyelitis
- Chagas' disease

Others

- Oesophagitis

management

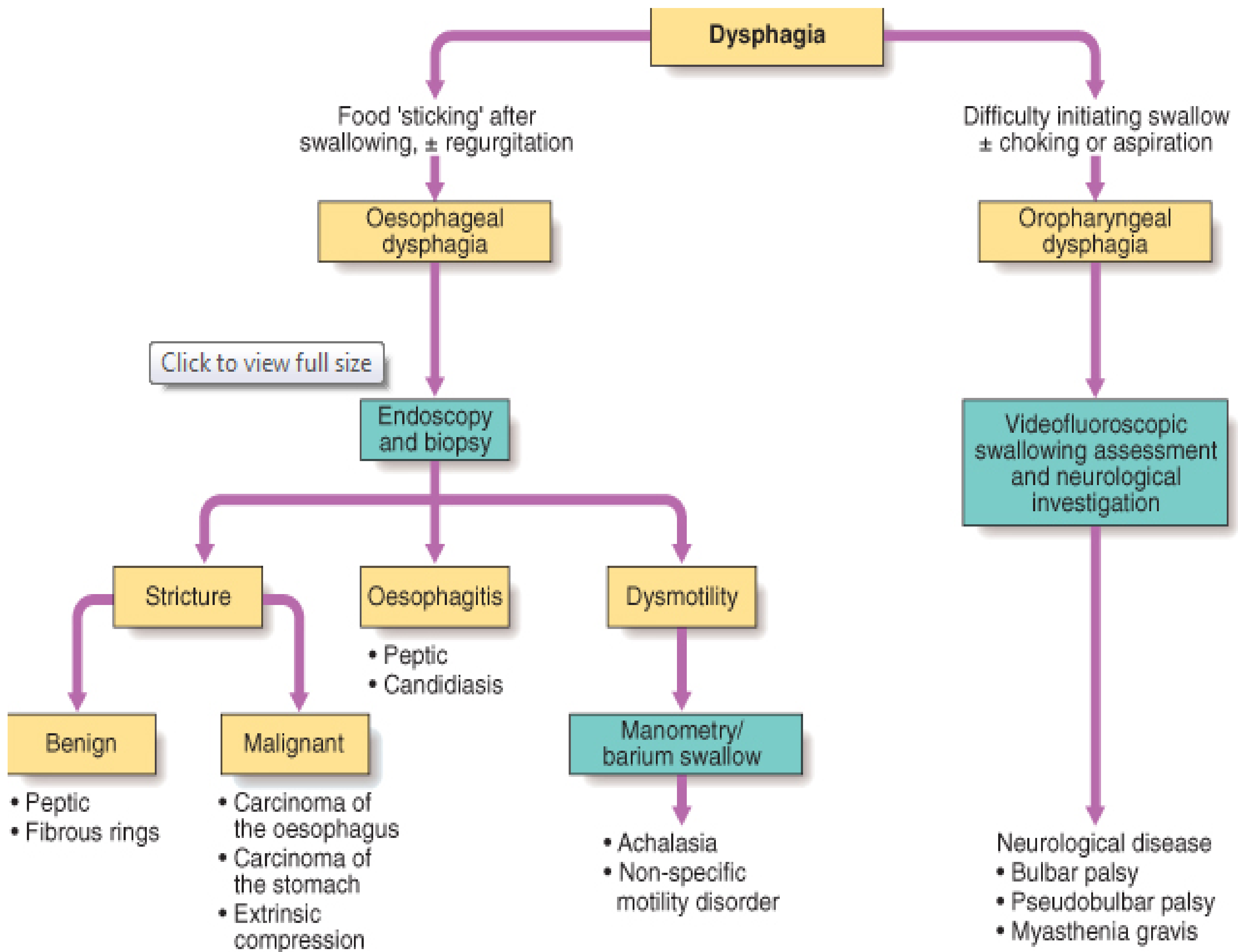
- There are a number of key questions to ask:
- Was there difficulty swallowing solids and liquids from the start?
- Yes: Motility disorder (achalasia, neurological), or pharyngeal causes.
- No: Solids then liquids: suspect a stricture (benign or malignant).
- Is it difficult to make the swallowing movement?
- Yes: Suspect bulbar palsy, especially if he coughs on swallowing.
- Is swallowing painful (odynophagia)?
- Yes: Suspect cancer, severe oesophagitis, achalasia, or oesophageal spasm.
- Is the dysphagia intermittent or is it constant and getting worse?
- Intermittent: Suspect oesophageal spasm.
- Constant and worsening: Suspect malignant stricture.
- Does the neck bulge or gurgle on drinking?
- Yes: Suspect a pharyngeal pouch

Signs •

Is the patient cachectic or anaemic? • Examine the mouth; feel for supraclavicular nodes suggests intra-abdominal malignancy); look for signs of systemic disease, eg systemic sclerosis, CNS disease

Investigations •

CBP AND ESR (anaemia); U&E • (dehydration); CXR (mediastinal fluid level, absent gastric bubble, aspiration); barium swallow (fig 1) +/- video fluoroscopy; upper GI endoscopy and biopsy. Further investigations: oesophageal manometry (if normal barium swallow); ENT opinion if suspected pharyngeal cause


Dysphagia
Food 'sticking' after swallowing, ± regurgitation
Difficulty initiating swallow ± choking or aspiration
Oesophageal dysphagia
Oropharyngeal dysphagia
Click to view full size
Endoscopy and biopsy
Videofluoroscopic swallowing assessment and neurological investigation
Stricture
Oesophagitis
Dysmotility
• Peptic
• Candidiasis
Benign
Malignant
Manometry/ barium swallow
• Peptic
• Fibrous rings
• Carcinoma of the oesophagus
• Carcinoma of the stomach
• Extrinsic compression
• Achalasia
• Non-specific motility disorder
Neurological disease
• Bulbar palsy
• Pseudobulbar palsy
• Myasthenia gravis

Dyspepsia (indigestion)

- Dyspepsia is a non-specific group of symptoms related to the upper GI tract
- CAUSES OF DYSPEPSIA
- **1-Upper gastrointestinal disorders**
- Peptic ulcer disease
- Acute gastritis
- Gallstones
- Motility disorders, e.g. oesophageal spasm
- 'Functional' (non-ulcer dyspepsia and irritable bowel syndrome)

Other gastrointestinal disorders

- Pancreatic disease (cancer, chronic pancreatitis)
- Hepatic disease (hepatitis, metastases)
- Colonic carcinoma

Systemic disease •

Renal failure •

Hypercalcaemia •

hyperglycemia •

Drugs •

Non-steroidal anti-inflammatory drugs (NSAIDs) •

Iron and potassium supplements •

Corticosteroids •

Digoxin •

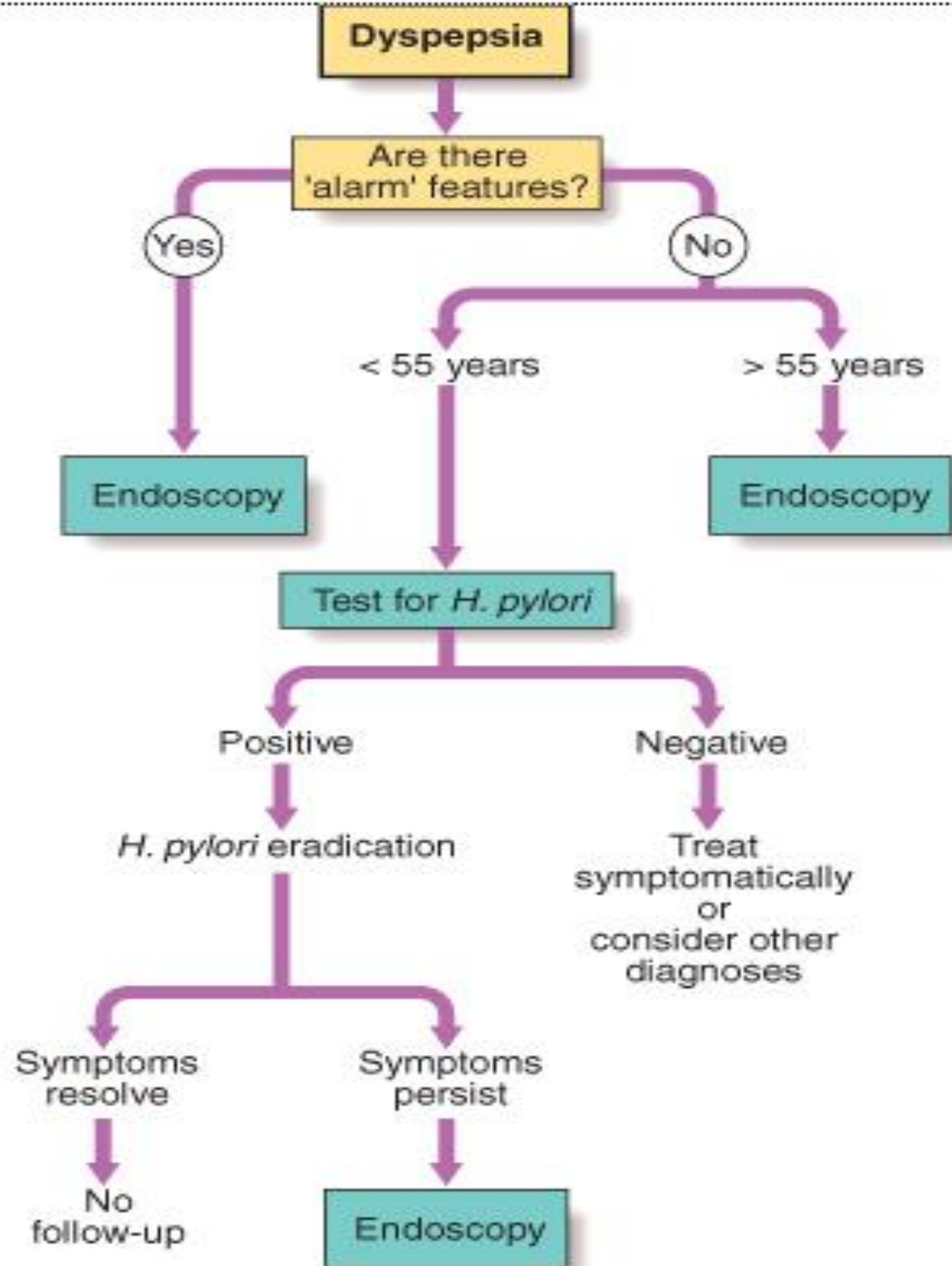
Others •

Alcohol •

Psychological, e.g. anxiety, depression •

- خطر

- 'ALARM' FEATURES IN DYSPEPSIA
- Weight loss
- Anaemia
- Vomiting
- Haematemesis and/or melaena
- Dysphagia
- Palpable abdominal mass



Dyspepsia
Are there 'alarm' features?
Yes
No
< 55 years
> 55 years
Endoscopy
Endoscopy
Test for H. pylori
Positive
Negative
H. pylori eradication
Treat symptomatically or consider other diagnoses
Symptoms resolve
Symptoms persist
No follow-up
Endoscopy

vomiting•

Nausea and vomiting

- **Nausea:** is the subjective feeling of a need to vomit. Associated symptoms can be pallor, sweating, hypotension, weakness.
- **Vomiting:** is the oral expulsion of gastrointestinal contents resulting from contractions of gut and thoracoabdominal wall musculature. Inspiratory thoracic and abdominal wall muscles contract, producing high intrathoracic and intraabdominal pressure that facilitate expulsion of gastric contents. The gastric cardia herniates across the diaphragma and the larynx moves upward to promote oral propulsion of the vomitus.
  - Vomiting is coordinates by the brain stem and is effected by neuromuscular responses in the gut, pharynx, and thoracoabdominal wall.

Approach to the patient with nausea and vomiting

The content of vomitus •

Food residue ingested hours or days previously – gastroparesis, – pyloric stenosis

Feculent emesis (miserere) – distal intestinal or colonic – obstruction

Emesis of undigested food – achalasia, oesophagus diverticuli –

Hematemesis – ulcer, malignancy, Mallory-Weiss syndrome, – rupture of oesophageal varices.

The effect of the emesis •

Relief the abdominal pain – small-bowel obstruction –

No effect on the pain – pancraetitis, cholecystitis –

Timing of the vomitus •

Immediatly after eating – psychogenic cause –

In the morning – hyperemesis gravidarum –

Within 1 h of eating – pyloric obstruction or gastroparesis –

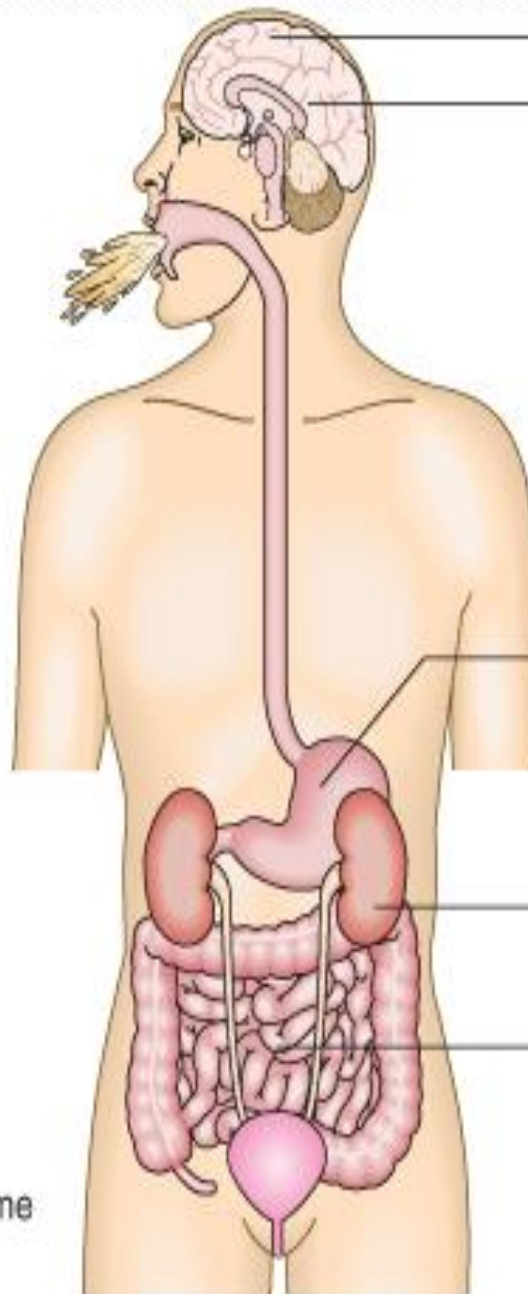
2-3 h or later after eating – ulcer disease, intestinal obstruction –

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

Gastrointestinal bleeding

- **Hematemesis:** vomitus of red blood or coffee-grounds material
- **Melena:** black, tarry, foul-smelling stool
- **Hematochezia:** the passage of red or maroon blood from the rectum
- **Occult GI bleeding:** may be identified in the absence of overt bleeding by a fecal occult blood test
- **Only symptoms of blood loss or anemia:** pallor, syncope, angina, dyspnea.

Sources of GI bleeding

- Peptic ulcer -H. pylori, NSAID, acid.
- Mallory-Weiss tears – vomiting, reching or coughing preceedes the hematemesis, especially in alcoholic patients.
- Esophageal varices – consequences of portal hypertension in patients with liver cirrhosis.
- Erosiv gastropathy – subepithelial hemorrhages and erosions in alcoholic patients or during NSAID therapy.
- Small intestinal sources – Meckel’s diverticulum in children, tumors in middle aged population, vascular ectasias in elderly patients.
- Colonic sources – hemorrhoids, diverticula, neoplasma, vascular ectasias.

DIARRHOEA

- **increase frequency,fluidity and amount of stool**
- The bowel frequency more than 3 time /day (the bowel frequency of the normal population ranges from three bowel movements per day to one bowel action every third day
- consistency ranges from porridge-like to hard and pellety amount :
- passage of more than 200 g of stool daily

ACUTE DIARRHOEA

- Duration of diarrhea less tha 1 month duration
- This is extremely common and usually due to faecal-oral transmission of bacteria, their toxins, viruses or parasites Infective diarrhoea is usually short-lived and patients who present with a history of diarrhoea lasting more than 10 days rarely have an infective cause. A variety of drugs, including antibiotics, cytotoxic drugs, proton pump inhibitors and NSAIDs, may be responsible for acute diarrhea
- If more than 1m, called chronic diarrhea
- **Chronic diarrhoea** can be categorised as disease of the colon or small bowel, or malabsorption

CHRONIC OR RELAPSING DIARRHOEA

- **Colonic(large bowel)**
- **clinical features1-**Blood and mucus in stool ,more frequent ,,tinismus ,
Cramping lower abdominal pain
- some causes 2-Inflammatory bowel disease
- -Neoplasia ,Ischaemia ,Irritable bowel syndrome
- main investigation3- GSE ,Colonoscopy with biopsies

Small bowel •

Large-volume, watery stool ,Abdominal bloating •
Cramping mid-abdominal pain ,bad ouder
,large,

VIPoma Drug- •
induced NSAIDs Aminosalicylates Selective
serotonin re-uptake inhibitors (SSRIs)

Stool volume Gut hormone profileBarium follow- •
through

Malabsorption •

Steatorrhoea Undigested food in the stool •
Weight loss and nutritional disturbances
Pancreatic Chronic pancreatitis Cancer of pancreas Cystic fibrosis
Enteropathy Coeliac disease Tropical sprue Lymphoma Lymphangiectasia
Ultrasound, CT and MRCPS mall bowel biopsy Barium follow-through

Clinical features •

Take a detailed history: •

Acute or chronic? If acute suspect gastroenteritis. Ask about • travel, change in diet, and contact history.

Chronic diarrhoea alternating with constipation suggests • irritable bowel

. Anorexia, weightâ†“, nocturnal diarrhoea & anaemia suggest • an organic cause.

Bloody diarrhoea: Campylobacter, Shigella, Salmonella, E. Coli, • amoebiasis, UC, Crohn's disease, colorectal cancer , colonic polyps, pseudomembranous colitis, ischaemic colitis (p488).

Fresh PR bleeding: . •

Mucus occurs in IBS, colorectal cancer, and polyps. •

Pus suggests IBD (inflammatory bowel disease), diverticulitis, • or a fistula/abscess.

± blood or mucus; pelvic Large bowel symptoms: Watery stool • pain relieved by defecation; tenesmus; urgency.

Small bowel symptoms: periumbilical (or RIF) pain not relieved • by defecation; watery stool or steatorrhoea.

Non-GI causes: Antibiotics; PPIs; cimetidine; propranolol, • cytotoxics; NSAIDs; digoxin; alcohol; laxative abuse); medical conditions: thyrotoxicosis; autonomic neuropathy; Addison's disease; carcinoid syndrome.

- **constipation**
- infrequent passage of stool (<3 times weekly) or difficulty in defecation, with straining or discomfort
- CAUSES OF CONSTIPATION
- **Gastrointestinal disorders**
- **Dietary**
- Lack of fibre and/or fluid intake
- **Motility**
- Slow-transit constipation
- Irritable bowel syndrome
- Drugs (see below)
- Chronic intestinal pseudo-obstruction

- **Structural**
- Colonic carcinoma
- Diverticular disease
- Hirschsprung's disease
- **Defecation**
- Obstructed defecation
- Anorectal disease (Crohn's, fissures, haemorrhoids

Non-gastrointestinal disorders •
Drugs •
Opiates •
Anticholinergics •
Calcium antagonists •
Iron supplements •
Aluminium-containing antacids •
Neurological •
Multiple sclerosis •
Spinal cord lesions •
Cerebrovascular accidents •
Parkinsonism •
Metabolic/endocrine •
Diabetes mellitus •
Hypercalcaemia •
Hypothyroidism •
Pregnancy •
Others •
Any serious illness with immobility, especially in the elderly •
Depression •

Clinical assessment and management

- The onset, duration and characteristics are important; for example, a neonatal onset suggests Hirschsprung's disease, IBS (,,,,,,,,,,).IBD(…….).CARCENOMA(…..
- Careful examination contributes more to the diagnosis than extensive investigation. A search should be made for general medical disorders as well as signs of intestinal obstruction. Neurological disorders, especially spinal cord lesions, should be sought. Perineal inspection and rectal examination are essential and may reveal abnormalities of the pelvic floor (e.g. abnormal descent, impaired sensation), anal canal or rectum (masses, faecal impaction, prolapse).

- It is neither possible nor appropriate to investigate every person with this very common complaint. Most will respond to dietary fibre supplementation and the judicious use of laxatives. Middle-aged or elderly patients with a short history or worrying symptoms (rectal bleeding, pain or weight loss) must be investigated promptly, by either barium enema or colonoscopy. For those with simple constipation, investigation will usually proceed along the following lines.
- Initial visit
- Digital rectal examination, proctoscopy and sigmoidoscopy (to detect anorectal disease), routine biochemistry, including serum calcium and thyroid function tests, and a full blood count should be carried out. If these are normal, a 1-month trial of dietary fibre and/or laxatives is justified.
- Next visit
- If symptoms persist, then examination of the colon by barium enema or colonoscopy is indicated to look for structural disease.

- Further investigation
- If no cause is found and disabling symptoms are present, then specialist referral for investigation of possible dysmotility may be necessary. The problem may be one of infrequent desire to defecate ('slow transit') or else may result from excessive straining ('obstructed defecation'. Intestinal marker studies, anorectal manometry, electrophysiological studies and defecating proctography can all be used to define the problem.
- TREATMENT:-primary cause-reasurance- Increase fluid intake- dietary fibre supplementation and use of laxatives