PRACTICAL GASTROENTEROLOGY

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Edited by Ronald L. Koretz, M.D.

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Preface

Gastroenterologic problems confront the practicing physician every day. At the same time, the literature in this field is growing at a seemingly exponential rate. (There are currently nine major clinical journals that deal solely with diseases of the gastrointestinal tract and liver in addition to the general medicine, surgery, and pediatric publications.) We are being continuously bombarded with new tests, new therapies, and, occasionally, even new diseases.

The intent of this book is to synthesize some of the accepted recent inroads with the older avenues and present a unified approach to particular gastrointestinal problems. It is not our purpose to review the recent literature in a "what's new" format; such works become outdated rapidly. Rather, the information in each chapter should provide a basis (for attacking these various disorders) that will remain appropriate for many years to come.

Emphasis has been placed on practicality. This is not a text-

book of gastroenterology. As you will see, pathophysiologic concepts have not been covered except where they have direct bearing on patient management. Similarly, obscure or sophisticated gastroenterologic disorders or decisions have been omitted or only covered to provide insight as to why particular steps might be taken. This book will not substitute for specialist consultation in patients with particularly complex problems. On the other hand the recommendations in the various chapters will direct primary physicians to reasonable steps that they can take themselves in common problems.

The authors have been selected because of their past proven ability to communicate effectively with audiences of clinicians. Although they have different particular fields of special interest, they all share the common background of a great deal of clinical experience. When they write of a particular method of handling a problem, they will be telling you what has worked for them in countless individual experiences. Sometimes a method is well established scientifically; at other times it is only supported by their "uncontrolled" observations.

The book has been divided into two sections, one dealing with common symptoms and the other with common disease entities. This reflects the situation in the real world, where patients have either isolated symptoms (and a diagnosis needs to be made) or identified disease complexes (where management considerations are the first priority).

The authors of the chapters in Part I were asked to construct their discussions around the answers to the following questions, aimed at establishing a diagnosis or providing nonspecific therapy:

1. What are the important aspects of history?
2. What are the important physical findings to seek?
3. What laboratory tests or procedures should be ordered?
4. What are the major diagnostic considerations?
5. What symptomatic therapy can be given in the absence of a specific diagnosis?

The chapters in Part II will pick up the story after a diagnosis has been established. Again the authors were requested to respond to a set of questions, this time dealing more with therapy and prognosis:

1. How do I make the diagnosis?
2. What additional workup does the patient require?
3. How should I treat the patient?
4. What should I expect from successful therapy?
5. What might cause a failure of treatment?
6. What are the side effects of treatment?
7. How should the patient be followed?
8. What complications of the disease can occur?
9. How should these complications be managed?

Although a few of the chapters (Chapters 12, 16, 20, and 22) could not be so structured, the remainder will follow these formats.

We hope this volume will find its major use in the day-to-day care of your patients. If the book finds its way to the more accessible area of your bookshelf, our efforts will have been justified.

R. L. K.

Contents

PART I

SYMPTOMS

PART I

SYMPTOMS

1

ARTHUR D. SCHWABE

Abdominal Pain

One of the most common complaints associated with disorders of the gastrointestinal tract is abdominal discomfort or pain. It may emanate from any segment of the digestive tube, from any of the solid viscera in the abdomen, or from any of the tissues lining, surrounding, or suspending these viscera, such as the visceral or parietal peritoneum, the mesentery, or the omentum. Pain in these structures may be caused by distention or stretching, inflammation, ischemia or, in the case of hollow viscera, by spasm.

WHAT ARE THE IMPORTANT ASPECTS OF HISTORY?

The history is of primary importance in arriving at a rapid diagnosis. Clinicians who are most proficient in eliciting the origin of the pain from a barrage of descriptive material rely on the answers to the following eight questions:

1. What is the exact location of the pain? (location)
2. How quickly did the pain arise? (onset)
3. How long did the pain last? (duration)
4. How does the pain feel? (character)
5. To what other areas does the pain radiate? (radiation)
6. What may aggravate or precipitate the pain? (aggravating or precipitating factors)
7. What measures relieve or stop the pain? (relief)
8. What other symptoms accompany the pain? (accompanying symptoms)

Let us now examine how the information elicited from these simple questions may help us to focus on the most likely cause of the pain.

Location

Pain from structures within the abdominal cavity is perceived in more superficial areas of the abdominal wall. Since a number of viscera are innervated by the same spinal segment, pain emanating from several viscera may be localized in one area. Patients should be asked to point to the area of discomfort.

In general, pain that arises from the stomach, duodenum, pancreas, liver, or biliary tree is felt in the upper part of the abdomen. Pain from the small bowel is appreciated in the periumbilical area, and pain from the colon is felt in the lower abdomen (Table 1). The discomfort is sometimes sharply localized to a small area of the abdomen. For example, many patients with duodenal ulcers can point to a half-dollar–sized area in the epigastrium, and those with sigmoid diverticulitis may have discomfort confined to the left lower quadrant. The localization of pain emanating from a hollow viscus also depends on the character and severity of the pathologic process and the involvement of adjacent structures. Distention and spasm are referred to the midline; inflammation with peritonitis localizes wherever the process lies.

Onset

The rate of onset of pain may indicate the pathologic process and may also help the physician to localize the pain. An abrupt or