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Clinical and Endoscopic Evaluation of Causes of Dyspepsia

KEYWORDS: DYSPEPSIA

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ABSTRACT *Dyspepsia affects more than one fourth of the general population.Dyspepsia may be caused by a number of foods, medications, systemic disorders & diseases of luminal gastro intestinal tract. An organic cause is found in only 40.Endoscopy is the gold standard investigation for dyspepsia and dyspepsia is the most common indication for the procedure. AIMS and OBJECTIVES:1.To study the distribution of causes of dyspepsia.2. Clinical and endoscopic evaluation of dyspepsia. MATERIALS AND METHODS :All cases of dyspepsia were studied in Department of Medicine, Kurnool Medical College , Kurnool between June 2014 to May 20015 for a period of one year. All subjects were assessed with complete hemogram and upper GI Endoscopy, done for all cases. SUMMARY AND CONCLUSION*

500 case of dyspeptic patients subjected to endoscopy were studied in Kurnool Medical College, Kurnool between June 2014to May 2015. Organic cause is found only in 42% of patients. More than half, 58% were endoscopically normal.

INTRODUCTION:
Dyspepsia affects more than one fourth of the general population Dyspepsia accounts up to 7% of office visits & 40% to 70% of Gastro Intestinal complaints in general practice. Dyspepsia may be caused by a number of foods, medications, systemic disorders & diseases of luminal gastro intestinal tract. An organic cause is found in only 40%. In over ½ of the patients no obvious cause is found and dyspepsia is labeled as idiopathic (or) functional dyspepsia. Endoscopy is the gold standard investigation for dyspepsia and dyspepsia is the most common indication for the procedure. Endoscopic results reliably distinguish between organic and functional complaints. Endoscopy has definite impact on patients management. Even negative endoscopic finding influences outcome since management may be simplified and patients anxiety may be relieved.

AIMS AND OBJECTIVES
- Clinical and endoscopic evaluation of dyspepsia.
- To study the distribution of causes of dyspepsia.

MATERIALS AND METHODS: All cases of dyspepsia were studied in Department of Medicine, Kurnool Medical College , Kurnool between June 2014 to May 2015 for a period of one year. Following clinical, biochemical and investigative parameters are considered in the study. SELECTION CRITERIA . Age 20 – 60 years. Dyspeptic symptoms present not less than one month. EXCLUSION CRITERIA . Age less than 20, greater than 60. Previously confirmed cases of malignancy. Systemic diseases like COPD, RA, CCF, CRF . CLINICAL DATA: Nausea, Anorexia, Heart burn, Bloating, Early satiety, Post prandial fullness, Regurgitation, Burping or belching . HAEMOTOLOGICAL PARAMETERS: Complete blood count – Hb% , TC, DC, ESR. BIOCHEMICAL PARAMETERS: Blood sugar Renal parameters- Blood urea, serum creatinine Liver function tests .OTHER TESTS:ECG,CXR- PA view, Ultrasound examination,2D – Echo, Upper GI Endoscopy

OBSERVATION AND RESULTS:
A total of 500 cases of patients were studied prospectively from June 2014 to May 2015 in Department of Medicine, Kurnool Medical College, Kurnool, Andhra Pradesh who are subjected to endoscope for dyspeptic symptoms. Study included 338 males and 212 females who were randomly selected with age above 20 years and below 60 years. Commonest presenting manifestations were Upper abdominal discomfort, Upper abdominal fullness ,Early satiety, Bloating (or) Nausea, Heart burn, Regurgitation, Burping or belching. All subjects were assessed with complete hemogram and upper GI Endoscopy, done for all cases. Systemic diseases like portal hypertensive gastropathy, COPD, COL, CRF are excluded and confirmed cases of gastric malignancies too.290 patients were having no demonstrable pathology by endoscopy.115 patients were having peptic ulcer disease.85 patients were having GERD.10 patients were having malignancy in the stomach.

DISCUSSION:
Dyspepsia is the most common problem encountered in practice and accounts for 2-5% of primary care visits[1]. Most studies suggest that nearly 25% of adults suffer dyspeptic symptoms at some point during the year. Dyspepsia is an important problem, it is associated with persistent symptoms, diminished quality of life.

Dyspepsia is defined as epigastric pain (or) discomfort with bowel habits remaining unchanged. Lifetime prevalence estimate range from 40-60% for dyspepsia. Dyspeptic patients who consult physicians are characterized by greater worry over serious illness of cancer, heightened levels of anxiety, depression and illness behavior and re-

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cent traumatic life events[2]. Only Psychic vulnerability was strongly related to dyspepsia[3]. In evaluation of dyspepsia it is important to distinguish dyspepsia, uninvestigated dyspepsia and functional dyspepsia. Dyspepsia means all relevant upper abdominal symptoms regardless of their underlying causes. Uninvestigated dyspepsia means new onset dyspepsia (or) recurrent dyspepsia for which no diagnostic investigation yet have been performed. Functional dyspepsia means persistent (or) recurrent dyspepsia for which diagnostic investigation including endoscopy has not determined an obvious organic cause of symptoms. In 50-60% of cases no cause is identified and patients are termed to have functional or non ulcer dyspepsia[4,5]. A variety of novel diagnostic modalities have been developed to further investigate dyspeptic symptoms. These are gastric emptying scans, USSG, Endoscopic USSG, electro gastrography, Gastric Barostat drink test, SPECT imaging, antroduodenal manometry and endoscopy. Upper gastrointestinal endoscopy is the most commonly performed diagnostic study performed in patients with dyspepsia. It is recommended by the American College of Physicians and American Gastroenterological association in the evaluation of patients with alarm symptoms (or) those refractory to (or) relapse quickly after an empirical of acid suppressive therapy[6]. Endoscopy is the gold standard investigation for dyspepsia and dyspepsia is the most common indication of the procedure, Endoscopy results reliably distinguish between patients with an organic cause of the symptoms and those with functional complaints. Endoscopy has a definite impact on patient management. Unpredicted diagnostic and therapeutic consequences for one third of endoscoped patients[7].Even a negative endoscopy findings influences outcome, since management may be simplified and patients anxiety may be relived[8,9]. 50-60% no cause is identified and termed as functional (or) non ulcer dyspepsia.

The majority of dyspeptic patients have normal endoscopic findings. Original causes for dyspepsia are food intolerance, medication intolerance. Peptic ulcers associated with dyspepsia, but with most dyspepsia patients do not have peptic ulcer disease. The endoscopy prevalence of ulcers is approximately 12% to 25%. Gastric or esophageal malignancy is present in less than 2% of dyspepsia patients referred for endoscopy. Normal endoscopic findings provide reassurance for both the patients and physician. Fear of gastric cancer is the main reason for considering endoscopy in patients older than 45 years age with recent onset of dyspeptic symptoms. It reduces the mortality by increasing the proportion of early gastric cancers detected. Endoscopic evidence of GERD seen in 15% with dyspepsia.

SUMMARY AND CONCLUSION

500 case of dyspeptic patients subjected to endoscopy were studied in Kurnool Medical College, Kurnool between June 2014to May 2015.

The study was aimed to detect distribution of causes of dyspepsia by endoscopy.

Organic cause is found only in 42% of patients. More than half, 58% were endoscopically normal.

Endoscopic evaluation of dyspepsia-58% patients are observed having no demonstrable pathology during endoscopy , no cause is identified for their symptoms, Peptic ulcer disease is identified in 23% of cases, GERD is observed in 17% of patients, Gastric malignancy is observed in 2% of patients(table 1).

DISTRIBUTION OF CAUSES OF DYSPEPSIA

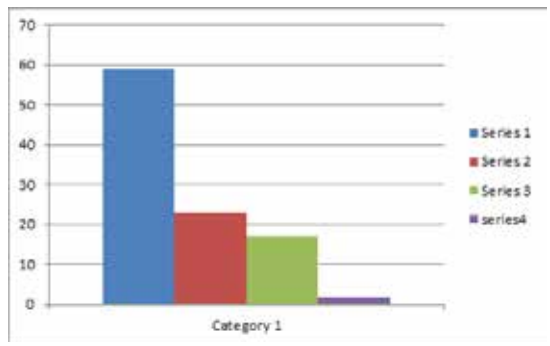

TABLE 1 DISTRIBUTION OF CAUSES OF DYSPEPSIA

Series 1- functional dyspepsia, Series 2-Peptic ulcer disease, Series 3-GERD, Series-4 Gastric malignancy

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