
بنام خداوند جان و خرد

بنام خدا

نحوه برخورد با درد و احساس پری ناحیه اپی گاستر دریک آقای ۵۶ ساله از دیدگاه پزشکی پزشکی خانواده

استاد راهنما سرکار خانم دکتر فنی
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ارایه دهنده کورش فرزین دستیار پزشکی خانواده
۱۷ تیر ۱۴۰۲

- بیما آقای ۵۶ ساله ایست که با احساس درد و پری ناحیه قسمت بالای شکم مراجعه کرده این درد از سال گذشته شروع شده البته اشاره میکرد که سالها است این مشکل را داشته که گهگاه بوده به طور مثال شاید ماهی یکبار علایم داشته که با خوردن شربت معده و گاهی اوقات دارو مثل رانیتیدین کنترل میشده ولی از سال پیش دردها تواترش بیشتر شده و از دو ماه پیش هر روز دچار این حالت بوده که علیرغم مراجعه به چند پزشک و استفاده از داروهای تجویزی بهبودی نسبی داشته ولی همچنان شاکی است درد بیمار تقریبا یک الی دو ساعت بعد از خوردن غذا شروع میشود که با احساس درد و سنگینی در ناحیه قسمت فوقانی شکم در خط وسط و زیر دنده ها همراه است به جای تیر نمیکشد گاهی اوقات حالت تهوع دارد ولی استفراغ خیر علایم ریفلاکس و سوزش پشت جناغ را گهگاه ذکر میکند ولی نه به صورت ممتد احساس نفخ را هم ذکر میکند و گاهی اوقات مرتب آروغ میزند ولی اینها تاثیری در شدت درد نداشته و یبوست را هم ذکر نمیکند سابقه کاهش وزن را ذکر نمیکند مشکلی در بلع را نیز نداشته درد و احساس ناخوشی فوق حدود دو ساعت طول میکشد و با خوردن دارو های که برایش تجویز شده و استراحت بهبود میابد ارتباط با غذای خاصی را به طور مشخص ذکر نمیکرد ولی با خوردن سرخ کردنی و سس مایونز به طور مشخص حملات بیشتر میشود تا کنون رژیم خاصی را هم برای درمان نداشته .

PMH & Drug– سابقه فشار خون از حدود ۲۰ سال پیش تحت درمان با لوزارتان ۲۵ دوبار در روز سابقه عمل جراحی و بیماری دیگری را ذکر نمیکند داروهای مصرفی در طول این مدت پنتاپرازول ۴۰ روزی یک عدد شربت Almg و کیلیدینیوم سی نه بصورت مرتب مصرف مسکن و Nsaid را در طول دو ماه اخیر ذکر نمیکند

- Habitual H – سابقه مصرف سیگار از سی سال پیش روزانه یک پاکت مصرف الکل و مواد مخدر را ذکر نمیکند عادت غذایی خاصی ندارد
- Familial H - سابقه کانسر گاسترو اینتستینال را در خانواده ذکر نمیکند متاهل است دارای دو فرزند و کارمند دارایی
- Physical Exam – BP=۱۳۵/۹۰ PR=۸۸ RR=۲۲ T=۳۷/۵ Weight= ۸۵ Height=۱۷۵ BMI= ۲۷/۸
- در معاینه در ظاهر ill و توکسیک نبود رنگ پریده و ایکتریک به نظر نمیرسید در سرو گردن ملتحمه نرمال بود در گردن تندرنس و محدودیت نداشت لنفادنوپاتی و توده ای در گردن و سوپراکلاویکل قابل لمس نبود در سمع برویی و سوفلی قابل شناسایی نبود Jvp برجسته نبود
- در معاینه قفسه سینه سمع قلب و ریه نرمال بود دفرمیتی تندرنس و لنفادنوپاتی در ناحیه زیر بغل در دو طرف قابل دیتکت نبود

- در معاینه شکم دور کمر ۹۸ سانت چاقی شکمی و مرکزی مشهود بود در سمع حرکات و صداهای روده ای طبیعی به نظر میرسید در دق Dullness و ماتیته ای قابل دیتکت نبود در لمس ارگانو مگالی مشهود نبود مقداری شکم نفاخ به نظر میرسید تندرنس مختصری در اپی گاستر داشت توده ای در ناحیه شکم قابل لمس نبود
- در معاینه اندامها مشکل خاصی نداشت

- Lab Test:
- Wbc=۶/۸ HB=۱۵ Hct=۴۵ Plat=۲۵۰۰۰۰Mcv=۸۶
- Fbs=۱۱۰ BUN=۲۲ Crea=۰/۹
- TG=۲۵۰ Chole=۲۲۰ HDL=۴۵ LDL=۱۲۵
- SGOT=۲۲ SGPT =۲۰ ALK-P=۱۵۵
- TSH=۲/۵
- VIT D۳=۳۵

Dyspepsia

- Dyspepsia was originally defined as any symptoms referable to the upper gastrointestinal tract
- Around ٨٠% of these patients do not have a structural explanation for their symptoms and are labeled functional dyspepsia
- Gastro-esophageal reflux and heartburn is not a symptom of dyspepsia, although it can coexist
- Vomiting is atypical and, if present, should prompt consideration of another disorder
- FD is diagnosed in the absence of a structural abnormality to explain the symptoms(organic, systemic or metabolic disease)

Table 1 Rome IV diagnostic criteria for functional dyspepsia

One or more of the following:

- Bothersome postprandial fullness
- Bothersome early satiation
- Bothersome epigastric pain
- Bothersome epigastric burning

Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

AND

No evidence of structural disease (including at upper endoscopy) that is likely to explain the symptoms

Epigastric pain syndrome (EPS)	***Postprandial distress syndrome (PDS)***
Must include one or both of the following symptoms *at least 1 day a week*: • Bothersome epigastric pain (i.e., severe enough to impact on usual activities) • Bothersome epigastric burning (i.e., severe enough to impact on usual activities) *Supporting criteria:* • Pain may be induced by ingestion of a meal, relieved by ingestion of meal or may occur while fasting • Postprandial epigastric bloating, belching, and nausea can also be present • Persistent vomiting likely suggests another disorder • Heartburn is not a dyspeptic symptom, but may often coexist • The pain does not fulfill biliary pain criteria • Symptoms that are relieved by evacuation of feces or gas generally should not be considered as part of dyspepsia • Other digestive symptoms (such as gastroesophageal reflux disease and irritable bowel syndrome) may coexist with the EPS	Must include one or both of the following symptoms *at least 3 days a week*: • Bothersome postprandial fullness (i.e., severe enough to impact on usual activities) • Bothersome early satiation (i.e., severe enough to prevent finishing a regular sized meal) *Supportive criteria:* • Postprandial epigastric pain or burning, epigastric bloating, excessive belching, and nausea can also be present • Vomiting warrants consideration of another disorder • Heartburn is not a dyspeptic symptom, but may often coexist • Symptoms that are relieved by evacuation of feces or gas should generally not be considered as part of dyspepsia • Other individual digestive symptoms or groups of symptoms (such as gastroesophageal reflux disease and irritable bowel syndrome) may coexist with PDS

Differential diagnosis of dyspepsia

Diagnosis
Functional dyspepsia
Dyspepsia caused by structural or biochemical disease
Peptic ulcer disease
Helicobacter pylori gastritis
Gastroesophageal reflux disease (GERD)
Biliary pain
Chronic abdominal wall pain
Gastric or esophageal cancer
Gastroparesis
Pancreatitis
Carbohydrate malabsorption
Medications (including potassium supplements, digitalis, iron, theophylline, oral antibiotics [especially ampicillin and erythromycin], nonsteroidal antiinflammatory drugs [NSAIDs], glucocorticoids, niacin, gemfibrozil, narcotics, colchicine, quinidine, estrogens, levodopa)
Infiltrative diseases of the stomach (eg, Crohn disease, sarcoidosis)
Metabolic disturbances (hypercalcemia, hyperkalemia)
Hepatocellular carcinoma
Ischemic bowel disease, celiac artery compression syndrome, superior mesenteric artery syndrome
Systemic disorders (diabetes mellitus, thyroid and parathyroid disorders, connective tissue disease)
Intestinal parasites (*Giardia*, *Strongyloides*)
Abdominal cancer, especially pancreatic cancer

- FD is associated with abnormalities in gastric compliance, abnormal fundus accommodation, delayed gastric emptying, and visceral hypersensitivity. Hence, treatment of patients is directed at targeting these mechanisms

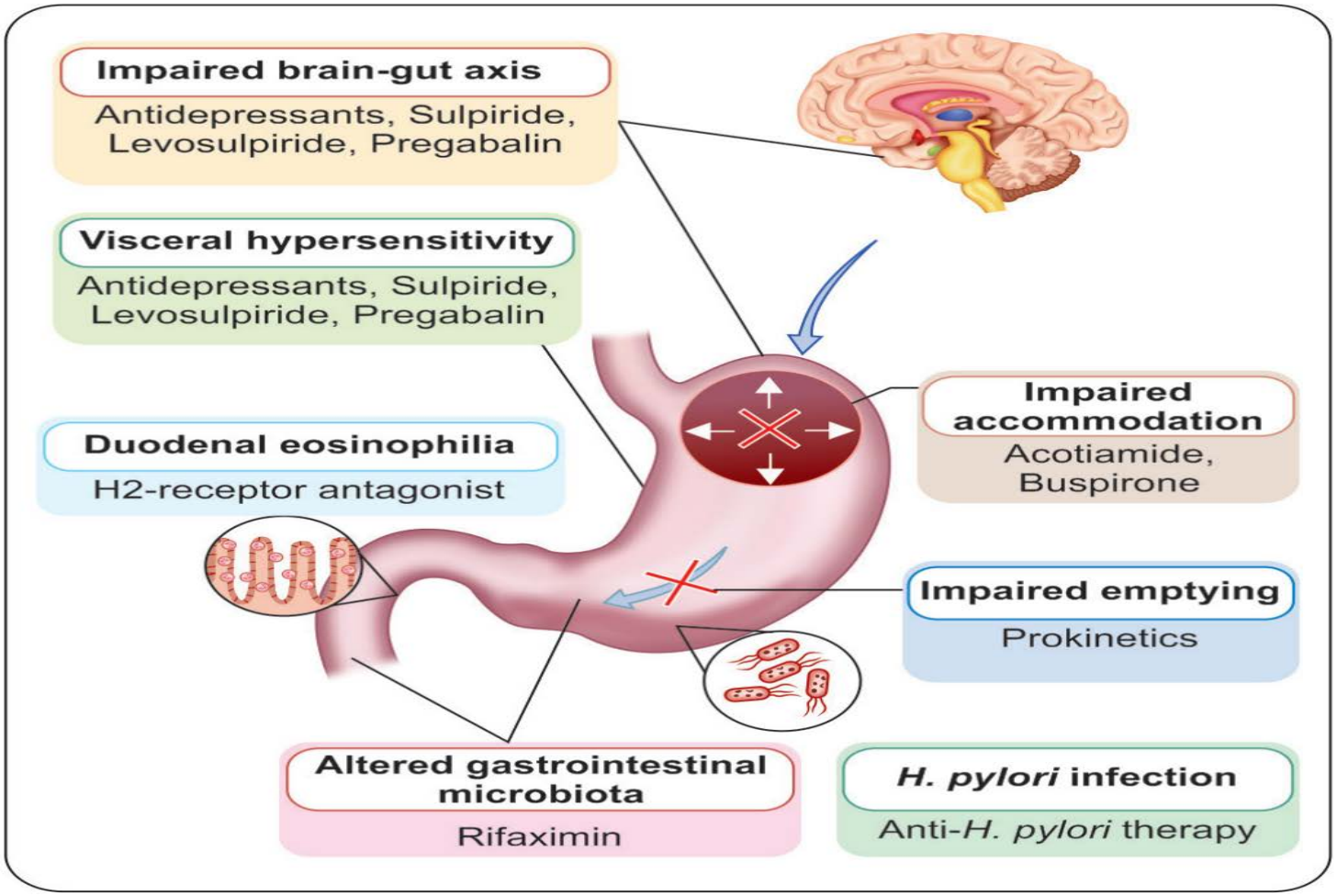


Fig. 1: Pathophysiology of functional dyspepsia with their pharmacotherapeutic targets.
Abbreviation: H. Pylori: Helicobacter pylori

Alarm features in dyspepsia

Unintentional weight loss
Dysphagia
Odynophagia
Unexplained iron deficiency anemia
Persistent vomiting
Palpable mass or lymphadenopathy
Family history of upper gastrointestinal cancer

Box 1 Upper gastrointestinal alarm symptoms or signs* that are referral criteria for suspected gastro-oesophageal cancer according to NICE.[112]

Definite referral criteria for urgent endoscopy to assess for gastro-oesophageal cancer

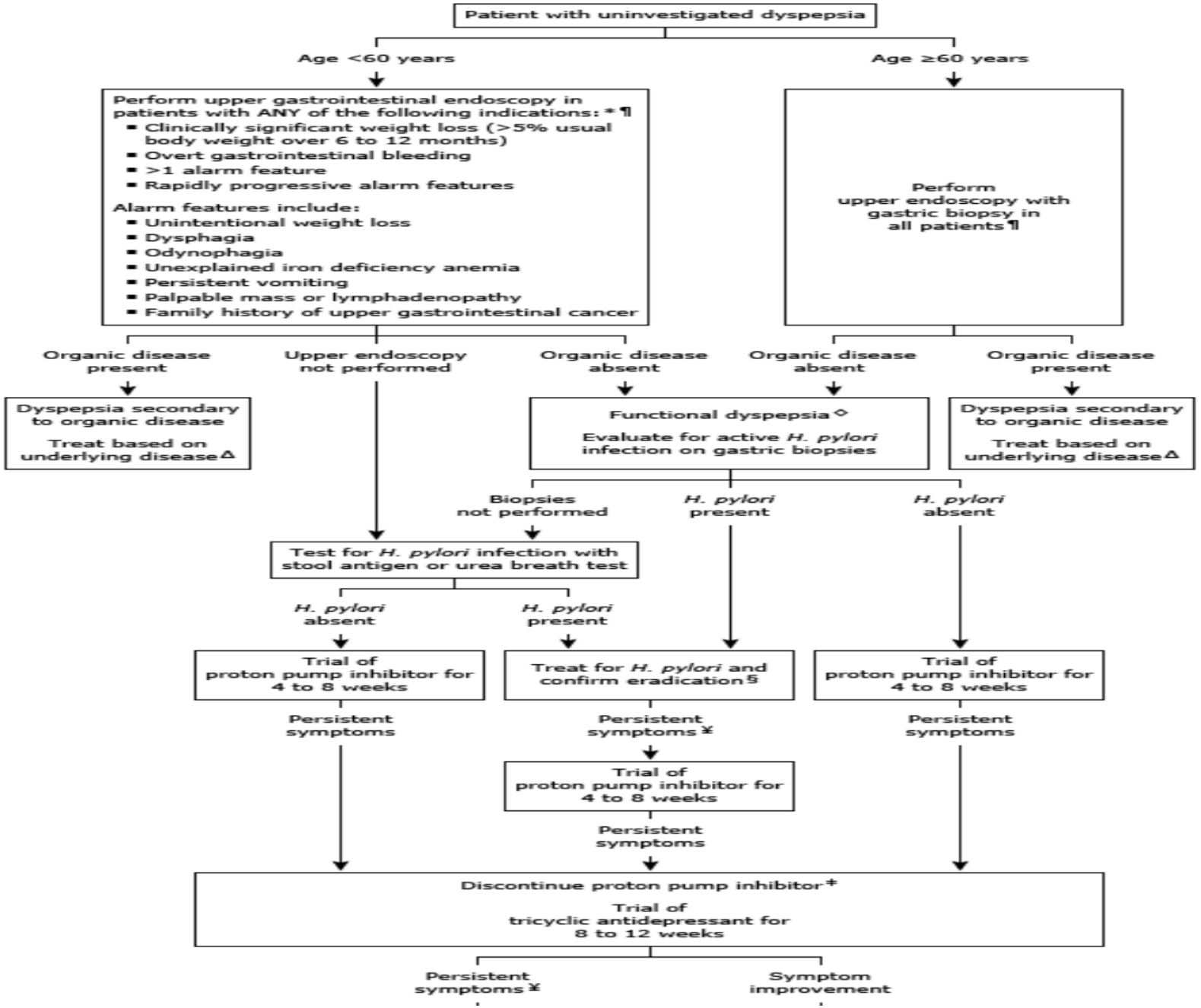
1. People of any age with dysphagia
2. People aged ≥55 years with weight loss and any of the following:
   i. Dyspepsia.
   ii. Upper abdominal pain.
   iii. Reflux.

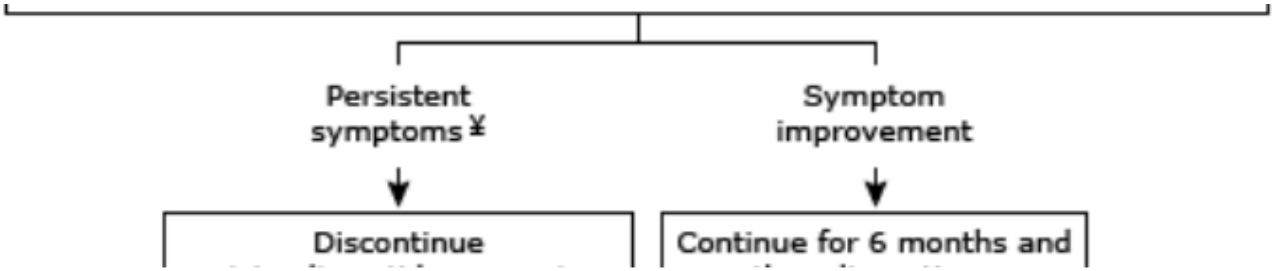
Probable referral criteria for non-urgent endoscopy to assess for gastro-oesophageal cancer

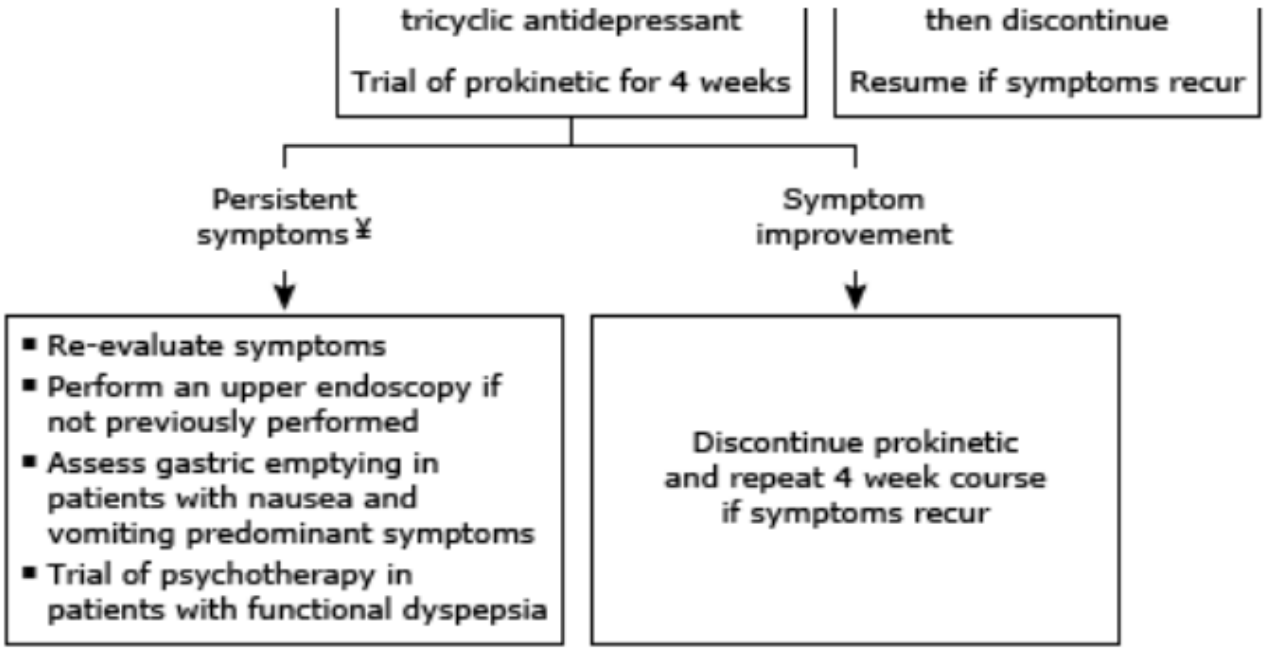
1. People with haematemesis.
2. People aged ≥55 years with:
   i. Treatment-resistant dyspepsia.
   ii. Dyspepsia with raised platelet count or nausea or vomiting.
   iii. Upper abdominal pain with low haemoglobin, raised platelet count or nausea or vomiting.
   iv. Reflux with raised platelet count, or nausea or vomiting.
   v. Nausea or vomiting with any of the following: weight loss, reflux, dyspepsia, or upper abdominal pain.

*An upper abdominal mass felt to be consistent with stomach cancer is a probable referral criterion for an outpatient clinic appointment within 2 weeks.

NICE, National Institute for Health and Care Excellence.


Patient with uninvestigated dyspepsia
Age <60 years
Age ≥60 years
Perform upper gastrointestinal endoscopy in patients with ANY of the following indications: * ¶
Clinically significant weight loss (>5% usual body weight over 6 to 12 months)
Overt gastrointestinal bleeding
>1 alarm feature
Rapidly progressive alarm features
Alarm features include:
Unintentional weight loss
Dysphagia
Odynophagia
Unexplained iron deficiency anemia
Persistent vomiting
Palpable mass or lymphadenopathy
Family history of upper gastrointestinal cancer
Perform upper endoscopy with gastric biopsy in all patients ¶
Organic disease present
Upper endoscopy not performed
Organic disease absent
Organic disease absent
Organic disease present
Dyspepsia secondary to organic disease
Treat based on underlying disease Δ
Functional dyspepsia ◇
Evaluate for active H. pylori infection on gastric biopsies
Dyspepsia secondary to organic disease
Treat based on underlying disease Δ
Biopsies not performed
H. pylori present
H. pylori absent
Test for H. pylori infection with stool antigen or urea breath test
H. pylori absent
H. pylori present
Trial of proton pump inhibitor for 4 to 8 weeks
Treat for H. pylori and confirm eradication §
Trial of proton pump inhibitor for 4 to 8 weeks
Persistent symptoms
Persistent symptoms ¥
Persistent symptoms
Trial of proton pump inhibitor for 4 to 8 weeks
Persistent symptoms
Discontinue proton pump inhibitor +
Trial of tricyclic antidepressant for 8 to 12 weeks
Persistent symptoms ¥
Symptom improvement


Persistent symptoms ¥
Symptom improvement
Discontinue
Continue for 6 months and


tricyclic antidepressant
Trial of prokinetic for 4 weeks
then discontinue
Resume if symptoms recur
Persistent symptoms ¥
Symptom improvement
Re-evaluate symptoms
Perform an upper endoscopy if not previously performed
Assess gastric emptying in patients with nausea and vomiting predominant symptoms
Trial of psychotherapy in patients with functional dyspepsia
Discontinue prokinetic and repeat 4 week course if symptoms recur

British Society of Gastroenterology guidelines on the management of functional dyspepsia

Recommendations

- We recommend that a full blood count is performed in patients aged ≥55 years with dyspepsia and coeliac serology in all patients with FD and overlapping IBS-type symptoms (recommendation: strong, quality of evidence: low).
- We recommend that if no other upper gastrointestinal alarm symptoms or signs are reported, urgent endoscopy is only warranted in patients aged ≥55 years with dyspepsia with weight loss, or those aged >40 years from an area at an increased risk of gastric cancer or with a family history of gastro-oesophageal cancer (recommendation: strong; quality of evidence: very low).
- We recommend that non-urgent endoscopy is considered in patients aged ≥55 years with treatment-resistant dyspepsia or dyspepsia with either a raised platelet count or nausea or vomiting (recommendation: strong, quality of evidence: very low).
- We recommend that urgent abdominal CT scanning is considered in patients aged ≥60 years with abdominal pain and weight loss to exclude pancreatic cancer (recommendation: strong; quality of evidence: very low).
- We recommend that all other patients with dyspepsia are offered non-invasive testing for *H. pylori* ('test and treat') and, if infected, given eradication therapy (recommendation: strong; quality of evidence: high).
- We recommend that successful eradication of *H. pylori* after 'test and treat' is only confirmed in patients with an increased risk of gastric cancer (recommendation: strong; quality of evidence: low).
- We recommend that patients without *H. pylori* infection are offered empirical acid suppression therapy (recommendation: strong; quality of evidence: high).

First-line treatment of FD

1. We recommend that all patients with FD are advised to take regular aerobic exercise (recommendation: strong, quality of evidence: very low).
2. There is insufficient evidence to recommend dietary therapies, including a diet low in fermentable oligosaccharides, disaccharides and monosaccharides, and polyols in FD (recommendation: weak; quality of evidence: very low).
3. Eradication therapy is an efficacious treatment for *H. pylori*-positive patients with FD. Adverse events are more common than with a control therapy (recommendation: strong; quality of evidence: high).
4. Histamine-$_2$-receptor antagonists may be an efficacious treatment for FD. These drugs are well tolerated (recommendation: weak, quality of evidence: low).
5. Proton pump inhibitors (PPIs) are an efficacious treatment for FD. There does not appear to be a dose response, so the lowest dose that controls symptoms should be used. These drugs are well tolerated (recommendation: strong, quality of evidence: high).
6. Some prokinetics may be an efficacious treatment for FD. However, efficacy varies according to drug class, and many of these drugs are unavailable outside of Asia and the USA. Most of these drugs are well tolerated (recommendation: weak, quality of evidence: low for acotiamide, itopride, and mosapride, recommendation: strong, quality of evidence: moderate for tegaserod).

- **Second-line treatment of FD**
- ► Tricyclic antidepressants (TCAs) used as gut–brain neuromodulators are an efficacious second-line treatment for FD. They can be initiated in primary or secondary care, but careful explanation as to the rationale for their use is required, and patients should be counselled about their side effect profile. They should be commenced at a low dose (eg, ١٠ mg amitriptyline once daily) and titrated slowly to a maximum of ٣٠–٥٠ mg once daily (recommendation: strong, quality of evidence: moderate).
- ► Antipsychotics, such as sulpiride ١٠٠ mg four times a day or levosulpiride ٢٥ mg three times a day, may be efficacious as a second-line treatment for FD. There should be careful explanation as to the rationale for their use and patients should be counselled on their side effect profile (recommendation: weak, quality of evidence: low).

- ► There is no evidence that selective serotonin reuptake inhibitors (SSRIs) used as gut–brain neuromodulators are an efficacious second-line drug for global symptoms in FD (recommendation: weak, quality of evidence: moderate).
- ► There is no evidence that serotonin norepinephrine reuptake inhibitors (SNRIs) used as gut–brain neuromodulators are an efficacious second-line drug for global symptoms in FD. However, as they are efficacious in other chronic painful conditions, more trials of these drugs are warranted (recommendation: weak, quality of evidence: low).
- ► Tandospirone ١٠ mg three times a day may be an efficacious second-line treatment for FD, but there is no evidence that other ٥-hydroxytryptamine-١A agonists, including buspirone ١٠ mg three times a day, are efficacious. However, more trials of these drugs are warranted (recommendation: weak, quality of evidence: low).

- ► Pregabalin ۷۵ mg once daily may be an efficacious secondline treatment for FD but further randomised controlled trials (RCTs) are needed and given its controlled drug status we advise this drug is only used in specialist settings (recommendation: weak, quality of evidence: low).
- ► Mirtazapine ۱۵ mg once daily may be an efficacious secondline treatment for patients with FD with early satiation and weight loss, but further RCTs are needed (recommendation: weak, quality of evidence: very low).

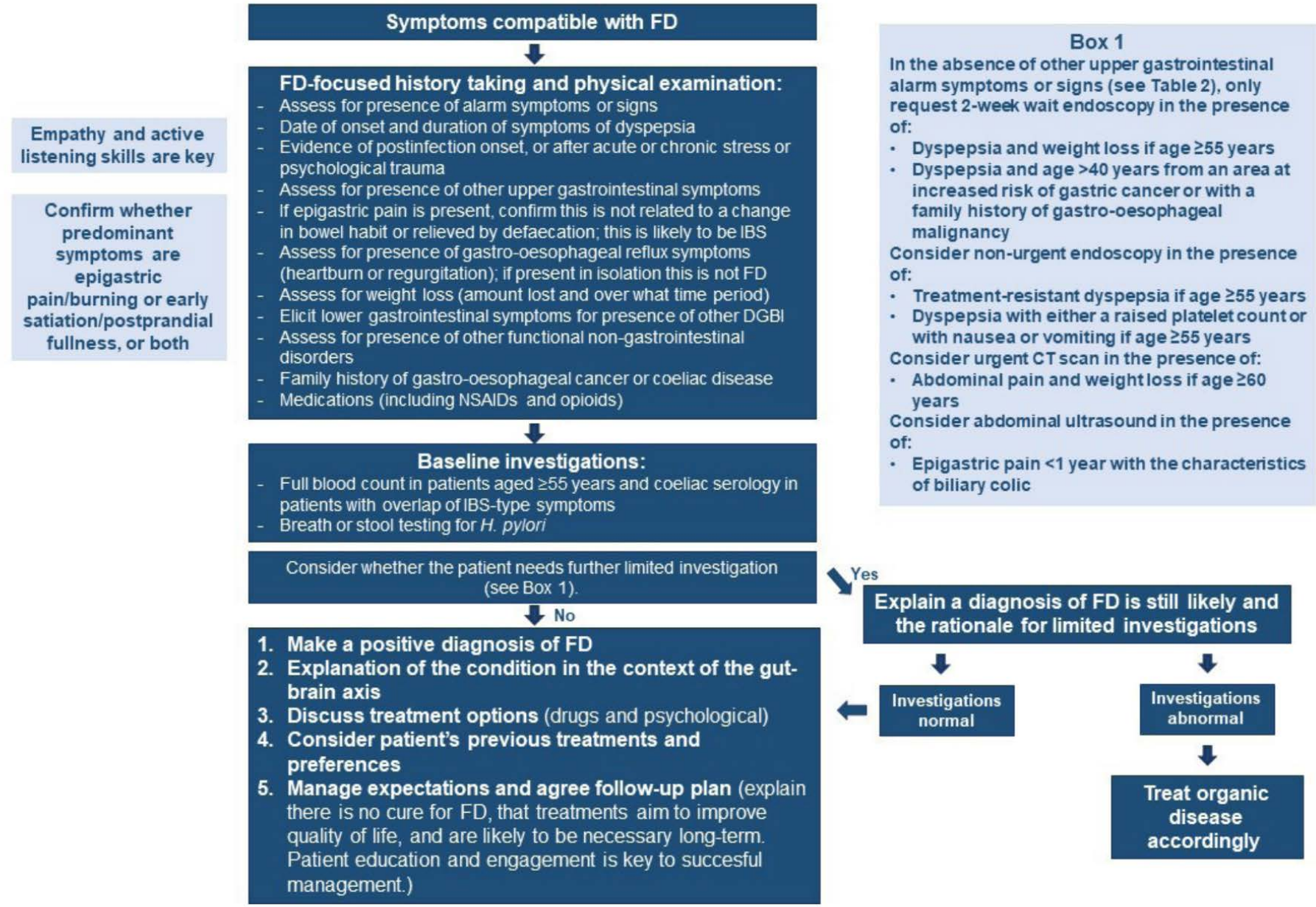
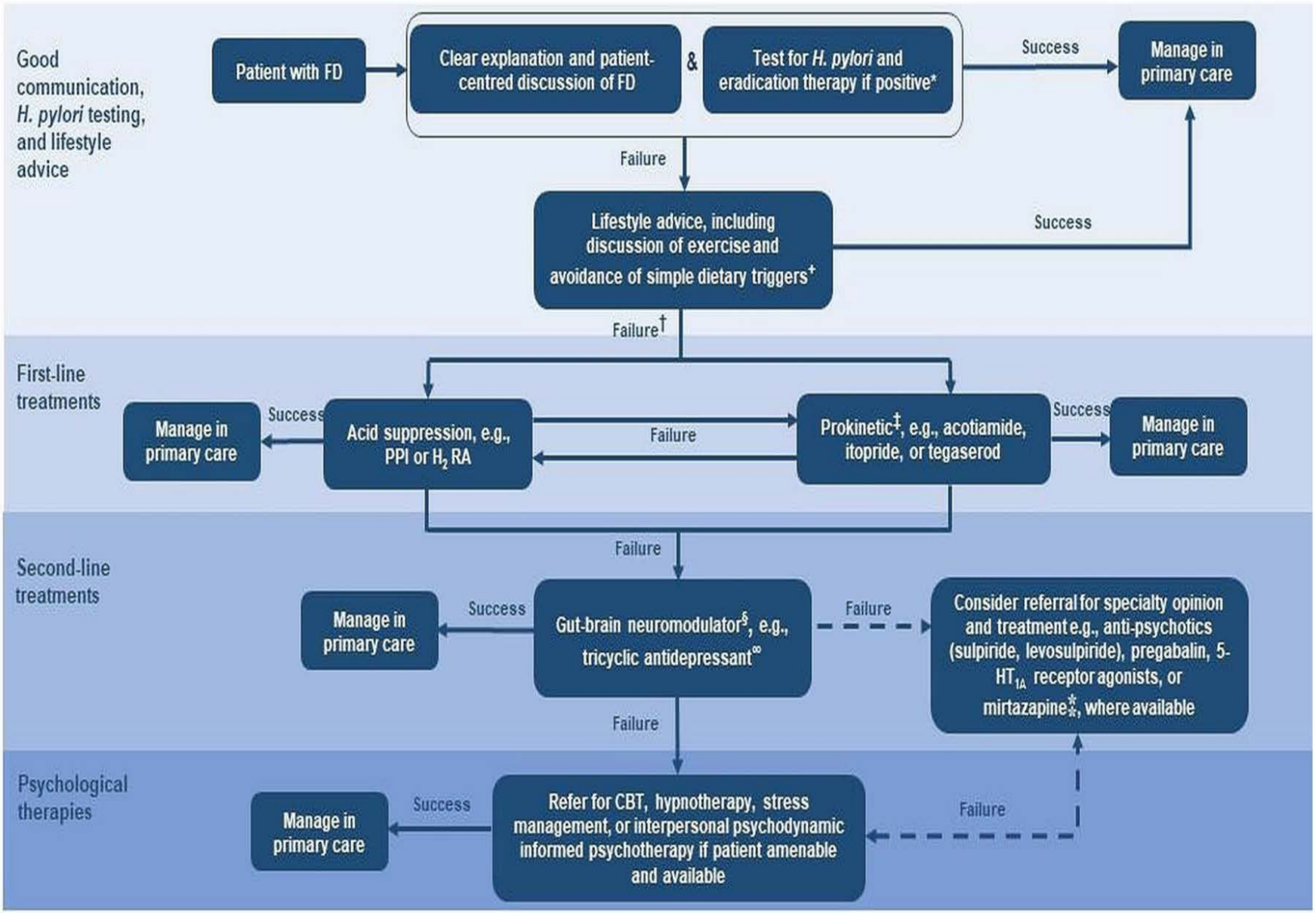


Figure 1 Diagnostic algorithm for functional dyspepsia. DGBI, disorder of gut–brain interaction; FD, functional dyspepsia.


Good communication, H. pylori testing, and lifestyle advice
Patient with FD
Clear explanation and patient-centred discussion of FD
&
Test for H. pylori and eradication therapy if positive*
Success
Manage in primary care
Failure
Lifestyle advice, including discussion of exercise and avoidance of simple dietary triggers+
Success
Failure†
First-line treatments
Manage in primary care
Success
Acid suppression, e.g., PPI or H2 RA
Failure
Prokinetic‡, e.g., acotiamide, itopride, or tegaserod
Success
Manage in primary care
Failure
Second-line treatments
Manage in primary care
Success
Gut-brain neuromodulator§, e.g., tricyclic antidepressant∞
Failure
Consider referral for specialty opinion and treatment e.g., anti-psychotics (sulpiride, levosulpiride), pregabalin, 5-HT1A receptor agonists, or mirtazapine⁂, where available
Failure
Psychological therapies
Manage in primary care
Success
Refer for CBT, hypnotherapy, stress management, or interpersonal psychodynamic informed psychotherapy if patient amenable and available
Failure

- **ACG and CAG Clinical Guideline: Management of Dyspepsia**

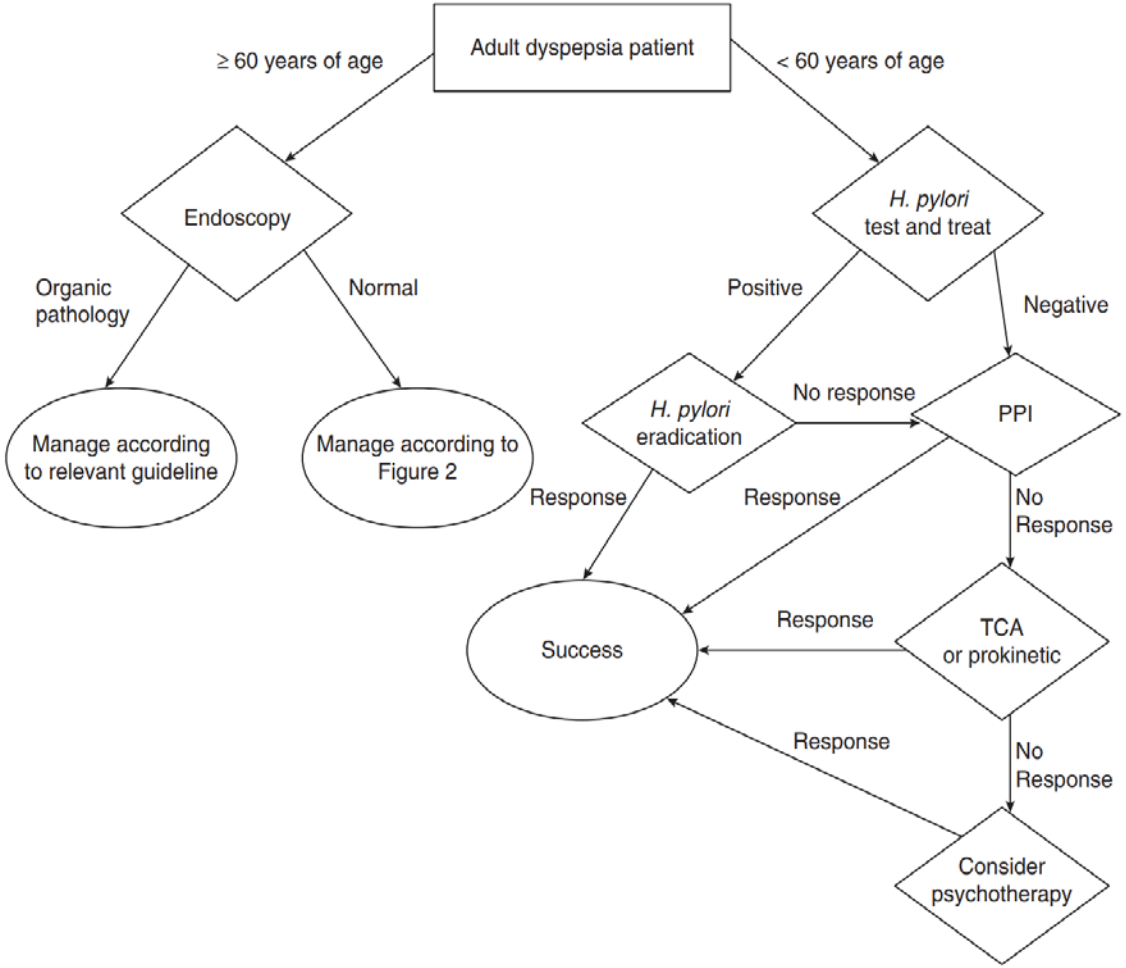


Figure 1. Algorithm for the management of undiagnosed dyspepsia.

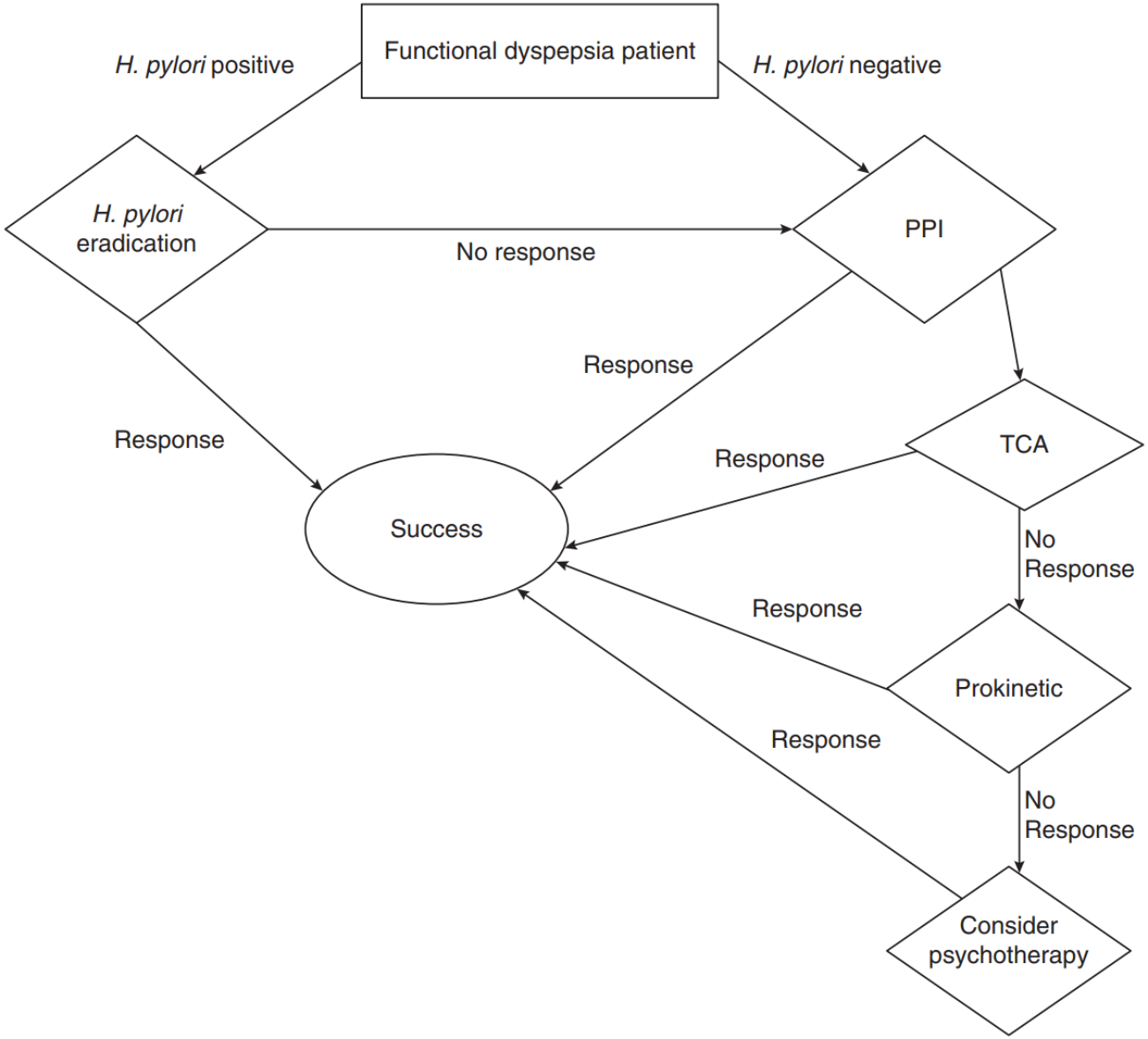


Figure 2. Algorithm for the treatment of functional dyspepsia.

Summary and strength of recommendations
ACG and CAG Clinical Guideline: Management of Dyspepsia

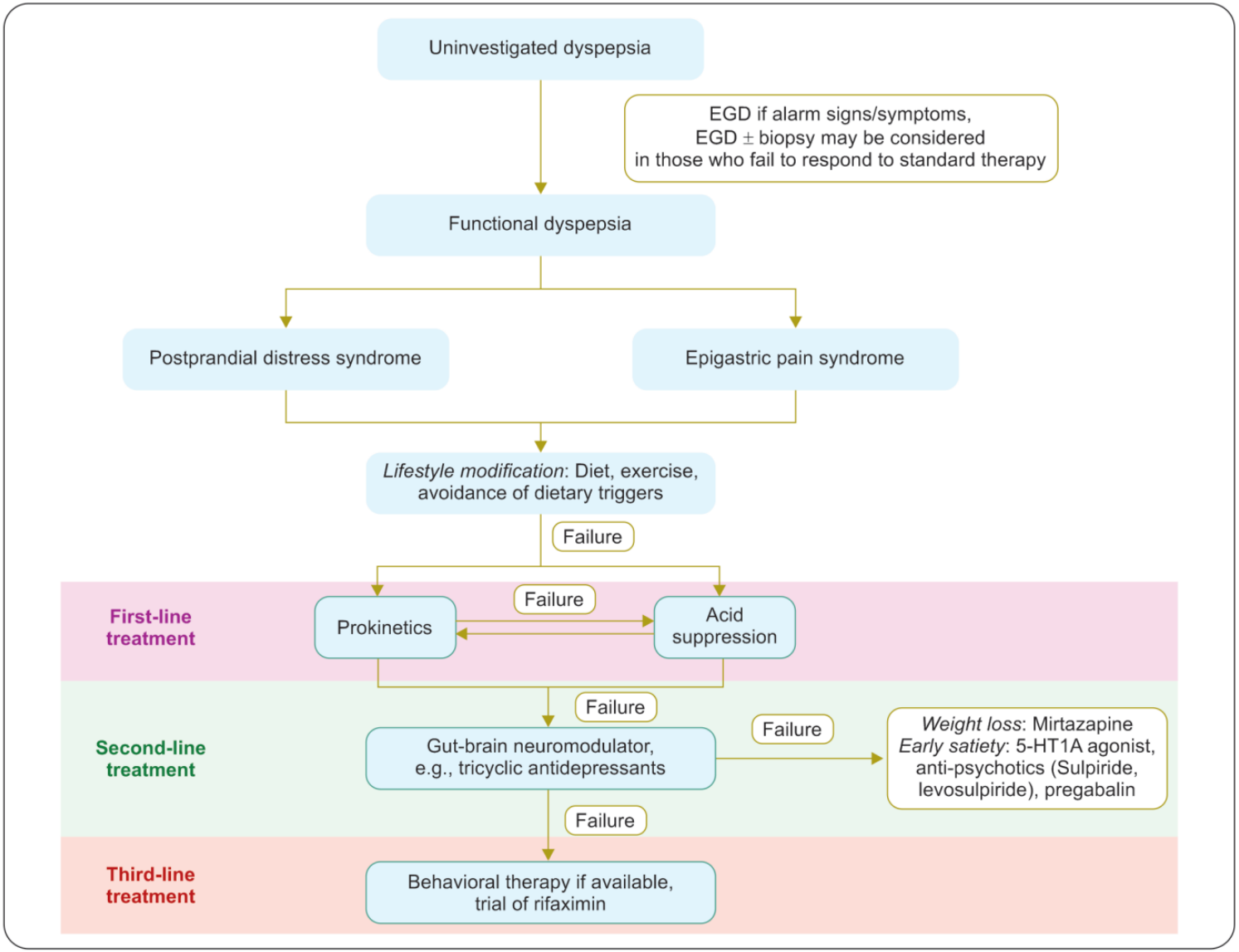
- ۱. We suggest dyspepsia patients aged ۶۰ or over have an endoscopy to exclude upper gastrointestinal neoplasia. Conditional recommendation, very low quality evidence.
- ۲. We do not suggest endoscopy to investigate alarm features for dyspepsia patients under the age of ۶۰ to exclude upper GI neoplasia. Conditional recommendation, moderate quality evidence.
- ۳. We recommend dyspepsia patients under the age of ۶۰ should have a non-invasive test for H. pylori, and therapy for H. pylori infection if positive. Strong recommendation, high quality evidence.
- ۴. We recommend dyspepsia patients under the age of ۶۰ should have empirical PPI therapy if they are H. pylori-negative or who remain symptomatic after H. pylori eradication therapy. Strong recommendation, high quality evidence.

- ۵. We suggest dyspepsia patients under the age of ۶۰ not responding to PPI or H. pylori eradication therapy should be offered prokinetic therapy. Conditional recommendation very low quality evidence.
- ۶. We suggest dyspepsia patients under the age of ۶۰ not responding to PPI or H. pylori eradication therapy should be offered TCA therapy. Conditional recommendation low quality evidence.
- ۷. We recommend FD patients that are H. pylori positive should be prescribed therapy to treat the infection. Strong recommendation, high quality evidence.
- ۸. We recommend FD patients who are H. pylori-negative or who remain symptomatic despite eradication of the infection should be treated with PPI therapy. Strong recommendation, moderate quality evidence.

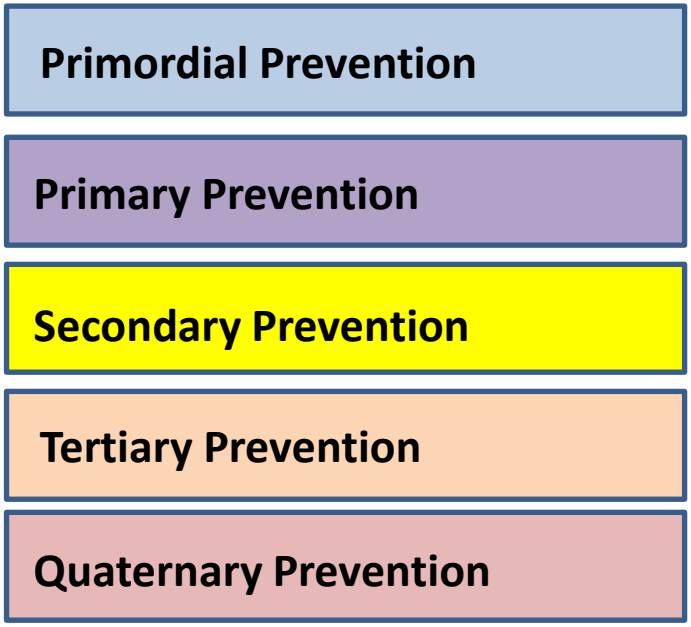
- ٩. We recommend FD patients not responding to PPI or H. pylori eradication therapy (if appropriate) should be offered TCA therapy. Conditional recommendation, moderate quality evidence.
- ١٠. We suggest FD patients not responding to PPI, H. pylori eradication therapy or tricyclic antidepressant therapy should be offered prokinetic therapy. Conditional recommendation, very low quality evidence.
- ١١. We suggest FD patients not responding to drug therapy should be offered psychological therapies. Conditional recommendation, very low quality evidence.
- ١٢. We do not recommend the routine use of complementary and alternative medicines for FD. Conditional Recommendation, very low quality evidence.

- ۱۳. We recommend against routine motility studies for patients with FD. Conditional recommendation, very low quality evidence.
- ۱۴. We suggest motility studies for selected patients with FD where gastroparesis is strongly suspected. Conditional recommendation, very low quality evidence

Flowchart 1: Approach to management of functional dyspepsia.



Abbreviations: EGD: Esophagogastroduodenoscopy; 5-HT1A: Serotonin1A recetoor


Primordial Prevention
Primary Prevention
Secondary Prevention
Tertiary Prevention
Quaternary Prevention

Primordial Prevention

- ۱- اقدام در خصوص ترویج سبک زندگی سلام و عدم مصرف سیگار فعالیت بدنی و ورزش کنترل وزن و رژیم غذایی سالم و بهداشت روانی
- ۲- آموزش در خصوص تشکیل پرونده الکترونیک سلامت جهت تمامی آحاد جمعیت کشور و ارزش و اهمیت انجام مراقبتهای لازم در هر گروه سنی
- ۳- آموزش های لازم در سطح ملی برای آشنایی با علایم بیماری و ریسک فاکتورها

Primary Prevention

۱- انجام مراقبتهای دورهای در هرگروه سنی حسب مورد

۲- شناسایی افراد پر خطر و در معرض ریسک جهت توصیه های لازم بهداشتی

Secondary Prevention

۱- بیماریابی بموقع در جمعیت در معرض ریسک و انجام اقدامات تشخیصی اولیه

۲- غربالگری کوموربیدتی های زمینه ای

Tertiary Prevention

- ۱- انجام اقدامات تشخیصی بموقع و بر اساس آخرین راهنماهای بالینی
- ۲- دادن اطلاعات لازم به بیمار جهت اطلاع از بیماری و شرکت فعال در انجام اقدامات تشخیصی و درمانی
- ۳-پیگیری مستمر بیماران و انجام آزمایشات و مراقبت های دوره ای

Quaternary Prevention

- ۱- مونیتورینگ دقیق و درمان بموقع جهت جلوگیری از عوارض احتمالی
- ۲- عدم انجام اقدامات پاراکلینیکی و دارویی که تاثیر خاصی بر پیش آگهی و عوارض بیماری ندارد