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DYSPEPSIA IN PRIMARY HEALTH CARE - CASE REPORT

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Abstract: Dyspepsia is a term originated from the Greek prefix dys- (bad) and the word pepsis (digestion) and it means indigestion. Dyspepsia is a symptom which indicates occasional or constant pain in the region of the upper abdomen or discomfort which is described in the form of early satiety or a feeling of fullness in the stomach. Sometimes it can be accompanied by nausea, vomiting and heartburn. The symptoms of dyspepsia are not specific enough to indicate a particular disease. And if indicated, additional diagnostics are performed in order to prove or rule out a physical disorder.

Dyspepsia is a frequent reason for visiting the doctor. About 40% of the world's population has symptoms of dyspepsia, most often the working population aged between 20-40 years, equally in both sexes. About 25% of patients seek doctor's help, while the rest seek help for their problems at a pharmacy. Dyspepsia is the reason for 40% of performed gastroenterology consultations.

This article presents the clinical picture, therapeutic and diagnostic course, as well as the outcome of the treatment of a 53-year-old patient who came to the doctor with symptoms of dyspepsia. The symptoms of dyspepsia had lasted for several years before coming to the doctor. During the first examination, an anamnesis was taken, the review of systems was performed, and a basic blood test done in the local Health center. Given that there was no data on the existence of alarming symptoms in this patient, symptomatic therapy and advised change of habits were included, as well as a planned checkup in one month. At the checkup, the patient reported a decrease in frequency and intensity of abdominal pain, so it was decided to perform additional diagnostics: test for Helicobacter pylori, fecal occult blood test, and ultrasound examination of the abdomen. Requested result of FOBT was negative, but the test for Helicobacter pylori was positive.

Ultrasound examination revealed the presence of small calculi in the gallbladder, but there were no other significant clinical findings. Eradication therapy for helicobacter infection was included, and an examination by a gastroenterologist for further diagnostics (esophagogastroduodenoscopy) was planned. Gastroscopy findings were described as chronic non-atrophic gastritis, predominantly antral. A follow-up gastroscopy was planned in five-year interval, the patient was given the proton pump inhibitors therapy, as well as dietary instructions.

Given that dyspepsia often occurs in clinical practice, it was necessary to make a proper assessment regarding further diagnostics, on the one hand for economic reasons and on the other hand for medical reasons. Here, the decision was made to carry out further diagnostics considering the duration of the health problems, the presence of the problems during symptomatic therapy, the age of the patient and his concerns. Given the absence of alarming symptoms, appointments were scheduled for all examinations, so a complete diagnosis of organic dyspepsia was reached after 13 months.

Key words: dyspepsia, clinical picture, diagnostic tests, therapy

INTRODUCTION

Dyspepsia is a term originated from the Greek prefix dys- (bad) and pepsis (digestion) and it means indigestion. Dyspepsia is a symptom that indicates occasional or constant pain in the region of the upper abdomen or discomfort that is described in the form of early satiety or a feeling of fullness in the stomach. Sometimes it can be accompanied by nausea, vomiting and heartburn. The symptoms of dyspepsia are not specific enough to indicate a particular disease.

Dyspepsia is a frequent reason for visiting the doctor. About 40% of the world's population has symptoms of dyspepsia, most often the working population aged between 20-40 years, equally in both sexes. About 25% of patients seek doctor's help, while the rest seek help at a pharmacy.

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The cause of dyspepsia can be an organic disease such as stomach ulcer disease, gastroesophageal reflux disease, stomach or pancreatic cancer and others, when it is marked as organic dyspepsia. If an organic disease is not identified, then they are marked as functional dyspepsia.

The most common causes of dyspepsia are: functional dyspepsia up to 60%, peptic ulcer 15-25%, reflux esophagitis 5-15%, stomach and esophagus cancer less than 2%. Less common causes of dyspepsia are: biliary diseases, pancreatitis, taking some medicines, ischemic bowel diseases, parasitosis, malabsorption of carbohydrates, systemic diseases, pancreatic cancer, and other abdominal tumors.

The main symptoms are burning, a feeling of discomfort and fullness in the stomach that occurs before or after eating. It can also be accompanied by a feeling of nausea, vomiting, heartburn, general weakness, as well as belching. If the predominant symptom of functional dyspepsia is pain, it is designated as ulcer-like dyspepsia, and if the predominant symptom is a feeling of discomfort in the epigastrium, it is designated as dysmotility-like dyspepsia.

Alarming symptoms are symptoms that may indicate the existence of an organic disease manifested by dyspepsia, such as ulcer disease, cancer of the esophagus or stomach. These include: sudden anemia due to bleeding from the digestive tract (within the last 10 days), severe unwanted weight loss (> 5% within 10 days), persistent vomiting within 10 days, dysphagia, and the presence of a palpable mass in the abdomen. In the presence of alarming symptoms, a quick consultation of a gastroenterologist is necessary within two weeks.

CASE REPORT

A 53-year-old patient comes to the doctor with symptoms that have been going on for several years in the form of discomfort in the upper abdomen, occasionally a feeling of early satiety, occasionally followed by pain and heartburn. The symptoms are stronger after taking some food and larger meals. Appetite is normal, he has not lost weight. The stools are tidy, without any appearance of blood and mucus. In case of the symptoms' aggravation, he takes baking soda. He occasionally drinks alcohol (once or twice a week, 0.3-0.5 l of beer), smokes about 10 cigarettes a day and has done so for the last 20 years. Due to back pain, he takes NSAIDs (ibuprofen, naproxen, ketoprofen). Family history is negative in terms of malignancy of the digestive tract. The patient's son has ulcerative colitis.

Physical examination is performed, the patient is in a good general condition, pre-obese, the review of the systems is normal, except for the light pain in the epigastrium region during deep palpation examination. The patient is given a written diet on food to avoid, as well as an advice on reducing the amount of meals he eats and the dynamics of their intake. Recommendation to avoid alcohol intake and referral to the Smoking Cessation Counseling Center. Pantoprazole 40mg is introduced half an hour before breakfast for the next two weeks, with further recommendation to reduce the dose to 20mg per day for another 2-4 weeks. In case of heartburn, sodium alginate suspensions are recommended. Checkup planned in 4-6 weeks with a basic blood test done at the local Health center.

At the checkup, the patient reports a decrease in frequency and intensity of abdominal pain, no weight loss, frequent regular stools. Blood test and biochemical results with no clinical significance. Given that the symptoms are still present, it is decided to perform additional diagnostics: test for Helicobacter pylori, fecal occult blood test, and ultrasound examination of the abdomen. Requested result of FOBT was negative, but the test for Helicobacter pylori was positive.

On ultrasound, apart from the presence of small calculi in the gallbladder, there are no other significant clinical findings. A 14-day eradication therapy for helicobacter infection is included (clarithromycin 2x500mg, amoxicillin 2x1000mg, bismuth subcitrate 4xdaily, pantoprazole 2x40mg, probiotics). After the therapy, the patient feels better, symptoms occasionally present.

For further diagnostics an examination by a gastroenterologist (esophagogastroduodenoscopy) is appointed after 4 months.

The gastroenterologist's diagnosis is Morbus refluxualis gastro-oesophageus, and the patient is put on the waiting list for gastroscopy, which is performed after 7 months. Gastroscopy findings are described as chronic non-atrophic gastritis, predominantly antral. A follow-up

gastroscopy is planned in five-year interval, the patient is given the proton pump inhibitors therapy, as well as dietary instructions. The patient suffers from dyspepsia only when he does not pay attention to his diet, during frequent use of NSAIDs analgesics and in stressful situations, but since the cause of dyspepsia symptoms is known, his concern for his own health is significantly less.

CONCLUSION

Given that dyspepsia often occurs in clinical practice, it is necessary to make a proper assessment regarding further diagnostics, on the one hand for economic reasons and on the other hand for medical reasons. Here, the decision is made to carry out further diagnostics considering the duration of the health problems, the presence of problems during symptomatic therapy, the age of the patient and his concerns. Given the absence of alarming symptoms, appointments were scheduled for all examinations, so a complete diagnosis of organic dyspepsia is reached after 13 months.

In the subsequent checkups, the patient is motivated to follow the dietary advice, it is explained to him when he needs to take proton pump inhibitors and sodium alginate and for how long. The controlled use of analgesics, mandatory with proton pump inhibitors, is explained. He stopped smoking and reduced his alcohol intake to a few times a year. Due to his stressful lifestyle, he is involved in working with a psychologist for training in relaxation techniques, which also contributes to the reduction of complaints. It is explained to him which symptoms and signs are worrisome and when it is necessary to report urgently for an examination. The patient, who rarely visited the doctor, is now interested in conducting preventive examinations, and if he has new health issues, he consults the doctor and avoids self-medication.

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