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Director's Forum

Center For Swallowing Disorders - University of South Florida Medical Center

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Dyspepsia

Dyspepsia - often called indigestion - is a common malady that many of us have come to associate with the TV ads featuring those poor souls who can't believe they ate the whole thing. While dyspeptic symptoms are often caused by overeating or eating the wrong foods, the disorder can be associated with a more serious problem.

Dyspepsia means painful, difficult, or disturbed digestion. The chronic recurrence and persistence of crippling dyspeptic symptoms disrupts the lives of many Americans. People suffering from the most severe symptoms can become disabled enough to miss work. Frequent doctor's visits and expensive diagnostic procedures can create a financial drain. In addition, many unnecessary operations are performed in an attempt to relieve the painful symptoms. Unfortunately, despite the surgery, patients often continue to suffer from the symptoms of dyspepsia.

There are multiple causes of dyspepsia and some of them are not clearly understood. Too often dyspepsia has been dismissed as a psychosomatic disorder. However, in recent years, doctors have begun to recognize that dyspepsia is often the result of a malfunctioning of either the nervous system or the muscular activity of the esophagus, stomach or small intestine.

What is Dyspepsia?

A person is said to have dyspepsia if she/he suffers from several of a group of symptoms which might include nausea, regurgitation (backwash of stomach contents into the esophagus and mouth), vomiting, heartburn, prolonged upper abdominal fullness or bloating after a meal, stomach discomfort or pain, and early fullness (satiety). Often people say that they have a "sick feeling in the stomach", "nausea", or "indigestion." or maybe, "nervous stomach" when they are suffering from dyspeptic symptoms. Sometimes a person will experience these symptoms after overeating, drinking too much alcohol, or eating foods that disagree with them. Sometimes the symptoms accompany disease such as peptic ulcer, disease of the gallbladder or pancreas, or gastritis. Other people experience the symptoms for no apparent reason. The symptoms can last for 3 to 4 days, sometimes longer. In some people, dyspeptic symptoms can be severe and continuous, disrupting daily routines and causing absences from work.

Who Gets Dyspepsia?

Although dyspepsia can afflict men and women from all walks of life, it is most common in women ranging in age from 16 to 60. A woman is even more likely to experience dyspepsia during her childbearing years. Also, patients in whom irritable bowel syndrome (IBS) has been diagnosed comprise the majority of dyspepsia sufferers.

What Causes Dyspepsia?

Dyspepsia can be caused by many different things. Symptoms can accompany gastritis (inflammation of the stomach), viral gastroenteritis (stomach flu), stomach ulcer, cancer of the stomach, gallbladder disease, pancreatic diseases, and IBS. Pregnancy and advanced diabetes mellitus can also be accompanied by dyspepsia.

But dyspepsia also can occur without the presence of other digestive disorders. If no disease is apparent, doctors have, in the past, tended to diagnose patients as having a stress-related psychosomatic disorder.

In recent years, however, medical research has recognized that the stomach and small intestine are regulated by "pacemakers" - much like the heart - that coordinate the movement of the muscles of the digestive tract. During normal digestion, the muscle wall contracts and relaxes, allowing the upper part of the stomach to serve as a reservoir and the lower part to begin the breakdown (digestion) of food. When the breakdown is complete, the stomach empties its contents into the upper part of the intestine (the duodenum) at a rate of about 5 milliliters (1 teaspoon) every 20 seconds.

The delicate motions of the esophagus, stomach and small intestine are regulated by the brain and by a network of nerves embedded in the muscle of the digestive tract wall. The coordination between these nerve endings that secrete a variety of chemical substances (called neurotransmitters or hormones) and the muscle fibers in the wall of the digestive tract regulate the movement of the tract and thereby promote the digestion, absorption, and elimination of the food we eat. Any disruption in the normal functioning of the nervous system or the muscular activity of the digestive tract can cause dyspepsia.

How is Dyspepsia Diagnosed?

If your symptoms are severe enough to interfere with your daily routine, you should see your doctor. To rule out diseases of the esophagus, stomach, pancreas, and gallbladder, your doctor will obtain a complete history and physical examination and may recommend studies that may include routine blood and urine tests, and upper GI (x-ray) series, abdominal sonogram, and endoscopy. Unfortunately, although these tests are necessary to eliminate serious gastrointestinal disorders, they offer little help in confirming dyspepsia that is caused by disruption in the normal functioning of the nervous system or the muscular activity of the digestive tract. Researchers are developing new procedures to monitor the activity of the stomach and duodenum in much the same way that an electrocardiogram records the electrical activity of the heart. Also, doctors can measure gastric (stomach) emptying to determine whether there is any abnormality in this phase of the digestive process. Such an abnormality is often found in patients with severe dyspepsia. It is important to understand that excessive fat intake slows emptying of the stomach in everyone and alone can cause symptoms typical for dyspepsia. More research is needed, however, before satisfactory procedures to diagnose dyspepsia can be developed.

Is Dyspepsia Caused By Emotional Tension Or Distress?

It is well known that dyspepsia-like symptoms can accompany emotional upsets. However, emotional tension may not be the most common cause or even the precipitating factor. Before emotional tension or distress can be named as the culprit causing dyspepsia, your doctor will conduct a careful medical evaluation to rule out other factors.

How Are Symptoms Controlled?

If your dyspepsia is associated with gastritis, peptic ulcer disease, gallbladder disease, or some other organic disorder, your doctor will begin by treating the specific disorder.

Most of the time, dyspepsia not associated with a specific illness can be controlled by diet. Avoiding greasy foods or solid foods containing meat often helps. And, if you are lactose intolerant, eliminating all dairy products from your diet may provide relief. If your symptoms are severe, your doctor may recommend that you take only liquids or small amounts of soft foods until the symptoms subside. If these measures do not work, your doctor may prescribe medications to control persistent symptoms.

In Summary

Dyspepsia is a common, non-specific, digestive disorder among Americans and has many causes. These include intestinal diseases, inappropriate diet, or a disturbance in the delicate mechanisms that govern the muscular activities of the stomach and small intestine.

Per-Oral Esophageal Dilation

Janet Jones, CGC
Patient Care Coordinator

An esophageal stricture is a mechanical obstruction or narrowing of the opening in the esophagus. Several causes of esophageal narrowing include chronic reflux of acid into the esophagus which can cause inflammation and scarring, pill-induced strictures (quinaglute, potassium, vitamin C and some antibiotics), lower esophageal rings (thickening of the esophageal mucosa of unknown cause), esophageal cancer, or congenital strictures present since birth.

In most instances, the treatment of choice is dilation (stretching) of the esophagus and reduction or removal of the esophageal irritant (e.g., acid, pills, etc.). Dilation is accomplished by passing special instruments (dilators) through the mouth and esophagus.

There are several types of dilators, all are flexible and can be seen under x-ray. Some are made of rubber, are tapered and weighted (Maloney type) and others are made of flexible plastic and require a guide wire to follow through the esophagus (Savary type). The type of dilator used depends on the cause and physical characteristics of the stricture. The procedure is performed under x-ray guidance (fluoroscopy) while the doctor

watches the dilator pass through the esophagus on the x-ray screen. This adds a measure of safety and assurance that the narrowed segment is stretched without exerting abnormal pressure against other areas above or beyond the stricture.

Frequently a series of dilations over several weeks are required to gradually stretch the narrowing enough to allow foods to pass without sticking. Many strictures require periodic dilation to keep the esophagus open. The patient is the best judge of response to the dilation and will be advised to call for discussion with the gastroenterologist regarding further dilation should two (2) successive episodes of solid food sticking occur.

The frequency of need for esophageal dilation is governed by the cause and severity or tightness of the stricture. No two strictures are exactly alike so it is not possible to determine a single program of treatment that is suitable for everyone.

Tips and Tricks on Tablets

Over-the-counter or prescription medication for relief of inflammation, or for minor injuries, is part of some persons daily routines. A few, however, have trouble swallowing pills.

If you take a time-released medication and can't swallow it whole, don't crush it and mix it with food. This might result in inappropriate dosing because these pills are designed to release their contents slowly during digestion.

A few simple tips may help your medicine go down:

1. Swallow the pill with food, to disguise the shape, size, and feel of the pill..
2. Do not tilt your head back. This stretches your esophagus and narrows the back of your throat and makes it harder to swallow.
3. Try to buy pills with a gelatin coating, they're easier to swallow.
4. Finally, find out if the medication comes in a liquid form.

If the pill you are taking has an unpleasant taste, this is easily resolved by swallowing it in a teaspoonful of butterscotch ice cream topping. The butterscotch seems to disguise most bad tasting medications. Remember though, you should count the calories if you use this trick very often.

Because there is the possiblility of any pill sticking, even in a normal esophagus, be sure to take all medications with 3 ounces of liquid per tablet or capsule and remain upright for at least 10 minutes. Never take pills without liquid or while lying down!

Things To Remember

1. **OFFICE HOURS:** 8:30 a.m. till 4:30 p.m. Monday through Friday.

   Our office is **closed on weekends** so it is important to make sure any medication refills are called to us during our regular office hours.

   Also, our emergency telephone number for after hours is (813) 974-2201. Please remember these calls will be responded to by one of our gastroenterology residents who will in turn contact the appropriate attending physician on call.

2. **BILLING:** Individuals who may have any problems with their accounts should contact the Patient Relations Department of the University of South Florida Medical Clinics at (813) 974-3573 between the hours of 10:00 a.m. till 4:00 p.m. Monday through Friday. For those patients who are from out-of-town, a new toll-free number has been added for you to call with billing questions. The number is 1-800-933-8672. This number is for calls originating in Florida and is **only for billing questions.**

3. **DILATIONS:** For our patients who receive periodic esophageal dilations: Please try to anticipate and contact our office at least 2 to 3 weeks in advance of your need for dilation if at all possible. We have been having to schedule routine cases 2 to 3 and sometimes 4 weeks in advance due to our heavy patient load. We do not want any of you to suffer unnecessarily, so please help us with your appointment needs.

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Continuing Medical Education

During the past year, members of the Center for Swallowing Disorders staff have continued their active participation in postgraduate and graduate medical education at regional, national, and international meetings. These presentations on topics related to swallowing disorders require considerable research and time to prepare teaching slides and videotapes. Contributions to the medical literature in journals and textbooks also have been significant.

Lecture Presentations by CSD Staff

1. December 4-7, 1991: University of South Florida College of Medicine Gastroenterology 15th Annual Postgraduate Course, Lake Buena Vista, FL. "Gastrointestinal Endoscopy: Update on Diagnostic and Therapeutic Techniques". Lectures: - EUS-Diagnosis of Submucosal Lesions; Polyvinyl & Silicone Esophageal Prosthesis; Diagnostic Laparoscopy - Patient Preparation & Site Selection; Laparoscopic Anatomy and Pathology. (Boyce).
2. December 12-13, 1991: College of Physicians and Surgeons of Columbia University, New York, NY Update in Gastroenterology & Hepatology. Lecture: Management of Dysphagia. (Boyce).
3. February 22, 1992: The North American Conference of Gastroenterology Fellows, Sarasota, FL. Lecture: Mechanisms and Management of Dysphagia. (Boyce).
4. March 5, 1992: Fitzsimmons Army Medical Center and St. Joseph's Hospital Grand Rounds, Denver, CO. Lecture: Diagnosis of Swallowing Disorders: Caveats for Clinicians. (Boyce).
5. March 19-21, 1992: Center for Swallowing Disorders Clinical Esophagology Postgraduate Course, Atlanta, GA. Lectures: Esophagogastric Junction - Endoscopic Observations; Clinical Manifestations of GERD; Treating Dysphagia Syndromes of GERD; Columnar-Lined Esophagus - Diagnosis and Management; Non-Reflux Esophagitis - Differential Diagnosis; Achalasia - Endoscopic Diagnosis and Therapy; Palliation of Malignant Esophageal Obstruction - Dilation/Prosthesis. (Boyce).
6. March 19-21, 1992: Center for Swallowing Disorders Clinical Esophagology Postgraduate Course, Atlanta, GA. Lecture: Upper Aero-Digestive and Pulmonary Sequelae of GERD - What We Know and Don't Know. Do Tests Help? (Davis).
7. March 19-21, 1992: Center for Swallowing Disorders Clinical Esophagology Postgraduate Course, Atlanta, GA. Lecture: Center for Swallowing Disorders - Overview Of A Four Year Experience. (Jones).

Contributions To Medical Literature

1. Blosser A, Gallagher J, Maher K, Barkin J, Boyce HW Jr., Gefland M, Hogan W, Kozarek R, Raskin J, Cattau E, Benjamin S. Initial report of a Randomized Controlled Trial of Methodology of Pneumatic Dilation (PD) for the Initial Treatment of Idiopathic Achalasia. Gastrointestinal Endoscopy 1991: 37(2):238 (abstract).
2. Boyce HW Jr.: Diagnosing Dysphagia: The Search for Strictures. Emergency Medicine Apr 1992, pp 65-72.

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