GI Review with Rob Brandt

Transfer dysphagia = difficulty moving food thru upper esophageal sphincter (early, "gagging")

-80% due to neuromuscular disorder (MS, Parkinson's, CVA)

Transport dysphagia = difficulty with movement of food thru esophagus (later, food is "stuck")

-80% due to obstruction (food, Schatzki ring, tumor), achalasia/Scleroderma

Food Impaction treatment: Glucagon 2mg IV, repeat x1, can give nifedipine (no meat tenderizer allowed!)

Swallowed FB: Coin Face on AP = esophagus. *C6 = cricopharyngeus 80% of the time, T4 10%, T10 <10%

Batter stuck in esophagus = remove now (<4hrs), must remove 5cm x 2cm

Esophageal Bleed: Often due to varices, which are due to portal HTN, due to liver dz

- *You can pass an NG tube safely even in pt with bleeding varices
- Tx: 1. Octreotide, 2. Sclerotherapy 3. Sengstaken-Blakemore tube (bad option)
- rebleed is very common

GERD: RF: caffeine, nicotine, fatty foods (similar RF as for PUD), TX: H2 and PPi

PUD: #1 cause of GI bleeding. *H. pylori* = 80% of gastric ulcers, 95% of duodenal. Exclusion diagnosis

GI outlet obstruction: occurs often after healing ulcers. See early satiety, distended stomach with air-fluid levels

GI bleed: Ligament of Treitz differentiates. NG lavage to confirm upper vs. lower.

GI perforation: Sudden onset of abdominal pain, free air, epigastric pain. TX: ABC, IVF, ABx, consult

Hepatitis: A and E = eating poo, have no chronic carriers. B & C from blood/sex, chronic (B=10%, C=50%)

Hepatitis B = the only DNA virus. HBsAg = active hepatitis/carrier Anti-HBs = indicates immunity

Gall bladder: charcot's triad = fever, jaundice, RUQ pain, seen in 50-75% of cholangitis

Pancreatitis: Grey Turner's = L flank bruising Cullen's=umbilical bruising, both due to retroperitoneal bleed

Ranson's on admit: Age>55, AST>350, WBC>16, glucose>200, LDH>350

Ranson's after 48hrs: Hct fall by 10%, BUN up by 5, Ca^{++}<8, PaO2<60, Base def>4, Fluid loss >6L

Mortality rate: 0-2 criteria =1%, 3-4 criteria =15%, 5-6 criteria =40%, >6 = 100%,

Appy: Most common emergent surgery (preggers as well), TX: NPO, consult, ABx: Zosyn or Amp+gent

<u>Psoas sign</u>:RLQ pain on R hip extension, <u>Obturator</u>:RLQ pain on internal rotation, <u>Rosvings</u> RLQ on LLQ palpation

Bowel Obstruction: LBO=Cancer #1 cause, gas in periphery, haustra do not cover entire diameter

SBO= *adhesions #1 cause*, hernia #2cause. Haustra across entire diameter on XRay

Mesenteric ischemia: Mortality rate 50%, *pain out of proportion to exam*, elevated lactate. Angiography=dx

Hernias: Reducible = contents can be pushed thru defect, Irreducible = not reducible

Strangulated = vascular compromise. Direct = thru floor, rare incarceration

Indirect = Most com thru inguinal ring, congenital defect. Umbilical= common in newborns, heal by 2 y/o

Crohn's disease: All layers of bowel, anywhere from mouth to anus, skip lesions, peri-anal involvement in 90%.

Ulcerative colitis:mucosa/submucosa, Rectum 99% of time, subtotal colectomy is curative

Pseudomembranous enterocolitis: C. diff colitis, due to Antibiotic killing of flora in gut. TX: Flagyl or oral Vanco

Often due to taking: Clindamycin, cephalosporins, ampicillin

Diverticulosis: Massive painless GI bleeding. Due to herniations in colon wall

Diverticulitis: Diverticulosis + inflammation (fecalith in diverticulum), Broad ABx (levaquin +flagyl)

Hemorrhoids: External: distal to dentate line, painful, <48hrs do sitz bath & creams, >48 hrs excise thrombosis

Internal: proximal to dentate line, Anoscopy to visualize, surgery for incarcerated

Anal fissure: Posterior midline 90% of time, often due to hard stool, c/o pain with pooping

TX: cleanse area well, sitz bath, high fiber diet (for hemorrhoids as well)