TABLE 344-1 COMMON CAUSES OF COMMON GASTROINTESTINAL (GI) SYMPTOMS

Abdominal Pain	Nausea and Vomiting	Diarrhea	GI Bleeding	Obstructive Jaundice
Appendicitis	Medications	Infection	Ulcer disease	Bile duct stones
Gallstone disease	GI obstruction	Poorly absorbed sugars	Esophagitis	Cholangiocarcinoma
Pancreatitis	Motor disorders	Inflammatory bowel disease	Varices	Cholangitis
Diverticulitis	Functional bowel disorder	Microscopic colitis	Vascular lesions	Sclerosing cholangitis
Ulcer disease	Enteric infection	Functional bowel disorder	Neoplasm	Ampullary stenosis
Esophagitis	Pregnancy	Celiac disease	Diverticula	Ampullary carcinoma
GI obstruction	Endocrine disease	Pancreatic insufficiency	Hemorrhoids	Pancreatitis
Inflammatory bowel disease	Motion sickness	Hyperthyroidism	Fissures	Pancreatic tumor
Functional bowel disorder	Central nervous system disease	Ischemia	Inflammatory bowel disease	
Vascular disease		Endocrine tumor	Infectious colitis	
Gynecologic causes				
Renal stone				

irritable bowel syndrome and functional disorders of the upper gut (including chronic idiopathic nausea and functional vomiting).

Altered Bowel Habits Altered bowel habits are common complaints of patients with GI disease. Constipation is reported as infrequent defecation, straining with defecation, passage of hard stools, or a sense of incomplete fecal evacuation. Causes of constipation include obstruction, motor disorders of the colon, medications, and endocrine diseases such as hypothyroidism and hyperparathyroidism. Diarrhea is reported as frequent defecation, passage of loose or watery stools, fecal urgency, or a similar sense of incomplete evacuation. The differential diagnosis of diarrhea is broad and includes infections, inflammatory causes, malabsorption, and medications. Irritable bowel syndrome produces constipation, diarrhea, or an alternating bowel pattern. Fecal mucus is common in irritable bowel syndrome, whereas pus characterizes inflammatory disease. Steatorrhea develops with malabsorption.

GI Bleeding Hemorrhage may develop from any gut organ. Most commonly, upper GI bleeding presents with melena or hematemesis, whereas lower GI bleeding produces passage of bright red or maroon stools. However, briskly bleeding upper sites can elicit voluminous red rectal bleeding, whereas slowly bleeding ascending colon sites may produce melena. Chronic slow GI bleeding may present with iron deficiency anemia. The most common upper GI causes of bleeding are ulcer disease, gastroduodenitis, and esophagitis. Other etiologies include portal hypertensive causes, malignancy, tears across the gastroesophageal junction, and vascular lesions. The most prevalent lower GI sources of hemorrhage include hemorrhoids, anal fissures, diverticula, ischemic colitis, and arteriovenous malformations. Other causes include neoplasm, inflammatory bowel disease, infectious colitis, drug-induced colitis, and other vascular lesions.

Jaundice Jaundice results from prehepatic, intrahepatic, or posthepatic disease. Posthepatic causes of jaundice include biliary diseases, such as choledocholithiasis, acute cholangitis, primary sclerosing cholangitis, other strictures, and neoplasm, and pancreatic disorders, such as acute and chronic pancreatitis, stricture, and malignancy.

Other Symptoms Other symptoms are manifestations of GI disease. Dysphagia, odynophagia, and unexplained chest pain suggest esophageal disease. A globus sensation is reported with esophagopharyngeal conditions, but also occurs with functional GI disorders. Weight loss, anorexia, and fatigue are nonspecific symptoms of neoplastic, inflammatory, gut motility, pancreatic, small-bowel mucosal, and psychiatric conditions. Fever is reported with inflammatory illness, but malignancies also evoke febrile responses. GI disorders also produce extraintestinal symptoms. Inflammatory bowel disease is associated with hepatobiliary dysfunction, skin and eye lesions, and arthritis. Celiac disease may present with dermatitis herpetiformis. Jaundice can produce pruritus. Conversely, systemic diseases can have GI consequences. Systemic lupus may cause gut ischemia, presenting with pain or bleeding. Overwhelming stress or severe burns may lead to gastric ulcer formation.

EVALUATION OF THE PATIENT WITH GASTROINTESTINAL DISEASE

Evaluation of the patient with GI disease begins with a careful history and examination. Subsequent investigation with a variety of tools designed to test gut structure or function are indicated in selected cases. Some patients exhibit normal findings on diagnostic testing. In these individuals, validated symptom profiles are used to confidently diagnose a functional bowel disorder.

HISTORY

The history of the patient with suspected GI disease has several components. Symptom timing suggests specific etiologies. Symptoms of short duration commonly result from acute infection, toxin exposure, or abrupt inflammation or ischemia. Long-standing symptoms point to underlying chronic inflammatory or neoplastic conditions or functional bowel disorders. Symptoms from mechanical obstruction, ischemia, inflammatory bowel disease, and functional bowel disorders are worsened by meals. Conversely, ulcer symptoms may be relieved by eating or antacids. Symptom patterns and duration may suggest underlying etiologies. Ulcer pain occurs at intermittent intervals lasting weeks to months, whereas biliary colic has a sudden onset and lasts up to several hours. Pain from acute inflammation as with acute pancreatitis is severe and persists for days to weeks. Meals elicit diarrhea in some cases of inflammatory bowel disease and irritable bowel syndrome. Defecation relieves discomfort in inflammatory bowel disease and irritable bowel syndrome. Functional bowel disorders are exacerbated by stress. Sudden awakening from sound sleep suggests organic rather than functional disease. Diarrhea from malabsorption usually improves with fasting, whereas secretory diarrhea persists without oral intake.

Symptom relation to other factors narrows the list of diagnostic possibilities. Obstructive symptoms with prior abdominal surgery raise concern for adhesions, whereas loose stools after gastrectomy or gallbladder excision suggest dumping syndrome or postcholecystectomy diarrhea. Symptom onset after travel prompts a search for enteric infection. Medications may produce pain, altered bowel habits, or GI bleeding. Lower GI bleeding likely results from neoplasms, diverticula, or vascular lesions in an older person and from anorectal abnormalities or inflammatory bowel disease in a younger individual. Celiac disease is prevalent in people of northern European descent, whereas inflammatory bowel disease is more common in certain Jewish populations. A sexual history may raise concern for sexually transmitted diseases or immunodeficiency.

For more than two decades, working groups have been convened to devise symptom criteria to improve the confident diagnosis of functional bowel disorders and to minimize the numbers of unnecessary diagnostic tests performed. The most widely accepted symptom-based