

FIGURE 345-36 Obstructing colonic carcinoma. **A.** Colonic adenocarcinoma causing marked luminal narrowing of the distal transverse colon. **B.** Endoscopic placement of a self-expandable metal stent. **C.** Radiograph of expanded stent across the obstructing tumor with a residual waist (arrow).

for adenocarcinoma of the esophagus and is readily detected endoscopically, due to proximal displacement of the squamocolumnar junction (Fig. 345-3). A screening EGD for Barrett's esophagus should be considered in patients with a chronic (≥ 10 year) history of GERD symptoms. Endoscopic biopsy is the gold standard for confirmation of Barrett's esophagus and for dysplasia or cancer arising in Barrett's mucosa.

PEPTIC ULCER

Peptic ulcer classically causes epigastric gnawing or burning, often occurring nocturnally and promptly relieved by food or antacids. Although endoscopy is the most sensitive diagnostic test for peptic ulcer, it is not a cost-effective strategy in young patients with ulcer-like dyspeptic symptoms unless endoscopy is available at low cost. Patients with suspected peptic ulcer should be evaluated for *Helicobacter pylori* infection. Serology (past or present infection), urea breath testing (current infection), and stool tests are noninvasive and less costly than endoscopy with biopsy. Patients with alarm symptoms and those with persistent symptoms despite treatment should undergo endoscopy to exclude gastric malignancy and other etiologies.

NONULCER DYSPEPSIA

Nonulcer dyspepsia may be associated with bloating and, unlike peptic ulcer, tends not to remit and recur. Most patients describe marginal relief on acid-reducing, prokinetic, or anti-*Helicobacter* therapy, and are referred for endoscopy to exclude a refractory ulcer and assess for other causes. Although endoscopy is useful for excluding other diagnoses, its impact on the treatment of patients with nonulcer dyspepsia is limited.

DYSPHAGIA

About 50% of patients presenting with difficulty swallowing have a mechanical obstruction; the remainder has a motility disorder, such as achalasia or diffuse esophageal spasm. Careful history-taking often points to a presumptive diagnosis and leads to the appropriate use of diagnostic tests. Esophageal strictures (Fig. 345-39) typically cause progressive dysphagia, first for solids, then for liquids; motility disorders often cause intermittent dysphagia for both solids and liquids. Some underlying disorders have characteristic historic features: Schatzki's ring (Fig. 345-40) causes episodic dysphagia for solids, typically at the beginning of a meal; oropharyngeal motor disorders typically present with difficulty initiating deglutition (*transfer dysphagia*) and nasal reflux or coughing with swallowing; and achalasia may cause nocturnal regurgitation of undigested food.

When mechanical obstruction is suspected, endoscopy is a useful initial diagnostic test, because it permits immediate biopsy and/or dilatation of strictures, masses, or rings. The presence of linear furrows and multiple corrugated rings throughout a narrowed esophagus (*feline esophagus*) should raise suspicion for eosinophilic esophagitis, an increasingly recognized cause for recurrent dysphagia and food impaction (Fig. 345-41). Blind or forceful passage of an endoscope may lead to perforation in a patient with stenosis of the cervical esophagus or a Zenker's diverticulum, but gentle passage of an endoscope under direct visual guidance is reasonably safe. Endoscopy can miss a subtle stricture or ring in some patients.

When transfer dysphagia is evident or an esophageal motility disorder is suspected, esophageal radiography and/or a video-swallow study

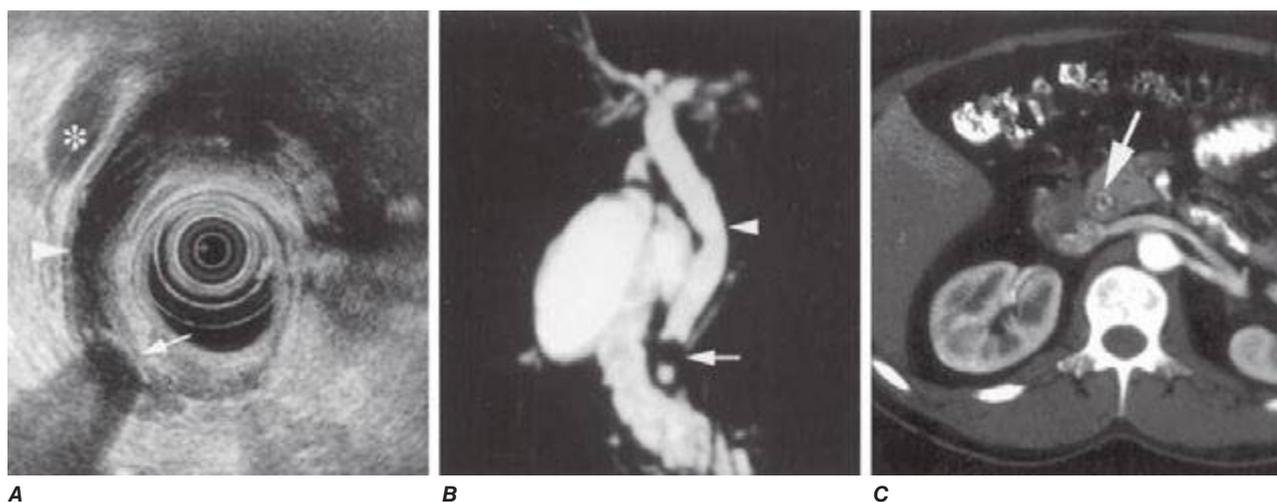


FIGURE 345-37 Methods of bile duct imaging. Arrows mark bile duct stones. Arrowheads indicate the common bile duct, and the asterisk marks the portal vein. **A.** Endoscopic ultrasound (EUS). **B.** Magnetic resonance cholangiopancreatography (MRCP). **C.** Helical computed tomography (CT).