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Clinico-Endoscopic profile of Egyptian Patients presenting with Upper Gastrointestinal Symptoms

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ORIGINAL ARTICLE

Clinico-Endoscopic profile of Egyptian Patients presenting with Upper Gastrointestinal Symptoms

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Abstract

Background: ***Symptoms of the upper gastrointestinal tract are frequently reported in clinical settings, and gastrointestinal disorders account for substantial medical utilization and loss of productivity.***

Aim and objectives: ***To investigate and compare the endoscopic results and diagnosis with the clinical profile of adult patients experiencing upper gastrointestinal problems. Also, we need to detect the alarming features and their final impact on our target patients. Also, the prevalence of the problem among different Egyptian populations should be assessed.***

Subjects and methods: ***400 patients were involved in the current investigation who presented to the Internal Medicine department in Al-Hussein University Hospital with upper gastrointestinal symptoms and were indicated for upper endoscopy.***

Result: ***The most prevalent complaints in the general public are related to upper gastrointestinal (GI) disorders, which carry a significant chance of morbidity and mortality. Because life-threatening consequences can be avoided with early identification and proper treatment of the illness, a gastrointestinal endoscopy is a proper diagnostic and therapeutic technique when a patient presents with upper gastrointestinal symptoms.***

Conclusion: ***Abdominal pain was the most commonly reported complaint in 35.0% of cases, followed by hematemesis and melena in 39.8%. Dysphagia was reported in 10.0% of cases, heartburn was reported in 6.0% of cases, and nausea and vomiting were reported in 9.2% of cases. Gastritis was the most frequent diagnosis in 21.2% of cases, followed by esophageal varices in 16.5% of patients, then antral gastritis was reported in 14% of patients. this article observed suspicious gastric masses in 1.8% of patients.***

Keywords: Clinico-Endoscopic profile; Egyptian Patients; Upper Gastrointestinal Symptoms

1. Introduction

Upper gastrointestinal bleeding from the stomach, duodenum, or esophagus is a typical medical emergency worldwide. Hematemesis, also known as bloody or coffee-ground emesis, melena, or black tarry stool, are the symptoms that patients come with; however, hematochezia can also occur during a significant hemorrhage and is usually linked to hemodynamic instability. Due to their more likely delayed presentation, patients with melena typically have worse hemoglobin values than those with hematemesis. Guidelines frequently distinguish between variceal and nonvariceal bleeding in upper gastrointestinal hemorrhage because treatment and results vary, even when the source of a bleeding episode is unknown until an endoscopy is performed.[1]

Based on cross-sectional research, it appears that individuals who are overweight or obese are more likely to suffer from gastro-oesophageal reflux disease (GERD), which has been shown to increase body mass index (BMI) and reflux symptoms in response to a given dosage. Although not all research agrees, several other investigations have found a robust correlation between rising BMI and GERD.[2,3]

Neuromuscular or structural esophageal abnormalities can cause dysphagia. Unlike patients with motility problems who present as well as liquid and solid food dysphagia, patients with structural diseases of the esophagus usually only develop dysphagia with solids. Both malignant and inflammatory diseases are classified as structural disorders. Malignant strictures are caused by intrinsic luminal tumor growth and extrinsic esophageal compression, whereas benign inflammatory strictures are caused by collagen and fibrous tissue deposition in individuals with severe or persistent esophageal inflammation.[4,5]

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As many as eighty percent of all benign esophageal strictures have been documented to be caused by peptic strictures, a GERD consequence. However, due to the increasing usage of proton pump inhibitors, their occurrence has over the past ten years. Currently acknowledged as a prevalent benign cause of dysphagia, eosinophilic esophagitis (EoE) has increased in prevalence. Achalasia, widespread esophageal spasm, hypomotility due to scleroderma, and various connective tissue illnesses are among the motility disorders that result in dysphagia.[6,7]

This work aims to investigate and correlate endoscopic findings and diagnosis with the clinical profile of adult patients with upper gastrointestinal symptoms. Additionally, we will identify concerning characteristics and their eventual effects on our target patients and determine how common the issue is among various Egyptian populations.

2. Patients and methods

The 400 patients who came to the Al-Hussein University Hospital's Internal Medicine department with upper gastrointestinal symptoms and were recommended for an upper endoscopy participated in the current study.

Inclusion criteria: Both sexes were included. Age: Adult patients above 18 years. Clinical presentation: Undiagnosed dyspeptic symptoms and Other upper gastrointestinal symptoms, including dysphagia, heartburn, abdominal pain, nausea, vomiting, and symptoms of upper gastrointestinal bleeding. Indications for upper gastrointestinal endoscopy (Considering the duration of symptoms). Persistent upper abdominal pain or pain associated with alarming symptoms such as weight loss or anorexia. Dysphagia, odynophagia, or feeding problems. Intractable or chronic symptoms of GERD. Hematemesis or persistent vomiting of unclear cause. In cases where an upper gastrointestinal (GI) source is clinically suspected, iron deficiency anemia is associated with presumed chronic blood loss. Malabsorption or persistent diarrhea. Evaluation of acute damage following consumption of caustic substances. They are monitoring for cancer in individuals with precancerous disorders, including polyposis syndromes, prior consumption of caustic substances, or Barrett's esophagus.

Exclusion criteria: Absolute contraindications to upper gastrointestinal endoscopy include toxic megacolon in an unstable patient, peritonitis, and perforated bowel. Generally speaking, severe neutropenia, severe coagulopathy, severe thrombocytopenia, or compromised platelet function are contraindications to upper GI endoscopy. Aneurysm of the abdominal and iliac aorta, recent bowel operations, bowel blockage, and connective tissue abnormalities are among the conditions that increase the risk of perforation.

Methods: The following was applied to every patient who was included:

Demographic data: Age and Gender.

Complete medical history: Focusing on upper gastrointestinal symptoms, including dysphagia, heartburn, regurgitation, abdominal pain, nausea, vomiting, and symptoms of upper gastrointestinal bleeding.

Complete clinical examination: Focusing on significant upper gastrointestinal signs.

Laboratory investigations: Complete blood count, serum creatinine, random blood sugar, INR, PT, albumin, GGT, ALT, AST, ALP, and total and direct bilirubin, as well as liver function tests, and prothrombin time.

Abdominal Ultrasound: Aiming for a significant correlation between clinical, radiological, and endoscopic profiles.

Upper endoscopy (with Biopsy and Histopathology if indicated):

Drugs: Propofol ampoules and Midazolam ampoules.

Equipment: FujiFilm BL-7000, Pentax Medical EG-3870, and Olympus CV 180.

Technique:

Every patient was placed in the left lateral position and connected to the monitor device. Once they had received enough sedation, the patient's tongue was examined with a scope in direct vision, and the uvula was in the six o'clock position. The instrument point was positioned behind the cricoarytenoid cartilage upon the appearance of the epiglottis, cricoarytenoid cartilage, and voice cords. The scope was progressively advanced to enable a thorough study of the mucosa and shape of the esophagus. The gastro-esophageal junction was next inspected, and its level was measured about the diaphragmatic hiatus.

After passing through the stomach, the scope was moved to the second portion of the duodenum, where the mucosa was thoroughly inspected. After taking out the scope, the stomach was thoroughly inspected, beginning with the antrum. The lack of longitudinal folds identified the antrum, while retroflection assessed the incisura and cardio. Following the removal of the scope, the patient was moved to the recovery unit.

Ethics considerations: The Ethical Committee of Al-Azhar University approved this investigation. Before the trial began, each patient gave informed consent.

Statistical analysis:

Version 25 of the SPSS program (SPSS Inc., PASW Statistics for Windows) was used to analyze the data: the SPSS Inc., Chicago. Numbers and percentages were used to describe the qualitative data. For non-normally distributed data, the median (lowest and maximum) and mean± were

used to characterize the quantitative data, and the standard deviation for data was regularly distributed following the Kolmogrov-Smirnov test for normalcy. The results were evaluated for significance at the (≤0.05) level.

When necessary, Chi-Square and Monte Carlo tests were used to compare the groups' qualitative data.

Wallis Kruskal and Mann Whitney For non-normally distributed data, the U test was used to compare data from two researched groups and data from more than two examined groups. When comparing two independent groups of non-normally distributed data, the student t-test was employed. The One-Way ANOVA test was employed when comparing more than two independent groups, and the post-hoc Tukey test was utilized to identify pairwise comparisons.

3. Results

Table 1. Demographic characteristics of the studied cases

AGE (YEARS)	MEAN±SD	41.77±15.74
	Median (min-max)	39 (16-80)
SEX	Male	224 (56.0%)
COUNT (%)	Female	176 (44.0%)

Mean age among studied cases was 41.77±15.74 years with median age of 39 years ranging between 16 and 80 years. Male % among studied patients was 56%.

Table 2. Distribution of complaints in studied cases.

	N=400	%
DYSPHAGIA	40	10.0%
HEART BURN	24	6.0%
NAUSEA AND VOMITING	37	9.2%
ABDOMINAL PAIN	140	35.0%
HEMATEMESIS AND MELENA	159	39.8%

Dysphagia was reported in 40 (10.0%) cases, heart burn was reported in 24 (6.0%) cases, nausea and vomiting were reported in 37 (9.2%) cases, abdominal pain was reported in 140 (35.0%) cases, while hematemesis and melena was reported in 159 (39.8%) cases.

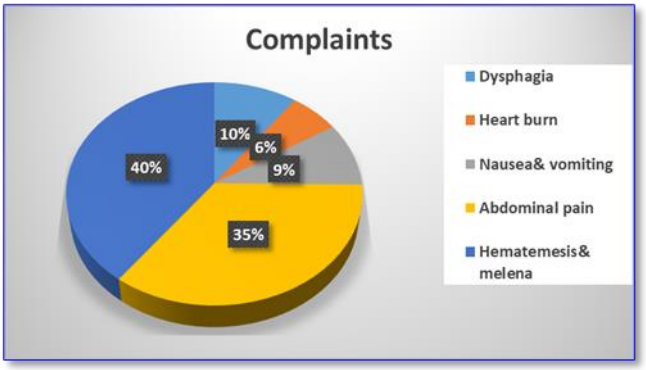

Figure 1. Distribution of complaints in studied cases

Table 3. Laboratory findings of the studied cases.

	MEAN ±SD	MEDIAN (MIN-MAX)
HEMOGLOBIN (GM/DL)	10.47±1.94	11 (3.5-14)
WBCS /MM	5916.2±2167.22	5400 (1610-19000)
PLATELET COUNT *10^3	249.94±185.68	240 (4.3-3450)
CREATININE (MG/DL)	0.856±0.367	0.8 (0.3-4.0)
ALT (U/L)	24.42±25.31	19 (10-361)
AST (U/L)	24.36±23.39	18.5 (11-432)
ALKALINE PHOSPHATASE (U/L)	118.41±66.35	166 (78-545)
GAMMA GLUTAMYL TRANSFERASE (U/L)	38.33±17.05	35 (11-208)
BILIRUBIN (UMOL/L)	1.34±2.82	0.80 (0.20-25.0)
ALBUMIN (G/DL)	3.95±0.50	4.0 (2.2-5.4)
PROTHROMBIN TIME (SECONDS)	11.49±0.89	11 (10-13.5)
RANDOM BLOOD SUGAR (MMOL/L)	126.4±84.34	90 (67-468)

AST: aspartate aminotransferase, ALT: alanine aminotransferase

Mean hemoglobin level was 10.47±1.94 gm/dl with median hemoglobin level 11 ranging between 3.5 and 14 gm/dl. Mean total leucocytic count was 5916.2±2167.22/mm3 with median total leucocytic count 5400 /mm3 ranging between 1610 and 19000 /mm3. Mean platelet count was 249.94±185.68*103 with median platelet count 0.8 *103 ranging between 0.3 and 4 *103. The average blood creatinine level was 0.856±0.367 mg/dl with median serum creatinine 0.8 mg/dl ranging between 0.3 and 4 mg/dl.

Mean ALT serum level was 24.42±25.31 U/L with median of 19 U/L ranging between 10 and 361 U/L. AST serum level was 24.36±23.39 U/L with median of 18.5 ranging between 11 and 432 U/L. Mean alkaline phosphatase serum level was 118.41±66.35 U/L with median of 166 U/L ranging between 78 and 545 U/L. Mean gamma glutamyl transferase serum level was 38.33±17.05 U/L with median of 35 U/L ranging between 11 and 208 U/L.

Mean bilirubin serum level was 1.34±2.82 umol/l with median of 0.80 umol/l ranging between 0.20 and 25.0 umol/l. Mean albumin serum level was 3.95±0.50 g/dl with median of 4.0 g/dl ranging between 2.2 and 5.4 g/dl. Mean prothrombin time 11.49±0.89 seconds with median of 11 seconds ranging between 10 and 13.5 seconds. Mean random blood sugar serum level was 126.4±84.34 mmol/l with median of 90 mmol/l ranging between 67 and 468 mmol/l.

Table 4. Ultrasound findings of the studied cases.

	N=400	%
UNREMARKABLE	137	34.2
SURGICALLY REMOVED GALL BLADDER	2	0.5
SPLENOMEGALY	5	1.2
NEPHROPATHY	4	1.0
PARENCHYMATOUS LIVER	2	0.5
GASEOUS DISTENSION	80	20.0
CIRRHOTIC HETROGENOUS LIVER	59	14.8
HEPATO-SPLENOMEGALY	24	6.0
FATTY LIVER	11	2.8
CHOLECYSTITIS	7	1.8
ABDOMINAL LYMPHADENOPATHY	1	0.2
EARLY HEPATIC ABSCESS	1	0.2
PELVIC COLLECTION	2	0.5
MULTIPLE HEPATIC FOCAL LESIONS LIKELY HEMANGIOMATA FOR DYNAMIC STUDY	1	0.2
NON VISUALIZED RIGHT KIDNEY WITH RELATIVELY ENLARGED LEFT KIDNEY	1	0.2

The majority of patients (34.2%) had unremarkable ultrasound changes. The most commonly reported pathological finding using ultrasound was gaseous distension in 20% of patients, with cirrhotic hepatic heterogenous liver accounting for 14.8% of cases.

The least commonly reported pathological finding using ultrasound were abdominal lymphadenopathy, early hepatic abscess, multiple hepatic focal lesions and non-visualized right kidney with relatively enlarged left kidney each was reported in 0.2% of patients.

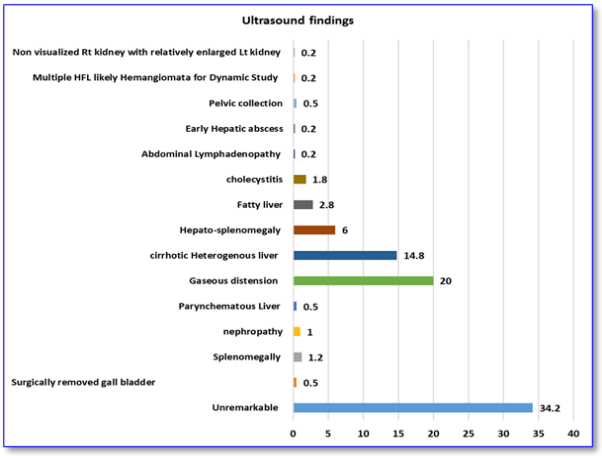

Figure 2. Ultrasound finding of the studied cases.

Table 5. Upper GIT endoscopic findings of the studied cases.

	N=400	%
NORMAL STUDY	26	6.5
BULB (ULCER/DUODENITIS/DIVERTICULUM)	4	1.0
GASTRIC MASS MOSTLY MALIGNANT	7	1.8
BARRET ESOPHAGITIS	3	0.8
DUODENAL TELANGIECTASIA	2	0.5
ESOPHAGEAL MONILIASIS	3	0.8
GASTRITIS/ESOPHAGITIS	85	21.2
DUODENAL ULCER/DUODENITIS	31	7.8
ANTRAL GASTRITIS	56	14.0
ATROPHIC GASTRITIS	17	4.2
ESOPHAGEAL STRICTURE	15	3.8
PORTAL HYPERTENSION GASTROPATHY	25	6.2
ESOPHAGEAL VARICES	66	16.5
FUNDAL VARICES INJECTED	11	2.8
HEALED GASTRIC ULCER	2	0.5
GASTRIC ANTRAL VASCULAR ECTASIA	4	1.0
GASTRIC POLYP	6	1.5
INCOMPETENT CARDIA	28	7.0
BILIARY REFLUX	8	2.0
HIATUS HERNIA	21	5.2
SLUGGISH GASTRIC MOTILITY	2	0.5
OTHERS		
HEMANGIOMA	1	0.25
IMPACTED FOREIGN BODY	1	0.25
FUNDAL TELANGIECTASIA FOR APC	1	0.25
GERD		
A	15	3.8
B	13	3.2
C	4	1.0
D	1	0.2

The most common finding was gastritis in 21.2% of patients, followed by esophageal varices in 16.5% of patients, then antral gastritis which was reported in14% of patients. The least commonly reported upper GIT endoscopic findings were duodenal telangiectasia, healed gastric ulcer and sluggish gastric motility, each was reported in 0.5% of patients. Normal study was reported in 6.5% of patients.

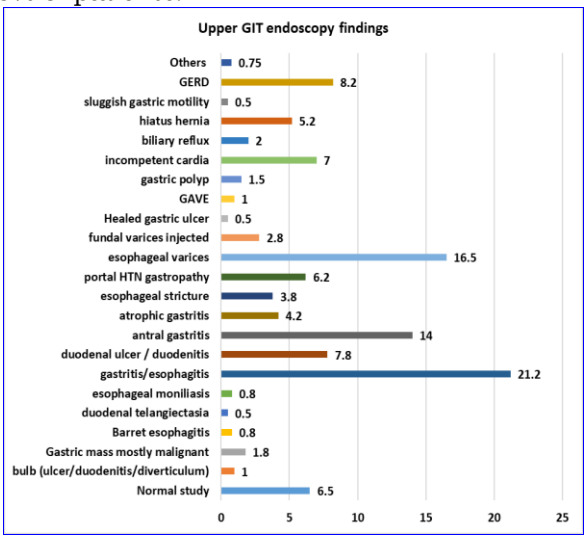

Figure 3. Upper GIT endoscopic findings of the studied cases.

Table 6. Relationship between the investigated cases' laboratory results and complaints.

	DYSPHAGIA N=40	HEART BURN N=24)	NAUSEA AND VOMITING N=37	ABDOMINAL PAIN N=140 (	HEMATEMESIS AND MELENA N=159	TEST OF SIGNIFICANCE
HEMOGLOBIN (GM/DL)	11.74±1.07	12.29±0.89	11.76±0.99	11.42±1.32	8.75±1.51	p<0.001*
WBCS /MM	4.0±0.28	4.35±0.47	4.05±0.41	4.09±0.43	3.72±0.53	p<0.001*
PLATELET COUNT *10^3	11.44±0.86	11.04±0.806	11.31±0.82	11.34±0.77	11.75±0.96	p<0.001*
CREATININE (MG/DL)	5400 (4000-9000)	4800 (3900-9000)	5600 (2300-11600)	5600 (3200-19000)	5300 (1610-13200)	p=0.054
ALT (U/L)	260 (170-454)	270 (220-345)	295 (115-465)	252 (4.3-459)	180 (11-489)	<0.001*
AST (U/L)	0.8 (0.4-1.3)	0.8 (0.4-1.0)	0.9 (0.3-1.6)	0.8 (0.4-3.7)	0.8 (0.3-4.0)	0.038*
ALKALINE PHOSPHATASE (U/L)	18 (12-36)	16 (12-38)	18 (11-40)	19(12-361)	22 (10-60)	0.004*
GAMMA GLUTAMYL TRANSFERASE (U/L)	18 (12-36)	18 (12-42)	18 (12-59)	21(11-432)	18 (12-67)	0.182
BILIRUBIN (UMOL/L)	206.5 (89.0-262)	133 (89-240)	178 (120-320)	166(78-545)	210 (120-439)	0.056
ALBUMIN (G/DL)	34 (22-57)	33 (23-46)	38 (23-130)	34(21-208)	36 (11-90)	0.203
PROTHROMBIN TIME (SECONDS)	0.8 (0.2-1.2)	0.7 (0.2-1.1)	0.80 (0.30-9.0)	0.80(0.2-25)	0.8 (0.3-25)	0.01*
RANDOM BLOOD SUGAR (MMOL/L)	88 (69-432)	84 (70-435)	90 (68-457)	90 (67-414)	90 (68-468)	0.550

Used test :One Way ANOVA test , Kruskal Wallis test Parameters described as mean±SD , median (min-max)

Laboratory findings revealed that patients with heart burn had significantly higher white blood cell counts (P<0.001), and significantly lower platelet counts (P<0.001) when compared to patients with other symptoms. Patients with nausea and vomiting had significantly higher serum levels of AST (P<0.001), and ALT (P=0.038) when compared to patients with other symptoms. Patients with hematemesis and melena had significantly higher serum levels of alkaline phosphatase (P=0. 004), and significantly longer prothrombin time (P=0.01) when compared to patients with other symptoms.

Table 7. Relation between complaints and Ultrasound findings of the studied cases.

		COMPLAINTS				
		Dysphagia n=40(%)	Heart burn N=24(%)	Nausea and vomiting N=37(%)	Abdominal pain N=140(%)	Hematemesis and melena N=159(%)
UNREMARKABLE	n	21	10	20	51	35
	%	52.5%	41.7%	54.1%	36.4%	22.0%
SURGICALLY REMOVED GALL	n	0	0	1	1	0
BLADDER	%	.0%	.0%	2.7%	.7%	.0%
NEPHROPATHY	n	0	0	0	2	2
	%	.0%	.0%	.0%	1.4%	1.3%
PARENCHYMATOUS LIVER	n	0	0	0	2	0
	%	.0%	.0%	.0%	1.4%	.0%
GASEOUS DISTENSION	n	0	0	0	7	73
	%	.0%	.0%	.0%	5.0%	45.9%
CIRRHOTIC HETEROGENOUS	n	4	3	8	21	23
LIVER	%	10.0%	12.5%	21.6%	15.0%	14.5%
HEPATO-SPLENOMEGALY	n	5	5	2	9	3
	%	12.5%	20.8%	5.4%	6.4%	1.9%
FATTY LIVER	n	0	0	0	2	9
	%	.0%	.0%	.0%	1.4%	5.7%
CHOLECYSTITIS	n	0	0	1	4	2
	%	.0%	.0%	2.7%	2.9%	1.3%
ABDOMINAL	n	0	0	0	0	1
LYMPHADENOPATHY	%	.0%	.0%	.0%	.0%	.6%
EARLY HEPATIC ABSCESS	n	0	0	0	1	0
	%	.0%	.0%	.0%	.7%	.0%
PELVIC COLLECTION	n	0	0	0	2	0
	%	.0%	.0%	.0%	1.4%	.0%
MULTIPLE HEPATIC FOCAL	n	0	0	0	1	0
LESIONS LIKELY HEMAGIOMATA FOR DYNAMIC STUDY	%	.0%	.0%	.0%	.7%	.0%
NON VISUALIZED RIGHT	n	0	0	0	1	0
KIDNEY WITH RELATIVELY ENLARGED LEFT KIDNEY	%	.0%	.0%	.0%	.7%	.0%
	p<0.001*					

There was significant difference between patients with different complaints regarding Ultrasound findings (P<0.001).

4. Discussion

The mean age among our studied cases was 41.77±15.74 years, with a median age of 39 and a range between 16 and 80. Similarly, Hassan et al.,[8] stated that the average age of Egyptians is 46.5 years.

In Gomaa et al.,[9] According to the survey, the age group with the highest prevalence was those between the ages of 41 and 60 (37.6%), followed by those between the ages of 21 and 40 (33.9%), with a mean age of 47.5. While Scheidl et al.,[10] comprised younger patients, with a mean age of 32.

The male percentage in the present study was 56%. In line with this study, Puttaraju et al.[11] showed that the percentage of males was much higher (60%) than that of girls (40%).

In the present study, abdominal pain was the most commonly reported complaint in 140 (35.0%) cases, followed by hematemesis and melena in 159 (39.8%) cases.

This was agreed with Shashikumar et al.,[12] who stated that abdominal pain was the most typical reason for upper GI endoscopy (32.1%).

Meanwhile, in a study by Chaurasia et al.,[13] 136 patients had upper gastrointestinal symptoms. They stated that the most frequent symptom and reason for an endoscopy was upper gastrointestinal hemorrhage, which was followed by nausea and vomiting.

The upper GIT endoscopic findings of the cases under study were as follows: The most frequent finding was gastritis, which was recorded in 21.2% of patients. Esophageal varices were found in 16.5% of patients, while antral gastritis was found in 14% of patients.

Similarly, in Agyei-Nkansah et al.[14] a study on 371 patients, most patients with dyspepsia had gastritis on endoscopy, followed by duodenitis.

In line with this study, Batool et al. [15] found that the most common finding in organic dyspepsia was reflux esophagitis 41 (22.8%), followed by gastritis 16 (8.9%), duodenal ulcers 12 (6.7%), and stomach ulcers 9 (5%). However,[15] 53 percent of individuals with dyspepsia showed normal endoscopic findings.

Hematemesis and melena in the current study were associated with a significantly higher incidence of esophageal varices (P<0.001) and injected fundal varices (P=0.002).

Supporting the finding, Yadav et al.,[16] investigated the clinical-endoscopic characteristics and outcome in 194 patients who arrived having symptoms or signs of upper GI bleeding. They stated that upper gastrointestinal bleeding was primarily caused by variceal hemorrhage.

4. Conclusion

Abdominal pain was the most commonly reported complaint in 35.0% of cases, followed by hematemesis and melena in 39.8% of cases. Dysphagia was reported in 10.0% of cases, heartburn was reported in 6.0% of cases, and nausea and vomiting were reported in 9.2% of cases. Gastritis was the most frequent diagnosis, occurring in 21.2% of patients. Esophageal varices were found in 16.5% of patients, while antral gastritis was seen in 14% of patients.

Disclosure

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Authorship

All authors have a substantial contribution to the article

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Conflicts of interest

There are no conflicts of interest.

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