

Final Review

- **GERD- Lower Esophageal Sphincter (LES) dysfunction.**
 - S/S: Heartburn (burning in chest), regurgitations, dysphagia, and chest pain.
 - Treatment: lifestyle modifications-HOB elevated, avoid citrus, alcohol, caffeine, carbonation, avoid eating before bedtime, smoking cessation as it weakens the sphincter.
 - Medications: Antacids, if it doesn't improve, EGD.
 - NP role in GERD management is to evaluate the effectiveness of treatment.
 - Warning signs of GERD: age over 50, dysphagia, odynophagia (pain on swallowing), N/V, wt loss, melena, feeling full after little food.
- **Esophageal Stricture**- chronic inflammation and the development of scar tissue that thickens the wall of the esophagus.
 - Risk factors: GERD, esophagitis, radiation therapy, ingestion of caustic substances like strong acids or bases, and tumors.
 - S/S: dysphasia, sensation of food sticking to the throat, pain when swallowing, food regurgitation, unintentional weight loss.
 - Diagnosis: Barium swallow or EGD.
 - Treatment: Meds to reduce inflammation, dilation of stricture, and addressing underlying cause.
- **Appendicitis**- involves obstruction of the lumen or the opening of the appendix which leads to a cascade of events resulting in inflammation, infection, and, if untreated, potential perforation.
 - Patho: luminal obstruction -> increased luminal pressure -> compromised blood flow (ischemia) -> bacterial overgrowth (E. coli) -> acute inflammation (pus formation) -> Perforation
 - S/S: Periumbilical pain, RLQ pain, fever and leukocytosis, N/V
 - Diagnosis: WBC > 10,000 and increased neutrophils and CRP, abd. ultrasound, CT scan, MRI
 - Treatment: appendectomy
 - Risk is colon CA among those aged 50-74 y/o
- **Hiatal Hernia**- Major risk factor for GERD.
 - Diaphragmatic weakness
 - Factors: aging, obesity, pregnancy, increased intra-abdominal pressure (chronic coughing or Valsalva maneuver), structural abnormalities of diaphragm
 - Treatment: lifestyle modification, eating small and frequent meals, meds (antacids, PPI;s, prokinetic agents), surgery to repair (usually w/ severe S/S).
- **Duodenal Ulcer- Most common peptic ulcer**
 - Usually caused by H. pylori 95-100% of the time (bacteria that stimulates gastrin secretion leading to gastric acid hypersecretion)
 - Disruption of the balance between aggressive and defensive factors:
 - Aggressive: Gastric acid, pepsin, H. pylori, NSAIDS
 - Defensive: Mucus-bicarbonate layer, prostaglandins, cellular repair mechanisms
 - S/S: Pain begins 30min-2hrs after eating when the stomach is empty, not unusual for pain to occur in the middle of the PM and disappear by AM.
 - Exam findings: anemia, dehydrated, pain in upper abd., guarding, rigidity, distention
 - Pain is usually relieved by ingestion of food or antacids.
 - Diagnosis: EGD (Gold standard), H. pylori testing, imaging studies
 - Treatment: lifestyle mods, meds, treat H. pylori if that's the reason
- **Gastric Ulcer**- Pain is relieved w/ food
 - Risk factors: h. pylori, NSAIDS, smoking, alcohol, stress, fam hx, obesity, age >65
- **Peptic Ulcer Disease (PUD)**- a break or ulceration in the protective mucosal lining of the lower esophagus, stomach, or duodenum.
 - Least likely to occur in the Large Intestine
 - Erosion- superficial ulcers, don't penetrate
 - Ulcer- damages blood vessels
 - S/S: epigastric pain 1-3 hrs after eating, pain relieved by eating

- Zollinger-Ellison syndrome causes increased risk of peptic ulcers d/t increase in gastric acid