Non-alimentary Causes of Dyspepsia

Renal Disease.—Patients with renal disease are not infrequently sent first to a gastroenterologist. Renal infection or stone, or hydropnephrosis, may be missed when the patient presents with dyspepsia. Pyelonephritis may of course occur in a patient with a duodenal ulcer or some other cause of dyspepsia.

Anaemia.—Patients with severe untreated Addisonian pernicious anaemia, or hypochromic anaemia, often suffer from indigestion, which always disappears, if there is no other cause for it, when their anaemia is cured.

Heart Disease.—Vague dyspepsia is associated in some patients with ischaemic heart disease (sensations of “wind round the heart,” abdominal flatulence and aperistalsis), or congestive heart failure (pain over the congested liver, and anorexia and possibly discomfort from a congested stomach). Diagnosis is especially difficult when, as is not rare, heart disease and hiatus hernia occur together in the same patient. The perfusion of hydrochloric acid through the oesophagus has been found to be a reliable test for differentiating oesophageal from cardiac ischaemic pain.

Other Conditions.—Patients with anxiety and/or depression often develop dyspepsia. It is usually not very suggestive of physical disease but often needs investigating, if only as part of the treatment of the nervous condition.

Ureaemia causes anorexia and sometimes indigestion. “Fibrositis” of the abdominal wall, and a small epigastric midline hernia can also cause much confusion in the diagnosis of dyspepsia.

Accounts of dyspepsia commonly refer to a long list of other aetiological factors. In the light of present knowledge it is questionable whether, for example, allergy, unhygienic eating habits, or an irregular mode of life (whatever that may mean) should be seriously considered as causes.

Tertiary syphilis has become rare and gastric crises now seldom trap the unwary into a diagnosis of peptic ulcer. If pulmonary tuberculosis ever did cause indigestion it was probably through associated aspernha, much as it is presumably caused in patients with untreated anaemia.

The relationship of indigestion to a variety of organic and nervous conditions has been interestingly and amusingly discussed by Alvarez. Accounts of dyspepsia commonly list numerous causes of “functional” indigestion. It is tempting to speculate about the real relationship, for example, of physical fatigue, frustration, and anger with dyspepsia. Sometimes such states of mind or body must be coincidental; sometimes perhaps they and the dyspepsia have a common cause. The anxious, depressed, obsessional dyspeptic, whose overactivity is a substitute for peace of mind, is like those whose chief characteristics are their power of sustained unthinking activity, and their lack of curiosity about their destinations. Does this provide a clue about aetiology and therapy for some types of dyspepsia?

REFERENCES


MEDICINE TODAY

Management of Rheumatoid Arthritis

“Medicine Today” is the television series for doctors produced by the B.B.C. Advice on the preparation of the programme is given by the Association for the Study of Medical Education. The programme on B.B.C. 2 on 10 October was on the subject of rheumatoid arthritis. Printed below is an article prepared with the help of experts to complement the television programme, which will be repeated on B.B.C. 1 on 18 October at about 11.20 p.m.

Anyone unfortunate enough to acquire rheumatoid arthritis should be given as intelligent an understanding of the disease as possible. Ten minutes of conversation can lay the foundation of many years’ effective care. There are many aspects of the disease which the patient should clearly grasp from the beginning—what is going on in the joints and what are the principles of treatment, together with the facts that inflamed synovia and erosions can heal, and that in most people the disease, even if it remains active over a long period, need not progress to serious incapacity. This last piece of reassurance is particularly important after a depressing visit to a hospital outpatient department, where the most severe forms of the disease are displayed. Yet it sometimes happens that all this gets left out; the general practitioner may have obtained a consultant opinion, and each has left the job of explaining things to the other. It is quite certain that there will be a good deal of advice from elsewhere. Friends, acquaintances, books, and women’s magazines, acting from one motive or another, all add their quota of misinformation, and it is as well for the doctor to get in first. However, not all the books that have been written for patients are bad, and a few are quite useful, one of the best and simplest being Rheumatoid Arthritis, a handbook for patients published by the Arthritis and Rheumatism Council.

Among the questions many patients ask are those relating to the effect of weather and diet, the value of various irregular forms of treatment (a newspaper cutting is usually produced at this stage), and the place of rest and exercise in the management of the disease. There is little doubt that symptoms in certain patients are exacerbated by weather conditions. Most dislike cold and damp, but a few find hot weather trying. Rheumatoid arthritis, however, occurs in all parts of the world, and there is no reason to suppose that climatic factors have any influence on the progress of the disease. Similarly, diet has no specific effect. Some patients with advanced disease may be unable to purchase or prepare their meals properly. A regimen of cups of tea and bread-and-butter will contribute towards iron deficiency and avitaminosis, so that where necessary arrangements must be made for proper meals, with supplementary vitamins and iron. With regard to “fringe” treatments, one can only sympathize with the desire to turn to any source of possible cure, but a firm hand sometimes has to be taken with foolish or expensive nonsense.

* Obtainable free by doctors only from the Secretary, Arthritis and Rheumatism Council, Faraday House, 8-10 Charing Cross Road, W.C.2.
Management of Rheumatoid Arthritis

Rest and Exercise

The question of rest and exercise is a difficult one on which to generalize, and both play a part in management. There is no doubt that local and general rest can lead to improvement, with diminution in joint pain and swelling and fall in sedimentation rate. This is particularly so in the early phases of the disease. A patient with moderate or severe early active rheumatoid arthritis should be given the benefit of a few weeks' rest in bed, preferably in hospital, where the break from work or household cares is complete, and where supervised physiotherapy, assessment of drug treatment, and investigative measures are more easily undertaken. Admission to hospital is not always practicable, however, nor is it necessarily desirable. Established daily routines, sometimes acquired with difficulty and practice, should not be interrupted, and older people are usually better off mobile and out of hospital. Whatever the circumstances, the posture in bed should receive careful attention. The mattress should be firm, prolonged flexion of the neck should be avoided by the use of a rigid back-rest during the day and restriction to one pillow at night, pressure on the legs and feet may be prevented by the use of a bed cage, but the use of pillows under the knees is prohibited.

Such measures help towards prevention of deformity and maintenance of function, which is the aim of treatment in rheumatoid arthritis. This is also accomplished by suitable exercises, supplemented where necessary by splinting. Exercises should be taught early and continued definitely. To encourage movements to be emphasized depend to some extent on the individual pattern of joint involvement. Flexion contracture of the knees can be prevented by quadripies exercises, contracture of the wrists by exercises of the forearm muscles and so on. Most of these exercises are straightforward enough, but sometimes some apparatus is desirable—for example, a rope over a pulley, easily fixed to a wall at home, can be very useful for shoulder movement. Formal exercises should be performed two or three times daily, but practised activity of many muscle groups can be carried out for a few moments at any time.

The patient should also be educated in the use of rest-splints for knees and wrists, which prevent prolonged flexion during the hours of sleeping. To summarize the rest and exercise problem: general and local rest are usually indicated during the acute onset or exacerbation of disease, and during subacute or chronic phases it is as well to avoid fatigue, taking a midday rest if possible, while active exercises must be carefully taught and continued as a habit. It is no exaggeration to say that scrupulous attention and encouragement by the practitioner in this regard can do more than anything else to maintain function in a patient with rheumatoid disease, while the plights of countless chair-bound or bed-bound arthritics is a testimony to the neglect of these simple measures.

Drug Treatment

Drug treatment was discussed in the television programme, and most of the principles are generally appreciated and accepted. The use of analgesics in maximum tolerated dosage is advisable in many patients, because relief of pain permits exercise and thereby assists in maintenance of function. However, pills should not be forced upon people who have a high threshold for pain and who are seen to be doing well without drug treatment. Despite all that has been written about its side-effects, aspirin is a relatively safe drug and its long-term use in rheumatoid arthritis is perfectly justified, but for patients who cannot tolerate it there are a number of alternative analgesics. Efficient analgesia and physical treatment of the sort already outlined are all that is required in the majority of patients with rheumatoid arthritis. Other anti-inflammatory agents—mainly gold salts and corticosteroid hormones—are necessary only where there is progressive and disabling disease activity. The enthusiasm for gold salts in the thirties and for corticosteroids in the fifties has been replaced by a healthy respect for their potential dangers. The schedule of dosage for gold indicated in the programme is reasonably safe provided that a careful clinical and haematological watch is kept for incipient dermatitis, proteinuria, or blood dyscrasia. In the same way the dangers of corticosteroids are widely known, but serious trouble has usually been confined to patients on high dosage. Prednisolone 2.5-7.5 mg. daily is very unlikely to cause toxicity, and in this dosage it can often be withdrawn if the activity of the disease subsides. The drug should be considered when it confers increased mobility and functional performance and relief from severe morning stiffness, if these are unobtainable by any other means.

Long-term Management

Still, however, we are faced with the core of patients in whom the disease progresses, and where chronic disability poses various further problems in long-term management. Certain limitations of physical performance may now have to be accepted and environmental adaptation must be carefully planned. For the housewife there are numerous appliances which can be used in the house to help with cooking, housework, and personal activities. Details of these, and information about where they can be obtained, are given in another book published by the Arthritis and Rheumatism Council called Your Home and Your Rheumatism.† For the manual worker the necessity may arise of modification in his work, an invalid motor vehicle, or a complete change of employment, and here the help and advice of the disablement rehabilitation officer of the Ministry of Labour must be sought. And over the years there must be constant observation for various local complications which may need attention. Excessive synovial proliferation in a dorsal tendon sheath on the hand requiring excision; sudden weakness of extension of a finger due to tendon rupture requiring early suture; painful paraesthesiae in the fingers indicating a carpal tunnel syndrome, amenable to injection or to operation; progressive pain and instability in a single joint such as the wrist indicating the need for a work splint or arthodesis; recurrent joint effusion requiring local injection of corticosteroids or synovectomy; exacerbation of joint pain raising the possibility of secondary infective arthritis; early flexion contracture of a knee requiring serial plasters in hospital; painful metatarsophalangeal subluxation requiring suitable footwear or perhaps remedial surgery; ischaemic ulceration on the legs—these and many other problems may arise from time to time, and their early detection and successful handling play an important part in the management of the patient and the maintenance of physical, economic, and mental independence.

† This can be ordered by members of the public from the Arthritis and Rheumatism Council, Faraday House, 8-10 Charing Cross Road, W.C.2. Price 1s. 6d. +6d. postage.

B.M.J. Publications

The following are available from the Publishing Manager, B.M.A. House, Tavistock Square, London W.C.1. The prices include postage.

- Is There an Alternative? .... Price 7s. 6d.
- Treatment of Common Skin Diseases .... Price 10s.
- Obstetrics in General Practice .... Price 32s. 6d.
- Child Care .... Price 32s. 6d.
- Charles Hastings and Worcester .... Price 3s. 6d.
- Health Centres and Group Practices .... Price 3s. 6d.