Abdominal Pain of Unknown Origin

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Introduction

Abdominal pain is a common presenting problem in both primary care settings and Emergency Departments. The underlying cause is not determined in about 1 in 3 patients.[1]

The following is a perplexing case of abdominal pain that presented to our University clinic.

Case Description

Case History

A 43-year-old female with a past medical history of diabetes and hypertension presented to the clinic with chief complaint of generalized abdominal pain. The pain started about 6 months prior, occurred about every 4 weeks, and typically lasted 3-4 days. The patient had tried many OTC treatments including TUMS and Maalox. There was an improvement with bowel movements. She described the abdominal pain as a throbbing with no radiation. She denied any urinary symptoms, vaginal bleeding, vomiting, or hematochezia.

On exam, the abdomen was soft, nontender to palpation, and nondistended. Bowel sounds were present in all four quadrants. There was no hepatosplenomegaly.

She had approximately 45 pounds of unintentional weight loss during this time. Of note, for her history of diabetes mellitus type II, she was currently taking metformin 1000mg BID and dilaglutide 1.5mg weekly. She had been on this regimen for approximately 11 months.

Patient was referred to Gastroenterology for an abdominal ultrasound, EGD, and colonoscopy.

Differential Diagnosis

- Irritable Bowel Syndrome
- Inflammatory Bowel Disease
- Eosinophilic Gastritis
- Iatrogenic
- Gastroduodenal Ulcers
- Abdominal Migraine

Case Description

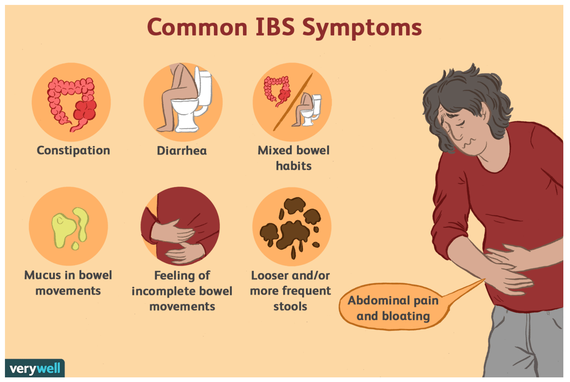
Initial Work Laboratory Values

CBC: WBC: 10,000; **Total Eosinophils 1710 cells/mcL** (normal <500cells/mcL)

Hgb 12.8; Plt 325; CRP 1.5; **ESR 28mm/hr** (normal 1-20mm/hr)

Stool O&P: negative for ova and parasites

Fecal Globin (occult blood): negative



Source: Very Well Health.[2]

Follow-Up Studies

Abdominal Ultrasound: only remarkable for fatty liver infiltration

HIDA scan: hyperkinetic gallbladder with EF 89%. No reproduction of patient's symptoms on gallbladder contraction

EGD: normal esophagus; negative for *H. pylori*

Colonoscopy: tortuous colon, diverticulosis present, otherwise unremarkable

Final Diagnosis

Irritable Bowel Syndrome

Discussion

Abdominal pain is a common complaint in primary care settings and emergency departments. The differential should include iatrogenic causes and abdominal migraines, along with the more common causes including IBS, IBD, *H. pylori* infection, and gastritis. This patient presented with a lengthy differential diagnosis given her comorbidities, medications, and eosinophilia. Given those findings, an EGD and colonoscopy were warranted in order to exclude eosinophilic gastroenteritis, IBD, and Celiac Disease. It is important to remember that Irritable Bowel Syndrome is a diagnosis of exclusion, and this case required an extensive workup to diagnose it. Her eosinophilia is currently being rechecked, and the likely differential is some sort of hematologic cause.[3]

Conclusion

Irritable Bowel Syndrome is a common pathology seen today. It is important to remember the diagnostic workup and treatment strategies.

References

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