



Rule out a heart attack

Tom was a 40 year old who was self-employed as a truck driver. His health was generally good, having given up smoking a few years ago. He was, however, about 10 pounds overweight and admitted to eating too much “fast food”. He blamed this on the nature of his job – long hours on the road and the fact that he was single.

Over a four-month period, Tom experienced two attacks of what he described as chest pain. On the first occurrence he presented himself to the Emergency Department at his local hospital. The physician ordered cardiac enzymes and an ECG. Upon physical examination he was found to be in some distress but the pain had not radiated to his left arm. A short time following his admission Tom said he was feeling more comfortable. His creatine kinase and troponin results both came back as normal, as did the ECG. He was discharged from the hospital with the recommendation to follow up with his family doctor. Tom never got around to doing this, saying that he was too busy.

His second attack of chest pain occurred a few months later and he visited the same Emergency Department as before. Once again the physical exam and the diagnostic tests did not indicate the presence of heart disease. However, at this stage Tom admitted to the doctor that he had been out celebrating with his buddies shortly before both of his admissions to hospital. Subsequently, a letter was sent to Tom’s doctor suggesting that he be investigated for a gastro-intestinal disorder.

Referral to a gastroenterologist involved having a series of radiological tests including the use of contrast media. The most significant result of these tests was that there was some evidence of erosion to Tom’s esophagus. Accordingly, he was given a provisional diagnosis of GERD – gastroesophageal reflux disease. Prilosec

(also known as Omeprazole) was prescribed. GERD, as it is called, is what happens when the hydrochloric acid in the stomach manages to pass up into the esophagus. This causes pain. Prolonged exposure to the acid can cause the lining of the esophagus to ulcerate/erode.

The drug’s clinical effect is to relieve, or to prevent patients’ dyspepsia. It does this by reducing the production of acid by the stomach. The use of this drug is not without risk of complication and the doctor must follow up on the treatment.

In some patients the use of antibiotics along with Prilosec may cause an allergic reaction, including trouble breathing and/or swallowing. In fact, several weeks after starting his treatment, Tom did suffer an acute attack of coughing and respiratory distress; this lasted for approximately an hour. Tom had not been taking an antibiotic, only his Prilosec.

As an aside, it should be noted that the hydrochloric acid that is normally present in the stomach has several benefits. These include the ability of the stomach to kill bacteria that are ingested. For instance, in the absence of the acid, *C. difficile* bacteria may be allowed to multiply and predispose the person to developing the disease. Also, an important function of the acid is to convert dietary sources of iron from the ferric form to the ferrous form. It is only when it is in the ferrous form that iron is absorbed in the small intestine.

Tom’s family doctor emphasized to him that it was important for Tom to change his lifestyle – better diet, limit his partying, and lose some weight. ❖

