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Summary

Diagnostic workup of non-cardiac chest pain

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Oesophagus

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This educational presentation outlines a systematic diagnostic approach to non-cardiac chest pain of esophageal origin, emphasizing that cardiac causes must be ruled out first because clinical history alone cannot distinguish between cardiac and non-cardiac chest pain.

KEY POINTS

- Non-cardiac chest pain accounts for 60% of chest pain emergency visits and has prevalence of 14-33%, being more common in young adults and decreasing with age.
- The speaker stated that GERD is the most common esophageal cause and should be evaluated following Lyon Consensus guidelines, which recommend PPI withdrawal for 2-4 weeks before esophagogastroduodenoscopy; the speaker noted about 70% of patients with reflux symptoms will have normal endoscopy requiring ambulatory reflux monitoring.
- For eosinophilic esophagitis diagnosis, the speaker recommended collecting at least 6 biopsies from at least 2 different esophageal sites after withdrawing PPIs, food elimination diets, and steroids, noting that up to 20% of EOE patients lack endoscopic findings.
- The speaker stated that high-resolution manometry following Chicago Classification version 4.0 should be performed to assess motility disorders, which are present in approximately 30% of non-cardiac chest pain patients and include achalasia, esophagogastric junction outflow obstruction, distal esophageal spasm, and hypercontractile esophagus.
- When all investigations show normal acid exposure time, the speaker explained that reflux-symptom association metrics should still be assessed to distinguish between reflux hypersensitivity and functional chest pain.

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