

Esophageal Chest Pain



Chest pain can be a frightening symptom. When patients experience chest pain, many often fear that they are having a myocardial infarction. In fact, chest pain is one of the most common reasons for visiting the emergency room. While the first step for treating these patients should always be to exclude a cardiac etiology for the pain, we as gastroenterologists and hepatologists know that chest pain has numerous non-cardiac sources, including several involving the esophagus. Esophageal chest pain can be caused by gastroesophageal reflux disease, esophageal hypersensitivity, dysmotility, and even psychological conditions, such as panic disorder and anxiety. Unfortunately, there is currently no systematic approach for diagnosing and treating patients who are experiencing esophageal chest pain, which has resulted in increased health care costs and disability.

In this issue of *Gastroenterology & Hepatology*, Drs Enrique Coss-Adame and Satish S. C. Rao review the current pathophysiology, diagnosis, and treatment of esophageal chest pain. According to the authors, the key to managing this challenging condition is to identify the underlying cause(s) or mechanism(s) for the pain. The authors examine various treatment approaches, including proton pump inhibitor therapy, antidepressants, and psychological treatments, such as cognitive behavioral therapy.

Our other feature this month focuses on the numerous infectious complications that can develop after liver transplantation. As Drs Maria Del Pilar Hernandez, Paul Martin, and Jacques Simkins note, orthotopic liver transplantation is the standard of care for decompensated cirrhosis and hepatocellular carcinoma, and there are over 6000 liver transplants each year in the United States. In addition, the agents currently being used for systemic immunosuppression have increased in potency, which is beneficial because this increase has led to improved graft and patient survival after transplantation. However, the increase in potency has also led to an increase in opportunistic infections, which are the leading cause of

morbidity and mortality after liver transplantation.

This month's hepatology coverage continues with a column on screening for hepatitis C virus infection. Dr Douglas Dieterich reviews the current screening guidelines, which include the screening of all baby boomers, and describes the advantages of birth cohort screening as well as its challenges. He notes that additional research is needed to develop effective ways to increase the rate of screening as well as to link patients with positive test results to appropriate medical care.

In our IBD column, Dr Andrew T. Chan discusses the large prospective cohorts of the Nurses' Health Study I and II and several findings from these studies linking environmental factors with the risk of inflammatory bowel disease. He also mentions several randomized, controlled trials currently underway to confirm some of these findings and plans for continuing study of these cohorts.

The endoscopy column focuses on the use of endoscopic cryotherapy for Barrett esophagus. Dr George B. Smallfield III describes the history of this technique as well as its advantages and disadvantages compared with other therapies for Barrett esophagus. He predicts that cryotherapy will likely be used more frequently for Barrett esophagus in the future as it becomes easier to use.

Lastly, the GERD column is authored by Dr John O. Clarke III. He provides a thorough overview of the various methods currently being used to evaluate eosinophilic esophagitis.

I hope you find this issue interesting and informative.

Sincerely,

Gary R. Lichtenstein, MD, AGAF, FACP, FACG