Introduction to Abdominal Pain and Diet

According to a recent study, abdominal pain accounts for roughly 7% of all ER visits to US ERs annually. This doesn't seem like a lot, but when you factor in the sheer number of people who go to the ER, suddenly 7 percent can reach into the millions of visits.

Your test results came back, and you still have pain. Everything is negative, there's no appendicitis, But something is still wrong. You're still not feeling good, you're having nausea.

Is the medication not helping? Is there something more sinister going on? What's being tested for? is your ER doctor just incompetent? Let's not answer the last one.

What if I told you that your abdominal pain could be due to your diet? In this episode of the Jaffercast, we're continuing to debate regarding diet and how processed foods relate not just to metabolic health, but perhaps unexplained abdominal pains as well.

So, grab the Pepto. This episode is definitely going to give you heartburn. Welcome everyone to this episode of the Jaffer'd Cast. I am your host, Dr.

Mark Papadakis, nobody particularly special, just another freaking ER doctor. So today we're going to be talking with the GI and hepatology fellow, Doctor Karolina Sinakowicz.

We're gonna be taking about gastritis, peptic ulcer disease, and basically stomach pain, a very common complaint in the ER and one that many of you have mostly after eating, well, Taco Bell and places like that.

So if you enjoy the content, please be sure to like and subscribe, follow along. We're on Apple Podcasts, YouTube, Spotify, and social media. If you have any comments, suggestions, or if want to be on the show as you're a medical professional, Please reach out to my email at jeffordcasts at gmail.com.

Good to meet you, good episode. So let's bring Dr. Karolina Sinakiewicz in here. Hi, Carolina. Thanks for joining me. Welcome aboard. Hey, thanks for having me!

So, you're a two-year-old college of osteopathic medicine graduate, just like me, but you were in 2015, so you are ahead of me and you went to do your residency at Hackensack, is that correct?

Yep. And that was internal medicine? Yeah. Alright, and then your fellowship trained, went Colorado and your technically GI and hepatology trained. Now, we talk about a lot of, you know, stomach pain.

People come in for abdominal pain a LOT through the ER. So I want to bring a GI doc and Ewan here to mostly talk, about when we are stumped in the E. R.

that we can't really find a cause for abominal pain, so we kind of chalk it up to, let's probably gastritis, could be an ulcer, have fun, see a G. I. doc.

And unfortunately, a lot of patients in my population, you know, the spicy food, greasy food is a very common denominator. I feel like that's a main cause.

Am I not wrong in that here? I would probably say I'd add a more common denomination and that would be chemical substances like alcohol. That's the most common I see.

Yeah, good call. I usually try to avoid mentioning alcohol because that makes me feel bad. You know, I like beer,

all those things, wine and all, so if I start saying alcohol, it's like, oh, should probably change my diet around here too, but nobody wants to do that.

So what do you normally deal with in your practice? What chief complaints are more common?

Guest Introduction and GI Practice Overview

Do you see coming into your office? You get a lot of your referrals. What's the deal? Yeah, so I happen to practice in a community. So we see a lot of community referrals.

I see patients who are coming in with GERD, postprandial fullness, fullness after eating. You know, I all of a sudden eat and I feel very full. Nausea and vomiting, extremely common.

Abdominal pain, just unspecified. And then I would say the two most common would be either significant constipation or diarrhea. And those are like the majority of my patients.

I can't stop going and I. Can't go at all. It's like, okay. All problems. And then I would probably say, um, third of patients I actually see for liver, for livers.

Okay. Again, alcohol related, I'm assuming, or is it like a combination of? You know, I would say right now the biggest thing is more patients are getting diagnosed with non-alcoholic fatty liver disease and that would be the metabolic liver diseases associated with diabetes and high blood pressure.

And those are incidentally found on imaging. You now, they went to the ER for a broken rib and someone CAT scanned them and all of a sudden they say, well, you also have fatty livers and you should see someone for it.

I usually see them. So interesting because I feel that when we think about fatty liver disease, we thing of the, your obese patients, you know, diabetes, but you mentioned high blood pressure in there too.

How does that end up working? How's that contribute? Yeah. So, high pressure, cholesterol, all of those, if you were to think syndrome, like the metabolic X syndrome.

So you think about someone who has diabetes, they may or may not be obese. I actually see a lot of patients who are not even obese, maybe they're a little bit overweight, but they have some genetic predispositions to fatty liver disease.

For example, their entire family has high cholesterol, the entire has vascular disease, so they've had heart attacks at the age of 50. Those are the patients who I see who are 30 years old, and they are coming to me with already stage two fatty liver disease.

And maybe they drink a little bit of alcohol, but it's kind of, you know, a more complex picture. How do you prevent progression for those patients? Can you actually prevent regression?

Is it reversible? Yeah, yeah, for sure. So basically, they just have to abstain from all the not great things for the body. And then ideally, what happens when we talk about fatty liver, I mean, is it just liver encased in fat?

Does it get reabsorbed? So, the way that I describe fatty-liver disease to patients is imagine if you have your entire liver. Over time, any stressor to the liver the, way the the response to it is by inflammation.

So we call that hepatitis. Most people get a little skittish around that word but that really just means inflammation of the liver. So let's say you drink a lot so you binge drink on the weekends but during the week you drank nothing.

Let's see maybe you have slightly high cholesterol, maybe have a little bit of high blood pressure. Maybe you're pre-diabetic. All of those things create the perfect storm for your liver to become inflamed.

Once in a while you'll have an episode where you had maybe right upper quadrant pain and we'll say maybe it's your gallbladder. But realistically, it's probably hepatitis.

It's probable inflammation of the liver. And if you capture that patient, you may see elevation of liver numbers, slight, but not a ton. Then you'll say, well, okay, your liver's inflamed now.

We do some fancy testing and we do fiber scans. Sometimes patients even need a liver disease or a live biopsy. In those cases, we you know, we diagnose you and we say, which stage of fatty liver disease do you have?

And then the problem is, how do we make it better? It's not just abstaining from alcohol, because how you fix your risk factors, right? So these patients would be good candidates for maybe a cholesterol medication.

Maybe we put them on a statin and see if that improves liver health. Nowadays, a lot of patients end up on these medications like you know, Ozempic and Monjaro and they end up on these GLP-1 analogs that help them lose 10% of body weight because that's really the goal.

The goal is to lose ten percent bodyweight to decrease the fat reabsorption into the liver. You know, we're seeing just a common denominator and now in a lot of episodes, how nutrition lifestyle really plays a role in many different forms of disease.

And obviously there's a big push now, in healthcare and elsewhere to talk and address the quote unquote, root causes of diseases, which I think is interesting that we, you know.

We're told that doctors never address root cause of the disease and yet here we are talking about the root of cause disease People don't want to hear the root cause of the disease.

Well, that's the key here. Yeah. We tell them about the cause a disease, smoking, diet, and it's like, you know, la la, do you, obviously you discuss diet with your patients.

we talk about medication, discipline. If you don' have the discipline, You can eat medication and things of that sort, the triad. Have you referred patients to a dietitian or started patients on diet plans?

How does that end up working out? Yeah, so we actually, our group is really, really unique because we have a group of dietitians that work with us specifically.

And what they do is they have access to my medical chart so they can see what testing the patients have. had done and they're not just nutritionists, because that's a big difference when you see a nutritionist versus seeing a registered dietitian.

Okay, so people don't understand that. And the way that I describe it is a Nutritionist is somebody to me, it's the same difference as seeing like a nurse practitioner or or a physician's assistant versus seeing a doctor.

The training is very similar. It's the extent of training and it's extent licensing. So we work with registered dietitians. These are people who have trained for several years, they've been in clinical practice, in hospitals, and they are state board certified for basically nutrition.

Fatty Liver Disease and Metabolic Risk

And what they do is they talk to the patient, five prong assessment. And they say, what is your sleep like? What is you stress like, What does your diet like what are your bad patterns?

And the even sometimes do heart rate variability monitoring and they said, Hey, you know, can we see where your triggers are? And I work with them, not only for my patients with metabolic liver disease, but I send my patient with inflammatory bowel disease to them.

And when a patient sees a dietician, IBD patients specifically, they don't get re-hospitalized as frequently. Their disease is better because- Go figure.

Yeah, because they are more compliant with their diet. So yeah, I utilize our diaticians. I would say probably, except for the very, very few patients who are very straightforward, they go straight to them.

I don't even tell the patient that there's an option of not seeing them just because I know they will do better. They're very resistant to do it because that's the pattern that people are in.

And they like what they, like, but I, don, t leave that as a, as an, option to, them and over time, they liked, to they to like to it. Now do you see, let's mention like IBS for example, do see a common denominator in diet specifically that seems to trigger these types of patients, dietitians?

Do you something of that sort that you can say, okay, this seems more of a problem than this for an example? Yeah. So my, I have kind of like a dual theory, so you know, you mentioned fatty foods and spicy foods.

And those are kind of, they may or may not cause an issue. But from my experience and my perspective, the big umbrella term is really processed food. That is your number one, right?

And the number two is dairy. Always. It's funny you mentioned dairy because I've known a couple of colleagues who really have started to notice changes in their overall health as they've gotten older and they'd cut out dairy and notice a significant improvement.

And we talk about dairy in lactose intolerance, you know, it's more of like a spectrum of disease. You can be lactos intolerant and only have a little bit of gas after eating some ice cream, or you can full on lacto intolerate and be in the bathroom for the next five hours after you drink a couple of milk.

Or severe constipation. And ideally, the human body really is a unique organism in the sense that we're the only species that drinks milk after we've been weaned.

We're not meant to do it. People can obviously do and I am thankful that I can eat ice cream and have cereal with milk in it, You know, I know many people who cannot, they have some shades of this and it's all based on the enzymes in the gut that break this protein down.

And even a little bit of GI upset can be a potential trigger. So it is interesting that you guys are looking at that much more closely than I think the medical establishment as an overall is.

That's just my opinion, obviously, a narrow opinion. What do I now, right? Just the ER doc over here. But, so you mentioned obviously milk and you. talk about processed foods and are we talking your TV dinners here?

Are we talk like little fruit snacks? Like when you say ultra, like we're talking like everything, what's the ultra? Everything. Everything that comes in a plastic package.

It is considered processed really. Because, you know, when I talk to patients, I get very, kind of honed in on their actual history because they'll come to me with random symptoms.

And for most people, those symptoms are a mystery. I mean, none of it makes sense. But once you get really good history, and this is where, you know, medicine is a little bit of detective work, because some patients are terrible historians.

Yes, 100%. So that's where the magic kind of happens in the office where you say, all right, well, my favorite question to patients is walk me through your, morning, afternoon and dinner routine.

What do you eat? And then I hear, you know, for the morning I skipped in at breakfast. I don't have breakfast, I have coffee, and then, what's your snack?

A power bar. Okay, great. Healthy. Yeah. Yeah, uh-huh. Okay. And then lunch, what do you eat for lunch? Well, sometimes I'll pack a lunch. What do have for launch?

I have a sandwich with cold cuts and bag of chips. Cool. Healthy. You didn't get McDonald's, right? Right. Exactly. Saving money. I'm not making my own lunch.

Yeah. And I get a lot of patients who say, come to me and they say I have a healthy diet. What am I doing wrong? Why do I not feel well? And then, you know, for dinner and I'll have something that's maybe pre-made.

So they'll maybe some sort of like they're working and, maybe they have spaghetti, but they bought the sauce from a can or from from the jar. still relatively healthy, not the end of the world when you think about it.

So, you know, these are the patients who have chronic problems and they say, I cannot pinpoint what the food is. And they come to me seeking food allergy testing, which I absolutely refuse to do.

I will never order a food allergies test because useless for GI completely. Unless you have angioedema and you're swelling up and have a rash after eating it, boom, that's your food Yeah, and there's a difference, this is very common among many patients, the idea of an allergy versus an intolerance.

It's medications, it's foods, everything. Just because you have a negative reaction to something doesn't mean it is an alogy. it means your body isn't tolerating it to some degree, whether it was known, like a side effect of a medication, Or unknown, like, you're eating this processed item, whatever it is, and suddenly, hey, my gut's not feeling too hot.

I'm having this issue. Yeah, that's technically more of an intolerance. And there's no way to test for that. The test is removing that substance. Don't eat it.

Exactly. So yeah, so I typically do a lot of counseling for patients and I tell them, you know, if you look at the ingredients and it's not just the ingredient, tomato or whatever else and no preservatives, that is technically processed.

If there's preservative and then it is processed, it' tough. It's tough, especially because we have a society, and again, we could want, you know, going back to the root cause comment, right?

We have this society that's a go, go go. You're working more than 40 hours a week, You working overtime, working two jobs. you are pressured to stay late, come in early.

And that is obviously terrible for circadian rhythms. I mean, have night shift workers, late shift, workers and. crying out loud, ER doctors are notorious for that.

And as a result of that, you have unhealthy habits, not unhealthy diets necessarily, like you just said. What that person ate was quote unquote healthy.

It wasn't fast food, wasn' t candy bars, no eating quote-unquote junk, but it's unhealthy habit that's leading to these chronic conditions, these diseases.

I am guilty of that. I will be the first to say that when I came home, when come home from a 2 to 11 shift, a 3 PM to 1 AM shift I'm starving because I was snacking through most of my shift and I come and eat a TV dinner at 2 o'clock in the morning because i'm famished and i can't go to bed hungry and they're chock full of sodium, they are choc full cholesterol containing stuff, fats and oils and whatnot, and it tastes great.

It hits the spot and then, you know, yeah, I don't feel great after eating it. You know? Yeah. I mean, that's something that I tell my patients, they love this term.

And I call it the restaurant syndrome. The best way to figure this out when you're talking to a patient is when your

making food for yourself, do you feel sick?

And when go out, Do you fell sick.

Processed Foods, Dairy, and Food Intolerance

Because I have a lot of patients who come to me and they say, oh my God, I feel sick all the time. And I ask them, how many times do we do go out for dinner or do you go for lunch?

And it doesn't matter if it's a healthy lunch or if its an unhealthy lunch. How many time do actually have food that is from a restaurant? People don't understand that in a restaurants setting, unless you're really going to a really, really fine dining restaurant, farm to table where they are making everything from scratch, to order, you are getting food that is processed.

You're getting that has preservatives because they have to. They can't have food sitting out and poisoning you. So it needs to have some form of preservative.

When I kind of rephrase that and frame it in that way for patients, I say, when you're making yourself food, exactly what goes into it. You know every ingredient that goes into it, and you can pronounce that ingredient.

When you're going out to a restaurant, things are going to be, by all accounts, more fatty than you would make it yourself. Unless you are, I don't know, really a huge fan of butter.

And lard and all that good stuff. Yeah, because you know, fat is tasty. So what is the goal of a restaurant is to make tasty food. No one is going to go unless you're going into like a vegan, clean restaurant.

Every other restaurant will be focused on the flavor. They want you to come back. they want to have a tasty meal. I will never forget that steak. Well, guess what?

That steak was like two and a half thousand calories. Yes. Get a nice ribeye, put a ton of butter on it, get some nice potatoes. I mean, that is like a whole meal for two in one sitting.

So that's one of the things. You're going to walk away from that meal. And what are you going do? You probably going go sit down. you may go for a little bit of a walk, but those 2000 calories are just going like percolate in your system.

Yeah. Not going burn it off. No. The thing that people don't understand and once I kind of tell them this, they're like, You know having an awakening in my office and you know, I usually tell people to go and watch the YouTube video of the McDonald's burger Okay, yes.

I'm really with that one Yeah, it was like years ago ten years if if a food is meant to be shelf stable Okay for days weeks. We buy bread bread and that's in packaging and it's good for three weeks.

And it will pretty much never grow mold unless you live in Florida and its really hot. If mold doesn't want to grow in something, it is so processed that imagine putting that into your body.

Your body is going to double, triple, quadruple the amount of acid to just digest it. That's how, you know, GERD and heartburn and dyspepsia, none of those things are created by a stomach that doesn t work.

It means your stomach actually is Pretty darn good. It's actually doing a really good job to the point where it's over-producing the stuff. Exactly. And it makes you feel unwell.

That's one of the things that people don't understand is that there's nothing wrong with your body. What you're doing to it is not right. Your body, without going into a theological debate here, Our bodies, whoever designed it, is designed perfectly.

That's just the way it is. There are some diseases, there are genetic disorders that aside from that, but the ways your body is made and the bodies connected and your digestive system works, it's designed.

Perfectly. We cannot make it better. And it's designed for thousands and thousands of years of evolution. It's fine-tuned itself for this purpose, too.

Yeah. it is not just, you know, slapped and here we are. You know this is something that has gone on thousands years, of advancement, perfection, if you want to call it, to now we're just kind of punishing it by giving it garbage.

Exactly. And there's a reason why, my husband and I went on a trip to Switzerland. I'll tell you a funny story. So I grew up in Poland. And I came here, I was 16, and I never lactose intolerant.

I am severely lactos intolerance in America. Interesting. When I go to Europe, i can eat whatever I want. So I know that I'm not lacto-intolerant, that i'm intolerate to whatever the processing thing is happening to specific foods.

Because if I have a more imported cheese, then I'll be okay. If I had milk, than I will die. I mean, I don't want to interrupt your story there, but do you know what about the process between European food and American food is different?

Has that been looked at, studied? There's all kinds of studies. There is nothing that they can pinpoint. They're always going back to the… GMOs and the fact that, you know, in America we're feeding all the animals corn.

Corn is actually a very, very highly pro-inflammatory food and it is not an easily digestible food. You say that as I just ate corn in the cob two nights ago.

Now I'm feeling guilty. All right. But that's the thing. It's, just adding corn into our system. That's one of the big differences because cows are not meant to eat corn, just a shocker for everybody, but they do.

Same with, you know, with all the flock and all of the chickens that we're eating. So I think that's one of it, one, of them. But the processing here is different, the pasteurizing process.

There are additives that are getting added. to the pasteurizing process. No one's like really talking about it. It's not just heating it up. So, you know, even in European countries, if you go and have a pasteuroized milk, that milk still, If it sits on the counter for three hours, it will go sour and it'll start separating.

American milk doesn't do that. It doesn't do that. I left it on the counter for a while and it's still pretty good. We just put it in the refrigerator.

Yeah. So there is some processing that takes place that really takes away the good bacteria, I think. And I that if you were to measure the amount of bacteria and the probiotics, the natural probiotic that are in dairy, it is much higher in Europe.

I think the natural lactobacillus that likes to be in lactose is so high in those. And that's why you get the sour cream. That's how you got the milk with the cream on top, because the bacteria in it is constantly replicating.

But the problem with American food industry is that we're feeding millions and millions of people. You're not feeding a small country of Switzerland. Yeah, the food supplies or central is easily, you know, it takes two hours to cross the country versus, several days by plane or by train.

Correct. So that's the big thing, and I hate to address blame it on the, food industry and the society and whatever, but as a person and as patient, You just really have to do your best and your, best has to be what is not actively making you sick.

And that has to be the priority that you cannot continue to ingest food that your body is actually just physically rebelling against and that people don't, they don t put those two things together frequently.

So the change is hard. And look, you know, I've been railing on, R. F. K. Jr. here for many reasons. It does make it difficult because there is a kernel of truth into his crazy lunatic, unhinged rants about things, which is processed food is problem.

But the difference is the medical community has recognized processed is food a problem, how do we go about improving it and regulating it to make better for us has always been the question.

And looking at what other countries do is a very good first step. So you talked about Switzerland, Poland, all them. What do European countries that we don't do, can we replicate that?

And like you said, we have a large country to feed and we feed other country too from our food supply. You know, other countries, we export a lot of our grains.

We export our meats and everything. So how do you balance shelf stability and preservation with health? And that's a very, it's almost like an oxymoron in a way.

You really can't do that to the exact perfect degree where it is completely healthy and completely shelf stable. Unless we're in Star Trek and you're talking about replicators.

Add the third component of affordable. And affordable, that's a good point too. So now you have this triangle of affordability, preservation and health, and you can't do it.

You're going to sacrifice one or two to make one better. It's the discussion that we're not going answer obviously today, or even I'm probably never gonna answer on this show, but it's something that the medical community is aware of that.

We are trying to advocate for and working towards, But there are ways to do with that won't harm us and we'll actually make improvements. Yeah. At the end of the day, I think that you can only do your best.

That's number one, right? And number two is we can do better. We can make better choices and those choices don't have to necessarily be more expensive.

It comes down to education and it comes to changing mentality and willingness to even approach it. The willingness is the key too. It's easy to take like Red 40 out of your fruit snacks, but at the end of the day, a fruit snack is still a fruits snack.

A Pop-Tart is a Pop Tart. You're not making it overall healthier by saying, well, you know, we're removing artificial diets and now it's healthier. Right, you're not making it safer.

You're just making less toxic. Right. That's it. Yeah. But you are not make it healthier. I think you have to like make a big differential of removing toxins.

And I don't understand how that's even like not a priority. It should be the priority, making food healthier is not equivalent with making non-toxic. Healthy food should not be toxic, obviously, but a non toxic food still can be unhealthy.

Correct. So that has to be a very like clear line. Where you like, yeah, I'm taking out food dice, It's still a freaking pop tart. Like we haven't changed that.

But yeah, you know, and I always tell patients that, part of the GI office visit, one of my questions for majority of patients is if I feel that their symptoms are tied to their diet, I tell them, are you willing to do the work that is required for you to feel better?

It will be long lasting and you will feel great. I guarantee it. 100%. Or do you want to be on a medication? And guess what? Some of them just choose the medication.

They say, I'm not changing what I am doing. And that's fair, but that question I have to ask because I honor and this is just God's honest truth. I can't afford to spend 45 minutes trying to convince you to do something you're just not going to willing to.

So am I going counsel on the diet that you are just telling me you aren't going follow? It is pointless for me.

Restaurant Food, Preservatives, and Lifestyle

I will still give you the information and I'll say, listen, I'm here for you. And that leads to my next question, which is how long are your visits typically for your patients?

We talk, so she's laughing because there's a lot out there about how, I saw the doctor for 15 minutes and we didn't talk about anything, whatever. And then they'll go somewhere that's less busy, maybe not as specialized and spend an hour.

Then the patient feels great. I spent an hours there and then there'll be sold supplements or a book or some kind of, you know, a 1995 diet plan here.

Yeah, yeah. So my office visits are scheduled for 15 minutes, 15 minute each. Now, if I have a patient who is more complicated, like my IBS patients, I'm never there for fifteen minutes.

That's a 25 to 30 minute visit. And I go over time and then I apologize to my patients and they wait for me. But I always tell them that, you know, I'm behind because I just, not going to run out of the room and say, see you later.

Right. So, which I wish I could sometimes, but I can't. And it's just not in my heart to do that. Some patients are more complex, they require that time, and I am willing to give them the time if I feel that they are actually going do it.

Um, you know, I'm certainly not going to sit there and this is me being very honest, like I am not gonna sit for 35 minutes talking to an alcoholic who I've seen five times and every time I see him it's in the ER because they're intoxicated.

And I've told them multiple times that they're going to die and they are leaving their family behind. And it's thrown everything at them. I'm just not going spend that time because I have somebody else who is going benefit from that more.

Am I going that spend time with someone who's going, you know, to benefit? Yeah, of course. And it sounds cruel. It sounds like, well, that means you don't care about the person.

No, no, I hear you. I care a lot. You lose sleep over those people. Yeah, you try. But at the same time, it's an old saying, You can lead a horse to water, but you can't make them drink.

At the end of the day, with anything, any medical therapy and any specialty, even emergency medicine, At the end of the day, if the patient is not going to do the thing that you are suggesting and you give them valid reasons for doing these things, then you're just wasting your own energy.

You're wasting you own mental health and trying to get these patients to try and follow the science or try to follow your line of thinking to trying and get themselves healthier.

At end the of day there are patients who they just want a pill. Give me the pill, I'll be on my way. Thank you very much. Okay. And you know what? And in some cases, that is okay.

In those cases if you're an 88-year-old lady and you are just like, my stomach is killing me and and your sitting here telling me that I shouldn't drink my glass of wine, God bless you, lady.

Please, I will send you any medicine you want. Do you have your wine? You're 88 years old, like fine. I think I have a rule. Like, congratulate you. I have a rule.

I think if you're over the age of 80 or maybe even younger, I don't know, but at least over age 80, you can eat and drink and do whatever the heck you want at that point.

Like, we're done. You got yourself there somehow, so. Exactly. But that's the thing, you know, it's, kind of like that Jerry McGuire, help me help you, like help, me, and then I can't, those people who are the ones that you are not confined.

You know that they're not going to do what you think is best for them or that, is not that there not worth the effort because I've had some people turn the corner and you're always available for, I'm always for my patients.

I'll never going say I will not see you because you drink. I don't care, but I want you to try something. But that, you know, that's kind of the reality of medicine that a lot of people kind-of poo-poo medicine these days and they say that we're not there to keep them healthy.

Well, where are you keeping yourself healthy? Like, I'm not going to go home and clean out your fridge and tell you you can't have Cheetos at midnight.

I am going tell that but then you're going say, well, my doctor is a skinny girl and she doesn't know anything about a diet. Well, like, there's reasons why, you know, some doctors are fit and some are not fit.

And those doctors who are no fit, yeah, I would agree with the patient. Like, if you look at a doctor who's morbidly obese, don't tell me what to eat.

I don' want to hear it. Yeah, exactly. Right? So, practice what you preach. You know I try to practice when I preach, do I still have a glass of wine and a beer or whatever?

a meal out in a restaurant? Yeah, of course. But that has to be with the knowledge of like… This is what I'm getting into. This was what i'm doing. Is my doctor going to yell at me because my labs are weird?

It's like they're seeing you at the restaurant having glass of wine. It is like, wait a second, you told me that's unhealthy. And you're just like yes, I did.

once a week, cheat day or something, I don't know. But yeah, it's a level of personal responsibility now. It's, a shared responsibility. I'm partially responsible for you and your health, yes, but you have to be responsible, for acknowledging what I am telling you, and acknowledging that this habit, i agree, is unhealthy.

We see it with smoking, right? I have a patient who comes into the ER and it is a diagnosed heart attack, And we asked them, all right, so listen, what's your medical history here?

And he says, oh, you know, hypercholesterole, whatever, my father had a heart attack and I smoke. Do you still smoke with all that says? Well, I quit.

Oh good, when did you quit? About an hour ago when I had my chest pain. Okay. Well yeah. When you talk about length of visit and, you know, obviously in emergency medicine, it's difficult for someone like me to have these conversations with patients.

And when the patient is in the ER, no matter what you're here for, is not a good day. If it is for something that's like, your stomach pain, It's hard for me, to talk to a patient and say, Your CAT scan came back, fine.

Your blood work came. Fine. Maybe your LFT is a little bit elevated, whatever. But overall, there's no infection. There's not signs of a heart attack.

there is no signs that your, you know, your appendix needs to come out. And there are no sign of anything that needs be addressed now that you need to be admitted for.

Well, I'm still in pain. I am sorry. Oh, well I can give you some medication to help you through the pain, but it's going to take days. It's gonna take weeks.

it is going require follow-up and acknowledgement that says maybe something is here that need a change on your lifestyle. And I don't have that extra 30 minutes, 45 minutes after, you know, when everything is said and come back to say, okay, now let's talk about your diet here.

Like, I can't do that. And unfortunately, many patients that I care for have no primary care doctor, let alone have the time to take out of work to go see someone like you, to see that specialist that has that conversation.

You know, so when you have a society that doesn't allow for that to happen, when have, a shortage of, of physicians, not just physicians all expanded for now, have qualified personnel to help a patient get healthy, then you're going to be left with an unhealthy population, an healthy society.

And as a person who sees people on their worst day, as the person that sees the end stage complications of bad choices, It's frustrating, you know, and it's frustrated on many reasons.

One of the reasons why I'm doing this show is to try and get this stuff out there. But at the end of day two, there needs to be a level of personal responsibility that I, that you cannot help the patient with.

It needs be done by them. And ideally with family, with a support group too, Yeah. And you know, you mentioned, patient coming to the ER and you telling them, all these things.

I think a couple of things that are helpful are, and I know every patient gets this and they throw it in the garbage, but the handouts that come from the E. R., this is maybe what you have.

And I have that at my office too, and I even use a transcription tool to write down things that we discuss during the visit and then give it to the patient.

Like, listen, I know we covered a lot, but I want you to really pay attention to these four things. I sometimes write on a post-it note. So when it comes to patients like that, the ER is tricky because you guys are really in the worst position out of everybody in healthcare because when you train, you're there to do emergency medicine.

And some people treat you as a primary doctor. So that is the problem. The problem is that there is, you know, there's a discrepancy with the patient expectation.

And what is The reality of your job? Your job description is emergency medicine. You know a stubbed toe is not emergency Medicine and chronic GERD that has been going on for 25 years.

It is Not emergency Madison, but people go to emergency rooms because They don't have a primary care doctor who's available to them. Yeah. Or they don' have one at all, or they dont have health insurance or.

They, you know, are so sick that now at this point, they, don have access to medications. they are not educated enough to do anything over the counter.

So it's a really complex problem that you guys deal with, but at the end of the day, patients need to understand that. The reason they are in the ER is to roll out all the big bad stuff.

When you don't find big, bad, stuff, guess what? You get to go home. And I often tell them, I say, hey, good news. We didn't fine anything.

ER Abdominal Pain, Gastritis, and Ulcer Workup

You know, and some patients who come fearing the worst are relieved. I thought I was having a heart attack. Yeah. It's like, Oh, thank God, you know, I thought it was appendicitis.

I was like thank god. And then the patients who are there for a diagnosis get frustrated. Let's say, well, then why am I having pain? I don't know. and I say that a lot, and tell my residents as I said, it's okay to say to a patient, if you truly don' know and you've done the things that you can, because you could say I suspect it could be gastritis.

But ultimately you're going to have to follow up. And the GI doctor for suspecting an ulcer is going to have to do an endoscopy, is gonna scope you to actually visualize it to make sure, yes, it is in fact an Ulcer, here's how we need to approach and treat this thing.

But oftentimes, you know, unexplained abdominal pain, I will sometimes say it's probably gastritis. And is that always the case? Or is it just, there could be food intolerance or is maybe a combination of both here?

You know? What, what do I say to the patient when they say I don't know what's causing your abdominal. Yeah. Well, I think there's a couple of things.

You know, when you have a patient who comes and they have, let's say they just have epigastric pain and say, you know my stomach hurts. When patients say their stomach hurt, so you really have to just differentiate which part of their stomache hurts because the stomach for a patients is anywhere from like here all the way down to their pelvis.

That's the stomach. So you need to figure out, that's step number one really and that is going to help you figure functionally what it is. So they say, okay, I have, you know, my stomach hurts here.

You figure out if it's, and really, when we talked about just to kind of backtrack, we talk about the 15 minutes of the visit, right, in my office. And I'm not like tooting my horn.

This is like a very standard thing that most GI doctors understand. I can diagnose you probably in about five minutes. I don't need more than that. i will ask you the right questions that I feel like will lead me to it, or at least to get you like 90% there.

That's all I need. I only need five minutes. And with the questions, you ask them, is your pain worse or better with food? And just my favorite question ever is, have you had this pain before?

If you've had the same before and they say, oh yeah, I've been having it up, back and forth. Months, years, yeah, exactly. Month, year, whatever. So I basically put patients in like three categories in my brain.

I say either they've had this pain for 30 years and it just happens to be the worst it's been, but it it has been there, right? Number two is they have had some sort of pain but not like this.

This is a different type of They've had their chronic reflux. They say, oh, you know, I, take my omeprazole or whatever, and you, know I'm taking it. It's not working.

And then this is different. This pain is, different than my normal type of discomfort. Then you have the third type, of patient who is like cruising through life, eating garbage.

All of a sudden they wake up one day and they feel awful and, they've never felt like that before. Usually after you hit 30. That's when I've noticed that for myself.

Or, or I am 50 and I m falling apart. Yeah. Yes. Basically, those people are, you know, in the emergency room setting. I think that's what you really just need to pay attention to.

Did you have this pain? It just happens to be the worst, but it's really the same type of pain you've had. And those patients, I may or may not scope.

You may think, there's some, she's just like a functional disease. This is something that is more dietary. this is a more lifestyle. A lot of patients actually have just untreated constipation.

They don't drink enough water. other things in their lower GI tract that are giving them upper GI symptoms. The most worrisome patient to me personally is the middle patient.

Is the patient who's like, yeah, I have GERD, but like this is different. This is definitely my Gerd. Yes. And that's what triggers me as an emergency physician as well.

Cause we're not snide when we ask that question in the ER, how is this different than usual? Like we are not trying to play a gotcha. You don't need to be here.

It's no, no. I need know this because your GERT could actually be a heart attack. Like if you're like, well, I have product reflux, but actually, you know, this is like different.

It's like going up a little bit higher or something like that. Okay. I need EKG. You know like there are triggers and you mentioned this, trigger words, or trigger phrases that get us like ooh, This is not good.

So a hundred percent. Yeah. So for me, it's, you know, and when we talk about gastritis, right. And not to be like a jerk or anything, but gastitis is a histological diagnosis.

Um, what you're most people refer to a gastritus is they're just deferring to, You know. Dispepsia, meaning just in indigestion, really. Oh, when patients come to the ER and they say, I have epigastric pain and, To me, for me to even think that it's the stomach or any part of the GI tract related, it has to have some relationship with food.

When someone comes in and they say, yeah, my stomach really hurts, but it only hurts when I walk. Super, you're having a heart attack. I go upstairs on a little shorter breath.

Are my lungs okay? Ho ho, sweetheart, it's not your lungs. That's the big thing. So for me, does it get worse when you eat or does get better when eat?

Do you feel better eating? Have you lost weight because you're really not eating as much as you used to and how long has it been going on? And then you have, you know, all your other types of questions, but, the most worrisome patient for me is going to be somebody who says, I have GERD and I take pentoprazole every day.

I took my nexium every. And today I woke up and they took me nexiom and just still have discomfort. So then I, took a second nexeom, and then it took some Tums and, then they, some Pepto-Bismol.

and Then I came to the ER and this is a patient who worries me. This patient may have an ulcer. Because guess what? They've already given themselves a treatment for an ulcer and it's not working.

So what is it? Right? So those patients, I scoped them quickly and I scope. I mean, you know, relatively quickly, if they're admitted, that's a different story.

But if their outpatient, That is the person who on our initial visit, they are going to get scopped. You know the patients who are the ones off like you know I have an iron stomach and today I feel awful and those patients I probably wouldn't even recommend scoping they don't they even need GI workup they need you some form of acid suppressing for two to four weeks give them a trial of that if they break through through it great send them over.

But aside from that, they really don't need that. So in places where seeing a GI doctor may take three, six months, that exists. It's six-months for us.

We're not at Health Care Desert either. So my waiting list is about two months, but ER patients, I'll see them quicker. But, you know, the big thing is those patients I'm not worried about.

This happened once, this could have been food poisoning, This could've been really anything. And that's one of the other things that I would say, food-poisoning, You're not going to diagnose in the ER.

You are going say all my tests are negative, and you still could still have gastritis from bacteria. and that will just go away, And you can treat them, give them things like carafate, A PPI, you know, within the GI world, we only have like six medications for like heartburn.

It's true. And it's like, nothing else is working. I got nothing, man. This is it. There's nothing. So, and, when patients are like hey, I took all those things and now those are not working, Uh, those are patients who I'm thinking about other things, you know, they probably have H.

pylori or they have an ulcer and they need just really intensive therapy for that ulcers. So, most GI patients, the, don't get diagnosed in the ER. They really don' because the only way you're going to diagnose an Ulcer is if they're perforated or if, or, if their hemorrhaging, right?

So if there coming in and there unstable. Those are the people. They're so sick. Your black tarry stools or you vomited like coffee ground looking stuff, that gets our attention very quickly.

And those are admitted for what we need to scope you here because this is bad. Yeah, someone comes in and they're like, hey, I I like my goody powder and both of my hips are broken and I take ibuprofen and leave twice a day.

Those things perk your ears up a little bit. But aside from that, most patients, in terms of GI stuff, you may really not get a diagnosis aside for the stuff you would actually take for an admission.

You know, the cholecystitis, appendicitis, like those things, it'll be a slam dunk diagnosis. Everything else aside from that in my world needs an endoscopy from my perspective.

And I had, I'll never forget a case, a patient who was a chronic Motrin, you know, NSAID user for chronic pain. I think it was like back pain or something like that.

And you're worsening abdominal pain and immediately like, again, like you say, it takes you five minutes to get the diagnosis. Sometimes it take us the same, right?

You know you ask a couple of questions and you are like it's this. As soon as they said, oh, its NSAIDS, backpain and my stomach is not really hurting.

Probably an ulcer. We get a CAT scan for a complete mistake because you know, they were tender and we're like, all right, you got to, check this out here.

And the CAT scan radiologist report actually showed that there is an ulcer in the stomach. You can actually see it on CAT Scan. It was that large. This thing was probably moments away from perforation, just because of how large and erosive it was on that CAT Scan.

That was the first and only time I've actually seen peptic ulcers on cat scan. I was able to actually diagnose them. Yeah, never good. Like you have a pepticellular ulce because we see Oh, that's great.

No, it's not. I can see it on CAT scan. It's a good thing. So, Dr. Karolina Sinakiewicz, thank you so much for coming on. We had a great conversation.

Hoping to get you back on for other topics and even updates to this one if you're so inclined. Sure. So we talked about, obviously, diet being a big, big factor in people with stomach pain, gastric upset, dyspepsia, and overall lifestyle.

And, of course, we've talked a little about gastritis and tuberculosis disease, but ultimately things can just go back

at the end of the day to diet, lifestyle choices, life style modification.

Very underrated. We're starting to become more aware of it now as a society, even though doctors were pushing for this for, I mean, decades at this point.

But some really good information. So thank you so, so much for coming on. Really appreciate it. Yeah, my pleasure. Thanks for having me.