Upper gastrointestinal (GIT) symptoms

Common upper gastrointestinal symptoms include nausea, vomiting, gastro-oesophageal reflux, anorexia, and early satiety. Taste changes are described separately.

1. Nausea, vomiting/dry retching, and gastro-oesophageal reflux

Nausea: The aetiology of nausea can be multifactorial, including central and peripheral mechanisms. Common causes in CKD include uraemia, dietary triggers, medications, gastroparesis, and constipation. Patients often use the word nausea to describe multiple upper GIT symptoms.

Vomiting/dry-retching: This is most commonly precipitated by uraemia, severe nausea, gastroparesis, and cough fits. Severe vomiting of sudden onset is likely to be infectious in origin and unrelated to CKD.

Gastro-oesophageal reflux (GORD): Reflux occurs commonly, although is not directly related to CKD. Description of this symptom varies (e.g. nausea, pain/burning in stomach, food coming back up oesophagus).

Management

The root causes of this should be explored and treated if possible (e.g. constipation).

Nonpharmacological strategies

- Small, regular meals
- Avoid cooking if the smell of food exacerbate nausea
- Avoid skipping meals, which can exacerbate nausea
- Dry, bland, room temperature food such as sandwiches
- Ginger products
- Sodium bicarbonate mouthwash (up to every 4 hours)
- GORD: dietary strategies to help manage include reducing high fat foods, reducing acidic foods, limit carbonated or caffeinated beverages.
- Also see section on **taste changes**

Pharmacological management

- Begin with a prokinetic agent, either metoclopramide 10mg tds or domperidone 10mg tds. (Avoid metoclopramide/haloperidol if concurrent restless legs syndrome or Parkinson's)
- Other anti-emetics include
  - Haloperidol 0.5mg bd
  - Cyclizine 12.5mg tds, can titrate up to 50mg tds
- Ondansetron is an option but causes constipation, and is expensive in the outpatient setting. This is generally avoided.
- Levomepromazine can be used in intractable nausea. This will require referral to palliative care.
- GORD: can be managed similarly to the general population, including antacids (Mylanta, Gastrogel), proton pump inhibitors (Somac, Nexium), and H2 antagonists

2. Anorexia

Anorexia is multifactorial. Causes in CKD patients include uraemia, taste changes, all other upper GIT symptoms, polypharmacy, and medical co-morbidities such as heart failure or oncological conditions.

Nonpharmacological strategies

- Treat other upper GIT symptoms.
- Small regular meals.
- Food fortification (link to resource, eg using extra oil or butter in cooking)
- Consider eating environment, such as social eating.
- Relax unnecessary dietary restrictions.
- Have foods that are easy to prepare in the house.
- Referral to dietitian to prescribe dietary supplements. Consider low electrolyte, high energy supplements.

3. Early Satiety

This is commonly caused by gastroparesis, which is in turn due to uraemia or co-morbidities such as diabetic gastroparesis.

Nonpharmacological strategies

- If diabetic, optimise blood sugar control.
- Small, regular meals.
- Avoid foods that are take longer to digest, such as fatty foods, high protein, and very high fibre foods.
- Consume drinks away from meals.

Pharmacological management

- Domperidone 10mg tds can be used 30mins pre-meals