Question 15 – November 13

A 56 year old woman with a PMH of depression presents to the hospital 6 months ago with RUQ pain, leukocytosis, and fever. She is found to have acute cholecystitis and undergoes cholecystectomy. Post-op she is given oxycodone for pain control. 2 months later the patient continues to complain of abdominal pain and her surgeon prescribes more narcotics. She attempts to stop the pain medication on her own but develops abdominal pain when they are reduced. 1 month later she presents to the ER with increasing severity of abdominal pain and nausea. Complete blood count, liver function test, and lipase are all normal. CT scan a/p and ultrasound are normal. HIDA scan rules out bile leak. MRCP shows normal caliber CBD. She is sent home with prescription for dilaudid and plan to follow up with the surgeon. 2 months later she sees a gastroenterologist who performs an EGD and colonoscopy which are both normal. She asks for more dilaudid but states she wishes she didn't have to take it and that she likes to continue working.

What is the most likely diagnosis?

A. Gastroparesis
B. Pain seeking behavior
C. Narcotic bowel syndrome
D. Type I Sphincter of oddi dysfunction

Answer: C

This patient has narcotic bowel syndrome, as evidenced by increasing abdominal pain severity and frequency, partially responsive to narcotics but requiring escalating doses. She has normal LFTS and normal CBD caliber which excludes sphincter of oddi dysfunction. Narcotic bowel syndrome is thought to be due to upregulation of the peripheral nociceptive signals causing central hyperalgesia. It can occur after several weeks of narcotics given for post-surgery pain or an intra-abdominal event. The treatment relies on therapeutic relationship of the doctor and patient and tapering off opiates, using alternatives for pain control like TCAs.

Reference

Keefer L et al, Centrally mediated pain syndromes. Gastroenterology 2016; 150(6).