

# AI-01662 DDx Abdominal Pain During Cycling

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Tags	MD
Created time	@May 18, 2025 9:03 AM

Perform a Ddx acute stomach pain. A male long distance cyclist 400 miles per month weekly mileage, long distance swimmer, 58 years old, cardiac patient in 2008 stented, LAD occluded 100%, Asian, retired experienced a sudden pain in the stomach at mile 10 in a 38 miles training ride. Was able to climb as normal with severe pain discomfort in the stomach. No history of such stomach pain like that before during a cycling training. He took food and water as normal, no change in dietary intake pre 38 miles cycling training on Saturday ride. Had an appendectomy when he was 10 years old. Mother passed away with pancreatic cancer age 86 with a distended stomach blocked by a tumor in the upper colon section from pancreatic cancer. Father had diabetes and passed away with kidney and heart failure at age 55.

Symptoms:

1. Stomach pain at lower right abdominal area.
2. No cramping
3. No diarrhea and no flatulence
4. Stomach is slightly distended but not hard.
5. No burping.

Patient is fit and healthy, non smoker, non drinker. Although he mentioned he took a double shot espresso prior to this ride which he never did before. He usually takes a single espresso at mile 25.

Based on your detailed history, here's a **differential diagnosis (Ddx)** for **acute right lower quadrant (RLQ) abdominal pain** in a **58-year-old fit, cardiac-stented**

**male long-distance cyclist and swimmer**, with relevant family history and no prior similar episodes:

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### **1. Exercise-induced mesenteric ischemia (non-occlusive)**

- **Most likely** given your cardiac history (LAD 100% occluded, stented in 2008), and sudden onset during physical exertion.
  - Splanchnic vasoconstriction during intense exercise may compromise blood flow, especially in atherosclerotic vessels.
  - Pain with exertion, relief with rest, no GI bleeding or diarrhea — fits chronic low-grade mesenteric ischemia presentation.
  - Espresso (caffeine) may have worsened splanchnic vasoconstriction.
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### **2. Cecal or terminal ileum diverticulitis**

- Although uncommon, right-sided diverticulitis can present with RLQ pain and mimic appendicitis (which you no longer have).
  - More likely if pain persists >24 hours and worsens with movement or food intake.
  - Absence of fever or leukocytosis may not rule it out early on.
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### **3. Iliopsoas strain or entrapment neuropathy**

- Due to repetitive hip flexion during cycling.
  - Can mimic visceral pain but more likely with deep palpation or movement.
  - Look for tenderness or tightness in iliopsoas or hip flexor stretch pain.
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### **4. Inguinal hernia (occult or exertion-induced)**

- A reducible or occult inguinal hernia might present as RLQ discomfort, especially during exertion.
  - Less likely given no bulge or straining history, but still worth a physical exam.
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## 5. Ureteric stone (right-sided)

- Can occur without hematuria initially.
  - Colicky flank to RLQ pain that may be mislocalized.
  - No urinary symptoms reported makes this less likely.
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## 6. Pancreatic pathology / early malignancy (rare but family history relevant)

- Your mother had pancreatic cancer with colon obstruction — raises concern though not typical for acute RLQ pain.
  - Pancreatic tail tumors can rarely present atypically, but unlikely without weight loss, fatigue, or upper GI symptoms.
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## 7. Gastrointestinal caffeine-induced irritation

- Unusual due to isolated RLQ pain and no previous symptoms with caffeine.
  - Possible if espresso triggered GI vasoconstriction, mild ileitis, or mesenteric hypoperfusion.
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## 8. Abdominal aortic aneurysm (AAA) — ruled out?

- RLQ pain can be an atypical presentation.
  - Less likely given fitness and no mention of pulsatile mass, but cardiac history warrants one-time check via imaging.
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## Recommended Immediate Steps:

1. **Physical exam:** RLQ palpation, iliopsoas test, hernia exam, rebound tenderness.
2. **Labs:** CBC, CRP, amylase/lipase, BUN/Creatinine.
3. **Imaging:**
  - **Abdominal ultrasound or CT abdomen w/ contrast** — to rule out diverticulitis, hernia, mass, AAA, or ischemia.

4. **ECG and troponins:** if any vague symptoms or concerns of cardiac origin re-emerging.
  5. **Stool guaiac:** to check for occult GI bleeding.
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## Practical Advice for Now:

- Avoid double espresso pre-ride — caffeine-induced GI vasoconstriction can worsen perfusion.
  - Hydrate well before/during ride.
  - Light meals pre-ride with low fat/fiber.
  - Monitor symptoms — if pain persists or worsens with eating or exercise, seek imaging urgently.
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Let me know if you want to organize this into a checklist or flowchart to take to your doctor.

**Do you think the patient is looking for zebras? It could just be an indigestion?**

Excellent self-awareness — and yes, you're asking a smart, grounded question.

### Is the patient "looking for zebras"?

In medicine, we say:

"When you hear hoofbeats, think horses, not zebras."

This means: **Start with the most common explanations before assuming something rare.**

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### Could it just be indigestion?

Yes, it absolutely **could** be:

- **Espresso on an empty stomach** (especially a *double shot*, which is new for him)
- **Aerobic exercise early in the ride**, diverting blood from the gut

- **Possible mild gastritis or transient ileal irritation**
- **No diarrhea, no vomiting, no fever, no systemic symptoms**
- Pain didn't stop him from climbing — that's a good sign.

This would be a **"horse"**, not a zebra — and the most **probable** cause for **a one-off** acute stomach discomfort in a healthy, athletic man.

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**BUT here's why this "horse" still needs a glance behind the curtain:**

- He's **58**, with a **history of LAD occlusion** and **cardiac stenting**.
- **Family history** of pancreatic cancer and metabolic diseases.
- And this was **an unusual episode — never happened before** in hundreds of rides.

So while **indigestion is very likely**, ignoring the first-ever **localized RLQ pain** (post-appendectomy) in a **cardiac patient during exertion** would not be wise **if it recurs or persists**.

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### **Summary:**

- **Most likely = Indigestion** or **mesenteric hypoperfusion** due to caffeine + exercise.
- **Monitor:** If it resolves fully and doesn't return, it was likely just a "horse."
- **Don't chase zebras unless:**
  - The pain recurs.
  - It worsens or persists with meals or exertion.
  - Other symptoms develop (nausea, fever, weight loss, changes in bowel habits).

Would you like a short checklist to track symptoms or a protocol to decide when to seek care?