MANAGEMENT OF DYSPESPSIA

- Patients of any age with ALARM signs should be referred through the 2-week referral system

- Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without ALARM signs, is not necessary

- In those with persistent symptoms, “test-and-treat” is the recommended option – the stool antigen test or the breath test are the recommended \textit{H. pylori} tests

- PPIs are not first line treatment for functional dyspepsia

- Endoscopy may be considered for patients over 55 if symptoms persist \textbf{despite} \textit{H. pylori} “test and treat” and acid suppression therapy, \textbf{and} when patients have one or more of the following: previous gastric ulcer or surgery, continuing need for NSAID treatment, or anxiety about cancer
Management of dyspepsia

The Derbyshire Health Community Guideline

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“INDIGESTION”

Consider
- Heart
- Liver
- Gall bladder
- Pancreas
- Bowel
- NSAIDs

Yes

PREDOMINANT HEARTBURN

No

DYSPEPSIA*

ALARM FEATURES
- Anaemia
- Loss of weight
- Abnormal barium meal
- Recurrent vomiting
- Melena/haematemesis
- Dysphagia
- Upper abdominal mass

Yes

MANAGE AS GORD
See page 4

No

UNCOMPLICATED DYSPEPSIA
- Encourage lifestyle changes
- Antacids/H2RA trial for 4 weeks

Persistent / recurrent symptoms

Hp test + ve

Eradicate Hp
(including second attempt if appropriate)

Asymptomatic 😊

Hp test - ve

Persistent / recurrent symptoms
Despite confirmed eradication

Manage as functional dyspepsia
See page 4

* Rome II definition – pain or discomfort centred in the upper abdomen
First Presentation of GORD

Patient History and Physical Examination

**Sinister Symptoms?**
- **Dysphagia**
- Persistent vomiting
- Weight loss
- Anaemia
- Bleeding

**NO**

Lifestyle advice and antacid / alginate (reflux only) for 4 - 6 weeks

Symptoms persist or relapse

H₂-antagonist and / or prokinetic agent for 4 – 6 weeks

Symptoms persist or relapse

Functional dyspepsia

**YES**

PPI at maintenance dose for 4 – 6 weeks

Symptoms persist or relapse

PPI at treatment dose

Symptoms persist and aged over 55 **and** have a previous gastric ulcer or surgery, continuing need for NSAID treatment, or anxiety about cancer

**REFER**
Management of dyspepsia

Background

Dyspepsia

Dyspepsia is a common complaint. More is spent on drugs for dyspepsia than on any other treatment for a symptom group. Universal investigation for dyspepsia is neither clinically desirable nor affordable and rational management poses a challenge.

Dyspepsia is a group of symptoms and is not itself a disease. According to the Rome II definition, dyspepsia refers to pain or discomfort centred in the upper abdomen. Pain in the lower abdomen does not constitute dyspepsia. “Discomfort” refers to subjective negative sensation such as upper abdominal fullness, early satiety, bloating, belching, nausea, retching and/or vomiting.

Up to 40% of the adult population suffer from dyspepsia/heartburn in any one year. The main causes are GORD (15-25%), gastric and duodenal ulcers (15-25%), and stomach cancer (2%). The remaining 60% are classified as “non-ulcer dyspepsia” (NUD) or “functional dyspepsia” (the preferred term these days). Such patients have symptoms but on investigation no causal pathology or disease is identified. Medication is not necessary for all patients with functional dyspepsia. There is a substantial placebo response to therapy. When medication is given, short-term treatment, intermittent if necessary, is likely to be more appropriate than long-term continuous therapy. Functional dyspepsia is not a condition caused by gastric hypersecretion: acid secretion is usually normal.

Management of symptoms in primary care is appropriate for most patients rather than routinely seeking a pathological diagnosis. **Long-term care should emphasise patient empowerment, for example by promoting ‘on demand’ use of the lowest effective dose.**

Alarm signals and signs are the major determinant of the need for endoscopy, not age on its own.

*Helicobacter pylori*

*Helicobacter pylori* infection is associated with up to 95% of duodenal and 70% of gastric ulcers, and with the development of gastric cancer and gastric mucosa-associated lymphoid tissue (MALT) lymphoma. *H. pylori* infection may also be associated with functional dyspepsia, though its role in this condition is less clear. No causative association with GORD and oesophagitis has been demonstrated.

How best to test for *H. pylori*? The stool antigen test and urea breath tests are the gold standard non-invasive tests for *H. pylori*. Near-patient *H. pylori* serology tests cannot be recommended as they are not accurate enough.

Management Strategy

**Dyspepsia**

**Test and treat**

In adults of any age with dyspeptic symptoms that are persistent or recurrent, the recommended strategy is to test for the presence of *Helicobacter pylori* and eradicate if present.

This does not apply to people who present with ALARMS symptoms (see below) who should have an urgent 2-week referral for endoscopy. Persons aged > 55 should also be considered for referral for endoscopy if symptoms persist despite *H. pylori* test-and-treat and acid suppression therapy, and when patients have previous gastric ulcer or surgery, continuing need for NSAID treatment, or anxiety about cancer.

ALARMS is an acronym for Anaemia, Loss of weight (unexplained), Abnormal barium meal, Recurrent vomiting, Melena, Swallowing problem (dysphagia). Other reasons for urgent referral are haematemesis, or upper abdominal mass.
The $^{13}$C Urea Breath Test
Breath testing is simple and effective. It can be used both for diagnosis and post-eradication confirmation (if this is appropriate). The test is available on prescription and can easily performed in the surgery with minimal supervision e.g. by a practice nurse, (or the patient can be sent home to perform the test unsupervised but this is not the preferred option). The test is best carried out in the morning after an overnight fast (no breakfast). The test should not be performed within 28 days of treatment with an antibiotic or bismuth preparation, or within 14 days of PPI treatment, NB omeprazole is now available OTC from pharmacies. It is best to stop an antacid or H2RA 24 hours before the test.

Available breath tests include ‘diabact UBT’ and ‘Helicobacter test INFAI’.

The stool antigen test
The $H.pylori$ stool antigen test has a similar sensitivity and specificity to the breath test and is an appropriate alternative test. It is the less costly option. As implied in the name, the test requires stool collection, which some patients may find unacceptable, and they may prefer the breath test. The stool test can be used both for diagnosis and post-eradication confirmation (if this is appropriate). If the patient is taking antibiotics, PPIs or bismuth, then a period of 2 weeks treatment free should elapse before testing or false negatives may occur.

To request a test, send a stool sample with a standard microbiology request form asking for $H.pylori$ antigen test and stating whether for diagnosis or eradication confirmation to Chesterfield Royal Hospital. The stool antigen test is available at Chesterfield Royal Hospital (and Stepping Hill Hospital) but not Royal Derby Hospital.

$H.pylori$ eradication regimens

One week triple therapy of

**First line:**
- Lansoprazole 30mg bd or omeprazole 20mg bd
- Amoxicillin 1g bd
- Clarithromycin 500mg bd

Penicillin allergy:
- Lansoprazole 30mg bd or omeprazole 20mg bd
- Clarithromycin 500mg bd
- Metronidazole 400mg bd

Only for use in cases of penicillin allergy – this is not a routine first line regimen.

NB eradication therapy attracts three prescription charges for those who are not exempt.

**Second line (in case of treatment failure):**
- Lansoprazole 30mg bd or omeprazole 20mg bd
- Amoxicillin 1g bd
- Metronidazole 400mg bd

Penicillin allergy:
- Lansoprazole 30mg bd or omeprazole 20mg bd
- Tetracycline 500mg qds
- Metronidazole 800mg bd

Two week triple therapy regimens offer the possibility of higher eradication rates compared to one week regimens, but adverse effects are common and poor compliance is likely to offset any possible gain.