Functional Dyspepsia

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Definitions

- **Epigastric Pain Syndrome**
  - Bothersome epigastric pain or burning
- **Postprandial distress syndrome**
  - Early satiation / post-prandial fullness

Diagnostic considerations

- Absence of Upper GI alarm symptoms
  - Dysphagia, weight loss (++), anaemia etc
- Symptoms for > 8weeks
- Exclude other common pathologies (e.g. reflux disease)
- Vomiting is not typical
  - clarify history – rumination syndromes vs cyclical vomiting syndrome
  - Consider other diagnosis /cause (extra gastric)
- Identify triggers / associated conditions
  - Anxiety / psychological stresses
  - Post infective (viral) onset
- Medication history
- Cannabis use
- Note CONSTANT pain is NOT gastric / gut specific (think GI physiology)

Examination

- Usually unhelpful in FD
- Identify other potential diagnoses
  - Exclude mass, pain typical of biliary pathology.
  - Clinically anaemic, LNs etc.
  - Presence or absence of epigastric pain is non-specific.
  - Neuropathic / superficial pain more typical of EPS / MSK pain.

Investigations

- DO NOT over investigate
  - H pylori exclusion / treatment
    - Off PPI for 2 weeks / antibiotics for 4 weeks
    - Only retest in high risk FH patients
  - FBC (age >55)
  - OGD – see next slide
    - As per OA / STT guidelines
  - USS / CT
    - If suspect biliary disease
    - Cancer exclusion (e.g. pain and weight loss)

OGD in Functional Dyspepsia

- Will NOT make the diagnosis
- Most likely finding – normal (consistent with FD)
- Beware the over-reporting of hiatus hernia and its relevance
- To exclude / identify OTHER pathology (**important**)

- OGD is a NON-PHYSIOLOGICAL test
- Does not replicate the processes that trigger FD symptoms
- A bit like doing a resting ECG for exertional chest pain!

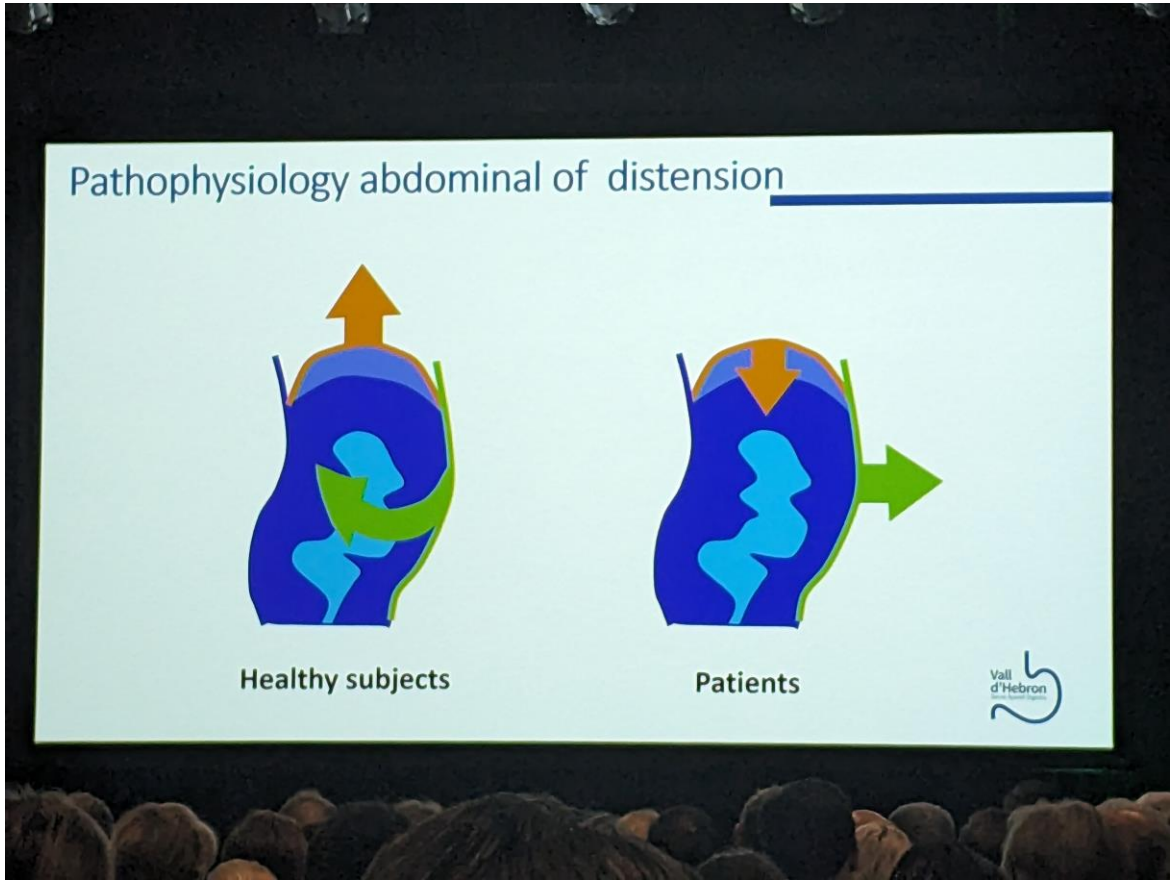
Treatments (1)

- Limited!!
- Very little available to primary OR secondary care
- As secondary care specialists we do not have access to an array of alternative therapies or tests!!!
- It is important to manage patient expectations of treatment and any forward referral

Treatments (2)

- **Upper GI symptoms**
  - Dietary changes (low fat; low fibre / residue; small regular portion sizes)
  - Low dose acid suppression (alginates; PPI; H2RA)
    - Note – no evidence that high dose PPI is helpful. May promote gastric stasis and worsening of symptoms
    - Eradicate H pylori if present
  - Spasmolytics (e.g. busopan, peppermint)
- **Prominent Bloating / Pain**
  - Physiotherapy / Biofeedback (where available)
    - Consider diaphragmatic breathing techniques (YouTube?)
  - Low dose Amitriptyline
  - Cognitive Behavioural Therapy / Mindfullness
- **Co-existing constipation / slow transit**
  - Consider prokinetic (e.g. prucalopride)

Bloating and Biofeedback



Finally…….

- **Functional Dyspepsia Mx Principles**
- 1. Active listening skills
  2. Patient education/ engagement
  3. Make a positive diagnosis of FD
  4. Explanation as disorder of GUT- BRAIN AXIS impacted by diet, stress, emotional response to symptoms and post infection changes
  5. Discuss treatment options Drugs/lifestyle/Psychological
  explain there is no cure for FD
  FD has no effect on mortality
  that treatments aims to improve quality of life and are likely to be necessary long term
  6. Consider patients previous treatments / preferences
  7. Manage expectations / agree follow up plan

- **Any Questions?**