NHS South Yorkshire Integrated Care Board

Un-investigated Dyspepsia - Primary Care Guidelines

Causes of Dyspepsia - Most patients with dyspepsia will have Functional Dyspepsia (FD)

Functional Dyspepsia – is diagnosed in the absence of upper GI alarm symptoms/signs

Diagnose **FD** in the presence of the following symptoms lasting > 8 weeks :-

a) Bothersome **epigastric pain/burning** (epigastric pain syndrome EPS)
AND/OR
b) **Early satiation/Postprandial fullness** (postprandial distress syndrome PDS)

Organic Dyspepsia -Peptic ulcer disease/Upper GI malignancy/medications/Coeliac disease/GORD/Barret's oesophagus Pancreato-biliary disease can present with upper GI symptoms - however, gallstones are associated with abdominal pain of biliary colic nature

History/Examination

- **alarm symptoms/signs** – e.g. – dysphagia/abdominal mass/haematemesis
- **date of onset/duration of symptoms** - longer duration favours FD over organic cause
- evidence of **post infection** onset
- after **acute/chronic stress**/psychological trauma
- presence of **other GI symptoms** e.g. belching, nausea or upper abdominal bloating, regurgitation
- **vomiting** is atypical - should prompt consideration of another disorder
- if epigastric pain is present, confirm this is not related to a change in bowel habit, or relieved by defaecation; this is likely to be IBS
- presence of **gastro oesophageal reflux symptoms** (heart burn/regurgitation; if present in isolation, is not FD)
- **weight loss** (amount lost – what time period)
- elicit **lower GI symptoms**/presence of other DGBI
- other **functional non GI disorders**
- **FHx of gastro oesophageal cancer/Coeliac disease/inflammatory bowel disease**
-**Drug History** NSAIDS/opioids (alpha blockers, aspirin, anticholinergics, BZ, betablockers, Calcium

Baseline investigations

H. Pylori test
stool antigen/
Urea breath testing

FBC-
aged ≥ 55yrs

Coeliac serology
if overlap of IBS type symptoms

- Check **weight**

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
treatments aim 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

Consider further investigations for following patients :
in the absence of other upper GI alarm symptoms/signs

only request 2ww endoscopy if :_
≥ 55yrs with Dyspepsia and **weight loss**
>40yrs with dyspepsia with **FHx** of Gastro-oesophageal malignancy/or from an area of increased risk of gastric cancer

Consider non-urgent endoscopy if :
≥ 55yrs with **treatment resistant** dyspepsia
≥ 55yrs with dyspepsia with **raised platelet count /vomiting**

Consider urgent CT scan if :
≥ 60yrs with **abdominal pain** and **weight loss**

Consider abdominal US if:
epigastric pain <1yr with the characteristic of **biliary colic**

Functional Dyspepsia Pathway - Management in Primary

Test for H. Pylori (Test and Treat)
- Ensure NO PPI in past 2wks/No antibiotic in past 4wks
- if positive - eradication Tx
(see BNF/CKS guidelines for 1st – 2nd line Rx)

→
- repeat test to confirm **H. Pylori eradication**
- ONLY if increased risk of gastric cancer
- repeat at least 4 weeks ideally 8 weeks after eradication Rx

Lifestyle advice
obesity, smoking,
discussion of aerobic exercise,
avoidance of simple dietary triggers,
smaller meals/evening meal 3-4 hrs before bedtime

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Food triggers
fatty foods, dairy products, high alcohol consumption especially beer/wine, coffee, chocolates, red meat, carbonated drinks, vegetables, spicy food, carbohydrates, wheat, citrus, tomatoes

First line treatment
Acid suppression:
Proton Pump Inhibitor/H2 Receptor Antagonist

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Proton Pump Inhibitor PPI
- there does not appear to be a dose related response
- hence lowest dose that controls symptoms should be used
- can be used on an as required basis
- Long term PPI use may cause increased risk of osteoporosis, hypomagnesaemia and possibly C. Difficile
-warn patients of rebound acid secretion on reducing dose
-drug interactions - citalopram/escitalopram, digoxin, warfarin, methotrexate, phenytoin, azole antifungals, clopidogrel, protease inhibitors

Second line treatment
Gut/Brain neuromodulator

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TCA - Tricyclic antidepressants
-e.g. amitriptyline - start low dose 10mg/titrate slowly in 10mg increments to max 30-50mg OD
-take in the evening due to sedation
-can take time to show benefit
-side effect of drowsiness lessens after 1-2 weeks of Tx
-follow up to assess efficacy/tolerability
-continue minimum of 6-12mths/longer term in some cases
-these are used for their pain modulatory properties and peripheral effects on GI motor/sensory function

Advise patient to arrange **follow up**
if refractory/recurrent symptoms
Annual follow up if on long term Rx

Psychological therapies

→
Refer for CBT/stress mx/relaxation exercises
Potential benefits of CBT and stress mx – they allow patients to increase their coping skills

Consider **non urgent endoscopy** in patients
> 55yrs with treatment resistant dyspepsia

Referral to secondary care if:
diagnostic doubt/severe symptoms
refractory to 1st line/2nd line Rx/patient request

NOTE:
- **Opioids/surgery** should be avoided in patients with severe/refractory FD to minimise **iatrogenic harm**
- **Opioids** are associated with vomiting, constipation and more severe dyspeptic symptoms, also higher rate of depression and worse quality of life in FD and **narcotic bowel syndrome**
- Unnecessary **surgery** may also be a danger for patients with severe FD and more severe symptoms/and opioid use were more likely after cholecystectomy

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