Dyspepsia - Full Clinical Guideline

Reference No: CG-T/2024/020

Aim

To provide clinicians with guidance on managing patients with dyspepsia, aiming to assist with identification of patients who need to be investigated rapidly and those whom require lifestyle advice and reassurance about the benign nature of their condition. Whilst these guidelines are primarily aimed at the out-patient population, they can equally be applied to in-patients.

Purpose and Scope

Dyspepsia can be defined as pain or discomfort that is attributable to the upper gastrointestinal (GI) tract and may be related to eating and drinking. The routine investigation of patients with dyspepsia is not always necessary.

Any patient with the alarm symptoms listed below require urgent investigation with gastrointestinal endoscopy:

- Dysphagia
- Age 55 and over with weight loss ***and*** ***any of the following***:
    - upper abdominal pain
    - reflux
    - dyspepsia
    - heartburn
    - nausea or vomiting
    -

Consider non-urgent investigation with gastrointestinal endoscopy in:

- Age 55 or over ***and*** ***one or more of the following:***
    - treatment resistant dyspepsia
    - upper abdominal pain and anaemia
    - raised platelet with any of the following;
        - nausea
        - vomiting
        - weight loss
        - reflux
        - dyspepsia
        - upper abdominal pain
    - nausea and vomiting **with**:
        - weight loss
        - reflux
        - dyspepsia
        - upper abdominal pain

- Haematemesis or melaena

- In any age
  - Gastro-oesophageal symptoms that are non-responsive to treatment or unexplained
  - Suspected GORD considering anti-reflux surgery
  - H pylori that has not responded to second line eradication
  - Iron deficiency anaemia
  - Abnormal radiological investigation

Consider differential diagnoses such as gallbladder and pancreatic disease and ovarian cancer in women as these can present with dyspeptic symptoms.

Guideline

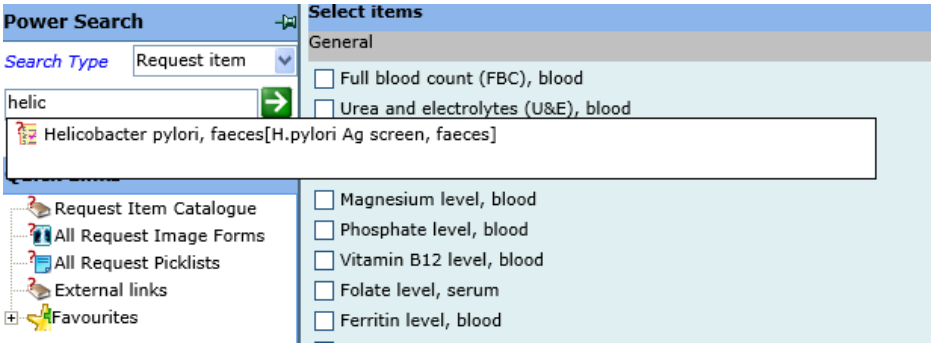
- Consider urgent gastroscopy with criteria above

- Review medications for possible causes of dyspepsia e.g. calcium antagonists nitrates, theophyllines, bisphosphonates, NSAIDs, Corticosteroids

- Give lifestyle advice e.g. healthy eating, weight reduction and smoking cessation, avoid known precipitants e.g. smoking, alcohol, coffee, chocolate and fatty/spicy foods. Raising the head of the bed and having a main meal well before bedtime may help if symptoms are worse at night

- Test for *Helicobacter pylori* (using *H pylori* stool antigen test) and treat with eradication therapy (see BNF)

For Lorenzo, type in Helicobacter in and the antigen test request will come up:



(A Universal container is used to collect the sample)

For Meditech, refer to training guides on Net-i

- Give a course of a proton pump inhibitor (PPI). If this relieves symptoms of heartburn it is diagnostic of gastro-oesophageal reflux disease (GORD). Follow-up with life style advice and suggest PPI prn

- Step down medication so that the patient is on the lowest possible dose to manage their symptoms e.g. PPI – H2 receptor antagonist (H2RA) – raft-forming preparation (antacid/alginate) which can bought over the counter

- Consider managing previously investigated patients without alarm symptoms according to previous endoscopic findings

- Patients who have persistent symptoms may require double dose PPI plus H2RA at bedtime

- Consider referral for laproscopic anti-reflux surgery

- Patients without alarm symptoms (as listed above) and a response to PPI therapy do not require endoscopy but can be managed symptomatically as above

References

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