2 Give lifestyle advice and antacids +/- alginates if not previously attempted by the patient.

Quick info:

- Give the patient lifestyle leaflets relating to the issues below
- Advise patient to avoid triggers that may be associated with dyspepsia, such as:
  - Smoking
  - Alcohol
  - Coffee
  - Chocolate
  - Fatty foods
- Advise patient on weight reduction, being overweight may cause dyspepsia
- Raising the head of the bed and not eating close to bedtime may reduce dyspepsia symptoms in some people
- Consider antacid and/or alginate therapy for immediate symptom relief
- Review medications and OTC treatments that may cause dyspepsia
- Consider whether the following may be reduced or stopped:
  - NSAID
  - Calcium antagonists
  - Nitrates
  - Theophyllines
  - Bisphosphonates
  - Steroids

References:

Local administrative info:
Health Trainers (formerly Connect 4 Life): Health Trainers work on a 1:1 basis to support clients to improve their health and wellbeing by making positive changes to their lifestyle. Each client agrees a personal health plan based on their particular lifestyle and sets challenging but realistic goals over a 6 month period. Health Improvement exercise classes for people who may be new to exercise or need a low impact class are also available through the Health Trainer programme. Appointments available in the evenings and weekends as well as during the working week at various venues across Tameside & Glossop. This service is available to adults with or without an existing long term condition.
Referral form available here:
www.tamesideandglossop.nhs.uk/Templates/FileListing_4285.aspx

7 Reflux-type dyspepsia

Quick info:

Gastro-irritant medicines

Drugs affecting lower oesophageal sphincter tone such as anticholinergics, calcium channel blockers (particularly nifedipine), nitrates, theophylline.

Drugs causing oesophageal mucosal injury such as NSAID, corticosteroids, bisphosphonates, tetracycline, potassium chloride and iron.

Drugs causing gastric mucosal injury such as NSAID, Clopidogrel, bisphosphonates and steroids. The combination of SSRI and NSAID is particularly potent in inducing peptic ulcer disease.

NSAID – If symptomatic try stopping. Use alternative analgesics where possible or use NSAID prn for pain.
Where NSAID use is unavoidable, select one with a lower GI risk such as ibuprofen, diclofenac or naproxen using the lowest possible dose. High Risk patients fall into any of the following categories:
Dyspepsia (no alarm signals)

• Have a definite history of peptic ulcer disease
• Are also taking corticosteroids, anticoagulants, clopidogrel etc
• Has serious co-morbidities e.g. cardiovascular disease
• Age>65 years old

If symptoms persist, refer for endoscopy.

Aspirin - if symptomatic consider stopping and reintroduce with PPI cover. Consider co-prescription of a PPI especially high risk patients with NSAID.

Clopidogrel - co-prescribing clopidogrel and a PPI is currently best avoided but co-prescribing with an H2 antagonist is an alternative option

10 H. Pylori test

Quick info:
• Helicobacter pylori is associated with peptic ulcer disease and non-ulcer dyspepsia
• H. pylori can be detected using:
  • stool antigen test
• if proton pump inhibitor (PPI) used, perform H. pylori test at least 2 weeks after finishing treatment
• Patient must not be on a course of antibiotics

H Pylori Stool Antigen
1) Patient must not have any acid reduction medications (Lansoprazole / Omeprazole / Esomeprazole / Pantoprazole within the last 2 weeks prior to the test.
2) Patient should not take antibiotics 2 weeks prior to the test
3) Antacids, Cimetidine, Famotidine, Nizatidine and Ranitidine do not interfere with the stool test

References:

13 Prescribe H. Pylori eradication therapy

Quick info:
Eradication regimens:
• proton pump inhibitor (PPI) plus amoxicillin and clarithromycin
• PPI plus metronidazole and clarithromycin

Compliance can be a problem with the high dose regimens, the number of tablets and the resulting side effects. Counselling the patient carefully about the importance of complying with the 1 week course to achieve eradication of H-Pylori.

Consideration should also be given to continuing the PPI at a treatment dose for 2 - 4 weeks following the eradication treatment

References:
Gatta et al;Am J Gastroenterology 2009:104 (12) pg3069-79
Dyspepsia (no alarm signals)

17 Prescribe 4-8 weeks course of full dose low cost PPI and review

Quick info:
(Begin GU and Reflux Oesophagitis can take up to 8 weeks to heal)

- 1st line Omeprazole 20mg (once or twice a day) or Lansoprazole 30mg od before meals is recommended for patients newly presenting with dyspepsia.
- Treatment needs to be regularly reviewed and stepped down or stopped as appropriate.
- N.B. PPI do have interactions such as with warfarin – intermittent use may cause problems with INR control and so best avoided.

22 Stop treatment or if maintenance required step down to maintenance dose PPI

Quick info:
Review annually - if symptoms recur re-enter pathway

23 Prescribe 4-8 weeks course of full dose low cost PPI twice daily, H2A or Prokinetic drugs

Quick info:
proton pump inhibitor (PPI):
- omeprazole (low cost)
- lansoprazole (low cost)
- pantoprazole (low cost)
H2 receptor antagonist:
- cimetidine
- famotidine
- nizatidine
- ranitidine
Prokinetic drug
- Metoclopramide (nb: use with caution in young people due to possible extra pyramidal effects)
- Domperidone

References:

27 Step down to full dose low cost PPI once daily or full dose generic PPI pm

Quick info:
Review annually - if symptoms recur re-enter pathway

28 Check for alarm symptoms, in some patients with inadequate response consider referral to specialist

Quick info:
If symptoms persist, consider alternative diagnosis i.e. cardiac/functional/ psychological /emotional factors
In most patients, management is based on explanation and reassurance
Dyspepsia (no alarm signals)

Routine endoscopic investigation of patients of any age presenting with dyspepsia and without alarm symptoms is not necessary. However, in patients aged 55 years and older with unexplained and persistent recent onset dyspepsia alone, an urgent referral for endoscopy should be made.

GORD

There are no clear and agreed recommendations for the use of endoscopy in these circumstances. Below are a number of contradicting recommendations from different sources:

- Screening for Barrett's maybe justified in special circumstances such as high risk individuals (white male, chronic reflux, aged >50)
- 'There is no evidence that endoscopic screening of heartburn patients to detect cancer is worthwhile and benefit is so unlikely that endoscopy with this intent cannot be recommended'.
- 'Screening endoscopy has been advocated for chronic heartburn patients aged 50 years or more with the aim of detecting CLO (Barrett's), if present. However, this policy has not been shown to be of benefit. Consequently, endoscopic screening of patients with chronic heartburn to detect CLO (Barrett's) cannot be recommended'.
- 'Screening endoscopy for Barrett's oesophagus should be considered in selected patients with chronic, longstanding GORD. After a negative screening examination, further screening endoscopy is not indicated'.

References:

Guidelines for the diagnosis and management of Barrett's columnar-lined oesophagus 2005
ASGE guideline: the role of endoscopy in the surveillance of premalignant conditions of the upper GI tract. GASTROINTESTINAL ENDOSCOPY, Volume 63, No.4. 2006: 570-80.
Dyspepsia (no alarm signals)

Medicine > Gastroenterology > Dyspepsia

Key Dates

Published: 19-Jan-2011, by Tameside & Glossop
Valid until: 20-Jul-2011

References

This is a list of all the references that have passed critical appraisal for use in the pathway Dyspepsia

**ID** | **Reference**
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