# Dyspepsia

## *Executive summary*

## Introduction

Dyspepsia refers to symptoms arising from the upper GI tract. They may be caused by gastro-oesophageal reflux disease (GORD), peptic ulcer disease or functional disorders. 60-75% of patients with dyspepsia are estimated to have a functional rather than an organic cause.

## Target users

* Doctors
* Nurses

## Target area of use

* Gate clinic
* Outpatients department

## Key areas of focus / New additions / Changes

This guideline outlines the management of dyspepsia due to reflux, peptic ulcer disease or functional disorders.

## Limitations

In view of our limited access to endoscopy, the guidelines aim to promote safe treatment of dyspepsia with relatively low usage of investigations.

## Presenting symptoms and signs

Dyspeptic symptoms divide into two groups:

* heartburn and other symptoms typical of GORD
* epigastric pain and other symptoms typical of peptic ulcer disease.

In both cases, symptoms may be structural or organic in origin.

### Heartburn / GORD

A retrosternal burning sensation that may move upwards from the epigastrium to the neck or face.

* May coexist with other upper GI symptoms.
* May be accompanied by regurgitation of sour tasting fluid or gastric contents into the mouth.
* Symptoms usually intermittent. Often experienced soon after eating, during exercise, whilst lying down and at night.
* Usually no abnormalities to identify on examination.

### Peptic ulcer disease / Functional dyspepsia

A chronic or recurrent pain in the upper abdomen.

* May be associated with a feeling of fullness when eating or inability to eat a full meal.
* May be accompanied by bloating, belching, nausea or heartburn.
* May be worsened or improved by eating.

### Alarm features and other diagnoses

The presence of any of the following features suggests the possibility of malignancy or another serious illness. **Refer to the Dr in OPD, in the presence of any of the following:**

* Dysphagia or odynophagia
* Persistent vomiting
* Aspiration pneumonia or respiratory symptoms
* Altered voice
* GI bleeding
* Persistent unintentional weight loss
* New onset of symptoms over the age of 50 years
* Family history of oesophageal or gastric carcinoma

Features which suggest other diagnoses include:

* Symptoms related to physical activity, the menstrual cycle, urination or defecation
* Urinary urgency
* Abnormalities on examination

All such patients should be referred to the doctor.

## Examination findings doctors should look for;

* Most common finding is usually epigastric tenderness.
* Melaena stool on PR, anaemia may suggest upper GI bleeding
* Succussion splash on abdominal examination may suggest partial or complete gastric outlet obstruction
* Severe abdominal pain, rebound tenderness, guarding & rigidity may indicate a perforated PUD.
* Epigastric mass, lymphadenopathy especially in the elderly strongly suggest malignancy.

## Investigations

Dyspepsia may initially not require investigation (see management flowchart below).

* The most important investigations in diagnosing PUD, gastric tumours, GORD are radiographic & endoscopy.
* Lab test (FBC, LFTs): laboratory abnormalities such as microcytic anaemia, low albumin, abnormal LFTs, raised ESR may suggest malignancy.
* Barium meal: addition image may suggest ulcer while a filling defect malignancy.
* Endoscopy is the mainstay of diagnosis and in some cases treatment.
* Urinalysis and Abdominal US can be done to rule out other differentials.

## Management

### Heartburn / GORD

In the absence of alarm symptoms, patients should manage their symptoms themselves.

Explain that this is likely to be a chronic problem which will recur from time to time.

* Identify trigger foods and behaviours and avoid these. Typical triggers include: ataya, coffee, alcohol, soft drinks, chocolate, oily foods, citrus fruits, tomatoes, garlic, onions and peppery foods.
* Encourage weight loss if overweight.
* Lifestyle changes may be effective and include: eating smaller meals more frequently, elevating the head of the bed by 20-25 cm by placing something under the legs and avoiding food or drink 3 hours prior to lying down at night.
* Avoid drugs which cause heartburn including: NSAIDs, iron, doxycycline, phenobarbitone, beta-blockers, nifedipine or amlodipine, OCP, codeine, aminophylline and amitriptyline. ART can also cause heartburn, but this cannot be avoided and instead, patients may need ongoing treatment with omeprazole.

For infrequent symptoms, patients may be offered antacids (such as magnesium trisilicate) to take when they are symptomatic. They may also take ranitidine 150 mg BD for short periods during symptomatic periods.

For more frequent symptoms, omeprazole 20 mg BD should be prescribed for 2 weeks. In most cases, this should cause acid-related symptoms to resolve. Omeprazole can then be given on a PRN basis – with patients taking treatment for a few days if symptoms recur.

**If symptoms persist after a 2 week course of omeprazole, *refer* the patient to the doctor** who should consider other diagnoses

Very severe cases of GORD may require ongoing treatment with omeprazole as well as the use of prokinetic agents. Metoclopramide is the only agent available in this context.

Although severe GORD is associated with complications such as oesophageal stricture, Barrett’s oesophagus and oesophageal carcinoma, these are rare occurrences and we do not have the resources to prevent them in this context. **Note that GORD is not associated with *H. pylori* infection and eradication does not usually help the patient.**

### Peptic ulcer disease / Functional dyspepsia

Any patient taking NSAIDs should stop these and be advised to avoid them in the future.

In the absence of alarm features, begin by presuming the presence of *H. pylori*. *Refer* to the doctor for *H. pylori* eradication. Also refer any patient with symptoms of peptic ulcer disease or functional dyspepsia.

See the flow chart on the next page for initial management of these patients.

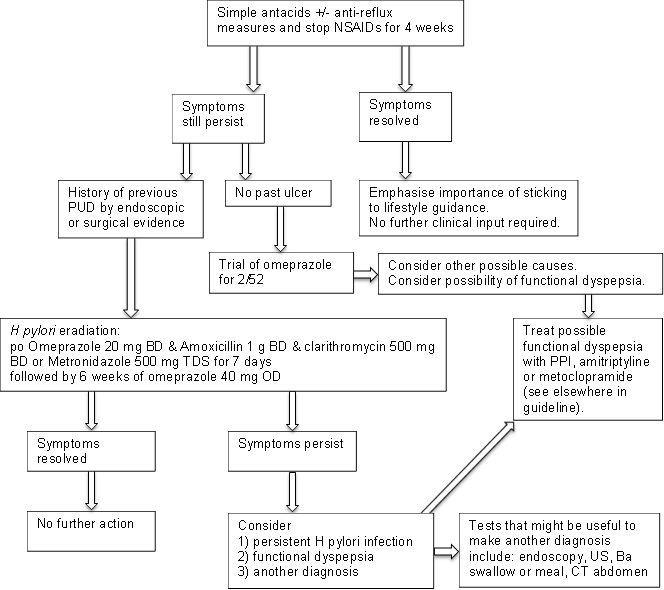
Patients with **functional dyspepsia** may benefit from longer term treatment with omeprazole 20-40 mg OD. Patients failing to respond to this may benefit from amitriptyline 10-25 mg nocte for a minimum of 8 weeks. Citalopram 20 mg nocte should be used in preference for staff and those who can afford it. If this effective it can be continued for 6 months in the first instance. If an attempt to withdraw treatment is unsuccessful, it can be continued long term. A small number of patients failing to respond to this may benefit from a 4 week trial of metoclopramide 10 mg 30 minutes prior to food and at night (QDS). This can be continued if it is effective.

**Refer to ESFTH Surgical unit, if the following complications arise:**

* Perforation (acute abdomen)
* Malignancy
* Gastric outflow obstruction

Complications like bleeding (hematemesis/melaena) should be managed by endoscopic therapy.

## Flow chart for management of PUD / functional dyspepsia

If ≥ 55 years or alarm features, request for urgent endoscopy – see separate guidance on when to request endoscopy. If on NSAIDs, stop. In all other cases, consider the following management plan**:**

## Key Issues for Nursing care

Refer to the doctor any patient with:

* Dysphagia or odynophagia
* Persistent vomiting
* Aspiration pneumonia or respiratory symptoms
* Altered voice
* GI bleeding
* Laboratory abnormalities such as microcytic anaemia, low albumin, abnormal LFTs, raised ESR
* Persistent unintentional weight loss
* Lymphadenopathy
* Epigastric mass
* New onset of symptoms over the age of 50 years
* Family history of oesophageal or gastric carcinoma
* Symptoms related to physical activity, the menstrual cycle, urination or defecation
* Urinary urgency
* Abnormalities on examination.

Also refer patients with reflux symptoms that persist despite treatment with omeprazole and any patient with symptoms of peptic ulcer disease or functional dyspepsia.

## References

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