Mid Nottinghamshire Dyspepsia Care Pathway 2018 - Guidance Notes

DYSPEPSIA

- Dyspepsia can be defined broadly to include patients with recurrent epigastric pain or discomfort, heartburn or acid regurgitation, with or without bloating, nausea or vomiting.
- Initial therapeutic strategies for dyspepsia are empirical treatment with a proton pump inhibitor (PPI) or testing for and treating *H Pylori.*
- H2RA (Histamine -2-Receptor Antagonists) may be considered as an option for treatment

Gastro-oesophageal reflux disease (GORD)

- The predominant symptom of GORD is heartburn- a burning feeling rising from the stomach or lower chest towards the neck.
- Acid reflux is a common condition and patients are often anxious and need reassurance.
- Offer those with GORD full dose generic PPI OD for 4-8 weeks.
- N.B. Reflux may occur with normal endoscopic appearances. Reflux symptoms that respond to treatment do not require endoscopic confirmation.

Functional Dyspepsia – (also known as non-ulcer dyspepsia)

- These patients have dyspepsia but have normal endoscopic findings.
- Acid suppressor drugs may be of little benefit as symptoms are not always acid related.
- The role of H.pylori remains controversial- eradication may benefit some patients

Peptic Ulceration

- Offer H.pylori eradication therapy to tested positive patients
- Stop the use of gastro-irritants where possible

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 NSAIDS, corticosteroids, bisphosphonates, tetracycline, potassium chloride and iron.
- Drugs causing gastric mucosal injury such as NSAIDS, Clopidogrel, bisphosphonates and steroids. The combination of SSRI's and NSAIDS is particularly potent in inducing peptic ulcer disease.
- Other drugs that may cause dyspepsia include nicorandil, doxycycline and dabigatran.
- NSAIDS – 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:
    - Have a definite history of peptic ulcer disease
    - Are taking corticosteroids, anticoagulants, antiplatelets, NSAIDs etc
    - Has serious co-morbidities e.g. cardiovascular disease
    - Age>65 years old
- Aspirin/ clopidogrel- dependent on cardiovascular risk BUT if symptomatic consider cardiology advice with regards to stopping and reintroduction with PPI cover.
- Consider co-prescription of a PPI (especially in high risk patients) whilst considering potential drug interactions, cautions and contraindications (See BNF)

LIFESTYLE ADVICE

- Weight Loss if necessary
- Don't smoke
- Avoid large meals and excessive amounts of fluid – in particular avoid fatty, spicy or "acidic" foods, excessive alcohol, "fizzy" drinks, caffeine and chocolate.
- Raise the head of the bed by 6 inches

PPI CHOICE

- 1st line **Omeprazole 20mg or Lansoprazole 30mg OD** is recommended for patients newly presenting with dyspepsia. (Advise to take 1hr prior to food for max effect).
- Treatment needs to be regularly reviewed and stepped down or stopped as appropriate.
- Consider potential drug interactions, cautions or contraindications (especially with HIGH dose PPI use).
- See BNF / local formulary for detailed guidance