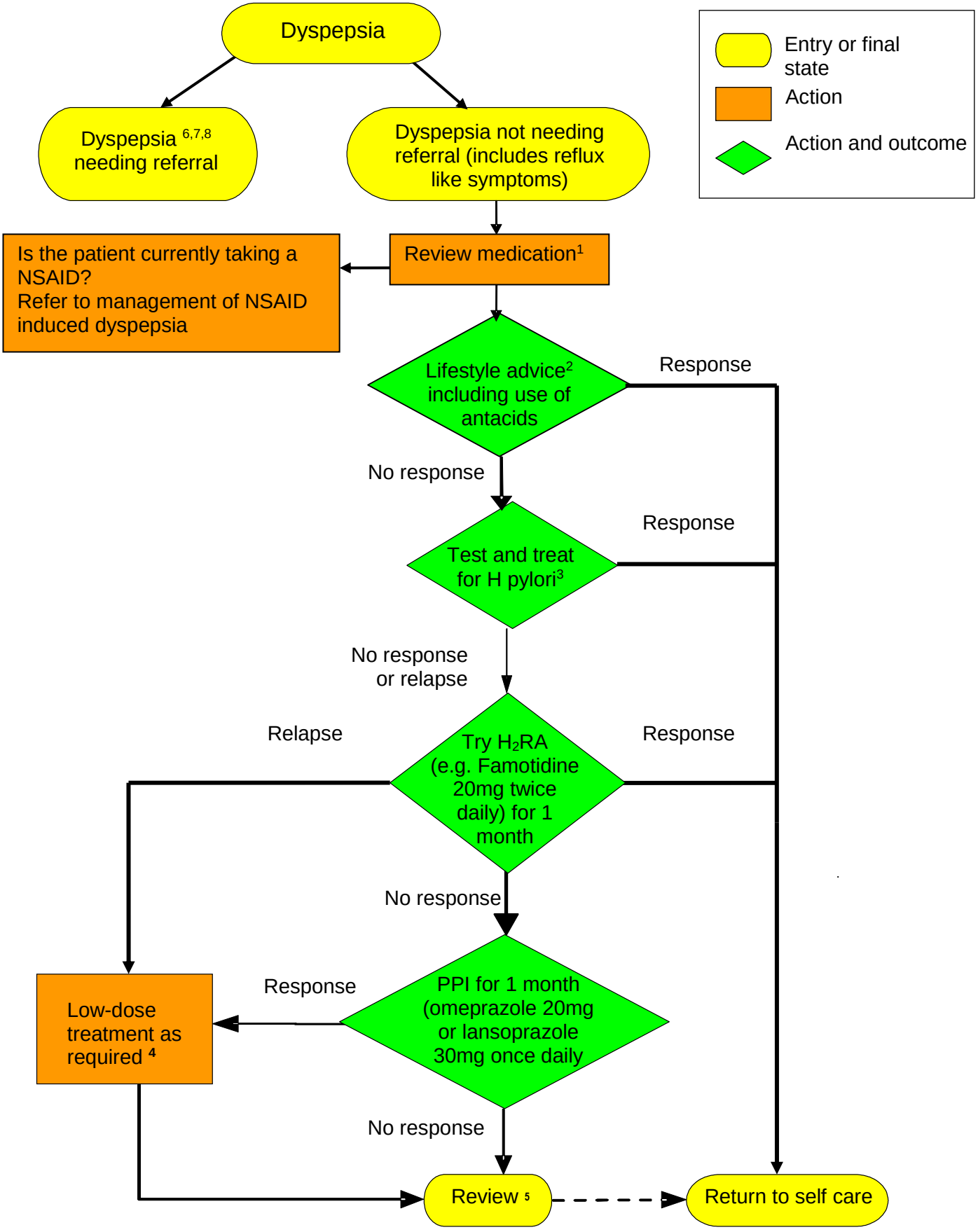
Management of patients with uninvestigated dyspepsia

See Prescribing Notes on Page 2. Reference NICE Clinical Guideline number 184 – 'Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management' September 2014, last modified October 2019



Prescribing Notes:

1 Review medications for possible causes of dyspepsia, for example, calcium antagonists, nitrates, theophyllines, bisphosphonates, corticosteroids and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs).

2 Offer lifestyle advice, including advice on healthy eating, weight reduction, smoking cessation, less or no alcohol intake, going to bed on an empty stomach (no food or drink within 2-3 hours of going to bed) and promoting continued use of antacid/alginates. Antacids, such as calcium carbonate tablets, are best sucked as their mixture with saliva is more soothing to the oesophagus.

3 Detection: use a carbon-13 urea breath test, stool antigen test or, when performance has been validated, laboratory-based serology.

Eradication: Discuss treatment adherence and emphasise its importance.

1st line treatment:

7 day twice-daily course of omeprazole 20mg **or** lansoprazole 30mg **and** amoxicillin 1g **and** clarithromycin 500mg **or** metronidazole 400mg (treatment choice should take into account previous exposure to clarithromycin or metronidazole).

If penicillin allergic: 7 day twice-daily course of omeprazole 20mg **or** lansoprazole 30mg **and** clarithromycin 500mg **and** metronidazole 400mg.

Seek advice from a gastroenterologist if eradication of H Pylori is not successful

4 Offer the lowest possible PPI therapy to control symptoms. Discuss the use of treatment on an as-required basis to help patients manage their own symptoms.

5 In some patients with an inadequate response to therapy or gastro-oesophageal symptoms that are unexplained it may become appropriate to refer to a specialist for a second opinion. In the referral guidelines for suspected cancer (NG12) 'unexplained' is defined as 'symptoms or signs that have not led to a diagnosis being made by the healthcare professional in primary care after initial assessment (including history, examination and any primary care investigations).'

6 Urgent specialist referral for endoscopic investigation (within two weeks) is indicated for patients with dysphagia, significant acute gastrointestinal bleeding, or in those aged 55 and over with unexplained weight loss and symptoms of upper abdominal pain, reflux or dyspepsia.

7. Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without alarm signs, is not necessary. However, in patients aged 55 years or over with treatment-resistant dyspepsia; dyspepsia/reflux with a raised platelet count; or dyspepsia/reflux with nausea or vomiting consider non-urgent specialist referral for endoscopic investigation.

8 Patients undergoing endoscopy should be free from medication with either a PPI or H_2 receptor antagonist (H_2RA) for a minimum of two weeks beforehand.