Camden Adult Dyspepsia Pathway

**Presentation with symptoms of dyspepsia**
i.e. recurrent epigastric pain, heartburn or acid regurgitation, with or without bloating, nausea or vomiting

**History**
1) Previous investigation or treatment for dyspepsia
2) Review medications for iatrogenic causes of dyspepsia (e.g. calcium antagonists, nitrates, theophylline, bisphosphonates, steroids, SSRIs and stop / reduce NSAIDs)
3) Consider cardiac or biliary disease as part of differential
4) Any foreign travel? Consider intestinal infections / infections e.g. giardia

**Examination**
Abdominal
Body mass index (BMI) - any weight loss?

**Lifestyle/Conservative management:**
- Diet (triggers associated with their dyspepsia) – e.g. chocolate, coffee, tomatoes, fatty or spicy foods
  - Main meal hours >3 hours before going to bed and raise head of bed by 10-20cm
  - Smoking cessation
  - Weight reduction
  - Avoidance of known precipitants of their dyspepsia- Reduce alcohol consumption if >14units/week.
  - Increased physical activity to ≥ 150mins per week.
  - Mental well-being (?stress/ anxiety) - Cognitive behavioural therapy (CBT) may reduce dyspepsia symptoms in short-term
  - Can use antacids/alginate as required

**Investigations:**
1) Consider H pylori stool antigen test (patients should have stopped bismuth or proton pump inhibitor (PPI) for > 2 weeks; antibiotics for 4 weeks; and H2 receptor antagonists (H2RA) >1 day before, or results may be unreliable)
  Retesting not usually necessary unless symptoms persist - Urea breath test on FP10> 4 weeks after eradication prescription and can try 2nd line prescription if positive.
2) Consider Full blood count (FBC), urea & electrolytes (U&E), liver function test (LFT), iron studies, coeliac screen (anti tissue transglutaminase (TTG) antibody / anti endomyosal antibody with immunoglobulin A (IgA) measurement)
3) Consider abdominal ultrasound if ?gallstones

**Acute GI Bleeding – Immediate referral**
Refer 2ww if patient has any red flags?
- Dysphagia at ANY age
- ≥ 55 years with weight loss and any of the following: upper abdominal pain/reflux / dyspepsia
- Abdominal mass
- ≥ 40 years with jaundice
- ≥ 60 years with weight loss AND any of the following: diarrhoea/back pain /abdominal pain /nausea/vomiting /constipation /new-onset diabetes

Direct urgent endoscopy is available - For the most up to date availability of direct urgent endoscopy please refer to the GP website.

**If other suspicious features for cancer- Eg Raised platelets, nausea and vomiting, new unexplained upper abdo pain but patient doesn’t meet 2ww criteria- refer to the Multi-disciplinary Diagnostic Centre (MDC)**

**Presentation with symptoms of dyspepsia**
Consider prescribing as per previous endoscopic findings (if no new alarm symptoms)

**Function Dyspepsia – no cause found on endoscopy**
Treat H pylori if present. If negative, no response or relapse post eradication – low dose PPI /H2RA for 4 weeks then treat as required.

**Prevalent peptic ulcer**
Treat H pylori if present. Use standard dose PPI or H2RA for 8 weeks
Endoscopy 6-8 weeks after treatment. Restest H pylori and use low dose prescription as required

**Oesophagitis/ gastrooesophageal reflux disease (GORD)**
Treat H pylori if present. Use standard dose PPI for 4-8 weeks
(If severe oesophagitis not responding to standard dose PPI will require high dose PPI for 8 weeks- if not responding switch to 8 weeks of an alternative high dose PPI or double dose and then continue on high dose longterm)

**Refer to gastroenterology or routine direct access endoscopy (Avoid H2RA/PPI for 2 weeks prior to oesophago-gastroduodenoscopy (OGD)**
Consider advice and guidance where appropriate

**If symptoms not adequately controlled**

**Camden’s prescribing recommendations:**
Antacids – Magnesium trisilicate mixture, co-magaidrox suspension 195/220
Alginate - Peptac® liquid
H2RA – Ranitidine tablets
PPI – Lansoprazole capsules Dose - Standard-30mg daily, Low-15mg daily, High-30mg twice daily
Omeprazole capsules Dose - Standard-20mg daily, Low-10mg daily, High-40mg daily

H. pylori eradication (7days) –
Omeprazole 20mg twice daily or lansoprazole 30mg twice daily
+ Amoxicillin 1g twice daily + either metronidazole 400mg twice daily or clarithromycin 500mg twice daily
For PENCILLIN ALLERGY: Omeprazole 20mg twice daily or lansoprazole 30mg twice daily
+ clarithromycin 500mg twice daily + metronidazole 400mg twice daily
For further details see Public Health England helicobacter pylori in dyspepsia test and treat

Patients with H. pylori that have not responded to second line eradication should be referred to a specialist

Dyspepsia in Pregnancy

NCL Pathway Clinical cabinet+MMT July/Aug18
Review due Aug 2021
Queries = Camden.pathways@nhs.net
References: NICE CG184 and NG12

Please refer to the Summary of Product Characteristics (SPC) of any drug considered. This pathway has been developed from published guidance in collaboration with local gastroenterologists. This guidance is to assist GPs in decision making and is not intended to replace clinical judgement
Patient Pregnant with dyspepsia

If ongoing symptoms

Drug treatments:
Antacids and alginates
1st line: Co-magaldrox suspension 195 / 220 on 'as required' basis up to a maximum of four times a day (off-label)
2nd line: Peptac® on as required basis up to a maximum of four times a day (off-label)

If ongoing symptoms

Omeprazole* (starting dose 10mg od then increase to 20mg od if required) or Rantidine* 150mg twice daily (off-label)
*DO NOT use other H2RA or PPI

When to refer:
NON URGENT to Gastroenterology:
• Symptoms not responding to outlined medical treatment
• Unable to eat due to symptoms
• Doubt about diagnosis
• Previous ulcer, Barretts, dysplasia, atrophic gastritis, intestinal metaplasia and symptoms not controlled
URGENT to Obstetrics
• If any suggestion of other pregnancy related disorder such as HELLP syndrome

Lifestyle advice:
• Eat smaller meals more frequently (every 3 hours, not eat late at night and avoid known irritants.
• Reassure resolves after pregnancy and not usually sinister underlying cause
• Raise head of bed 10 – 15cm with sturdy items beneath frame
• Do not use pillows (can increase intra-abdominal pressure)
• Avoid medications that can worsen symptoms
• Stop smoking if applicable
• Advise to return if symptoms no better, worsening or evolving

ALARM features
• chronic Gi bleeding, progressive unintentional weight loss, progressive dysphagia, persistent vomiting
• NB: abdo mass, anaemia and weight loss may be difficult to interpret in pregnancy

ALARM features?

Refer URGENTLY To Gastroenterology

Yes

No

Manage in Primary Care

Consider other diagnoses: eg hyperemesis gravidarum, HELLP syndrome, cardiac cause

Refer to Gastroenterology

Source: CKS April 2017, Camden Medicines Management Team

* Contradicts CKS but confirmed as safe in pregnancy with manufacturer