Dyspepsia treatment

Recent onset dyspepsia

No Alarm symptoms

Under 55 years – Test for H. pylori using stool antigen test (preferred option), serology or urea breath test

Over 55 years - Refer for endoscopy

Positive – Hp eradication therapy as per BNF – one week course is recommended

Abnormal – Appropriate treatment or further referral

Negative – aluminium / magnesium mixture eg Asilone Low dose PPI Lifestyle advice

Normal – treat as for under 55 years and H. pylori negative

Persistent or recurrent symptoms – refer for endoscopy

GORD
Mild – alginate suspension
Severe – lansoprazole or omeprazole

Urgent referral to G.I. Consultant

“ALARMS”
Anaemia
Loss of weight
Anorexia
Reccurrent symptoms* (dysphagia, odynophagia, persistent continuous vomiting)
Mass/Melaena
Progressive swallowing problems (dysphagia)

When Not to Refer for Endoscopy

• Aged under 55 years and no alarm signs
• Not yet tested for H. pylori and treated, if necessary
• Recent normal endoscopy result but persistent symptoms
• Long established dyspepsia that has not become worse over a period of time

NB
• Most G.I. ulcers are strongly associated with H. pylori infection
• 30% of endoscopy results are normal
• 2% diagnose oesophago/gastric cancer
• Endoscopy is expensive

Additional Information on PPIs

• PPIs are over-prescribed.
• Many patients can be adequately treated with an alginate such as Gaviscon Advance
• Patients should have a documented and appropriate indication for receiving a PPI
• PPIs suppress gastric acid and cause bacterial overgrowth eg with C difficile
• Long-term use of PPIs can cause temporary problems of rebound hyperacidity on withdrawal
• Increased risk of hip fracture with long-term PPI use
• If NSAID treatment is essential and the patient has an ulcer, prescribe the treatment dose of omeprazole or lansoprazole (cheapest options)
• If NSAID treatment must continue and the patient has non-ulcer dyspepsia, use a maintenance PPI dose
Acid Related Dyspepsia (GORD)

- Lansoprazole 15mg or omeprazole 20mg capsule daily

  Review at 2 to 4 weeks. Consider stopping/stepping down to H2 antagonists or alginates.

Prophylaxis of NSAID GU, DU or gastroduodenal erosions.

- Lansoprazole 15mg or omeprazole 20mg capsule daily

  Review at 4 weeks, and then 8 weeks where necessary. Consider stopping or stepping down as before.

PUD NSAID-induced GU, DU or gastroduodenal erosions.

- Lansoprazole 30mg or omeprazole 40mg (2x20mg) capsule daily

  Review at 4 weeks, and then 8 weeks and consider maintenance dose of 30mg daily.

Severe erosive GORD

- Lansoprazole 30mg capsule twice daily (Consultant Gastroenterologist only)

  Review at intervals for step down or discontinuation

Barrett’s oesophagus

- Omeprazole 40mg (2x20mg) daily. Dose should not be reduced even if patient is asymptomatic. Ranitidine 150-300mg and alginates can be added if necessary

NG / PEG tubes / dysphagia

- Lansoprazole (Fastabs) 15mg-30mg daily

Severe erosive GORD

- Lansoprazole 30mg capsule twice daily

  Review at intervals for step down or discontinuation

Unable to step down.

- Lansoprazole 30mg or omeprazole 40mg (2 x 20mg capsules) daily

  Review at intervals for step down or discontinuation

Maintenance dose required.

- Lansoprazole 15mg or omeprazole 20mg capsule daily

  Review at intervals for step down or discontinuation

Note: Lansoprazole FasTabs should be placed on the tongue, allowed to disperse and then swallowed, or dispersed in water and then swallowed/administered via a feeding tube.
### Additional Information

#### Gastric ulcer

70% of gastric ulcers are associated with *H. pylori*

The remainder are associated with NSAIDs

**Hp positive:** Eradication therapy plus ranitidine or PPI for 2 months. Consider long term treatment with PPI in patients with a proven ulcer who **continue to take** NSAIDs

**Hp negative:** Ranitidine or PPI therapy for 2 months and stop the NSAIDs if possible. Consider long term therapy with a PPI if the NSAID cannot be stopped.

**Follow up:** Repeat endoscopy with biopsies is essential until ulcer is completely healed because of the small risk that cancer is present. Consider surgery if ulcer remains unhealed for six months

#### Duodenal ulcer

95% of duodenal ulcers are associated with *H. pylori*

**Hp positive:** One week triple therapy. No continued PPI required.

**Hp negative:** GI referral is advised if ulcers are not associated with NSAID. Prescribe ranitidine or PPI

PPI maintenance is only needed in patients with persistent *H.pylori* infection or those at risk of serious complications while receiving NSAIDs

**Follow up:** Repeat endoscopy is not needed. A follow up test for *H.pylori* should be performed one month or longer after eradication therapy if symptoms persist or recur

#### NSAIDs and COX-2 Inhibitor therapy

If possible, these should be avoided in the following patients
- History of an ulcer
- Dyspepsia
- Those receiving low-dose aspirin
- The elderly – patients over 70 years on an NSAID are at **significant** risk of peptic ulcer disease

High risk patients should be co-prescribed a PPI if an NSAID is considered essential and should also be tested and treated, if necessary, for *H pylori*

#### *H. pylori*

If patient tested positive and symptoms persist after triple therapy, re-test at least two weeks after treatment has ended before referring for endoscopy. Serum antigen testing is not appropriate for a re-test (stool antigen test is preferred) and patient must have been off PPIs for at least 2 weeks prior to either test or it is not valid.

### References

- BSG guidelines
- NICE guideline CG17
- Wirral Hospital NHS Trust Medicines Guide 2007-8