**Dyspepsia Guidelines**

- **Recent onset dyspepsia**
  - *ALARMS*:
    - Anaemia
    - Loss of weight
    - Anorexia
    - Recurrent symptoms (dysphagia, odynophagia)
    - Persistent continuous vomiting
    - Epigastric mass
    - GI bleed/melaena
    - Previous gastric surgery
    - Progressive swallowing problems (dysphagia)
  - Urgent referral to G.I. Consultant
  - Under 55 years – Test for *H. pylori* using stool antigen test (preferred option), serology or urea breath test
  - Positive – *H. pylori* eradication therapy as per BNF – one week course is recommended
  - Negative – aluminium/magnesium mixture eg Maalox Plus® Ranitidine
  - Low dose PPI
  - Lifestyle advice
  - Persistent or recurrent symptoms – refer for endoscopy
  - GORD:
    - Mild – alginate suspension
    - Severe – lansoprazole or omeprazole

- **No Alarm symptoms**
  - Over 55 years - Refer for endoscopy
  - Abnormal – Appropriate treatment or further referral
  - Normal – treat as for under 55 years and *H. pylori* negative

**Additional Information on PPIs**
- PPIs are over-prescribed.
- Many patients can be adequately treated with a cost effective alginate such as Peptac
- 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 (cost effective options)
- If NSAID treatment must continue and the patient has non-ulcer dyspepsia, use a maintenance PPI dose

**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 GI ulcers are strongly associated with *H. pylori* infection
- 30% of endoscopy results are normal
- 2% diagnose oesophago/gastric cancer
- Endoscopy is expensive
CHOICE OF PROTON PUMP INHIBITOR (PPI)

Acid Related Dyspepsia GORD

Lansoprazole 15mg or omeprazole 20mg capsule daily

Review at 2 to 4 weeks. Consider stepping/stopping 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 stepping 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 lansoprazole 15-30mg daily.

Severe erosive GORD

Lansoprazole 30mg capsule twice daily

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

Barrett’s oesophagus

Lansoprazole Orodispersible tablets 15mg-30mg daily

NG / PEG tubes / dysphagia

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

Appropriate lifestyle modifications such as diet, alcohol intake and smoking should always be encouraged

Note: Lansoprazole orodispersible tablets 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

**Treatment of Gastric and Duodenal Ulcers**

PPIs are effective short term treatments for gastric and duodenal ulcers

*H. pylori* causes 80% of gastric ulcers and 95% of duodenal ulcers.

NSAIDs are responsible for most of the remainder of peptic ulcers

All patients should be tested for *H. pylori*

**H. pylori negative:** Ranitidine or PPI therapy for 1-2 months and stop the NSAID if possible.

Consider long term therapy with a PPI if the NSAID cannot be stopped.

**H. pylori positive:** Eradication therapy as recommended in the BNF for one week, followed by a further three weeks of PPI therapy if the ulcer is large or complicated by haemorrhage or perforation. Offer *H pylori* retesting for *H pylori* 6-8 weeks after beginning treatment depending on the size of the lesion. See box below if symptoms persist.

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

GI referral is advised if the ulcer is not associated with *H.pylori* or an NSAID

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

Repeat endoscopy is not needed for duodenal ulcers but 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 and those with a proven ulcer 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 6-8 weeks after previous eradication therapy and prescribe an alternative eradication therapy. If the retest is positive and the ulcer is still present after 6-8 weeks, refer for endoscopy. Serum antigen testing is not appropriate for a re-test (stool antigen test or carbon-13 urea breath test is preferred) and patient must have been off PPIs for at least 2 weeks prior to either test or it is not valid.


Updated by Helen Dingle, Prescribing Adviser, NW CSU Medicines Management Team

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References

NICE Clinical Guideline CG186 September 2014 Dyspepsia and gastro-oesophageal reflux disease: Investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both

https://www.nice.org.uk/guidance/cg184

British National Formulary