

GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Clinical Approach to Adult Patients with Dyspepsia Revised 2004

Scope

This guideline applies to adult patients with dyspepsia in the primary care setting. Dyspepsia is defined in this guideline as a persistent or recurring upper abdominal pain or discomfort. Patients presenting predominantly with reflux symptoms are addressed in the guideline for gastroesophageal reflux disease. Symptom onset after the age of 50 years, gastrointestinal blood loss, weight loss, early satiety, dysphagia, persistent vomiting or symptoms refractory to standard therapy represent “alarm features” and require prompt investigation.

RECOMMENDATION 1: Causative factors

Identify aggravating factors such as the use of alcohol, tobacco, ASA, NSAIDs, and long-term systemic corticosteroids (especially if combined with NSAIDs). If these factors are identified, then withdrawal or dosage modification should be considered as a first step. Emotional stress is not a risk factor for peptic ulcer disease but is frequently associated with functional (non-ulcer) dyspepsia.

RECOMMENDATION 2: Alarm features - present

Symptom onset after the age of 50 years, gastrointestinal blood loss, weight loss, early satiety, dysphagia, persistent vomiting or symptoms refractory to standard therapy represent “alarm features” and require prompt investigation. The preferred investigation is upper gastrointestinal endoscopy ± biopsy. Air-contrast barium imaging may be used as an alternative.

RECOMMENDATION 3: Alarm features - absent

Two approaches are acceptable:

a) Test for *H. pylori* infection

This approach is most appropriate for patients in whom the predominant symptom is epigastric pain that is alleviated by food or that awakens the patient at night. See Appendix 1 for tests used for the diagnosis of active *H. pylori* infection. If the test is positive, treat using a currently recommended regimen. If negative, follow empiric therapy as below.

b) Empiric Therapy

A 4-week course of treatment with a histamine-2 receptor antagonist or proton pump inhibitor may be prescribed.

RECOMMENDATION 4: Treatment failure

Failure to respond to treatment (Recommendation 3) justifies referral and/or further investigation.

RECOMMENDATION 5: Chronic non-progressive symptoms

Patients with chronic non-progressive symptoms previously investigated with negative results, and with no alarm symptoms, do not require repeat consultation or investigation.

Rationale

Dyspepsia is a common clinical problem that seldom represents life-threatening disease. When a patient presents with dyspepsia, a history and physical examination are essential. Functional dyspepsia is the most common cause. Other possible causes include peptic ulcer disease, gastroesophageal reflux disease and gastric cancer (<1%). There is increasing evidence that a detailed description of the pain does not reliably differentiate the cause, although the presence of heartburn (burning sensation rising from the epigastrium or lower retrosternal region toward the neck), strongly suggests gastroesophageal reflux. Malignancy is unlikely in the absence of any alarm features, especially in patients under the age of 50 years.

Alarm features suggest a higher risk of significant disease and require prompt investigation. Endoscopy is more sensitive and specific than barium studies and allows tissue sampling. An acceptable alternative when endoscopy is not readily available is double contrast upper GI barium study which detects the majority of clinically significant lesions.

In the absence of alarm features, testing for and treating *Helicobacter pylori* infection will benefit up to 30% of patients.

Symptoms that persist unchanged for many years after initial negative investigation are rarely accompanied by any changes in findings. Such patients should be treated supportively.

References

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Sponsors

This guideline, revised by the Guidelines and Protocols Advisory Committee, supersedes *Clinical Approach to Adult Patients with Dyspepsia* developed in 1999 and revised in 2001. The revision has been approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

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- to encourage appropriate responses to common medical situations
- to recommend actions that are sufficient and efficient, neither excessive nor deficient
- to permit exceptions when justified by clinical circumstances.

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Appendix 1: Tests for the diagnosis of active *Helicobacter pylori* infection

Tests for <i>H. Pylori</i>	Test detects presence of:	Sensitivity	Specificity	Availability in BC
Serology – whole blood or serum	antibody – active or past infection*	high	low	widely available through local labs
Endoscopic gastric biopsy – pathology	active infection	high	high	widely available
C13 urea breath test – nonradioactive	active infection	high	high	widely available
Fecal antigen testing	active infection	high	high	limited availability

*Antibody tests will remain positive at least 1-2 years following successful eradication.