MANAGEMENT OF DYSPEPSIA AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)

- Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without ALARM signs, is not necessary. Alarm signs and signals are the major determinant of the need for endoscopy, not age on its own.

- Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for oesophago-gastric cancer in people:
  - with dysphagia or
  - aged 55 and over with weight loss and any of the following:
    - upper abdominal pain
    - reflux
    - dyspepsia

- Consider non-urgent upper gastrointestinal endoscopy to assess for oesophago-gastric cancer in people with haematemesis.

- Consider non-urgent upper gastrointestinal endoscopy to assess for oesophago-gastric cancer in people aged 55 or over with:
  - treatment-resistant dyspepsia or
  - upper abdominal pain with low haemoglobin levels or
  - raised platelet count with any of the following:
    - nausea
    - vomiting
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain, or
  - nausea or vomiting with any of the following:
    - weight loss
    - reflux
    - upper abdominal pain

- For the management of un-investigated dyspepsia use clinical judgement to offer either *H pylori* “test-and-treat” or full dose PPI for one month. The stool antigen test is the preferred *H pylori* test across Derbyshire.

- Consider a referral to a specialist service for people of any age with gastro-oesophageal symptoms where *H pylori* that has not responded to second-line eradication therapy

- Patients should receive an annual review of their condition. Patients on a long-term PPI for GORD should be encouraged to either step-down to the lowest effective dose to control symptoms, continue treatment on a when needed bases or stop treatment

- Long-term use of PPIs is associated with adverse effects e.g. hip fractures, hypomagnesaemia and Clostridium difficile. See local PPI guideline.
Dyspepsia
The British Society of Gastroenterologists (BSG) defines dyspepsia as a group of symptoms that alert doctors to consider disease of the upper GI tract, and states that dyspepsia itself is not a diagnosis. These symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, nausea or vomiting.

Some of the costs associated with treating dyspepsia are decreasing, but the overall use of treatment is increasing. As a result, the management of dyspepsia continues to have potentially significant costs to the NHS.

Management of symptoms in primary care is appropriate for most patients rather than routinely seeking a pathological diagnosis. Long-term care should emphasise patient empowerment, for example by promoting 'on demand' use of the lowest effective dose.

Alarm signals and signs are the major determinant of the need for endoscopy, not age on its own.

Functional dyspepsia
Functional dyspepsia refers to patients whose endoscopic investigation has excluded gastric or duodenal ulcer, malignancy or oesophagitis.

Gastro-oesophageal reflux disease (GORD)
GORD is a chronic condition where gastric juices from the stomach (usually acidic) flow back up to the oesophagus. It can be severe or frequent enough to cause symptoms, or damage the oesophagus or both. There are several risk factors for GORD including hiatus hernia, certain foods, heavy alcohol use, smoking, pregnancy.

*Helicobacter pylori*
*H pylori* is widely present in the general population, often causing no harm, but is strongly associated with gastric and duodenal ulcers. The eradication of the bacterium is important in the management of peptic ulcer disease. *H pylori* infection may also be associated with functional dyspepsia, though its role in this condition is less clear. No causative association with GORD and oesophagitis has been demonstrated.

Test for *H pylori* using a stool antigen test. Near-patient *H pylori* serology tests cannot be recommended as they are not accurate enough.

Self-care
Include life style changes (healthy eating, weight reduction, stop smoking) or using over the counter antacid and/or alginate therapy. However, long-term, frequent dose, continuous antacid therapy is not recommended.
Management of dyspepsia and GORD

New episode of dyspepsia

No

2WW referral criteria met*

Yes

Suspend NSAID use and review medication for possible causes of dyspepsia**

Endoscopy findings

Normal/minor abnormalities

Upper GI malignancy

GORD

PUD

Refer to upper GI MDT

Treat as un-investigated dyspepsia

Page 4

Treat as functional dyspepsia

Page 5

Treat as gastro-oesophageal reflux disease (GORD)

Page 6

Treat as peptic ulcer disease (PUD)

Page 7 (duodenal ulcer)

Page 8 (gastric ulcer)

*ALARM FEATURES REQUIRING REFERRAL VIA 2 WEEK WAIT SYSTEM

- Dysphagia or
- Aged 55 and over with weight loss and any of the following:
  - upper abdominal pain
  - reflux
  - dyspepsia
- Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer.

Consider non urgent upper gastrointestinal endoscopy:

- to assess for oesophago-gastric cancer in people with haematemesis
- to assess for oesophago-gastric cancer in people aged 55 or over with
  - treatment-resistant dyspepsia or
  - upper abdominal pain with low haemoglobin levels or
  - raised platelet count with any of the following:
    - nausea
    - vomiting
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain, or
  - nausea or vomiting with any of the following:
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain

** Review medication for possible causes of dyspepsia e.g.:
Calcium antagonists, nitrates, theophylline, bisphosphonates, steroids, NSAIDs and SSRIs
Interventions of un-investigated dyspepsia

Dyspepsia not needing referral

Review medication for possible cause of dyspepsia e.g. calcium antagonists, nitrates, theophylline’s, bisphosphonates, steroids, SSRIs, and NSAIDs

Lifestyle advice:
- Healthy eating
- Weight reduction
- Smoking cessation
Promote self-care (which may include OTC PPIs)

Offer one of the following strategies to depending on clinical judgement

Test and treat for H Pylori infection if the person’s status is not known or Full dose PPI for 1 month

No response or relapse

Test and treat, leave a 2-week washout period after PPI use before testing for Helicobacter pylori

No response

Low-dose treatment as required

Response

H2RA for 1 month (see appendix 2 for more detail)

No response

Review

Return to self-care

1 In some patients with an inadequate response to therapy it may become appropriate to refer to a specialist for a second opinion. Emphasise the benign nature of dyspepsia. Review long-term patient care at least annually to discuss medication and symptoms

For full and double doses of PPI see appendix 1
Management of functional dyspepsia

Functional dyspepsia

Yes

$H$ pylori present

No

PPI or $H_2$RA# for 4 weeks if symptoms persist

No response or relapse

PPI or $H_2$RA# at lowest possible dose to control symptoms

Response

Review$^1$

Discuss using PPI treatment on an ‘as-needed’ basis with people to manage their own symptoms

1 In some patients with an inadequate response to therapy or new emergent symptoms it may become appropriate to refer to a specialist for a second opinion

# see appendix 2 for more detail
Management of gastro-oesophageal reflux disease (GORD) post endoscopy

Confirmed endoscopy diagnosis of GORD

Endoscopic negative reflux disease

Oesophagitis

Yes

Severe grade?

No

Full dose PPI for 4 or 8 weeks

Full dose PPI for 4 or 8 weeks

Double-dose PPI for 1 month

Low dose treatment as required

H₂RA# for 1 month

No response or relapse

Response

Response

Symptoms resolved

Symptoms resolved

Symptoms resolved

Symptoms persist

Symptoms persist

Symptoms persist

Continue full-dose PPI

Discuss patient preferences and risk factors for endoscopy to exclude Barrett’s oesophagus

Review at least annually

Refer to specialist

Return to self-care

Manage as uninvestigated dyspepsia – see page 4

N.b. do not ‘test & treat for GORD– there is currently no evidence that H pylori should be investigated in patients with GORD. Treating H Pylori in GORD may actually worsen it due to rebound hyperacidity

Confirmed endoscopy diagnosis of GORD

No response

Symptoms persist

Oesophagitis

Full/ double dose PPI for 8 weeks

Full dose PPI for 8 weeks

Manage as uninvestigated dyspepsia – see page 4

N.b. do not ‘test & treat for GORD– there is currently no evidence that H pylori should be investigated in patients with GORD. Treating H Pylori in GORD may actually worsen it due to rebound hyperacidity

1 Review long term patient care at least annually to discuss medication and symptoms. In some patients with an inadequate response to therapy or new emergent symptoms, it may be appropriate to refer to a specialist for a second opinion

# see appendix 2 for more detail
Management of peptic ulcer disease post endoscopy - Duodenal ulcer

Duodenal ulcer

Stop NSAID if used\(^1\)

Test for *H pylori*

Test positive, ulcer associated with NSAID use

Test negative

Full dose PPI for 8 weeks

1\(^\text{st}\) line eradication therapy – see page

Response

No response or relapse

Re-test for *H pylori*

Positive

2\(^\text{nd}\) line eradication therapy – see page 10

Response

No response or relapse

Return to self-care

Test negative

Test positive, ulcer not associated with NSAID use

Full dose PPI or H\(_2\)RA (see appendix 2) for 4 to 8 weeks

Response

Low dose treatment as required

No response

Exclude other cases of duodenal ulcer\(^2\)

Review annually\(^3\)

\(^1\) If NSAID use is necessary, after ulcer healing offer long-term gastric protection

\(^2\) Consider:

- Non-compliance with treatment
- Possible malignancy
- Failure to detect *H pylori* infection due to recent PPI or antibiotic use
- Inadequate testing
- Inadvertent use of aspirin or NSAID use
- Ulceration due to ingestion of other drugs
- Zollinger-Ellison syndrome
- Crohn’s disease

\(^3\) Review care annually, to discuss symptoms, promote stepwise withdrawal of therapy when appropriate and provide lifestyle advice
Management of peptic ulcer disease post endoscopy - Gastric ulcer

Gastric ulcer

Stop NSAID if used¹

Test for *H pylori*

Test positive, ulcer not associated with NSAID use

Test positive, ulcer associated with NSAID use

Gastric ulcer

Full dose PPI for 8 weeks

Eradication therapy – see page 10

Test negative

Endoscopy and test for *H pylori*²

Ulcer healed, test negative

Refer to specialist

Ulcer not healed, test negative

Low dose treatment as required

Periodic review³

Return to self-care

Endoscopy²

Healed

Not healed

Refer to specialist

¹ If NSAID use is necessary, after ulcer healing offer long-term gastric protection
² Offer people with gastric ulcer and *H Pylori* repeat endoscopy 6 to 8 weeks after beginning treatment, depending on the size of the lesion
³ Review care annually to discuss symptoms, promote stepwise withdrawal of therapy when appropriate and provide lifestyle advice. In some patients with an inadequate response to therapy it may become appropriate to refer to a specialist.
Management strategy for *Helicobacter pylori*

Advise the person to arrange a follow-up appointment if there are refractory or recurrent symptoms following initial management.

Assess or review for
- New alarm symptoms
- Alternative diagnosis
- Alternative antacids
- Reducing dose of NSAIDs if possible and or long term gastro-protection is necessary

If the person has received first-line *Helicobacter pylori* eradication therapy, do not routinely offer *H pylori* re-testing. Use clinical judgement considering:
- compliance to first-line eradication therapy
- whether the initial test was performed within 2 weeks of proton pump inhibitor (PPI) or within 4 weeks of antibiotic therapy
- family history of gastric malignancy
- if patient has severe, persistent, or recurrent symptoms.

If *H pylori* re-testing is indicated, arrange this at least four weeks (ideally 8 weeks) after initial eradication therapy (if this was needed)

Consider referral from primary care if there are refractory or recurrent symptoms despite optimal management in primary care.
- If endoscopy is planned, ensure the person stops any acid suppression therapy for at least two weeks before the procedure date, and suggest self-treatment with antacid and/or alginate therapy if needed.
- Treatment with a second-line *H pylori* eradication regimen has been unsuccessful

**Testing**

The *H pylori* stool antigen test can be used both for diagnosis and post-eradication confirmation (if this is appropriate). If the patient is taking PPIs or bismuth, then a period of 2 weeks treatment free should elapse before testing or false negatives may occur. If the patient is taking antibiotics, leave a period of 4 weeks treatment free period before testing.

To request a test, send a stool sample with a standard microbiology request form asking for *H pylori* antigen test and stating whether for diagnosis or eradication confirmation.

**Treatment – *H pylori* eradication regimens** (as recommended by NICE CG 184)

All courses are for 7 days unless stated otherwise.

If the ulcer is large or complicated by haemorrhage or perforation then the PPI should be continued for at least another 3 weeks.

**First-line**

Choose the treatment regimen with the lowest acquisition cost, and take into account previous exposure to clarithromycin or metronidazole

<table>
<thead>
<tr>
<th>NICE/BNF</th>
<th>RDH</th>
<th>CRH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-line treatment</strong></td>
<td></td>
<td></td>
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<tr>
<td>Lansoprazole 30mg BD or omeprazole 20 to 40mg BD</td>
<td>Omeprazole 20mg BD</td>
<td>Lansoprazole 30mg BD</td>
</tr>
<tr>
<td>Amoxicillin 1gram BD</td>
<td>Amoxicillin 1gram BD</td>
<td>Amoxicillin 1gram BD</td>
</tr>
<tr>
<td>Either clarithromycin 500mg BD or metronidazole 400mg BD</td>
<td>Either clarithromycin 500mg BD or metronidazole 400mg BD</td>
<td>Clarithromycin 500mg BD</td>
</tr>
<tr>
<td><strong>If allergic to penicillin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lansoprazole 30mg BD or omeprazole 20 to 40mg BD</td>
<td>Omeprazole 20mg BD</td>
<td>Lansoprazole 30mg BD</td>
</tr>
<tr>
<td>Clarithromycin 500mg BD</td>
<td>Clarithromycin 500mg BD</td>
<td>Clarithromycin 500mg BD</td>
</tr>
<tr>
<td>Metronidazole 400mg BD</td>
<td>Metronidazole 400mg BD</td>
<td>Metronidazole 400mg BD</td>
</tr>
</tbody>
</table>
Second-line
Offer second-line treatment to people who still have symptoms after first-line eradication treatment

<table>
<thead>
<tr>
<th>NICE/ BNF</th>
<th>RDH</th>
<th>CRH</th>
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<tr>
<td><strong>Second-line treatment</strong></td>
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<td>AS PER NICE/BNF</td>
</tr>
<tr>
<td>Lansoprazole 30mg BD or omeprazole 20 to 40mg BD</td>
<td>Omeprazole 20mg BD</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin 1gram BD</td>
<td>Amoxicillin 1gram BD</td>
<td></td>
</tr>
<tr>
<td>Either clarithromycin 500mg BD or metronidazole 400mg BD (whichever was not used first line)</td>
<td>Either clarithromycin 500mg BD or metronidazole 400mg BD (whichever was not used first line)</td>
<td></td>
</tr>
<tr>
<td>Previous exposure to clarithromycin and metronidazole NICE recommend 7 days, RDH recommend 10 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lansoprazole 30mg BD or omeprazole 20 to 40mg BD</td>
<td>Omeprazole 20mg BD</td>
<td>AS PER NICE/BNF</td>
</tr>
<tr>
<td>Amoxicillin 1gram BD</td>
<td>Amoxicillin 1gram BD</td>
<td></td>
</tr>
<tr>
<td>A quinolone or tetracycline 500mg QDS</td>
<td>Levofloxacin 250mg BD (unlicensed)</td>
<td></td>
</tr>
<tr>
<td>If allergic to penicillin (and no previous exposure to a quinolone) NICE recommend 7 days, RDH recommend 10 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lansoprazole 30mg BD or omeprazole 20 to 40mg BD</td>
<td>Omeprazole 20mg BD</td>
<td>AS PER NICE/BNF</td>
</tr>
<tr>
<td>Metronidazole 400mg BD</td>
<td>Metronidazole 400mg BD</td>
<td></td>
</tr>
<tr>
<td>Levofloxacin 250mg BD</td>
<td>Levofloxacin 250mg BD (unlicensed)</td>
<td></td>
</tr>
</tbody>
</table>

Seek advice or consider referral to a specialist service if eradication of *H pylori* is not successful with second-line treatment

**Reviewing patient care**
Patients who need long-term management of dyspepsia symptoms should be offered an annual review of their condition. Patients should be encouraged to step down or stop treatment. It may be appropriate to advise patients to return to self-treatment with antacid and/or alginate therapy.

**References**
- NICE clinical guideline 184: Dyspepsia and gastro-oesophageal reflux disease, September 2014
- Suspected cancer: recognition and referral NICE guideline Published: 23 June 2015 NICE guidelines [NG12]

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**Document control**

<table>
<thead>
<tr>
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<th>Date</th>
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<tr>
<td>p.9 correction to state 2 weeks treatment free for PPI; 4 weeks for antibiotics before *H.*Pylori testing</td>
<td>September 219</td>
</tr>
<tr>
<td>p.9-10 H. <em>Pylori</em> eradication clarithromycin/ tetracycline dose updated following BNF update</td>
<td>February 2020</td>
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<td>Appendix 2 added</td>
<td>August 2020</td>
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Appendix 1 – Dosage information on PPIs

Table 1 – PPI doses

<table>
<thead>
<tr>
<th>Proton pump inhibitor</th>
<th>Full/standard dose</th>
<th>Low dose (on-demand dose)</th>
<th>Double dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lansoprazole</td>
<td>30mg once a day</td>
<td>15mg once a day</td>
<td>30mg¹ twice a day</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>20mg once a day</td>
<td>10mg¹ once a day</td>
<td>40mg once a day</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>40mg once a day</td>
<td>20mg once a day</td>
<td>40mg¹ twice a day</td>
</tr>
</tbody>
</table>

¹ Off-label dose for GORD

Table 2 – PPI doses for severe oesophagitis

<table>
<thead>
<tr>
<th>Proton pump inhibitor</th>
<th>Full/standard dose</th>
<th>Low dose (on-demand dose)</th>
<th>Double dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lansoprazole</td>
<td>30mg once a day</td>
<td>15mg once a day</td>
<td>30mg² twice a day</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>40mg¹ once a day</td>
<td>20mg¹ once a day</td>
<td>40mg¹ twice a day</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>40mg once a day</td>
<td>20mg once a day</td>
<td>40mg² twice a day</td>
</tr>
</tbody>
</table>

¹ NICE CG184 updated dosing specifically for severe oesophagitis

² Off-label dose for GORD

Appendix 2 Ranitidine/ H2 receptor antagonist shortage

JAPC has classified ranitidine BROWN (May 2020) as per EMA’s human medicines committee (CHMP) recommendation to suspend all ranitidine medicines in the EU due to the presence of low levels of an impurity called N-nitrosodimethylamine (NDMA).

A DHSC disruption alert, October 2019 recommends healthcare professionals to identify current patients prescribed oral ranitidine and review to establish if ongoing treatment is still required. If so consider switching to an alternative treatment:-
- For patients switching from ranitidine use a PPI where clinically appropriate
- If a PPI is unsuitable then other cost effective H2RA should be considered.

There are ongoing supply disruptions for ranitidine and all other H2RAs. JAPC advises the types of patients who may require an alternative H2RA to ranitidine include:
1. those needing acid suppression who are genuinely allergic or intolerant or contraindicated to all PPIs, which is rare;
2. those needing acid suppression where low magnesium occurs, which is felt as very rare;
3. those who have needed upward titration for reflux symptoms despite high dose PPIs, where addition of H2RA, generally at night time, helps*.
4. occasionally there seems to be a small number who claim not to do well on PPI yet symptomatically get better on H2RA.

For all cases, those not responding well to PPIs should be investigated to make sure diagnosis correct e.g. to rule out bile reflux, functional pain etc. No particular problems should arise with stopping H2RA as the rebound hyper acid phase tends not to occur (compared to PPIs).

* Patients suitable for antireflux procedures should be referred at this point, but generally the H2RA+PPI combination is used for those not suitable for or who would not do well with antireflux surgery (e.g. elderly frail, or those where there is a functional element to symptoms). Patient may be advised to go back to PPI+ antacid.