Wakefield CCG Dyspepsia

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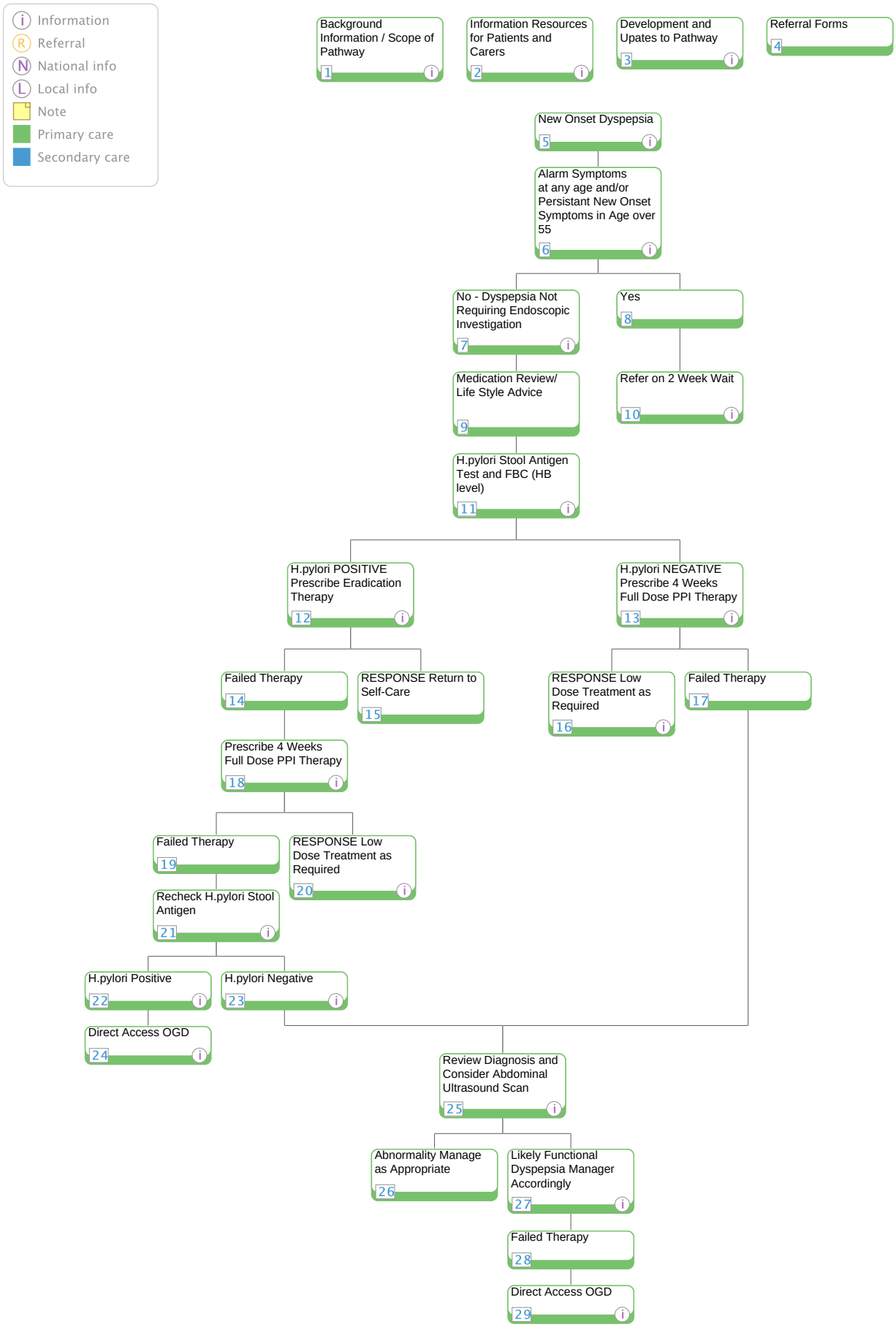

Published: 15-Nov-2013 Valid until: 31-Mar-2017 Printed on: 09-Apr-2015

Wakefield CCG Dyspepsia

1 Background Information / Scope of Pathway

Quick info:

The pathway is applicable to patients aged 18 years and over. It provides guidance on how to manage patients presenting with dyspepsia within primary care.

2 Information Resources for Patients and Carers

Quick info:

Recommended resources for patients and carers, produced by organisations certified by The Information Standard:

- 'Dyspepsia (indigestion)' (URL) from Bupa at http://www.bupa.co.uk
- 'Dyspepsia (indigestion)'(PDF) from Patient UK at http://www.patient.co.uk
- 'Indigestion (dyspepsia) in adults: understanding NICE guidance – information for people with dyspepsia, their families and carers, and the public'from National Institute for Health and Clinical Excellence (NICE) at http://www.nice.org.uk
- 'Healthtalkonline'(URL) from DIPEx at http://www.healthtalkonline.org/
- 'Non-ulcer (functional) dyspepsia' (PDF) from Patient UK at http://www.patient.co.uk

For details on how these resources are identified, please see Map of Medicine's document on Information Resources for Patients and Carers (URL).

3 Development and Upates to Pathway

Quick info:

The development of the Wakefield Dyspepsia Pathway was overseen, approved and signed off by Wakefield & North Kirklees Gastroenterology Clinical Commissioning Group Steering Group.

Key Stakeholders involved:

Dr Abdul Mustafa, Cancer Clinical Lead, Wakefield Clinical Commissioning Group
Dr Natarajan Chandra, Cancer Clinical Lead, North Kirklees Clinical Commissioning Group
Dr Syed G Shah, Consultant Gastroenterologist, Mid Yorkshire Hospitals NHS Trust
Debra Taylor-Tate, Senior Commissioning Manager, Wakefield Clinical Commissioning Group
Jane Maskill, Commissioning Manager, Wakefield Clinical Commissioning Group
Allison Hall, Senior Sister, Endoscopy Unit, Mid Yorkshire Hospitals NHS Trust
Anne Smithers, Endoscopy Service Administrator, Mid Yorkshire Hospitals NHS Trust
Helen Higgins, Specialist Pharmacist, Wakefield Clinical Commissioning Group
Marieke Jordan, Head of Clinical Service for Pathology, Mid Yorkshire Hospitals NHS Trust
Paul Howatson, Senior Programme Manager, North Kirklees Clinical Commissioning Group
Valerie Aguirregoicoa, Commissioning Quality Manager, Wakefield Clinical Commissioning Group

5 New Onset Dyspepsia

Quick info:

Dyspepsia is broadly defined as any symptom referable to the upper gastrointestinal tract, present for four weeks or more, including upper abdominal pain or discomfort, heartburn, acid reflux, nausea, or vomiting. [1]

When broadly defined, dyspepsia occurs in 40% of the general population at any one time, leads to GP consultation in 5% and referral for endoscopy in 1% of the population annually. [2] In patients with signs or symptoms severe enough to merit endoscopy, more than 70% have functional or non-ulcer dyspepsia, 15% have gastro-oesophageal reflux disease and 8% have some form of ulcer. [3]

Eradication of the bacterium *Helicobacter pylori* (*H. pylori*)is important in the management of peptic ulcer disease and functional dyspepsia. [2] Gastric and oesophageal cancers are very rare, occurring in less than 1% of endoscopies performed for uncomplicated dyspepsia without alarm symptoms or signs. [3]

Dyspeptic symptoms are a poor predictor of significant disease. Only around 25% of patients with uncomplicated dyspepsia without alarm symptoms or signs have significant disease confirmed by endoscopy. In primary care, symptoms as reported by the patient are a poor predictor of underlying pathology. [2]

References:

[1] Lancet. 1988 Mar 12; 1(8585): 576-9.

[2] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

[3] Ford AC, Marwaha A, Lim A, Moayyedi P. Clin Gastroenterol Hepatol. 2010 Oct; 8(10): 830-7.

6 Alarm Symptoms at any age and/or Persistant New Onset Symptoms in Age over 55

Quick info:

Immediate (same day) specialist referral is indicated for patients presenting with dyspepsia together with signs that suggest significant acute gastrointestinal bleeding (haematemesis or melaena). [1] Urgent specialist referral for endoscopic investigation (seen within 2 weeks) is indicated for patients of any age with dyspepsia when presenting with any of the following: progressive unintentional weight loss, progressive difficulty swallowing, persistent vomiting, iron deficiency anaemia, epigastric mass or suspicious barium meal. [1] Routine endoscopic investigation of patients of any age, presenting with uncomplicated dyspepsia without alarm symptoms or signs, is not necessary. **However, in patients aged 55 years and older with unexplained and persistent recent onset dyspepsia alone, an urgent referral for endoscopy should be made.** Referral for dysphagia or significant weight loss at any age plus age older than 55 years with alarm symptoms would have detected 99.8% of the cancers found in the cohort. [1] The possibility of cardiac or biliary disease should be considered as part of the differential diagnosis.

Reference:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

7 No - Dyspepsia Not Requiring Endoscopic Investigation

Quick info:

Dyspepsia (indigestion) http://medical.cdn.patient.co.uk/pdf/4868.pdf

(PDF) from Patient UK

http://medical.cdn.patient.co.uk/pdf/4868.pdf

Review medications for possible causes of dyspepsia, for example aspirin, clopidogrel, non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, bisphosphonates, selective serotonin reuptake inhibitors (SSRIs), digoxin, macrolide antibiotics and iron salts. Calcium antagonists, nitrates and theophyllines may reduce lower oesophageal sphincter pressure and pre dispose patient to gastro-oesophageal reflux disease (GORD). In patients requiring referral suspend NSAID use. [1] Offer simple lifestyle advice, including healthy eating, weight reduction and smoking cessation. [1]

Available trials of lifestyle advice to reduce symptoms of dyspepsia are small and inconclusive. Epidemiological studies show a weak link between obesity and GORD but no clear association between dyspepsia and lifestyle factors such as smoking, alcohol, coffee or diet. However, individual patients may be helped by lifestyle advice and there may be more general health benefits that make lifestyle advice important. [1]

Self-treatment with antacid and/or alginate therapy may continue to be appropriate for many patients, either prescribed or purchased over-the-counter and taken as required for immediate symptom relief, However, additional therapy becomes appropriate to manage symptoms that persistently affect patients' quality of life. [1]

Reference:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

10 Refer on 2 Week Wait

Quick info:

Upper GI Malignancies Referral Form

In a recent prospective observational study the prevalence of gastric cancer was 4% in a cohort of patients referred urgently for alarm features. Referral for dysphagia or significant weight loss at any age plus age greater than 55 with alarm symptoms would have detected 99.8% of the cancers found in the cohort. These findings are supported by other retrospective studies. [1]

Retrospective studies have found that cancer is very rarely detected in patients under the age of 55 years without alarm symptoms,

and, when found, the cancer is usually inoperable. [1] In the UK, morbidity (non-trivial adverse events) and mortality rates for upper gastrointestinal endoscopy may be as high as 1 in 200 and 1 in 2000 respectively. [1]

Reference:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

11 H.pylori Stool Antigen Test and FBC (HB level)

Quick info:

References:

[1] Wakefield Health Pathways

[2] NICE Quick Reference Guide Dyspepsia Page 8 -2004

All acid suppression treatment (excluding simple antacids) should be stopped 2 week before testing, Bismuth compounds and antibiotics should be stopped 4 weeks before testing. [1] The sensitivity and specificity of the *H. pylori* stool antigen test are both around 95%. [1]

Blood tests -to exclude iron deficiency anaemia and coeliac disease. There is currently inadequate evidence to guide whether full dose PPI for one month or *H. pylori* test and treat should be offered first. Either treatment may be tried first with the other being offered where symptoms persist or return. NICE

12 H.pylori POSITIVE Prescribe Eradication Therapy

Quick info:

Do not use clarithromycin or metronidazole if used in the past year for any infection

Option 1

PPI (Omeprazole capsules 20mg BD or Lansoprazole capsules 30mg BD) and Clarithromycin 500mg BD and Amoxicillin 1g BD All for 7 days **Option 2** (without penicillin) Full dose(Low cost) PPI BD(Omeprazole capsules 20mg BD or Lansoprazole capsules 30mg BD) and Clarithromycin250mg BD and Metronidazole 400mg BD All for 7 Days

If symptoms persist refer to Option 3

Option 3

PPI (Omeprazole capsules 20mg BD or Lansoprazole capsules 30mg BD) and Bismuth (De-noltab®) 120mg QDS and Metronidazole 400mg TDS and Oxytetracycline 500mg QDS All for 7 Days

Eradication regime as suggested on Wakefield Health PathwaysPPI dose from BNF http://www.bnf.org/bnf/org_450080.htmhttp://www.bnf.org/bnf/org_450080.htm

13 H.pylori NEGATIVE Prescribe 4 Weeks Full Dose PPI Therapy

Quick info:

Offer empirical full dose proton pump inhibitor (PPI) therapy (Lansoprazole 30mg OD in the morning before food, or Omeprazole 20mg OD or Pantoprazole 40mg OD) for four weeks to patients with dyspepsia. [1] PPIs are more effective than antacids at reducing dyspeptic symptoms in trials of patients with uninvestigated dyspepsia. The average rate of response taking antacid was 37% and PPI therapy increased this to 55%: a number needed to treat for one additional responder of 6. [1] PPIs are more effective than H2 receptor antagonists (H2RAs) at reducing dyspeptic symptoms in trials of patients with uninvestigated dyspepsia. The average response rate in H2RA groups was 36% and PPI increased this to 58%: a number needed to treat for one additional responder of 5. [1]

Early endoscopy has not been demonstrated to produce better patient outcomes than empirical treatment, and while providing some reassurance in the short-term, this beneficial effect soon ameliorates. [1]

Doses of medication came from the BNF

References:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

16 RESPONSE Low Dose Treatment as Required

Quick info:

Offer patients requiring long-term management of symptoms for dyspepsia an annual review of their condition, encouraging them to try stepping-down the dose of their medication or stopping treatment altogether, unless there is an underlying condition or co-medication requiring continuing treatment. [1] Dyspepsia is a relapsing and remitting disorder, with symptoms recurring annually in about half of patients. [1] Patients requiring long-term management of symptoms for dyspepsia should be encouraged to reduce their use of prescribed

medication stepwise: by using the lowest effective dose, by trying ‘on demand' use when appropriate, and by returning to self treatment with antacid and/or alginate therapy. [1]

Reference:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

Incidences of CDiff and MHRA

Increased risk of C difficile infections and of fractures: two more good reasons to review PPI prescribing http://www.npc.nhs.uk/rapidreview/?p=1494

:Clostridium difficile infection – are acid suppressant medicines a risk factor? http://www.northwest.nhs.uk/document_uploads/cdiff/QA244_C_difficile_are_acid_suppressant_medicines_a_risk_factor.pdf

18 Prescribe 4 Weeks Full Dose PPI Therapy

Quick info:

Offer empirical full dose proton pump inhibitor (PPI) therapy (Omeprazole capsules 20mg OD or Lansoprazole capsules 30mg OD in the morning before food, or or Pantoprazole 40mg OD) for four weeks to patients with dyspepsia. [1] PPIs are more effective than antacids at reducing dyspeptic symptoms in trials of patients with uninvestigated dyspepsia. The

average rate of response taking antacid was 37% and PPI therapy increased this to 55%: a number needed to treat for one additional responder of 6. [1] PPIs are more effective than H2 receptor antagonists (H2RAs) at reducing dyspeptic symptoms in trials of patients with uninvestigated dyspepsia. The average response rate in H2RA groups was 36% and PPI increased this to 58%: a number needed to treat for one additional responder of 5. [1]

Early endoscopy has not been demonstrated to produce better patient outcomes than empirical treatment. [1]

Doses of medication came from the BNFhttp://www.bnf.org/bnf/index.htm

References:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

20 RESPONSE Low Dose Treatment as Required

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Offer patients requiring long-term management of symptoms for dyspepsia an annual review of their condition, encouraging them to try stepping-down the dose of their medication or stopping treatment altogether, unless there is an underlying condition or co-medication requiring continuing treatment. [1] Dyspepsia is a relapsing and remitting disorder, with symptoms recurring annually in about half of patients. [1] Patients requiring long-term management of symptoms for dyspepsia should be encouraged to reduce their use of prescribed

medication stepwise: by using the lowest effective dose, by trying ‘on demand' use when appropriate, and by returning to self treatment with antacid and/or alginate therapy. [1]

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[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

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Increased risk of C difficile infections and of fractures: two more good reasons to review PPI prescribing http://www.npc.nhs.uk/rapidreview/?p=1494

:Clostridium difficile infection – are acid suppressant medicines a risk factor? http://www.northwest.nhs.uk/document_uploads/cdiff/QA244_C_difficile_are_acid_suppressant_medicines_a_risk_factor.pdf

21 Recheck H.pylori Stool Antigen

Published: 15-Nov-2013 Valid until: 31-Mar-2017 Printed on: 09-Apr-2015

Quick info:

Re-test for *H. pylori* at least 4 weeks after treatment. [1] All acid suppression treatment (excluding simple antacids) should be stopped 2 week before testing, Bismuth compounds and

antibiotics should be stopped 4 weeks before testing. [1]

H. pylori is causally implicated in the pathogenesis of peptic ulcer, MALT lymphoma, and gastric cancer, and is classed as a human carcinogen by the World Health Organisation. For this reason, all patients whose symptoms persist and who remain *H. pylori*positive on re-testing after eradication therapy should be offered endoscopy.

Reference:

[1] Wakefield Health Pathways

22 H.pylori Positive

Quick info:

Patient leaflets and services to be available

23 H.pylori Negative

Quick info:

Prescribe lowest acquisition cost PPIs (omeprazole capsules, lansoprazole capsules & pantoprazole) in preference to high acquisition cost, there

is no evidence that any one PPI is more effective than another.

24 Direct Access OGD

Quick info:

GI 1 Upper GI Endoscopy Form

Some providers are not on choose and book so please use existing paper routes for these providers.

Choose and Book

You can find some providers of direct access endoscopy under: **Speciality:** Diagnostic Endoscopy **Clinic Type:** Gastroscopy or **Speciality:** GI and Liver (Medicine and Surgery) **Clinic Type:** Upper GI including Dyspepsia

25 Review Diagnosis and Consider Abdominal Ultrasound Scan

Quick info:

Differential diagnoses and other conditions to consider in any patient presenting with unexplained upper gastrointestinal symptoms include gallstones, biliary dyskinesia, and coeliac disease, hence the need for bloods (including coeliac serology) and abdominal ultrasound in patients whose symptoms do not settle. However, the vast majority of these individuals will have functional dyspepsia.

27 Likely Functional Dyspepsia Manager Accordingly

Quick info:

Non-ulcer (functional) dyspepsia

* Please refer to link below for latest European Medicines Agency Committee (EMA) 2013 regarding advice on use of Metoclopramide. Locally it is recommended that Metoclopramide is not an option. [2]

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON300404

Please refer to link below for latest guidance from electronic Medicines Compendium (eMC) for the relief of symptoms of post-prandial stomach discomfort:

Adults and children 16 years of age and older:

Up to 10 mg three times daily and at night.

Maximum duration of course of treatment 2 weeks. [3]

http://www.medicines.org.uk/emc/medicine/20011/SPC/Motilium+10/Dyspepsia:

Management of dyspepsia in adults in primary care:National Institute for Health and Clinical Excellence (NICE) 2004.

http://medical.cdn.patient.co.uk/pdf/4622.pdf(PDF) from Patient UK

Management of endoscopically-confirmed functional dyspepsia involves initial treatment for *H. pylori* if present, followed by symptomatic management and periodic monitoring. -The number needed to treat with *H. pylori* eradication therapy in functional dyspepsia to improve or cure one patient's symptoms is 13.

-Retesting after eradication should not be offered routinely, although the information it provides may be valued by individual patients. -The effect of repeated eradication therapy on *H. pylori* status or dyspepsia symptoms in functional dyspepsia is unknown. [1]
If *H. pylori* has been excluded or treated and symptoms persist, offer either a low dose PPI (Omeprazole capsule 10mg OD or Lansoprazole capsule15mg OD in the morning before food or or Pantoprazole 20mg OD) or a H2 receptor antagonist (Ranitidine 150mg BD) for four weeks. -Full dose PPIs are no more effective than maintenance or low dose PPIs in the management of functional dyspepsia. [1] If PPIs or H2 receptor antagonists provide inadequate symptomatic relief, offer a trial of a prokinetic (Domperidone# 10mg TDS before meals or Metoclopramide 10mg TDS) for four weeks*. [1] If symptoms continue or recur following initial treatment, offer a PPI or H2 receptor antagonist to be taken at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions. [1] Discuss using PPI treatment on an 'on demand' basis with patients to manage their own symptoms. Evidence is taken from patients with endoscopy negative reflux disease. Patients using PPI therapy as needed (waiting for symptoms to develop before taking treatment) reported similar 'willingness to continue' to those on continuous PPI therapy.

-Patients taking therapy as needed used about 0.4 tablets per day, averaged across studies of 6 to 12 months duration. Taking therapy when symptoms occur may help patients to tailor their treatment to their needs Long term, frequent dose continuous prescription of antacid therapy is inappropriate and only relieves symptoms in the short term rather than preventing them. -Antacid therapy is no more effective than placebo in reducing the symptoms of functional dyspepsia. [1]

Doses of medication came from the BNFhttp://www.bnf.org/bnf/index.htm

References:

[1] National Institute for Health and Clinical Excellence (NICE). Dyspepsia: management of dyspepsia in adults in primary care. Clinical guideline 17. London: NICE; 2004.

[2] European Medicines Agency (EMA): recommends changes to the use of Metoclopramide: EMA 2013.

[3] electronic Medicines Compendium (eMC).

29 Direct Access OGD

Quick info:

GI 1 Upper GI Endoscopy Form

Some providers are not on choose and book so please use existing paper routes for these providers.

Choose and Book

You can find some providers of direct access endoscopy under: **Speciality:** Diagnostic Endoscopy **Clinic Type:** Gastroscopy or **Speciality:** GI and Liver (Medicine and Surgery) **Clinic Type:** Upper GI including Dyspepsia

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Key Dates

Published: 15-Nov-2013, by Wakefield
Valid until: 31-Mar-2017

