10 minute consultation: dyspepsia


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10 MINUTE CONSULTATION

Dyspepsia

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This is part of a series of occasional articles on common problems in primary care. The BMJ welcomes contributions from GPs.

A 35 year old woman attends with a three month history of a recurrent burning sensation in her upper abdomen. The symptom is worse at night and has no relation to exercise. The periods of discomfort have increased in frequency and they are no longer relieved by over the counter remedies.

What you should cover

This history is typical of dyspepsia. Self management before presenting to a doctor is common. Distinguishing between epigastric pain, heartburn, and acid reflux is unlikely to change management, but atypical or increasingly severe symptoms require consideration of other diagnoses such as angina, biliary colic, or pancreatitis.

Consider:

- Red flags in the history and examination (box)—these should be documented
- Possibility of pregnancy, which can affect symptoms and management
- Medical history: specifically pernicious anaemia, Barrett’s oesophagitis, intestinal dysplasia, or previous peptic ulcer surgery, as these conditions are associated with increased risk of malignancy and would lower the threshold for referral
- Family history: particularly of upper gastrointestinal cancer
- Recent or current medication: over the counter and prescribed. Commonly implicated drugs include non-steroidal anti-inflammatory drugs, calcium channel antagonists, nitrates, theophyllines, bisphosphonates, and steroids
- Social history: recent stressful life events or occupation. Anxiety can contribute to dyspepsia
- Lifestyle, including smoking, dietary habits, weight, and alcohol and caffeine consumption.

What you should do

After establishing a working diagnosis:

- Discuss any anxieties about possible diagnoses and expectations regarding endoscopy
- Explain that dyspepsia is a common condition that usually responds well to treatment
- Stop or reduce any medication that may be contributing to symptoms (if appropriate)
- Offer lifestyle advice, including smoking cessation, weight loss, reduced alcohol and caffeine intake, and regular exercise. Evidence for long term effects of lifestyle changes on dyspepsia is lacking, but consensus is that patients should avoid behaviours known to exacerbate symptoms
- Prescribe pharmacological therapy: either test and treat for Helicobacter pylori, or four weeks of acid suppression with full dose proton pump inhibitor. There is insufficient evidence to support the choice of one over the other, but if one is unsuccessful the other should be tried afterwards.

The preferred tests for H pylori are 13C urea breath test or stool antigen test, as serology is less specific and cannot confirm eradication. These tests are best done before starting proton pump inhibitor, as a two week washout is needed after taking these drugs before testing by either method. If H pylori testing is positive, prescribe eradication therapy (consult local prescribing guidelines, as patterns of resistance vary geographically). Review at four weeks and re-test if symptoms persist. If H pylori persists, prescribe an alternative eradication regimen.

If choosing full dose proton pump inhibitor acid suppression, review at four weeks to discuss effect and stop proton pump inhibitors or decrease to the lowest possible dose that controls symptoms. If the response is incomplete then a further four weeks of treatment could be tried before considering test and treat.

If symptoms remain uncontrolled reconsider diagnosis. Individual patients may respond to H2 antagonists or pro-kinetic
Red flags

- Evidence of gastrointestinal bleeding (change in bowel habit/stool colour, anaemia)
- Unintentional weight loss
- Recurrent vomiting
- Dysphagia
- Abdominal mass

agents but further advice could be sought. Long term use of proton pump inhibitors for recurrent symptoms without red flags is safe, but because of their cost and small associated risk of infectious complications or nutritional deficiencies they should be prescribed at the lowest dose for the shortest period necessary.1

When to refer

In patients younger than 55 presenting with dyspepsia without red flags, routine endoscopy is unnecessary, because the chances of having upper gastrointestinal cancer are estimated at one in a million.1 Refer patients if:

- Red flags present in history or examination
- Older than 55 with new onset persistent dyspepsia despite lifestyle and drug modification and four weeks' treatment
- Younger than 55 and symptoms unresponsive to full dose proton pump inhibitors, H pylori eradication, and lifestyle modifications where concern exists about diagnosis.

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