Management of Dyspepsia in Primary Care and Referral for Endoscopy Surgical Threshold Policy

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

This policy covers

Upper Gastrointestinal (GI) Endoscopy or Gastroscopy - an examination of the upper digestive tract using an endoscope. Dyspepsia is defined broadly to include recurrent epigastric pain, heartburn or acid regurgitation, with or without bloating, nausea or vomiting.

Referring and treating clinicians should ensure compliance with this policy.

Referral proforma MUST be attached to the patient notes as evidence of compliance.

If criteria not met, use the exceptional funding section of the **referral proforma** to apply for funding.

Urgent Dyspepsia

Upper GI for Dyspepsia is funded according to NICE GUIDANCE 12 (Suspected Cancer Recognition and referral [**NG12**]) and when the referral is being made in order for the GP to exclude a diagnosis of cancer.

Use the local Two Week Wait (2ww) forms for patients with dyspepsia if:

The patient has an upper abdominal mass. **OR**

The patient is ≥55 years and has symptoms as described below:

- weight loss with ANY of dyspepsia or upper abdominal pain or reflux;
- nausea OR vomiting and ANY of: dyspepsia or weight loss or reflux upper or abdominal pain;
- upper abdominal pain and low Hb levels;
- raised platelet count with ANY of dyspepsia or nausea or vomiting or weight loss or reflux;
- if ≥55 with treatment-resistant dyspepsia: follow local policy first then refer on **2ww** form.

CCG funding criteria for referral for Non-urgent Dyspepsia for upper GI endoscopy or a specialist opinion in dyspepsia patients without suspicion of cancer in the following circumstances:

Persistent clinically significant symptoms after trial of over-the-counter medications; lifestyle modifications; review of NSAID/other prescribed medications; and NICE-advised proton pump inhibitors (Omeprazole 20mg or Lansoprazole 30mg for at least 4 weeks), *H. pylori* "test and treat", Histamine2 receptor antagonist (H2RA) or higher dose PPI (Proton Pump Inhibitor) for 4 weeks has been completed. **AND**

Blood tests for FBC (full blood count), MCV (mean corpuscular volume), ESR (erythrocyte sedimentation rate), coeliac serology, CRP (c-reactive protein) and LFT (liver function test) as well as tests of ferritin level (if patient presents with dyspepsia and anaemia) and *H. pylori* tests (together with results of eradication therapy), must be available or accessible at the hospital assessment. **AND**

A specialist opinion is required to assess possible underlying pathology and to advise on further management.

See pathway on page 3.

Management of Non-Urgent Dyspepsia in Primary Care

1. Age of the patient:

- Routine endoscopic investigation of patients of any age, presenting with dyspepsia, but without alarm signs, is not necessary.
- Offer older patients (over 80 years of age) the same treatment as younger patients, taking account of any comorbidity and their existing use of medication

2. **Review medication for possible causes of dyspepsia:**
   - calcium antagonist
   - theophyllines
   - steroids
   - nitrates
   - bisphosphonates
   - non-steroidal anti-inflammatory drugs (NSAIDs)
3. **Offer lifestyle advice*:**
   - healthy eating
   - weight reduction
   - smoking cessation
   - promote continued use of antacid/ alginates
   - advise patients to avoid other known precipitants of dyspepsia: coffee, chocolate and fatty foods
   - raising the head of the bed
   - having the main meal well before going to bed may also help

*** Self-care should be promoted where the patient is willing and able in line with the CCG self-care policy and advice.**

4. **Consider alternative diagnoses and treat accordingly:**
   - Irritable bowel syndrome (IBS) or gall stones, particularly in young patients.
   - Ischaemic heart disease.
5. **Treatment with PPI (Proton Pump Inhibitor)** – drugs that reduce the amount of acid made by the stomach**:**
   - Always prescribe generic PPI:
     - Omeprazole 20 mg or Lansoprazole 30 mg are treatment of choice (Lansoprazole-FT is not generic PPI).
     - It is worth remembering that a **second line PPI or** addition of H2RA (H2 Receptor Antagonists**)** could be more useful and could be tried **for one more month** before referral.
   - If symptoms recur following initial treatment, offer a PPI at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.
   - If symptoms are not predominantly of heartburn/reflux you may wish to consider testing for *H. pylori* prior to starting a PPI (see below).
   - It is **not necessary to endoscope patients who require maintenance PPI.**

   Offer patients requiring long-term treatment for dyspepsia an annual review and encourage them to try stepping down to effective lowest dose or stopping treatment and trying as-required use when appropriate; and by returning to self-treatment with antacid or alginate therapy.
6. **Investigation and treatment for *H. pylori*:**
   - *H.* pylori status should not affect the decision to refer for suspected cancer.
   - Prior to testing for *H pylori*, patients should be free from acid suppression medication, including proton pump inhibitors or H2 receptor agonists, for a minimum of 2 weeks
   - NICE recommends the 'test and treat' strategy: test for *H. pylori* and give eradication therapy if positive, but only expect 1:15 patients to make a lasting response.
   - Treat if positive with full-dose PPI and a 7-day twice-daily course consisting of either amoxicillin 1g and clarithromycin 500mg (or metronidazole 400mg) OR if penicillin allergy metronidazole 400mg and clarithromycin 500mg. Go to the **CCG netformulary** for guidance.
   - Seek advice from gastroenterologist if eradication failure with second-line treatment.

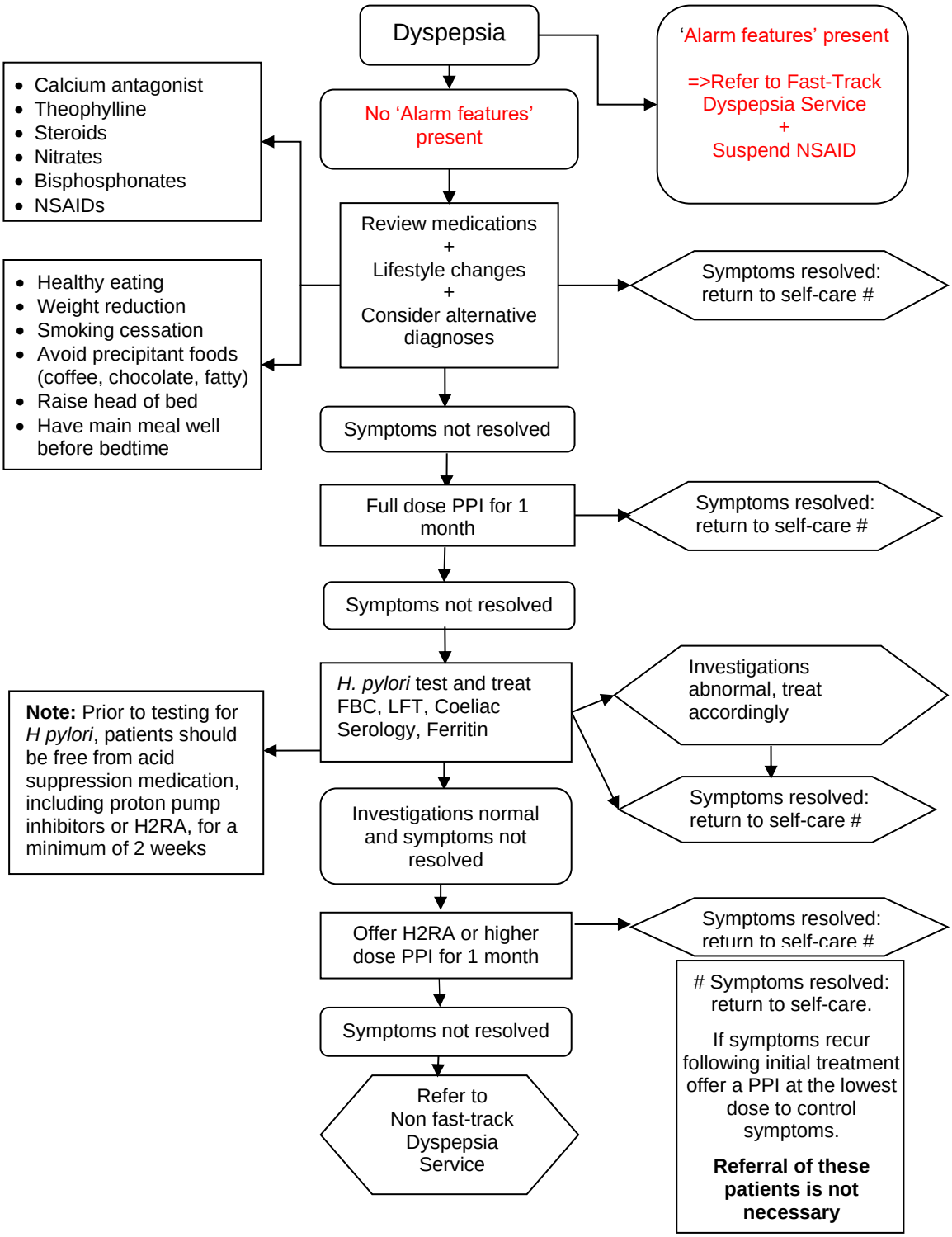
   Non responders and *H. pylori* negative patients can be treated empirically with antacids and acid-suppressing agents– **they do not need endoscopy at this stage**.
7. **Offer** H2RA **if** there is an **inadequate response** to a **PPI for one month.**
8. If the patient is unresponsive to management according to the given pathway, or has atypical symptoms, refer for specialist opinion to the Consultant Gastroenterologist. Please give the relevant clinical details and explain the reasons for referral.

Investigations prior to referral

The following investigations should be done before referral to secondary care for non-urgent presentations. These investigations may help the primary care physicians in the diagnosis:

- Full blood count (Hb haemoglobin), platelets, MCV (mean corpuscular volume) – presence of anaemia or raised platelets may lead to a fast-track referral. Serum Ferritin if anaemic.
- LFTs (liver function tests) – to exclude alternative explanations for the symptoms such as cholelithiasis.
- Coeliac serology – important in all patients with unexplained GI symptoms. Genetic testing or gastroscopy with duodenal biopsy on gluten diet may be required to confirm a diagnosis of Coeliac disease.

Pathway for Management of Dyspepsia in Primary Care



Glossary	
Barium meal:	A radio-opaque white power used in x-ray examinations of the stomach and gastrointestinal tract. The barium meal is swallowed to enable the oesophagus, stomach, and small and large intestines to be assessed for disorders.
Cholelithiasis:	Medical term for gallstone disease.
Endoscope:	A tube-shaped instrument that is flexible and equipped with lenses and a light source that is inserted into a cavity of the body to investigate and treat disorders.
H. pylori:	Helicobacter pylori bacterium present in the stomach cavity of people with peptic ulcers. The ulcers heal if the bacterium is eradicated.
H2 Receptor Antagonists (H2RA):	Drugs that heal gastric and duodenal ulcers by reducing gastric acid output as a result of histamine H2-receptor blockade; they are also used to relieve symptoms of gastro-oesophageal reflux disease.
PPI:	Proton Pump Inhibitor.

Evidence and references to support this policy are available in Part 2 of this policy.