

Dyspepsia



BY

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Dyspepsia

OBJECTIVES

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- **To review some common causes**
- **To review the evidence based management strategies**
- **What to treat & when to refer safely & effectively ??**

DYSPEPSIA

Definition ?

Group of symptoms consisting mostly **upper** abdominal or epigastric pain or discomfort, heartburn, or acid regurgitation.

Often associated with belching, bloating, nausea or vomiting

INTRODUCTION_(cont)

- **Dyspepsia**
- **25% of population / year**
- **Substantial health care cost:**
 - **Medication**
 - **Diagnostic evaluation**
 - **Time cost from work**
- **Out of 100 pts. 90% will be pain free after 2-3 wks without Rx**
- **Definitive established guidelines (NICE)**
- **H.pylori & PUD – well accepted & confirmed**

causes??

FIVE COMMON DIAGNOSIS

- 1. NUD**
- 2. GERD**
- 3. Gastritis**
- 4. Gastritic Ulcer**
- 5. Duodinal Ulcer**

RARE CAUSES

- **Gastric & Esophageal Ca**
- **Others**

Uncommon causes of upper abdominal pain

- **Aerophagy**
- **Biliary colic**
- **Abdominal wall pain**
- **Malignancy**
- **Mesenteric vascular insufficiency**
- **Angina**
- **Metabolic disease**

DRUGS ASSOCIATED WITH DYSPEPSIA

- * NSAID
- * Iron
- * Metformin
- * Codeine
- * Antibiotic
- * Orlistat
- * Corticosteroid
- * Theophyllin

DRUGS ASSOCIATED WITH DYSPEPSIA

***Digoxin**

***Colchicine**

***Alendronate**

***Nitrates**

*** Quinidine**


***Gemfibrozil**

***Ca Antagonist**

FIVE COMMON DIAGNOSIS

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NON-ULCER DYSPEPSIA

- **Most common cause**
- **Younger age group more than later life**
- **Causes ?**
- **GI motility ?**
- **Gastric secretion  normal**
- **Presence of H-Pylori**
- **Incidence decrease with advancing age**

- Pathogenesis:
functional *dyspepsia*

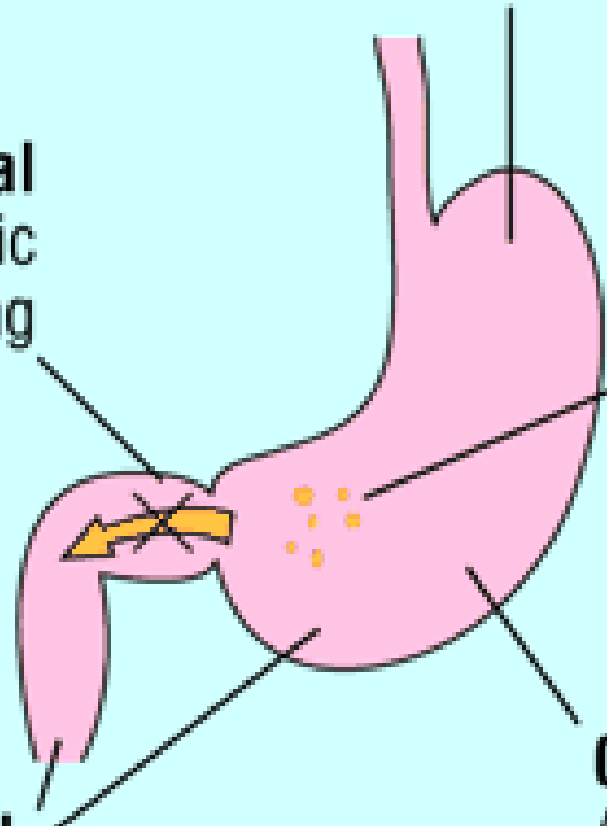
Other conditions
Psychological distress

Functional
Delayed gastric
emptying

Bacterial
H pylori

Mechanical
Altered gastric and
duodenal sensation
(such as to balloon
distension)

Chemical
Acid dysregulation or
mucosal sensitivity
NSAID
Bile



Treatment for functional dyspepsia

Initial treatment :

- Diet , beverages, smoking
- Antisecretory drug (H2RAs, PPI)
- *or*
- Prokinetic drug (domperidone) if antisecretory treatment fails
- Switch treatment if first drug type fails

Treatment for functional dyspepsia

- *Systematic review (98 randomised controlled trials) The Cochrane Library, Issue 1, 2005. :*
- RRR = 48% in the Prokinetics group compared to placebo.
- RRR = 22%; in the H2RAs group
- RRR = 14%; in PPI group
- Antacid & bismuth effects were not statically significant

Treatment for functional dyspepsia(cont)

Resistant cases (failed initial treatment) :

- *H pylori* eradication
- Sucralfate or bismuth
- Antispasmodic agent (such as mebeverine)
- Antidepressant (such as SSRI or tricyclic drug)
- Behavioural therapy or psychotherapy
- No treatment is proved to be fully beneficial in these patients

No of patients still dyspeptic

Study	Treatment	Placebo	Risk ratio (95% CI)	Risk ratio (95% CI)
Blum et al	119/164	130/164		0.92 (0.81 to 1.03)
Koelz et al	67/89	73/92		0.95 (0.81 to 1.11)
McCull et al	121/154	143/154		0.85 (0.77 to 0.93)
Talley et al	101/133	111/142		0.97 (0.85 to 1.11)
Talley et al	81/150	72/143		1.07 (0.86 to 1.34)
Miva et al	33/48	28/37		0.91 (0.70 to 1.18)
Malfertheiner et al	269/460	143/214		0.88 (0.77 to 0.99)
Bruley des Varannes et al	74/129	86/124		0.83 (0.68 to 1.00)
Froehlich et al	31/74	34/70		0.86 (0.60 to 1.24)
Total				0.91 (0.60 to 0.96)

Test for heterogeneity $Q=7.09$, $df=8$, $P=0.53$

$P=0.0002$

- *Systematic review (17 randomised controlled trials) The Cochrane Library, Issue 1, 2005. :*
- **RRR= 8% in the H pylori eradication group (95% CI = 3% to 12%) compared to placebo. NNT to cure one case of dyspepsia = 18**

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GORD

- **Very common**
- **Heartburn , Sharp stabbing substernal pain(probability :89%)**
- **Regurgitation (probability :95%)**
- **At night or after heavy meal**
- **Chronic cough, asthma like wheezing**
- **MI ??**

GORD (Cont'd)

- **Weakness or incompetence of lower esophageal sphincter**
- **Esophagitis, esophageal structure**
- **Barret's esophagus**

Dx & Management of GORD

- **Dx : Hx , PPI test , Endoscopy**
- **Life style modification ??**
- **Medication :**
- **Antacid**
- **Antisecretory drug:**
 - H₂ receptor blocker**
 - * proton pump inhibitor (2months)**
- **Prokinetics**
- **Surgery : Laproscopic fundoplication or open ?**

PUD

- **Less than before**
- **P/H ulcer, recurrence more likely**
- **Risk factors include:**
 - **H-pylori**
 - **Family Hx**
 - **NSAID**
 - **Cigarette smoking**
 - **Chronic renal failure**
 - **Blood group “O”**

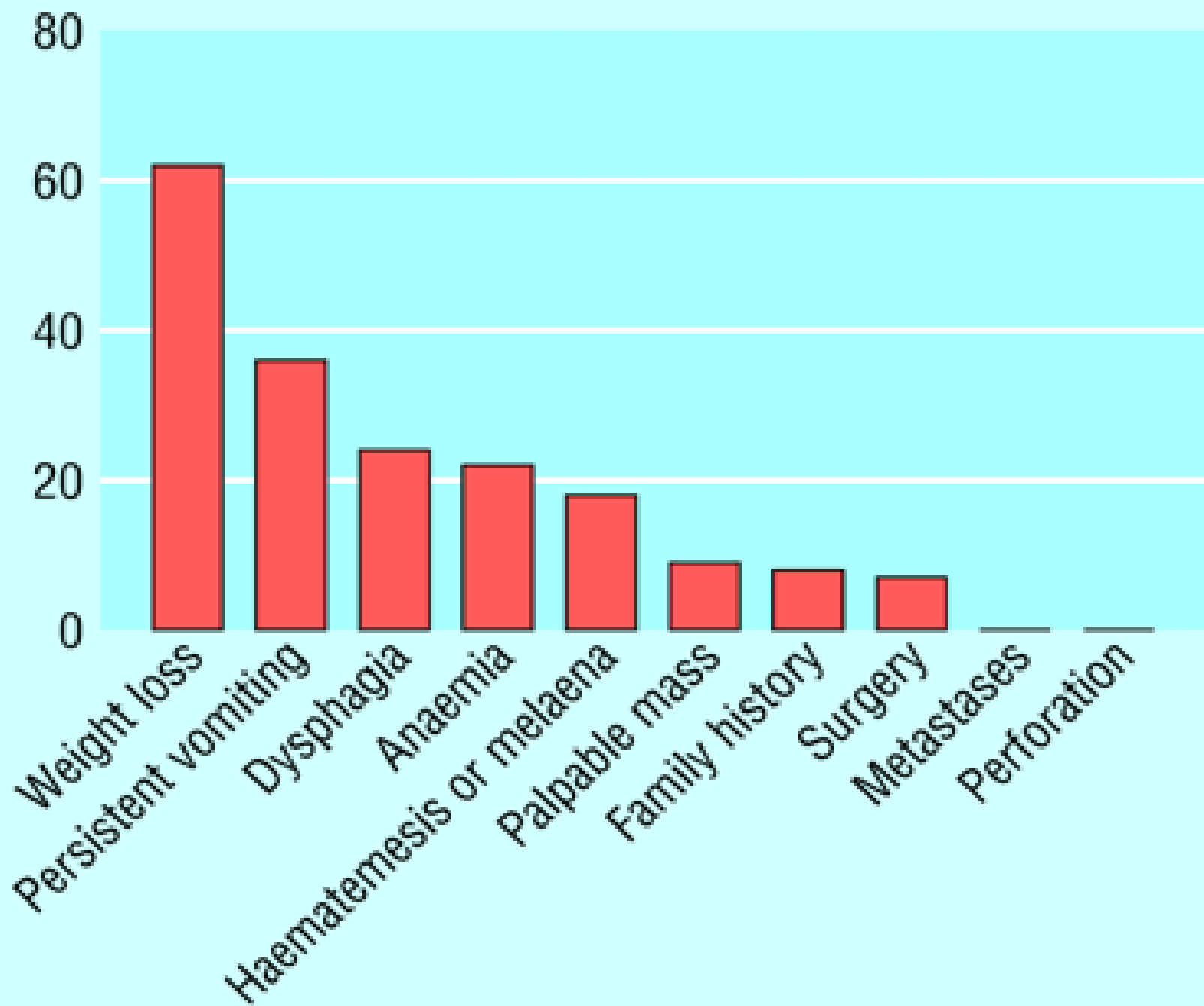
DIAGNOSTIC DIFFICULTIES

- * **Not text book presentation**
- * **Early presentation**
- * **History:**
 1. **ALARM symptoms ??**
 2. **Specific symptoms**
 3. **NUD**
- * **MI ??**
- * **NSAID**
- * **Smoking**

Alarm symptoms

- **Anorexia**
- **Loss of weight (progressive & unintentional)**
- **Anaemia due to iron deficiency**
- **Recent onset of persistent symptoms :vomiting**
- **Melaena, haematemesis**
- **Dysphagia (progressive)**
- **Epigastric mass or**
- **Suspicious barium meal.**

Prevalence of symptoms (%)



Gen.Management

- 1.Management of symptoms in primary care is appropriate for most patients rather than routinely seeking a pathological diagnosis.
- 2.Alarm signals and signs are the major determinant of the need for endoscopy, not age on its own.
- 3.Long term care should emphasize patient empowerment with 'on demand' use of the lowest effective dose PPI.

Gen. Management

- **Simple lifestyle advice:**
 - healthy eating**
 - weight reduction**
 - smoking cessation**
- **Offer empirical antacid, H2A or PPI therapy for one month to patients with dyspepsia.**

H-Pylori

- **Gram –ve flagellated spiral**
- **Casually related to:**
 - **GU**
 - **DU**
 - **Gastritis**
 - **Gastric B – cell lymphoma**
 - **Gastric adenoma**
- **Prevalence - high**
- **More in developing countries**
- **Roughly related to age**
- **Saudi local study 67-89%**

H-Pylori testing

- **Serology**
- **Urea Breath test**
- **Fecal antigen test**
- **Endoscopy**
- **Stript test**

H-PYLORI ERADICATION

H-PYLORI ERADICATION

Benefits :

Cure rate

Recurrence

Bleeding

****All cases of dyspepsia ??**

H-PYLORI ERADICATION

Triple regimen:

**Proton pump inhibitor +
two antibiotics**

ENDOSCOPY

- **Early endoscopy v/s empirical treatment.**
- **Test and endoscopy v/s empirical treatment.**

ENDOSCOPY

- **Age < 55 years, presenting with dyspepsia and without alarm S/S, is not necessary.**
- **Age > 55 years presenting with dyspepsia and without alarm S/S do not require routine endoscopy.**

ENDOSCOPY

Considered if :

1. **ALARM** signals and signs are the major determinant of the need for endoscopy, not age on its own.
2. **No response to medication 7-10 days.**
3. **Symptoms persist after 6-8 wks**
4. **Signs of systemic illness**
5. **Recurrence after treatment**
6. **Long standing GORD**

ENDOSCOPY

Patients undergoing endoscopy should be free from medication with either a PPI or an H2 receptor antagonist for a minimum of two weeks.

Reasons for referral

- **cancer suspected or proven;**
- **diagnostic uncertainty;**
- **treatments not available**
- **failure of treatment, symptoms persisting;**
- **patients' wishes**

Take Home Message



Take home message

1. Aggravating factors :

tobacco, ASA, NSAIDs,
other medications and alcohol

2. Alarm features –

absent **OR present**

Take home message Cont...

A. Alarm features – absent:

Two approaches are acceptable:

1. Test for *H. pylori* infection

2. Empiric Therapy –

A 4-week course a histamine-2 receptor –
antagonist or PPI –

****Failure to respond to treatment justifies
further investigation and/or referral**

Take home message Cont...

B. Alarm features – present:

Endoscopy ± biopsy, referral

Barium may be as an alternative.

3. Life style modification ??



National Institute for
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Quick reference guide

Dyspepsia – management of dyspepsia in adults in primary care

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Adobe Reader

...Dyspepsia New article

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THANKS