key points

SELECTED BY
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NICE recommends immediate referral for patients with dyspepsia and significant acute GI bleeding and urgent specialist referral for investigation if any of the following alarm symptoms are present: progressive difficulty swallowing; chronic GI bleeding; unintentional weight loss; persistent vomiting; abdominal mass; iron deficiency anaemia; suspicious findings on barium meal.

Patients aged >55 with unexplained and persistent dyspepsia, despite *H.pylori* testing and acid suppression therapy, should also be considered for endoscopy, as should those with previous gastric ulcer or surgery, continuing need for NSAIDs or raised risk of gastric cancer.

Patients with uninvestigated dyspepsia should be managed by empirical treatment with a PPI or testing for and treating *H.pylori* if present. Testing by urea breath test, stool antigen test, or locally validated lab-based serology is suggested. *H.pylori* eradication is usually given as triple therapy for seven days involving a PPI, clarithromycin and either amoxicillin or metronidazole.

It is important to take a thorough history and to enquire about any medication the patient is taking. Drugs that are common culprits for dyspepsia include: NSAIDs; calcium antagonists; bisphosphonates; steroids; theophyllines; nitrates. NSAIDs can also cause GI bleeding. Absence of dyspepsia in patients taking NSAIDs does not indicate a reduced risk of bleeding.

Generally uncomplicated duodenal ulcers do not need to be re-examined but gastric ulcers may be associated with malignant lesions. It is common practice to re-examine patients by endoscopy 6-8 weeks after diagnosis. Peptic ulcers fall into three categories: *H.pylori* associated ulcers; drug-induced ulcers (particularly NSAIDs); and ulcers in *H.pylori*-negative patients not taking causative medication. *H.pylori* is associated with both gastric and duodenal ulcer disease but it is in the duodenum where the closest relationship exists.

In any 6-12 month period, 20-40% of healthy people, more commonly men, will experience symptoms of heartburn. Oesophageal reflux can progress to more serious disease such as erosive oesophagitis, stricture or Barrett's oesophagus. Less than half of patients with reflux disease have diagnostic endoscopic findings. Endoscopy should be performed if there are alarm symptoms such as dysphagia or symptoms refractory to treatment.

When patients are investigated for typical dyspepsia symptoms but no cause is found even after endoscopy, the condition is termed functional dyspepsia (non-ulcer dyspepsia). Patients should have *H.pylori* eradicated, when present, followed by symptomatic treatment and monitoring. Functional dyspepsia is more common than dyspepsia caused by organic illness and is the likely diagnosis in younger patients with no alarm features or reflux.