

Management of dyspepsia and of *Helicobacter pylori* infection

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Community management of dyspepsia

- **Scottish SIGN guidelines**
 - Published 2003
- **UK NICE guidelines**
 - Published 2004
- **(UK cancer screening guidelines**
 - Published 2005)

Prevalence and economic importance of dyspepsia

- **Prevalence 25-40 %**, of which
 - 50% self medicate
 - 25% consult their G.P.
- 5% of G.P. consultations are for dyspepsia
- Prescribed drugs and endoscopies cost £600M in 2000
- OTC indigestion remedies sold for £100M in 2002

Main causes of dyspepsia

Diseases outside the upper GI tract

Prevalence UK (endoscopies 1980-2000)

Reflux oesophagitis	12% (rising)
Duodenal ulcer	10% (falling)
Gastric ulcer	6% (falling)
Gastric carcinoma	1% (falling)
Oesophageal carcinoma	0.5% (rising)

Non-erosive GORD

Functional (non-ulcer) dyspepsia

First approach to dyspepsia

- **Consider possible causes outside upper GI tract**
 - Heart, lung, liver, gall bladder, pancreas, bowel
- **Consider drugs and stop if possible**
 - Aspirin/NSAIDs, calcium antagonists, nitrates, theophyllines, etidronate, steroids

Who should be referred for endoscopy ?

- **Those in whom upper GI cancer is a real possibility**

Alarm symptoms/signs (prompting urgent referral)

- **GI bleeding (same day referral)**
- **Persistent vomiting**
- **Weight loss (progressive unintentional)**
- **Dysphagia**
- **Epigastric mass**
- **Anaemia due to possible GI blood loss**

- **Thus all patients with new-onset dyspepsia should have abdominal examination and FBC**

Alarm symptoms/signs (prompting urgent referral)

- **GI bleeding (same day referral)**
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- **Weight loss (progressive unintentional)**
- **Dysphagia**
- **Epigastric mass**
- **Anaemia due to possible GI blood loss**
- **Worsening dyspepsia if known Barrett's oesophagus, gastric atrophy, peptic ulcer surgery >20 years ago**

Refer if dyspepsia in 55+ year old and

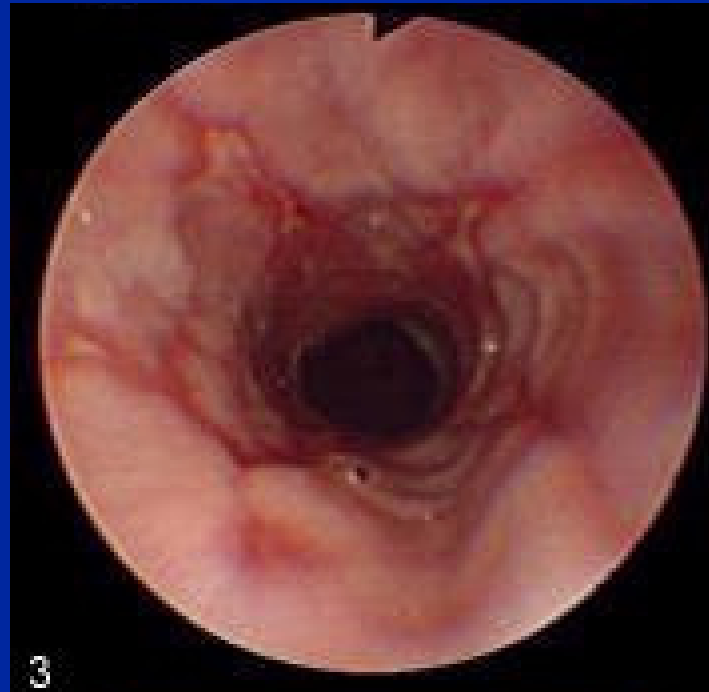
- Alarm symptoms/signs (2 week referral)
- **Unexplained** and **persistent** recent-onset dyspepsia without alarm symptoms
 - **Unexplained** means no cause known (and implies no recent endoscopy)
 - **Persistent** implies present for a length of time (NICE suggest 4-6 weeks)
 - **Recent-onset** implies new – not a recurrent episode

What to do when refer for endoscopy

- **Get maximum information**
 - **Avoid acid suppression if possible – at least for two weeks and preferably for 4 weeks**
 - **If need acid suppression prefer H-2ra to PPI**

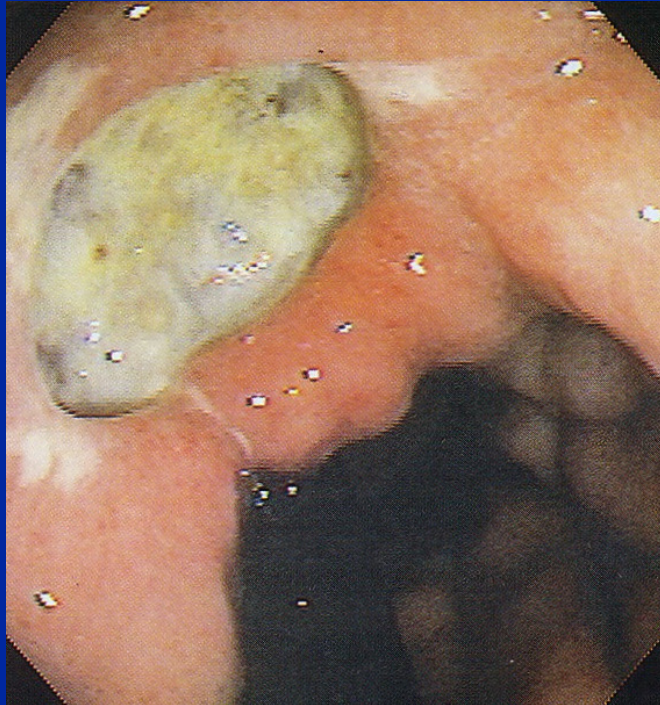
Post-endoscopy, management is easy

Reflux oesophagitis



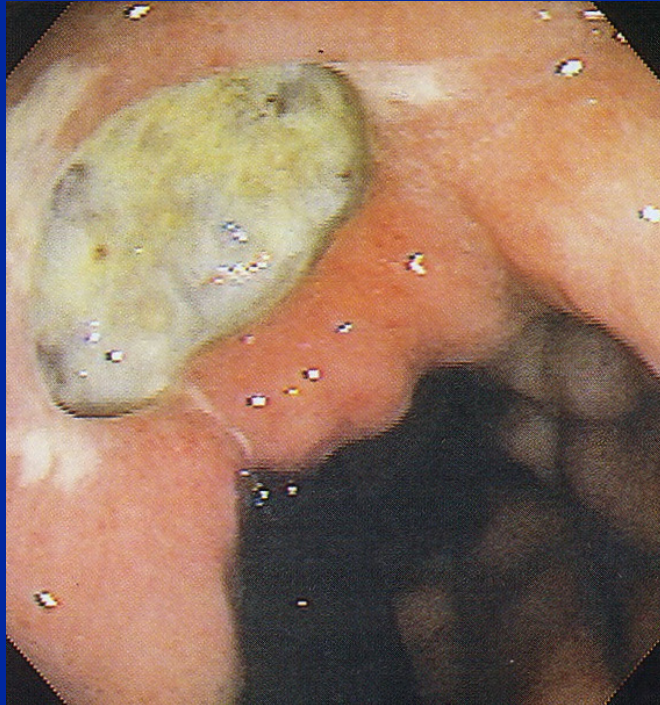
**Action: Proton pump inhibitor and
“step down”**

Gastric or duodenal ulcer



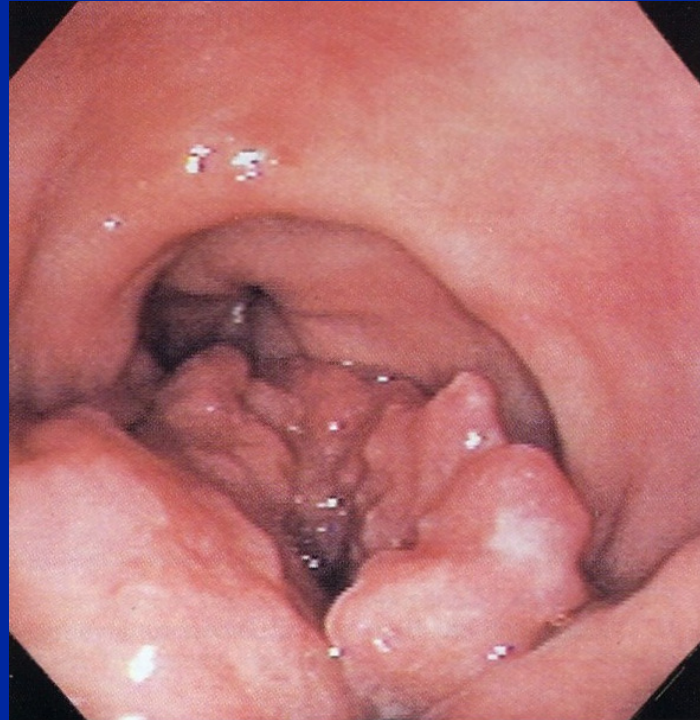
Action: Take biopsies to test for *H. pylori*
Eradicate *H. pylori* if biopsies positive
Cures ulcer and prevents recurrence

Gastric or duodenal ulcer



Action: If *H. pylori* negative or result awaited
Treat with proton pump inhibitor
Stop NSAIDs / aspirin

Gastric adenocarcinoma



Action: Surgery or other appropriate management

Normal endoscopy

- Exclude causes outside upper gastrointestinal tract
- Treat as “Functional dyspepsia”

New approach to community dyspepsia (SIGN and NICE)

- **Manage symptoms rather than make a diagnosis (i.e. treat dyspepsia, not its cause)**
- **Avoid endoscopy for dyspepsia ALONE if <55 years (do if “alarm” symptoms or >55)**
- **Empower patients to manage their own symptoms**

Management of simple dyspepsia in those aged < 55 years

- **Stress benign nature of dyspepsia**
- **Lifestyle advice**
 - **Healthy eating**
 - **Weight reduction**
 - **Stop smoking**
 - **Use of antacids**

Management of simple dyspepsia in those aged < 55 years

Then what next if persistent ?

NICE guideline summary

Refer if “alarm symptoms” at any stage

Test and treat

(Test for *H. pylori* and treat positives)

THEN, IF STILL SYMPTOMATIC

PPI for one month

} **or**
vice
versa

THEN

**Manage recurrent symptoms as
functional dyspepsia**

How to test ?

- **Urea breath test**
 - most accurate but most costly
- **Stool antigen test**
 - Acceptability ?
- **Serology**
 - Near patient tests are inaccurate
 - Best serum-based ELISAs are accurate
 - Advantage of being less affected by PPIs and concurrent antibiotics

How to treat *H. pylori*

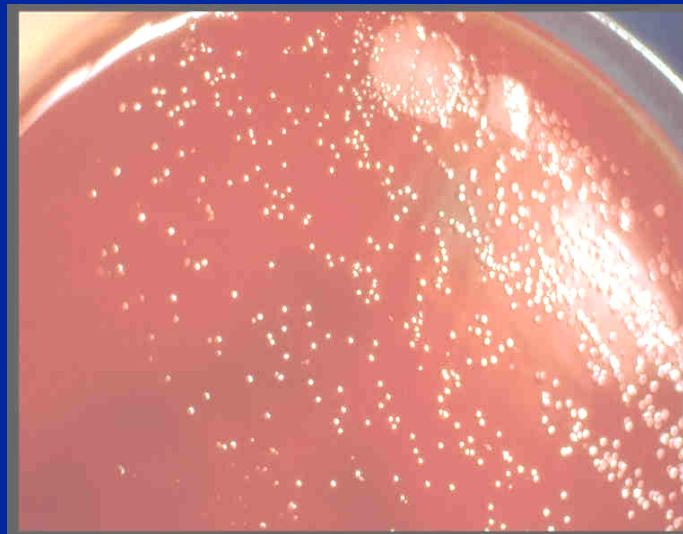
- **One week triple therapy**
 - Full dose PPI bd e.g. omeprazole 20mg bd
 - Clarithromycin 500mg bd
 - Amoxicillin 1g bd
(or Metronidazole 400mg bd)
- **Measures to improve close compliance**
 - Combination packs
 - Patient information on importance and side effects

Second line treatment

- **PPI e.g. omeprazole 20mg bd**
- **DeNol (bismuth subcitrate) i qds**
- **Tetracycline HCl 500mg qds**
- **Metronidazole 400mg tds**

Third line treatment

- Referral to John Atherton
- Usually endoscopy + *H. pylori* culture/abio sens
- Treat according to sensitivities



Retesting after treatment

- Usually unnecessary if treatment for uninvestigated dyspepsia
- If needed, do urea breath test or stool antigen test **NOT SEROLOGY**
 - Avoid antibiotics and bismuth for 4 weeks and PPIs for 2-4 weeks before test

NICE guideline summary

Refer if “alarm symptoms” at any stage

Test and treat
(Test for *H. pylori* and treat positives)
THEN, IF STILL SYMPTOMATIC
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} or
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THEN

**Manage recurrent symptoms as
functional dyspepsia**

Management of functional dyspepsia

- Reassurance and explanation
- Lifestyle advice
- *H. pylori* testing and eradication ?
- Acid suppression ?
- Prokinetics ?
- Cytoprotectives ?
- Anti-depressants ?

Management of aspirin/NSAID -associated dyspepsia

- Reduce problem by rational prescribing
- Consider testing for and treating *H. pylori* in patients likely to need recurrent courses of potent NSAIDS
 - Prevents ulcers (7% vs 26%) and probably symptomatic ulcers (2% vs 13%) where no previous dyspepsia

Chan, Lancet 1997;350:975

Management of aspirin/NSAID -associated dyspepsia

- Reduce problem by rational prescribing
- Consider testing for and treating *H. pylori* in patients likely to need recurrent courses of potent NSAIDS
 - Prevents complicated ulcers (4% vs 27%) in patients with previous dyspepsia.....**but PPIs better**

Management of aspirin/NSAID -associated dyspepsia

If dyspepsia (or ulcer)

- Stop drug (endoscopy if alarm symptoms)
- Treat with PPI, not immediate *H. pylori* eradication
- Test for and treat *H. pylori* if likely to need recurrent NSAIDs or continuous aspirin
- Reduce relapse with future NSAIDs/aspirin by co-prescribing a PPI

Should we treat *H. pylori* in patients on long term PPIs ?

- *H. pylori* treatment slows development of atrophy and intestinal metaplasia
- No evidence that *H. pylori* treatment prevents gastric cancer in this group.
- PPIs are more effective in some people if *H. pylori* positive
- Treatment can have side effects
- **Risk-benefit too unclear to recommend treatment in all**

Dyspepsia management - summary

Endoscopy-guided approach

- Needed **ONLY** if “alarm” symptoms or unexplained, persistent, recent-onset dyspepsia in patients **55+ years**

Simple dyspepsia in < 55 year old – Two options

1. Test and treat approach

- Equivalent or better for simple dyspepsia in the community
- Less costly
- Most clearcut benefit where *H. pylori* prevalence high

Simple dyspepsia in < 55 year old – Two options

2. PPI course approach

- May be best where prevalence of *H. pylori* is low
- This will include younger patients

Simple dyspepsia in < 55 year old

- Try both options
- If continuing symptoms – reassure
 - Manage as functional dyspepsia
- Re-assess on yearly basis
- Referral always an option if inadequate response to therapy or if you are worried

Further reading

- **NICE guidelines on Managing dyspepsia in adults in primary care at**
<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10950>
- **Mason JM, Delaney B, Moayyedi P, Thomas M, Walt R. Managing dyspepsia without alarm signs in primary care: new national guidance for England and Wales. Aliment Pharmacol Therap 2005;21:1135-43**
- **Malfertheiner P and the European Helicobacter study group. Current concepts in the management of *Helicobacter pylori* infection: the Maastricht III consensus report. Gut 2007;56:772-781**