MANAGEMENT OF FUNCTIONAL DYSPEPSIA

☑	A working diagnosis of functional dyspepsia is likely to be appropriate for most patients with dyspepsia who have no alarm features and in whom initial investigations are negative. Repeated or increasingly invasive investigation in pursuit of an organic cause for the symptoms may be both futile and counter-productive.
☑	Patients with functional dyspepsia should be advised to stop smoking, and to exclude, or take only moderate amounts of alcohol and caffeine, in line with general healthy lifestyle recommendations.
☑	If patients have adopted extreme dietary measures, they should be encouraged to follow a balanced diet to minimise the risk of nutritional deficiencies.
☑	Medication is not necessary for all patients with functional dyspepsia. When medication is given, short term treatment, intermittent if necessary, is likely to be more appropriate than long term continuous therapy.
A	**_Hp_ eradication therapy should be considered in the management of functional dyspepsia.**
B	**A trial of acid suppression therapy may be considered in the management of functional dyspepsia.**

It is not possible to make a recommendation on the role of antidepressants, cytoprotectives, prokinetics or psychosocial interventions in the management of functional dyspepsia.

HP TESTS

B	**The CUBT or faecal antigen tests are recommended for the pre-treatment diagnosis of _Hp_ infection in the community. Less accurate, hospital-based serology tests have a place within the non-invasive test and treat strategy.**
B	**CUBT is the recommended test to determine whether _Hp_ has been successfully eradicated.**
☑	The CUBT should not be performed within two weeks of PPI therapy or within four weeks of antibiotic therapy as false negative results may occur.

HP ERADICATION OPTIONS

- Triple therapies including PPIs and two antibiotics give consistently high eradication rates
- Metronidazole or clarithyromycin resistance established by laboratory testing is associated with reduced eradication of Hp by regimes including these antibiotics
- Two weeks of triple therapy versus a one week regimen does not increase the eradication rate.

RESOURCES FOR PATIENTS

A patient version of the guideline and a patient information leaflet are available from the SIGN website: **www.sign.ac.uk**

ABBREVIATIONS

CUBT	^{13}C and ^{14}C urea breath tests
H_2RA	Histamine receptor antagonists
Hp	*H. Pylori*
PPI	Proton Pump Inhibitor

The Scottish Intercollegiate Guidelines Network (SIGN) supports improvement in the quality of health care for patients in Scotland by developing national clinical guidelines containing recommendations for effective practice based on current evidence.

The recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations and their application in practice can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

This guideline was issued in 2003 and will be considered for review as new evidence becomes available.

For more information about the SIGN programme, contact the SIGN Executive or see the website.

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Quick Reference Guide

SIGN

This Quick Reference Guide provides a summary of the main recommendations in the SIGN dyspepsia guideline. It **specifically** addresses the investigation and management of dyspepsia and also updates the evidence base for *Hp* eradication in duodenal ulcer, gastric ulcer and low grade gastric MALT lymphoma. Dyspepsia denotes symptoms and is not itself a disease. The guideline development group accepted the Rome II definition: ***Dyspepsia refers to pain or discomfort centred in the upper abdomen.*** On investigation, organic disease likely to explain the dyspepsia will be found in some patients, in others, no causal pathology/disease is identified: these patients are said to have ***functional dyspepsia***.

DYSPEPSIA IN THE COMMUNITY

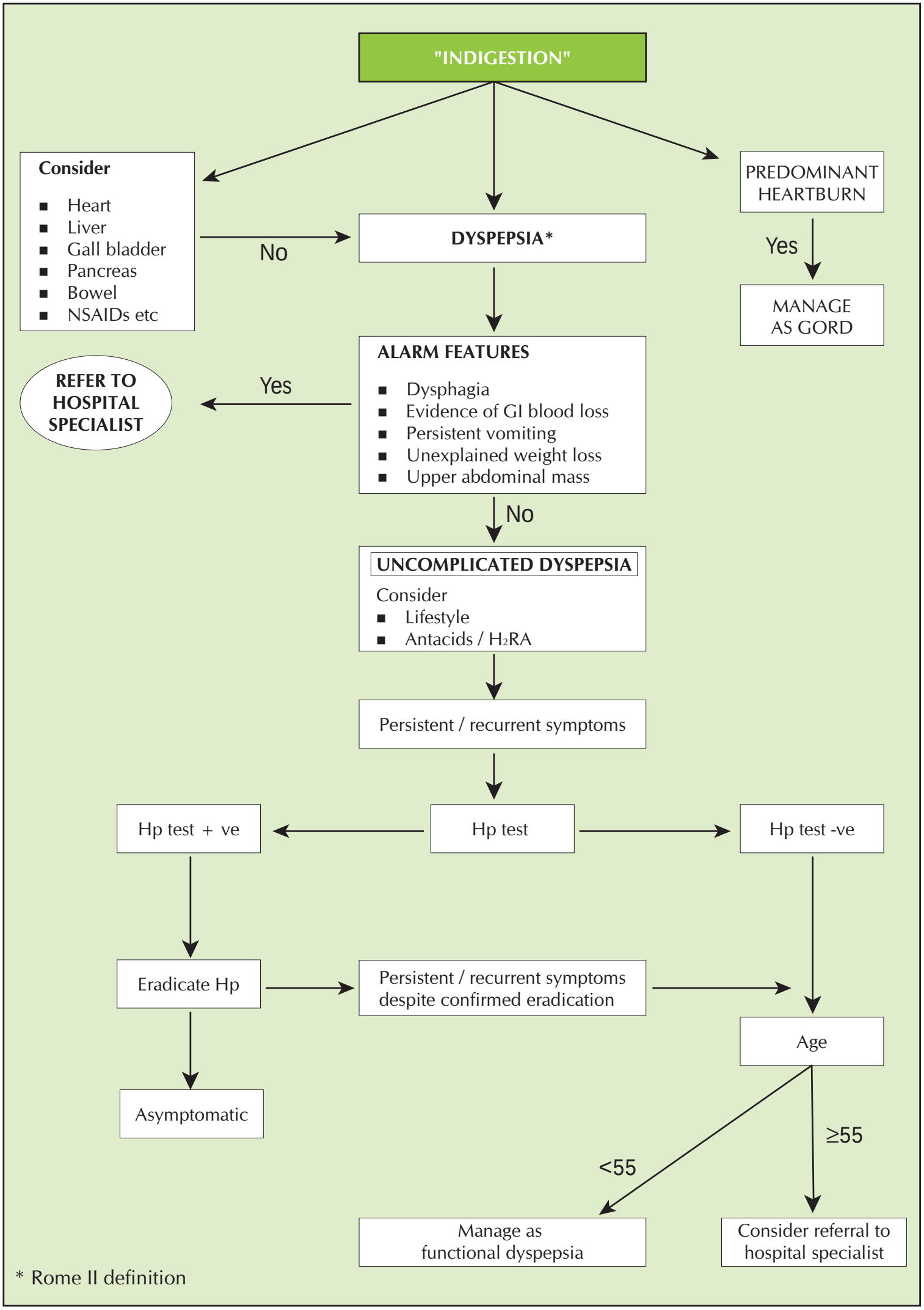
People with dyspepsia may choose several routes for the initial management of the condition. Some people purchase antacids or H_2RA medicines over the counter, some consult with a community pharmacist and others will consult their general practitioner.

D	**Community pharmacists should advise patients suffering from dyspepsia associated with alarm symptoms to consult their GP.**
C	**Symptom assessment cannot be relied upon to make a diagnosis of the cause of dyspepsia.**
B	**Patients with dyspepsia and alarm features should be referred to a hospital specialist for assessment.**
C	**Upper GI endoscopy is the investigation of choice when further evaluation is warrented and should be widely available.**
☑	Barium meal studies are appropriate where the local endoscopy services are unavailable or for patients who cannot tolerate endoscopy.

There is no evidence to support the mandatory use of early upper GI endoscopy to investigate patients over 55 years old who present with new onset uncomplicated dyspepsia.

MANAGEMENT OF UNCOMPLICATED DYSPEPSIA

A	**A non-invasive _Hp_ test and treat strategy is as effective as endoscopy in the initial management of patients with uncomplicated dyspepsia who are less than 55 years old.**
C	**A non-invasive _Hp_ test and treat policy may be as appropriate as early endoscopy for the _initial_ investigation and management of patients over the age of 55 years presenting with uncomplicated dyspepsia.**
☑	Referral for assessment should be considered for patients over 55 years old with uncomplicated dyspepsia whose symptoms persist after initial management with the *Hp* test and treat strategy.



* Rome II definition