





Dyspepsia Pathway and Referral Proforma for open access upper GI endoscopy

Attach referral to Choose & Book referral, or Fax to relevant Endoscopy Unit:

 NNUH (Colney) 01603 288304	 QEH (Kings Lynn) 01553 613227
 GPSI (Dersingham) St Nicholas Endoscopy 01553 692181	
 Prime Diagnostic (Thetford) 01842 767624	



Request for endoscopy may be declined unless ONE of the shaded boxes is ticked

Dyspepsia	Epigastric pain Heartburn Nausea Vomiting
Yes	

Name: _____
 Address: _____
 Date of Birth: _____
 NHS No. _____
 (or affix Hospital label here)

Alarm Symptoms • Chronic GI bleeding, • Progressive un-intentional weight loss • Progressive difficulty swallowing • Persistent vomiting • Iron deficiency anaemia • Epigastric mass • Suspicious barium meal	Yes
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Urgent: 2 week rule referral
**** Immediate:** same day referral:
 indicated for significant acute gastrointestinal bleeding.

Hospital No. _____
 Tel Home: _____
 Tel Work: _____
 GP: _____
 Address: _____
 Tel: _____
 Referral Date _____

Over 55 years old ¹	Yes
No	

Unexplained or persistent recent onset dyspepsia ²

Yes

Reflux symptoms
(any age group) ³

If on NSAID do these need to be continued?	Yes <input type="checkbox"/>
No	

Refer for Endoscopy ⁹

Review medication ⁴	Responds to the review
No response	

Review Lifestyle ⁵	Responds to life style advice
No Response	

Test for H Pylori, ⁶ Treat if positive	Responds to treatment
No Response	

Try generic PPI, H ₂ RA and/or Prokinetic ⁷	Responds to treatment
No Response	

Manage in Primary Care

Request for Endoscopy if no response to any of the above or Outside of guidelines ⁸	Yes <input type="checkbox"/>
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Refer for Endoscopy ⁹

Other medical problems	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Oral hypoglycaemics	<input type="checkbox"/>	<input type="checkbox"/>
Ischaemic Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic valve	<input type="checkbox"/>	<input type="checkbox"/>
Previous endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
Warfarin	<input type="checkbox"/>	<input type="checkbox"/>
Symptomatic chest disease	<input type="checkbox"/>	<input type="checkbox"/>
COPD / Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Poor mobility	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Specify 'other': _____

Medication: _____

GUIDANCE AND EXPLANATIONS

1. 55 is an acceptable age threshold to use for patients with new dyspeptic symptoms. An endoscopy for patients aged <55 without alarm symptoms does not influence outcome and it is more expensive than just treating the symptoms.
2. Unexplained = symptoms or signs that have not led to a diagnosis after initial assessment and primary care investigations. Persistent = continuation of symptoms and signs beyond a period associated with self-limiting problems. The upper limit should be 4-6 weeks. It should be a new rather than a recurrent episode.
3. Patients aged >55 with typical reflux symptoms do not require an endoscopy.
4. Review medications for possible causes of dyspepsia, e.g. calcium antagonists, nitrates, theophyllines, biphosphonates, steroids and NSAIDs. Also review antacid or alginate therapy. It is NOT necessary to test for helicobacter when there are clear reflux symptoms responding to therapy.
5. Offer lifestyle advice, including advice on healthy eating, weight reduction and smoking cessation, promoting continued use of antacid/alginate. Advise patients to avoid other known precipitants of dyspepsia – coffee, chocolate and fatty foods. Raising the head of the bed and having the main meal well before going to bed may also help.
6. For patients without clear reflux symptoms NICE recommends the test and treat strategy: Test for helicobacter and give eradication therapy if positive, but only expect 1:15 patients to make a lasting response. For H. pylori detection continue to use the serology test in Central Norfolk. West Norfolk has introduced the stool antigen test. Treat if positive with a 7-day twice-daily course consisting of a full-dose PPI, with either Metronidazole 400 mg and Clarithromycin 250 mg or Amoxicillin 1 g and Clarithromycin 500 mg. Do not retest after treatment even if dyspepsia remains unless there is strong clinical need. Non-responders and helicobacter negative patients can be treated empirically with antacids, acid suppressing agents and prokinetics – they do not need an endoscopy.
7. There is currently inadequate evidence to guide whether full dose PPI for 1 month or H. pylori test should be offered first. Either treatment may be tried first with the other being offered where symptoms persist or return. It is NOT necessary to endoscope patients who require maintenance PPI. Always prescribe generic PPI; Lansoprazole capsules are treatment of choice (Lansoprazole-FT is not a generic PPI). Offer H2 RA or prokinetic therapy if there is an inadequate response to a PPI after 1 month. It is worth remembering that a second line PPI could be more useful and should be tried for one 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. 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.
8. It would be worthwhile emphasising the consideration of alternative diagnoses in the younger patient. E.g. consider irritable bowel or gall stones, particularly in younger patients. Then consider referral for endoscopy if there has been no response to lifestyle advice, Test and Treat strategy for H. pylori and PPI/H2RA/Prokinetic treatment. Please give the relevant clinical details and explain the reasons for referral.
9. Patients undergoing endoscopy should be free from medication with either a proton pump inhibitor (PPI) or an H2 receptor antagonist (H2RA) for a minimum of 2 weeks.