**Dyspepsia Pathway and Referral Proforma for open access upper GI endoscopy**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Attach referral to Choose & Book referral, or Fax to relevant Endoscopy Unit: | | | | | | | | | | | | | | | | | | nhsnw_logo_55 | | | | |
| NNUH (Colney) 01603 288304 | | | | | | | | | | QEH (Kings Lynn) 01553 613227 | | | | | | | |  | | | | |
| cab2 GPSI (Dersingham) St Nicholas Endoscopy 01553 692181 | | | | | | | | | | | | | | | | | |  | | | | |
| cab3 Prime Diagnostic (Thetford) 01842 767624 | | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | |
| **Request for endoscopy may be declined** | | | | | | | | | Name: | | | |  | | | | | | | | |
| **unless ONE of the shaded boxes is ticked** | | | | | | | | | Address: | | | |  | | | | | | | | |
| **Dyspepsia** | Epigastric pain  Heartburn  Nausea  Vomiting | | | | |  | | |  | | | |  | | | | | | | | |
| Yes |  | | | | |  | | | Date of Birth: | | | |  | | | | | | | | |
|  | | | | | | | | | NHS No. | | | |  | | | | | | | | |
| Alarm Symptoms • Chronic GI bleeding,  • Progressive un-intentional  weight loss  • Progressive difficulty  swallowing  • Persistent vomiting  • Iron deficiency anaemia  • Epigastric mass  • Suspicious barium meal | | | Yes |  | | | | | (or affix Hospital label here) | | | | | | | | | | | | |
|  | | |  |  | | |  | | | | | | | |  | Hospital No. |  | | | | |
|  | | |  |  | | | **Urgent**: 2 week rule referral  **\*\* Immediate:** same day referral: indicated for significant acute gastrointestinal bleeding. | | | | | | | |  | Tel Home: |  | | | | |
|  | | |  |  | | |  | | | | | | | |  | Tel Work: |  | | | | |
|  | | |  |  | | |  | | | | | | | |  | GP: |  | | | | |
|  | | |  |  | | |  | | | | | | | |  | Address: |  | | | | |
|  | | | |  | | |  | | | | | | |  | | Tel: |  | | | | |
| Over 55 years old 1 | | | Yes |  | | | Unexplained or persistent recent onset dyspepsia **2** | | | | | | |  | | Referral Date |  | | | | |
|  | | |  |  | | |  | | | | | | |  | |  |  | | | | |
| No | | |  |  | | |  | | | | | | |  | | **Other medical problems** | | | **Yes** | | **No** |
|  | |  | |  | | | | **Yes** | | | | | |  | | Diabetes | | | |  |  |
| **Reflux symptoms** (any age group) **3** | |  | |  | | | |  | | | | | |  | | Insulin | | | |  |  |
|  | |  | |  | | | |  | | | | | |  | | Oral hypoglycaemics | | | |  |  |
|  | | | | | | | | | | | | | | | | Ischaemic Heart disease | | | |  |  |
| If on NSAID do these need to be continued? | | Yes | |  | | | | **Refer for Endoscopy 9** | | | | | |  | | Prosthetic valve | | | |  |  |
|  | |  | |  | | | |  | | | | | |  | | Previous endocarditis | | | |  |  |
| No | |  | |  | | | |  | | | | | |  | | Warfarin | | | |  |  |
|  | |  | |  | | | |  | | | | | |  | | Symptomatic chest disease | | | |  |  |
| Review medication4 | | Responds to thereview | | | | | |  | | | |  | |  | | COPD / Asthma | | | |  |  |
| No response | |  | | | | | |  | | | |  | |  | | Poor mobility | | | |  |  |
|  | |  | |  | | | |  | | | |  | |  | | Other | | | |  |  |
| Review Lifestyle **5** | | Responds to life style advice | | | | | |  | | |  |  | |  | | Specify ‘other’: | | | | | |
| No Response | |  | | | | | |  | | |  |  | |  | |  | | | | | |
|  | |  | | | | | |  | | |  |  | |  | |  | | | | | |
| Test for H Pylori, 6  Treat if positive | | Responds to  treatment | | | | | |  | | |  |  | |  | | **Medication:** | | | | | |
|  | |  | | | | | |  | | |  |  | |  | |  | | | | | |
| No Response | |  | | | | | |  | | |  |  | |  | |  | | | | | |
|  | |  | | | | | |  | | |  | | |  | |  | | | | | |
| Try generic PPI, H2RA and/or Prokinetic 7 | | Responds to treatment | | | | | |  | | | **Manage in Primary Care** | | |  | |  | | | | | |
|  | |  | | | | | |  | | |  | | |  | |  | | | | | |
| No Response | |  | | | | | |  | | |  | | |  | |  | | | | | |
|  | |  | | |  | | | | | |  | | |  | |  | | | | | |
| Request for Endoscopy if no response to any of the above orOutside of guidelines 8 | | **Yes** | | |  | | | | | | **Refer for Endoscopy 9** | | |  | |  | | | | | |

**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/alginates. 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 Amoxycillin 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.