Surgical Threshold Policy

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Management of Dyspepsia in Primary Care and Referral for Endoscopy

Definition

Upper Gastrointestinal Endoscopy or Gastroscopy is an examination of the upper digestive tract using an endoscope. Dyspepsia is defined broadly to include recurrent epigastric pain, heartburn or acid regurgitation, with or without bloating, nausea or vomiting.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid clinical audit and evidence compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma*: Click* **policies** *– select the Endoscopy Policies drop down option and select the Management of Dyspepsia… Policy to access the referral proforma.*

1. Urgent (two week wait fast track) with upper GI Symptoms

The CCG will fund fast track (two week wait) referral for upper GI endoscopy in dyspepsia as per NICE Cancer Guidance NG12 NICE Upper GI Cancer Referral Guidance, and when the referral is being made in order for the GP to exclude a diagnosis of cancer.

2. Non-urgent Dyspepsia

The CCG will fund **non-urgent** referral for upper GI endoscopy or a specialist opinion in dyspepsia patients without suspicion of cancer in the following circumstances:

- Persistent clinically significant symptoms after trial of over-the-counter medications; lifestyle modifications; review of NSAID/other prescribed medications; and NICE-advised proton pump inhibitors (Omeprazole 20mg or Lansoprazole 30mg for at least 4 weeks), H Pylori "test and treat", Histamine2 receptor antagonist (H2RA) or higher dose PPI for 4 weeks has been completed.

  AND

- Blood tests for Hb, MCV, ESR, coeliac serology, CRP and LFT as well as tests of ferritin level (if patient presents with dyspepsia and anaemia) and H pylori tests (together with results of eradication therapy), must be available or accessible at the hospital assessment.

  AND

- A specialist opinion is required to assess possible underlying pathology and to advise on further management.

See pathway on page 3

Management of Non-Urgent Dyspepsia in Primary Care

1. **Age of the patient:**
   - Routine endoscopic investigation of patients of any age, presenting with dyspepsia, but without alarm signs, is not necessary.
   - Offer older patients (over 80 years of age) the same treatment as younger patients, taking account of any comorbidity and their existing use of medication.

2. **Review medications for possible causes of dyspepsia:**
   - calcium antagonist
   - theophyllines
   - steroids
   - nitrates
   - bisphosphonates
   - non-steroidal anti-inflammatory drugs (NSAIDs)

3. **Offer lifestyle advice:**

- healthy eating
- weight reduction
- smoking cessation
- promote 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
- having the main meal well before going to bed may also help

4. **Consider alternative diagnoses and treat accordingly:**
   - Irritable bowel syndrome or gall stones, particularly in young patients.
   - Ischaemic heart disease.

5 **Treatment with PPI (Proton Pump Inhibitor)** – drugs that reduce the amount of acid made by the stomach**:**

- Always prescribe generic PPI:
  - Omeprazole 20 mg or Lansoprazole 30 mg are treatment of choice (Lansoprazole-FT is not generic PPI).
  - It is worth remembering that a **second line PPI or** addition of H2RA could be more useful and could be tried **for one more 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.
- It is **not necessary to endoscope patients who require maintenance PPI.**

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.

6. **Investigation and treatment for *H. pylori*:**
   - *H. pylori* status should not affect the decision to refer for suspected cancer.
   - Prior to testing for H pylori, patients should be free from acid suppression medication, including proton pump inhibitors or H2 receptor agonists, for a minimum of 2 weeks
   - NICE recommends the 'test and treat' strategy: test for *H. pylori* and give eradication therapy if positive, but only expect 1:15 patients to make a lasting response.
   - Treat if positive with full-dose PPI and a 7-day twice-daily course consisting of either metronidazole 400mg and clarithromycin 250mg; or amoxcycillin 1g and clarithromycin 500mg. Click here for formulary for details and second-line treatment options
   - Seek advice from gastroenterologist if eradication failure with second-line treatment.

Non responders and *H. pylori* negative patients can be treated empirically with antacids and acid-suppressing agents– **they do not need endoscopy at this stage**.

7. **Offer** H2RA (histamine 2 receptor antagonist) **if** there is an **inadequate response** to a **PPI for one month.**

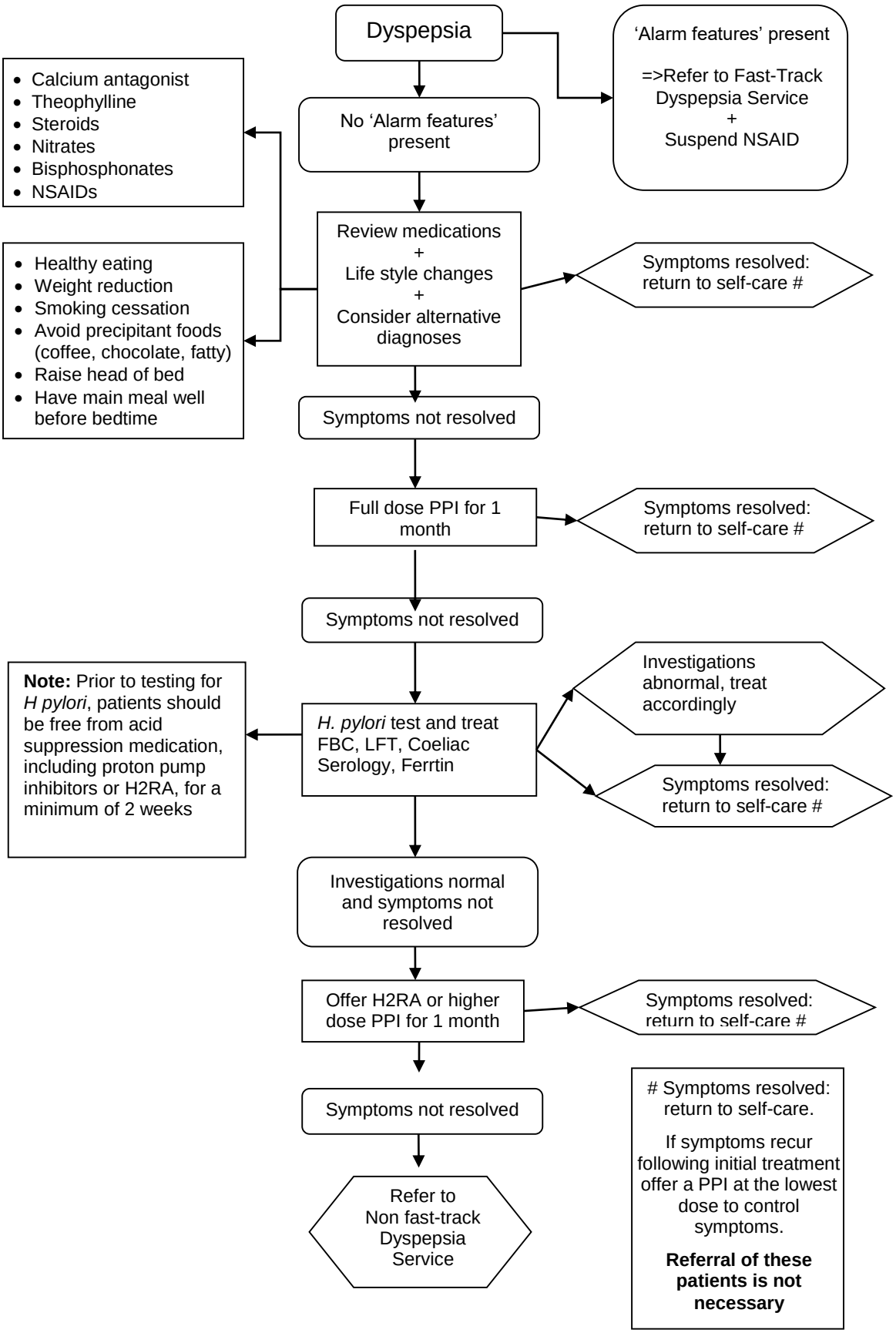
8. If the patient is unresponsive to management according to the given pathway, or has atypical symptoms, refer for specialist opinion to the Consultant Gastroenterologist. Please give the relevant clinical details and explain the reasons for referral.

Investigations prior to referral

The following investigations should be done before referral to secondary care for non-urgent presentations. These investigations may help the primary care physicians in the diagnosis:

- Full blood count (Hb, MCV) – presence of anaemia would lead to a fast-track referral. Serum Ferritin if anaemic.
- LFTs – to exclude alternative explanations for the symptoms such as cholelithiasis.
- Coeliac serology – important in all patients with unexplained GI symptoms. Genetic testing or gastroscopy with duodenal biopsy on gluten diet may be required to confirm a diagnosis of Coeliac disease.

Pathway for Management of Dyspepsia in Primary Care



***PLEASE NOTE THIS REFERRAL WILL RESULT IN GASTROSCOPY.**
IT IS THE RESPONSIBILITY OF THE REFERRER TO SURE THAT THE PROFORMAS ARE COMPLETE AND MEET THE GUIDELINES

Rationale

Dyspepsia is a common condition affecting approximately **40%** of the population annually, but only a very few people are likely to have significant morbidity such as gastric cancer. It is, therefore, neither practical nor desirable to refer patients routinely for endoscopic investigation. NICE commissioning tool recommends an annual benchmark endoscopy rate of 0.75%.

Although clinical evidence shows that symptoms of gastric cancer may be non-specific, and that alarm symptoms do not predict cancer as accurately as would be desired, at the present time, there are no available methods of testing in primary care that would give a greater sensitivity and specificity in identifying potential pathology.

The rationale for the CCG policy on indications for funding of endoscopy, therefore, remains as set out by NICE in its advice on the potential benefits of commissioning an effective service for upper GI endoscopy which is as follows:

- effective management of patients with dyspepsia in primary care, in line with NICE guidance on dyspepsia CG184, to ensure that patients receive the most appropriate and effective treatments, and that endoscopies are carried out only when necessary;
- referral for endoscopy is prioritised, especially for those with alarm symptoms detailed in NICE guidance on referral for suspected cancer NG12;
- reduction in unnecessary referrals – there is a small risk following upper GI endoscopy: in the UK one in 200 patients experience adverse events and the risk of mortality is one in 2000. However, the mortality for ambulatory patients attending an outpatient endoscopy service is much lower;
- optimising availability of endoscopy resources for appropriate cases;
- helping GP practices to manage their commissioning budgets more effectively – this may include opportunities to undertake local service redesign to meet local requirements.

Evidence

The evidence was obtained from NICE guidance CG184 and NG12.

References

1. NICE CG184 (September 2014), *Dyspepsia and gastro-oesophageal reflux disease* http://www.nice.org.uk/guidance/cg184
2. NICE NG12 Suspected cancer: recognition and referral. Published June 2015: https://www.nice.org.uk/guidance/ng12/resources/suspected-cancer-recognition-and-referral-1837268071621

Glossary

Barium meal:	A radio-opaque white power used in x-ray examinations of the stomach and gastrointestinal tract. The barium meal is swallowed to enable the oesophagus, stomach, and small and large intestines to be assessed for disorders.
Endoscope:	A tube shaped instrument that is flexible and equipped with lenses and a light source that is inserted into a cavity of the body to investigate and treat disorders.
H. pylori:	Helicobacter pylori bacterium present in the stomach cavity of people with peptic ulcers. The ulcers heal if the bacterium is eradicated.
H2 Receptor Antagonists (H2RA)	Drugs that heal gastric and duodenal ulcers by reducing gastric acid output as a result of histamine H2-receptor blockade; they are also used to relieve symptoms of gastro-oesophageal reflux disease.
PPI:	Proton Pump Inhibitor.

Policy effective from/ developed:	Reviewed policy endorsed by CCG Governing Body on 6 March 2018 Reviewed policy approved by CEC on 13 February 2018 Reviewed policy approved by CPF on 9 January 2018 Policy adopted by CCG 1 April 2013 Effective from March 2018
Policy to be reviewed:	March 2020
Reference:	*R:\CPF Pols & working Area\Surg Threshold Pols - Draft and Agreed\CCG Policies\ENDOSCOPY\agreed\ UPPER GI ENDOSCPY MARCH 2018 V7*