Suggested management pathway: upper GI symptoms

Any age: Dysphagia*

Age >55*: with weight loss plus another upper GI symptom

Age >40:* with jaundice **or** upper abdominal mass **or** **Age >60:** with weight loss and any of:

- Abdominal pain
- Diarrhoea or constipation
- New diabetes
- Nausea or vomiting
- Back pain

Age >55: with dyspepsia or upper GI pain or heartburn **and** one of nausea, vomiting or raised platelets.

Any age: Haematemesis: stable patient **

Age >55: with dyspepsia/ heartburn but **without** nausea, vomiting, anaemia, weight loss or raised platelets

Age 40-55: no previous endoscopy, with any upper GI symptoms (except dysphagia)

Age <55: previous endoscopy **Age <40:** with any upper GI symptoms (except dysphagia or haematemesis)

Dyspepsia – non-invasive management pathway (DNIMP) for 8 weeks

Refer to urgent 2ww clinic and/ or urgent 2ww CT abdomen/ pancreas as available locally

Symptoms not controlled or new symptoms

Success at 8 weeks

Manage symptomatically using DNIMP or refer on 'Advice and guidance'

Urgent, 2WW endoscopy

Non-urgent endoscopy

Further investigations rarely needed

Notes:

* **If cancer not suspected**, refer as routine to OPC or non-urgent endoscopy as appropriate.

** **Haematemesis** will usually need A and E assessment for endoscopy if unstable or if Blatchford score >1.

*** **Patients may need** referral on more than one pathway.

North East June 2018

Suggested simplified guidance:

Non-invasive dyspepsia management pathway

June 2018

Step 1: Entry criteria:

- Upper GI symptoms are the primary presenting complaint of the patient
- Age 18 upwards unless there are red flags
- Symptoms of dyspepsia (indigestion, usually related to eating), upper GI pain, heartburn, nausea or vomiting with amber or green flags
- Not suitable for people with red flags for two week wait (dysphagia at any age, or age >55 with weight loss plus another upper GI symptom) or the amber NICE 'non-urgent endoscopy' criteria (dual upper GI symptoms and age >55 or haematemesis)

Step 2: Baseline investigations

- Fbc, U and E's, LFTs
- Calculate Blatchford score for haematemesis patients
- Stool for faecal Helicobacter pylori (unless done in last 5 years or simple heartburn)
- Weight/BMI
- Consider USS for gallstones if pain severe and related to eating

Step 3: Initial management

- Base management on patient's own ideas, concerns and expectations using a shared decision making approach
- Has patient had a previous endoscopy – check result and treat on the basis of the result. Was any follow up required? Was it done?
- Review and consider stopping other medications – e.g. metformin, bisphosphonates, steroids, aspirin and NSAID use prescribed or OTC
- Treat Hp if present
- Provision of accurate information on non-ulcer dyspepsia (perhaps label of 'irritable stomach syndrome' is easier to comprehend) (eg https://patient.info/health/non-ulcer-functional-dyspepsia) and reflux disease (https://patient.info/health/acid-reflux-and-oesophagitis) is key
- Address lifestyle factors (recommended by NICE) such as weight, diet, alcohol consumption and smoking. Consider referral to health coach or dietitian
- Address psycho-social factors – masked depression and stress are common factors in dyspepsia
- Trial of PPI providing there are no contra-indications

Step 4: Review at 6-8 weeks

- Review history and symptoms and concordance
- If symptoms fully controlled or resolved, continue with therapy, consider reducing dose or stopping
- If symptoms not sufficiently controlled and/or patient's quality of life significantly impacted, consider referral for direct access endoscopy for amber flag patients
- Patients remaining in the green flag category can still be managed symptomatically in most circumstances
- If treatment stopped and symptoms return, restart treatment. Dyspepsia is a chronic condition and symptoms are likely to persist without treatment. If symptoms remain controlled on treatment and no red flags, treatment can be restarted without need for endoscopy
- Consider possibility of anti-reflux surgery for reflux that is not controlled with adequate dose of PPI or if intolerant of PPI