Editorial

MANAGING DYSPEPSIA

Dyspepsia is an important symptom. It is widely prevalent, affecting up to 40% of the population, and may represent the onset of significant organic pathology such as gastric cancer. It frequently requires investigation using either endoscopy or radiology, and often necessitates long-term drug therapy. Thus dyspepsia results not only in widespread morbidity, but also in a major financial burden to the health services. Not surprisingly, dyspepsia has been the focus of several 'management guidelines' in order to try and restrict costs by reducing, or stratifying, patients undergoing endoscopy; and by decreasing, or more appropriately targeting, the prescribing of drugs for dyspepsia. National guidelines for the management of dyspepsia have been published by the British Society of Gastroenterology (BSG).[1] In this edition of *Proceedings*, Tan has outlined his approach to the management of dyspepsia which is at variance with the BSG guidelines in some of its aspects.[2] No doubt these discrepancies represent a difference in practice between the UK and Singapore, as well as in the availability of access to both endoscopy and/or consultations with specialist gastroenterologists between the two countries.

The BSG dyspepsia guidelines suggest that patients should be endoscoped within two to four weeks of presentation, and ideally within two weeks; and therefore all those patients requiring endoscopy would be endoscoped 'early'. In many centres, however, waiting time for endoscopy far exceeds the ideal, and therefore some degree of prioritisation is required to ensure patients who are likely to have significant pathology are not waiting an inordinately long time for endoscopy. Tan suggests several groups of patients who would be deserving of an 'early' endoscopy. These groups, however, represent a significant proportion of patients undergoing endoscopy, and it might be better to *prioritise* only those dyspeptic patients who have alarm symptoms or signs for early endoscopy, given that all the others will be endoscoped in any case.

Another area worthy of discussion is whether all patients who develop dyspepsia require endoscopy. Tan does not comment on this, however from the BSG guidelines it would seem that the only group of people who do **not** require investigation would be patients under 45, with no alarm symptoms or signs, and who have experienced a single episode of dyspepsia. As these patients often do not present, even to the primary care services, most patients who consult a medical practitioner would appear to require some form of investigation.

Screening for *H. pylori* pre-endoscopy in patients under 45 with no alarm symptoms or signs has been advocated as a way to reduce endoscopy. By not endoscoping *H. pylori*-negative patients with no alarm features, it is highly unlikely that any 'significant' pathology will be missed.

If the avoidance of 'missing' cancer is the main aim of endoscopy then this would appear to be an appropriate strategy; however, if the aim is to make a definitive diagnosis to allow appropriate therapy, this strategy is flawed.

Alternatively, therapeutic trials before endoscopy may be appropriate, and these may also reduce the number of patients requiring endoscopy. In contrast with Tan's opinion that endoscopy should not be deferred whilst a patient undergoes a therapeutic trial, the BSG guidelines suggest that this is a satisfactory approach in patients under 45 with simple dyspepsia. A more defined therapeutic trial designed to try and reduce the number of dyspeptic patients requiring endoscopy is the so-called 'test and treat' strategy. As most endoscopic dyspeptic diagnoses are either *H. pylori* related (e.g. gastric ulcer, duodenal ulcer, erosive gastro-duodenitis) or not (e.g. reflux disease), it has been suggested that dyspeptic patients under 45 could be screened for *H. pylori* prior to endoscopy. If found to be positive, a therapeutic trial of eradication therapy could be undertaken. Endoscopy would only be required in patients who remained symptomatic despite satisfactory *H. pylori* eradication. In patients under 45 found to be *H. pylori* negative, the chance of finding 'significant' pathology is unlikely, and the probable diagnosis would be reflux disease or non-ulcer dyspepsia. In such cases it could be argued that endoscopy is not worthwhile, and a therapeutic trial of therapy would be appropriate. The results of clinical trials of this strategy are awaited to determine if this is clinically acceptable and/or a cost-effective method of management.

There is no doubt that in a diagnostic and therapeutic utopia all patients presenting with dyspepsia would receive an immediate endoscopy before any treatment is prescribed, the rationale being that this would result in a definitive diagnosis and appropriate therapeutic measures. However, given the current staffing and financial constraints, a more rational approach is required. With both primary and secondary care physicians paying more attention to the current guidelines for the management of dyspepsia, endoscopic workload would be managed more appropriately, until further research clarifies the outstanding issues.

REFERENCES

1 *Guidelines in gastroenterology 1: dyspepsia management guidelines* British Society of Gastroenterology, September 1996.

2 Tan CC. How I manage the dyspeptic patient and non-ulcer dyspepsia. *Proc R Coll Physicians Edinb* 1999; **29:**153-158.