That burning feeling: current management of dyspepsia and reflux

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Dyspepsia: definition

- Rome III criteria
  - Post-prandial fullness
  - Early satiety
  - Epigastric pain, burning
- Affects 25% of population
  - 75% of these are “functional”
Dyspepsia: differential

- Functional (non-ulcer dyspepsia)
  - 75% of cases
- Organic
  - Reflux
  - Peptic ulcer
  - Drugs eg NSAID
  - Malignancy
  - Biliary
  - Coeliac, chronic pancreatitis
Dyspepsia: history

- Positive features of functional dyspepsia
- Heartburn, regurgitation $\rightarrow$ reflux
- Medications: aspirin, NSAIDs, COX2i
- Severe epigastric, RUQ pain $>$ 1hr $\rightarrow$ biliary
- Radiation to back $\rightarrow$ pancreatic
- Alarm symptoms $\rightarrow$ cancer
  - anaemia, weight loss, anorexia, dysphagia
Dyspepsia: examination

- General impressions
- Positive features of functional disease
- Anaemia
- Epigastric tenderness (non-specific)
- Abdominal wall vs visceral tenderness
- Mass
Dyspepsia: alarm features

- Dysphagia
- Weight loss
- Vomiting (intractable)
- Bleeding
- Iron deficiency anaemia
- Mass
Dyspepsia: investigations

- Basic blood tests
- Coeliac serology
  - TTG Ab most accurate for coeliac
  - Need biopsy to confirm diagnosis
- H pylori testing (breath test)
- Upper GI endoscopy (< 10% yield)
  - Onset > 50 yo
  - Alarm
  - No response to 4 weeks PPI, Hp eradication
- Ultrasound if biliary pain suspected
  - Misleading if bloating, non-biliary symptoms
Functional Dyspepsia

- Rome III criteria
  - Post-prandial fullness
  - Early satiety
  - Epigastric pain, burning
  - > 6 months
  - normal investigations

- Other features
  - bloating
  - overlap: IBS, chronic fatigue, fibromyalgia
Functional Dyspepsia: pathophysiology

- abnormal motility, compliance
- visceral hypersensitivity
- altered gut microbiome
- psychosocial issues
Functional Dyspepsia: diagnosis

- Characteristic symptoms
- Bloating very common
- Vague, inconsistent pattern
- Non-GI symptoms
- Associated features, overlap symptoms
- Young age, female more common
- Other causes excluded on history
- Psychosocial issues, sometimes subtle
Functional Dyspepsia: approach

- Make positive diagnosis
  - name it: “functional”, “non-ulcer dyspepsia”
- Avoid “diagnosis of exclusion” approach
- Explain pathophysiological basis
- Acknowledge symptoms and impact
- Do not assume psychological basis
  - sometimes not present
  - sometimes patients do not accept it
- Explain that tests cannot resolve the cause, technologies not advanced enough
  - analogies e.g. with migraine
Functional Dyspepsia: treatment (i)

- Limited effects with all treatment options
- Make expectations realistic
  - Aim is to blunt severity, not abolish or cure
- Acknowledge symptoms
  - Acknowledge impact, disability
  - Reassure about lack of serious consequence
  - Do NOT trivialise
Functional Dyspepsia treatment (ii)

- Start simply
  - Lifestyle aspects, consistent exacerbators
  - Dietary factors e.g. fats, rich meals, wheat, dairy, spicy, IBS precipitants e.g. FODMAPs
  - Soothing teas, distractions, hot packs
  - Rubbing, massage
  - Peppermint oil

- Encourage self determination
  - Help patients to look for own solutions
  - Open but cautious of complementary therapy
Functional Dyspepsia: refractory

- Eradicate H pylori if not already
  - Limited benefits
- PPI therapy, persist for > 4 weeks
- Tricyclics e.g. Amitriptyline, Nortriptyline
  - For pain modulation, NOT depression
  - Start at 10mg, increase to 100mg max
- Others: Domperidone, Gabapentin
- Psychological review
Functional Dyspepsia: difficult challenges

- Poor doctor-patient engagement
- Patient issues
  - Not convinced by explanations
  - Misinformed pathophysiological ideas
  - Denies psychological factors
  - Angry, frustrated
  - Convinced diagnosis is incorrect, serious abnormality has been missed, no one knows what’s going on
- Doctor factors
  - Impatient, judgemental
  - Focusses entirely on psychological factors
  - Implies somatisation, exaggeration
Reflux: definition

• Passage of gastric contents into oesophagus
  • Physiological event
• Termed “disease” if:
  • troublesome symptoms
  • macroscopic damage
• Very common
  • 40% have some symptoms per month
Reflux: pathophysiology

- Lower oesophageal sphincter
  - Reduced tone
  - Excessive relaxation
- Hiatus hernia
- Reduced oesophageal clearance
- Oesophageal tissue resistance
- Duodenogastric reflux
- Delayed gastric emptying
Reflux: clinical features

- Heartburn
- Regurgitation, vomit-like taste
- Dysphagia
- Others:
  - Chest pain, odynophagia
  - Globus, nausea
  - Water brash
- Non-oesophageal
  - Asthma, cough, pneumonia
  - Posterior laryngitis, hoarseness
  - Dental erosions
Reflux: differential

- Functional dyspepsia
- Peptic ulcer
- Cardiac disease
- Eosinophilic oesophagitis
- Motility disorder
- Biliary
- Cancer
- Acute: pill, infectious
Reflux: diagnosis

- Clinical
- Trial and response to PPI
- Therapy required long term
Reflux:
indications for endoscopy

• If diagnosis is unclear
• Alarm: dysphagia, weight loss, anaemia, bleeding, recurrent vomiting
• Men presenting > 50 yo
  • higher risk for cancer
• Failure of response to PPI bd, > 8 weeks
• Commonest reason: reassure patient
• Symptoms recurring after stopping PPI is NOT indication for endoscopy
Reflux management: lifestyle factors

- Weight loss
- Dietary reduction:
  - fatty, chocolate, caffeine, spice, acidic, carbonated
- Reduce ethanol, smoking
- Smaller meals, not too late
- Elevate bed head
- Looser clothing
Reflux management: pharmacotherapy

- PPI most effective, > 60% respond
- Long term use is frequently required
- If insufficient response:
  - regular daily use rather than PRN
  - double dose
  - PRN antacids
  - add Domperidone 10mg tds
  - review lifestyle factors esp. weight
Reflux: refractory cases

- Ensure compliance
- Further investigate
  - Upper GI endoscopy
  - pH monitoring and manometry
- Baclofen up to 20mg tds
  - reduces LOS relaxation
- Neuromodulation e.g. tricyclics
  - reduces oesophageal hypersensitivity
- Surgery
  - Difficult to predict success
  - Limited long term data
Summary: that burning feeling

- “Organic” dyspepsia:
  - relatively easy
- Reflux disease
  - usually straightforward
- Functional dyspepsia
  - “least serious” but most challenging
  - requires skilful holistic approach
  - needs more consultation, not procedures
Case 1

- 32 yo woman
- Dyspepsia, epigastric pain
- Like hunger pains, gnawing, burning
- On and off for years, lasts hours
- Differential diagnoses?
- Management approach?
Case 1: approach

- Differentials:
  - ulcer, reflux, functional
- H. pylori breath test, eradicate if (+)
- Trial of PPI
- Endoscopy only to reassure, low yield
Case 2

- 58 yo business man, stressful job
- Poor diet, irregular meals, overweight
- Long history reflux on and off
- 3 months food sticking low sternum
- 5 kg weight loss
- Differentials?
Case 2: approach

- Cancer must be absolutely excluded
- Less serious possibilities:
  - Peptic reflux stricture, acid-induced dysmotility
- Urgent upper GI endoscopy
  - Distal oesophagus adenocarcinoma
Case 3

- 32 yo mother of 3, slightly overweight
- 6 months: episodes of severe epigastric pain X4, occurring at rest, sudden onset
- Doubles up with pain, knot-like
- Sweaty, hard to breathe
- Lasts 60-90 minutes, spontaneous relief
- Considered going to ED each time
- Differentials?
Case 3: approach

- Typical for biliary colic
- Ensure not cardiac ischaemia (unlikely)
- Any viscus "spasm" can cause this
- Needs ultrasound as a minimum
  - if negative, treat as functional
- Endoscopy unlikely to be helpful
Case 4

- 45 yo woman
- Longstanding epigastric pain
- Can last 10-100 minutes, 3-4 X daily
- No diagnosis after 5 years investigation
- OGD, Colonoscopy X3
- Normal CT, ultrasound
- Associated bloating, halitosis, foul smelling stool, pre-syncopal with pain, swollen neck glands, blurred vision, fatigue, poor sleep
- Specialists X3 think it is imagined, stress
- Differential?
Case 4: approach

- Classical functional dyspepsia, severe, plus more!
- Take complaints seriously
- Acknowledge symptoms, do not trivialise
- Ensure all basic investigations are normal
  - include FBP, biochemistry, thyroid, coeliac serology
- Explain functional nature
- Consider simple measures, then neuromodulation
- Show preparedness to follow-up
- Book for long consultation next time
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