Evaluation and treatment of dyspepsia

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Dyspepsia is a common symptom. Dyspeptic symptoms may be caused by a variety of conditions such as peptic ulcer disease, gastro-oesophageal reflux, and malignancy. Most often, however, no cause is identified and dyspepsia is deemed to be functional. While symptom severity does influence frequency of consultation, dyspeptic consultants also differ from non-consulters with respect to symptom perception and anxiety. This highlights the importance of understanding the patient's agenda early in the course of evaluation. Patients over the age of 55 years or with alarm symptoms should be referred for prompt endoscopy. In the absence of other clinically apparent aetiologies, uninvestigated dyspeptics can be either tested and treated for *Helicobacter pylori* or empirically treated with proton pump inhibitors. Uninvestigated dyspeptics failing empiric therapy should be referred for evaluation that includes endoscopy. Further therapy with prokinetics, tricyclic antidepressants, fundal relaxants, antidepressants, or psychotherapy is guided by predominant symptoms and assessment of possible psychiatric factors.

Dyspepsia literally means “bad digestion” and it’s a problem that most of the population has experienced at some point in their lives. While most of us have experienced dyspepsia, the symptoms we’ve had likely differed in timing, nature, severity, and impact on our lives. Additionally, for most, dyspepsia is simply a symptom while for others it’s a manifestation of underlying disease. This is the dilemma of dyspepsia: a common problem with multiple manifestations caused by a variety of things or by nothing at all.

**DEFINING THE PROBLEM**

Defining dyspepsia is like describing a close relative—easily recognised but difficult to describe. A variety of criteria exist. Most define dyspepsia as symptoms arising from the upper digestive tract unrelated to colonic function. Often symptoms are brought on or worsened by eating. The Rome II consensus report, a recent widely endorsed document, the differential diagnosis of dyspepsia is shown in...
Box 1: Differential diagnosis of dyspepsia

- Non-ulcer dyspepsia.
- Gastro-oesophageal reflux disease.
- Peptic ulcer disease.
- Medication related: non-steroidal anti-inflammatory drugs, antibiotics, iron, potassium supplements, digoxin.
- Carbohydrate malabsorption (lactose, fructose, sorbitol).
- Cholelithiasis or choledocholithiasis.
- Chronic pancreatitis.
- Systemic disorders (diabetes, thyroid, parathyroid, hypoparathyroidism, connective tissue disease).
- Intestinal parasites.
- Abdominal malignancy (especially pancreatic and gastric cancer).
- Chronic mesenteric ischaemia.

Box 1. While important clues to symptom aetiology may be obtained from interview and examination, symptom patterns alone do not discriminate organic from functional dyspepsia. In 50%–60% of cases, no cause is identified and patients are considered to have functional dyspepsia. The prevalence of peptic ulcer disease is 15%–25% and oesophagitis prevalence is 5%–15%. Upper digestive cancer is seen in typically <2%. Because cancer of the upper digestive tract is uncommon in Western countries under the age of 50, it is recommended that patients over the age of 55 be referred promptly for endoscopy. It is also recommended that patients with significant weight loss, gross or occult bleeding, dysphagia, severe vomiting, or profound early satiety also be referred for early endoscopy.

Dyspepsia is a common sequel of non-steroidal anti-inflammatory medication use and these drugs are clearly ulcerogenic. Although most patients with dyspepsia taking non-steroidal anti-inflammatory drugs will not have ulcer, this cannot be predicted clinically. The most prudent course in these patients is to discontinue non-steroidals. If that cannot be done for valid clinical reasons, endoscopy should be performed.

Patients with dyspeptic symptoms who are not candidates for early endoscopy are termed “uninvestigated dyspepsics”. These patients may be empirically treated most often using antisecretory or prokinetic agents. Antisecretory agents are preferred as they are better tolerated and effectively treat underlying gastro-oesophageal reflux disease or peptic ulcer disease. While H₂ receptor antagonists have been widely used in this setting for many years, proton pump inhibitors should presently be regarded as first line agents. Proton pump inhibitors offer some superiority over H₂ receptor antagonists in the treatment of peptic ulcer disease and are substantially superior in providing symptom relief in reflux disease. Given the inherent diagnostic uncertainty present when empirically treating dyspepsia, it seems reasonable to not further complicate matters by adding the confounding variable of a suboptimal therapy. Additionally, there are now several studies with omeprazole and lansoprazole demonstrating superiority of these agents over H₂ receptor antagonists in this setting.

The optimal dose of proton pump inhibitor for a therapeutic trial is not known but given the desired goal of controlling gastric acid secretion and normalising the intraoesophageal pH profile, a twice daily dose of a newer proton pump inhibitor should probably be used.

Some authors have advocated a symptom-tailored approach with proton pump inhibitors given to those patients with principal complaints of upper abdominal pain and prokinetics used initially in patients with fullness, bloating, or early satiety. There are no good clinical data to support this approach at present.

Because some dyspeptics will have underlying peptic ulcer disease that can be cured by eradication of H pylori, the strategy of testing uninvestigated dyspeptics for H pylori and treating those who are infected has become quite popular. Proponents have argued this strategy eliminates ulcer disease and is cost saving. The utility of this approach is obviously highly dependent upon the prevalence of H pylori, the prevalence of peptic ulcer disease, the degree to which eradication of H pylori improves symptoms of functional dyspepsia, and the cost and availability of alternative management strategies.

As shown in fig 2, the prevalence of H pylori and peptic ulcer disease are highly correlated and vary considerably across the United States. H pylori and ulcer disease are quite common in urban Detroit but uncommon in suburban and rural practices in Ohio and Pennsylvania. Obviously, the utility of a test and treat strategy is dependent upon the prevalence of H pylori in the specific population being treated. Additionally, despite some data to the contrary, the majority of well done clinical trials have failed to demonstrate symptom improvement in functional dyspepsia after H pylori eradication.

In summary, patients with new onset dyspepsia who are over the age of 55 years or with alarm symptoms should undergo early endoscopy. In the remaining patients, the likelihood of organic pathology is low. “Uninvestigated dyspepsias” can be managed empirically. If the background prevalence of H pylori and ulcer disease is high, a “test and treat” approach is reasonable. H pylori negative patients or those not responding to eradication therapy can be given a trial of proton pump inhibitors. If there is a clinical response to either acid suppressive therapy or H pylori eradication, patients can be managed intermittently for recurrent symptoms. For patients who require additional reassurance, fail empiric therapy, or require chronic treatment, referral for further investigation including upper gastrointestinal endoscopy is indicated.
Evaluation and treatment of dyspepsia

From H2 receptor antagonists. More recent studies using ulcer and reflux disease have tended to show little benefit of acid suppression in true functional dyspepsia. Studies in patients with dyspepsia attributable to peptic ulcer-like or reflux-like dyspepsia. The therapeutic benefits were restricted to those patients with differences between groups with respect to quality of life and 8% for omeprazole 10 mg daily. There was no significant net therapeutic gain was 10% for omeprazole 20 mg daily and control in two combined trials involving 1262 patients (fig 3). The difference between groups with respect to quality of life and 8% for omeprazole 10 mg daily. There was no significant net therapeutic gain was 10% for omeprazole 20 mg daily and 20 mg doses was superior to placebo when using the end-points of complete symptom relief or sufficient symptom control in two combined trials involving 1262 patients (fig 3). The net therapeutic gain was 10% for omeprazole 20 mg daily and 8% for omeprazole 10 mg daily. There was no significant difference between groups with respect to quality of life and the therapeutic benefits were restricted to those patients with ulcer-like or reflux-like dyspepsia. A third double blind, placebo control trial of omeprazole 20 mg daily in 197 patients with functional dyspepsia showed omeprazole to be superior to placebo in providing complete symptom relief after two weeks.

For patients unresponsive to acid suppressive therapy or H pylori eradication, mechanisms of symptom generation are largely speculative. This means therapeutic interventions are also speculative. A variety of potential causes have been proposed with varying degrees of support (box 2). While patients often complain of excess acid, there is no evidence for abnormal gastric acid secretion. The role of H pylori has already been discussed. It should be kept in mind that "gastritis" is neither an endoscopic diagnosis nor a cause of recognised cause of dyspepsia. Three aetiologies deserve particular attention: dysmotility, visceral hypersensitivity, and psychiatric disorders. Abnormalities of gastric neuromuscular function can be detected by scintigraphic gastric emptying studies, electrogastrography, or antroduodenal manometry in between 30% and 60% of patients. In addition to impaired motor function, a subset of dyspepsics has impaired postprandial relaxation of the proximal stomach. Some investigators have suggested that certain symptoms are associated with altered gastric physiology. Predictors of delayed gastric emptying include female sex, excessive postprandial fullness, and severe vomiting. Impaired postprandial relaxation of the proximal stomach has already been associated with early satiety. The acute administration of the interstitial serotonin receptor (5-HT, agonists, buspirone and sumatriptan, has been shown to improve accommodation and tolerance to balloon distension of the proximal stomach. While these observations are encouraging, most studies have failed to demonstrate a relationship between disturbed gastrointestinal motor function and symptoms. In particular, there is little evidence that abnormalities of commonly employed tests of gastric function identify therapies that reliably improve symptoms.

Much recent attention has focused on the concept that patients with functional dyspepsia have augmented perception of visceral pain or visceral hypersensitivity. Many dyspepsics will report pain at levels of balloon distension in the stomach or proximal intestine that are not perceived as adverse by controls. These observations should be interpreted cautiously. Many of these studies have used protocols prone to response bias. Borrowing from studies of visceral hypersensitivity in irritable bowel syndrome, studies using less bias-prone methods tend to not demonstrate visceral hypersensitivity. This raises the possibility that much of visceral hypersensitivity is actually hyperalgiesia. Although tricyclic antidepressants have been shown to have efficacy in treating the hyperalgiesia of irritable bowel syndrome and non-cardiac chest pain, there is presently no evidence for their efficacy in the treatment of non-ulcer dyspepsia. As visceral hypersensitivity is common to these disorders, use of tricyclics in functional dyspepsia would seem reasonable even if unstudied. Presently no controlled trials exist regarding the use of selective serotonin reuptake inhibitors in functional dyspepsia apart from their use to treat concomitant psycho-pathology.

The coexistence of psychiatric disturbances and dyspeptic symptoms is well documented. Importantly, it appears that dyspeptic consulters do not differ from non-consulters with respect to objective symptoms, but they tend to perceive their symptoms as more severe and have greater associated anxiety. The implication is clear—in managing functional dyspepsia, answers are less likely to be found by taking an ever more microscopic view of the digestive tract and more likely to be found by taking a more macroscopic view of the entire patient. Patients with psychiatric distress have a high prevalence of digestive symptoms. Conversely, patients with longstanding unexplained digestive symptoms are vulnerable to the development of reactive psychiatric disorders. Anxiety, depression, personality disorders, and a history of physical or sexual abuse are all seen with increased frequency in this population. Understanding these issues is critical to managing patients with functional disorders. The importance of addressing patient concerns and exploring the psychosocial context of symptoms cannot be overstated, particularly in

**Box 2: Potential causes of non-ulcer dyspepsia**

- Duodenogastric reflux.
- Duodenitis.
- Carbohydrate malabsorption (lactose, fructose, sorbitol).
- Cholelithiasis or cholecystocholia.
- Chronic pancreatitis.
- Systemic disorders (diabetes, thyroid, parathyroid, hypoadrenalism, connective tissue disease).
- Intestinal parasites.
- Psychiatric disorders.
- Visceral hypersensitivity.
- Gastric/small intestinal dysmotility.
- Gallbladder/biliary dysmotility.

**INVESTIGATION OF DYSPESIA AND NON-ULCER DYSPESIA**

Eradication of *H pylori* and use of acid suppressive therapy will benefit those patients with dyspepsia attributable to peptic ulcer and reflux disease. There additionally appears to be some benefit of acid suppression in true functional dyspepsia. Studies of functional dyspepsia that have aggressively excluded ulcer and reflux disease have tended to show little benefit from H2 receptor antagonists. More recent studies using proton pump inhibitors have demonstrated modest gains in more carefully selected patients. Omeprazole in both 10 mg and 20 mg doses was superior to placebo when using the end-points of complete symptom relief or sufficient symptom control in two combined trials involving 1262 patients (fig 3). The net therapeutic gain was 10% for omeprazole 20 mg daily and 8% for omeprazole 10 mg daily. There was no significant difference between groups with respect to quality of life and the therapeutic benefits were restricted to those patients with ulcer-like or reflux-like dyspepsia. A third double blind, placebo control trial of omeprazole 20 mg daily in 197 patients with functional dyspepsia showed omeprazole to be superior to placebo in providing complete symptom relief after two weeks.

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**Figure 3** Efficacy of omeprazole in functional dyspepsia.

The acute administration of the interstitial serotonin receptor (5-HT1) agonists, buspirone and sumatriptan, has been shown to improve accommodation and tolerance to balloon distension of the proximal stomach. While these observations are encouraging, most studies have failed to demonstrate a relationship between disturbed gastrointestinal motor function and symptoms. In particular, there is little evidence that abnormalities of commonly employed tests of gastric function identify therapies that reliably improve symptoms.

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consultors more in terms of symptom perception and anxiety than objective symptom measures. This highlights
the importance of understanding the patient’s agenda early in the course of evaluation. Patients over the age of 55
years or with unexplained upper abdominal pain who have failed proton pump inhibitors may be treated with
tricyclic antidepressants, although good supporting data are lacking.

Those with dysmotility-like symptoms can be treated initially with either acid suppressive therapy, prokinetic
agents, or 5-HT3 antagonists. Both metoclopramide and domperidone have been shown to be superior to placebo in the
management of functional dyspepsia.8,9 Available literature suggests 5-HT3 antagonists may be efficacious in patients
with impaired accommodation. Since formal assessment of accommodation is not widely available, it is reasonable to use
these agents in patients with excessive early satiety. The lack of supporting data and the adverse reactions associated with
sumatriptan argue against the use of this agent. Buspirone has comparable effects, fewer adverse events, and may provide
additional anxiolytic benefits in a non-confrontational way.

For all patients, the psychosocial context of symptoms should be assessed. Patients with a history of psychiatric dis-
tress, multiple unexplained physical symptoms, or symptoms refractory to standard therapies should be evaluated for
concomitant psychopathology. If identified, appropriate therapy is offered. At present there are no data to support the
use of selective serotonin reuptake inhibitors in functional dyspepsia in the absence of disorders for which these medica-
tions are otherwise indicated.

**SUMMARY**

Dyspepsia is a common symptom and is most often functional. Importantlyn, dyspeptic consultants differ from non-
consultors more in terms of symptom perception and anxiety than objective symptom measures. This highlights
the importance of understanding the patient’s agenda early in the course of evaluation. Patients over the age of 55
years or with unexplained symptoms should be referred for prompt endoscopy. In the absence of other clinically apparent actiologies, uninvestigated dyspepsies can be either tested and treated for H pylori or empirically treated with proton pump inhibitors.

Uninvestigated dyspepsias failing empiric therapy should be referred for evaluation that includes endoscopy. Further therapy with prokinetic, tricyclic antidepressants, fundal relaxants, antidepressants, or psychotherapy is guided by predominant symptoms and assessment of possible psychiatric factors.

**REFERENCES**

Perichondritis: a complication of piercing auricular cartilage

A 20 year old woman presented to the ear, nose, and throat clinic with auricular perichondritis two days after piercing the helix of her left ear with the aid of a piercing gun. Two thirds of the upper part of her auricle was swollen, red, and tender. The lobule (which does not contain cartilage) remained intact, which indicated that the infection was perichondritis and not simply cellulitis (fig 1). The patient was treated with ciprofloxacin by mouth for a period of one week; by then the infection was entirely resolved.

Body piercing has become a widespread phenomenon in the last decade. Although other parts of the body have become subject to this new ritual of body piercing, the ear remains a most common site, with piercing of the ear cartilage ("high" ear piercing) gaining more popularity. Patients who are more than 18 years old because of their potential damage to young developing cartilage should be aware of this risk.

The use of guns for piercing cartilage presents an additional risk of perichondritis. The gun applies shear forces to the perichondrium, which may slip off the cartilage. An avascular cartilage (which is normally nourished by the perichondrium), may then become necrotic. Abscess formation and loss of cartilage are potential complications that often require surgical intervention. Despite timely treatment, including antibiotic therapy, drainage, and debridement, an unsightly deformity ("cauliflower ear") may result.

The treatment of choice for auricular perichondritis is fluoroquinoline antibiotics, such as ciprofloxacin, since they show good antipseudomonal activity in addition to their effect against staphylococci. They also penetrate well into the cartilage. However, their use is limited to treatment of choice for auricular perichondritis is fluoroquinoline antibiotics, such as ciprofloxacin, since they show good antipseudomonal activity in addition to their effect against staphylococci. They also penetrate well into the cartilage. However, their use is limited to

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