

Managing Patients on Continuing Treatment For Dyspepsia and Associated Symptoms: Practical Guidelines

These guidelines have been developed by the following:

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These guidelines have been developed for use in primary care (GPs, Practice Nurses and Nurse Practitioners) to give practical, clinical and financial help in the management of acid-related disorders.

Upper GI Prescribing In The UK^(1,2,3)

- GI spend is the third largest area for GP prescribing in the UK (£1.2 billion a year, increasing at a rate of 8-9% a year)
- PPIs represent 83% of NHS spend on upper GI medicines, but account for 34% of the volume
- In contrast, 4% is spent on alginates, which represent 41% of the volume
- 40% of PPIs are being prescribed to long-term users
- "Maintenance" doses now represent the minority of PPI prescriptions

Target Population

- Search by drugs prescribed
- History of repeat/active prescriptions (>3 in a 6 month period) for PPIs, H2RAs, antacids and alginates

Exclusion Criteria

- Patients on treatment doses of PPIs <1 month
- Patients awaiting referral or under the continuing care of a consultant
- Barrett's oesophagus and strictures
- Patients who are frail / have co-morbidity / >90 years
- Terminal illness
- High-dose steroids
- Immunosuppressed patients
- NSAID therapy (only eligible for "step down")
- Presence of any alarm symptoms (e.g. weight loss, bleeding, vomiting, etc.)

Review Process

- Invite patients for review (opportunistically, by letter or clinical appointment)
- Ensure patients are seen:
 - i) within 12 weeks of first prescription for an acid suppressant, or
 - ii) when presenting with alarm symptoms

Review Checklist

Ask about current symptoms:

- when do they experience symptoms (nocturnal/diurnal)?
- severity of symptoms?
- symptom triggers?
- what medication are they currently being prescribed?
- any additional OTC medication?
- lifestyle factors (smoking, alcohol, weight/BMI)
- concordance with self-management plan?
- *H. pylori* eradication?; confirmed?
- endoscopy?; findings?
- check for alarm symptoms

Management of dyspepsia and associated symptoms

Further information visit

A step-wise approach to the treatment of patients under review should be encouraged, according to the following principles:

- > Symptoms are relapsing/remitting in nature
- > "Step down" therapy when patients are in remission
- > Contingency plan to "step up"/ add in another agent (e.g. Alginate/antacid) when relapses occur

- www.digestivedisorders.org.uk
- www.sign.ac.uk
- www.nice.org.uk
- www.pcsg.org.uk
- www.totalGORDmanagement.co.uk

a) Patients whose symptoms are well-controlled:

- Lifestyle advice
- If patient is not taking medication - discontinue medication
- If patient is taking medication intermittently - query over treating condition - consider alternative (e.g. alginate) and/or reduce PPI dose
- If patient is using high-dose PPI regularly
 - "step down" PPI dose
 - combine with alginate for breakthrough symptoms
- If patient is using low-dose PPI regularly
 - "step off" with a rescue medication for breakthrough symptoms (e.g. alginate)
 - education and lifestyle advice
- Review if symptoms recur
- Review patients who have been "stepped down" to maintenance PPI doses as potential candidates for a "step off" strategy

b) Patients whose symptoms are not well-controlled:

- Establish current patterns of treatment:
 - PPI, alginate, antacid, H2RA
- Reconsider diagnosis, taking into account:
 - alarm symptoms
 - endoscopy and other investigations
- Establish pattern of symptoms:
 - consider testing for *H. pylori* for those with acid-related disorders
 - predominantly nocturnal symptoms > consider taking low-dose PPI at night + alginate for breakthrough symptoms
 - predominantly daytime symptoms > consider "stepping up" (double dosing) PPI (e.g. lansoprazole 15mg to 30mg) + alginate for breakthrough symptoms
 - review after 1 month if PPI dose has been "stepped up"

Acid Suppressants: Co-prescribing Risks

- PPI / H₂ Receptor Antagonists
- PPIs (diazepam, phenytoin, warfarin, digoxin)
- NSAIDs
- Slow-release preparations (e.g. antibiotics)
- Calcium antagonists (e.g. antianginals, antihypertensives)
- Alendronic acid (Fosamax) for osteoporosis
- Oral steroids

H. pylori

- If *H. pylori* eradication therapy has not already been given and there is evidence of continuing symptoms, carry out a *H. pylori* test and consider eradication if the test is positive
- If *H. pylori* eradication therapy has been completed and there is still evidence of continuing symptoms, check if eradication was successful
- If eradication therapy has been unsuccessful after two attempts, and symptoms persist, refer patient to a specialist
- "Gold standard" investigation for *H. pylori* is the urea breath test, available on FP10 (must be carried out in the presence of a health care professional)

Lifestyle

Lifestyle advice, for example raising the head level of the bed, should be given to patients whilst ensuring that patients understand the nature of acid-related disorders and the aims of their treatment.

Avoid:

- Trigger foods
- Smoking
- Over indulgence (food/alcohol)
- Eating/drinking late at night
- Poor posture (stooping/bending)
- Tight-fitting clothes

Drug Therapy for Dyspepsia and Associated Symptoms

PPIs

Omeprazole, Esomeprazole, Rabeprazole, Pantoprazole, Lansoprazole

H₂ Receptor Antagonists

Cimetidine, Ranitidine, Famotidine, Nizatidine

Alginates

Compound sodium alginate

Antacids

Magnesium hydroxide, Aluminium hydroxide

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