

CARE GUIDE for *Acid-Related Stomach Disorders (ARSD)*

SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTION	FOLLOW - UP
Gastroesophageal Reflux Disease (GERD) ^(1,2,6)	<ul style="list-style-type: none"> Symptoms are troublesome heartburn, acid regurgitation or both, often occurring after meals Symptoms occur two or more times a week Evaluate for history of overeating, recent weight gain, laryngitis, dental erosion, asthma, sleep disturbance, non-cardiac chest pain, Evaluate patient for alarm features 	Presence of alarm features: <ul style="list-style-type: none"> sudden total or troublesome dysphagia Odynophagia Chronic cough Choking Early satiety Hematemesis Persistent vomiting Melena Involuntary weight loss >5% Iron deficiency anemia 	<ul style="list-style-type: none"> Refer patients for endoscopy who: <ul style="list-style-type: none"> ➢ have alarm features ➢ are suspected of having Barrett's esophagus Consider endoscopy in patients who: <ul style="list-style-type: none"> ➢ have symptoms >10 years ➢ are > 50 years of age Otherwise treat for 8 weeks with proton pump inhibitor (PPI) and institute behavioral/dietary/ lifestyle changes 	<ul style="list-style-type: none"> If symptoms improved after 8 weeks, consider step-down therapy If no improvement, refer for endoscopy
Dyspepsia (post-prandial epigastric pain) ^(2,4,5)	<ul style="list-style-type: none"> Symptoms are pain or discomfort in the upper GI tract >25% of the time in the last four weeks Rule out non-acid-related causes of upper abdominal pain Evaluate patient for alarm features 	<ul style="list-style-type: none"> Rule out: <ul style="list-style-type: none"> ➢ cardiac ➢ hepatobiliary ➢ medication ➢ lifestyle ➢ dietary ➢ other non GI causes (such as, ovarian cancer) Presence of alarm features: <ul style="list-style-type: none"> ➢ sudden total or troublesome dysphagia 	<ul style="list-style-type: none"> History and physical exam to rule out non-GI causes Refer patients for endoscopy who have alarm features or are > 55 years of age Refer patients with dyspepsia and prior documented gastric or duodenal ulcer to a gastroenterologist or direct-access endoscopy Be aware of environmental, genetic and geographical 	<ul style="list-style-type: none"> If non-acid-related causes are ruled out, proceed with GI work-up as indicated

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		<ul style="list-style-type: none"> ➤ odynophagia ➤ hematemesis ➤ persistent vomiting ➤ melena ➤ involuntary weight loss >5% ➤ iron deficiency anemia 	factors for increased risk of gastric cancer and the need for early endoscopy	
Test – and – treat strategy ^(2,3,4,5,7)	<ul style="list-style-type: none"> • Test for <u>Helicobacter pylori</u> (<u>H. pylori</u>) in patients with uncomplicated dyspepsia who are < 55 yrs and have no “alarm features”. 	<ul style="list-style-type: none"> • “<u>H. pylori</u> and NSAIDs (non-steroidal anti-inflammatory drugs) are independent risk factors for development of peptic ulcer disease”. However, <u>H. pylori</u> infection increases the risk of NSAID - related GI complications. • All patients should be tested for and treated if positive for <u>H. pylori</u> whether or not they are taking NSAIDs. • NSAIDs should be discontinued if possible. If not possible, PPI therapy should be extended to 12 weeks vs. the typical 8 weeks of therapy when not on NSAIDs 	<ul style="list-style-type: none"> • Recommended <u>H. pylori</u> tests for initial diagnosis and eradication <ul style="list-style-type: none"> ➤ Urea Breath Tests (UBT) (preferred over serological testing if cost is comparable) ➤ Fecal Antigen Test (FAT) (preferred non – invasive office test) ** Patient must discontinue PPI for 2 wks prior to UBT ** All patients who are about to start long-term traditional NSAID therapy should be considered for testing for <u>H. pylori</u> and treated, if positive. 	<ul style="list-style-type: none"> • Positive test: treat as below
Positive <u>Helicobacter pylori</u> (2,3,4)	<ul style="list-style-type: none"> • Use triple or quadruple therapy to treat <u>H. pylori</u> 	<ul style="list-style-type: none"> • Positive testing for <u>H. pylori</u> 	Treatment choice # 1 <ul style="list-style-type: none"> • PPI standard dose BID x 7 – 14 days • Clarithromycin 500 mg BID x 7 – 14 days 	<ul style="list-style-type: none"> • Repeat testing after treatment for: <ul style="list-style-type: none"> -Persistent dyspeptic symptoms despite test-and-treat strategy

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			<ul style="list-style-type: none"> Amoxicillin 1 gm BID x 7 – 14 days Treatment choice # 2 PPI standard dose BID x 7 – 14 days Tetracycline 250 mg QID x 7 – 14 days Bismuth 2 tabs QID x 7 – 14 days *Substitute metronidazole 500 mg BID x 7 days if intolerant to tetracycline or amoxicillin <p>Optimal treatment is 14 days, but a 7 day treatment is almost similar</p>	<ul style="list-style-type: none"> -<u>H. pylori</u> associated ulcer or mucosa-associated lymphoid tissue (MALT) lymphoma -Resection of early gastric cancer Testing should not be performed for 4 weeks after treatment • Non-endoscopic follow-up is most reliable with either UBT or FAT • Serology is not useful for documenting eradication • For persistent infection refer to GI specialist.
Negative <u>Helicobacter pylori</u> ^(1,2,4,5)	<ul style="list-style-type: none"> Use Proton Pump Inhibitors (PPIs) 	<ul style="list-style-type: none"> Negative testing for <u>H. pylori</u> 	<ul style="list-style-type: none"> Treat with PPIs Discontinue NSAIDs/ASA if possible. If not possible, PPI therapy of 12 weeks is recommended. Antacids are not likely to be effective in functional dyspepsia with negative <u>H. pylori</u> testing 	<ul style="list-style-type: none"> After 4 weeks discontinue treatment if symptoms resolved Patients may require long term treatment with PPI

References

<p>1. DeVault KR, Castell DO. Updated guidelines for the diagnosis and treatment of gastroesophageal reflux disease. Am J Gastroenterol. 2005;100:190-200</p>	<p>2. Institute for Clinical Systems Improvement. Health Care Guideline: Initial Management of Dyspepsia and GERD. Institute for Clinical Systems Improvement . 2006. http://www.icsi.org/dyspepsia_gerd/dyspepsia_9.html</p>
<p>3. Chey WD, Wong BC. American College of Gastroenterology guideline on the management of Helicobacter pylori infection. Am J Gastroenterol. 2007;102:1808-25</p>	<p>4. Talley, Vakil, Moayyedi. American Gastroenterological Association Technical Review on the Evaluation of Dyspepsia. Gastroenterology-2005 11 (Vol 129, Issue 5). 2005;129:1756-80.</p>
<p>5. Talley NJ, Vakil N. Guidelines for the management of dyspepsia. Am J Gastroenterol. 2005;100:2324-37.</p>	<p>6. AGA Institute. American Gastroenterological Association Medical Position Statement on the Management of Gastroesophageal Reflux Disease. Gastroenterology 2008;135:1383-91. http://download.journals.elsevierhealth.com/pdfs/journals/0016-5085/PIIS0016508508016065.pdf.</p>
<p>7. Lanza F, Chan F, Quigley E. American College of Gastroenterology Guidelines for Prevention of NSAID – Related Ulcer Complications. Am J Gastroenterol 2009; 104:728 – 738; doi: 10.1038/ajg. 2009.115.</p>	