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

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<th>PROCESS</th>
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| Gastroesophageal Reflux Disease (GERD) | • 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, pharyngitis, laryngitis, dental erosion, asthma, sleep disturbance, non-cardiac chest pain  
• Evaluate patient for alarm features | Presence of alarm features:  
• sudden total or troublesome dysphagia  
• Odynophagia  
• Chronic cough  
• Choking  
• Early satiety  
• Hematemesis  
• Persistent vomiting  
• Melena  
• Involuntary weight loss >5%  
• Iron deficiency anemia | • Refer patients for endoscopy who:  
  ➢ have alarm features  
  ➢ are suspected of having Barrett’s esophagus  
• Consider endoscopy in patients who:  
  ➢ 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 | • If symptoms improved after 8 weeks, consider step-down therapy  
• If no improvement, refer for endoscopy |
| Dyspepsia (post-prandial epigastric pain) | • Symptoms are pain or discomfort in the upper gastrointestinal (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 | • Rule out:  
  ➢ cardiac  
  ➢ hepatobiliary  
  ➢ medication  
  ➢ lifestyle  
  ➢ dietary  
  ➢ other non-GI causes (such as, ovarian cancer)  
• Presence of alarm features:  
  ➢ sudden total or troublesome dysphagia  
  ➢ odynophagia  
  ➢ hematemesis  
  ➢ persistent vomiting  
  ➢ melena | • 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 factors for increased risk of gastric cancer and the need for early endoscopy | • If non-acid-related causes are ruled out, proceed with GI work-up as indicated |
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<td>Test – and – treat strategy (2,3,4,5,7)</td>
<td>• Test for <em>Helicobacter pylori</em> (<em>H. pylori</em>) in patients with uncomplicated dyspepsia who are &lt; 55 yrs and have no “alarm features”.</td>
<td>• “<em>H. pylori</em> and non-steroidal anti-inflammatory drugs (NSAIDs) are independent risk factors for development of peptic ulcer disease”. However, <em>H. pylori</em> infection increases the risk of NSAID - related GI complications. • All patients should be tested for and treated if positive for <em>H. pylori</em> 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</td>
<td>• Recommended <em>H. pylori</em> tests for initial diagnosis and eradication • 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 weeks prior to UBT ** All patients who are about to start long-term traditional NSAID therapy should be considered for testing for <em>H. pylori</em> and treated, if positive.</td>
<td>• Positive test: treat as below</td>
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<td>Positive <em>H. pylori</em> (2,3,4,9,10)</td>
<td>• Use triple or quadruple therapy to treat <em>H. pylori</em></td>
<td>• Positive testing for <em>H. pylori</em> • Blood antibody testing for <em>H. pylori</em> can indicate current or past infection</td>
<td><strong>Treatment choice # 1</strong> • PPI standard dose BID x 7 – 14 days • Clarithromycin 500 mg BID x 7 – 14 days • Amoxicillin 1 gm BID x 7 – 14 days <strong>Treatment choice # 2</strong> • PPI standard dose BID x 7 – 14 days</td>
<td>• Repeat testing after treatment for: -Persistent dyspeptic symptoms despite test-and-treat strategy -<em>H. pylori</em> associated ulcer or mucosa-associated lymphoid tissue (MALT) lymphoma -Resection of early gastric cancer</td>
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|Negative *H. pylori* (1,2,4,5) | Use PPIs | Negative testing for *H. pylori* | 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  
Optimal treatment is 14 days, but a 7 day treatment is almost similar | 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. |

| Immunizations (9) | Influenza Vaccination | Document patient has an influenza vaccination  
Document if adverse event occurs | Influenza vaccine to all patients yearly | Yearly |
| | Pneumonia Vaccination | Document patient has received a pneumonia vaccination  
Document if adverse event occurs | Pneumonia vaccine to all patients once before age 65, with a booster given to those who are age 65 and older if at least 5 years have passed since their previous vaccine | As indicated |
These guidelines are intended as an educational reference and not as a substitute for the clinical judgment of the treating physician concerning appropriate and necessary care for a specific patient. These guidelines are based on the clinical references listed at the end of the document. Note that a specific treatment or therapy listed may not be a covered benefit for all individuals. Please check the individual’s eligibility and benefits plan.

Reference List

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