Dyspepsia/GORD stakeholder workshop – 7 February 2012

The purpose of the workshop session was to obtain the views of the group on the draft scope, clinical questions and the guideline development group (GDG) composition. A series of presentations provided a summary of the proposed scope, guideline development timetable & process and how stakeholders could become involved. Attendees were then divided into two groups which included a facilitator and a scribe, and each group had a structured discussion around the key issues and in particular the clinical questions within the scope:

Notes from the discussion groups

General

- Potentially a big difference in effectiveness of treatment between primary and secondary management, this needs to be explored in the guideline
- Problem with definitions / title dyspepsia is symptom based whereas GORD disease based – perhaps move to a symptom based description of GORD for consistency

Key issues that will be covered

3.3.1 a)

1. What is the effectiveness of prophylactic treatment using PPIs or H. pylori test and treat for the prevention of dyspepsia or its causes in those taking prescribed drugs that might cause dyspepsia symptoms (calcium antagonists, nitrates, theophyllines, bisphosphonates, corticosteroids and NSAIDs)?

Group 1

- Most evidence will be on endoscopic outcomes rather than clinical ones.
- Proposal to split the question into two – the 1st focusing on drugs that may cause pathological damage to oesophagus – i.e. Bisphosphonates, Corticosteroids, NSAIDs, Aspirin / clopidogrel / dipyridamole, and SSRIs.

The 2nd on drugs that cause symptoms but not pathology – i.e. calcium antagonists, nitrates, and theophylines.

3.3.1 b)

2. What is the safety and effectiveness of pharmacist-administered PPIs to reduce dyspepsia symptoms?

Group 1

- Question needs to cover both dyspepsia AND GORD symptoms.
- Pharmacist 'ADVISED' rather than administered
- Also include antacids, alginates (gaviscon).
- Questions remain concerning which order of medication to recommend
- Potential concern about excessive duration of medication – either if resolved symptoms, or remaining on without control of reflux.

Group 2

- It was noted that only 2 PPIs are currently available over the counter. The pharmacist in the group considered that pharmacists do not routinely sell these unless it is specifically requested by patients. Reasons might be because pharmacists were not confident, and also that PPIs were quite expensive when bought over the counter. Pharmacists might be more likely to signpost patients to their GP as they could get a prescription without charge.
- Currently there is limited guidance about administering PPIs by pharmacists so NICE guidance could be quite useful.
- There was some discussion and confusion about what dosage pharmacists can prescribe.

3.3.1 c)

3. What is the effectiveness of lifestyle interventions to reduce symptoms in dyspepsia?

Group 1

- Question needs to cover both dyspepsia AND GORD symptoms – lump with question 4

- Outcome of interest is likely to be acid control too – not just symptoms.
- Interventions might include weight loss, diet composition (fat, spices), timing of meals, alcohol, smoking cessation, BMI, Stress.
- Relatively few RCTs on interventions.
- Remains an important question to ask – 20% of patients in GP care might have stress related symptoms.

Group 2

- It was felt that it is important to ask Q3 & Q4, despite that it was felt that the evidence is lacking in this area (particularly RCT evidence but there may be non-randomised controlled studies designs). This may be for a number of reasons including the possible unwillingness of patients to participate in trials requiring them to change their lifestyle when PPIs work well at treating symptoms as well as the difficulty finding funding for trials on lifestyle interventions in general.
- The discussion initially focused around dietary advice, such as around food avoidance. Patients with dyspepsia/heartburn are not often referred to dieticians for advice about diet.
- The team queried whether or not we should consider 'lifestyle advice' rather than 'lifestyle interventions' as assessing the effectiveness of different lifestyle interventions is quite time consuming. The group generally felt that it was not appropriate to look specifically at 'lifestyle advice' without considering the content of the advice; looking at 'lifestyle interventions' was appropriate.

4. What is the effectiveness of lifestyle interventions to reduce symptoms in GORD?

Group 1

- See Q3 for comment

3.3.1 d)

5. What information should be given to patients initially presenting to a GP with dyspepsia or heartburn?

Group 1

- Question is relevant and advice should be based on interventions covered in Q 3 and Q 4.
- Advice at GP consultation point of care pathway is most crucial.

3.3.1 e)

6. What are the alarm signs and symptoms for upper gastrointestinal cancer among people that present with dyspepsia, which require further investigation with endoscopy?

Group 1

- Question is likely to be covered in cancer referral advice guideline – remove question.
- Nothing particular / different about alarm signs in patients with dyspepsia compared to population as a whole.

7. What are the alarm signs and symptoms for upper gastrointestinal cancer among people that present with heartburn which require further investigation with endoscopy?

Group 1

- See Q6 for comment

8. In patients presenting with dyspepsia and / or heartburn symptoms without alarm signs or symptoms, what is the clinical utility of endoscopy compared to an empirical trial of PPI therapy?

Group 1

- Merge with Q9 – look at comparison between, Endoscopy, PPI trial, and H pylori test and treat.
- Again – the indication should be both dyspepsia and GORD related symptoms.

9. In patients presenting with dyspepsia and / or heartburn symptoms without alarm signs or symptoms, what is the clinical utility of endoscopy compared with h pylori test and treat?

Group 1

- See Q8 for comment

3.3.1 f)

10. What tests should be used in patients with suspected GORD who have normal findings on endoscopy? (pH monitoring, oesophageal manometry, impedance, or a combination of these tests)?

Group 1

- Merge with Q11. Ask what tests to use in patients with normal edoscopy AND failed on PPI
- Clinical decision making needs to know which sequence in which to use PPI trial, endoscopy, and specialist tests (pH monitoring / manomety / impedance)

11. What is the diagnostic accuracy of combined pH and impedance testing in patients with suspected GORD who have had normal findings on endoscopy, no major motor abnormality on manometry and who have not responded to empirical trial of PPI therapy?

Group 1

- See Q10 for comment

12. What characteristics /symptoms of GORD indicate endoscopy (with biopsy) in order to exclude Barrett's Oesophagus?

Group 1

- Patients with greater severity and longer duration of symptoms tedn to be at higher risk
- This is an area where patients will ask about surveillance.
- There will be case control studies looking at risk factors of endoscoic appearance, clinical symptoms, and pathological factors.

3.3.1 g)

13. What is the diagnostic utility of the various tests to confirm H. pylori infection?

Group 1

- All these tests still used.
- Biopsy is still indeed the gold standard
- Serology may be less accurate for re-testing

3.3.1 h)

14. What is the comparative effectiveness of different PPIs for uninvestigated dyspepsia, gastric ulcer, duodenal ulcer, functional dyspepsia, and GORD?

Group 1

- Re-order questions with this one linked to Q17, and Q19.
- Little good data – mostly subgroup analysis. Perhaps some RCTs comparing different PPIs in severe (grade C and D) oesophagitis with GORD.
- Need to look at 'alternative' PPI regimens – Double dose, and varied timing – i.e. with food, or nocturnal.
- Also should consider safety of long term PPI use – probably as an outcome measure to look out for.

Group 2

- The group considered the difference between different PPIs. All PPIs can achieve acid suppression, though the acid suppression achieved with one PPI may require different dosages with others. The group did feel that it was probably ok to consider that all PPIs are equal, but stated that they were not sure that this was evidence-based.
- The group considered whether or not GPs generally need guidance on which PPI to prescribe, but did not come to any specific conclusion about this. When discharging care of a patient, most specialists do not specify which PPI the GP should prescribe in primary care.

15. In patients with symptoms of dyspepsia who are positive for helicobacter pylori, which eradication regimens are the most clinically effective in the eradication of H. pylori?

Group 1

- Should consider linking to work with NHS evidence group on Barretts' (John Houston).
- Re-order questions so this is linked to Q18 and Q22.
- Need to look for 2nd 3rd and 4th line
- Do include sequential eradication.

Group 2

- The group emphasised that local bacterial resistance is an important issue and that may impact on national guidance. This is further complicated with the fact that resistance is something that is continually changing. As a result, it was felt that advice from a microbiologist is important (this led into the discussion about the GDG constituency – see below). At the moment, it was felt that triple therapy is currently considered first-line and quadruple therapy as second-line treatment.

16. Should H. pylori eradication be used in patients with endoscopically confirmed GORD?

Group 1

- Useful to ask this question – but hard to define / identify this population.

17. What is the comparative effectiveness of different pharmacological treatments for uninvestigated dyspepsia, gastric ulcer, duodenal ulcer, functional dyspepsia, and GORD?

Group 1

- May be possible to lump all PPIs for this analysis

Group 2

- H2 blockers are generally not used as much as they were since PPIs are now considered more effective; however, they may be used in patients who do not tolerate PPIs. It was suggested that data on prescribing could be checked to confirm this.
- Pharmacological treatment is the same for both gastric and duodenal ulcers but the management is different as gastric ulcers have a higher chance of becoming malignant (so this may have an impact about follow-up after treatment for later questions here).

18. What H. pylori eradication regimens should be offered as second (or third) line treatments when first-line treatments fail?

Group 1

- See Q15 for comment

Group 2

- This is important to ask. It will depend on increasing resistance (as with question about first-line treatments).

19. What pharmacological treatments should be offered as second-line treatment when first-line treatment fails in uninvestigated dyspepsia, gastric ulcer, duodenal ulcer, functional dyspepsia, and GORD?

Group 1

- Linked to Questions 14 and 17.
- We should also look at H_2RAs for 2^{nd} and subsequent lines.

Group 2

- It was highlighted that it may not be appropriate to treat 'uninvestigated' dyspepsia with second line treatments when first-line has failed without doing further investigation into the cause of the symptoms. This will be removed from the scope for consultation.

20. What other medical treatments are effective if all the above pharmacological treatments fail?

Group 1

- No comment on this question – relates to Q17 also. Might require sensitivity analysis for different / alternative regimens.

Group 2

- Additional medical treatments include motility drugs and botox among others.
- However, the group commented that there are a large number of experimental treatments but group members felt they were not able to comment about the evidence base for these treatments.

- The group highlighted the difficulty in the situation where there are many alternative treatments for a difficult to define entity. The majority of patients will be effectively treated with PPIs. However, the evidence may show that there are other things that could currently be used.
- There was some discussion about probiotics but the group felt that patients do not commonly ask about the use of probiotics to treat these symptoms.

3.3.1 i)

21. Are psychological interventions effective in reducing symptoms in functional dyspepsia compared with no psychological intervention?

Group 1

- Yes limit to functional heartburn / dyspepsia only
- These interventions might be particularly useful in patients not responding to pharma therapy / refractory.

Group 2

- The group felt that it was good to ask this question as patients may be quite interested in psychological interventions.
- It was also highlighted that there is a difference between psychological interventions and complementary and alternative medicines.

3.3.1 j)

22. Should all patients treated with H. pylori eradication be retested for H. pylori to assess their response to treatment? Should only patients who do not respond to H. pylori eradication be retested for H. pylori?

Group 1

- Retesting may be necessary in non healing ulcers.
- Could compare retesting Vs going to 2nd lien therapy straight away.

Group 2

- The group felt that it was important to subdivide this question. Duodenal ulcer is different than dyspepsia in the GP/community setting. It may be of more relevance for ulcers that do not heal as there may be more concern that H pylori is eradicated. In the GP or community setting when symptoms have been treated, it may be less important to retest. GPs are likely to refer for a second opinion if symptoms aren't treated.

- It was also thought that this would be dependent on antibiotic resistance in the area.

23. Should patients with dyspepsia that respond to empirical treatment with PPIs or H. pylori eradication receive an endoscopy?

Group 1

- Group agreed that this question should be removed.

Group 2

- It was felt that this question is not necessary.

24. Should a repeat endoscopy be performed on all patients treated for ulcer dyspepsia to assess the response to treatment or should a repeat endoscopy be performed only on those patients where treatment has failed?

Group 2

- This question is different for gastric and duodenal ulcer. Repeat endoscopy is more important for gastric ulcer where treatment has failed to address symptoms.

25. Should a repeat endoscopy be performed on all patients treated for GORD with oesophagitis to assess response to treatment, or should a repeat endoscopy be performed only in those patients where treatment has failed?

Group 1

- Repeat endoscopy could identify either improvement in oesophagitis, or also progression to Barrett's Oesophagus.

Group 2

- It was felt that it may be important at some stage to consider repeat endoscopy in patients with oesophagitis without response to PPI treatment and no findings on biopsy, to see if there is another cause.

This was probably the only situation when patients with reflux symptoms should be considered for repeat endoscopy in GORD. It was suggested that this question be amended to take this into consideration.

3.3.1 k)

26. Are step-down regimens effective for patients being treated pharmacologically for dyspepsia or GORD?

Group 1

- Perhaps keep in scope but this is a low priority.
- Meta analysis concluded that there is no difference
- Patients will naturally step down without instruction if treatment is successful

Group 2

- It was felt that this was probably important to look at. One group member found that they do see situations where stepping down treatment brings back symptoms (ie. That it is not enough to control symptoms), therefore guidance on this issue would be helpful.

3.3.1 l)

27. What patient characteristics / criteria indicate referral of a patient with dyspepsia or GORD to a consultant-led medical or surgical service?

Group 1

- This could be a cost saving area if more patients are treated in GP.
- Patients who are referred tend to have co-morbidities
- Case control studies are available of long term care in the community.

Group 2

- The group felt that this was a key question for the interface between primary and secondary care.

3.3.1m)

28. What symptoms and/or diagnostic tests should be used to confirm a diagnosis of functional heartburn?

Group 1

- Wording of question should be changed to 'After what investigations can a diagnosis of functional heartburn be made'
- Should include H pylori eradication, PPI, Endoscopy and pH test on medication.

Group 2

- This question seemed reasonable. It is important to make sure all diagnostic tests, etc are done to confirm that there is nothing else that is treatable.

29. What is the effectiveness of tricyclic antidepressants in the management of functional heartburn?

Group 1

- Likely to be very little RCT data in this area (so could look at all comparisons between drugs and placebo), but a valid question nonetheless

Group 2

- The group commented that this is really a subquestion under question #17 above or even question 20 above when all other medical treatments have failed. Tricyclic antidepressants should be considered against PPIs or H2RA.

3.3.1 n)

30. What is the effectiveness of antral resection for treating refractory peptic ulcers (when the ulcer is not due to cancer) compared to long-term medical treatment?

Group 1

- This is very rare clinical situation. One consultant had seen 2 in 15 years…
- Remove question.

Group 2

- It was felt that a situation where antral resection was considered for refractory, benign cases would be extremely rare and only used as a very last resort. It was thought that it may have been done in the past but it was very unlikely that people are still doing this. If this question is considered, it would probably be best to limit the number of older studies (ie. using a date limit) since the comparators used in this older evidence may not be relevant comparators today (for example, older, more ineffective PPIs). There may be some more recent evidence but it is unlikely to be UK based.

3.3.1 o)

31. What is the effectiveness of laparoscopic fundoplication compared to medical management in patients with GORD?

Group 1

- This is a valid question. We should ensure that GDG member for surgery is a Laparoscopist.

Group 2

- It was felt that this is an important question.
- However, members felt that it may not be appropriate to lump all fundoplication procedures together (partial, full etc as was done in the REFLUX trial). The group also considered that fundoplication itself may not be especially effective, as sometimes stimulation of the oesophageal sphincter may have the same effect. For this reason, they felt that the literature may not tell the whole truth.

3.3.1 p)

32. Should surveillance be used for patients with Barrett's Oesophagus to detect progression to cancer?

Group 1

- This is a big question. Age and smoking may be risk factors.
- Should this fall within the remit of this guideline or elsewhere?

Group 2

- The group felt that this question does not fit within this guideline as it is really a much bigger question. A big issue is that the way that high-grade dysplasia has been treated has substantially changed. High-grade dysplasia was previously treated with oesophagectomy but now minimally invasive techniques are being used and are still being developed. Any recommendations made about surveillance are likely to require changing in the near future.

Proposed GDG composition

- 2 x Gastroenterologist
- 1 x Surgeon
- 2 x Pharmacist (Hospital & Community)
- 2 x Patient/carer member
- 2 x GP (1 x GP with specialist interest in commissioning)
- 1 x Microbiologist
- 1 x Nurse
- 1 x Dietician – potentially as a co-opted advisor
- 1 x Psychologist - potentially as a co-opted advisor
- 1 x Pathologist - potentially as a co-opted advisor

Group 1

- Surgeon should have experience of Laparoscopic surgery.
- Useful to have an expert in H pylori – this might come from microbiologist / gastroenterologist / epidemiologist.

Group 2

- There was general agreement with the proposed constituency. However, it was suggested that an additional microbiologist could be contacted as a co-opted advisor.