Appendix J: Recommendations from NICE clinical guideline 17 [2004] that have been amended

J.1.1 Amended recommendation wording (change to meaning)

Recommendation in 2004 guideline	Recommendation in 2014 guideline	Reason for change
1.2.3 Consider the possibility of cardiac or biliary disease as part of the differential diagnosis.	1.3.3 Think about the possibility of cardiac or biliary disease as part of the differential diagnosis. **[2004, amended 2014]**	Changed to make recommendation active.
1.3.6 Psychological therapies, such as cognitive behavioural therapy and psychotherapy, may reduce dyspeptic symptoms in the short term in individual patients. Given the intensive and relatively costly nature of such interventions, routine provision by primary care teams is not currently recommended.	1.2.4 Recognise that psychological therapies, such as cognitive behavioural therapy and psychotherapy, may reduce dyspeptic symptoms in the short term in individual people. **[2004, amended 2014]**	Changed to make recommendation active and to bring in line with the Guideline Manual 2012 and editorial guidance.
1.3.7 Patients requiring long-term management of dyspepsia symptoms should be encouraged to reduce their use of prescribed medication stepwise: by using the effective lowest dose, by trying as-required use when appropriate, and by returning to self-treatment with antacid and/or alginate therapy.	1.2.5 Encourage people who need long-term management of dyspepsia symptoms to reduce their use of prescribed medication stepwise: by using the effective lowest dose, by trying 'as-needed' use when appropriate, and by returning to self-treatment with antacid and/or alginate therapy (unless there is an underlying condition or comedication that needs continuing treatment). **[2004, amended 2014]**	Changed to make this recommendation active and for clarity as this recommendation now only applies to people without an underlying condition or comedication that needs continuing treatment.
1.4.1 Dyspepsia in unselected patients in primary care is defined broadly to include patients with recurrent epigastric pain, heartburn, or acid regurgitation, with or without	1.4.1 Be aware that dyspepsia in unselected people in primary care is defined broadly to include people with recurrent epigastric pain, heartburn or acid regurgitation, with or	Changed to make recommendation active and for clarity

Recommendation in 2004 guideline	Recommendation in 2014 guideline	Reason for change
bloating, nausea or vomiting. Review common elements of care for managing dyspepsia (section 1.3).	without bloating, nausea or vomiting. Also see 'Common elements of care'. **[2004, amended 2014]**	
1.4.2 Initial therapeutic strategies for dyspepsia are empirical treatment with a PPI or testing for and treating *H pylori*. There is currently insufficient evidence to guide which should be offered first. A 2-week washout period following PPI use is necessary before testing for *H pylori* with a breath test or a stool antigen test.	1.4.2 Leave a 2-week washout period after proton pump inhibitor (PPI) use before testing for *Helicobacter pylori* (hereafter referred to as *H pylori)* with a breath test or a stool antigen test. **[2004, amended 2014]**	Changed to make recommendation active and for clarity
1.4.6 Offer H_2RA or prokinetictherapy if there is an inadequate response to a PPI.	1.4.6 Offer H_2 receptor antagonist (H_2RA) therapy if there is an inadequate response to a PPI. **[2004, amended 2014]**	Reference to prokinetic therapy has been removed as the original guideline only reviewed the evidence for cisapride, not domperidone or metoclopramine. Cisapride has been suspended in the UK since the publication of CG17.
1.5.1 Offer people requiring long-term management of symptoms for dyspepsia an annual review of their condition, encouraging them to try stepping down or stopping treatment.	1.5.1 Offer people who need long-term management of dyspepsia symptoms an annual review of their condition, and encourage them to try stepping down or stopping treatment (unless there is an underlying condition or comedication that needs continuing treatment). **[2004, amended 2014]**	Changed for clarity.
1.5.2 A return to self-treatment with antacid and/or alginate therapy (either prescribed or purchased over-the-counter and taken as-required) may be appropriate.	1.5.2 Advise people that it may be appropriate for them to return to self-treatment with antacid and/or alginate therapy (either prescribed or purchased over-the-counter and taken as needed). **[2004, amended 2014]**	Changed to make recommendation active.
1.6.1 Gastro-oesophageal reflux disease (GORD)	1.6.1 Manage uninvestigated 'reflux-like'	Changed to make recommendation active.

Recommendation in 2004 guideline	Recommendation in 2014 guideline	Reason for change
refers to endoscopically determined oesophagitis or endoscopy-negative reflux disease. Patients with uninvestigated 'reflux-like' symptoms should be managed as patients with uninvestigated dyspepsia.	symptoms as uninvestigated dyspepsia. **[2004, amended 2014]**	
1.6.3 If symptoms recur following initial treatment, offer a PPI at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.	1.6.3 If symptoms recur after initial treatment, offer a PPI at the lowest dose possible to control symptoms. **[2004, amended 2014]**	Removed 'with a limited number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.6.5 Offer H_2RA or prokinetic therapy if there is an inadequate response to a PPI.	1.6.5 Offer H_2RA therapy if there is an inadequate response to a PPI. **[2004, amended 2014]**	Reference to prokinetic therapy has been removed as the original guideline only reviewed the evidence for cisapride, not domperidone or metoclopramine. Cisapride has been suspended in the UK since the publication of CG17.
1.7.3 Patients with gastric ulcer and *H pylori* should receive repeat endoscopy, retesting for *H pylori* 6–8 weeks after beginning treatment, depending on the size of the lesion.	1.7.3 Offer people with gastric ulcer and *H pylori* repeat endoscopy 6 to 8 weeks after beginning treatment, depending on the size of lesion. **[2004, amended 2014]**	The GDG felt the original recommendation needed to be split to reflect the different actions taken in each flowchart within the Full guideline. People with gastric ulcers needed an endoscopy and retesting, however just retesting for *H pylori* was necessary for people with duodenal ulcers.
1.7.3 Patients with gastric ulcer and *H pylori* should receive repeat endoscopy, retesting for *H pylori* 6–8 weeks after beginning treatment, depending on the size of the lesion.	1.7.4 Offer people with peptic ulcer (gastric or duodenal) and *H pylori* retesting for *H pylori* 6 to 8 weeks after beginning treatment, depending on the size of lesion. **[2004, amended 2014]**	The GDG felt the original recommendation needed to be split to reflect the different actions taken in each flowchart within the Full guideline. People with gastric ulcers needed an endoscopy and retesting, however just retesting for *H pylori* was necessary for people with duodenal ulcers.

Recommendation in 2004 guideline	Recommendation in 2014 guideline	Reason for change
		The GDG felt peptic ulcer was the more appropriate term to use and included gastric and duodenal for further clarification.
1.7.8 If symptoms recur following initial treatment, offer a PPI to be taken at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions. Discuss using the treatment on an as-required basis with patients to manage their own symptoms.	1.7.9 If symptoms recur after initial treatment, offer a PPI to be taken at the lowest dose possible to control symptoms. Discuss using the treatment on an 'as-needed' basis with people to manage their own symptoms. **[2004, amended 2014]**	Removed 'with a limited number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.8.4 If *H pylori* has been excluded or treated and symptoms persist, offer either a low-dose PPI or an H_2RA for 1 month.	1.8.4 If *H pylori* has been excluded and symptoms persist, offer either a low-dose PPI (see table 1 in appendix A) or an H_2RA for 4 weeks. **[2004, amended 2014]**	Treatment has been removed from this recommendation and this is now covered by recommendations on *H pylori* eradication.
1.8.5 If symptoms continue or recur following initial treatment offer a PPI or H_2RA to be taken at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.	1.8.5 If symptoms continue or recur after initial treatment offer a PPI or H_2RA to be taken at the lowest dose possible to control symptoms. **[2004, amended 2014]**	Removed 'with a limited number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.8.7 Long-term, frequent dose, continuous prescription of antacid therapy is inappropriate and only relieves symptoms in the short term rather than preventing them.	1.8.7 Avoid long-term, frequent dose, continuous antacid therapy (it only relieves symptoms in the short term rather than preventing them). **[2004, amended 2014]**	Changed to make recommendation active and for clarity.
1.9.1 *H pylori* can be initially detected using a carbon-13 urea breath test or a stool antigen test, or laboratory-based serology where its performance has been locally validated	1.9.1 Test for *H pylori* using a carbon-13 urea breath test or a stool antigen test, or laboratory-based serology where its performance has been locally validated. **[2004, amended 2014]**	Changed to make recommendation active.

Recommendation in 2004 guideline	Recommendation in 2014 guideline	Reason for change
1.9.3 Office-based serological tests for *H pylori* cannot be recommended because of their inadequate performance.	1.9.3 Do not use office-based serological tests for *H pylori* because of their inadequate performance. **[2004, amended 2014]**	Changed to make recommendation active.