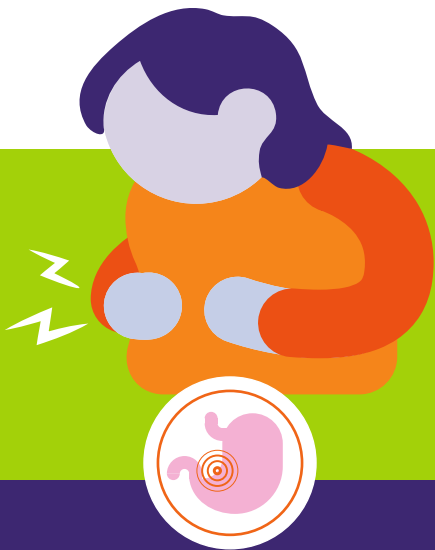


YOUR

FUNCTIONAL DYSPEPSIA DIAGNOSIS CHECK LIST



How to define functional dyspepsia?

The two subtypes of functional dyspepsia

What do we know about the pathophysiology?

How to make a confident diagnosis?

What are the warning signs to be excluded?

Which investigations are needed?

What are the general management concepts?

When to schedule follow-up care?

References

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HOW TO DEFINE FUNCTIONAL DYSPEPSIA?

A **chronic disorder** defined by **abdominal** symptoms originating from the **upper gastrointestinal (GI) region**

A disorder of **gut-brain interaction (DGBI)** ⁽¹⁾



4 MAIN SYMPTOMS ⁽²⁾

It's like being stabbed from the inside out. ,



Epigastric pain

My stomach burns like it's on fire. ,



Epigastric burning

I feel full even if I don't eat much. ,



Early satiety
(inability to finish a meal)

I feel like I have a stone in my stomach. ,



Postprandial fullness
(after a normal-size meal)



the **absence of structural disease** on routine investigations (endoscopy)



• Prevalence of **7% of adults** ⁽⁴⁾ depending on the geographical region and the criteria used for assessment ⁽⁵⁾

• **Very common overlap with gastroparesis, reflux, Irritable Bowel Syndrome, and bloating symptoms**

LIST OF SYNONYMOUS DISORDER NAMES:
Indigestion, gastritis, non-ulcer dyspepsia



What to tell the patient?



What is a DGBI?

The stomach and bowel talk to the brain, and the brain talks to the gut.

A disorder of gut-brain interaction (DGBI) means the signalling is disturbed leading to symptoms. One common example of a DGBI is functional dyspepsia (FD).

In FD the brain receives too many signals from the stomach which are normally filtered.

What to say about functional dyspepsia?

Recurrent fullness (often called bloating), epigastric pain or burning and difficulty finishing a normal meal (early satiation), characterize this symptom-based disorder named FD.

FD is a disorder of gut-brain interaction, the two organs don't communicate with each other properly.

FD is a symptom-based disorder with no tissue damage.

Gastrointestinal symptoms do not come alone, FD is often accompanied by higher levels of psychological upset such as anxiety, stress and depression.

THE TWO SUBTYPES OF FUNCTIONAL DYSPEPSIA

Postprandial Distress Syndrome (PDS) → The most common form



POSTPRANDIAL
FULLNESS



EARLY
SATIATION

May be associated with other
postprandial* symptoms :
**pain, burning, nausea, bloating,
excessive belching**

* Symptoms triggered/worsened within 2 hours after meal intake

Epigastric Pain Syndrome (EPS)



EPIGASTRIC PAIN



EPIGASTRIC
BURNING

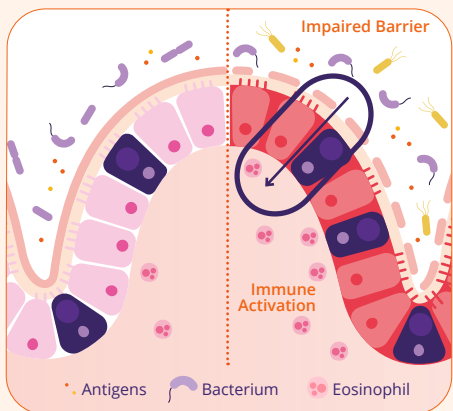
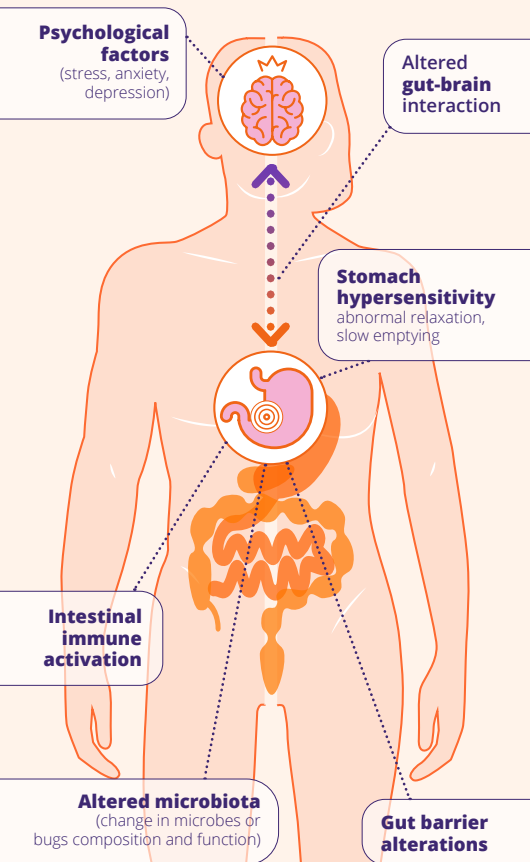
Symptoms **may be meal-related**
or **meal-unrelated**

Sources : (3), (4)

Postprandial epigastric pain/burning
associated with PDS symptoms
should always be classified as PDS



WHAT DO WE KNOW ABOUT THE PATHOPHYSIOLOGY?



Source: adapted from (1)



What to tell the patient?



What is microbiota?

The microbial communities that live inside the gut are called microbiota.

An unbalanced duodenal microbiota or dysbiosis, is a change in the composition and functions of the microorganisms that live in the gut.

Food, bacteria, or substances found in the gut can sometimes cause the gut to malfunction and trigger symptoms.

What is the management of FD?

FD is a chronic disorder where symptoms can be managed through lifestyle changes, dietary therapy, medications and psychological therapies.

We will meet every 2-3 months to follow up the effectiveness of the treatment/strategy.

HOW TO MAKE A CONFIDENT DIAGNOSIS?

The diagnosis is based on symptoms according to Rome V criteria^{(2), (3)}:

Question to ask

When do the symptoms start?

- ✓ Presence of at least one symptom severe enough to impact usual activities → in the last past **3 months** and at least for **6 months** prior to diagnosis

PDS

at least 2 days
per week



Postprandial fullness
(after a normal-size meal)



Early satiation
(inability to finish a meal)

EPS*

at least once
per week



Epigastric pain



Epigastric burning

- ✓ and no evidence of structural disease (including on upper endoscopy) that is likely to explain the symptoms.

* Symptoms localized to the epigastrium (central upper abdomen).

RISK FACTORS⁽⁴⁾

- ✓ *Helicobacter pylori* infection
- ✓ Being female
- ✓ Using certain pain relievers such as aspirin and ibuprofen
- ✓ Smoking
- ✓ Anxiety or depression
- ✓ History of childhood physical or sexual abuse





WHAT ARE THE WARNING SIGNS TO BE EXCLUDED?

**Checklist of alarm signs to exclude
to confirm the diagnosis**

ALARM SYMPTOMS ⁽⁶⁾

- ☒ Age > 55 years* with new-onset dyspepsia
- ☒ Evidence of overt gastrointestinal bleeding including melena or haematemesis
- ☒ Dysphagia, especially if progressive, or odynophagia
- ☒ Predominant nausea and/or persistent vomiting
- ☒ Symptoms consistently relieved by defecation
- ☒ Unintentional weight loss
- ☒ Family history of gastric or oesophageal cancer
- ☒ Palpable abdominal or epigastric mass or abnormal adenopathy
- ☒ Evidence of iron-deficiency anaemia after blood testing

**In regions with a high background prevalence rate of gastric cancer, such as Southeast Asia, a lower age threshold should be considered.*

**IN CASE OF A YES ADDITIONAL
EVALUATION SHOULD BE
CONSIDERED**

**REFER TO
GASTROENTEROLOGIST
FOR REVIEW**





WHAT INVESTIGATIONS ARE NEEDED

RECOMMENDED AS ROUTINE TESTS



- *H. pylori* test is recommended as the first one to be carried out: *stool antigen, urea breath test*
 - *Evaluation of the lower GI symptoms as IBS frequently overlaps with FD; in that case essential to assess for celiac disease*
 - *Assessment of the drug history (particularly about opioids and cannabis) + NSAIDs*
-

CONSIDER IN SPECIFIC CASE



- *Endoscopy for patients with recent onset symptoms and weight loss, and more than 55 years old; biopsy should be done if H. pylori status is unknown at endoscopy*
 - *Gastric emptying testing (preferable scintigraphy) in case of nausea/vomiting*
-

NOT USEFUL AS ROUTINE TEST



- **Blood testing**



WHAT ARE THE GENERAL MANAGEMENT CONCEPTS?

1 LIFESTYLE ADVICE



Healthy diet

Limiting the intakes of potential dietary triggers (caffeine, spicy food...)

Regular physical activity



Regular sleep

Probiotics



If failure

2 DRUG-BASED TREATMENT

Acid suppression

PPIs or H2RA

Prokinetics

D2-antagonist, 5HT4/motilin-agonists



If failure



Consider referral to a Gastroenterologist

3 NEUROMODULATORS

Tricyclic antidepressant

If failure

4 Cognitive behaviour therapy, hypnotherapy, stress management





What to tell the patient?



Most frequently asked questions

Can I be cured? Is it chronic/forever?

FD can be treated but not cured.
Recovery by itself is possible

Am I likely to develop cancer?

FD is not putting the patient at risk in developing any cancers

What causes FD?

FD is multifactorial disorder caused by altered gut sensitivity, motility, microbiota and communication between the gut and the brain

Can diet help reduce symptoms?

Diet is relevant and constitutes a strong ally

Does drinking water help dyspepsia?

Water does not improve FD

Can I die from FD?

FD does not increase the risk of death

WHEN TO SCHEDULE FOLLOW-UP CARE?



Follow-up approach depends on response to treatment (many non-responders)

2-3 months

is a good interval for follow-up, with increasing intervals in case of treatment response

Depending on the patient's initiative

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