Editorial

Dyspepsia

HG Desai

Dyspepsia is a Greek word meaning “duis” (bad or difficult) and “peptin” (to digest), which is described by patients as indigestion; both these words are a poor expression, as dyspepsia has no relation to digestion of food. Dyspepsia refers to upper abdominal symptoms usually following intake of food, which appear to arise from an abnormality in the upper gastrointestinal tract. Dyspepsia is a symptom and not a diagnosis. Symptoms may last for decades (even lifetime) and remissions and relapses are common. It is one of the commonest gastrointestinal malady affecting at least 25% of the population during a year. Its prevalence varies in different countries, depending upon the prevalence of Helicobacter pylori (H. pylori) infection, obesity, drug - alcohol - tobacco intake and spices in diet; furthermore, a significant and varying number of subjects do not seek medical treatment.1

Symptomatology: Symptoms of dyspepsia are due to diseases of stomach - duodenum and include: abdominal pain above umbilicus, retrosternal burning, regurgitation, belching (or eructation), abdominal distension (fullness), nausea, vomiting (occasional), early satiety after meals.

Functional dyspepsia was defined as “upper abdominal or retrosternal pain or discomfort, heartburn, nausea or vomiting or other symptoms considered to be referable to the proximal alimentary tract and lasting for more than 4 weeks, unrelated to exercise and for which no local lesion or systemic disease can be responsible.2

Symptoms of dyspepsia are divided into reflux-type (retrosternal burning, regurgitation), ulcer-type (epigastric pain on empty stomach relieved with bland food, antacids or acid suppression drugs), dysmotility-type (postprandial fullness, distension, early satiety, nausea). Rome II criteria excluded symptoms of reflux-type, irritable bowel syndrome (pain relieved with defecation, with diarrhoea or constipation) and hepatobiliary diseases (biliary dyskinesia); chronicity of symptoms for 12 weeks at least (not continuous) during 12 months was emphasised.3,4 Rome III criteria divided functional dyspepsia in 2 groups : (i) predominant epigastric pain or burning (the epigastric pain syndrome) and (ii) early satiety or fullness following a meal (the postprandial distress syndrome).

Rome I, Rome II, Rome III criteria described by renowned gastroenterologists indicate that dyspepsia (difficult to digest) is in fact difficult to define. Are “Rome IV” criteria required, to exclude chronic gastritis (gastric biopsy), giardia lamblia (duodenal fluid or biopsy), lactase deficiency (milk intolerance history)?

Dyspepsia may be classified as :

a. Organic dyspepsia: erosive oesophagitis, gastric erosions, acute or chronic gastritis, gastric ulcer, duodenal ulcer, duodenitis, malignancy (carcinoma, lymphoma). Evidence of an organic disease is observed on upper gastrointestinal endoscopy (and gastric biopsy), or barium meal. It is suspected in presence of alarm symptoms (weight loss, anaemia, bleeding or occult blood positive, and loss of appetite) or symptoms occurring at night.

b. Functional or non-ulcer dyspepsia: A patient with anxiety, worry over serious illness (cancer) and/or experiencing adverse events recently, is likely to suffer from dyspepsia. No organic lesion is detected on investigations.

c. Drug related: aspirin, non-steroidal anti-inflammatory drugs (NSAID), antibiotics, bisphosphonates (alendronate), oestrogens, steroids, digoxin, chloroquine, potassium supplements, iron, etc. Detailed history of drug intake (present and recent past) should be recorded and rechecked.

d. Extraintestinal systemic diseases such as diabetes mellitus, hypothyroid, hyperparathyroid, Addison’s disease, uremia. Symptoms of endocrine diseases, are looked for after organic dyspepsia is excluded.

Treatment: Young patients (<40 years) with dyspepsia without any alarm symptoms may be treated empirically with proton pump inhibitors (PPI), with or without prokinetics, for 2-4 weeks. Proton Pump Inhibitors should be given in dosage of omeprazole or rabeprazole (20 mg), or lansoprazole (30 mg), or pantoprazole or esomeprazole (40 mg) per day. Endoscopy is not considered necessary as incidence of malignancy is very low in this group. The other option is to perform non-invasive test for Helicobacter pylori (urea breath or stool antigen) and treat accordingly.

Prokinetics are preferred for dysmotility – type dyspepsia. Dopamine receptor antagonists: metoclopramide, domperidone (10 mg TDS) are used. Antidepressant amitryptyline 25 mg at bedtime may help. Anxious patients may benefit from anxiolytic drug (lorazepam).

Patients with functional dyspepsia should be reassured that they do not have serious illness after minimum investigations. Drugs, excessive tea, alcohol, tobacco ingestion, smoking, causing gastritis are omitted. Dietetic instructions such as small frequent meal, less water with meals, omission of chillies, will help. A physician-patient relationship determines the success rate.

Various chapters have been written by senior gastroenterologists in this issue from different institutions of India and deserve congratulations for their excellent presentation.

References

*Department of Gastroenterology, Jaslok Hospital and Research Centre, Mumbai