Patient summary from British Society of Gastroenterology guidelines on the management of functional dyspepsia.

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This guideline has been produced on behalf of the British Society of Gastroenterology (BSG) to update the previous one published in 1996. The guideline has been written by a team of specialists including gastroenterologists, psychiatrists, general practitioners (GPs) and physiologists. Patients have reviewed the guideline and added their perspective. The guideline is intended for healthcare professionals who look after patients with FD.

Dyspepsia, often referred to as indigestion, is very common. It consists of symptoms such as pain or burning in the upper part of the abdomen (tummy), feeling abnormally full-up early on in a meal, or experiencing a heaviness in the abdomen that may be worse after eating. These symptoms arise from problems with the stomach or the first part of the small intestine, called the duodenum. Together these are referred to as the upper gut. Sometimes these symptoms can be due to an underlying cause, such as an ulcer. However, in most cases, tests find no abnormality and this condition is referred to as FD.

Importantly, normal test results do not mean that there is no cause for FD. It is caused by issues with the two-way communication between the upper gut and the brain. Problems with the nerves supplying the stomach and duodenum may make them more sensitive to normal function. Sometimes the stomach may be slower to empty, contributing to feelings of early fullness. Psychological factors, such as stress, certain foods or changes in the micro-organisms (bugs) living in the upper gut may also play a role in triggering symptoms.

Some patients with FD learn to manage their symptoms themselves, by changing their lifestyle or diet or managing stress differently. Other patients will consult with their GP who can normally make a diagnosis of FD based on typical symptoms. However, if patients are older when their symptoms start, or if they have a family history of cancer of the oesophagus (gullet) or stomach, referral to a specialist for further tests is required. This may include a

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camera test (endoscopy) to look inside the oesophagus, stomach and duodenum, or a scan of the abdomen to exclude any serious cause for symptoms. Even among patients who undergo further investigation, the likelihood of finding serious problems, like cancer, remains low.

Regular exercise and lifestyle changes, like avoiding certain foods that may trigger symptoms, will be helpful for some patients. However, these is no evidence for any specialised diets for treating FD and restricting diet too much could lead to malnutrition or abnormal eating habits.

All patients with FD should be offered a stool test or breath test to look for a stomach infection called H. pylori. If the test is positive, they should receive a short course of antibiotic treatment for the infection to see if their symptoms improve. Patients who test negative, or patients who test positive, but whose symptoms continue after antibiotics, should be offered other medications to treat their symptoms.

This guideline has reviewed the evidence for which medications work, and the possible harms they may cause. We have only recommended medications with good evidence that they are more efficacious than a placebo. We have not recommended tests or treatments where the evidence is that they do not help, are harmful, or where there is not enough evidence. Some medications have most of their effect in the gut, often working to reduce stomach acid or helping the stomach to empty more quickly. Other drugs work at the level of the brain and the nervous system also present in the upper gut. These are so-called ‘neuromodulators’, and they help reduce the abnormal sensitivity of these nerves. Unfortunately, not all drugs that may be efficacious in FD are available in all countries.

There is some evidence to suggest that psychological or behavioural therapies may be beneficial for treating symptoms in FD. These therapies use the fact our brain and upper gut nerves are connected and can influence each other. With appropriate training our brain can help control the sensations from our upper gut. Work is needed to improve the availability of these treatments for patients.

Very severe symptoms that do not respond to any of the treatments discussed above are rare. In this situation, it is recommended that patients are managed by a multidisciplinary team of specialists, including GPs, dietitians, gastroenterologists and psychologists. This should help to ensure that patients have access to high-quality, expert, advice based on up-to-date research, while reducing harm from unnecessary investigations and procedures, or harmful drugs.

Our knowledge of the causes and treatment of FD has improved over the past 20 years. However, there are still things that we do not fully understand about the condition. This

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means that there are many active areas for future research and new treatments to be explored. We hope that this guideline will also help to highlight and prioritise these issues.

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