

# Dyspepsia and gastro-oesophageal reflux disease in adults: investigation and management

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**NICE quality standard 96**

[guidance.nice.org.uk/qs96](http://guidance.nice.org.uk/qs96)

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## Contents

Introduction.....	5
Why this quality standard is needed .....	5
How this quality standard supports delivery of outcome frameworks .....	6
Patient experience and safety issues.....	11
Coordinated services .....	11
List of quality statements .....	13
Quality statement 1: Advice to support self-management .....	14
Quality statement .....	14
Rationale .....	14
Quality measures .....	14
What the quality statement means for service providers, healthcare professionals and commissioners .....	15
What the quality statement means for patients, service users and carers .....	16
Source guidance .....	16
Definitions of terms used in this quality statement .....	16
Equality and diversity considerations .....	17
Quality statement 2: Urgent endoscopy .....	18
Quality statement .....	18
Rationale .....	18
Quality measures .....	18
What the quality statement means for service providers, healthcare professionals and commissioners .....	20
What the quality statement means for patients, service users and carers .....	21
Source guidance .....	21
Definitions of terms used in this quality statement .....	21
Equality and diversity considerations .....	21
Quality statement 3: Testing conditions for <i>Helicobacter pylori</i> .....	22

---

Quality statement .....	22
Rationale .....	22
Quality measures .....	22
What the quality statement means for service providers, healthcare professionals and commissioners .....	23
What the quality statement means for patients, service users and carers .....	23
Source guidance .....	24
Definitions of terms used in this quality statement .....	24
Equality and diversity considerations .....	25
<b>Quality statement 4: Discussion about referral for non-urgent endoscopy .....</b>	<b>26</b>
Quality statement .....	26
Rationale .....	26
Quality measures .....	26
What the quality statement means for service providers, healthcare professionals and commissioners .....	27
What the quality statement means for patients, service users and carers .....	28
Source guidance .....	28
Definitions of terms used in this quality statement .....	28
Equality and diversity considerations .....	29
<b>Quality statement 5: Referral to a specialist service .....</b>	<b>30</b>
Quality statement .....	30
Rationale .....	30
Quality measures .....	30
What the quality statement means for service providers, healthcare professionals and commissioners .....	31
What the quality statement means for patients, service users and carers .....	32
Source guidance .....	32
Definitions of terms used in this quality statement .....	32

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Equality and diversity considerations .....	33
Using the quality standard .....	34
Quality measures .....	34
Levels of achievement .....	34
Using other national guidance and policy documents .....	34
Information for the public.....	35
Diversity, equality and language.....	36
Development sources.....	37
Evidence sources.....	37
Policy context .....	37
Definitions and data sources for the quality measures .....	37
Related NICE quality standards .....	39
Published.....	39
In development.....	39
Future quality standards.....	39
Quality Standards Advisory Committee and NICE project team .....	41
Quality Standards Advisory Committee .....	41
NICE project team.....	43
About this quality standard .....	45

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## Introduction

This quality standard covers the investigation and management of dyspepsia and gastro-oesophageal reflux disease (GORD) symptoms in adults 18 and older. It includes the investigation of dyspepsia and GORD symptoms as a risk factor for oesophagogastric cancer but it does not include the diagnosis and management of oesophagogastric cancer because this will be covered by a separate quality standard. For more information see the [topic overview](#).

NICE quality standards focus on aspects of health and social care that are commissioned locally. Areas of national policy, such as surveillance of *Helicobacter pylori* (*H pylori*), or public health campaigns to highlight cancer risk, are therefore not covered by this quality standard.

### ***Why this quality standard is needed***

Dyspepsia describes a range of symptoms arising from the upper gastrointestinal (GI) tract. Symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, and nausea or vomiting. The causes of dyspepsia symptoms include gastric and duodenal ulcers (strongly associated with the bacterium *H pylori*), GORD, oesophagitis and oesophageal or gastric cancers. In many cases, the cause is unknown (functional dyspepsia). In addition, certain foods and medicines (such as non-steroidal anti-inflammatory drugs) are believed to contribute to the symptoms and underlying causes.

GORD is a chronic condition in which gastric juices from the stomach (usually acidic) flow up into the oesophagus. It can lead to an abnormality of the cells in the lining of the oesophagus (Barrett's oesophagus), which is itself considered the most important risk factor for oesophageal adenocarcinoma. There are several risk factors for GORD, including hiatus hernia, certain foods, heavy alcohol use, smoking, and pregnancy, but there is also a genetic component. There is some evidence to suggest that GORD is more likely to occur in socially disadvantaged people, and its prevalence increases with age.

The prevalence of dyspepsia depends on the definition used and is estimated to be between 12 and 41% of the general population.

Almost all causes of dyspepsia are recurrent and intermittent in nature. The only definitive treatments for dyspepsia symptoms are *H pylori* eradication therapy if the person has peptic ulcer disease and *H pylori*, and surgery if the person has GORD. Other treatments such as

proton pump inhibitors (PPI) do not address underlying reasons for dyspepsia; once treatment stops, symptoms may return.

Dyspepsia accounts for between 1.2 and 4% of all consultations in primary care in the UK. Half of these are for functional dyspepsia, in which the cause cannot be determined. There has been an upward trend in prescribing for dyspepsia and GORD, particularly proton pump inhibitors. The use of endoscopy has also increased considerably over the past decade, as awareness of its value in diagnosing dyspepsia and GORD has grown. Some of the costs associated with treating dyspepsia and GORD are decreasing, but the overall use of treatments is increasing. As a result, the management of dyspepsia and GORD continues to have potentially significant costs to the NHS.

This quality standard focuses on improving the overall care of adults with dyspepsia and GORD and the management of their condition, to promote self-management, support people with persistent and unexplained symptoms, improve consistency of referral for endoscopy and the quality of testing for *H pylori*.

The quality standard is expected to contribute to improvements in the following outcomes:

- incidence of oesophagogastric cancer
- oesophagogastric cancer mortality rates
- oesophagogastric cancer survival rates
- *H pylori* antimicrobial resistance rates
- self-management of dyspepsia
- health-related quality of life
- patient experience of primary care.

## ***How this quality standard supports delivery of outcome frameworks***

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical

effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1 NHS Outcomes Framework 2015–16**

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><b>Overarching indicator</b></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p><b>Improvement area</b></p> <p><b>Reducing premature mortality from the major causes of death</b></p> <p>1.4 Under 75 mortality rate from cancer (PHOF 4.5*)</p> <p>i One and ii Five-year survival from all cancers</p> <p>v One and vi Five-year survival from cancers diagnosed at stage 1&amp;2 (PHOF 2.19**)</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p><b>Overarching indicator</b></p> <p>2 Health-related quality of life for people with long-term conditions (ASCOF1A**)</p> <p><b>Improvement areas</b></p> <p><b>Ensuring people feel supported to manage their condition</b></p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p><b>Improving functional ability in people with long-term conditions</b></p> <p>2.2 Employment of people with long-term conditions (PHOF 1.8*, ASCOF 1E**)</p>
<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p><b>Overarching indicator</b></p> <p>3a Emergency admissions for acute conditions that should not require hospital admission</p> <p><b>Improvement area</b></p> <p><b>Improving outcomes from planned treatments</b></p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p>i <i>Physical health-related procedures</i></p>

<p>4 Ensuring that people have a positive experience of care</p>	<p><b>Overarching indicator</b></p> <p>4a Patient experience of primary care</p> <p>i GP services</p> <p>4b Patient experience of hospital care</p> <p><i>4c Friends and family test</i></p> <p><i>4d Patient experience characterised as poor or worse</i></p> <p><i>i Primary care</i></p> <p><i>ii Hospital care</i></p> <p><b>Improvement area</b></p> <p><b>Improving people's experience of outpatient care</b></p> <p>4.1 Patient experience of outpatient services</p>
<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p><b>Improvement area</b></p> <p><b>Reducing the incidence of avoidable harm</b></p> <p>5.2 Incidence of healthcare-associated infection (HCAI)</p> <p>ii <i>C. difficile</i></p>
<p><b>Alignment across the health and care system</b></p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p><i>Indicators in italics are in development</i></p>	

**Table 2 Public health outcomes framework for England, 2013–16**

Domain	Objectives and indicators
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<p>Vision: To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest</p>	<p><b>Outcome measure</b></p> <p>Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life</p> <p>Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)</p>
<p>1 Improving the wider determinants of health</p>	<p><b>Objective</b></p> <p>Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p><b>Indicators</b></p> <p>1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services (NHSOF 2.2*, ASCOF 1E**)</p> <p>1.9 Sickness absence rate</p>
<p>2 Health improvement</p>	<p><b>Objective</b></p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p><b>Indicators</b></p> <p>2.11 Diet</p> <p>2.12 Excess weight in adults</p> <p>2.14 Smoking prevalence – adults (over 18s)</p> <p>2.19 Cancer diagnosed at stage 1 and 2</p> <p>2.23 Self-reported well-being</p>

<p>4 Healthcare public health and preventing premature mortality</p>	<p><b>Objective</b></p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p><b>Indicators</b></p> <p>4.3 Mortality rate from causes considered preventable (NHSOF 1a<sup>**</sup>)</p> <p>4.5 Under 75 mortality rate from cancer (NHSOF 1.4<sup>*</sup>)</p> <p>4.13 Health-related quality of life for older people</p>
<p><b>Alignment across the health and care system</b></p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p>	

## ***Patient experience and safety issues***

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to dyspepsia and GORD.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

## ***Coordinated services***

The quality standard for dyspepsia and GORD specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole dyspepsia and

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GORD care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with dyspepsia and GORD.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality dyspepsia and GORD service are listed in [related quality standards](#).

### **Training and competencies**

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults with dyspepsia and GORD should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

### **Role of families and carers**

Quality standards recognise the important role families and carers have in supporting adults with dyspepsia and GORD. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

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## List of quality statements

Statement 1. Adults with dyspepsia or reflux symptoms who present to community pharmacists are given advice about making lifestyle changes, using over-the-counter medicines and when to consult their GP.

Statement 2. Adults presenting with dyspepsia or reflux symptoms are referred for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia, or are aged 55 and over with weight loss.

Statement 3. Adults with dyspepsia or reflux symptoms have a 2 week washout period before a test for *Helicobacter pylori* if they are receiving proton pump inhibitor therapy.

Statement 4. Adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment have a discussion with their GP about referral for non-urgent direct access endoscopy.

Statement 5. Adults with persistent, unexplained dyspepsia or reflux symptoms have a discussion with their GP about referral to a specialist service.

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## Quality statement 1: Advice to support self-management

### *Quality statement*

Adults with dyspepsia or reflux symptoms who present to community pharmacists are given advice about making lifestyle changes, using over-the-counter medicines and when to consult their GP.

### *Rationale*

Adults with dyspepsia or reflux symptoms who present to their community pharmacist may be able to alleviate and manage their symptoms by making changes to their lifestyle (eating healthily, losing weight if they are overweight, not smoking) and using over-the-counter medicines. It is also important that adults receive advice about when they should consult their GP to ensure that symptoms are investigated and managed appropriately.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure that adults with dyspepsia or reflux symptoms who present to their community pharmacist are given advice about making lifestyle changes, using over-the-counter medicines and when to consult their GP.

**Data source:** Local data collection.

#### **Process**

Proportion of presentations of adults with dyspepsia or reflux symptoms to community pharmacists in which advice is received about making lifestyle changes, using over-the-counter medicines and when to consult a GP.

Numerator – the number in the denominator in which advice is received about making lifestyle changes, using over-the-counter medicines and when to consult a GP.

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Denominator – the number of presentations of adults with dyspepsia or reflux symptoms to community pharmacists.

**Data source:** Local data collection.

## Outcome

Adults with dyspepsia or reflux symptoms are satisfied that they are able to self-manage their condition.

**Data source:** Local data collection.

Patient-reported health outcomes for adults with dyspepsia or gastro-oesophageal reflux disease.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (community pharmacists) ensure that processes are in place so that adults presenting with dyspepsia or reflux symptoms receive advice about making lifestyle changes, using over-the-counter medicines and when to consult their GP. This may include providing information leaflets when over-the-counter medicines are purchased.

**Community pharmacists** advise adults presenting with dyspepsia or reflux symptoms about making lifestyle changes, using over-the-counter medicines and when to consult their GP.

**Commissioners** (NHS England area teams and clinical commissioning groups) commission services that ensure community pharmacists advise people presenting with dyspepsia or reflux symptoms about making lifestyle changes, using over-the-counter medicines and when to consult their GP. Commissioners should work collaboratively with available minor ailment schemes to ensure that advice to adults with dyspepsia or reflux symptoms is included in any relevant service specifications.

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## ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** receive advice from their pharmacist about what they can do to relieve their symptoms. This should include advice about eating healthily, losing weight if they are overweight and not smoking. They should also receive information about medicines that can be bought 'over-the-counter' without a prescription and when people should make an appointment to see their GP. This information will help adults with indigestion or heartburn to manage their condition themselves.

### ***Source guidance***

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184, recommendations 1.1.1, 1.2.1, 1.2.2, and 1.2.3.

## ***Definitions of terms used in this quality statement***

### **Advice about lifestyle changes**

Adults presenting with dyspepsia or reflux symptoms should be given simple lifestyle advice including:

- Healthy eating, weight loss for people who are overweight and smoking cessation for people who smoke.
- Avoiding known causes that may be associated with symptoms, including smoking, alcohol, coffee, chocolate, fatty foods and being overweight.
- Other factors that might help, such as raising the head of the bed and having a main meal at least 3 hours before going to bed.

[[Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.2.1, 1.2.2 and information for the public]

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## Advice about using over-the-counter medication

Adults presenting with dyspepsia or reflux symptoms should be advised to avoid long-term, frequent dose, continuous antacid therapy, because it only relieves symptoms in the short-term rather than preventing them. Adults with these symptoms should also be advised that non-steroidal anti-inflammatory drugs (NSAIDs) can be a potential cause.

[Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.3.2 and 1.8.7]

## Advice about when to consult their GP

Adults presenting with dyspepsia or reflux symptoms should be advised to see their GP if their symptoms have persisted for several weeks, get worse over time, or do not improve with medication. They should be advised to see their GP urgently if they have dysphagia or if they are aged 55 and over with additional symptoms that may be a cause for concern including weight loss, haematemesis, nausea or vomiting, or upper abdominal pain.

[Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE full guideline CG184) section 4.1.2.1, [Suspected cancer](#) (NICE guideline NG12) recommendations 1.2.1, 1.2.2, 1.2.3, 1.2.7, 1.2.8, 1.2.9, and expert opinion]

## ***Equality and diversity considerations***

Healthcare professionals should offer prescriptions to socially disadvantaged adults for over-the-counter medicines for dyspepsia or reflux symptoms if needed.

Community pharmacists should take into account cultural and communication needs when providing advice and educational materials.

Not all adults will want to self-manage their dyspepsia or reflux symptoms, or be able to do so, and community pharmacists should identify any vulnerable people who may need additional support.

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## Quality statement 2: Urgent endoscopy

### *Quality statement*

Adults presenting with dyspepsia or reflux symptoms are referred for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia, or are aged 55 and over with weight loss.

### *Rationale*

There is currently wide geographical variation in referral rates for endoscopy for adults with dyspepsia or reflux symptoms. Although many adults presenting with dyspepsia or reflux symptoms will not need an endoscopy, it is important that those with additional symptoms that indicate a higher risk of oesophagogastric cancer are referred urgently for investigation. Direct access endoscopy will ensure that referrals from primary care to the suspected cancer pathway are focused on people with symptoms of suspected cancer.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure that adults presenting with dyspepsia or reflux symptoms are referred for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia, or are aged 55 and over with weight loss.

**Data source:** Local data collection.

#### **Process**

a) Proportion of adults presenting with dyspepsia or reflux symptoms and dysphagia who are referred for urgent direct access endoscopy.

Numerator – the number in the denominator who are referred for urgent direct access endoscopy.

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Denominator – the number of adults presenting with dyspepsia or reflux symptoms and dysphagia.

**Data source:** Local data collection. [Hospital Episode Statistics](#) collects data on upper gastrointestinal endoscopies.

b) Proportion of referrals for adults presenting with dyspepsia or reflux symptoms and dysphagia who receive urgent direct access endoscopy within 2 weeks.

Numerator – the number in the denominator who receive endoscopy within 2 weeks.

Denominator – the number of referrals for urgent direct access endoscopy for adults presenting with dyspepsia or reflux symptoms and dysphagia.

**Data source:** Local data collection. [Hospital Episode Statistics](#) collects data on upper gastrointestinal endoscopies.

c) Proportion of adults aged 55 and over presenting with dyspepsia or reflux symptoms and weight loss who are referred for urgent direct access endoscopy.

Numerator – the number in the denominator who are referred for urgent direct access endoscopy.

Denominator – the number of adults aged 55 and over presenting with dyspepsia or reflux symptoms and weight loss.

**Data source:** Local data collection. [Hospital Episode Statistics](#) collects data on upper gastrointestinal endoscopies.

d) Proportion of referrals for adults aged 55 and over presenting with dyspepsia or reflux symptoms and weight loss who receive urgent direct access endoscopy within 2 weeks.

Numerator – the number in the denominator who receive endoscopy within 2 weeks.

Denominator – the number of referrals for urgent direct access endoscopy for adults aged 55 and over presenting with dyspepsia or reflux symptoms and weight loss.

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**Data source:** Local data collection. [Hospital Episode Statistics](#) collects data on upper gastrointestinal endoscopies.

## Outcome

a) Incidence of oesophagogastric cancer.

**Data source:** Local data collection. [Cancer Registration Statistics](#) collects data on the incidence of cancer.

b) Oesophagogastric cancer survival rates.

**Data source:** Local data collection. [Geographic patterns of cancer survival in England](#) provide data on 1- and 5-year survival rates.

c) Patient satisfaction with investigation of dyspepsia and reflux symptoms.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices and community healthcare providers) ensure that processes and resources are in place so that adults presenting with dyspepsia or reflux symptoms are referred for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia or are aged 55 and over with weight loss. Endoscopy services should record and report inappropriate urgent direct access referrals for adults with dyspepsia or reflux symptoms.

**Healthcare professionals** refer adults presenting with dyspepsia or reflux symptoms for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia or are aged 55 and over with weight loss.

**Commissioners** (clinical commissioning groups and NHS England area teams) ensure that they commission services that refer adults presenting with dyspepsia or reflux symptoms for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia or are aged 55 and

over with weight loss. Commissioners should monitor inappropriate urgent direct access referrals for endoscopy for adults with dyspepsia or reflux symptoms as well as investigate particularly low rates of referral.

## ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** will be referred for an endoscopy if they have additional symptoms that need to be investigated, such as pain or difficulty swallowing or weight loss when they are over 55. An endoscopy is a procedure that is sometimes carried out to investigate indigestion symptoms and find out what is causing them. It involves using an endoscope (a narrow, flexible tube with a camera at its tip), to see inside the oesophagus and stomach. The person may be offered sedation before the procedure or given a local anaesthetic to numb the throat. The endoscope is then guided down the person's throat and into their stomach. Not everyone with indigestion or heartburn will need an endoscopy.

## ***Source guidance***

- [Suspected cancer](#) (2015) NICE guideline NG12, recommendations 1.2.1 and 1.2.7.

## ***Definitions of terms used in this quality statement***

### **Urgent direct access endoscopy**

Primary care arranges for an endoscopy to be carried out within 2 weeks and retains clinical responsibility throughout, including acting on the result.

[[Suspected cancer](#) (NICE guideline NG12)]

## ***Equality and diversity considerations***

Healthcare professionals should take into account cultural and communication needs when arranging and explaining a referral for direct access endoscopy.

Healthcare professionals should respect an adult's choice to refuse an endoscopy if they consider themselves to be too frail due to age.

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## Quality statement 3: Testing conditions for *Helicobacter pylori*

### Quality statement

Adults with dyspepsia or reflux symptoms have a 2-week washout period before a test for *Helicobacter pylori* if they are receiving proton pump inhibitor therapy.

### Rationale

To improve the accuracy of *Helicobacter pylori* (*H pylori*) testing it is important to have a 2-week washout period after using a proton pump inhibitor (PPI). Improving the accuracy of the test will ensure that treatment for *H pylori* infection is given only if needed. Treatment for *H pylori* infection is complex and there is concern that treatment without an accurate diagnosis may lead to increasing antimicrobial resistance. In addition, treatment for *H pylori* can be unpleasant for the patient and has an increased risk of antibiotic-associated diarrhoea and enteric infections such as *Clostridium difficile*.

### Quality measures

#### Structure

Evidence of local arrangements to ensure that adults with dyspepsia or reflux symptoms have a 2-week washout period before a test for *H pylori* if they are receiving PPI therapy.

**Data source:** Local data collection.

#### Process

Proportion of adults with dyspepsia or reflux symptoms receiving PPI therapy who are tested for *H pylori* who had a 2-week washout period before the test.

Numerator – the number in the denominator who had a 2-week washout period before the test.

Denominator – the number of adults with dyspepsia or reflux symptoms receiving PPI therapy who are tested for *H pylori*.

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**Data source:** Local data collection.

## Outcome

*H pylori* antimicrobial resistance rate.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices and hospitals) ensure that adults with dyspepsia or reflux symptoms have a 2-week washout period before a test for *H pylori* if they are receiving PPI therapy.

**Healthcare professionals** ensure that adults with dyspepsia or reflux symptoms have a 2-week washout period before testing for *H pylori* if they are receiving PPI therapy.

**Commissioners** (clinical commissioning groups and NHS England area teams) commission services that ensure that adults with dyspepsia or reflux symptoms have a 2-week washout period before a test for *H pylori* if they are receiving PPI therapy.

## ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** may need to have a test for an infection called *Helicobacter pylori* (*H pylori* for short), which can cause stomach and duodenal ulcers (the duodenum is the section of intestine immediately after the stomach). *H pylori* infection is detected using a breath or stool test, or sometimes a blood test. If the person is taking a medicine called a proton pump inhibitor (PPI) for their indigestion or heartburn symptoms, their GP will tell them if they need to stop taking the PPI or any other medicine before the *H pylori* test.

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## Source guidance

- [Dyspepsia and gastro-oesophageal reflux disease \(2014\) NICE guideline CG184](#), recommendations 1.4.2 (key priority for implementation), 1.4.4 and 1.9.1.

## Definitions of terms used in this quality statement

### Proton pump inhibitor (PPI)

Proton pump inhibitors inhibit gastric acid secretion by blocking the hydrogen-potassium adenosine triphosphatase enzyme system (the 'proton pump') of the gastric parietal cell. PPIs include esomeprazole, lansoprazole, omeprazole, pantoprazole, and rabeprazole.

[[British National Formulary section 1.3.5 Proton pump inhibitors](#)]

### Test for *H pylori*

Use a carbon-13 urea breath test, a stool antigen test or laboratory-based serology where its performance has been locally validated to test for *H pylori*. Ensure that no antibiotics have been taken for any infection in the 4 weeks before the test.

If laboratory-based serology is to be used, its performance should be locally validated to test for *H pylori*. The serology test should have high positive predictive value in the intended population, or positives should be confirmed with a second test. Validation is an evidence-based assessment of how a test performs in the laboratory, and demonstrates suitability for intended purpose. Local validation will provide documentary evidence that a commercial serology kit is performing within the manufacturer's specifications. This will include results of experiments to determine its accuracy, sensitivity, reliability and reproducibility. Local validation should meet the requirements set out in the [UK Standards for Microbiology Investigations](#).

[Adapted from [Dyspepsia and gastro-oesophageal reflux disease \(2014\) NICE guideline CG184](#) recommendations 1.4.2 and 1.9.1, [UK Standards for Microbiology Investigations – SMI Q1: Commercial and in-house diagnostic tests: evaluations and validations \(2014\) Public Health England Quality Guidance](#), and expert opinion]

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## ***Equality and diversity considerations***

Serological tests are less reliable in older people and therefore, where laboratory-based serology tests are used, their suitability for people over 65 should be carefully considered.

It is important to use an accurate test for *H pylori* for people from ethnic minority groups because resistance rates are higher than in the general population. Where laboratory-based serology tests are used, their suitability for people from ethnic minority groups should be carefully considered.

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## Quality statement 4: Discussion about referral for non-urgent endoscopy

### *Quality statement*

Adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment have a discussion with their GP about referral for non-urgent direct access endoscopy.

### *Rationale*

There is currently wide geographical variation in referral rates for endoscopy for adults with dyspepsia or reflux symptoms. Although many adults with dyspepsia or reflux symptoms will not need an endoscopy, it is important that those with an increased risk of oesophagogastric cancer have a discussion with their GP about referral for endoscopy to investigate the cause.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure that adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment have a discussion with their GP about referral for non-urgent direct access endoscopy.

**Data source:** Local data collection.

#### **Process**

Proportion of adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment who have a recorded discussion with their GP about referral for non-urgent direct access endoscopy.

Numerator – the number in the denominator who have a recorded discussion with their GP about referral for non-urgent direct access endoscopy.

Denominator – the number of adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment.

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**Data source:** Local data collection.

## Outcome

a) Incidence of oesophagogastric cancer.

**Data source:** Local data collection. [Cancer Registration Statistics](#) collect data on the incidence of cancer.

b) Oesophagogastric cancer survival rate.

**Data source:** Local data collection. [Geographic patterns of cancer survival in England](#) provide data on 1- and 5-year survival rates.

c) Patient satisfaction with investigation of dyspepsia and reflux symptoms.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices) ensure that processes are in place so that adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment have a discussion with their GP about referral for non-urgent direct access endoscopy.

**Healthcare professionals** (GPs) discuss referral for non-urgent direct access endoscopy with adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment.

**Commissioners** (NHS England area teams) commission services that ensure adults aged 55 and over with dyspepsia or reflux symptoms that have not responded to treatment have a discussion with their GP about referral for non-urgent direct access endoscopy.

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## ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** whose symptoms do not respond to treatment should have a discussion with their GP about referral for an endoscopy. An endoscopy is a procedure that is sometimes carried out to investigate indigestion symptoms and find out what is causing them. It involves using an endoscope (a narrow, flexible tube with a camera at its tip), to see inside the oesophagus and stomach. The person may be offered sedation before the procedure or given a local anaesthetic to numb the throat. The endoscope is then guided down the person's throat and into their stomach. Not everyone with indigestion or heartburn will need an endoscopy.

### ***Source guidance***

- [Suspected cancer](#) (2015) NICE guideline NG12, recommendations 1.2.3 and 1.2.9.

## ***Definitions of terms used in this quality statement***

### **Not responded to treatment**

Adults with uninvestigated dyspepsia or reflux symptoms should try a full dose proton pump inhibitor (PPI) for a month and, if there is an inadequate response, H<sub>2</sub> receptor antagonist (H<sub>2</sub>RA) therapy for a month, in order to manage their symptoms. If there is no improvement in symptoms after 8 weeks of treatment and testing for *Helicobacter pylori* is negative, it should be concluded that the condition has not responded to treatment.

[Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.4.3, 1.4.4 and 1.4.6]

### **Discussion about referral for endoscopy**

Endoscopy should not routinely be offered to diagnose Barrett's oesophagus. If endoscopy is considered, the discussion should focus on the person's preferences and their individual risk factors (long duration of symptoms, increased frequency of symptoms, previous oesophagitis, previous hiatus hernia, oesophageal stricture or oesophageal ulcers, or male gender)<sup>[1]</sup>. If people have had a previous endoscopy and there is no change in symptoms, discuss continuing management according to previous endoscopic findings.

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[[Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.3.4 and 1.6.11]

### **Non-urgent direct access endoscopy**

Primary care arranges for a non-urgent endoscopy to be carried out and retains clinical responsibility throughout, including acting on the result.

[[Suspected cancer](#) (NICE guideline NG12)]

### ***Equality and diversity considerations***

Healthcare professionals should take into account cultural and communication needs when discussing a referral for non-urgent direct access endoscopy.

Healthcare professionals should respect a person's choice to refuse an endoscopy if they consider themselves to be too frail due to age.

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<sup>[1]</sup> [BOB CAT: a large-scale review and Delphi consensus for management of Barrett's Esophagus with no dysplasia, indefinite for, or low-grade dysplasia](#). Bennett et al, The American Journal of Gastroenterology 2015

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## Quality statement 5: Referral to a specialist service

### *Quality statement*

Adults with persistent, unexplained dyspepsia or reflux symptoms have a discussion with their GP about referral to a specialist service.

### *Rationale*

Long-term symptoms can negatively affect an adult's quality of life, so they should have a discussion with their healthcare professional about possible referral to a specialist service based on their individual risk factors and preferences. A referral to a specialist service will enable treatment and potential causes to be reviewed in order to reduce symptom burden. It could also reduce the risk of further complications developing, such as scarring of the oesophagus and pylorus, oesophageal stricture, pyloric stenosis and Barrett's oesophagus, which is a risk factor for cancer.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure that adults with persistent, unexplained dyspepsia or reflux symptoms have a discussion with their GP about referral to a specialist service.

**Data source:** Local data collection.

#### **Process**

Proportion of adults presenting with persistent, unexplained dyspepsia or reflux symptoms with a recorded discussion with their GP about referral to a specialist service.

Numerator – the number in the denominator with a recorded discussion with their GP about referral to a specialist service.

Denominator – the number of adults presenting with persistent, unexplained dyspepsia or reflux symptoms.

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**Data source:** Local data collection.

## Outcome

a) Incidence of Barrett's oesophagus.

**Data source:** Local data collection.

b) Incidence of oesophageal stricture.

**Data source:** Local data collection.

c) Incidence of pyloric stenosis in adults.

**Data source:** Local data collection.

d) Patient-reported health outcomes for people with dyspepsia or reflux symptoms.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices) ensure that processes are in place so that adults with persistent, unexplained dyspepsia or reflux symptoms discuss referral to a specialist service.

**Healthcare professionals** (GPs) discuss referral to a specialist service with adults with persistent, unexplained dyspepsia or reflux symptoms.

**Commissioners** (NHS England area teams) ensure that they commission services that ensure that GPs discuss referral to a specialist service with adults with persistent, unexplained dyspepsia or reflux symptoms. Commissioners should also ensure that a suitable specialist service is available.

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## ***What the quality statement means for patients, service users and carers***

**Adults with unexplained indigestion or heartburn** that does not go away should talk to their GP about the possibility of being referred to see a specialist.

### ***Source guidance***

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184, recommendation 1.11.1 (key priority for implementation).

## ***Definitions of terms used in this quality statement***

### **Persistent unexplained dyspepsia or reflux symptoms**

Symptoms that have not led to a diagnosis being made by the healthcare professional in primary care after initial assessment (including history, examination and any appropriate primary care investigations such as endoscopy or *Helicobacter pylori* test). Symptoms have continued beyond a period that would normally be associated with self-limiting problems.

[[Suspected cancer](#) (NICE guideline NG12) and expert opinion]

### **Discussion about referral to a specialist service**

The discussion should focus on the person's preferences and their individual risk factors (long duration of symptoms, increased frequency of symptoms, previous oesophagitis, previous hiatus hernia, oesophageal stricture or oesophageal ulcers, or male gender). If people have had a previous endoscopy and there is no change in symptoms, discuss continuing management according to previous endoscopic findings.

[[Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.3.4 and 1.6.11]

## **Specialist service**

A consultant-led medical or surgical service. [Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE full guideline CG184) review question 4.9.1]

## ***Equality and diversity considerations***

Healthcare professionals should take into account cultural and communication needs when discussing referral to a specialist service.

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## Using the quality standard

### *Quality measures*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [what makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

### *Levels of achievement*

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

### *Using other national guidance and policy documents*

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

## ***Information for the public***

NICE has produced [information for the public](#) about this quality standard. Patients, service users and carers can use it to find out about the quality of care they should expect to receive; as a basis for asking questions about their care, and to help make choices between providers of social care services.

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## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare practitioners and adults with dyspepsia or GORD is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with dyspepsia or GORD should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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## Development sources

Further explanation of the methodology used can be found in the quality standards [process guide](#).

## Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Suspected cancer](#) (2015) NICE guideline NG12
- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184

## Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Public Health England (2014) [Helicobacter pylori: diagnosis and treatment guide for primary care](#)
- Department of Health (2005) [National service framework: long-term conditions](#)

## Definitions and data sources for the quality measures

- National Institute for Health and Care Excellence (2015) [British National Formulary](#)
- Health and Social Care Information Centre (2015) [Hospital Episode Statistics](#)
- Health and Social Care Information Centre (2014) [Care.data](#)
- Public Health England Quality Guidance (2014) [UK standards for microbiology investigations – SMI Q1: Commercial and in-house diagnostic tests: evaluations and validations](#)
- Office for National Statistics (2012) [Cancer registration statistics](#)

- Office for National Statistics (2012) [Geographic patterns of cancer survival in England](#)

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## Related NICE quality standards

### ***Published***

- [Managing medicines in care homes](#) (2015) NICE quality standard 85
- [Smoking cessation: supporting people to stop smoking](#) (2013) NICE quality standard 43
- [Acute upper gastrointestinal bleeding](#) (2013) NICE quality standard 38
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [Alcohol dependence and harmful alcohol use](#) (2011) NICE quality standard 11

### ***In development***

- [Obesity – prevention and management in adults](#). Publication expected January 2016
- [Gastro-oesophageal reflux in children and young people](#). Publication expected January 2016
- [Medicines optimisation](#) (covering medicines adherence and safe prescribing). Publication expected March 2016
- [Effective antimicrobial stewardship](#). Publication expected April 2016
- [Referral for suspected cancer](#). Publication expected May 2016

### ***Future quality standards***

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Community pharmacy: promoting health and wellbeing
- Hernia (including femoral and inguinal)
- Long-term conditions, people with comorbidities, complex needs
- Managing symptoms with an uncertain cause

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- Medicines management: managing the use of medicines in community settings for people receiving social care
  - Oesophagogastric cancers

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

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## Quality Standards Advisory Committee and NICE project team

### *Quality Standards Advisory Committee*

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

**Ms Deryn Bishop**

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## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathways on [dyspepsia and gastro-oesophageal reflux disease](#) and [suspected cancer recognition and referral](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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