Consensus belge sur la dyspepsie fonctionelle

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Neuro-Gastroentérologie

Conflicts of interest

- Sébastien Kindt — Speaker’s fee from Truvion Healthcare and Schwabe, Consultancy for Truvion Healthcare, Advisory for Truvion Healthcare
- Joris Arts — No conflicts of interest
- Philip Caenepeel — No conflicts of interests
- Frederik de Clerck — Speaker's fee from Truvion healthcare, Advisory for Truvion Healthcare
- Heiko De Schepper — Speaker’s fee from Truvion Healthcare, Menarini, Mayoli, Dr. Falk. Consultancy for Truvion Healthcare, Takeda
- Hubert Louis — Speaker's fee from Takeda, Advisory for Truvion Healthcare
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- Hubert Piessevaux — Advisory board for Truvion Healthcare
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- Kathleen Van Malderen — No conflicts of interests
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- Fabien Wuestenberghs — Consulting and/or lecturing fees from Biocodex Belfium, Biocodex France, Grünenthal, Menarini Belgium, Sanofi, Viatris.
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United European Gastroenterology (UEG) and European Society for Neurogastroenterology and Motility (ESNM) consensus on functional dyspepsia

ACG and CAG Clinical Guideline: Management of Dyspepsia

Paul M. Moayyedi, MB, ChB, PhD, MPH, FACG[1], Brian E. Lacy, MD, PhD, FACG[2], Christopher N. Andrews, MD[3], Robert A. Enns, MD[4], Colin W. Howden, MD, FACG[5] and Nimish Vakil, MD, FACG[6]

ORIGINAL ARTICLE

ueg journal WILEY

United European Gastroenterology (UEG) and European Society for Neurogastroenterology and Motility (ESNM) consensus on functional dyspepsia

Revista Española de Enfermedades Digestivas
The Spanish Journal of Gastroenterology

Title:
Updated document on the management of functional dyspepsia by the Asociación Española de Neurogastroenterologia y Motilidad (ASENEM) and Sociedad Española de Medicina Familiar y Comunitaria (semFYC)

Vietnam Association of Gastroenterology consensus for the diagnosis and treatment of functional dyspepsia

K-T T. Tran[1,*], B.H. Mai[2], L.Ta[2], L.V. Dao[3], H.V. Tran[4], M.K. Tran[5], D.T. Quach[5], K.T. Vu[6], Q.D.D. Ho[7], K.V. Vu[1], T.T. Tran[5], T-H.T. Pham[3], D.T. Trinh[6], V.T. Nguyen[3], T.V. Tran[8], T.H. Duong[9], H.H. Bui[5], V.-H.T. Nguyen[3], T.T. Nguyen[2], T.D. Nguyen[10], B.C. Nguyen[2], H.Q. Phan[2], L.C. Nguyen[11], T.L. Nguyen[2], H.V. Dao[3], K.D. Thai[2], N.T. Phan[4], N.V. Le[12], L.T. Le[7], M.-C.H. Vo[13], T.-P.T. Le[14], P.T Ho[7], Q.D Le[5], P.-T.P. Tran[1], Q.-L.Dau[3]

Purpose of (national) guidelines:

- Improvement of clinical practice
- Reduction of unwarranted practice variation
- Translation of international guidelines, taking national specificities into account:
  - Availability and access
  - Financial aspects
  - Address local trends in practice

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Delphi process

- Drafting of statements
  - Grouped in 12 topics
- Summaries of existing evidence within topic groups
- Presentation of summaries to the panel
- Online voting round
- Presentation of results to the panel + discussion
- Grading of evidence by the steering committee

Mullen, J Health Organ and Manag 2003

Interpretation

Agreement

- A++ Totally agree
- A+ Agree with minor reservation
- A Agree with major reservation
- D Disagree with major reservation
- D- Disagree with minor reservation
- D-- Totally disagree

%(A++, A+)

- >= 80% endorsed statement
- 70 - 80% borderline

In a nutshell

- 109 distinct statements in 12 categories
- 20 panellists, 19 voters (dietitian only for statements about nutrition)
- all statements presented
- Agreement: 64 statements (59%) – borderline 11 statements

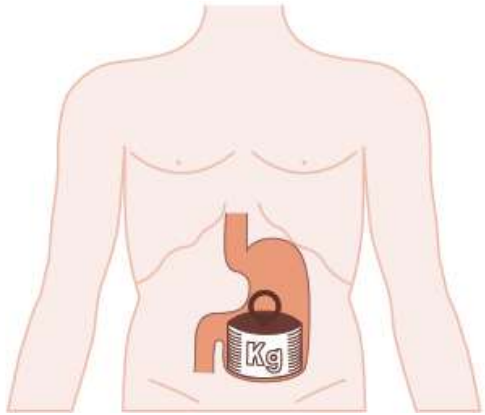
A. Definitions and symptoms

Statement	A++	A+	A	D	D-	D--		Grade
1. Dyspepsia refers to any of the following epigastric symptoms: early satiety, postprandial fullness, epigastric burning, epigastric pain.	100%	0%	0%	0%	0%	0%	*	B
2. Functional dyspepsia is characterised by chronic dyspeptic symptoms in the absence of a readily identifiable organic cause.	94%	6%	0%	0%	0%	0%	*	A
3. FD symptoms persist long-term in the majority of FD patients.	66%	22%	6%	6%	0%	0%	*	B
4. The use of pictograms is useful to clarify dyspeptic symptoms.	61%	28%	11%	0%	0%	0%	*	C
5. Functional dyspepsia should be divided into the epigastric pain syndrome and postprandial distress syndrome.	66%	28%	%	0%	0%	0%	*	C
6. In functional dyspepsia, symptom relationship to a meal enables the identification of subgroups	66%	22%	6%	6%	0%	0%	*	C
7. Postprandial distress syndrome is characterised by any dyspeptic symptom occurring within 120 minutes after a meal.	33%	55%	6%	0%	0%	6%	*	C
8. Epigastric pain or epigastric burning unrelated to meal intake characterize the epigastric pain syndrome.	72%	33%	6%	0%	0%	0%	*	C
9. Epigastric pain or epigastric burning in the absence of PDS symptoms characterize the epigastric pain syndrome.	72%	6%	16%	0%	6%	0%	+/-	C

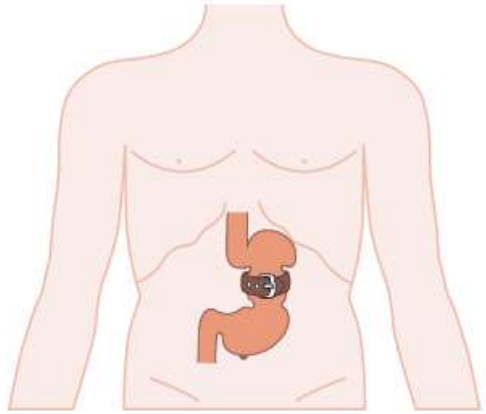
(Functional) dyspepsia

- Cardinal symptoms - pictograms

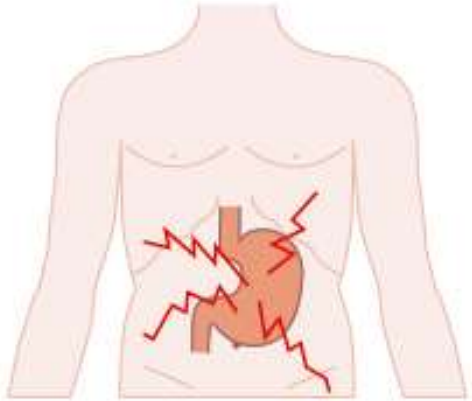
Postprandial fullness



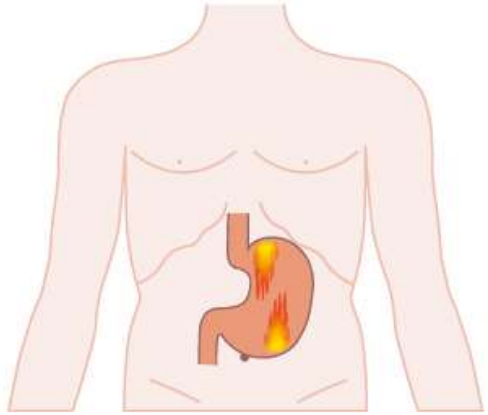
Early satiation



Epigastric pain



Epigastric burning



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Tack et al., AP&T 2014 - Goelen et al, NGM 2025

A. Definitions and symptoms

Statement	A++	A+	A	D	D-	D--		Grade
1. Dyspepsia refers to any of the following epigastric symptoms: early satiety, postprandial fullness, epigastric burning, epigastric pain.	100%	0%	0%	0%	0%	0%	*	B
2. Functional dyspepsia is characterised by chronic dyspeptic symptoms in the absence of a readily identifiable organic cause.	94%	6%	0%	0%	0%	0%	*	A
3. FD symptoms persist long-term in the majority of FD patients.	66%	22%	6%	6%	0%	0%	*	B
4. The use of pictograms is useful to clarify dyspeptic symptoms.	61%	28%	11%	0%	0%	0%	*	C
5. Functional dyspepsia should be divided into the epigastric pain syndrome and postprandial distress syndrome.	66%	28%	%	0%	0%	0%	*	C
6. In functional dyspepsia, symptom relationship to a meal enables the identification of subgroups	66%	22%	6%	6%	0%	0%	*	C
7. Postprandial distress syndrome is characterised by any dyspeptic symptom occurring within 120 minutes after a meal.	33%	55%	6%	0%	0%	6%	*	C
8. Epigastric pain or epigastric burning unrelated to meal intake characterize the epigastric pain syndrome.	72%	33%	6%	0%	0%	0%	*	C
9. Epigastric pain or epigastric burning in the absence of PDS symptoms characterize the epigastric pain syndrome.	72%	6%	16%	0%	6%	0%	+/-	C

B. Associated symptoms

Statement	A++	A+	A	D	D-	D--		Grade
1. There is a high intra- and inter-individual variation in FD severity.	77%	17%	6%	0%	0%	0%	*	B
2. Upper abdominal bloating is part of the spectrum of functional dyspepsia.	28%	66%	6%	0%	0%	0%	*	C
3. Belching is part of the spectrum of functional dyspepsia.	11%	39%	11%	11%	22%	6%		C
4. Heartburn is part of the spectrum of functional dyspepsia.	11%	22%	17%	11%	11%	28%		C
5. Heartburn is distinguishable from epigastric burning.	22%	50%	28%	0%	0%	0%	+/-	C
6. Nausea is part of the spectrum of functional dyspepsia.	11%	66%	11%	6%	0%	6%	+/-	C
7. Vomiting is part of the spectrum of functional dyspepsia.	6%	22%	17%	17%	17%	22%		C
8. Nausea and vomiting are more prominent in gastroparesis as compared to FD.	72%	28%	0%	0%	0%	0%	*	B
9. FD can result in significant weight loss.	47%	47%	5%	0%	0%	0%	*	B

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C. Aetiology and pathophysiology

Statement	A++	A+	A	D	D-	D--		Grade
1. The origin of symptoms in FD is multifactorial.	89%	11%	0%	0%	0%	0%	*	B
2. Delayed gastric emptying contributes to FD in some patients.	44%	33%	22%	0%	0%	0%	+/-	C
3. Gastric hypersensitivity contributes to FD in some patients.	50%	39%	11%	0%	0%	0%	*	C
4. Impaired gastric accommodation contributes to FD in some patients.	44%	44%	12%	0%	0%	0%	*	C
5. Acute GI infection is a risk factor for development of FD.	61%	33%	0%	0%	0%	6%	*	B
6. Duodenal immune activation contributes to FD in some patients.	11%	44%	39%	0%	6%	0%		C
7. Impaired gut mucosal permeability contributes to FD in some patients.	0%	50%	39%	0%	11%	0%		C
8. Altered microbiota composition contributes to FD in some patients.	0%	28%	44%	11%	6%	11%		C
9. HP contributes to dyspeptic symptoms in some patients.	61%	33%	0%	6%	0%	0%	*	B
10. Altered central processing contributes to FD in some patients.	44%	33%	22%	0%	0%	0%	+/-	C
11. Stress, anxiety and depressive mood are risk factors for FD.	61%	22%	6%	6%	6%	0%	*	B
12. Genetic factors determine susceptibility to FD	11%	39%	39%	6%	0%	6%		C

D. Associated disorders

Statement	A++	A+	A	D	D-	D--		Grade
1. IBS and other DGBI often co-exists with FD.	83%	17%	0%	0%	0%	0%	*	A
2. GERD often co-exists with FD.	78%	22%	0%	0%	0%	0%	*	A
3. There is an overlap between FD and idiopathic gastroparesis.	50%	22%	22%	0%	6%	0%	+/-	B

E. Initial diagnostic work-up

Alarm symptoms
Weight loss
GI bleeding
Vomiting
Area with increased risk of gastric cancer
Family history of oesophageal of gastric cancer

Statement	A++							Grade
1. Limited laboratory testing is mandatory in all patients presenting with dyspepsia.	28%							C
2. Testing for and treating H pylori is mandatory in all patients presenting with dyspepsia.	89%							A
3. In the absence of alarm symptoms or risk factors in dyspeptic patients < 50 years, upper g.i. endoscopy is not mandatory for initial management.	61%	39%	0%	0%	0%	0%	*	A
4. In the presence of vomiting at least once a week and/or unintentional weight loss of > 5%, other causes need to be excluded before diagnosing FD.	83%	11%	6%	0%	0%	0%	*	D
5. When performing upper g.i. endoscopy in patients with dyspepsia, gastric biopsies are mandatory.	72%	28%	0%	0%	0%	0%	*	B
6. When performing upper g.i. endoscopy in patients with dyspepsia, duodenal biopsies are mandatory.	11%	11%	22%	22%	11%	22%		C
7. Abdominal imaging is not mandatory in all patients presenting with dyspepsia.	72%	11%	6%	0%	6%	6%	*	D
8. Abdominal Imaging is mandatory in dyspeptic patients with weight loss.	11%	72%	16%	0%	0%	0%	*	D
9. Imaging findings suggesting Wilkie/Dunbar are unlikely to explain dyspepsia symptoms.	50%	50%	0%	0%	0%	0%	*	C
10. Gastric emptying assessment has no place in the initial	72%	17%	11%	0%	0%	0%	*	B

1. Diagnostic workup in patients with refractory symptoms

Statement	A++	A+	A	D	D-	D--		Grade
1. Absence of explanatory findings on upper g.i. endoscopy is mandatory to confirm a diagnosis of functional dyspepsia for research purposes or in treatment-refractory patients.	56%	33%	6%	6%	0%	0%	*	C
2. In the absence of improvement by initial treatment, additional testing to rule out other (organic) disease is not routinely required.	17%	39%	17%	17%	6%	6%		C
3. Assessment of gastric emptying should be considered in FD patients with refractory symptoms.	22%	50%	22%	0%	6%	0%	+/-	C
4. Assessment of gastric emptying should be considered in refractory dyspeptic patients with prominent nausea and/or vomiting.	61%	33%	0%	6%	0%	0%	*	C
5. Assessment of gastric emptying should be considered in refractory dyspeptic patients with weight loss.	17%	67%	17%	0%	0%	0%	*	B
6. There is no place for pyloric impedance planimetry in FD patients with delayed gastric emptying.	78%	17%	6%	0%	0%	0%	*	C
7. There is no place for routine pH/imp monitoring in FD patients in the absence of reflux symptoms.	78%	11%	11%	0%	0%	0%	*	C
8. There is no place for food allergy testing in FD patients.	83%	17%	0%	0%	0%	0%	*	C
9. There is no place for gut permeability testing in FD patients.	78%	17%	0%	0%	0%	6%	*	C
10. Psychological evaluation should be considered in treatment-refractory FD.	56%	28%	17%	0%	0%	0%	*	C
11. Psychiatric evaluation to exclude eating disorders is mandatory in FD patients with major weight loss.	22%	56%	22%	0%	0%	0%	+/-	C

G. General management considerations

Statement	A++	A+	A	D	D-	D--		Grade
1. A positive diagnosis can be established in most patients based on symptom pattern, absence of alarm symptoms and selected additional tests.	78%	22%	0%	0%	0%	0%	*	C
2. In the absence of alarm symptoms, treatment can be initiated without the immediate need for further investigation.	56%	33%	6%	6%	0%	0%	*	D
3. Explanation and communication of the diagnosis of FD is a crucial part of the management.	83%	11%	6%	0%	0%	0%	*	C
4. Patient should be reassured about long-term evolution.	50%	39%	6%	6%	0%	0%	*	C
5. Different aspects of QOL are impaired in FD.	89%	11%	0%	0%	0%	0%	*	B
6. The management of FD includes the assessment of co-existing IBS symptoms.	50%	39%	6%	0%	0%	6%	*	D
7. Treatment of FD patients should address lifestyle factors.	61%	28%	11%	0%	0%	0%	*	C
8. The initial management of patients with FD should address stress, anxiety and depressive symptoms.	22%							C

Lifestyle measures
Smaller, more frequent meals
Limit fatty food, carbonated drinks and caffeine
Regular physical exercise
Regular sleep schedule

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H. First-line treatment

Statement	A++	A+	A	D	D-	D--		Grade
1. PPI are effective in the management of FD.	72%	17%	6%	0%	0%	6%	*	A
2. PPI are the preferred first-line treatment for FD.	50%	33%	6%	6%	0%	6%	*	C
3. Dopamine-2 receptor antagonists are effective in the management of FD.	11%	28%	44%	6%	6%	6%		C
4. Dopamine-2 receptor antagonists/acetylcholinesterase inhibitors are effective in the management of FD.	11%	72%	17%	0%	0%	0%	*	C
5. Motilin receptor agonists are effective in the management of FD.	11%	28%	6%	33%	17%	6%		C
6. Serotinine-4 receptor agonists are effective in the management of FD.	6%	50%	22%	17%	6%	0%		C
7. Management of constipation may improve dyspeptic symptoms.	39%	17%	39%	6%	0%	0%		C
8. Ginger extract is effective in the management of FD.	11%	44%	33%	6%	6%	0%		C
9. Peppermint oil/Caraway oil combination is effective in the management of FD.	11%	50%	22%	11%	0%	6%		C
10. Artichoke extract is effective in the management of FD.	11%	28%	39%	17%	6%	0%		C
11. Selected probiotics are effective in the management of FD.	6%	33%	44%	6%	11%	0%		C
12. Antihistaminics (H1) are effective in the management of FD.	6%	6%	17%	44%	28%	0%		C
13. Spasmolytics are not effective in the management of FD (in the absence of IBS symptoms).	61%	28%	6%	6%	0%	0%	*	C
14. Antibiotics are not recommended in the management of FD.	56%	39%	0%	6%	0%	0%	*	C

PPI

Prokinetics

Other "drugs"

Don't

I. Invasive management

Statement	A++	A+	A	D	D-	D--		Grade
1. Gastric electrical stimulation should not be proposed for the management of FD.	83%	11%	0%	6%	0%	0%	*	C
2. Intrapyloric botulinum toxin injection should not be proposed for the management of FD with delayed gastric emptying.	83%	6%	6%	6%	0%	0%	*	C
3. G-POEM should not be proposed for the management of refractory FD with delayed gastric emptying.	50%	33%	0%	11%	6%	0%	*	C
4. Endoscopic or surgical procedures targeting the pylorus and the stomach should not be proposed to patients with FD.	67%	28%	6%	0%	0%	0%	*	C
5. Surgical correction of Wilkie/Dunbar should not be proposed for the management of FD.	61%	39%	0%	0%	0%	0%	*	C

J. Pharmacological management targeting the brain-gut axis

Statement	A++	A+	A	D	D-	D--		Grade
1. TCA are effective in the management of PDS.	17%	11%	33%	6%	22%	11%		C
2. TCA are effective in the management of EPS.	83%	17%	0%	0%	0%	0%	*	B
3. Antipsychotics (e.g. Sulpiride) are effective in the management of FD.	22%	61%	17%	0%	0%	0%	*	C
4. Tetracyclic antidepressants (e.g. Mirtazapine) are effective in the management of FD.	28%	56%	11%	0%	0%	16%	*	C
5. SSRI are effective in the management of FD.	6%	6%	0%	11%	39%	39%		C
6. SNRI are effective in the management of FD.	6%	17%	17%	17%	22%	22%		C
7. A2d ligand agents (pregabalin) are effective in the management of FD.	6%	6%	33%	6%	28%	22%		C
8. Melitracen /flupentixol (Deanxit) is effective in the management of FD.	6%	6%	44%	22%	6%	17%		C
9. Treatment success evaluation should be timed in accordance with study protocol/ results.	22%	28%	17%	6%	6%	22%		D

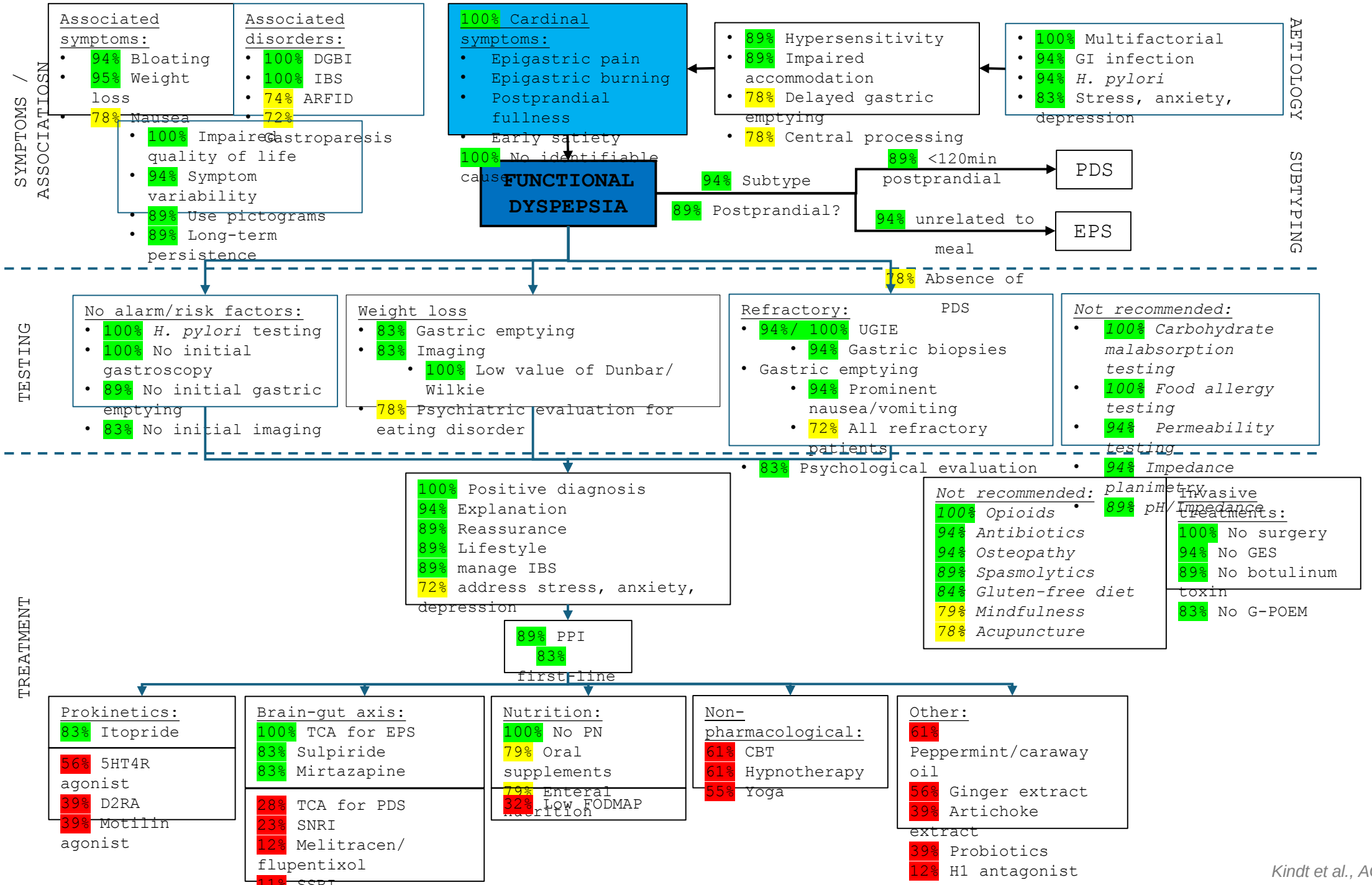
K. Nutritional considerations

Statement	A++	A+	A	D	D-	D--		Grade
1. Dietary advice should be provided to all FD patients.	26%	21%	32%	5%	5%	11%		D
2. A gluten free diet is not recommended in FD in the absence of coeliac disease.	74%	11%	5%	5%	0%	5%	*	C
3. A low FODMAP diet is effective in FD.	5%	26%	42%	16%	11%	0%		C
4. In FD patients with severe weight loss, oral nutritional supplements should be considered.	53%	26%	21%	0%	0%	0%	+/-	D
5. In FD patients with insufficient improvement on oral nutritional supplements, enteral nutrition can be considered.	37%	42%	21%	0%	0%	0%	+/-	D
6. Parenteral nutrition should be avoided in FD patients.	89%	11%	0%	0%	0%	0%	*	D
7. In underweight FD patients, or FD patients with severe weight loss, eating disorders should be excluded.	47%	37%	11%	0%	5%	0%	*	C
8. ARFID can be a consequence of FD.	37%	37%	16%	5%	%	0%	+/-	C

ARFID definition: Eating or feeding disturbance, causing subsequent nutritional deficiencies that are associated with one (or more) of the following: weight loss, nutritional deficiency, dependence on enteral feeding or oral nutritional supplements or marked interference with psychosocial functioning

L. Non-pharmacological management

Statement	A++	A+	A	D	D-	D--		Grade
1. Cognitive behavioural therapy is effective in the management of FD.	17%	44%	39%	0%	0%	0%		C
2. Medical hypnotherapy is effective in the management of FD.	6%	56%	39%	0%	0%	0%		C
3. Mindfulness is not recommended in the management of FD.	22%	33%	17%	6%	17%	6%		C
4. Yoga is not recommended in the management of FD.	28%	28%	28%	0%	17%	0%		D
5. Acupuncture is not recommended in the management of FD.	50%	28%	0%	22%	0%	0%	+/-	C
6. Osteopathy is not recommended in the management of FD.	61%	33%	6%	0%	0%	0%	*	D



Kindt et al., AGEB 2025

Take home messages

- Symptom based definition of FD
- Aetiopathophysiology unclear
  - Role of gastric emptying unclear
- Additional investigations (including upper GI endoscopy) early on in selected patients:
  - Vomiting, weight loss, refractory cases
- Positive approach
- Treatment:
  - Explanation
  - PPI
  - Itopride, sulpiride, mirtazapine, TCA
  - Avoid PN
  - No place for invasive treatment

The Belgian FD consensus group