Managing the dyspeptic patient: experience of a single-visit dyspepsia clinic

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Summary

During a one-year period, 206 of 245 patients referred directly to a single-visit dyspepsia clinic underwent gastroscopy after clinical consultation. Endoscopic findings enabled diagnosis in the majority and no complications occurred. In 12 patients with positive endoscopies there was an unrelated clinical diagnosis, and 23 with normal endoscopies had organic disease. Such a clinic has advantages both for patients in providing single-visit diagnosis and management for the majority, and for the hospital in reducing the load on outpatient services. Prior consultation may prevent both unwarranted use of endoscopy facilities and inappropriate diagnosis.

Introduction

The best management of the dyspeptic patient is under debate. One approach is to reserve hospital resources for the older patient in whom serious pathology is more likely[1], but this is less than ideal because the management of any dyspeptic patient is easier when there is a diagnosis[2]. An alternative is to offer an 'open access' endoscopy service[2] but the value of such services has been questioned[3].

This paper describes the preliminary experience of a single-visit dyspepsia clinic, which was designed to optimize the diagnosis and management of dyspeptic patients referred to this hospital.

Methods

Between 1 October 1984 and 30 September 1985, all patients referred by their general practitioner to one unit because of suspected upper gastrointestinal pathology were seen in a special clinic. Each patient was instructed to come starved from midnight in expectation of a gastroscopy, and following routine enquiry and examination the gastroscopy, if indicated, was performed under sedation.

The clinic was held in the Central Treatment and Daycase area of the hospital, which is remote from the main outpatient department. There are facilities here for consultation and recovery adjacent to the endoscopy unit.

Results

Of 245 patients seen, 206 were included in the study; 125 were male, 81 female, and their mean age was 48.5±15.1 years (range 18-88). The endoscopic findings are shown in Table 1. The final clinical diagnosis was based on the history, the findings on examination, the endoscopy and additional investigations as indicated.

In a majority of cases the endoscopic findings enabled diagnosis, but there were 12 patients (5.8%) with a positive endoscopy in whom an alternative diagnosis was thought to explain the symptoms, 7 of whom were thought to have functional disorders in spite of positive findings at endoscopy (Table 2).

Table 1. Endoscopic and clinical diagnoses in 206 patients with dyspepsia

Endoscopic diagnoses		*Clinical diagnoses*	
Normal	93	*Upper gastrointestinal*	
Duodenal ulcer	42	Non-ulcer 'functional' dyspepsia	82
Oesophagitis	26	Duodenal ulcer	45
Gastritis	18	Oesophageal reflux	44
Gastric ulcer	13	Gastric ulcer	12
Hiatus hernia	11	Gastritis	7
Duodenitia	5	Gastric cancer	3
Gastric cancer	3	Eosinophilic gastroenteritis	1
Oesophageal candidiasis	2		
Gastric xanthelasma	1	*Other disease*	
	214●	Cholelithiasis	6
		Hyperemesis gravidarum	1
		Acute leukaemia	1
		Carcinomatosis■	4
			206

●A few patients had more than one endoscopic abnormality
■Primaries in pancreas (1), bronchus (1), and unknown (2)

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Table 2. Discrepant endoscopies: positive findings versus clinical diagnosis

Endoscopic diagnosis	*Clinical diagnosis*	*No. of patients*
Gastritis	Functional dyspepsia	5
Gastritis	Gallstones	2
Gastritis	Carcinoma of the bronchus	1
Oesophagitis	Functional dyspepsia	1
Gastric xanthelasma	Functional dyspepsia	1
Duodenal erosions	Eosinophilic gastroenteritis	1
Oesophageal candida	Leukaemia	1

Table 3. Normal endoscopies in association with organic disease

Clinical diagnosis	*No. of patients*
Oesophageal reflux	15
Biliary colic	4
Hyperemesis gravidarum	1
Retroperitoneal carcinoma	1
Disseminated adenocarcinoma	1
Carcinoma of the pancreas	1

Normal gastroscopies were likewise found in 23 patients (11%) who had an organic cause for their symptoms (Table 3), including one patient who had hyperemesis gravidarum. This diagnosis was not initially suspected, both because of the nature of the upper gastrointestinal symptoms and because the patient not only denied pregnancy but also had recently been sterilized.

No complications occurred and many patients expressed satisfaction with the service provided.

Discussion

In this series several patients were shown to have disease outside the upper gastrointestinal tract, while in others positive findings at endoscopy did not contribute to the diagnosis. In some instances positive endoscopic findings were thought to be unrelated to the patients' symptoms. Notable amongst these was the finding of gastritis. Gastritis was reported endoscopically if there was diffuse erythema, often with marked biliary reflux, or multiple erosions or both and usually confirmed by biopsy. While this finding was made endoscopically in 18 patients, it was considered, somewhat arbitrarily, to be a possible cause of the symptoms in 7 patients only. 'Gastritis' is, however, a common endoscopic finding and its relationship to symptoms is often uncertain[4]. In the other patients in whom there was a discrepancy between the endoscopic findings and the clinical diagnosis there are less grounds for controversy. In any event, there was sufficient discrepancy in this series between the endoscopic findings and clinical diagnosis to suggest that endoscopy without consultation could lead to diagnostic confusion and delay.

A disadvantage of a clinic such as this is that, theoretically at least, the threshold to endoscopy may be reduced because of the state of preparedness of the patient and because of the adjacent facility of the endoscopy suite. In practice, we do not believe this to be a major problem and at least 10% of patients referred to this clinic are managed without an initial endoscopy. It is our belief that some barrier, be it a gastroenterological opinion or a computer scoring system[5], be best placed between the dyspeptic patient and the endoscopy suite in order to avoid mistaken diagnosis, overloading of the service and the risk of unwarranted complications of an invasive procedure. At present, we are seeing over 250 patients a year in this clinic (with a district population of about 125 000) and the waiting time between referral letter and consultation with gastroscopy is usually less than 4 weeks. Whether or not our clinic is leading to earlier diagnosis and management is difficult to know, but there are clearer advantages of this system. For the majority of patients there is the advantage of consultation, diagnosis and treatment all on the same day, usually with no follow up in the hospital. For the hospital service, there are the advantages of a decreased demand for outpatient barium meals and a reduced load on the outpatient department.

A similar clinic to this was reported by Beavis *et al.*[6]. In their clinic, however, the patients were endoscoped without sedation (with a proportionately higher failure rate) and they made no mention of discrepancies between endoscopic and clinical diagnosis. We would share the same conclusion, however, that a dyspepsia clinic probably offers the best means of management of dyspeptic patients, providing the demands on the service are reasonable and there are suitable facilities for its performance.

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