

Functional Dyspepsia: An unsolved dilemma.

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Functional dyspepsia (FD) is a clinical syndrome presented with persistent or recurrent pain or discomfort localized in the epigastric region without evidence of organic disease likely to explain the symptoms. For a very long time, dyspepsia has been defined in very different ways without any generally agreed consensus causing difficulties for both clinicians and researchers. Long back in 1865 Dr. Henry Browns MD defined dyspepsia to be an organic condition related to mouth, stomach and duodenum.¹ Only during late 1980s, an international working group, assembled in Chicago, suggested dyspepsia as epigastric or retrosternal symptom of gastrointestinal origin lasting for more than four weeks.²

However concept of functional dyspepsia has been ventilated during the last 25 to 30 years and there has been a concerted effort to standardize the definitions. Functional dyspepsia has been defined more clearly by the Rome III criteria consisting of a sensation of pain or burning in the epigastrium, early satiety (inability to finish a normal-sized meal), fullness during or after a meal, or a combination of these symptoms which must be chronic, occurring at least weekly and over a period of at least 6 months and there is not an organic explanation.³

Functional dyspepsia has further been subdivided into two diagnostic categories of meal-induced Postprandial Distress Syndrome (PDS), characterized by postprandial fullness and early satiation and Epigastric Pain Syndrome (EPS) characterized by epigastric pain and burning.⁴ However it is a great challenge for the physicians to differentiate between

functional dyspepsia and organic conditions of the stomach or duodenum with similar symptoms.

A number of alarm symptoms have been identified to diagnose potentially hazardous serious underlying disease in dyspepsia, especially malignancy. These symptoms include new-onset dyspepsia in older age group, unexplained weight loss, anorexia, early satiety, vomiting, progressive dysphagia, odynophagia, bleeding, anemia, jaundice, an abdominal mass, lymphadenopathy, a family history of upper GIT cancer, or a history of peptic ulcer, previous gastric surgery or malignancy.

Patients without alarm symptoms are usually managed by testing for *Helicobacter pylori*, with subsequent treatment if positive (the "test and treat" approach), an empiric trial of acid suppression, or initial endoscopy.⁵ In the first step patient reassurance and education, with use of H₂-blockers, or PPIs and a simple noninvasive H.pylori testing may be considered. Another strategy is prescription of empirical full-blown antisecretory therapy according to guideline proposed by the American College of Physicians. For either unresponsive patients or for those who will have an early symptomatic relapse further investigations are recommended. In another approach, the patients are initially subjected to comprehensive investigations including tests for H. Pylori and upper GIT endoscopy.

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The potential adverse effects of long term PPI therapy has recently been brought into account in respect to the vast population receiving this medication over a prolonged period of time.⁶ A recent report shows that Proton pump inhibitor use is associated with a higher risk of incident CKD.⁷ Observational studies suggest a modest risk of osteoporosis and fracture, community acquired pneumonia, and *Clostridium difficile* infection in PPI users.⁸ The PPIs are overprescribed in many patients and attempts should be justified to refrain from prescribing this medication where it is not needed.

In a placebo controlled trial of the tricyclic antidepressant amitriptyline or the selective serotonin reuptake inhibitor escitalopram, only amitriptyline showed a significant benefit over placebo in case of functional dyspepsia.⁹

Managing functional dyspepsia is challenging when both initial acid suppression therapy and *H. pylori* eradication fail. Modification of eating habits, reducing stress, avoiding medications and foods that seem to exacerbate symptoms, and refraining from tobacco, caffeine, alcohol, and carbonated beverages have been advocated in different ways but of unproven value.¹⁰

We are trying to formulate a differential approach for the management of functional dyspepsia. We are suggesting full range of available investigations including upper GIT endoscopy, USG abdominal scanning, H. Pylori testing and others as and when necessary. Majority of our patients with functional dyspepsia appears to have psychosomatic components in predominance. However our suggestions must be validated by further studies. And definitely there are a lot of projections for studies in management of functional dyspepsia.

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