



Complete Summary

GUIDELINE TITLE

Dyspepsia. A national clinical guideline.

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Dyspepsia. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Mar. 27 p. (SIGN publication; no. 68). [114 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline was issued in 2003 and will be considered for review as new evidence becomes available.

Any amendments to the guideline will be noted on the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

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SCOPE

DISEASE/CONDITION(S)

- Uncomplicated or functional dyspepsia
- *Helicobacter pylori* eradication in duodenal ulcer, gastric ulcer, and low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma

GUIDELINE CATEGORY

Diagnosis
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Gastroenterology
Geriatrics
Internal Medicine
Radiology
Surgery

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To provide recommendations based on current evidence for best practice in the management of dyspepsia in adults
- To update the evidence base for the key indications for *Helicobacter pylori* eradication in duodenal ulcer, gastric ulcer, and low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma.

This guideline does not specifically address the clinical management of:

- Diagnosed gastro-oesophageal reflux disease (GORD)
- Diagnosed gastric or duodenal ulcers (see Annex 1 of the original guideline document for an update on *H. pylori* eradication)
- Dyspepsia associated with the use of non-steroidal anti-inflammatory drugs (NSAIDs).

TARGET POPULATION

Patients with dyspepsia or *Helicobacter pylori* infection resulting in duodenal ulcer, gastric ulcer, and low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma.

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Upper gastrointestinal (GI) endoscopy
2. Referral to specialist for assessment
3. Barium meal studies

4. C urea breath test (CUBT)
5. Faecal antigen test
6. Hospital-based serological test, such as enzyme-linked immunosorbent assays (ELISAs)

Management/Treatment

1. *Helicobacter pylori* "test and treat," including non-invasive *H. pylori* test, eradication of infection in those testing positive, and symptomatic treatment for those testing negative
2. Lifestyle changes, such as stop smoking and only moderate amounts of alcohol and caffeine intake for patients with functional dyspepsia
3. *H. pylori* eradication therapy
4. Acid suppression therapy

(Note: Recommendations cannot be made on the role of the following in the management of functional dyspepsia: diet and lifestyle; psychosocial interventions; prokinetics; cytoprotectives; and antidepressants.)

MAJOR OUTCOMES CONSIDERED

- Patient's symptoms, such as pain or discomfort
- Sensitivity and specificity of diagnostic tests

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using an explicit search strategy devised by the SIGN Information Officer in collaboration with members of the guideline development group.

Searches were restricted to systematic reviews, meta-analyses, randomised controlled trials (RCTs), and longitudinal studies. Internet searches were carried out on the Web sites of the Canadian Practice Guidelines Infobase, the New Zealand Guidelines Programme, the UK Health Technology Assessment Programme, the US National Guidelines Clearinghouse, and the US Agency for Healthcare Research and Quality. Searches were also carried out using Google and OMNI search engines, and all suitable links followed up. Database searches were carried out on Cochrane Library, Embase 1990 to 2000, and Medline 1990 to 2000. Embase and Medline searches were later extended back to 1980 in relation to specific questions where more recent evidence was lacking. All searches were later updated to 2001.

An independent information specialist reviewed the search strategies. The Medline version of the main search strategies is available on the SIGN Web site, in the section covering supporting material for published guidelines. The main searches were supplemented by material identified by individual members of the development group. All selected papers were evaluated using standard methodological checklists before conclusions were considered as evidence.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++ - High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ - Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1- - Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++ - High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+ - Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2- - Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3 - Non-analytic studies, e.g. case reports, case series

4 - Expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Scottish Intercollegiate Guidelines Network (SIGN) carries out comprehensive systematic reviews of the literature using customized search strategies applied to

a number of electronic databases and the Internet. This is often an iterative process whereby the guideline development group will carry out a search for existing guidelines and systematic reviews in the first instance and, after the results of this search have been evaluated, the questions driving the search may be redefined and focused before proceeding to identify lower levels of evidence.

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. SIGN has developed checklists to aid guideline developers to critically evaluate the methodology of different types of study design. The result of this assessment will affect the level of evidence allocated to the paper, which in turn will influence the grade of recommendation it supports.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the [SIGN Web site](#).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The process for synthesizing the evidence base to form graded guideline recommendations is illustrated in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the SIGN Web site.

Evidence tables should be compiled, summarizing all the validated studies identified from the systematic literature review relating to each key question. These evidence tables form an important part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

In order to address how the guideline developer was able to arrive at their recommendations given the evidence they had to base them on, SIGN has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups are expected to summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- Generalisability of study findings
- Applicability to the target population of the guideline
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources need to treat them.)

Guideline development groups are provided with a pro forma in which to record the main points from their considered judgement. Once they have considered these issues, the group are asked to summarise their view of the evidence and assign a level of evidence to it, before going on to derive a graded recommendation.

The assignment of a level of evidence should involve all those on a particular guideline development group or subgroup involved with reviewing the evidence in relation to each specific question. The allocation of the associated grade of recommendation should involve participation of all members of the guideline development group. Where the guideline development group is unable to agree a unanimous recommendation, the difference of opinion should be formally recorded and the reason for dissent noted.

The recommendation grading system is intended to place greater weight on the quality of the evidence supporting each recommendation, and to emphasise that the body of evidence should be considered as a whole, and not rely on a single study to support each recommendation. It is also intended to allow more weight to be given to recommendations supported by good quality observational studies where randomised controlled trials (RCTs) are not available for practical or ethical reasons. Through the considered judgement process guideline developers are also able to downgrade a recommendation where they think the evidence is not generalisable, not directly applicable to the target population, or for other reasons is perceived as being weaker than a simple evaluation of the methodology would suggest.

On occasion, there is an important practical point that the guideline developer may wish to emphasise but for which there is not, nor is their likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as "good practice points." It must be emphasized that these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

Grade A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or randomized controlled trial rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rate as 2++

Grade D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A national open meeting is the main consultative phase of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group presents their draft recommendations for comment. The national open meeting for this guideline was held in October 2001 and was attended by representatives of all the key specialties relevant to the guideline. The draft guideline was also available on the SIGN web site for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

The guideline was reviewed in draft form by a panel of independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline.

The guideline was then reviewed by an Editorial Group comprising relevant specialty representatives on SIGN Council, to ensure that the peer reviewers' comments had been addressed adequately and that any risk of bias in the guideline development process as a whole had been minimised.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based

recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The grades of recommendations (A-D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Dyspepsia in the Community

The Role of the Community Pharmacist

D - Community pharmacists should advise patients suffering from dyspepsia associated with alarm symptoms to consult their general practitioner (see section 2.4, "Alarm Features and Risk of Cancer" of the original guideline document).

Symptoms of Dyspepsia

C - Symptom assessment cannot be relied upon to make a diagnosis of the cause of dyspepsia.

Alarm Features and Risk of Cancer

B - Patients with dyspepsia and alarm features should be referred to a hospital specialist for assessment.

(Note: There is no evidence to support the mandatory use of early upper gastrointestinal [GI] endoscopy to investigate patients over 55 years old who present with new onset uncomplicated dyspepsia.)

C - Upper GI endoscopy is the investigation of choice when further evaluation is warranted and should be widely available.

Management of Uncomplicated Dyspepsia

Patients Less Than 55 Years of Age

A - A non-invasive *Helicobacter pylori* test and treat strategy is as effective as endoscopy in the initial management of patients with uncomplicated dyspepsia who are less than 55 years old.

Patients Over 55 Years Old

C - A non-invasive *H. pylori* test and treat policy may be as appropriate as early endoscopy for the initial investigation and management of patients over the age of 55 years presenting with uncomplicated dyspepsia.

H. pylori Tests

B - The C urea breath test (CUBT) or faecal antigen tests are recommended for the pre-treatment diagnosis of *H. pylori* infection in the community. Less

accurate, hospital-based serology tests have a place within the non-invasive test and treat strategy.

B - C urea breath test is the recommended test to determine whether *H. pylori* has been successfully eradicated.

Management of Functional Dyspepsia

Lifestyle Advice

(Note: There is no clear evidence to support a recommendation on the role of diet and lifestyle in the management of functional dyspepsia.)

Psychological Treatments

(Note: It is not possible to make a recommendation on the role of psychosocial interventions in the management of functional dyspepsia.)

Pharmacological Treatments

A - *H. pylori* eradication therapy should be considered in the management of functional dyspepsia.

B - A trial of acid suppression therapy may be considered in the management of functional dyspepsia.

(Note: In view of the problems with the quality of the trials involved, the value of prokinetic drugs is uncertain. It is not possible to make a recommendation on the role of prokinetics in the management of functional dyspepsia.)

(Note: It is not possible to make a recommendation on the role of cytoprotectives in the management of functional dyspepsia.)

(Note: It is not possible to make a recommendation on the role of antidepressants in the management of functional dyspepsia.)

Definitions

Grades of Recommendations

A - At least one meta-analysis, systematic review of randomised controlled trials (RCTs), or randomised controlled trial rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B - A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C - A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rate as 2++

D - Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Levels of Evidence

1++ - High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ - Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1- - Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++ - High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+ - Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2- - Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3 - Non-analytic studies, e.g. case reports, case series

4 - Expert opinion

CLINICAL ALGORITHM(S)

A clinical algorithm is provided for the investigation and management of dyspepsia.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

There are advantages to eradicating *Helicobacter pylori* infection in dyspeptic patients without underlying ulcer disease. They include:

- Symptomatic benefit from eradicating the infection in a small subgroup of patients with functional dyspepsia
- Reducing the risk of subsequent ulcer disease
- Removing a risk factor for gastric cancer
- Removing concerns about potential adverse interactions between the infection and the subsequent long term use of proton pump inhibitors.

The *H. pylori* test and treat strategy is as effective and safe as endoscopy in determining the management of patients less than 55 years old with uncomplicated dyspepsia. In view of the fact that the *H. pylori* test and treat strategy is both non-invasive and cheaper than upper gastrointestinal (GI) endoscopy, it is considered to be the preferred strategy. Facilities for non-invasive *H. pylori* testing should therefore be widely available.

Sensitivity and Specificity of *H. pylori* Tests

- C urea breath tests (CUBTs) have been used widely in patients both before and after *H. pylori* eradication therapy. A randomised controlled trial has shown that, compared to an accepted gold standard, accuracy was 94.8% before antimicrobial therapy and 95.4% afterwards.
- Enzyme-linked immunosorbent assays (ELISAs) are the most commonly used serological method for the detection of *H. pylori*. Studies of sensitivity and specificity of these tests have produced inconsistent results. Sensitivity ranged from 85% to 92% and specificity ranged from 79% to 83%. One study showed an overall accuracy of 78% (range 68-82%).
- Studies of the accuracy of several new rapid whole blood test kits have shown a sensitivity and specificity of 82-95% and 83-94%, respectively, with positive and negative predictive values of 89-91% and 93-97%.
- Using the stool antigen test for the initial diagnosis of *H. pylori* infection and the mean sensitivity and specificity has been calculated at 93.1% and 92.8% respectively. Caution is needed following eradication therapy as omeprazole significantly reduces faecal antigen values, resulting in decreased accuracy.

POTENTIAL HARMS

There are disadvantages to eradicating *Helicobacter pylori* infection in dyspeptic patients without underlying ulcer disease. They include:

- Potential risks from wider use of antibacterial therapy (e.g., resistance and complications)
- Possibility of inducing reflux oesophagitis following eradication of strains of *H. pylori*.

CONTRAINDICATIONS

CONTRAINDICATIONS

The C urea breath test (CUBT) should not be performed within two weeks of proton pump inhibitor therapy or within four weeks of antibiotic therapy as false negative results may occur.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor, following discussion of the options with the patient, in light of the diagnostic and treatment choices available. However, it is advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) organisation and is an essential part of clinical governance. It is acknowledged that not every guideline can be implemented immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Key points for audit are identified in the original guideline document.

A set of Microsoft PowerPoint slides detailing implementation options is also available for download from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

IMPLEMENTATION TOOLS

Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides
Slide Presentation

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Dyspepsia. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Mar. 27 p. (SIGN publication; no. 68). [114 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Mar

GUIDELINE DEVELOPER(S)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

Scottish Executive Health Department

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group: Ms Angela Timoney (Chairman); Mr Colin MacKay (Secretary); Dr Robin Balfour; Mrs Janice Bancroft; Mr Graham Bell; Ms Anne Crozier; Dr Michael Gray; Dr Bob Heading; Mr Robin Harbour; Dr Stuart Hislop; Mrs Phoebe Isard; Ms Moira Kinnear; Professor Kenneth McColl; Dr John Murchison; Mr William R Murray; Dr Stephanie Morris; Mrs Fiona Phillips; Dr Rita Rigg; Dr Jack Taylor; Ms Joanne Topalian; Dr Craig Williams

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development groups are required to complete a declaration of interests, both personal and non-personal. A personal interest involves payment to the individual concerned, e.g., consultancies or other fee-paid work commissioned by or shareholdings in the pharmaceutical industry; a non-personal interest involves payment which benefits any group, unit or department for which the individual is responsible, e.g., endowed fellowships or other pharmaceutical industry support. SIGN guideline group members should be able to act as independently of external commercial influences as possible, therefore, individuals who declare considerable personal interests may be asked to withdraw from the group. Details of the declarations of interest of any guideline development group member(s) are available from the SIGN executive.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline was issued in 2003 and will be considered for review as new evidence becomes available.

Any amendments to the guideline will be noted on the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Quick reference guide: Dyspepsia. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Mar. 2 p. Available in Portable Document Format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).
- Overview of the guideline to aid implementation - Microsoft PowerPoint slides. Available for download from the [SIGN Web site](#)

- SIGN 50: a guideline developers' handbook. Edinburgh (UK): Scottish Intercollegiate Guidelines Network. (SIGN publication; no. 50). Available from the [SIGN Web site](#).
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research and Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the [SIGN Web site](#).
- A background paper on the legal implications of guidelines. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network.

PATIENT RESOURCES

The following are available:

- Patient information. In: Dyspepsia. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Mar. 27 p. (SIGN publication; no. 68). Electronic copies: Available in Portable Document Format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#)
- Advice to patients – dyspepsia. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 1 p. Electronic copies: Available in Portable Document Format (PDF) from the [SIGN Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was prepared by ECRI on November 20, 2003. The information was verified by the guideline developer on XX.

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