The Choosing Wisely Canada / Canadian Association of Gastroenterology Dyspepsia Toolkit: When It is OK to Say "Nope to the Gastroscope"

Choosing Wisely Canada National Meeting

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UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE
Continuing Medical Education
and Professional Development

Physician Learning Program

Choosing Wisely Alberta

Choosing Wisely Canada

Canadian Association of Gastroenterology

L'Association Canadienne de Gastroentérologie

Disclosures

Relationships with financial interest in past 2 years:

Faculty: Kelly Burak

- Grants/Research Support:
  World Gastroenterology Organisation
- Speakers Honoraria:
  American College of Gastroenterology
- Consulting Fees: none
- Patents: none
- Other:
  - Employee of University of Calgary
  - Former Co-Lead of PLP

Faculty: Sander Veldhuyzen van Zanten

- Grants/Research Support:
  University Hospital Foundation UofA
- Speakers Honoraria:
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- Consulting Fees: none
- Patents: none
- Other: none

Learning Objectives

By the end of this presentation, you will be able to:

1) Describe the long journey of implementing CWC / CAG Dyspepsia Recommendations in Alberta
2) Introduce the new CWC/CAG Dyspepsia Toolkit

The Problem

- **1 in 4 adults** will have dyspepsia
- **$18 billion / year** spent in USA

2005 Clinical Practice Guidelines (CPG)

CAG, ACG, AGA

Recommend against endo for patients < 55 without red flags

2014 CWC/CAG Recommendation

Avoid performing endoscopy for dyspepsia without alarm symptoms for patients < 55*

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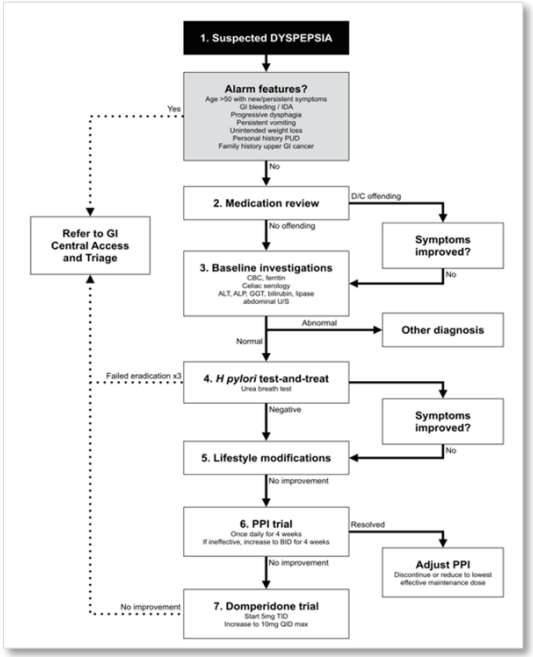
*change to age 60 after updated CPG in 2017[1]

2016 Specialist *LINK* Linking Physicians

Primary Care Pathway



2017 PLP CAL Project - Dr. K. Novak

Calgary A&F Framework[2]

1) Relationships
2) Question Choice
3) Data Visualization
4) Facilitated audit & group feedback

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1. Moayyedi PM, et al. Am J Gastroenterol 2017; 112:988-1013.

2. Cooke, L. et al. Implementation Science 2018; 13(1):104 and 131.

A&F -> Spread Scale -> Tools

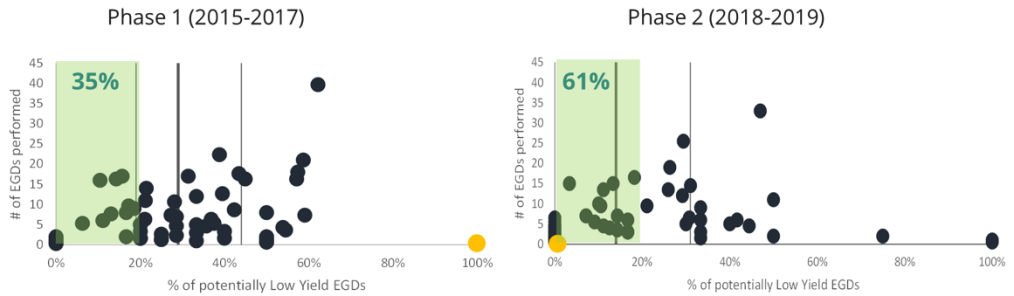
2018 A&F Session[1]

- **1800 endo / year** in pts < 55 with dyspepsia in Calgary
- At least **35% are low yield**
- 2% had findings (no cancers)
- A&F reports with peers coaching for change

2020 A&F Session

- ASGE performance target for GIs ↑ **35% to 61%**
- **300 fewer endo / year** in pts < 55 with dyspepsia in Calgary

2020 A&F Report for Dr. Kelly Burak



2019 CWA grant

Dr. K. Novak

Spread and scale to Edmonton[2,3]

PLP Human-Centred Design

- Co-Creation of Tools

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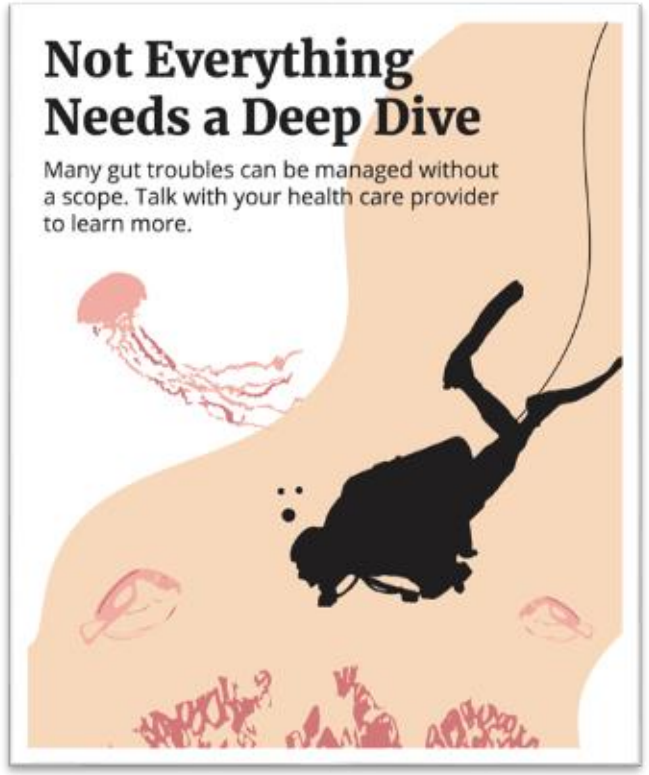
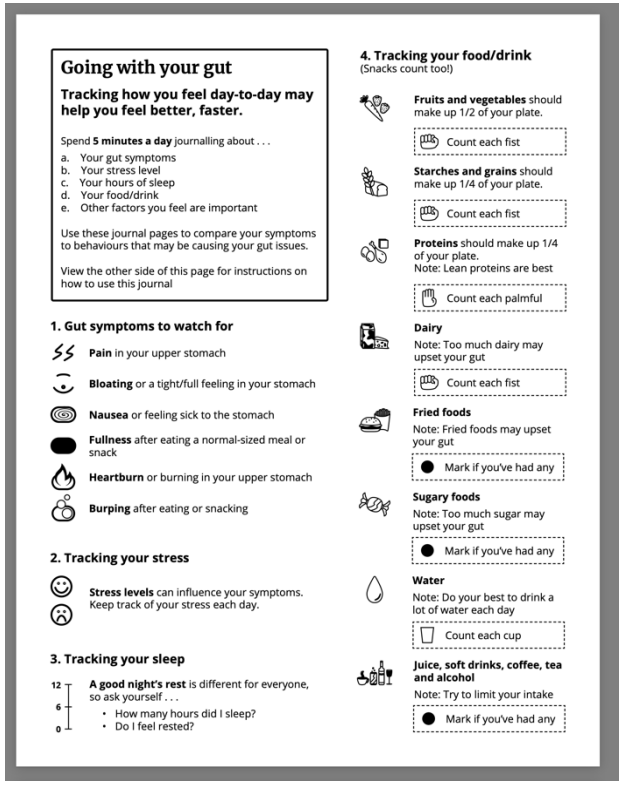
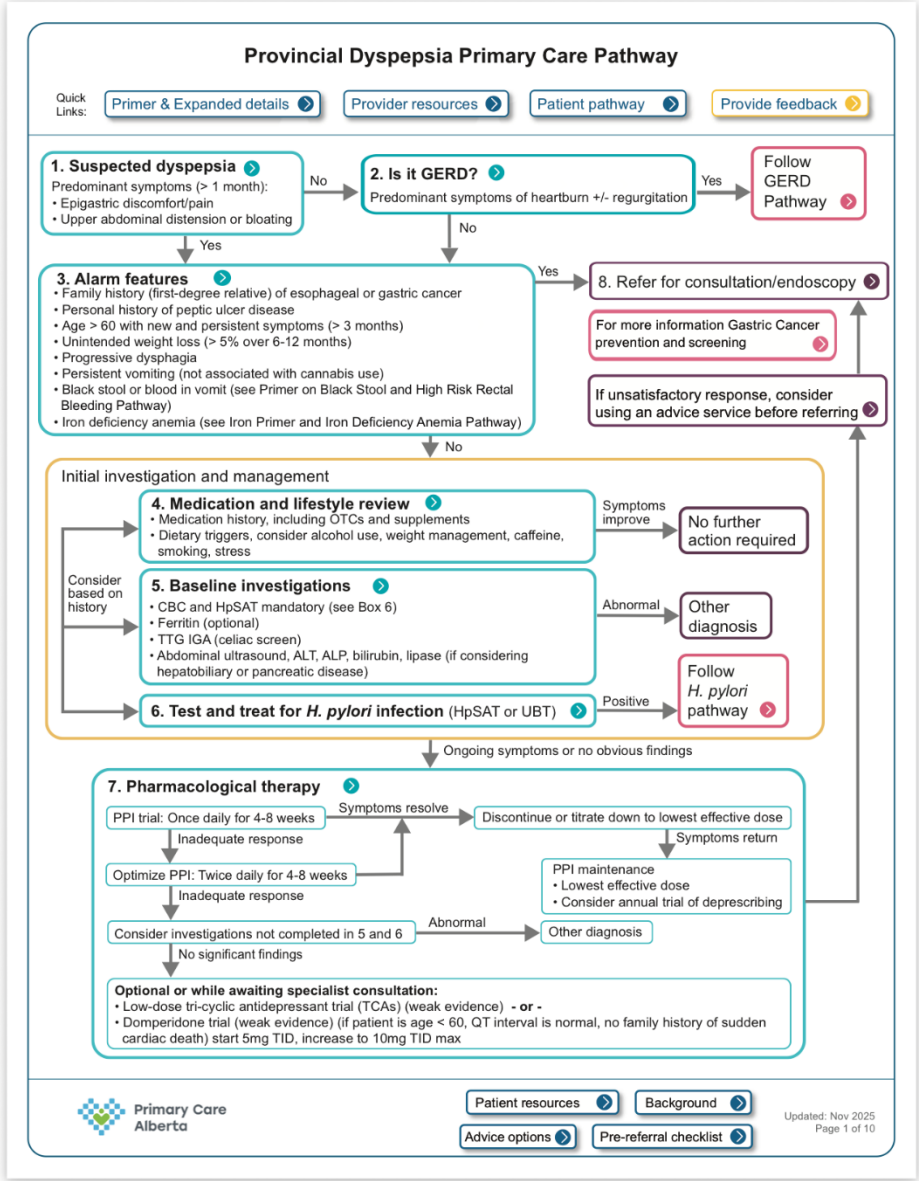
1. Halasz JB, et al. J Can Assoc Gastroenterol 2021;5(1):32-38.
2. Barber T, et al . J Can Assoc Gastroenterol 2023;6(7):1-10.
3. Maracle B, et al . J Can Assoc Gastroenterol 2024;7(12):230-7

Tools in Alberta







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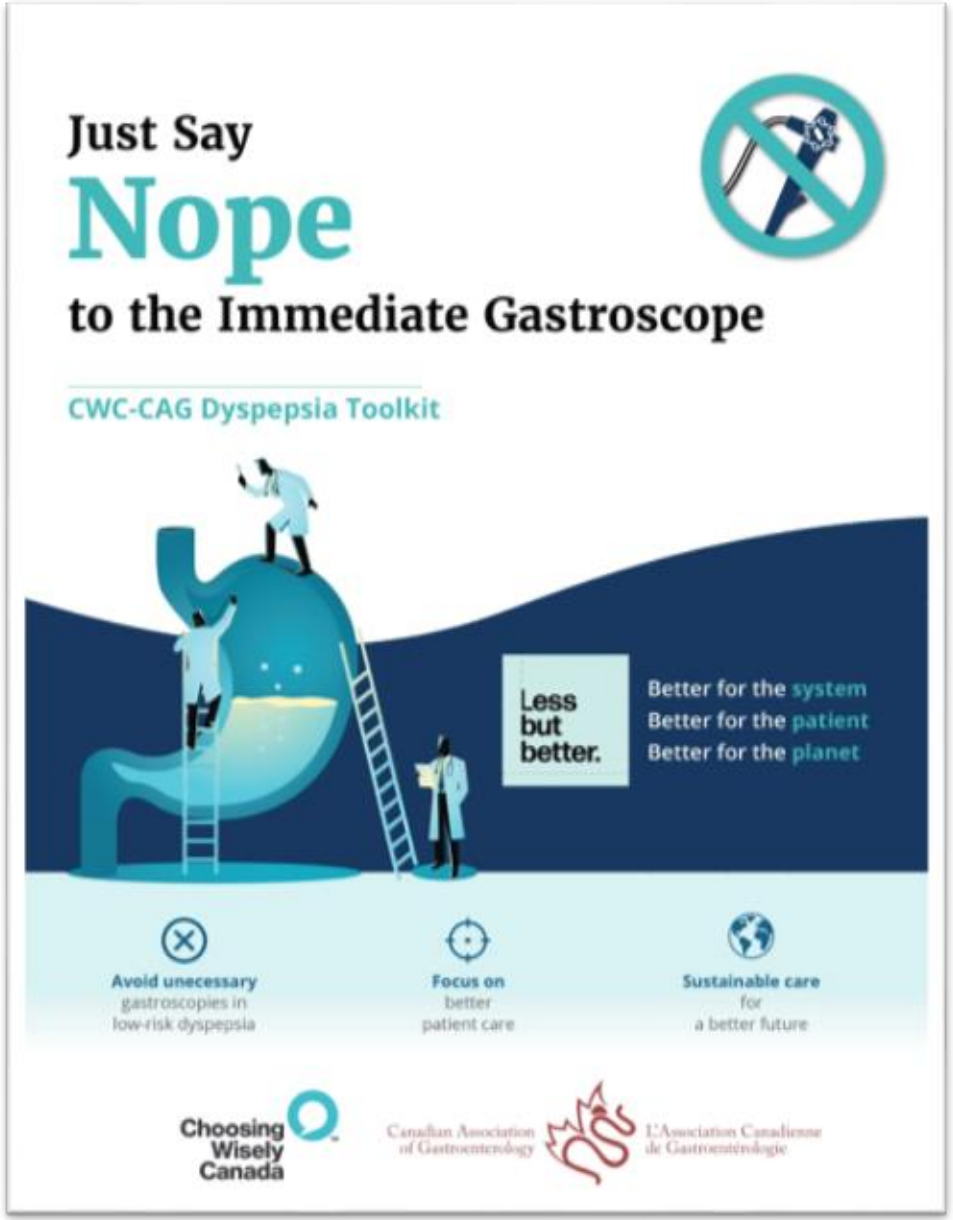
https://www.albertaplp.ca/our-tools

https://www.albertahealthservices.ca/assets/info/aph/if-aph-scn-dh-pathway-dyspepsia.pdf

Developing a National Toolkit

- CAG obtained grant obtain from CWC
  - Dr. Sander Veldhuyzen van Zanten
  - Dr. Kelly Burak
- CWA Project Coordination
  - Erika Johnson
- PLP Human Centred Design
  - Indra Budiyanto
- Expert Advisory Panel
  - Family Physicians
  - Gastroenterologists



DRAFT – Pending Final Approval

Purpose of the Toolkit

Support primary care and specialty care physicians, and their patients with upper GI symptoms, in implementing interventions to improve clinically appropriate utilization of gastroscopy by encouraging:

- Primary care physicians to appropriately manage patients < 60 years presenting with UGI symptoms without alarm features, by prescribing a PPI and/or a test & treat strategy for *H pylori* without the need for immediate referral for gastroscopy.
- Specialist physicians to avoid performing low yield gastroscopy, which will increase access to this limited resource.
- Patients to use resources to help them understand how their symptoms can be safely managed without the need for gastroscopy, if no alarm features are present.

Potential Benefits of the Toolkit

Better for the system

- Improved use of endoscopy resources
- Decrease in wait times for specialist care and procedures with more urgent indications
- Cost saving for the healthcare system

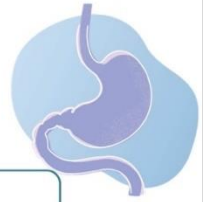
Better for patients

- Fewer invasive, sedated procedures
- Less time traveling and off work

Beneficial to the planet

- The “Greenest Endoscopy” is one that is not done!

Should Patient with Upper GI Symptoms have a **Gastroscopy**?



START: Patient presents with upper GI symptoms

1. Identify symptom pattern

Dyspepsia symptoms:
- Epigastric pain/discomfort (>1 month)
- Upper abdominal bloating

GERD symptoms:
- Heartburn AND/OR regurgitation

2. Does the patient need an immediate gastroscopy?

Is patient ≥60 with NEW, persistent symptoms (>3 months)?

Any of the following present?
- GI bleeding or anemia
- Progressive dysphagia
- Persistent vomiting
- Unintentional weight loss (≥5%/6 months)

- History of peptic ulcer disease
- Family history esophageal/gastric cancer

Yes → Refer for Gastroscopy

No

3. Review medications & lifestyle

Medications
- NSAIDs/ASA
- Calcium-channel blockers
- Antibiotics
- Iron, magnesium supplements
- Others

Lifestyle
- Diet
- Alcohol, caffeine
- Smoking
- Stress, weight gain
- Cannabis (may cause vomiting)

Lifestyle modification can occur alongside treatment

4. Manage according to dominant symptom *Overlap is common

If **EPIGASTRIC PAIN** dominant:
- Diagnose **Dyspepsia**
- **Start PPI once daily** (trial 4–8 weeks)
- Test H. pylori*, Use the tests that are available: UBT or stool antigen test

If **HEARTBURN/REGURG** is dominant:
- Diagnose **GERD**
- **Start PPI once daily** (trial 4–8 weeks)
- Routine H. pylori testing not required

*Do Hp test before initiating PPI or stop PPI for 2 weeks before testing For H. pylori cases:
- **Confirm Hp eradication** (test-of-cure)
- **If Hp eradicated and symptoms still present or return** Manage as chronic Dyspepsia/ GERD

5. Reassess & optimize treatement

- Ensure adherence
- Increase PPI to twice daily (4–8 weeks) if inadequate response
- Consider further testing

- **Tests:** CBC, Ferritin, Celiac serology
- **If indicated:** ALT, ALP, bilirubin, abdominal ultrasound, lipase

6. Resolution vs persistence

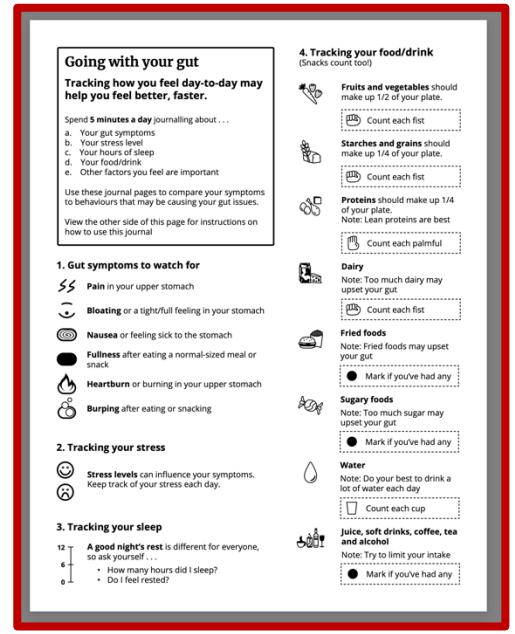
If symptoms RESOLVE:
- Taper/discontinue PPI
- Maintain lowest effective dose
- Annual deprescribing trial if appropriate

If symptoms PERSIST:
- Consider alternative diagnosis
- Consider referal to GI specialist

→ Refer for Gastroscopy

Patient Journey Map – Should Patient with Upper GI Symptoms (Dyspepsia and/or GERD) have a **Gastroscopy**?

	1 Initial Assessment: Symptoms	1 Initial Assessment: Risk & Alarm Features	1 Initial Assessment: Contributors	2 Diagnosis & Initial Treatment	3 Treatment Trial & Follow-Up Checks	4 Resolution or Escalation
Patient Perspective	*"My upper abdomen is painful and/ or with burning sensation, bloating with regurgitation*."*	*"I'm older / losing weight / vomiting, I'm worried this could be something serious."*	*"Could it be something I eat, take, or do?"*	*"I want to know how I can get better."* *"What needs to be done next?"*	*"I'm trying the treatment... I hope it works." "I track my symptoms during treatment."*	*"I feel better, do I stay on meds?" "I'm still struggling, what's next?"*
Clinician Goal	Identify the **dominant symptom pattern.**	Identify patients who need **urgent gastroscopy.**	Address common causes that may lead to symptoms.	Determine whether this is **Dyspepsia or GERD**.	Give a course of meds first to see if symptoms improve.	Assess treatment response and determine next steps.
Clinical Actions	Clarify symptoms: **Dyspepsia** - upper abdominal pain, bloating (discomfort)  **Gastroesophageal reflux disease (GERD)** - heartburn and/or regurgitation*  *Heartburn = burning sensation in upper abdomen behind the breastbone *Regurgitation = feeling of burning rising up to the chest	Check two categories: **Age-Based Risk** Age≥60+ new, persistent symptoms (>3 months) **Alarm Features** GI bleeding or anemia Dysphagia progressive feeling that food sticks when swallowing Persistent vomiting Unintentional weight loss (≥5% in 6 months) Stomach ulcer history Family history of stomach/esophageal cancer	Review: **Lifestyle** Smoking Alcohol, Caffeine (coffee, energy drinks) Spicy/fatty foods Stress Cannabis use **Medications** • NSAIDs/ASA • Calcium-channel blockers • Antibiotics • Iron or magnesium supplements • Others	**Dyspepsia Pathway** • Plan H. pylori test • Do test **BEFORE** PPI or stop PPI 2 weeks before testing **Hp results guide** • Hp+ → treat infection • Hp– → start PPI* *A Helicobacter pylori infection is a common stomach. PPI use can affect diagnostic test results for Hp. PPI should be stopped for 14 days when a test is done **GERD Pathway** (**No** H. pylori testing) • Start PPI* • Reinforce lifestyle modification *PPI = a strong blocker of stomach acid	• Trial PPI for 4–8 weeks • If PPI doesn't improve symptoms→ consider increase the dose or alternatives **Further Checks** **If symptoms persist:** • Increase the dose (twice daily) • Review adherence & timing AM before breakfast & PM before dinner • Consider test o **Core tests:** CBC, Ferritin, Celiac serology You can consider the core testing upfront o **If indicated:** ALT, ALP, bilirubin, abdominal ultrasound, lipase if pancreatic symptoms suspected • Consider **Patient Journal tool** to track your symptoms for a period of time	**Symptoms RESOLVE** • Stop PPI and see if **symptoms recur** **Symptoms RECUR** • Retreat with PPI Decrease PPI to lowest effective dose Consider annual trial deprescribing for those on continuous PPI Rx **Symptoms PERSIST & DO NOT RESPOND** Reassess and consider further evaluation biliary disease, pancreatic disease, functional dyspepsia,etc. Consider **Gastroscopy** if appropriate
Decision Point	• Do the symptoms sound like **Dyspepsia** or **GERD**? • You can consider **the core test (see no. 3)** at the initial visit or after the referral	**Are there any high-risk features?** • **Yes** → Refer for Gastroscopy • **No** → Continue	**Is something contributing to the symptoms?** • **Yes** → Adjust lifestyle and reassess symptoms • **No** → Continue	• **Dyspepsia** → Treat the symptoms with PPI and/or treat Helicobacter infection if present • **GERD** → Treat with PPI	**Are symptoms getting better?** • **Yes** → Continue PPI at the lowest dose that prevents symptoms from recurring • **No** → Consider further testing	**Symptoms resolved?** • **Yes** → Continue PPI. Once a year consider to stop PPI • **No** → Consider the dose of PPI and Gastroscopy. Consider alternative diagnosis



Going with your gut

Tracking how you feel day-to-day may help you feel better, faster.

Spend **5 minutes a day** journalling about . . .

a. Your gut symptoms
b. Your stress level
c. Your hours of sleep
d. Your food/drink
e. Other factors you feel are important

Use these journal pages to compare your symptoms to behaviours that may be causing your gut issues.

View the other side of this page for instructions on how to use this journal

1. Gut symptoms to watch for

Pain in your upper stomach
Bloating or a tight/full feeling in your stomach
Nausea or feeling sick to the stomach
Fullness after eating a normal-sized meal or snack
Heartburn or burning in your upper stomach
Burping after eating or snacking

2. Tracking your stress

Stress levels can influence your symptoms. Keep track of your stress each day.

3. Tracking your sleep

A good night's rest is different for everyone, so ask yourself . . .
- How many hours did I sleep?
- Do I feel rested?

4. Tracking your food/drink
(Snacks count too!)

Fruits and vegetables should make up 1/2 of your plate. Count each fist
Starches and grains should make up 1/4 of your plate. Count each fist
Proteins should make up 1/4 of your plate. Note: Lean proteins are best. Count each palmful
Dairy Note: Too much dairy may upset your gut. Count each fist
Fried foods Note: Fried foods may upset your gut. Mark if you've had any
Sugary foods Note: Too much sugar may upset your gut. Mark if you've had any
Water Note: Do your best to drink a lot of water each day. Count each cup
Juice, soft drinks, coffee, tea and alcohol Note: Try to limit your intake. Mark if you've had any

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Clinical Tips / Dispelling Myths

CLINICAL TIPS	FACT
Gastroscopy is not always needed to investigate dyspepsia	Many patients do not need an up-front gastroscopy for dyspepsia management. Based on clinical assessment they can be managed with either starting a PPI once daily and/or testing for Helicobacter.
Alarm symptoms or risk factors can be indications for gastroscopy	VBAD= Vomiting, Bleeding, Abdominal Mass, Dysphagia or unintentional weight loss (>5% over six months), especially if new onset at higher age, *and/or* History of peptic ulcer disease or family history of esophageal or gastric cancer. However, these symptoms in patients <60 do not always predict pathology.
MYTH: PPIs twice a day always controls reflux better than once a day	There is no evidence that starting with PPI twice daily for GERD gives better symptom control or better healing of erosive esophagitis if present. However, some GERD patients will need PPI twice day to maintain symptom control.
MYTH: Some PPIs are more effective than others	Standard Dose (SD) PPIs are considered therapeutically equivalent: Pantoprazole (Pantoloc™) 40 mg; Esomeprazole (Nexium™) 40 mg; Lansoprazole (Prevacid™) 30 mg; Dexlansoprazole (Dexilant™) 30 mg; Omeprazole (Losec™) 20 mg; Rabeprazole (Pariet™) 20 mg.

Conclusions

- New dyspepsia toolkit provides guidance for family physicians, GI specialists and patients on appropriate use of gastroscopy to investigate UGI symptoms
- Pathway breaks it down into 5 easy steps to provide guidance/ education / tools
    1) Recognize pattern (Dyspepsia vs GERD)
    2) Rule out need for more immediate referral
    3) Identify modifiable risks (Patient Journal)
    4) Manage according to predominant symptoms (PPI, Hp testing)
    5) Reassess response
- When it is OK to "Say Nope to the Immediate Gastroscope"

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Dyspepsia Toolkit Advisory Group

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