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GASTROENTEROLOGY BOARD REVIEW MANUAL

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Nonulcer Dyspepsia and Peptic Ulcer Disease

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INTRODUCTION

Dyspepsia was defined by the experts at the Rome II Multinational Consensus on Functional Gastrointestinal Disorders as "pain or discomfort centered in the upper abdomen."[1] Specific subtypes of dyspepsia recognized by the Rome II committee include *ulcer-like dyspepsia, dysmotility-like dyspepsia,* and *unspecified* or *nonspecific dyspepsia.*[1,2] (Abdominal pain that is mainly located in the left or right sides of the abdomen is not regarded as dyspepsia and will not be considered further in this manual.) Dyspepsia is a highly prevalent complaint and can result from a number of potentially identifiable causes. In 1997, approximately 2% of the adult population in the US received some form of outpatient or inpatient care because of dyspepsia.[3] Expenditures for this care totaled approximately $2.5 billion. Dyspepsia is, therefore, an extremely important topic. It is frequently a reason for consultations in gastroenterologists' offices and in primary care facilities.

It is important that the terms *dyspepsia* and *nonulcer dyspepsia* (NUD) not be confused; these terms are not interchangeable or synonymous. The term *dyspepsia* should be used to refer to patients who present before any investigation has been performed. For patients with dyspepsia, there are a number of potential causes of their symptoms including peptic ulcer disease (PUD) and gastric cancer. However, in clinical practice in the US, such patients are usually found to have NUD. The diagnosis of NUD can only be made once the condition has been investigated. In order for a patient to be diagnosed with NUD, he or she must have had a normal esophagogastroduodenoscopy (EGD) while being symptomatic and while not taking acid-suppressing or other ulcer-healing medicines.

The Rome II Multinational Consensus on Functional Gastrointestinal Disorders developed additional specific diagnostic criteria for NUD.[1] According to the criteria, for a diagnosis of NUD to be made, a patient must have had persistent or recurrent dyspepsia for 12 weeks, which need not be consecutive, during the past 12 months. Furthermore, there should be no evidence of organic disease—including at EGD—that is likely to explain the symptoms.

Some patients with irritable bowel syndrome may have pain that is predominantly or exclusively located in the upper abdomen and might erroneously be considered to have NUD. For a diagnosis of IBS to be made, there must be evidence that the abdominal pain can be relieved by defecation exclusively, and/or is associated with a change in stool frequency, and/or is associated with a change in stool appearance or form.[4] However, many patients may have diagnostic features

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