Lansoprazole was not effective in young dyspeptic patients without Helicobacter pylori


Clinical impact ratings: GIM/FP/GP ★★★★★✩✩ Gastroenterology ★★★★★☆☆

Question
Is lansoprazole effective in reducing dyspepsia and enhancing quality of life in young dyspeptic patients without Helicobacter pylori?

Methods
Design: Randomized placebo-controlled trial.
Allocation: Concealed.*
Blinding: Blinded (patients, data collectors, [health care providers]†, and outcome assessors).*
Follow-up period: 12 months.
Setting: Outpatient clinic of a hospital in Hong Kong, China.
Patients: 157 uninvestigated patients 18 to 45 years of age (mean age 31 y, 78% women) with pain or discomfort in the upper abdomen persisting for ≥ 12 weeks. Exclusion criteria included symptoms indicative of gastroesophageal reflux disease (GERD) or the irritable bowel syndrome; alarming symptoms, such as unintentional weight loss, gastrointestinal bleeding, repeated vomiting, or anemia; use of nonsteroidal antiinflammatory drugs; family history of weight loss, gastrointestinal bleeding, repeat endoscopy when empirical therapy initially fails is not useful unless there are typical symptoms of acid reflux disease (GERD). If a patient presents with heartburn, GERD is likely and proton pump inhibitors will be useful (1, 2).

Commentary
In patients with uninvestigated dyspepsia and no alarm features, there is consensus that noninvasive testing for H. pylori and empirical treatment of all infected cases is a rational and safe strategy, largely eliminating peptic ulcer disease (1). Identification of patients with H. pylori-negative dyspepsia is, however, common when this strategy is applied, and current guidelines recommend an empirical trial of acid suppression therapy (1, 2). The results of Leung and colleagues challenge the dogma that acid suppression is superior to placebo in patients with H. pylori-negative dyspepsia.

Importantly, the population studied was from China and was young and otherwise healthy; if upper endoscopy had been performed, almost all patients would presumably have had functional (nonulcer) dyspepsia. Patients who had treatment failure and those who were dissatisfied with study medication were offered upper endoscopy; of 40 patients so investigated, only 3 had any abnormalities. This suggests that performing endoscopy when empirical therapy initially fails is not useful unless new alarm features manifest.

Western countries have reported higher rates of endoscopic abnormalities in uninvestigated dyspepsia—in particular, reflux esophagitis—and nonerosive reflux disease may be more prevalent (3). This implies that results from the East do not necessarily apply to the West, and vice versa. In North America, high rates of unrecognized GERD probably account for the response to acid suppression therapy (1, 2). Epigastric pain or nausea with little or no heartburn can be the presenting symptom of GERD. If a patient presents with heartburn, GERD is likely and proton pump inhibitors will be useful (1, 2).

Treatment of H. pylori-negative dyspepsia not associated with reflux remains challenging. Not all such patients need drugs, and Leung and colleagues showed that the treatment failure rate was relatively low in both groups at 12 weeks. Limited prokinetic options are available, and their efficacy has been questioned (1, 2). Antacids, sucralfate, and bismuth do not work (2). The value of other drugs (e.g., antidepressants) has not been established (1).

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References