Costing statement: Dyspepsia and gastro-oesophageal reflux disease
Implementing the NICE guideline on dyspepsia and gastro-oesophageal reflux disease (CG184)

Published: September 2014
1 Introduction

1.1 This costing statement considers the cost implications of implementing the recommendations made in Dyspepsia and gastro-oesophageal reflux disease: investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both (NICE clinical guideline 184).

1.2 It is considered that implementing the recommendations will not have a significant national resource impact.

1.3 This guidance is an update of Dyspepsia: managing dyspepsia in adults in primary care (NICE clinical guideline 17; 2004) and replaces it. New and updated recommendations have been included for the diagnosis and treatment of gastro-oesophageal reflux disease (GORD) in primary care and to cover aspects of specialist hospital care in secondary care settings.

1.4 Services for managing dyspepsia and GORD are commissioned by clinical commissioning groups (CCGs). Providers include primary care services and acute hospitals, with proton pump inhibitors (PPIs) mainly prescribed by GPs in primary care.

1.5 The guideline is unlikely to have a significant impact on NHS resources because many of the recommendations are embedded in current standard practice. However, organisations are advised to assess the resource implications of the guidance locally and evaluate their own practices against the recommendations in the NICE guideline. Some of the resource effects to be considered locally are discussed in this statement.

1.6 Only new or updated recommendations have been considered in this costing statement, because evidence suggests that the 2004 recommendations are now embedded in current practice. The updated recommendations considered for costing focused on:
• Interventions for severe oesophagitis (recommendations 1.6.7–1.6.10).
• Offering laparoscopic fundoplication to people with GORD (recommendation 1.10.1).
• Surveillance for people with Barrett’s oesophagus (recommendation 1.12.1).

2 Background

2.1 The guideline covers adults (18 years and over) with symptoms of dyspepsia, symptoms suggestive of GORD, or both. It also covers endoscopic surveillance for adults with a diagnosis of Barrett’s oesophagus, but it does not cover the management of Barrett’s oesophagus. The guideline does not cover children and young people (younger than 18 years) and people with a diagnosis of oesophagogastric cancer.

2.2 If there is a suspicion of cancer the guideline cross refers to Referral for suspected cancer (NICE clinical guideline 27). This guideline is currently being updated and the update is expected to publish in 2015.

2.3 The prevalence of dyspepsia is estimated to be between 23% and 41% of the general population (British Society of Gastroenterology, 2002). The approximate prevalence of GORD is between 10% and 20% of the general population (Amarasiri et al. 2010).

2.4 Approximately a quarter of people with symptoms of dyspepsia will consult a primary care clinician and about 10% of these consultations will lead to a referral for further investigation (British Society of Gastroenterology, 2002).

2.5 Dyspepsia accounts for between 1.2% and 4% of all consultations in primary care (NICE guideline 184). As a result, the management of dyspepsia continues to have a significant burden in primary care, with only a small proportion of people being referred for specialist opinion.
3 Recommendations with potential resource impact

3.1 Resource implications associated with implementing the guideline should be determined at a local level. However, some of the possible costs and savings associated with its implementation are discussed below. Costs for medication are listed in table 1. Tables 1 and 2 of appendix A in the guideline detail the dosage information for PPIs.

Table 1 Summary of medication costs (British National Formulary, 2014)

<table>
<thead>
<tr>
<th>Recommendation number</th>
<th>Dose</th>
<th>Length of time on medication</th>
<th>Minimum cost (£)</th>
<th>Maximum cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6.7</td>
<td>Full/standard-dose PPI</td>
<td>8 weeks</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>1.6.8</td>
<td>Full/standard-dose with a different PPI</td>
<td>8 weeks</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>1.6.8</td>
<td>High-dose PPI</td>
<td>8 weeks</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>1.6.9</td>
<td>Full-dose PPI (maintenance treatment)</td>
<td>Per year</td>
<td>18</td>
<td>60</td>
</tr>
</tbody>
</table>

Costs

Severe oesophagitis

3.2 Only a small proportion (22%) of people with oesophagitis have severe oesophagitis (Los Angeles classification grade C/D) (Genta et al. 2011). The guideline recommends a full-dose PPI for 8 weeks to heal severe oesophagitis (first-line treatment; recommendation 1.6.7). If initial treatment fails, the guideline recommends a high dose of the initial PPI, switching to another full-dose PPI, or switching to another high-dose PPI (second-line treatment; recommendation 1.6.8). According to the North of England Dyspepsia Guideline Development Group 2004, the average healing rate for full-dose PPI is 72%, but doubling the dose results in an absolute increase of 5% in the healing rate.

3.3 The guideline recommends that people with severe oesophagitis should remain long-term on a full-dose PPI as maintenance treatment to prevent its recurrence (recommendation 1.6.9). This would result in an
 approximate cost of between £18 and £60 per person per year (see table 1).

3.4 No additional staff time should be required so prescribing PPIs is not expected to incur any extra staff costs.

**Barrett’s oesophagus**

3.5 Barrett’s oesophagus is found in about 2% of the adult population and in about 5% of people with GORD (Jankowski et al. 2010). It is more common in men, and the prevalence increases with age. The guideline recommends considering surveillance to check progression to cancer for people who have a diagnosis of Barrett’s oesophagus (recommendation 1.12.1). This could result in a change in the number of people receiving surveillance at a local level.

3.6 Barrett’s oesophagus is confirmed by endoscopy and histopathology, and surveillance for progression to cancer is via further endoscopy and histopathology, so any change in surveillance levels could lead to additional costs. Endoscopic procedures could cost commissioners between £344 (HRG code FZ60Z diagnostic endoscopic procedures on the upper GI tract 19 years and over, 2014/15 national tariff) and £382 (HRG code FZ61Z diagnostic endoscopic procedures on the upper GI tract with biopsy 19 years and over, 2014/15 national tariff).

**Potential savings**

3.7 The guideline recommends considering laparoscopic fundoplication for people who do not wish to continue long-term therapy or for those who cannot tolerate acid suppression therapy (recommendation 1.10.1).

3.8 After 5 years, laparoscopic fundoplication continues to provide better relief of GORD symptoms with associated improved health-related quality of life (Grant et al. 2013). Despite being initially more costly, £2,076 (HRG code FZ05B major stomach or duodenum procedures 2 years and over without complications and comorbidities, Payment by Results tariff 2014/15), cost
savings may be realised in the longer term. This is because the number of people having surgery will no longer need long-term PPI maintenance treatment and there will be a decrease in visits to GPs and hospital attendances (inpatient and outpatient).

4 Other considerations

4.1 In England most PPIs are prescribed in the primary care setting (Grant et al. 2013) and therefore impact on CCG budgets.

5 Conclusion

5.1 The guideline is unlikely to have a significant impact on NHS resources because many of the recommendations are believed to be highlighting current standard practice. However, NHS organisations are advised to assess the resource implications of the guidance locally and evaluate their own practices against the recommendations in the NICE guideline.

6 References


Grant AM, Boachie C, Cotton SC et al. Clinical and economic evaluation of laparoscopic surgery compared with medical management for gastro-oesophageal reflux disease: 5-year follow-up of multicenter randomized trial (the REFLUX trial) (2013) Health Technology Assessment 17: 22

NICE, (2014) *Dyspepsia and gastro-oesophageal reflux disease: investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both* NICE clinical guideline 184.


[National tariff payment system, 2014/15](https://www.nice.org.uk/guidance/cg184)
About this costing statement

This costing statement accompanies Dyspepsia and gastro-oesophageal reflux disease: investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both (NICE clinical guideline 184).

Issue date: September 2014

This statement is written in the following context

This statement represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. It should be read in conjunction with the NICE guideline. The statement is an implementation tool and focuses on those areas that were considered to have potential impact on resource utilisation.

The cost and activity assessments in the statement are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.

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