Appendix K: Recommendations from NICE clinical guideline 17 [2004] that have been deleted or changed

K.1.1 Recommendations to be deleted

The table shows recommendations from 2004 that NICE proposes to delete in the 2014 update. The right-hand column gives the replacement recommendations, or explains the reason for the deletion if there is no replacement recommendation.

Recommendation in 2004 guideline	Comment
1.2.4 Urgent specialist referral or endoscopic investigations indicated for patients of any age with dyspepsia when presenting with any of the following: chronic gastrointestinal bleeding; progressive unintentional weight loss; progressive difficulty swallowing; persistent vomiting; iron deficiency anaemia; epigastric mass or suspicious barium meal.	This recommendation has been deleted as it was felt more appropriate to cross-refer to the relevant recommendations from CG27 and its update
1.2.5 and 1.5.5 Routine endoscopic investigation of patients of any age presenting with dyspepsia and without alarm signs is not necessary. However, in patients aged 55 years and older with unexplained and persistent recent-onset dyspepsia alone, an urgent referral for endoscopy should be made.	This recommendation has been deleted as it was felt more appropriate to cross-refer to the relevant recommendations from CG27 and its update
1.2.6 Patients undergoing endoscopy should be free from medication with either a proton pump inhibitor (PPI) or an H_2 receptor antagonist (H_2RA) for a minimum of 2 weeks beforehand	This recommendation has been deleted as it was felt more appropriate to cross-refer to the relevant recommendations from CG27 and its update
1.3.1 For many patients, self-treatment with antacid and/or alginate therapy (either prescribed or purchased over-the-counter and taken 'as required') may continue to be appropriate for immediate symptom relief. However, additional therapy is appropriate to manage symptoms that persistently affect patients' quality of life	This recommendation is now considered background information and not in line the Guideline Manual 2012 and current editorial guidance.
1.3.2 Offer older patients (over 80 years of age) the same treatment as younger patients, taking account of any comorbidity and their existing use of medication.	This recommendation has been deleted because it was considered that an age limit is no longer appropriate
1.5.3 Offer simple lifestyle advice, including healthy eating, weight reduction and smoking cessation.	This recommendation has been deleted as it is a duplicate of recommendation 1.2.2
1.5.4 Advise patients to avoid known	This recommendation has been deleted as

Recommendation in 2004 guideline	Comment
precipitants they associate with their dyspepsia where possible. These include smoking, alcohol, coffee, chocolate, fatty foods and being overweight. Raising the head of the bed and having a main meal well before going to bed may help some people.	it is a duplicate of recommendation 1.2.3
1.6.6 Surgery cannot be recommended for the routine management of persistent GORD although individual patients whose quality of life remains significantly impaired may value this form of treatment.	Replaced by: 1.11.1 Consider referral to a specialist service for people: • of any age with gastro-oesophageal symptoms that are persistent, non-responsive to treatment or unexplained[1] • with suspected GORD who are thinking about surgery • with *H pylori* and persistent symptoms that have not responded to second-line eradication therapy. **[new 2014]** [1] In Referral guidelines for suspected cancer (NICE clinical guideline 27), 'unexplained' is defined as 'a symptom(s) and/or sign(s) that has not led to a diagnosis being made by the primary care professional after initial assessment of the history, examination and primary care investigations (if any)'. (Please note that an update is in progress; publication expected May 2015. For more information see http://guidance.nice.org.uk/CG/Wave0/618).
1.9.4 For patients who test positive, provide a 7-day, twice-daily course of treatment consisting of a full-dose PPI, with either metronidazole 400 mg and clarithromycin 250 mg or amoxicillin 1 g and clarithromycin 500 mg.	Replaced by: 1.9.4 Offer people who test positive for *H pylori* a 7-day, twice-daily course of treatment with: • a PPI (see table 3 in appendix A), and • amoxicillin, **and** • either clarithromycin or metronidazole. Choose the treatment regimen with the lowest acquisition cost, and take into account previous exposure to clarithromycin or metronidazole. **[new 2014]** 1.9.5 Offer people who are allergic to penicillin a 7-day, twice-daily course of treatment with: • a PPI (see table 3 in appendix A) **and** • clarithromycin **and** • metronidazole. **[new 2014]** 1.9.6 Offer people who have had previous exposure to clarithromycin and who are allergic to penicillin a 7-day, twice-daily course of treatment with:

Recommendation in 2004 guideline	Comment
	• a PPI (see table 3 in appendix A) **and** • bismuth **and** • metronidazole **and** • tetracycline. **[new 2014]** 1.9.7 Discuss treatment adherence with the person and emphasise its importance. For more information about supporting adherence, see Medicines adherence (NICE clinical guideline 76). **[new 2014]**
1.9.5 For patients requiring a second course of eradication therapy, a regimen should be chosen that does not include antibiotics given previously (see the *British National Formulary* for guidance).	Replaced by: 1.9.8 For people who still have symptoms after first-line eradication treatment, offer a 7-day, twice-daily course of treatment with: • a PPI (see table 3 in appendix A) **and** • amoxicillin **and** • either clarithromycin or metronidazole (whichever was not used first-line). **[new 2014]** 1.9.9 Offer people who have had previous exposure to clarithromycin and metronidazole a 7-day, twice-daily course of treatment with: • a PPI (see table 3 in appendix A) **and** • amoxicillin **and** • a quinolone or tetracycline (whichever has the lowest acquisition cost). **[new 2014]** 1.9.10 Offer people who are allergic to penicillin (or who have had previous exposure to clarithromycin) a 7-day, twice-daily course of treatment with: • a PPI (see table 3 in appendix A) **and** • metronidazole **and** • levofloxacin. **[new 2014]** 1.9.11 Offer people who have had previous exposure to clarithromycin, quinolones and who are allergic to penicillin: • a PPI (see table 3 in appendix A) **and** • bismuth **and** • metronidazole **and** • a tetracycline. **[new 2014]**

K1.2 Amended recommendation wording (change to meaning)

Recommendations are labelled **[2004, amended 2014]** if the evidence has not been reviewed but changes have been made to the recommendation wording (indicated by highlighted text) that change the meaning.

Recommendation in 2004 guideline	Recommendation in update	Reason for change
1.2.3 Consider the possibility of cardiac or biliary disease as part of the differential diagnosis.	1.3.3 Think about the possibility of cardiac or biliary disease as part of the differential diagnosis.	Changed to make recommendation active.
1.3.6 Psychological therapies, such as cognitive behavioural therapy and psychotherapy, may reduce dyspeptic symptoms in the short term in individual patients. Given the intensive and relatively costly nature of such interventions, routine provision by primary care teams is not currently recommended.	1.2.4 Recognise that psychological therapies, such as cognitive behavioural therapy and psychotherapy, may reduce dyspeptic symptoms in the short term in individual people.	Changed to make recommendation active and to bring in line with the Guideline Manual 2012 and editorial guidance.
1.3.7 Patients requiring long-term management of dyspepsia symptoms should be encouraged to reduce their use of prescribed medication stepwise: by using the effective lowest dose, by trying as-required use when appropriate, and by returning to self-treatment with antacid and/or alginate therapy.	1.2.5 Encourage people who need long-term management of dyspepsia symptoms to reduce their use of prescribed medication stepwise: by using the effective lowest dose, by trying 'as-needed' use when appropriate, and by returning to self-treatment with antacid and/or alginate therapy (unless there is an underlying condition or comedication that needs continuing treatment).	Changed to make this recommendation active and for clarity as this recommendation now only applies to people without an underlying condition or comedication that needs continuing treatment.
1.4.1 Dyspepsia in unselected patients in primary care is defined broadly to include patients with recurrent epigastric pain, heartburn, or acid regurgitation, with or without bloating, nausea or vomiting. Review common elements of care for managing dyspepsia (section 1.3).	1.4.1 Be aware that dyspepsia in unselected people in primary care is defined broadly to include people with recurrent epigastric pain, heartburn or acid regurgitation, with or without bloating, nausea or vomiting. Also see 'Common elements of care'.	Changed to make recommendation active and for clarity
1.4.2 Initial therapeutic strategies for dyspepsia are	1.4.2 Leave a 2-week washout period after proton	Changed to make recommendation active and

Recommendation in 2004 guideline	Recommendation in update	Reason for change
empirical treatment with a PPI or testing for and treating *H pylori*. There is currently insufficient evidence to guide which should be offered first. A 2-week washout period following PPI use is necessary before testing for *H pylori* with a breath test or a stool antigen test.	pump inhibitor (PPI) use before testing for *Helicobacter pylori* (hereafter referred to as *H pylori)* with a breath test or a stool antigen test.	for clarity
1.4.6 Offer H_2RA or prokinetictherapy if there is an inadequate response to a PPI.	1.4.6 Offer H_2 receptor antagonist (H_2RA) therapy if there is an inadequate response to a PPI.	Reference to prokinetic therapy has been removed as the original guideline only reviewed the evidence for cisapride, not domperidone or metoclopramine. Cisapride has been suspended in the UK since the publication of CG17.
1.5.1 Offer people requiring long-term management of symptoms for dyspepsia an annual review of their condition, encouraging them to try stepping down or stopping treatment.	1.5.1 Offer people who need long-term management of dyspepsia symptoms an annual review of their condition, and encourage them to try stepping down or stopping treatment (unless there is an underlying condition or comedication that needs continuing treatment).	Changed for clarity.
1.5.2 A return to self-treatment with antacid and/or alginate therapy (either prescribed or purchased over-the-counter and taken as-required) may be appropriate.	1.5.2 Advise people that it may be appropriate for them to return to self-treatment with antacid and/or alginate therapy (either prescribed or purchased over-the-counter and taken as needed).	Changed to make recommendation active.
1.6.1 Gastro-oesophageal reflux disease (GORD) refers to endoscopically determined oesophagitis or endoscopy-negative reflux disease. Patients with uninvestigated 'reflux-like' symptoms should be managed as patients with uninvestigated dyspepsia.	1.6.1 Manage uninvestigated 'reflux-like' symptoms as uninvestigated dyspepsia.	Changed to make recommendation active.
1.6.3 If symptoms recur	1.6.3 If symptoms recur after	Removed ‘with a limited

Recommendation in 2004 guideline	Recommendation in update	Reason for change
following initial treatment, offer a PPI at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.	initial treatment, offer a PPI at the lowest dose possible to control symptoms.	number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.6.5 Offer H_2RA or prokinetic therapy if there is an inadequate response to a PPI.	1.6.5 Offer H_2RA therapy if there is an inadequate response to a PPI.	Reference to prokinetic therapy has been removed as the original guideline only reviewed the evidence for cisapride, not domperidone or metoclopramine. Cisapride has been suspended in the UK since the publication of CG17.
1.7.3 Patients with gastric ulcer and *H pylori* should receive repeat endoscopy, retesting for *H pylori* 6–8 weeks after beginning treatment, depending on the size of the lesion.	1.7.3 Offer people with gastric ulcer and *H pylori* repeat endoscopy 6 to 8 weeks after beginning treatment, depending on the size of lesion.	The GDG felt the original recommendation needed to be split to reflect the different actions taken in each flowchart within the Full guideline. People with gastric ulcers needed an endoscopy and retesting, however just retesting for *H pylori* was necessary for people with duodenal ulcers.
1.7.3 Patients with gastric ulcer and *H pylori* should receive repeat endoscopy, retesting for *H pylori* 6–8 weeks after beginning treatment, depending on the size of the lesion.	1.7.4 Offer people with peptic ulcer (gastric or duodenal) and *H pylori* retesting for *H pylori* 6 to 8 weeks after beginning treatment, depending on the size of lesion.	The GDG felt the original recommendation needed to be split to reflect the different actions taken in each flowchart within the Full guideline. People with gastric ulcers needed an endoscopy and retesting, however just retesting for *H pylori* was necessary for people with duodenal ulcers. The GDG felt peptic ulcer was the more appropriate term to use and included gastric and duodenal for further clarification.
1.7.8 If symptoms recur following initial treatment, offer a PPI to be taken at the lowest dose possible to control symptoms, with a	1.7.9 If symptoms recur after initial treatment, offer a PPI to be taken at the lowest dose possible to control symptoms. Discuss using	Removed 'with a limited number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time

Recommendation in 2004 guideline	Recommendation in update	Reason for change
limited number of repeat prescriptions. Discuss using the treatment on an as-required basis with patients to manage their own symptoms.	the treatment on an 'as-needed' basis with people to manage their own symptoms.	of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.8.4 If *H pylori* has been excluded or treated and symptoms persist, offer either a low-dose PPI or an H_2RA for 1 month.	1.8.4 If *H pylori* has been excluded and symptoms persist, offer either a low-dose PPI (see table 1 in appendix A) or an H_2RA for 4 weeks.	Treatment has been removed from this recommendation and this is now covered by recommendations on *H pylori* eradication.
1.8.5 If symptoms continue or recur following initial treatment offer a PPI or H_2RA to be taken at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.	1.8.5 If symptoms continue or recur after initial treatment offer a PPI or H_2RA to be taken at the lowest dose possible to control symptoms.	Removed 'with a limited number of repeat prescriptions' as the GDG felt this was included due to the costs of PPI at the time of original publication. Costs have since fallen and therefore limiting repeat prescriptions due to costs is not a factor in current practice.
1.8.7 Long-term, frequent dose, continuous prescription of antacid therapy is inappropriate and only relieves symptoms in the short term rather than preventing them.	1.8.7 Avoid long-term, frequent dose, continuous antacid therapy (it only relieves symptoms in the short term rather than preventing them).	Changed to make recommendation active and for clarity.
1.9.1 *H pylori* can be initially detected using a carbon-13 urea breath test or a stool antigen test, or laboratory-based serology where its performance has been locally validated	1.9.1 Test for *H pylori* using a carbon-13 urea breath test or a stool antigen test, or laboratory-based serology where its performance has been locally validated.	Changed to make recommendation active.
1.9.3 Office-based serological tests for *H pylori* cannot be recommended because of their inadequate performance.	1.9.3 Do not use office-based serological tests for *H pylori* because of their inadequate performance.	Changed to make recommendation active.

K.1.3 Changes to recommendation wording in line with current NICE style (no change to meaning)

Recommendation in 2004 guideline	Comment
All recommendations except those labelled [new 2014]	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in clinical

Recommendation in 2004 guideline	Comment
1.1.1, 1.1.2, 1.2.1,1.2.2, 1.2.3, 1.3.1, 1.3.2, 1.3.4, 1.4.3, 1.4.4, 1.4.5, 1.6.2, 1.6.4, 1.6.6, 1.7.1, 1.7.2, 1.7.5, 1.7.6, 1.7.7, 1.7.8, 1.7.10,1.8.1, 1.8.2, 1.8.3, 1.8.6, 1.9.2	guidelines) where possible. Yellow highlighting has not been applied to these changes.

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