

Dyspepsia: A Common Riddle in Practice, Both for Patients and Doctors!

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In our everyday clinical practice, we are faced with patients worried about their chronic stomach pain, of which a substantial proportion have functional dyspepsia. Prevalence of dyspepsia is approximately 25% in the United States and other western countries.^{1,2}

Although, at first glance, dyspepsia appears to be an easily solvable problem it has different pathophysiological mechanisms. The putative mechanisms include abnormal gastric emptying, impaired fundic accommodation, increased gastroduodenal sensitivity to mechanical distention, impaired acid clearance and increased acid sensitivity in the duodenum.

Disagreement about the definition of dyspepsia has complicated the results of related clinical studies. Previous guidelines used the term to mean all symptoms which referred to the upper gastrointestinal tract. In recent years, an international committee of clinical investigators (Rome III Committee) defined dyspepsia as one or more of the following symptoms: postprandial fullness, early satiety, epigastric pain or burning for at least three months with symptom onset at least six months before diagnosis. Patients with predominant reflux symptoms are excluded.³ In this issue, Khademolhosseini et al.

have studied the prevalence of dyspepsia in Shiraz (southern Iran).⁴ The results of their study should be considered in the light of various limitations inherent in an observational database study of this type. The most important of these is the definition of dyspepsia used for patients in this study. The authors defined dyspepsia as epigastric pain or upper abdominal symptoms within the previous year, which is an outdated definition. In the Rome III criteria, heartburn is not included. In this study, patients with GERD dominant symptoms were not excluded.

The other problem is that in clinical practice, there is considerable overlap between functional dyspepsia and IBS. Population-based studies have shown the prevalence of dyspepsia among patients with IBS to be 29-87%,⁵⁻⁷ however in this study patients with IBS were not excluded.

In a US study the prevalence of dyspepsia was 13% among volunteer households; one-third of the population had heartburn. However, if heartburn and IBS symptoms were excluded from the dyspepsia category, only 3% of the population still had a diagnosis of dyspepsia.⁸

Dyspepsia is associated with significant impairment of quality

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of life. Unfortunately, because of terminological confusion, epidemiological studies have produced different estimates of the incidence and prevalence of dyspepsia, and of its association with potential risk factors.⁹

Most data on the epidemiology of dyspepsia have come from population based cross-sectional studies. Although these studies have provided valuable information, they give no information on the relationship between the onset of dyspepsia and risk factors. It seems, therefore that further research is needed to elucidate the potential risk factors for dyspepsia. There is also a need to define more precise criteria for dyspepsia to make better differential diagnosis in order to distinguish dyspepsia from GERD and IBS, in general practice.

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