Endoscopic studies of dyspepsia in the community: an "open-access" service

Endoscopy gives a more accurate diagnosis of the upper gastrointestinal tract than barium studies. General practitioners investigating upper gastrointestinal symptoms should be able to request endoscopy as an alternative to a barium study. Because of conflicting reports about the value of such a service we reviewed the diagnostic yield for the first two years that the Gloucester endoscopy unit received referrals.

Patients, methods, and results

Most patients were examined in the endoscopy department at the Gloucester Royal Hospital and a few at Stroud Hospital. There were no specific criteria for referral except in one practice studying patients with dyspepsia. Patients with a serious coincident disease (for example, severe cardiorespiratory symptoms) often were not examined or endoscopy was deferred. Endoscopic findings and cytological and histological reports were sent to the referring doctors, who continued to look after their own patients. However, a follow-up endoscopic examination was always done when a gastric ulcer was found because of the risk of misdiagnosing an ulcerating malignancy. All patients were also screened for biliary tract disease.

There are 302 000 patients in the Gloucester Health District; 968 patients were referred for endoscopy in the first two years of the service (629 men and 339 women). This is the same size as the population of Gloucester, including 16.5% with active peptic ulceration, 9.3% with pyloroduodenal disease (defined as pyloric or duodenal scarring with or without inflammation indicating previous ulceration), 2.2% with carcinoma, and 2.6% with benign oesophageal stricture (table). Hiatus hernia and evidence of mucosal disease were also found.

Of 610 patients who had a cholecystogram taken, 55 had gall stones or a non-functioning gall bladder. The incidence of biliary tract disease was similar to that found in the general population at necropsy. One elderly patient died from an oesophageal tear complicated by a perforated duodenal ulcer.

The principal diagnosis in each case is recorded. 21 patients with hiatus hernia also had oesophagitis.

Comment

The distribution of disease in this large series is similar to that found in a small, well-documented population (see page 1136). Men outnumbered women by 3:1, demonstrating that dyspepsia is more common in men. Many of the patients seen in outpatient clinics had received long or repeated courses of drugs, such as cimetidine, without endoscopic examination. Having an "open-access" service for rapid diagnosis should ensure that patients with dyspepsia are not treated empirically with expensive drugs and that patients with carcinoma or ulcer receive prompt and appropriate treatment. We emphasise too that finding a normal upper gastrointestinal tract may be as helpful as finding a specific lesion.

In over 6000 endoscopies performed on outpatients here, there have been two deaths (one during this study). Endoscopy is considered a safe procedure, but is not without hazard. There is no waiting list for endoscopy. The maximum delay between referral and examination was six weeks. Referrals for barium-meal examinations, however, had not fallen appreciably. Holdstock and colleagues reported a similar finding.

The endoscopy units in Gloucester and Stroud are staffed by two consultant surgeons; three general practitioners, who work four sessions between them; and two junior hospital doctors in training. Five part-time senior nurses work a total of 100 hours per week. Two endoscopists can work at the same time. In the first two years 2465 endoscopic procedures were performed. We expect the number of referrals to increase, however. If 71 patients a year presented with dyspepsia to a single general practitioner from a population of 7800, then we should expect about 3000 referrals a year from a population of 300 000, more than doubling the number of examinations now carried out. We expect to increase both nursing and medical staff slightly.

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