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Summary

# When to think about functional dyspepsia or gastroparesis

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**A primary care physician discusses the recognition and initial approach to gastroparesis versus functional dyspepsia in the context of limited appointment time and the need to identify patients requiring specialist referral.**

## KEY POINTS

- The speaker stated that functional dyspepsia accounts for up to one-third or over 70% of upper GI cases referred to gastroenterologists, while gastroparesis is much less common, with one colleague diagnosing only 3-4 cases per year.
- Symptoms of gastroparesis include postprandial nausea, vomiting, early satiety, and bloating, overlapping substantially with functional dyspepsia symptoms, and a formal diagnosis cannot be made by clinical presentation alone.
- Key risk factors for gastroparesis include long-standing diabetes mellitus, GLP-1 receptor agonists, opioids, cannabis, anticholinergics, previous vagal nerve surgery, cardiac ablation, neurologic and connective tissue diseases, and post-viral syndromes including COVID-19.
- Primary care doctors should first consider functional dyspepsia as the more likely cause, review medications affecting gastric emptying, rule out structural disease with endoscopy if alarm symptoms are present, and check for Helicobacter pylori if symptoms persist.
- Referral to gastroenterology is recommended when symptoms are refractory, vomiting is prominent, or gastroparesis is suspected, as primary care physicians do not order gastric emptying studies.
- The speaker stated in the Q&A that diabetic gastroparesis can occur even in well-controlled diabetes if the disease is long-standing (10-20 years) due to vascular damage affecting nerves.

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