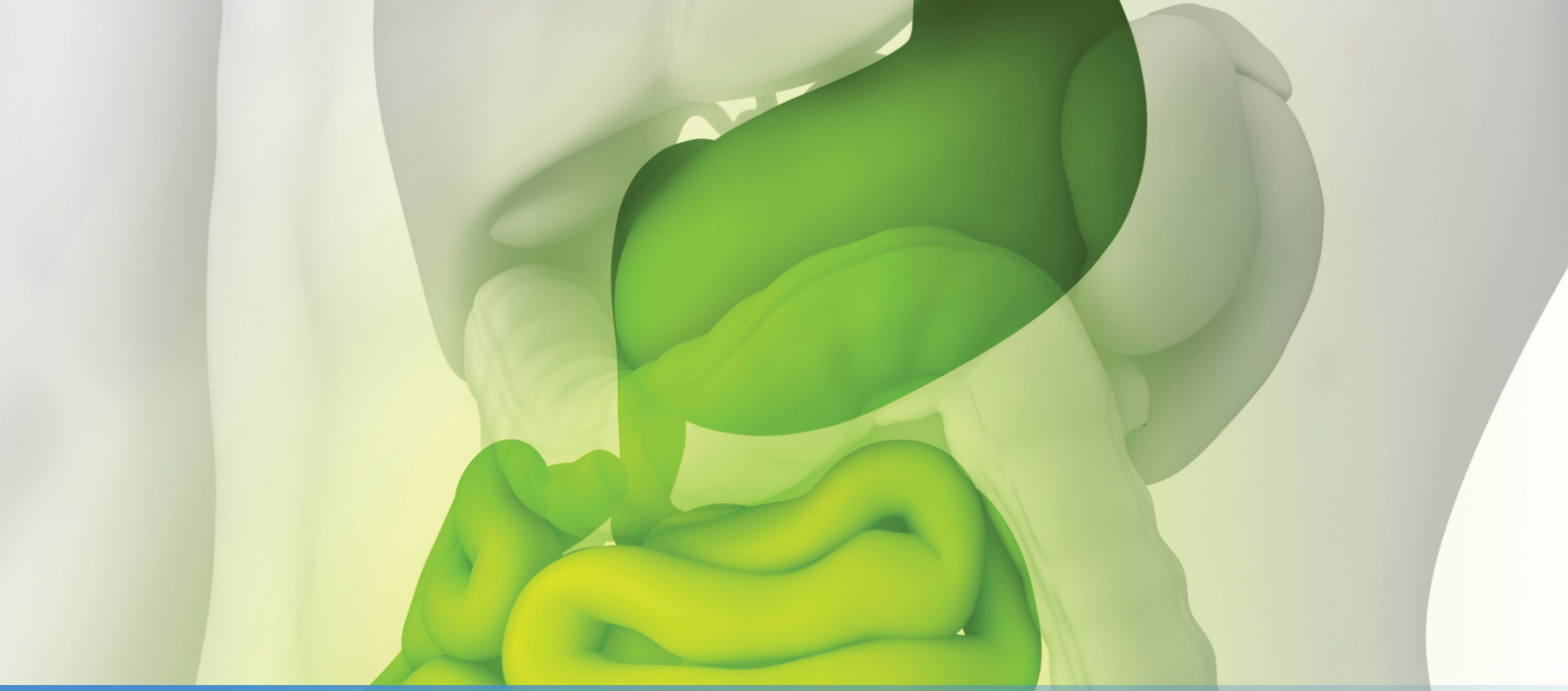

GUT FEELING GASTROLAB NEWS FOR GPs AUTUMN 2017

Overview of Reflux Symptoms: Tips for General Practice

Gastro-oesophageal reflux disease (GORD) is one of the most common gastrointestinal disorders managed by primary care physicians. There has been an increase in the prevalence of GORD. Proton pump inhibitors have become the mainstay of medical therapy, whilst the frequency of surgical measures has decreased. In particular, it is essential to consider other differential diagnoses in cases of refractory reflux symptoms and tailor investigations accordingly.

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SYMPTOMATOLOGY

The prevalence of gastro-oesophageal reflux disease in Australia is approximately 12%. Typical symptoms include heartburn and regurgitation but others include atypical chest pain, epigastric pain, nausea, belching, dysphagia and bloating. It is important to consider that patients may experience extra-oesophageal symptoms – these include cough, hoarseness, throat pain, sleep disturbances and wheezing.

Alarm symptoms that would warrant surveillance with upper gastrointestinal endoscopy include:

- dysphagia
- odynophagia
- anorexia
- weight loss
- upper gastrointestinal bleeding

Important note: Elderly patients experience milder or more atypical symptoms with more severe mucosal disease.

DIAGNOSIS

These include:

- Clinical history
- Upper endoscopy
- Barium swallow
- Catheter-based pH test
- Wireless pH capsule
- Impedance +pH

The selection of test(s) is dependent upon the pre-test probability of a particular diagnosis. Confirmation of GORD or the presence of alarm symptoms necessitate an upper endoscopy. It is important for the specialist to obtain oesophageal biopsies if a diagnosis of eosinophilic oesophagitis (EoE) is suspected. Diagnosis of EoE is particularly relevant in patients who complain of 'food getting stuck' and who are not obtaining relief from proton pump inhibitors (PPIs).

Continued overleaf >

MEDICAL MANAGEMENT

Lifestyle changes remain some of the most important aspects of managing reflux symptoms and ought to remain first line treatment before medical therapy. A large cohort study has demonstrated obesity to be an important risk factor; an increase in body mass index (BMI) in normal weight individuals was associated with an increased risk of GORD. Other measures that may assist include elevating head of the bed, sleeping in the right decubitus position and avoidance of eating within 3 hours prior to sleep. There is still a lack of high-level evidence correlating a reduction in chocolate, caffeine, alcohol and citrus intake with an improvement in GORD symptoms.

Medical therapy includes PPIs, histamine 2 receptor antagonists (H2RA), antacids, sucralfate and prokinetic agents. The use of PPIs is now the mainstay of management and is considered one of the most effective therapies. Several studies have demonstrated their superiority over H2RA for symptomatic relief of reflux symptoms. PPIs have also been shown to be the most effective medical therapy for treatment of EoE, preventing relapse of both symptoms and oesophageal inflammation. The addition of H2RAs to PPI therapy is a useful adjunct for treatment of GORD and can be used as a trial in PPI-refractory patients. Antacids have no significant impact on the underlying process and are thus not routinely advised for use.

Optimisation of PPI use includes improvement of compliance, patient education, appropriate lifestyle modifications, proper dosing time (prior to meals) and split-dosing. Surgical therapy includes fundoplication; indications for consideration of surgical intervention include poor compliance with medical therapy, side effects from medical therapy, large coexisting hiatus hernia, and an abnormal pH test despite maximum medical therapy.

DIFFERENTIAL DIAGNOSES TO CONSIDER IN REFRACTORY SYMPTOMS

Refractory heartburn is defined as symptoms of reflux that do not respond to a double dose of a PPI given for at least 8 weeks. Most studies have demonstrated that the majority of patients with such symptoms do not have GORD as the underlying mechanism. Other pathophysiological mechanisms (overlap) include:

- functional dyspepsia
- functional bowel disorder
- eosinophilic oesophagitis
- gastric emptying issues
- bile reflux
- acid and nonacid reflux
- reflux hypersensitivity and functional heartburn
- oesophageal dysmotility in the elderly (e.g. presbyoesophagus)

Investigation of such patients includes gastroscopy and oesophageal biopsy (for EoE), impedance plus pH studies (formal documentation of reflux symptoms) and management of stress/anxiety (for functional dyspepsia).

TAKE HOME MESSAGES

- **Be alert to alarm symptoms and obtain endoscopic assessment in such instances.**
- **Consider other mechanisms in PPI-refractory heartburn.**
- **Lifestyle modification is an important adjunct to medical therapy.**
- **Optimise medical and PPI therapy use before deeming patient to have refractory symptoms.**

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