Burning Questions about GERD

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Heartburn and related symptoms of gastroesophageal reflux disease (GERD) are among the most common presenting complaints of patients seen in general practice. It is also increasingly recognized that GERD may contribute to diseases and symptoms outside the esophagus, including [illegible] cough, laryngitis and asthma. The recomm[illegible] nosis and outpatient treatment[illegible] nificant changes in[illegible]

How do I diagnose GERD?

[illegible]ton pump [illegible]rovides a simple, cost-[illegible]ategy for making the diagnosis. [illegible]mately 70% of patients with symptoms of GERD will respond to standard doses of PPIs.[1] Non-responders can be prescribed a twice-daily, standard-dose PPI which will lead to a symptomatic response in an additional 25% of patients who did not respond to once-daily therapy.

Further invasive testing, such as endoscopy or 24-hour hydrogen ion concentration (pH) monitoring, is unnecessary for a GERD diagnosis in most patients who respond to intensive medical therapy.

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Who should I refer for endoscopy?

Approximately 30% to 50% of patients with symptoms of GERD will have no evidence of esophagitis on endoscopy, limiting the use of endoscopy as a diagnostic test for GERD. The Canadian Association of Gastroenterology currently recommends endoscopy at presentation only for patients who have warning signs of complicated disease (progressive dysphagia, odynophagia, gastrointestinal bleeding, unexplained anemia, weight loss) and in those at risk for Barrett's esophagus (*i.e.*, patients older than age 50 with 10 or more years of GERD symptoms).[2]

Who should I refer for ambulatory pH testing?

As ambulatory esophageal pH monitoring is invasive and uncomfortable for the patient, it should generally be reserved for patients who continue to have symptoms of GERD despite the use of high-dose PPIs. It may also be useful to evaluate patients with atypical symptoms, including isolated otolaryngeal symptoms and non-cardiac chest pain, particularly if their symptoms have not improved on PPIs.

What is the best approach to the pharmacologic management of GERD?

The mainstay of GERD therapy is acid suppression. At present, PPIs are the most potent acid suppressive agents available and are also associated with the highest rates of symptomatic response and esophageal mucosal healing.[3,4] However, chronic PPI therapy is expensive and may not be necessary for patients with only mild to moderate symptoms of GERD. Prescription H2-receptor antagonists (H2RAs) as well as over-the-counter H2RAs and/or antacids may provide sufficient symptom relief in such patients.

We advocate the use of a "step-down" approach to pharmacologic therapy for GERD, which consists of starting patients on a standard dose of PPI with an incremental "step-down" to less expensive therapy at two- to four-week intervals in patients with a symptomatic response (Figure 1). This has recently replaced the traditional "step-up" approach to pharmacologic management, based on numerous studies demonstrating increased overall cost-effectiveness and improved patient compliance due to faster onset of symptom relief.[5,6] Many patients may have sufficient symptom relief with only intermittent use of PPIs ("on-demand") and this also is a reasonable "step-down" approach for complete responders to continuous PPI therapy. Patients who do not respond to a trial of full-dose PPI should be referred for further diagnostic testing.

We recommend that patients who are known to have severe esophagitis or Barrett's esophagus remain on continuous standard or high-dose PPI therapy, although data demonstrating PPI therapy will

decrease the risk of progression of Barrett's esophagus to esophageal adenocarcinoma is limited.

Is there a preferred PPI for GERD treatment?

There are very few trials in which individual PPIs have been compared head-to-head in the treatment of GERD. While esomeprazole is slightly more effective than other PPIs for healing lesions and providing symptom relief in patients with known severe erosive esophagitis, it likely has little incremental benefit for GERD patients in the primary-care setting, where the majority of GERD patients have non-erosive esophagitis or only mild erosive changes. There is also limited data that switching between PPIs leads to symptom relief in patients who have not adequately responded to the initially prescribed PPI. At present, the cost of the specific PPI should be the most important factor when choosing which PPI to prescribe.

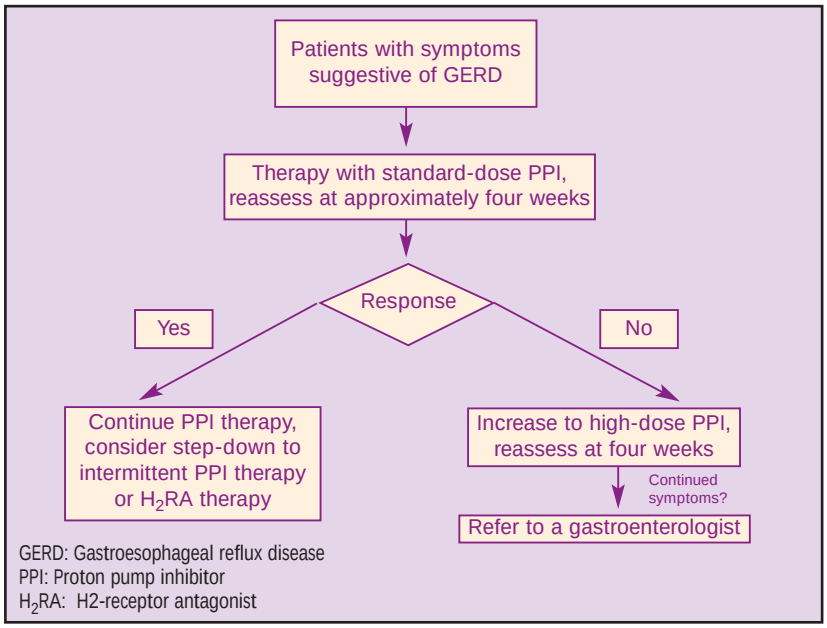

Figure 1. Approach to the initial management of patients with symptoms suggestive of GERD.

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