

Treating reflux disease: Know the options

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Gastroesophageal reflux disease (often referred to by the acronym GERD) is an increasingly common disorder.

The fundamental abnormality of GERD is excessive exposure of the esophagus (the swallowing tube between the mouth and the stomach) to secretions, primarily acid and bile.

This may be caused by an increased amount of stomach acid, weakening of the valve between the stomach and the esophagus (the lower esophageal sphincter), or an inability of the esophagus to clear these secretions.

Common symptoms are heartburn (a burning sensation behind the breastbone arising from the upper abdomen, often radiating toward the neck) or regurgitation (the sensation of a sour or burning liquid in the back of the throat without nausea or vomiting).

These symptoms most commonly occur within 60 minutes after eating, during exercise, or while lying down, and may be relieved with drinking water or an antacid.

According to estimates, 7 percent of adult Americans experience daily episodes of heartburn and as many as 40 percent have symptoms at least monthly.

Less common symptoms of GERD include a feeling of fullness in the throat, chronic cough, hoarseness, laryngitis, chest pain, or asthma. More serious complications of GERD such as bleeding, perforation, strictures or cancer are rare.

Typical symptoms of heartburn and/or regurgitation are sufficient to establish a diagnosis and begin treatment in most cases.

Additional tests such as X-rays or endoscopy (examining the stomach and esophagus with a flexible, lighted instrument) may be necessary in certain circumstances such as atypical symptoms, complications or patients who fail to respond to treatment.

The clinical course of GERD is highly variable and often chronic and relapsing over many years. Initial management is medical and the majority of patients can be successfully managed without surgery.

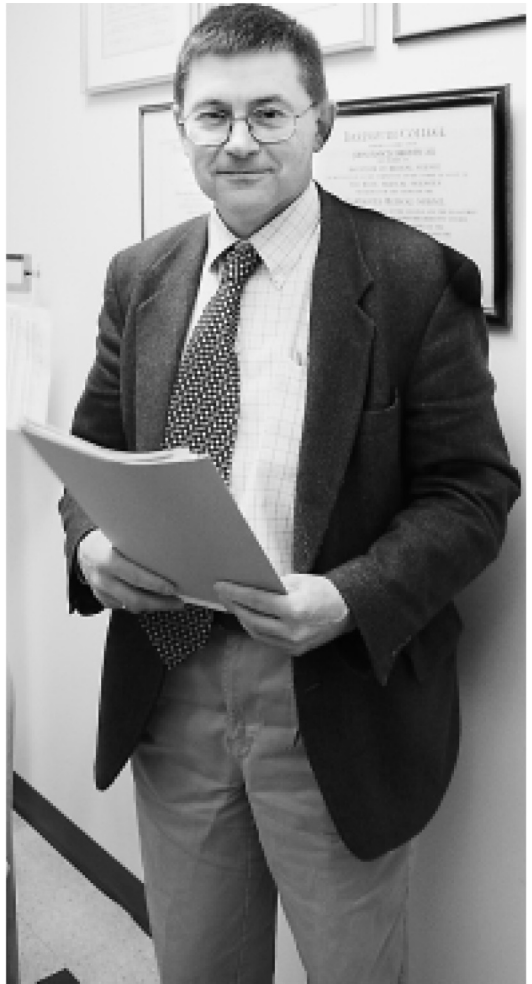
Medical management can be separated into two categories: lifestyle modification and drug therapy.

Lifestyle modifications include avoidance of smoking and excessive alcohol consumption, reducing dietary fat, avoidance of large meals and bedtime snacks, weight reduction if overweight, elevation of the head of the bed if symptoms occur at night, and avoidance of foods such as chocolates, citrus fruit juices and coffee. Certain drugs may also worsen symptoms and should be avoided if possible.

Most drug therapy is aimed at limiting the amount of acid in the stomach.

Liquid antacids (e.g. Maalox and Riopan) act by buffering acid in the stomach, while other drugs such as "H2 blockers" (e.g. Pepcid or Zantac) or the more potent "proton pump inhibitors" (e.g. Prilosec or Prevacid) act by blocking acid secretion into the stomach.

As GERD is typically a chronic and relapsing condition, long-term medical treatment, either



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continuously or intermittently, is often necessary. A small proportion of patients fail to adequately respond to medical treatment and may undergo surgery.

Surgery is aimed at tightening the lower esophageal sphincter in order to prevent stomach contents from entering the esophagus. Following surgery, patients may or may not also require continued medical treatment.

BARRETT'S ESOPHAGUS

Approximately ten percent of patients with GERD, particularly those with frequent or long-standing symptoms, develop an abnormal lining of the esophagus called Barrett's esophagus. Barrett's esophagus, diagnosed with a biopsy of the esophagus at the time of endoscopy, is an important risk factor for esophageal cancer. Routine periodic endoscopy and biopsy are recommended for patients with Barrett's esophagus to identify those at especially high risk for cancer. Surgery or other newer nonsurgical treatments may be recommended for these high-risk patients.