10-minute consultation

Gastro-oesophageal reflux disease

Janusz Jankowski, Roger Jones, Brendan Delaney, John Dent

A 45 year old man complains of heartburn (retrosternal burning) and regurgitation, usually after food but also at night, for six months. Symptoms are particularly bad after a heavy, fatty meal. Physical straining, bending, stooping, or lying flat also worsen the symptoms.

What issues you should cover

- Heartburn is common (7% of adults have daily and 35% monthly symptoms) and is chronic and relapsing but usually benign. Consider why the patient has consulted; many are worried about heart disease or cancer.
- In two thirds of patients, heartburn does not progress. Those with longstanding disease (>5 years), however, may develop more severe symptoms as a result of secondary strictures or ulcers.
- In patients not receiving treatment, severity of heartburn does not predict the presence, absence, or severity of oesophagitis. More specific symptoms for reflux are postural symptoms, a rising from lower to upper sternum, and response to treatment with a proton pump inhibitor (PPI). In patients taking acid suppressants, relief of heartburn predicts healing of oesophagitis, allowing doses to be adjusted in initial and long term treatment.
- No strong evidence exists to justify mandatory *Helicobacter pylori* eradication in patients taking PPIs long term. Eradication is important, however, in those with proved peptic ulcer disease.
- Barrett's oesophagus develops in about 5% of people with endoscopy positive reflux disease (erosive reflux disease); 1% of these annually develop oesophageal adenocarcinoma. This aggressive malignancy affects 5-15 people per 100 000 population, and its incidence is increasing. Men over 45 with at least 10 years of bothersome heartburn are most at risk. If subsequent endoscopy confirms Barrett's oesophagus, long term surveillance may be indicated, and a gastroenterologist with an interest should guide management.

What you should do

Patient's lifestyle—The place of non-drug measures and antacids has not been firmly established. The exception is raising the head of the bed, although patients rarely do this long term. However, always give appropriate, individualised advice about obesity, smoking, alcohol, and avoidance of provocative foods.

Screening for alarm features—Refer the patient for endoscopy if indicated (box).

A trial of acid suppressants for four weeks is appropriate for most patients with gastro-oesophageal reflux disease, providing prompt symptoms relief and efficient diagnosis. Because 50-60% of patients have no endoscopically recognisable oesophagitis (non-erosive reflux disease), endoscopy is an insensitive test for gastro-oesophageal reflux disease.

Optimal dose and type of PPI—Standard dose PPI therapy once daily is the treatment of choice and will achieve prompt and lasting symptom relief within four weeks in most patients. If symptoms do not disappear completely, patients can take a second dose of PPI before the evening meal. All PPIs have similar efficacy, although some achieve better results in more severe oesophagitis than others.

Laparoscopic antireflux surgery can achieve an efficacy similar to PPIs when done in specialist centres. However, many patients still require long term PPIs, and surgery is associated with mortality (0.25%) not seen with PPI therapy.

Other drugs—H_2 receptor antagonists are only moderately effective at standard doses, and higher and more frequent doses offer little long term advantages. Antacids and prokinetics are only appropriate if symptoms occur occasionally. In the vast majority of patients combination therapy is less effective than increasing the PPI dose.

Tests for more recalcitrant cases—When symptoms are not adequately relieved, even with a twice daily PPI (about 10% of patients with reflux), consider whether symptoms are truly related to reflux and if the patient is taking the treatment properly. Other more specialised diagnostic tests, such as labelled swallow tests, and 24 hour pH monitoring, may then be needed.

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Useful reading

De Caestecker J. ABC of the upper gastrointestinal tract. Oesophagus: heartburn. *BMJ* 2001;323:736-9.

Jankowski J, Harrison RF, Perry I, Balkwill F, Tselepis C. Barrett's metaplasia. *Lancet* 2000; 356:2079-85.

Indications for prompt gastroscopy

- Alarm symptoms suggesting malignancy, stricture, or severe ulceration: dysphagia, jaundice, iron deficiency anaemia, unintentional weight loss, or abdominal mass
- Age more than 45-55 years* with new onset dyspepsia or continuous epigastric pain
- Non-specific or atypical symptoms not responding to PPI therapy
- Longstanding symptoms, especially in those over 45-55,* who may be at risk of complications such as stricture, severe oesophagitis, or Barrett's oesophagus

*Regional differences in gastro-oesophageal cancer exist in the United Kingdom. Use audit to determine the local threshold age for referral

This is part of a series of occasional articles on common problems in primary care

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