GUIDELINES & PROTOCOLS
ADVISORY COMMITTEE

# Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease

Revised 2004

## Scope

This guideline outlines the clinical approach to the diagnosis and treatment of gastroesophageal reflux disease (GERD). Clinical approaches to adult patients with dyspepsia and with *H. pylori* infection are reviewed in separate guidelines, *Clinical Approach to Adult Patients with Dyspepsia* and *Detection and Treatment of Helicobacter pylori Infection in Adults.*

GERD is diagnosed by history. Symptoms typically include retrosternal burning and may also include sour or bilious regurgitation, belching, hypersalivation, and epigastric or chest pain. Symptoms may be aggravated by spicy or fatty foods, caffeine, alcohol, citrus fruits, recumbency or bending forward.

Certain symptoms ('alarm features') require prompt investigation. These include dysphagia, weight loss, gastrointestinal blood loss (acute or chronic), or failure to respond to an adequate trial of therapy.

### Recommendation 1: Management of typical presentation

In the absence of alarm features or complications (Barrett's esophagus, ulceration, bleeding, peptic stricture), the initial management should consist of diet and lifestyle modifications and the intermittent use of antacids or histamine-2 receptor antagonists (H2RA). Under these circumstances barium X-rays and endoscopy are frequently normal and are, therefore, not recommended.

### Recommendation 2: Severe symptoms or poor response

In the absence of improvement with the above management strategy, the following regimens may be tried in sequence for up to 4 weeks each:

a) Full dose H2RA

b) Proton Pump Inhibitors (PPI)

Note: GERD is a chronic disease and many patients require prolonged therapy.

### Recommendation 3: Refractory symptoms

Absence of response to the above regimen justifies specialist consultation and/or further investigation.

## Rationale

GERD is a common chronic recurrent problem. Most individuals with GERD experience only occasional heartburn, which is usually responsive to simple measures. More severe reflux can cause esophageal mucosal injury (esophagitis) and its complications (see Recommendation 1), as well as respiratory symptoms (chronic cough, hoarseness, bronchospasm, recurrent aspiration).

Chronic longstanding GERD may be complicated by Barrett's esophagus in up to 10% of individuals. Barrett's esophagus predisposes to adenocarcinoma. Risk factors include:

* Male
* Caucasian
* Age >50 years
* Smoking
* More than 10 years of symptoms, and symptoms more than 3 times per week

Endoscopy is superior to radiography for assessing the severity of esophagitis and allows biopsy detection of Barrett's esophagus and other lesions. Patients with the above risk factors may be offered endoscopy on one occasion to rule out Barrett's esophagus.

GERD and hiatus hernia are not synonymous and do not imply each other's presence. Treatment of *H. pylori* infection is not part of the management of GERD and may worsen symptoms.

When antacids are ineffective or required more than twice per day, H2RAs may be helpful. PPIs are the most effective but also the most expensive agents. Any form of anti-reflux surgery is reserved for refractory patients with severe GERD or its complications.

Patient education regarding dietary and lifestyle factors is essential in managing GERD. See the following Web site for patient information on GERD: http://www.badgut.com

## References


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