**Gastroesophageal Reflux Disease** *(as of 12/2014. Expect changes in coming years!)*

**Symptoms**: Initial diagnosis is made by symptoms alone. Heartburn (pyrosis) / chest pain, regurgitation, water brash (hypersalivation), unexplained nausea. *Can eventually lead to dysphagia or odynophagia, but those are more likely to indicate GERD with progression to a stricture or an ulcer, or a non-GERD diagnosis*.

**Differential:** Infectious esophagitis, pill esophagitis, eosinophilic esophagitis, PUD, dyspepsia, cholelithiasis, CAD, esophageal motor disorders, achalasia, gastroparesis, esophageal stricture, cancer

**GERD definition:** when reflux of stomach contents causes troublesome symptoms (mild symptoms 2+ days/week, or moderate to severe symptoms more than once/week) and/or when reflux causes complications (esophagitis); *severity and duration of symptoms do not correlate with severity of esophagitis*

**Treatment**:

“Step up” approach for mild/intermittent symptoms

* Start with lifestyle changes (**weight loss/belly loss, head of bed elevation, tobacco and alcohol cessation, avoidance of late-night meals**; no need to stop eating certain foods unless the patient notices a specific correlation with symptoms), antacids (once/week or less), H2 blockers (but tachyphylaxis occurs in 2-6 weeks)

“Step down” approach (recommended by American College of Gastroenterology)

* **8 week course of any PPI** (to relieve symptoms and allow healing of erosive esophagitis), coupled with lifestyle changes
* Dose once daily, 30-60 mins before the first meal of the day. If only partial response, or persistent nighttime awakening, try nighttime dosing or twice a day, or try changing to a different PPI. ***If no response to PPI****, consider it “refractory GERD” and* ***refer or work-up****.*
* **Then, try to taper PPI**. If patients have persistent/recurrent symptoms after PPI taper, keep them on a PPI, add an H2 antagonist, or switch from the PPI to an H2 antagonist. If kept on a PPI, use the lowest effective dose and consider intermittent/PRN use. ***No need to work-up.***
* With known erosive esophagitis or Barrett’s esophagus, keep them on a PPI (lowest effective dose).

**Additional testing**:

Endoscopy - For *alarm symptoms* (dysphagia, odynophagia, GI bleed, anemia, weight loss, recurrent vomiting). For those who *do not respond* to twice-daily PPI. Also consider in *men >50 with GERD x 5+ years* and Barrett’s risk factors (nocturnal reflux, hiatal hernia, elevated BMI with central obesity, tobacco).

Ambulatory pH monitoring - to confirm diagnosis if endoscopy shows nothing, but PPI has failed *(negative endoscopy doesn’t rule-out GERD, they may have “NERD” - non-erosive reflux esophagitis)*

Manometry - to rule-out major motor disorder (especially with dysphagia), or to evaluate peristaltic function in preparation for antireflux surgery

**Also consider**: biliary ultrasound, EKG, cardiac stress test, *H. pylori* (controversial!)

*H. pylori* eradication can make GERD worse, depending which part of the stomach is infected

*H. pylori* makes pts extra PPI-sensitive, so it can be very hard to wean PPI

*Long-term PPI Risks -* pneumonia, *C. diff*, osteoporosis, B12 deficiency