

GERD/Heartburn Guideline*

Diagnosis	Treatment
<ul style="list-style-type: none"> ▪ Empiric trial of therapy (including lifestyle modification) for patients with symptoms consistent with GERD ▪ Further diagnostic testing should be considered if the patient does not respond to therapy, when there are symptoms suggesting complicated disease and when patients have a sufficient duration of symptoms to put them at risk for Barrett's esophagus. <ul style="list-style-type: none"> ➢ Endoscopy – technique of choice to identify suspected Barrett's esophagus and diagnose complications of GERD. ➢ Ambulatory Reflux Monitoring – helps to confirm gastroesophageal reflux in patients with persistent symptoms (both typical and atypical) without evidence of mucosal damage, especially when a trial of acid suppression has failed. ➢ Esophageal Manometry – may be used to ensure accurate placement of ambulatory monitoring probes and may be helpful prior to anti-reflux surgery. 	<ul style="list-style-type: none"> ▪ Lifestyle modifications <ul style="list-style-type: none"> ➢ Education of the patient about factors that may precipitate reflux ▪ Patient Directed Therapy <ul style="list-style-type: none"> ➢ OTC H2 blockers and Antacids ➢ OTC proton pump inhibitors may be used up to 14 days, unless directed by a physician ▪ Acid Suppression <ul style="list-style-type: none"> ➢ Mainstay therapy for GERD ➢ Rx strength H2 blockers – for treatment of mild/moderate GERD ➢ Proton Pump Inhibitors – eliminate symptoms and heal esophagitis more frequently and more rapidly than other agents. ▪ Promotility agents <ul style="list-style-type: none"> ➢ Not ideal monotherapy for most patients ▪ Maintenance Therapy <ul style="list-style-type: none"> ➢ Continuous therapy to control symptoms and prevent complications is appropriate. ▪ Anti-reflux surgery <ul style="list-style-type: none"> ➢ Controversy remains over the long-term effectiveness of surgical intervention versus chronic medical therapy. ▪ Endoscopic Therapy <ul style="list-style-type: none"> ➢ Use is mainly limited to clinical trials ▪ Refractory GERD <ul style="list-style-type: none"> ➢ Consider increasing dose of PPI to twice daily dosing ➢ If symptoms are refractory to medical treatment the diagnosis should be reconsidered and confirmed.

* DeVault KR, Castell MD and the Practice Parameters Committee of the American College of Gastroenterology. Updated guidelines for the diagnosis and treatment of gastroesophageal reflux disease. The American Journal of Gastroenterology 2005; 100:190-200
See supporting document for more details.

Colorado Access Clinical Practice Guideline GERD/Heartburn

Clinical Considerations –GERD/Heartburn*

DIAGNOSIS

Empirical Therapy

- For patients with symptoms consistent with GERD it is appropriate to offer empiric therapy.
- For patients who respond to empiric therapy it is reasonable to assume a diagnosis of GERD.
- Further diagnostic testing (listed below) should be considered if the patient has:
 - no responsive to therapy
 - symptoms present suggesting complicated disease (dysphagia, odynophagia, bleeding, weight loss, or anemia)
 - duration of symptoms sufficient to put them at risk for Barrett's esophagus.

Endoscopy

- Although a normal endoscopy does not exclude GERD, it is the technique of choice to identify suspected Barrett's esophagus and to diagnose complications of GERD.
- A biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia.

Ambulatory Reflux Monitoring

- For patients with persistent symptoms of GERD, without mucosal damage, ambulatory reflux monitoring can confirm the presence of GERD. This is especially true in patients who have failed acid suppression.
- This is considered the best approach to studying the actual amount of reflux occurring in a patient.
- There may also be benefit to ambulatory pH testing while on reflux, in patients with refractory symptoms.

Esophageal Manometry

- Used to confirm accurate placement of ambulatory monitoring probes.
- May be used to document effective esophageal peristalsis, when anti-reflux surgery is being considered.
- May be used in the diagnostic work-up of rare motility disorders.

TREATMENT

Lifestyle modifications

- Patients should be educated about factors that may precipitate reflux including: elevation of the head of the bed, decreased fat intake, cessation of smoking, and avoiding recumbency for 3 h postprandial.
- Patients should be cautioned that certain foods may precipitate reflux by lowering LES pressure. (chocolate, alcohol, peppermint, coffee and perhaps onions and garlic).
- Although the benefits have not been proven through evidence based medicine, it is assumed that the 20-30% placebo response rate seen in clinical trials is due to lifestyle modification.

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Patient Directed Therapy

- All OTC H2 blockers are clinically equivalent.
- The combination of antacids (Maalox, Mylanta) and alginic acid (Gaviscon) may provide better symptom relief than either medication on its own.
- Outcomes in two long-term trials suggest 20% improvement in symptoms when patients use OTC agents.
- OTC agents can be used prophylactically, prior to an activity that may potentially result in reflux symptoms.
- Patient should visit their physician before using OTC PPIs beyond 14-days because of the risk of Barrett's esophagus or other upper gastrointestinal pathology.

Acid Suppression

H2 blockers

- Histamine2-receptor blockers are less effective than PPIs but may provide benefit in some patients with less severe GERD.

Proton Pump Inhibitors

- Acid suppression is the treatment of choice for GERD, with the proton pump inhibitors being the most effective in most patients.
- PPIs have been found to provide symptomatic relief of GERD in 83% of patients compared with 27% of placebo treated and 60% of H2 blocker treated, and esophagitis healing in 78% of patients compared with 24% of placebo treated and 50% of H2RA treated.
- All five PPIs (omeprazole/Prilosec, lansoprazole/Prevacid, rabeprazole/Aciphex, pantoprazole/Protonix, and esomeprazole/Nexium) demonstrate efficacy in controlling GERD symptoms and esophagitis healing.
- PPIs should be dosed prior to meals, based on specific instructions in package insert.
- Although PPIs are most commonly given prior to breakfast they may be taken prior to the evening meal to control night time acid.
- Higher than approved doses, given twice a day, are reasonable in patients under the following circumstances:
 - during a diagnostic trial for non-cardiac chest pain,
 - during empiric treatment trial for supraesophageal symptoms of GERD,
 - partial response to standard dose therapy,
 - patients experiencing breakthrough symptoms,
 - GERD patients with severe esophageal dysmotility,
 - patients with Barrett's esophagus.
- Patients should have access to chronic PPI therapy if they have break through symptoms on less effective therapy.
- Physicians should taper PPI therapy for those patients without symptoms

Promotility agents:

- Although promotility agents are not indicated for monotherapy of GERD, they may be used as an adjunct to acid suppression in selected patient.
- The use of metoclopramide and bethanechol has decreased because of frequent Central Nervous System side effects.

Maintenance Therapy

- Continuous therapy may be needed to control symptoms and prevent complications.
- The type of maintenance therapy will vary. Some patients with mild symptoms may respond to antacids and lifestyle modifications.
- In patients with moderate/severe GERD, chronic PPI therapy may be needed to control symptoms. Lowering the dose of PPIs has not been shown to be effective in the treatment of GERD.

Anti-reflux surgery

- Antireflux surgery is an option for patients with chronic GERD, but should be performed by an experienced surgeon.

Endoscopic Therapy

- Endoscopic therapy; including radiofrequency application to the LES area, endoscopic sewing devices, and injection into the LES region can be used in patients with well documented GERD.
- The use of these techniques is mainly limited to clinical trials, but can be used outside of clinical trials in certain well-informed patients with PPI responsive GERD.

Refractory GERD

- Diagnosis should be reconsidered in a patient with typical or atypical symptoms of GERD, that don't respond to therapy.