Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/diving-into-the-science-art-behind-gerd-treatment/13674/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Diving into the Science & Art Behind GERD Treatment

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And joining us today is Dr. Harish Gagneja, who's ready to help us find the balance between science and art when treating gastroesophageal reflux disease, or GERD for short. Dr. Gagneja is an educator at the Dell Medical School at the University of Texas in Austin. He has also served as President of the Texas Society of Gastroenterology and Endoscopy and is the Governor of the South Texas Region of the ACG. This is only a tiny fraction of all of his activities.

So, with that being said, Dr. Gagneja, welcome to the program.

Dr. Gagneja:
Thank you, Dr. Buch. Thank you for having me.

Dr. Buch:
So let's just jump right in, Dr. Gagneja. When should we suspect dyspepsia rather than GERD in our patients?

Dr. Gagneja:
So, if we look at the symptom complex, as there are some overlapping symptoms in gastroesophageal reflux disease and dyspepsia, with dyspepsia it's more of an upper abdominal discomfort, indigestion kind of symptoms, some bloating, some gas, maybe nausea. That more points towards dyspepsia. But if patient is having regurgitation, acid reflux, burning behind the chest, retrosternal burning, that points more towards gastroesophageal reflux disease. Yes, there is overlap. Upper abdominal discomfort, abdominal pain can also be associated with reflux as well. Other symptoms I mentioned can also be associated with reflux, but more than likely it's reflux if it is heartburn, regurgitation, etc.

Dr. Buch:
I think some of our primary care colleagues have difficulty in understanding sometimes why proton pump inhibitors don't work very well for what they suspect is GERD. Could you follow up on that question?

Dr. Gagneja:
Definitely. So, proton pump inhibitors work really, very, very well in gastroesophageal reflux disease, so you really have to make sure that the patient you're treating does have gastroesophageal reflux disease. For non-gastroesophageal reflux disease upper GI symptoms, proton pump inhibitors don't work as well. Studies are done where they looked at whether people are taking the proton pump inhibitors regularly or not. People who are taking it regularly, miss maybe one here one there, 83 percent of those patients really responded well to proton pump inhibitors. But you also want to make sure that they're taking it correctly. How? They should be taken half an hour to 60 minutes before breakfast or before supper if they are on the double-dose proton pump inhibitors. Why is this? The proton pumps are the pumps which secrete acid. Proton pump inhibitors bind to active proton pumps only. If your proton pump is inactive, proton pump is of no use. In fasting state, your proton pumps are not active. Once you eat something—It's not active. So you take the medication. Now your blood level of PPI is—in next 30 minutes or so is really rising in your body. You eat something at that time, now you have an active proton pump, so you get the best bang for your buck when you are giving the medication on empty stomach and eating something about 30 to 60 minutes afterwards.

Dr. Buch:
That's great and very useful information. And once we determine that a patient does in fact have GERD and not dyspepsia, under what circumstances do you recommend endoscopic or surgical procedures to treat the disease?

Dr. Gagneja:
Excellent question because especially nowadays when there is a fear of proton pump inhibitors out there, right? So, first of all, you want to make sure that patients truly have proton pump inhibitor-responsive gastroesophageal reflux disease. Those are the best patients who will respond to any kind of endoscopic or surgical treatment. That's very, very important. When we will start talking about refractory GERD and let's do the surgery or endoscopic treatment for refractory GERD, nope; stop; take a step back and think whether patient is truly having a refractory GERD or something else going on. So, are they taking their PPIs regularly? Are they taking their PPIs on half an hour before breakfast and right time? Is there something else going on, such as achalasia or eosinophilic esophagitis? Is there any gastroparesis? Is their esophagus moving okay? Is their contractility going as better—as normal? So you've got to look at all those things.

I'll tell you, there was a study done, which is a very interesting study, actually. There was, I think it was 565 patients. When they labeled those patients with refractory GERD and then they did the extensive analyses, only 22 percent or 21 percent of those patients were refractory GERD, and they responded well to the surgery. I would say surgery or other procedure endoscopic, such as TIF or what we call magnetic augmentation, which is a LINX procedure, they are also good for patients with regurgitation. A very well-done study where they looked at medical management of regurgitation versus LINX procedure published in Gastrointestinal Endoscopy I think two years ago clearly showed the LINX procedure was a better procedure for regurgitation patients.

I also would recommend that we're very, very, very careful recommending surgery for any kind of extraesophageal manifestations of reflux disease, such as—which is a very big buzzword on internet and otherwise—laryngopharyngeal reflux, asthma, chronic cough or globus sensation or constant clearing of throat.

Dr. Buch:
Thank you very much. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Harish Gagneja about the art and science of GERD management.

So, Dr. Gagneja, let's continue looking at some patient scenarios. What approach do you use for weight loss in overweight patients with GERD?

Dr. Gagneja:
Of course, I encourage medical management first, which usually fails because, as you know, patients are not, not really following the rules. Everybody is looking for, you know, shortcuts to weight loss. There's an endoscopic management of weight loss such as balloons, which is not recommending in patients—not recommended in patients with gastroesophageal reflux disease. Then, if you look at the surgical approaches, gastric sleeve has shown to increase gastroesophageal reflux disease. If you are really looking for a surgical management of a patient with gastroesophageal reflux disease which will not make the gastroesophageal reflux worse, it's probably Roux-en-Y gastric bypass surgery. Actually, in the remote past it used to be one of the operations for gastroesophageal reflux disease.

Dr. Buch:
Thank you. How do you approach a GERD patient who loses response to PPIs?

Dr. Gagneja:
Yeah. So you really want to make sure whether they have truly lost a response to PPI because usually, PPIs don't have tachyphylaxis. They really don't lose response. The question is have they developed any big hiatal hernia? Now they need a double-dose PPI. Again, I'm coming back to these two important, very important points. One is, Are they taking their proton pump inhibitor on a daily basis? Are they taking it at the right time? Are they on the right dose? And also, which is very interesting, sometimes if you—let's say you lost, lost a response. Can we switch to a different class of PPI? I do recommend sometimes switching to a different class of PPI. It's very interesting, actually. There was a study done where they looked at omeprazole equivalent, omeprazole equivalent 1.0. What are the other PPIs equivalent in that regard?

Okay, now, nothing against pantoprazole and nothing for rabeprazole, but I can tell you what the study showed. This study showed that a 1 equivalent omeprazole, pantoprazole is only 0.29 I think it was, 0.27, something like that. Lansoprazole was 0.9. Omeprazole was 1, and esomeprazole was 1.6, and rabeprazole was 1.8. So I sometimes switch between PPIs. Some people do need a double-dose PPI, so I also increase the dose half an hour before breakfast or half an hour before supper. There's also sometimes, if there is what we call a breakthrough symptoms, then I ask them to take an H2 blocker at night. If you take an H2 blocker on a regular basis at night, there is tachyphylaxis. Most people will lose response after a while, but it's a very sound strategy if you use H2 blocker on intermittent basis at night. And I also tell my patients that as you know that you are eating a heavy meal or you're going to have some alcohol or you're eating late at night, just preemptively take one H2 blocker to prevent those nighttime symptoms.

Dr. Buch:

Very useful information. And as a quick follow-up to that, how would you treat a patient who is having trouble weaning from PPIs? They're feeling better and they're having trouble weaning themselves from PPIs.

Dr. Gagneja:
I will say, Why was this patient started on PPI? Was there a diagnosis of GERD? How the diagnosis of GERD was made. Do they have any erosive esophagitis? If you have erosive esophagitis A or B, which is Los Angeles class A or B, which is considered mild erosive esophagitis, yes, I would favor weaning off PPI, but if somebody had a grade C or grade D or Barrett's esophagus, I won't even favor weaning off PPI.

So let's say we're talking about either non-erosive reflux disease when there's no erosions, or we're talking about grade A esophagitis, or we're talking about grade B esophagitis. If they are not able to wean off completely, sometimes I do "Can you go every other day?" A lot of my patients really benefit from every other day. If you look at the GERD guidelines, they will not suggest that. And again, I said before—we talked before—guidelines are guidelines, and there's an art of medicine, so you also—Guidelines guide you certain way, but how you practice in medicine a certain way, and that's what I do.

Dr. Buch:
That's great. Now, we've certainly covered a lot of ground today, Dr. Gagneja. But before we conclude, are there any other thoughts you'd like to share with our audience today?

Dr. Gagneja:
Very important I will share that our gastroenterologists, and I can tell you all the primary care physicians, most patients come to our offices and they are really talking about the side effects of PPIs. They all really are scared of using PPIs. So, when they come to me, I really give them what I call a PPI pep talk, so that's an important thing to understand. So I really say that for the treatment of GERD, if you look at—there's well-established benefit of PPI which far outweigh the theoretical risks of PPI. PPI are the safest, one of the safest medicines around.

Dr. Buch:
So those were all very important insights. And I want that thank my guest, Dr. Harish Gagneja, for an excellent discussion on GERD. Dr. Gagneja, it was a pleasure having you on the program today.

Dr. Gagneja:
Thank you, Dr. Buch. It was my real pleasure talking to you regarding GERD, which is one of my very favorite topics. And I also would like to thank ReachMD for having me as a guest. Thank you so much. It was a pleasure.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit reachmd.com/giinsights, where you can be Part of the Knowledge. Thanks for listening.