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Getting to Know Gastroesophageal Reflux Disease

Dr. Buch:
Gastroesophageal Reflux Disease, or GERD, is one of the most common GI disorders. Fortunately, the last few years have brought significant changes to our understanding and treatment of this disease, which is why today, we're going to explore what those changes are and what they mean for gastroenterologists and others.

This is *GI Insights* on ReachMD, and I'm your host, Dr. Peter Buch. Joining me today is Dr. Arlene Wright, who is President of the Florida Nurse Practitioner Network and the Executive Vice President of the Nurse Practitioners of Lee County in Florida. Welcome to the program, Dr. Wright.

Dr. Wright:
Well, thank you very much, doctor, I appreciate the invitation.

Dr. Buch:
Pleasure to have you here. So let's gets right into it. Dr. Wright, how do we diagnose GERD?

Dr. Wright:
Well, that's a great question, and usually, we basically evaluate that based on their common clinical symptoms that we know, the heartburn, the pyrosis, the burning, the regurgitation, but one of the things that I wanted to mention that here in Florida, we have something that's a little bit more specific because of the fact that we are always exposed to something in bloom 24/7, 365 days out of the year, so we have to differentiate between is this allergic rhinitis symptoms, is this GERD, is this LPR, are they presenting with hoarseness, frequent throat-clearing? So we really have to do a deeper dive to determine what their symptoms are. Of course, some patients come in and they're telling you that they're eating tums out of the bottle; then we pretty much know that we have our work cut out for them.

Dr. Buch:
And can you tell us which patients need endoscopy?

Dr. Wright:
Sure. Those would be the patients that, obviously, are not responding to the lifestyle and dietary modifications and medications, but also those that possess those red flag alarm symptoms, such as an unintentional weight loss, melana, hemoptysis, iron-deficiency anemia, nausea, and vomiting, and even a family history, a first-degree relative of gastric carcinoma.

The other thing too is if patients that have had abnormal findings via an imaging study, be it an upper GI or a barium swallow, that indicates changes in the mucosa or a possible stricture, those would definitely be candidates that would need to have an endoscopy.

Dr. Buch:
And moving on, what are the complications of GERD?

Dr. Wright:
Sure. I mean, definitely when we see people that think that it's normal for them to have to make themselves vomit because they're experiencing dysphagia, that's kind of a serious thing, and again, that can lead to weight loss and then just the whole malnutrition and just a whole cascade of events that could just make them very vulnerable. Or even exacerbate some other comorbidities that they might have.

And the other complications are more from a personal standpoint and the fact that, as we know, that we are all very social beings and I

think we've learned that more from the pandemic and the isolation, so food is our way of being social, when you are not able to eat or having complication of dysphagia or other issues, it really can create a quality-of-life issue.

Dr. Buch:
And how should we approach a patient who is refractory to GERD treatment?

Dr. Wright:
So I think that if they're refractory in terms of they've already challenged the dietary and lifestyle modifications and maxed out their medication management, I think the next step would be to determine if they are a surgical candidate for Nissen fundoplication or is there an tertiary care center in your area that would just specialize in treatments that might not be pertinent or might not be available to those on a local level.

Dr. Buch:
And again, before we think of a tertiary care center, I do believe we want to make sure that the patients are taking medications as directed and following your directions.

Dr. Wright:
Correct, and that's a very good point, because unfortunately, just because they've been prescribed, doesn't mean they're necessarily using them. And again, wanting to make sure that they are utilizing all the dietary and lifestyle modifications and that there isn't something else behind the scenes underlying that's possibly causing their symptoms.

Dr. Buch:
For those of you just joining us, this is *GI Insights* on ReachMD. I'm your host Dr. Peter Buch, and joining me today to discuss gastroesophageal reflux disease is Dr. Arlene Wright. So Dr. Wright, how do we distinguish GERD from dyspepsia?

Dr. Wright:
That's a very, very good question and it kind of lends back to what we talked about before about really delving into the patient's clinical symptoms, but to get a little bit more aggressive. Once again, if they've failed conservative treatment and lifestyle and dietary modifications and medications, there are other tools that you can use and more sophisticated such as the ambulatory PH manometry. So definitely other testing that can be used to determine is this really an acid reflux problem, or are we going down another trail?

Dr. Buch:
And again, the vast majority of dyspepsia patients are functional. So can you address that for a moment for our audience, please?

Dr. Wright:
So again, I think you really kind of have to drill down to what the patients are experiencing and also, you know, what are their other comorbidities? Is there something else that's causing this too? And I want to revert back to one of the things you said about medications, because I think something that we forget, as well, is that medications that patients are being treated for other conditions, i.e., calcium channel blockers, they certainly can co-interfere with reflux; there's many, many medications that people can be being treated for, like I said. There are other comorbidities that definitely can contribute to their functional dyspepsia.

Dr. Buch:
Absolutely, and when should patients have anti-reflux surgery?

Dr. Wright:
I think really when you've exhausted everything else, and again I'm gonna revert back to that quality of life issue again, as well, when people, you know, yes, they've been taking their medications, they've been diligently trying to adhere to the dietary and lifestyle modifications, not eating late, not only making sure they're staying away from some of the causative agents, but when their symptoms are totally refractory and again, you're starting to see a decline in other health issues, that would definitely be an indication that they should consider having the surgery. And again, you know, not without risk, and one of the things that I'm sure you can appreciate this, too, I've seen patients that have tried to go down the course of having sleeve gastrectomy or whatever, if they don't, if they have not changed their behaviors, unfortunately, they're not gonna have positive outcomes and so that's why it's so important on our end to make sure that we've discovered and kind of can really do the whole 360 to make sure that they are suitable candidates.

Dr. Buch:
And again, the thing that I'd like you to comment on is in our experience over the past few years, at least my experience has been, that there are far fewer patients going for anti-reflux surgery than there were previously.

Dr. Wright:
I agree. I agree. And, you know, it's interesting that you talk about that, too, because having, like I said, you know, been on the other

side there, seeing people that have not had the success from it and, you know, people think again it's gonna be an end-all, cure-all where ok now I'm gonna be able to eat everything that I want, it's just like, you know, people that have diabetes and think they're on medications and therefore they can eat all the carbs and sugar that they want, it's unfortunate that when they realize that that's not the case, and then they are now, they're not symptom-free anymore, I think that becomes somewhat of the defeating purpose, too. But I agree and I want to think that maybe the fact that we're not seeing as much surgery is that maybe people are being more mindful or (laughter) cognizant of what they're eating, I don't know. It'll be interesting to see what the future holds.

Dr. Buch:
And I think surgeons are being a lot more careful about who they select for surgery.

Dr. Wright:
Correct. And I even want to say that, too, about any kind of gastric bypass, as well. I think that they are really kind of looking into the whole psycho-social aspect before they just delve into it.

Dr. Buch:
And patients are much better off for that.

Dr. Wright:
I think more patients now because of access that they have to social media and the internet, I mean, we know that that can be a good and a bad thing, you know, Dr. Google and everything else, but I think that they are doing their due diligence and possibly doing a little bit more research, so, you know, maybe that is why they're making better choices.

Dr. Buch:
Now, we're almost out of time for today, Dr. Wright, but when considering reflux, are there differences among the PPIs?

Dr. Wright:
And that's a very good question and one of the things now I'm gonna really date myself, because of the fact that years ago, when PPIs first came on the scene, we thought they were the best thing since sliced bread, because basically overnight the patient's symptoms disappeared. But then over time, we learned, well, you probably shouldn't be using them for long term because of the concern with possible gastric cancer. Then we started seeing the fact that they were being way overused in my opinion; people that had just mild symptoms were being prescribed a PPI. And then the pendulum turned into the fact that we started seeing the drug-to-drug interactions; the first being the reaction with clopidogrel and the ineffectiveness of people suffering recurrent MIs after having stents. And we know that unfortunately there is the link between PPIs and C. diff and also some malabsorption where magnesium and again mentioning the drug-to-drug interaction.

So, you know, are all PPIs created equal? I don't think so; I think that we need to be very cognizant when we're using them. Again we try to look at their symptoms, start out with using the antacids, H2 blockers, which we know are somewhat limited, and then, you know, if all else fails, going to the PPIs. But I'm gonna kind of backtrack and say if for patients who have the diagnosis of Barrett's or suffering from chronic non-healed ulcers, well then, yes, definitely the PPIs do have a stake in the game, there.

Dr. Buch:
So, the summary of that is when it comes to PPIs, less is more?

Dr. Wright:
Pretty much. And again, what people don't realize too is that there is a weaning process because you can wind up having the refractory symptoms when they abruptly withdraw the PPI. And that's something that's a concern with unfortunately, as you know, the advent of the over-the-counter products, I think we all kind of cringed when that happened because even though they do have the warnings of, you know, use only for 14 days unless prescribed by a healthcare provider, but we know that unfortunately, our patients will sometimes self-treat, and that's a concern that it could possibly mask some underlying symptoms.

Dr. Buch:
Well, that brings us to the end of today's program. And I want to thank you, Dr. Wright, for helping us better understanding GERD.

Dr. Wright:
Well, thank you so much for having me. It's one of my very favorite topics.

Dr. Buch:
For ReachMD, this is Dr. Peter Buch. To access this episode, as well as others from this series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Looking forward to joining you, soon.