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Personalizing Care to Fit GERD Patient Needs

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch, and today we're joined by Dr. John Pandolfino, who will be discussing the personalized approach to gastroesophageal reflux disease, or GERD. Dr. Pandolfino is the Hans Popper Professor and Chief of Gastroenterology and Hepatology in the Department of Medicine at Northwestern Medicine Feinberg School of Medicine in Chicago.

Welcome back to the program, Dr. Pandolfino.

Dr. Pandolfino:
Nice to be here.

Dr. Buch:
Let's dive right in. What are the current treatment options for GERD patients?

Dr. Pandolfino:
It's a great question, and it really goes to the heart of the talk about providing a personalized approach because you can really have a wide spectrum or gamut of therapeutic options with GERD ranging from something like simple lifestyle modifications all the way to a surgical procedure, which is quite invasive. So of course, when you first start developing GERD symptoms, there are some specific lifestyle modifications that you will make, avoiding triggers that you identify; if you have nighttime symptoms, not eating too close to bed, and maybe elevating the head of the bed, and then, of course, if you're a little overweight, losing about 10 or 15 pounds can have a dramatic effect on improving reflux. But then, certainly, if those don't work some people will try antacids, but if you're taking antacids, like Tums or Rolaids or something like that more than twice a week, then you start thinking about more chronic maintenance therapy, attacking the acid in the stomach, and that can either be done with an H2 blocker, something like famotidine or a proton pump inhibitor, which is a little bit more potent—or actually, a lot more potent than an H2 blocker and provides more aggressive acid suppression. Now if people don't respond to the proton pump inhibitors, that's when you start to think about more invasive procedures, like endoscopic antireflux procedures or antireflux surgery, which really not only deals with the reflux but really focuses on correcting the anatomy that is driving that abnormal reflux.

Dr. Buch:
Thank you. And there are a couple of other questions in follow-up for that. Can you talk a little bit briefly about baclofen usage for intractable reflux?

Dr. Pandolfino:
Yeah. It's very interesting. Baclofen is a medicine that's been around for a pretty long time. It's really a muscle relaxant. But what we found was that this particular medicine blocks something called the transient lower esophageal sphincter relaxation. It's a fancy terminology for belching. The primary mechanism of reflux is belching. When you belch, you release air, but also trailing behind that if you have a defective antireflux barrier is liquid, and that's the liquid that is basically introduced to the esophagus that causes injury, symptoms, and then even into the oropharynx, which can cause extraesophageal complaints. What baclofen does is it blocks this reflex at two levels, peripherally and centrally, so it is in essence blocking this belch reflex that occurs when you distend the stomach, and thereby it reduces the overall number of reflux events, and it's a very effective therapy for people who have a lot of belching related to their reflux.

Dr. Buch:

And there's another item that we should talk about because it's the future of therapy, vonoprazan. Can you tell us about the potential use of vonoprazan and talking about vonoprazan as opposed to PPIs?

Dr. Pandolfino:
Yeah. There's a whole new class of medicines beyond proton pump inhibitors, called potassium channel acid blockers, P-CABs, and really what these medicines provide you with is a much more potent acid suppression that occurs a lot quicker and more reliably, so this is really going to be reserved for these patients who require significant acid suppression. So when you have people who fail PPI, who continue to have refractory reflux, meaning that they have overt evidence of gastroesophageal reflux despite being on a proton pump inhibitor, this is really where I think P-CABs can have a major effect because we do know that there are patients who require more aggressive acid suppression, and these are the patients that will derive benefit from these new P-CAB medicines. You'll see a lot more time during the day where the acid in the stomach is low or the pH is above four, and that's really a predictor of how well you'll heal esophagitis and how effectively you can treat reflux disease. So really, exciting advance, and we're looking forward to having this medicine in our toolbox.

Dr. Buch:
And when do we expect that this might be available for us?

Dr. Pandolfino:
Quite soon. We're expecting this within the year. I think we've had a couple of glimpses into how this medicine is working in Asia and Europe, where they are already approved, and it seems to be making a big impact in the treatment of refractory GERD.

Dr. Buch:
Thank you for that information. And moving on, how can we explain symptom relief using PPIs in patients who do not have reflux?

Dr. Pandolfino:
Yeah, so that's pretty common. Many times when people present with reflux-like symptoms, they are given a proton pump inhibitor, and then about 30 percent of people who have no evidence of gastroesophageal reflux disease—and sometimes it's even up to 50 percent of people—can actually feel better on a PPI, and there's too many reasons for that. One is the obvious placebo response that some people can get, and we do see that quite often in GI problems because of this really direct communication between the brain and the gut, but the other thing is sometimes we're actually treating dyspepsia, which can be a little bit difficult to differentiate from reflux. Dyspepsia is a little bit lower in the stomach, a little bit lower than the subxiphoid process area or the chest area, so when people have burning and they point to closer to their belly button or their umbilicus, then it's probably more in line with dyspepsia. Similarly, if people have more profound nausea that also is more consistent with dyspepsia. People who have typical reflux tend to not have as much nausea. So location of where the burning sensation is and the presence of nausea can help you better differentiate dyspepsia from reflux, and that's what you might be treating with PPIs when people start to feel better.

Dr. Buch:
And moving on from there, how should we treat acid rebound when stopping PPIs?

Dr. Pandolfino:
Yeah, so acid rebound is a physiologic phenomenon that occurs due to the negative feedback loop that there is with acid suppression and food and how the stomach deals with that. When you start to have a suppression of acid, what happens is you rev everything up so that you have high gastrin levels, and your parietal cells are very sensitive so that they want to make acid, so they're gearing up for that. So when you stop the proton pump inhibitor, which blocks the parietal pumps, all of a sudden you unleash the parietal cell, which is really geared up to secrete acid, there are high gastrin levels, and people can have abnormal acid secretion into their stomach.

Now if you don't have reflux disease, it's not a big deal, but if you have reflux disease or a slightly incompetent anti-reflux barrier, when that happens it's almost like there's a surge of acid, and people will get more acid into their esophagus. This typically happens over the first seven to 21 days after you stop the PPI. So typically, what we do in our practice is if we're going to wean someone off of a PPI, we can do one of two things. We can either wean them off slowly, meaning that we have the dose every three to seven days, and then we have them come off of that in a very slow way, and we've had pretty good success with that. The other way that some people combat it is to use antacids intermittently or H2 blockers while they're getting people off of a proton pump inhibitor so that they have that in case they develop rebound, and then they can ride it out eventually stopping the more on-demand antacid therapies or H2 blocker therapies.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. John Pandolfino about current treatments for patients who experience GERD.

So with all of that in mind, Dr. Pandolfino, how can we personalize our approach to treating patients with GERD?

Dr. Pandolfino:
Yeah, so I think the way that we would personalize our treatment to GERD is really focus on a couple different things. One is understanding what the patient wants. I think that's very important. Many patients don't want to be on medicines. Some patients would rather be on a medicine and have a more liberal lifestyle. So I think you really have to talk to the patient and get an idea is this someone who really wants to attack the lifestyle; is this someone who would rather have medications and be a little bit more flexible with their lifestyle? Or is this someone who is suffering a lot and really wants to just get beyond this and have something done to fix their anatomy?

The second thing that we need to do is we really need to understand the anatomy and physiology. If you have a large hiatal hernia, there's really no lifestyle modification or medication that's going to help you in that regard. So if you have a large hernia, you're going to have large volume reflux, and a PPI, although it will suppress the acid, you're still going to have that liquid reflux, and you're going to need something more anatomical.

So I think a good conversation with the patient to understand their goals, a great assessment of their anatomy—and that can be done with a good endoscopy—and then, if needed, physiologic testing to assess the overall reflux burden in terms of acid exposure and the number of reflux events, and with that I think you can effectively treat patients.

Dr. Buch:
And how do you approach extraesophageal manifestations of GERD without evidence of reflux?

Dr. Pandolfino:
That's actually a great question also. This is probably one of the most difficult problems that we deal with in gastroenterology, specifically, in the esophagus, are patients who have extraesophageal symptoms that may be related to reflux, symptoms like hoarseness, throat clearing, coughing. Now they can be associated with reflux, but there are a number of patients who have no evidence of reflux but continue to have those symptoms. And really, if you think about it, the oropharynx is a very hostile zone. You're breathing all day. There are irritants in the environment. You're swallowing and you're talking. You're stressing your throat. Well, in those particular instances, you can have hypersensitivity, so even physiologic stimuli, like swallowing, even saliva, or breathing and talking can irritate the larynx. And in many of those patients, we use neuromodulators like low-dose antidepressants or potentially hypnotherapy.

Dr. Buch:
In the last few minutes of our discussion, Dr. Pandolfino, do you have any closing thoughts you'd like to leave with our audience today?

Dr. Pandolfino:
Well, I think, once again, although gastroesophageal reflux disease seems like a simple disease and you just treat the acid and people get better, I do think it's much more complicated, and I think a really good discussion with your patient around what their goals are in terms of treatment and then a really good assessment of anatomy and physiology are crucial to providing a precise and personalized approach to patients.

Dr. Buch:
This was an excellent review of the personalized approach to GERD. I want to thank my guest, Dr. John Pandolfino, for sharing his insights.

Dr. Pandolfino, thanks so much for joining us today.

Dr. Pandolfino:
Thank you very much.

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.