

### 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/the-new-gerd-guidelines/3834/>

### ReachMD

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

---

The New GERD Guidelines

### NEW GERD GUIDELINES

You are listening to ReachMD, The Channel for Medical Professional. Welcome to GI Insight where we cover the latest clinical issues, trends and technologies in gastroenterological practice. GI Insight is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals, North America. Your host for GI Insight is Professor of Medicine and Director of the Digestive Disease Center at the Medical University of South Carolina, Dr. Mark DeLegge.

Your host for GI Insight is Professor of Medicine and Director of a Digestive Disease Center at the Medical University of South Carolina, Dr. Mark DeLegge.

There are numerous ways to treat gastroesophageal reflux disease commonly known as GERD, but which ones are the best. New GERD guidelines developed by the AGA established the most effective management strategies for the condition. Joining us to discuss the new GERD guidelines is co-author of the guidelines Dr. Michael Vaezi, Professor of Medicine at Vanderbilt University Medical Center in a Division of Gastroenterology and Hepatology as well as Director of Clinical Affairs for the division.

**DR. MARK DELEGGE:**

Welcome Dr. Vaezi.

**DR. MICHAEL VAEZI:**

Thank you very much. Thank you for having me

**DR. MARK DELEGGE:**

Michael, first I want to know these guidelines sound very, very interesting, and I know that were almost inundated by with guidelines. So, I have to ask you how where these developed, was it opinions were exactly what went into these?

**DR. MICHAEL VAEZI:**

Right, that's an important question. We were put to task by the AGA to come up with a position statement that was evidence based and that was an important factor that it was not just opinion, although when there is no evidence, i.e. there are no randomized control trials in an area, then it would be based on practices and expert opinion, but majority of what we were tasked to do was based on what is the evidence currently that is published, are they randomized control studies and what are the certainties and what are the uncertainties in the field.

**DR. MARK DELEGGE:**

Now, were these guidelines, did you have a ranking system that you came up with to try to figure out what was a good study or what wasn't?

**DR. MICHAEL VAEZI:**

Right, so we were basically used to gradation that we were asked to do grades A through D and this was the USPSTF recommendation and grades. The strength of recommendations and the quality of evidence, for example grade A recommendation was if there was strong evidence and we strongly recommended that clinicians provide this to eligible patients and then going down the line grade D was recommending against providing such therapy or that recommendation to asymptomatic patients and then the quality of evidence was judged based on good or poor, good being evidence that included consistent results from well designed studies to poor being evidence that was insufficient to assess the effect and the outcome for the patients.

**DR. MARK DELEGGE:**

We will jump right in here. I have to start off with lifestyle modification because that's what we usually talk about first, things such as raising the head of your bed or perhaps changing your diet or some of your social activities, so I have to ask what role do lifestyle modifications play for GERD patients in the guidelines?

**DR. MICHAEL VAEZI:**

That's an important question that we were asked and we searched for evidence in the literature. Many of us we see patients recommend elevating the head of the bed, not eating chocolate, not eating soda, reducing the fat intake. When we looked at the evidence based on publish results, they were predominantly old and case series and not really lot of evidence that was in control fashion showing there is benefit. Nonetheless, we do know that there were certain dietary factors that play a role in patients with reflux disease. So, the recommendations that were made based on the review of the literature was a grade D recommendation, which suggested there is fair evidence that it does improve symptom and the predominant evidence was on weight loss as opposed to other factors that are currently recommended because it is increasingly recognized that obesity may be playing a factor and weight loss may play an important role in reducing the symptoms of reflux disease. Where it came to the elevation of head and bed and other factors, there is evidence based on again case series that it does help patients, but we all agreed based on reviewing literature that it is probably best to leave that to the individual physicians to tailor that to patients, i.e. if a patient has symptoms with certain dietary factors, then eliminating that dietary factor becomes important because there is really no control study suggesting that 1 or combination of those factors are important.

**DR. MARK DELEGGE:**

Yeah, it is interesting on lifestyle, as a gastroenterologist, we see patients in our offices all the time and frankly many of them are getting

larger and larger, so I am hearing from you that we should start paying attention to perhaps the patients body mass index or their weight.

**DR. MICHAEL VAEZI:**

Yeah and that's a sensitive subject that I think most of us when we see patients, we ask patients what is changed in you that resulted in either worsening symptoms, increasing symptoms, and often times it is, you know, I just gained 10 pounds or you know, it is in that I started eating chocolate, it is in that I started drinking beer, it is predominantly about the body mass index. So, you are absolutely right, although sensitive we do need to address it and we do need to put the patient on certain regimen and that's where we haven't done well. We tend to prescribe medications without necessarily looking at the overall picture and the recommendation at least that I would make is to really pay special attention to that.

**DR. MARK DELEGGE:**

Well the main stay of what I do as a gastroenterologist and I am sure yourself with reflux disease is prescribe acid suppression therapy such as H2 blockers or proton pump inhibitors. What did the guidelines have to say about that?

**DR. MICHAEL VAEZI:**

There is strong evidence the guidelines based on the review of literature, they are well controlled, well designed studies that suggest that acid suppression, H2 receptor antagonists, as well as proton pump inhibitors do help with patients with reflux disease and that we know and that is our current practice, so the recommendation is grade A, we strongly recommended, at least the evidence strongly recommends the use of acid suppression and there is also strong evidence that proton pump inhibitors have better capacity to suppress acid than H2 receptor antagonist and this was based on Med Analysis that have been published in the field. So, we know that PPIs or the main stay of treatment for this condition and the question that came up is, you know, we used to do step up and then it became step down therapy, although we didn't specifically address that, it is recommended that we do step down therapy, i.e. we strong with our proton pump inhibitors and then end up with the least amount of acid suppression that keeps the patient's symptoms at bay.

**DR. MARK DELEGGE:**

Speaking at that, when you were looking at that therapy, just try another pharmacologic agent, what about we talk about as far as promotility agents, did that come into the picture?

**DR. MICHAEL VAEZI:**

Yeah. That was a great deal as in recommend against and there is fair evidence that is ineffective was the conclusion, you know, we do that in practice, I get that question all the time, what about adding metoclopramide, for example. There is no evidence necessarily that for reflux disease, it will be beneficial, but there is evidence for gastroparesis, so we know we stayed out of that. If reflux is secondary to gastroparesis, the recommendation is obviously to treat both reflux but really to pay attention to the primary source, i.e. the reason for the gastroparesis and how to treat that but for reflux alone, there is no evidence that a promotility agent such as metoclopramide would be beneficial.

**DR. MARK DELEGGE:**

Michael, I offered a lot of people to talk about using proton pump inhibitors during the day and H2 blockers at night, is there any evidence to support that?

**DR. MICHAEL VAEZI:**

There is not strong evidence to support this. The use of H2 receptor antagonist in addition to the use of twice daily PPI, for example for the nocturnal acid breakthrough, we did not feel that there was strong evidence to suggest adding H2 receptor antagonist to such a regimen. Now, there is evidence and we call that grade B that is there is fair evidence that if someone does not respond or only partially responds to once daily therapy, to increase the dose to twice daily therapy. I think most physicians are doing that, but adding H2 receptor antagonist to maximum, i.e. b.i.d. dosing of PPI, there is we felt that there was not much evidence to support it.

**DR. MARK DELEGGE:**

My other question is that with regards to just over-the-counter agents that patients coming on, was there any evidence that any of these over-the-counter agents were effective such as Maalox or Mylanta or some other oral antacid?

**DR. MICHAEL VAEZI:**

Yeah. We didn't actually get into the antacid because right now the trend in treatment is changing somewhat, as we all see patients often coming have already tried antacid, their short course is that will suppress the acid in the short way or "the stomach or the esophagus" to help the patient with symptom, but as far as long-term relief or healing esophagitis, the recommendation is obviously the use of PPIs initially. Most patients will have tried those and the ones that come, seek attention, primary care or gastroenterologist or those that require higher dose of acid suppression than antacids.

**DR. MARK DELEGGE:**

If you just tuning in, you are listening to GI Insight on ReachMD, The Channel for Medical Professionals. I am your host, Dr. Mark DeLegge and joining me to discuss the new GERD guidelines is Dr. Michael Vaezi, Professor of Medicine at Vanderbilt University Medical Center in Division of Gastroenterology and Hepatology as well as Director of Clinical Affairs for the division.

So, Michael, moving onto more testing type issues, when should we actually start to test people, meaning to treat people right upfront, to go ahead and do testing, then treat, what are the guidelines have to say about that?

**DR. MICHAEL VAEZI:**

The guidelines now, at least what we recommend is based on the evidence that empiric treatment should still be the first line unless there are warning symptoms in patients and again, we felt that using alarm symptoms alone, there was some insufficient evidence for that, but overall guideline for physicians practicing to use proton pump inhibitors initially and then when patients are either partially or not at all responsive to acid suppression, at that point diagnostic testing with endoscopy or pH monitoring or manometry if appropriate would be the second step in our algorithm for patients with reflux disease.

**DR. MARK DELEGGE:**

With regards to diagnostic testing, were there any specific instances where perhaps a pH probe should be ordered or was that up to the clinician?

**DR. MICHAEL VAEZI:**

Well, there is not a specific instance per se other than lack of response to therapy, you know, as far as patients that are partially responsive or not at all responsive, yet we are trying to either rule in reflux, i.e. is it patient, is it because of compliance, is it because of continued acid reflux or is it because this is not reflux at all, i.e. ruling out reflux disease that is where diagnostic testing come in and to be truthful, diagnostic tests are designed to in a sense rule reflux out as opposed to in because our proton pump inhibitors and acid suppression is so effective now a days that by default they rule reflux out in a large group of patients and our diagnostic tests are designed to tell us what else could be playing a role on patient's symptoms other than reflux and pH monitoring, for example we will do that in non-responsive or partially responsive to tell us is reflux really still playing a role in that group of patients.

**DR. MARK DELEGGE:**

I would like to thank my guest from Vanderbilt University Medical Center, Dr. Michael Vaezi. DR. MICHAEL VAEZI:, thank you very much for being our guest this week on GI Insight.

**DR. MICHAEL VAEZI:**

Thank you so much. I appreciate it.

**DR. MARK DELEGGE:**

You have been listening to GI Insight on ReachMD, The Channel for Medical Professionals. GI Insight is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals, North America. For additional information on this program and on-demand podcast, visit us at [www.reachmd.com](http://www.reachmd.com) and use promo code AGA.