

# Reflux Threat to Upper Airway Might Be Missed

BY BRUCE K. DIXON  
Chicago Bureau

KEYSTONE, COLO. — Physicians treating patients with asthma and other airway symptoms should not rely solely on gastroenterologists' interpretations of pH probe tests, because they might miss laryngeal-pharyngeal reflux that threatens the upper airway, Dr. Donna Bratton said at a meeting on allergy/clinical immunology, asthma, and pulmonary medicine.



"Gastroenterologists may not be familiar with patients with asthma, chronic cough, or laryngitis, and pH probe patterns may look unfamiliar in the context of what they usually see," said Dr. Bratton, an allergist with the National Jewish Medical and Research Center in Denver. "If they don't find something significant in the lower esophagus, they may miss something significant in the larynx or pharynx."

Asthma patients with suspected gastroesophageal reflux (GER) or laryngeal-pharyngeal reflux (LPR) are a heterogeneous population in terms of esophageal acidification. Some patients have short episodes of reflux and others show prolonged episodes associated with esophageal injury, she said at the meeting, which was sponsored by the National Jewish Medical and Research Center.

"GI doctors are very good at treating GER with proton pump inhibition therapy, which appears to work best in the most severe cases. But when patients have

short periods of acid reflux that are full column to the top probe and don't result in prolonged acid exposure, they don't know what it means, and we see this same pattern in LPR," the allergist said.

Some of the patterns and parameters that are known to injure the esophagus are not necessarily seen in airway dysfunction

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DR. BRATTON

patients, but that doesn't mean they aren't having significant reflux that might go into the esophagus or even higher into the pharyngeal area, Dr. Bratton said in an interview. Standard pH probe monitoring is unable to detect nonacid GER, which doesn't concern GI doctors because it doesn't injure the esophagus. Although the esophagus has many defense mechanisms against acid, other compounds in reflux might damage the airway, Dr. Bratton said.

"Bile and enzymes from the duodenum do not show up on a pH probe, and when you get all the way up out of the esophagus into the LP area, those tissues do not have some of the defenses that the esophagus does," she said. Symptoms might be generated merely from those protective mechanisms being repeatedly triggered by nonacidic material, she added.

Dr. Bratton's message to doctors treating airway disease is simple: "Either have a close relationship with your GI doc if he or she shows an interest in airway disease, or look at these probe studies yourself and see if the patterns are posing significant problems that are correlated with patients' symptoms or disease," she said. ■

## TIPS Remains a Treatment Option For Ascites, but Not in all Patients

MIAMI BEACH — Transjugular intrahepatic portosystemic shunt placement remains an effective treatment for ascites in select patients, Dr. Florence Wong said at a meeting on hepatobiliary disease sponsored by the University of Miami.

The treatment, commonly known as TIPS, has been shown to significantly improve urinary sodium excretion by eliminating portal hypertension, explained Dr. Wong, of the University of Toronto.

In studies of TIPS in patients with this complication of cirrhosis, urinary sodium excretion has been shown to improve gradually over 14 months without the use of diuretic therapy, she noted.

Additionally, five randomized controlled trials comparing TIPS with repeat large-volume paracentesis showed that TIPS was better for controlling ascites.

A recent meta-analysis using individual patient data points shows a survival advantage for TIPS, compared with large-volume paracentesis, said Dr. Wong, who

has submitted the meta-analysis data for publication.

But TIPS is not appropriate for all patients. The studies show that outcomes are worse with increasing age and with cardiac or renal dysfunction at baseline. Renal excretion of sodium tends to worsen with increasing age and baseline renal dysfunction, as well as in those with preexisting cardiac or coronary disease, she explained.

Furthermore, patients with a history of hepatic encephalopathy tend to have worsening of the condition following TIPS.

"We also now know that in those with more severe liver disease, with shunting the liver becomes mildly ischemic, and by placing TIPS, we may actually precipitate liver failure," Dr. Wong said.

TIPS can be considered in those under age 65 with normal cardiac and renal function, and without a history of hepatic encephalopathy or severe liver disease, she said.

—Sharon Worcester

# Gastric Bypass for Intractable GERD Remains Controversial

BY BRUCE JANCIN  
Denver Bureau

SAN DIEGO — Roux-en-Y gastric bypass is an effective albeit technically challenging option for the common problem of intractable gastroesophageal reflux disease following failed fundoplication, Dr. Omar Awais said at the annual meeting of the Society of Thoracic Surgeons.

The procedure has an 80% success rate for control of GERD symptoms. That rate is as good as or better than the results usually reported for a first redo fundoplication. Second redo fundoplications have a success rate of about 60%, while third repeat fundoplications work less than 50% of the time, according to Dr. Awais of the University of Pittsburgh.

Another surgical option for patients with intractable GERD after failed antireflux surgery is esophagectomy. However, that operation has a mortality of 5% in expert hands, compared with the 0% mortality seen in this study, the cardiothoracic surgeon added.

Obesity is an important risk factor for GERD. With the worsening obesity epidemic, Dr. Awais and colleagues are seeing increasing referrals for failed antireflux operations. Indeed, they received 183 such referrals during 2000-2005. Most of these patients underwent redo partial or complete fundoplication. But 25, including 11 with two or more prior Nissen fundoplications, underwent Roux-en-Y gastric bypass (RNY).

Three-quarters of RNY recipients were obese or morbidly obese. All had severe GERD symptoms involving heartburn, regurgitation, dysphagia, and/or reflux-associated pulmonary symptoms.

The RNY operations began laparoscopically, although 40% were intraoperatively converted to open procedures. Surgery began by taking down the prior fundoscopies and reducing recurrent hiatal hernia. Surgeons then performed a standard RNY with one important modification: Instead of creating the 30-cc gastric pouch typical in bariatric surgery, they fashioned a much smaller pouch—just 5-10 cc—in order to divert acid.

The mean operative time was nearly 6½ hours. One-quarter of patients experienced at least one major postoperative morbidity. These included two cases of anastomotic leak, three of pneumonia, a Roux-limb intussusception requiring reoperation, an MI, pulmonary embolism, and anoxic encephalopathy. There were no deaths.

Follow-up at a mean of more than 16 months showed 80% of patients were satisfied. The mean score on a 45-point GERD symptom scale on which 15 is considered clinically significant fell from 30 preoperatively to 7.

Moreover, patients lost a mean weight

of 60 pounds, and more than two-thirds of comorbid conditions showed significant improvement. For example, 12 of 15 previously hypertensive patients required lower doses of antihypertensive drugs or no medication at all. Sleep apnea and hypercholesterolemia also showed marked improvement.

Dr. Awais' report had a decidedly mixed reception. Dr. Thomas J. Watson of the University of Rochester (N.Y.) declared RNY is an important operation for thoracic surgeons to master because they are the specialists best suited to perform it in the challenging group of patients with severe GERD after failed antireflux surgery.

He added that at the most recent meeting of the Society for Surgery of the Alimentary Tract he presented a case series of RNY patients; rates of symptomatic improvement and major complications were similar to those Dr. Awais described.

Not all patients with failed fundoplication who'll benefit from RNY present with intractable GERD symptoms, however. They may instead present with symptoms of poor esophageal emptying, with gastroparetic symptoms such as nausea and vomiting, or with pain, Dr. Watson said.

But Dr. Mark B. Orringer took a dim view of RNY for severe GERD after failed antireflux surgery.

"I hate to see the stomach being attacked when the culprit is the esophagus in these patients with reflux," said Dr. Orringer, the John Alexander Distinguished Professor and head of thoracic surgery at the University of Michigan, Ann Arbor. "It just hurts me to the quick to see patients having the best organ with which to replace the organ that's causing their symptoms be injured or made unusable for esophageal replacement. You're explanting the wrong organ."

He urged anyone considering doing such surgery to first perform upper GI endoscopy. "We're seeing patients referred to us who've had gastric bypass operations for obesity done in the presence of Barrett's mucosa and who now need esophagectomy for Barrett's adenocarcinoma because the Barrett's mucosa was overlooked."

Dr. Daniel L. Miller concurred. "You had a dysmotility problem in two-thirds of your patients before surgery and dysphagia in more than 40%, and then you go on and do the surgery and leave the esophagus intact. I think you're going to have problems on down the road," warned Dr. Miller of Emory University, Atlanta.

"Dysphagia is a very common problem in these patients, and I think this might not be the right operation for them. Esophagectomy would probably be better," he said. ■

**Follow-up at a mean period of more than 16 months showed that 80% of the 25 patients were satisfied with Roux-en-Y after failed fundoplication.**