

# Medication Confirmed as First Choice for GERD

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Antisecretory drug therapy should be the first-line treatment for gastroesophageal reflux disease, with antireflux surgery offered only to those whose symptoms are not controlled by medication or who can't tolerate the drugs, according to a new management guideline from the American Gastroenterological Association.

Proton pump inhibitors remain the most effective medical therapy, followed by histamine<sub>2</sub>-receptor agonists, according to the position paper (Gastroenterology 2008;135:1383-91).

"There is ample evidence that, as a drug class, proton pump inhibitors are more effective in these patients than are histamine receptor blockers," wrote lead author Dr. Peter J. Kahrilas of Northwestern University, Chicago.

The document was based on a technical

review by Dr. Kahrilas and his colleagues. Despite fair evidence that some lifestyle modifications can benefit patients with gastroesophageal reflux disease (GERD), the authors found no strong evidence that such changes should be broadly recommended. Patients with nighttime symptoms may benefit from elevating the head of their bed. Overweight or obese patients should be urged to lose weight, as this may prevent or delay the need for acid suppression.

The authors found strong evidence that

antisecretory drugs, especially proton pump inhibitors, improve outcomes, and there is fair evidence to support twice-daily dosing for some patients. Expert opinion "is essentially unanimous in recommending twice-daily dosing of PPIs to improve symptom relief in patients with ... an unsatisfactory response to once-daily dosing." They found no evidence that metoclopramide is useful, and recommend against its use because of its substantial side effect profile.

## A Colonoscopy Screen Every 5 Years May Be Safe

For patients at average risk for colorectal cancer whose initial screening colonoscopy reveals no abnormalities, an interval of 5 years or longer before the next exam appears to be safe.

The 5-year risk of colorectal cancer in such patients is extremely low, and the risk of advanced neoplasms also is low—findings that "provide support for rescreening after an interval of 5 years or longer," said Dr. Thomas F. Imperiale, professor of medicine, Indiana University, Indianapolis, and his associates.

They studied 1,256 middle-aged people at average risk for colorectal cancer who had undergone initial screening colonoscopy with 36 gastroenterologists in Indiana between 1995 and 2000. A total of 1,057 subjects had no polyps, and 199 had only hyperplastic polyps at that time.

No cancers were discovered 5 years later at follow-up colonoscopy at a mean age of 57 years. But 201 subjects (16%) had neoplastic polyps at rescreening, including 16 (1.3%) with advanced neoplasms. These results are similar to those of previous studies of rescreening among people with normal findings on baseline colonoscopy, the researchers said (N. Engl. J. Med. 2008;359:1218-24).

In an editorial, Dr. Robert H. Fletcher, professor emeritus at Harvard Medical School, Boston, said that even though intervals of 5-10 years between screenings have been recommended, "in clinical practice, intervals between colonoscopic examinations have apparently not reflected the evidence. In a survey, endoscopists in the United States said they performed follow-up colonoscopies at substantially shorter intervals than those recommended by expert groups. Perhaps with stronger evidence that longer intervals are safe, practicing endoscopists will be persuaded to extend the time between colonoscopic examinations," Dr. Fletcher said (N. Engl. J. Med. 2008;359:1285-7).

Dr. Imperiale's study involved employees, retirees, and dependents of Eli Lilly & Co. The study was supported by a grant from the National Institute of Diabetes and Digestive and Kidney Diseases, and no potential conflict of interest was noted. Dr. Fletcher reports serving as a paid consultant for Exact Sciences.

—Mary Ann Moon



Strong evidence supports a three-tiered diagnostic algorithm. Patients with suspected GERD syndrome and troublesome dysphagia should undergo endoscopy with biopsy as an initial evaluation. Those with suspected GERD who fail to respond to twice-daily PPIs may benefit from either an endoscopy or manometry. Ambulatory pH testing should be done to substantiate a GERD diagnosis for those who have not responded to empirical therapy and who have had unremarkable endoscopy and manometry.

There is no evidence that endoscopy used as a screening tool for Barrett's esophagus reduces mortality from

esophageal adenocarcinoma in the setting of chronic GERD, the authors said.

They found strong evidence that antisecretory drugs also benefit patients with suspected extraesophageal reflux symptoms (cough, laryngitis, and asthma). But there was no evidence to support the drugs' use for extraesophageal symptoms in the absence of an esophageal GERD diagnosis. "Empirical therapy with twice-daily PPIs for 2 months remains a pragmatic clinical strategy for subsets of these patients if they have a concomitant esophageal GERD syndrome. Failing such a trial, etiologies other than GERD should be explored."

There are no firm data suggesting that

GERD is always a progressive disease, going from nonerosive to erosive to Barrett's esophagus, the authors said. Therefore, routine endoscopy to monitor progression is not recommended.

For maintenance therapy, the authors found strong evidence that long-term PPIs are safe and effective and can be titrated downward in many patients. But most patients need daily therapy, as "the likelihood of spontaneous remission of disease is low."

There was fair evidence supporting long-term maintenance therapy for patients with extraesophageal reflux symptoms, but only if they have concomitant esophageal GERD syndrome.

The authors found no significant safety issues with long-term use of antisecretory drugs. There is no need for routine bone studies or calcium supplementation, beyond that which would normally be recommended based on individual risk factors.

Surgery may be considered for those who can't tolerate the drugs or whose symptoms are not controlled by them. Dysphagia severe enough to require surgical correction occurs in up to 6% of surgical cases, and "both controlled and uncontrolled trials have shown a significant increase in flatulence, an inability to belch, and increased bowel symptoms after antireflux surgery," the authors wrote. ■

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