GERD Guidelines Deem Surgery a Last Resort

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Medical therapy with antisecretory drugs 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 released by the AGA Institute.

Proton pump inhibitors remain the most effective medical therapy, followed by histamine$_2$-receptor agonists, according to the position paper.

"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 addresses 12 broad issues concerning the diagnosis and management of gastroesophageal reflux disease (GERD), and was developed based on a technical review undertaken by Dr. Kahrilas and his colleagues Dr. Nicholas J. Shaheen and Dr. Michael Vaezi. For each question, the authors performed a comprehensive literature review.

While the authors said there is fair evidence that some lifestyle modifications can benefit patients with GERD, they found no strong evidence that such changes should be broadly recommended for all patients. Patients with nighttime symptoms may benefit from elevating the head of their bed, they wrote. 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 fair evidence to support twice-daily dosing for some patients. Although essentially all drug trials used once-daily dosing, 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, either as mono- or adjunctive therapy, and recommend against its use because of its substantial side effect profile.

Strong evidence supported 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 treated empirically who fail to respond to twice-daily PPIs may benefit from either an endoscopy or esophageal manometry to pursue alternative diagnoses. Ambulatory pH testing, off of PPI therapy, 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.

They found strong evidence that antisecretory drugs are also beneficial for patients with suspected extraesophageal reflux symptoms (cough, laryngitis, and asthma) when those patients also experience esophageal GERD symptoms. "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."

No firm data suggest 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. The limited data available suggest that any risk of progression is very small—less than 2% over 7 years—and endoscopic monitoring has not been shown to lessen the risk of cancer.

Regarding maintenance therapy, the authors found strong evidence that long-term PPIs are safe and effective, and can be titrated downward in many patients. However, daily therapy will still be necessary for most, 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.

Medical therapy should be the first-line treatment. Surgery may be considered for those who can't tolerate the drugs, or whose symptoms are not controlled by them. However, the benefits of antireflux surgery need to be weighed carefully against the problems it can engender, the authors wrote. ■