Supraesophageal Signs of GERD Tricky to Treat

BY SHARON WORCESTER
Tallahassee Bureau

ORLANDO, FLA. — Supraesophageal manifestations of reflux disease pose a treatment challenge, Reza Shaker, M.D., said at the annual meeting of the American College of Gastroenterology.

There is a misperception that when reflux is treated, other related disorders—such as laryngitis—will disappear as well, but that's not always the case, said Dr. Shaker, chief of gastroenterology and hepatology at the Medical College of Wisconsin, Milwaukee.

When faced with a patient who has lingering laryngitis, throat clearing, and other conditions presumed to be associated with gastroesophageal reflux disease, he recommends the following:

▶ **Interview the patient carefully.** A thorough history is imperative for ensuring the correct diagnosis. Most patients won't present with cut-and-dried signs and symptoms of GERD. More often, there is a little redness in the area of the supraesophageal structures. Studies show that the presence or absence of symptoms may not be as specific for diagnosis as previously thought.

▶ **Evaluate the therapeutic options.** Reevaluate the use and value of therapy; the treatment must be tailored to individual patient needs. Although some patients need simple acid suppressive therapy, others with mild disease could respond well to reflux precautionary measures, such as having an empty stomach at bedtime, he said. Others need a combination approach, and still others will require surgery.

Surgeons, however, are increasingly requiring that patients have shown a prior response to medical therapy, indicating that the diagnosis is correct.

In evaluating the effectiveness of the current therapy, check to see if acid has been adequately suppressed. The use of esophageal acid monitoring can be helpful. Also, ensure proper timing of medication dosing. "How many patients do we encounter who take their medicine at the wrong time in the morning and then drink a cup of coffee?" he asked.

In addition, confirm that the dosage is adequate.

▶ **Recommend the use of precautionary measures.** A key difference between the esophageal and supraesophageal structures is that nonacidic and minimally acidic materials can cause injury to the supraesophageal structures. Having an empty stomach before bedtime is an important preventive strategy.

Patients should be evaluated for delayed gastric emptying, which occurs in about 40% of GERD patients. This may not be important when dealing with complications of the esophagus in this age of proton pump inhibitors, but it can create a reservoir for acid and nonacid material that can be harmful to the supraesophageal area.

▶ **Consider referral to an ear, nose, and throat specialist.** Remember that reflux is not exclusive for aerodigestive tract disorder, and consider referring patients who fail to respond to therapy to an ENT physician for additional evaluation, he advised. ■

Combo Therapy Cuts Risk of Rebleeding in Clotted Ulcers

BY JEFF EVANS
Senior Writer

ORLANDO, FLA. — A combination of endoscopic and medical treatment of bleeding peptic ulcers with adherent clots results in a significantly lower rebleeding rate than does medical therapy alone, according to findings from a metaanalysis of randomized clinical trials.

Peptic ulcers with adherent clots are problematic because of highly variable rebleeding rates that range from 8% to 36%, Charles J. Kahi, M.D., said at the annual meeting of the American College of Gastroenterology.

Patients who received a combination of endoscopic and medical treatment had a 60% lower risk of rebleeding than those who received medical therapy alone.

In the metaanalysis, patients who received combination therapy had about a 60% lower risk of rebleeding than did those who received medical therapy alone.

During a search of four databases (Medline, Embase, Thomson Biosis, and Brown University Cochrane Center's Central) for trials published during 1966-2003, Dr. Kahi and his colleagues located six randomized trials that compared the combination of endoscopic and medical therapies with medical therapy alone for bleeding peptic ulcers with adherent clots. They contacted the primary authors of the studies, obtained the raw data from each of the trials, and combined all the data into one database.

Four studies were fully published reports, and two were published in abstract form. The six studies included a total of 240 patients.

Overall, three of the trials found no difference in rebleeding rates, whereas the remaining three trials found that the combination treatment gave a significantly lower rebleeding rate than did medical therapy alone, said Dr. Kahi of Indiana University, Indianapolis.

In the four fully published studies, rebleeding occurred in significantly fewer patients (8% [5 of 61 patients]) who received endoscopic plus medical therapy than in those who received medical therapy alone (25% [21 of 85 patients]).

The two groups did not differ in their length of hospital stay, number of transfusions, or mortality.

In each of the studies, endoscopic therapy consisted of clot removal and treatment of the underlying lesion with thermal energy, electrocoagulation, and/or injection of sclerosing agents. Medical therapy included supportive care, ICU monitoring, and acid suppressive medications, such as histamine-2 receptor antagonists or proton-pump inhibitors.

Dr. Kahi cautioned that the metaanalysis might include publication bias because reports of negative studies might not have been published. He also noted that the trials included patients from the United States, Hong Kong, Spain, and South Korea, who may have different responses to medical therapy because of genetic differences. ■