Management of uncomplicated GORD

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Lifestyle modification Patients are recommended to have a healthy diet, avoid over eating and avoid dietary items (e.g. carbonated drinks, alcohol, tea or co ff ee) or activities that in the patient’s experience would provoke the symptoms. Patients with nocturnal symptoms should have early dinner and avoid r ecumbence after meals. Elevation of the head of the bed may also help. Smoking cessation reduces severe reflux symptoms in normal-weight individuals on medical treatment. Weight management is recommended for overweight patients. Medical management Most patients with GORD self-medicate with over-the counter medicines such as simple antacids, antacid–alginate Gastro-oesophageal reflux disease /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF preparations and H -receptor antagonists. Consultation is 2 more likely when symptoms are severe, prolonged and unre - sponsive to simple measures and treatments. Pharmacological treatments mainly target acid reduction or neutralisation. With the development of PPIs in the 1980s, they have quickly become the first-line tr eatment for symptomatic GORD. Given an adequate dose for 8 weeks, most patients have a rapid improvement in symptoms (within a few days), and more than 90% can expect full mucosal healing of oesophagitis (if present) at the end of this time. A policy of ‘step-down’ medical treatment is advocated after the initial 8 weeks of treatment to a dose that keeps the patient free of symptoms, and this might even mean the cessation of PPI. Most patients do not make sustained major lifestyle changes and because PPIs are so e ff ective many remain on long-term treatment. Those patients who have an inadequate - treatment response may benefit from changing to another - PPI, an increased dosage of the same PPI, a twice-a-day regi - -receptor antagonist. PPI is also men or the addition of an H 2 important in patients with reflux-induced strictures, resulting in significant prolongation of the intervals between endoscopic dilatations. There have been numerous reports on the associ - ation between chronic PPI use and a myriad of side e ff ects. Most could not demonstrate a causal relationship except some enteric infections and fundic gland polyps. However, patients - ar e still advised to use the lowest e ff ective dose for symptom control. Prokinetic agents, e.g. metoclopramide and domperidone, are not particularly useful and have potential safety issues. Other TLOSR inhibitors were also disappointing. Antacid–alginate pre parations target the acid pockets and form a polysaccha - ride barrier at the proximal stomach. A more recent develop - ment are the potassium-competitive acid blockers (P-CABs). - Compared with PPIs, P-CABs have a more rapid, competitive, reversible inhibition of proton pumps. How ever, they are avail - able in only limited regions. With pH monitoring, it is possible to identify patients with di ff erent phenotypes, especially distin - guishing those having pathological versus physiological reflux, and positive v ersus negative symptom correlations. For patients with discordant reflux activity and symptom association, as in oesophageal hypersensitivity or functional disorder, antireflux therapy is likely to fail. Other treatment options include per - ception modulators, e.g. tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs), or

alternative therapies, - e.g. hypnosis and beha vioural therapy .

GORD is common but symptomatology may be confused with other disorders, such as achalasia; both may present with regurgitation Sliding hiatus hernia predisposes to GORD Heartburn and regurgitation are typical GORD symptoms Beware of extraoesophageal manifestations of GORD A PPI is the most effective medical treatment, but regurgitation is not well controlled by PPIs (c) .

(c) (d) Figure 66.16 Examples of various types of fundoplication. (a) Normal anatomy. (b) Nissen 360° fundoplication. (c) Dor anterior fundoplica tion. (d) Toupet posterior fundoplication.

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