Version 1.0

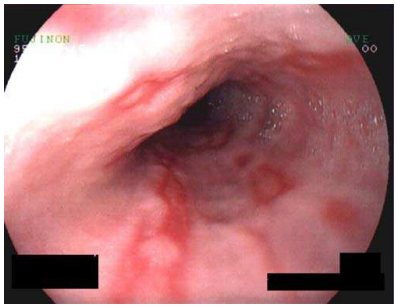
Gastro-Oesophageal Reflux Disease (GORD)

8/06/2012

Overview

A certain amount of gastro-oesophageal reflux of acid is normal. It is usually limited by the lower oesophagus sphincter. If reflux is prolonged, excessive or bilious it may → oesophagitis.

Epidemiology



- 2-3M:1F
- Barrett's oesophagus is 10x more common in men.
- Prevalence increases over the age of 40.
- Up to 40% of people report in any 6 to 12 months period.
- <10% have moderate or severe oesophagitis.

Risk Factors

- Incompetent LOS
- Surgery of the cardia in achalasia
- Hiatus hernia
- Smoking, alcohol, fat, coffee
- Systemic sclerosis
- Raised intra-abdominal pressure
  - Pregnancy
  - Obesity, Tight clothes
  - Big meals
- Drugs (TCA, anticholinergics, nitrates & CCB)

There is controversy over the role of H. pylori and GORD. It is probably not a causative factor.

Presentation

Typical symptoms: Heartburn, retrosternal discomfort, acid brash, water brash, odynophagia.
Atypical symptoms: CP, epigastric pain, bloating, and chronic hoarseness/cough/wheeze/SOB.

Investigations

- Endoscopy if >55 or severe symptoms, but findings may not correlate with symptoms.
- Perform FBC to exclude significant anaemia
- Barium swallow may show hiatus hernia (fluid level on CXR does not prove oesophagitis)
- 24 hours pH monitoring to assess if symptoms coincide with acid in the oesophagus

Differential diagnosis

- Oesophagitis from swallowed corrosives/drugs e.g. NSAIDs, doxycycline, biphosphonates
- Infection (esp in the immunocompromised); CMV, herpes, candida
- Peptic ulcer or non-ulcer dyspepsia
- Oesophageal spasm
- GI cancers (red flags: wt loss, anaemia, vomiting, dysphagia)

Complications

Oesophagitis/ulcer, anaemia, oesophageal stricture, Barrett's oesophagus.

Management

Life style: ↓wt/smoking/EtOH/spicy food/coffee/fat/stooping. ↑head of bed. Small reg. meals.
Avoid drugs likely to worsen symptoms: NSAIDs, CCBs etc
Pharmacotherapy:

- Mild infrequent episodic GORD – Antacids e.g. alginates
- If more significant then low dose PPI x 1 month (more effective than H_2-antagonists)
- If endoscoped and oesophagitis found give high-dose PPI for 2mo. then low-dose maint.
- If H.pylori test positive & not endoscoped can consider eradiation Rx (see PUD article)

Surgery: fundoplication for HH, often not curative.