Referral Support Service

General Surgery

GS07
Upper GI topic: Gastro Oesophageal Reflux Disease

Definition

Typical GORD symptoms are above the diaphragm featuring heartburn, sour taste, belching or regurgitation which are common 2 hours after a fatty/large volume meal.

Dyspepsia refers to persistent or recurrent abdominal discomfort/pain located in the upper abdomen i.e. below the diaphragm present for at least 4 weeks. (If the symptoms and signs are more suggestive of dyspepsia, please refer to the separate dyspepsia referral guidelines.)

Exclude Red Flag Symptoms

Routine endoscopy (and hence secondary care referral) is not indicated for GORD without alarm symptoms (red flags) or risk factors for cancer (1). Normal endoscopy is the common finding for patients with GORD as they have *non-erosive* reflux disease. Red flags are:

- Weight loss (unintentional)
- Iron deficiency anaemia
- Vomiting – persistent
- Dysphagia
- Evidence of GI bleeding (blood loss from upper GI tract is a prokinetic agent so may be reflected in change in bowel habit and/or stool colour change.
- Epigastric mass
- Patients aged over 55 with **unexplained**, **persistent** and **recent** onset dyspepsia***

  - Unexplained = No obvious reason found in the history for dyspepsia
  - Persistent = Continuation of symptoms/signs beyond a period that would normally be associated with self-limiting problems (usually regarded as 4-6 weeks)
  - Recent = New onset and not recurrent symptoms.

Risk factors for cancers: In addition to the red flags above, a lower threshold for referral is suggested in those with a history of Barrett's oesophagus, pernicious anaemia, intestinal dysplasia, peptic ulcer surgery or a family history of upper GI cancer.

Management

- The incidence of upper GI cancer in those under the age of 55 years without red flags is 1 per million population per year (2).

- The majority of cases of GORD can be treated in primary care.
- Success of anti-reflux treatment is a reasonable diagnostic test in primary care.
- H pylori eradication is not indicated for GORD. Barret's oesophagus, GORD and oesophageal adenocarcinoma are less common in patients positive for H pylori.
- Long term PPI treatment is safe (but should be used at the minimum effective dose) (3)
- 10-20% of people have episodes of reflux more than weekly and is a common reason for referral.
- Mechanisms causing reflux
    - Reflux through gastro-oesophageal junction
    - Reduced clearance of acid from oesophagus
    - Hypersensitivity to acid.
- Nocturnal reflux is associated with severe oesophagitis and intestinal metaplasia (Barret's oesophagus) and can lead to sleep disturbance. Recommend trying to raising the head level during sleep.
- Extra-oesophageal symptoms include hoarseness, cough and asthma.

Review medications, in particular:

- Calcium antagonists
- Nitrates
- Bisphosphonates
- Theophylines

Lifestyle advice

Weight optimization, exercise, reduce ETOH, exclude food triggers (citrus, white bread etc.), review OTC alginate/antacid use, raising head position for sleep.

Patient education and reassurance.

Step up/Step down approach

- Step 0 - lifestyle advice as above +/- alginates (forms a viscous gum that makes a cap on the stomach preventing GOJ reflux)
- Step 1 – PPI (ensure 30-60 mins before food) or H2RA at lowest dose to control symptoms, daily or PRN (NICE suggest 1 month)
- Step 2 – Maximise PPI dose or use bd or try different PPI
- Step 3 – Add prokinetic such as Domperidone (Max 80mg per day) or metoclopramide (1 month trial)
- Step 4 – If there is a response, use low dose prophylaxis or PRN treatment to manage symptoms.
- Step 5 – If no response then consider referral for consideration of anti-reflux surgery (Nissen fundoplication)

Perform 6-12 month medication reviews to try and step down.

USS if history more suggestive of pancreatic or biliary origin.

Referral Information

Information to include in referral letter

- Details of primary care management to date
- Relevant past medical / surgical history
- Current regular medication
- BMI/ Smoking status

Investigations prior to referral

- FBC, U&E, LFT's
- USS if history suggestive of biliary/pancreatic involvement

Patient Information Leaflets/ PDAs

http://www.patient.co.uk/health/Dyspepsia-Non-ulcer-(Functional).htm
http://www.patient.co.uk/health/dyspepsia-indigestion
http://www.patient.co.uk/health/Helicobacter-Pylori-and-Stomach-Pain.htm

References

(1) NICE. Dyspepsia:Management of dyspepsia in adults in primary care. London: NICE 2004
(2) Gillen D, McColl KE. Does concern about missing malignancy justify endoscopy in uncomplicated dyspepsia in patient aged less than 55? Am J. Gastroenterol. 1999;94, 75-9
(3) BMJ. 10 minute consultation – Dyspepsia, 2011; 343: 6234.
(4) http://rms.kernowccg.nhs.uk/