Faculty Disclosure

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Dr. Goodman has listed no financial interest/arrangement that would be considered a conflict of interest.
WHEN TO ORDER INVASIVE TESTING/REFERRAL FOR GERD?

THE PRIMARY CARE PERSPECTIVE
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OBJECTIVES

1. Describe the typical patient presenting with GERD
2. Review the typical order of treatment for the patient presenting with GERD
3. Review the recommendations for referral and esophageal endoscopy
1. THE TYPICAL PATIENT PRESENTING WITH GERD
Usually: patients present with painful burning/heartburn/cough/sour taste/regurgitation in the throat

- Usually worse at night and after meals
- Usually patients have already identified some of their triggers
- Usually there has been only partial attempt at trigger avoidance 😊
Prior association with GERD and asthma was discounted in a recent study.
TYPICAL TRIGGERS

- Alcohol
- Soda pop
- Heavy meals
- Late meals
- Caffeine
- Big meals
RARELY IDENTIFIED TRIGGERS

- Mint
- Chocolate
- Abdominal obesity 😊
- Bending over
- Recumbancy
2. TYPICAL ORDER OF TREATMENT
Patients have often already tried over the counter products, such as calcium carbonate tabs, liquid anti-acids, gas reduction agents.

Often, too, they’ve tried the store brand H2 receptor-blockers, and sometimes the PPI’s.

Sometimes they have attempted the lifestyle factors, or propped up the headboard (rarely).
Lifestyle factors: smoking cessation, caffeine, soda, portion sizes, late night eating, and physical activity issues are addressed.

Secretagogues: identify with the patient things likely to increase stomach acid: caffeine, alcohol, nicotine, carbonation.
Ulcer risk is addressed: NSAIDS, prednisone,
Heliobacter pylori antibody is obtained, and treated with at least two weeks of triple therapy if identified
STEP-UP THERAPY

- Starting with H2 receptor blockers, and advancing to PPI’s as needed to control symptoms
STEP-DOWN THERAPY

- Starting out with PPI’s, and reducing to H2-RB’s if tolerated
3. WHEN TO REFER
- If there is relief (and there usually is), we might not see patients again for a long time (which might be risky)
- If there is treatment failure, or the patient is older than 45 years and more worrisome symptoms of weight loss/blood loss etc refer for GI consult
If PPI therapy is required for more than 16 weeks, patients are also advised to have endoscopy (but in practice, patients are occasionally on these meds for months or years without intervention).
EVIDENCE SUGGESTS

- that effective acid-suppression and symptom relief does NOT reduce the risk for progression to Barrett’s
- and does not reduce the risk of Barrett’s progressing to adenocarcinoma
So when in doubt: refer the patient for EGD!