Gastroesophageal Reflux Disease (GERD) in Adults
Reference # 248

Summary of Recommended Guideline

Gastroesophageal Reflux Disease (GERD) in Adults

Key Highlights from the Recommended Guideline

- Routine endoscopy is not required to diagnose GERD if there are no atypical or alarm features.
- PPIs are the preferred treatment for GERD and erosive esophagitis.

Scope: Physicians and other healthcare professionals involved in the care of patients with gastroesophageal reflux disease (GERD)

Does GERD really need to be treated?

- Realize that GERD significantly impairs health-related quality of life. [Level of evidence: I, A]
- Determine the severity of the patient’s GERD by considering the severity and frequency of symptoms, as well as reflux-related problems including esophageal erosions, ulcers, hemorrhages, strictures or Barrett’s esophagus (columnar metaplasia). [Level of evidence: I, A]

What is the best way to diagnose GERD in adults? When does the patient need an endoscopy? Do I need to test for H. pylori?

- Recognize the archetypal symptoms of GERD: heartburn (a retrosternal burning sensation that may rise to the back of the throat) and acid regurgitation. [Level of evidence: I, A]
- Also look for alarm features: vomiting, evidence of GI blood loss, anemia, involuntary weight loss, dysphagia or chest pain. [Level of evidence: III, A]
- Do not endoscope routinely to diagnose GERD. [Level of evidence: I, A]
- Use endoscopy to:
  - Investigate atypical or alarm features [Level of evidence: III, B]
  - Detect Barrett’s esophagus [Level of evidence: III, B]
  - Investigate dysphagia that has not resolved with 2-4 weeks of adequate PPI therapy [Level of evidence: III, C]
  - Determine the severity of erosive esophagitis (look for erosions or mucosal breaks) [Level of evidence: I, A]
- You do not need to test for Helicobacter pylori before starting treatment for typical GERD symptoms. [Level of evidence: I, B]

Which treatment options should I consider for GERD?

- First, suggest over-the-counter medications (e.g. alginates, antacids, low-dose histamine H2-receptor antagonists [H2RAs]) for mild symptoms, i.e. fewer than 3 episodes per week. [Level of evidence: I, A]
- Do not recommend lifestyle modifications for frequent or severe GERD symptoms. [Level of evidence: II-2, A]
• Do not choose prokinetic or promotility agents for routine initial treatment [Level of evidence: II-1, C] or for long-term treatment. [Level of evidence: I, A]

• For more severe symptoms use proton pump inhibitors (PPIs) instead of H2RAs to reduce heartburn and heal esophagitis (they reduce intragastric acidity more effectively). [Level of evidence: I, A]
  o Start with a once-daily PPI; twice-daily PPIs are not usually required. [Level of evidence: I, A]
  o Reassess the patient’s symptoms after 4-8 weeks of treatment. [Level of evidence: II-1, B]
  o Use twice-daily standard-dose PPI therapy if the patient has severe esophagitis (LA Grade C or D, or stricture). [Level of evidence: I, B]
  o After a good symptomatic response, consider discontinuing the PPI to ascertain whether the patient still needs ongoing therapy. [Level of evidence: II-3, C]
  o If the patient needs long-term maintenance therapy, use the lowest dose and frequency that controls the symptoms. [Level of evidence: III, B]
    • Consider using on-demand acid suppression therapy for some patients. [Level of evidence: I, B]
    • Reassure the patient that long-term PPI therapy is not associated with clinically significant adverse effects. [Level of evidence: II-2, A]

• If the patient does not respond adequately, try double-dose PPI therapy; do not add H2RAs. [Level of evidence: I, A]
  o Consider surgical antireflux therapy for selected patients. [Level of evidence: I, A]
  o Endoscopic antireflux procedures are not yet ready for clinical practice. [Level of evidence: II-3, D]

How should I screen for and manage the patient with Barrett’s esophagus?

• Screen patients with > 10 years of GERD symptoms for Barrett’s esophagus, but recognize that screening does not reduce mortality from esophageal adenocarcinoma. [Level of evidence: III, C]

• Do not recommend medical or surgical therapy to prevent the development or progression of Barrett’s esophagus (or development of esophageal adenocarcinoma). [Level of evidence: I, D]

• If you detect high-grade dysplasia for the first time, repeat the endoscopy in 3 months with a concentrated biopsy protocol and have an expert pathologist review all biopsies. [Level of evidence II-3, B]

• Consider ablation therapy for patients with high-grade dysplasia or esophageal adenocarcinoma who are not candidates for surgery. [Level of evidence: I, A]

Levels of Evidence

The levels of evidence used to grade the recommendations in this guideline are as follows:

<table>
<thead>
<tr>
<th>Quality of Evidence</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from at least one properly randomized controlled trial</td>
</tr>
<tr>
<td>II-1</td>
<td>Evidence obtained from well-designed controlled trials without randomization</td>
</tr>
<tr>
<td>II-2</td>
<td>Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one centre or research group</td>
</tr>
<tr>
<td>II-3</td>
<td>Evidence obtained from comparisons between times or places with or without the intervention, or dramatic results in uncontrolled experiments</td>
</tr>
<tr>
<td>III</td>
<td>Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Classification of Recommendations</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>There is good evidence to support the procedure or treatment</td>
</tr>
<tr>
<td>B</td>
<td>There is fair evidence to support the procedure or treatment</td>
</tr>
<tr>
<td>C</td>
<td>There is poor evidence to support the procedure or treatment, but recommendations may be made on other grounds</td>
</tr>
<tr>
<td>D</td>
<td>There is fair evidence that the procedure or treatment should not be used</td>
</tr>
<tr>
<td>E</td>
<td>There is good evidence that the procedure or treatment should not be used</td>
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</table>
The above recommendations were derived from the following GAC endorsed guideline:


Rating (out of 4): 🍈

**Endorsed Date:** December 2007  
**Planned Review Date:** December 2010

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