GAC GUIDELINES ADVISORY COMMITTEE

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]**
  - Start with a once-daily PPI; twice-daily PPIs are not usually required. **[Level of evidence: I, A]**
  - Reassess the patient's symptoms after 4-8 weeks of treatment. **[Level of evidence: II-1, B]**
  - 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]**
  - After a good symptomatic response, consider discontinuing the PPI to ascertain whether the patient still needs ongoing therapy. **[Level of evidence: II-3, C]**
  - 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]**
  - Consider surgical antireflux therapy for selected patients. **[Level of evidence: I, A]**
  - 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:

Quality of Evidence

I	Evidence obtained from at least one properly randomized controlled trial
II-1	Evidence obtained from well-designed controlled trials without randomization
II-2	Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one centre or research group
II-3	Evidence obtained from comparisons between times or places with or without the intervention, or dramatic results in uncontrolled experiments
III	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees

Classification of Recommendations

A	There is good evidence to support the procedure or treatment
B	There is fair evidence to support the procedure or treatment
C	There is poor evidence to support the procedure or treatment, but recommendations may be made on other grounds
D	There is fair evidence that the procedure or treatment should not be used
E	There is good evidence that the procedure or treatment should not be used

The above recommendations were derived from the following GAC endorsed guideline:

Armstrong, D., Marshall, J.K., Chiba, N., Enns, R., Fallone, C.A., Fass, R., et al. (2005, January). Canadian consensus conference on the management of gastroesophageal reflux disease in adults: Update 2004. *Canadian Journal of Gastroenterology 19*(1), 15-35.

Rating (out of 4): 

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