

key points

SELECTED BY

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GORD is defined as a condition which develops when the reflux of stomach contents causes troublesome symptoms and/or complications. Many patients with GORD complications such as oesophagitis, and up to a third of patients with Barrett's oesophagus have no reflux or heartburn symptoms. Conversely, patients can be symptomatic even when normal reflux levels are found and there is an absence of mucosal damage. Significant GORD symptoms are becoming more common and occur at least once a week in 8.8-26% of Europeans, with equal prevalence of symptoms in men and women.

The frequency and severity of symptoms do not accurately predict the degree of oesophageal damage. If patients with GORD also describe symptoms of dyspepsia this should be considered first with *Helicobacter pylori* testing or direct referral for gastroscopy if the patient is over 55 given the risk of gastric cancer in these patients.

Extra-oesophageal GORD should be considered for chronic cough. Oesophageal disease can account for up to 20% of cases of chronic cough. Guidelines on chronic cough suggest use of empirical treatment for GORD including a therapeutic trial of three to six months of treatment for GORD. Symptoms of GORD occur in more than 45% of patients with asthma, and erosive oesophagitis on endoscopy has a 50% higher likelihood of a diagnosis of asthma.

GORD is a risk factor for both Barrett's oesophagus and oesophageal adenocarcinoma. The risk increases with duration, severity and frequency. Endoscopy should not be routinely offered at initial presentation unless the patient has dysphagia or other symptoms suggestive of upper gastrointestinal cancer.

Smoking cessation and weight loss are beneficial in reducing GORD symptoms. Weight loss advice is a standard part of GORD management. Abdominal obesity causes GORD by elevating intra-abdominal pressure, which promotes reflux and the development of hiatus hernia. GORD symptoms are increased by 70% among daily smokers who have been smoking for more than 20 years.

If there is a clear history of GORD then empirical treatment with full dose PPI therapy for 4-8 weeks is recommended. If symptoms return a PPI is then restarted at the lowest dose possible to control symptoms. Patients with oesophageal complications of peptic stricture or Barrett's oesophagus require long-term PPI therapy to prevent recurrence or reduce cancer progression risk. Patients with no response to PPIs should be referred for further investigation of alternative causes other than GORD.

Only carefully selected patients should undergo fundoplication for reflux disease. Obesity is a major factor in the increased prevalence of GORD. Bariatric surgery, particularly gastric bypass, should be considered in appropriate patients.