

Madigan Army Medical Center

Referral Guidelines

Gastroesophageal Reflux

Diagnosis/Definition

Defined by a typical history of mid-epigastric or retrosternal burning pain, sour taste or gastric contents in the mouth after eating, aggravated by recumbency or bending and consumption of large, fatty or spicy meals and, if attempted, relieved with antacids.

Initial Diagnosis and Management

- History and response to therapy make the diagnosis.
- Physical exam is usually normal.
- Upper GI not required.
- Initial management should include lifestyle modifications (avoid fatty, spicy foods, chocolate, peppermint, coffee, tea, colas, alcohol; eat smaller meals, avoid recumbency 2-3 hours after eating; stop smoking; avoid tight clothing; maintain ideal body weight and elevate head of bed for nocturnal symptoms) and antacids or histamine type 2 receptor antagonists (H2RA)
- For cases that seem initially severe, an H2RA should be given BID with instruction on lifestyle modification.

Ongoing Management and Objectives

- If H2RA therapy is begun, therapy should be reassessed at 1–2 months.
- Patients responding to therapy should have a trial off medication.
- Patients with recurring symptoms > 3 months off therapy will require only intermittent maintenance therapy.
- Patients not responding to H2RA therapy should be started on daily proton pump inhibitor (PPI) therapy (taking 30 minutes before meals and NOT at bedtime) and reassessed in 1–2 months. If they continue to have significant symptoms, patients should be increased to BID therapy.
- Patients responding to PPI therapy can be considered for a trial off medication.
- Patients with extraesophageal symptoms (chronic cough, hoarseness, shortness of breath, asthma or non-cardiac chest pain, with or without reflux symptoms) should be given BID PPI therapy for 3 months to confirm the diagnosis.

Indications for Specialty Care Referral

- Patients with warning signs/symptoms: dysphagia, odynophagia, bleeding (hematemesis/melena), iron deficiency anemia, significant weight loss, and/or family history of esophageal or gastric cancer require a GI evaluation.
- Patients with history of GERD > 5 years require a referral for endoscopy to rule out Barrett's esophagus. (Highest risk patients: Caucasian males who are > 50 years of age)

- Patients not responding to BID PPI after 6-8 weeks of continuous therapy.
- Patients with extraesophageal symptoms confirmed to be caused by GERD by response to high dose PPI therapy should be referred for endoscopy to rule out Barrett's esophagus.
- Patients with Barrett's esophagus need endoscopy at least every 1-3 years to rule out dysplasia (pending on the length of Barrett's epithelium)

Criteria for Return to Primary Care

- Completed endoscopy and outline of chronic care plan.
- Patients with Barrett's esophagus or esophageal stricture can be managed by primary care providers with intermittent referral for endoscopy (at least every 1-3 years for Barrett's and for recurrent dysphagia with history of stricture).

Last Review for this Guideline: **June 2011**

Referral Guidelines require review every three years

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator