

Optimizing the Management of Gastroesophageal Reflux Disease and Its Complications

This Special Report supplement to *The American Journal of Managed Care* reviews the current paradigm changes in gastroesophageal reflux disease (GERD) and in the diagnosis and treatment of Barrett's esophagus. The articles presented here are summaries of presentations from 2 symposia that took place during the Digestive Diseases Week conference in San Diego, California, on May 22 and 24, 2000.

In "Managed Care Issues in the Treatment of Gastroesophageal Reflux Disease," Kenneth R. DeVault, MD, reviews the decreased quality of life that patients with GERD experience. GERD significantly impacts quality of life to an extent similar to other chronic diseases such as diabetes and hypertension. Dr. DeVault also examines the effectiveness of the current step-up/step-down philosophy embraced by some managed care plans. That philosophy is critiqued by examining the efficacy of proton pump inhibitors (PPIs) and histamine-2 receptor antagonists in different severity grades of esophagitis.

There are several complications of acid reflux, including damage to the esophagus, posterior laryngitis, chronic coughing, recurrent pneumonitis or nocturnal choking, chronic hoarseness, pharyngitis, and dental disease. In the presentation "Maximizing Outcome of Extraesophageal Reflux Disease," Peter J. Kahrilas, MD, reviews the data that indicate that

acid reflux has a role in asthma and posterior laryngitis and discusses the role of acid-induced tracheopulmonary damage in patients with chest pain.

The detection of supraesophageal GERD is difficult because readily identifiable "markers" have not been defined. In "Changes in the Hypopharynx May Suggest Supraesophageal Reflux Disease," Paul F. Castellanos, MD, offers a practical approach to help identify reflux damage landmarks in the hypopharynx, given the limitations of current endoscopy technology.

In "Diagnosing and Managing Barrett's Esophagus," Richard E. Sampliner, MD offers a definition for Barrett's esophagus, differentiating short- and long-segment Barrett's esophagus. Surveillance strategies are discussed based on risk stratification and the natural history of high-grade dysplasia. Dr. Sampliner also reviews the possible role of p53 mutations in the development of esophageal adenocarcinoma.

Short-segment Barrett's esophagus has its own set of challenges, partly because it has never been clearly defined. It is difficult to observe endoscopically, and the risk of its progression to cancer is not yet known. Therefore, the decision to include short-segment Barrett's esophagus in screening and surveillance practices is in dispute. In "Guidelines for Managing Short-Segment Barrett's

Esophagus,” Stuart J. Spechler, MD reviews the American College of Gastroenterology guidelines for diagnosis, surveillance, and therapy of Barrett’s esophagus and short-segment Barrett’s esophagus; the cellular changes observed with Barrett’s esophagus at or near the gastroesophageal junction; and the importance of where metaplasia appears with regard to the appropriate location to biopsy and the risk of cancer.

The concept of total acid suppression has been proposed as a requirement for long-term treatment and prevention of Barrett’s esophagus. In “Total Acid Suppression and Its Effect on Barrett’s Esophagus,” Donald O. Castell, MD, reviews the origin of the total acid suppression hypothesis and the effects of high-dose PPI therapy on 24-hour pH readings in patients with Barrett’s esophagus.

A review of ablative therapies is presented by M. Brian Fennerty, MD

in “Ablative Therapies for Barrett’s Esophagus,” with an emphasis on adjuvant antireflux pharmacologic (PPI) or surgical therapy. Ablative therapies are not recommended for all patients with Barrett’s esophagus so a review of the characteristics of appropriate candidates and the potential for incomplete ablation is discussed.

Finally, in “Evaluating Treatments of Barrett’s Esophagus That Shows High-Grade Dysplasia,” Bergein F. Overholt, MD, reviews the possible role of antireflux therapy and photodynamic therapy (PDT), currently a research technique, in treating Barrett’s esophagus. The principles of PDT are reviewed as well as the work up, logistics, injury, and complications associated with this procedure. The treatment results to date are reviewed, and PDT is compared with surgery in terms of hospital length of stay, stricture development, time to return to work, and cost.