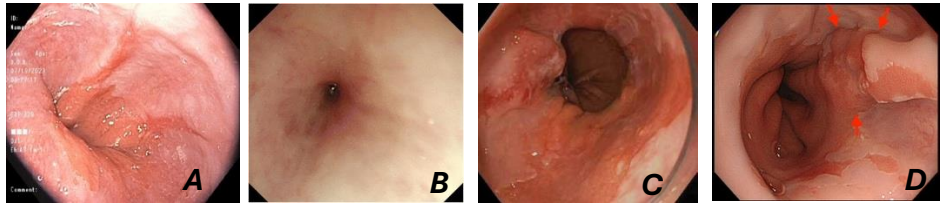
ASGE Guideline on the Diagnosis and Management of GERD

By: Luis M. Nieto, M.D.

Background

- Gastroesophageal reflux disease (GERD) is characterized by persistent heartburn and/or regurgitation.
- Is the most prevalent gastrointestinal condition, impacting about one-third of the adult population in the United States.

- Chronic uncontrolled acid reflux can cause several adverse outcomes, including:
  - Image A - Erosive esophagitis.
  - Image B - Peptic stricture.
  - Image C - Barrett's esophagus (BE).
  - Image D - Esophageal adenocarcinoma.
- The incidence of GERD and its complications are rising alongside the global increase in obesity prevalence.
- GERD can also lead to:
  - Reduced quality of life.
  - Higher healthcare costs due to frequent physician visits, endoscopies, and treatment of GERD-related complications.



A, Simadibrata DM, et al.. Clin Endosc. 2023 Nov;56(6):681-692. B, Yamasaki Y, et al. Surg Case Rep. 2016 Dec;2(1):64. C, Gill RS, et al. Ann Gastroenterol. 2012;25(2):89-95. D, Ishihara R, et al. J Gastroenterol. 2019 Jan;54(1):1-9. doi: 10.1007/s00535-018-1491-x. Epub 2018 Jun 30.

When to Perform Endoscopy

Recommendation #1a:

- Alarm symptoms :
  - Dysphagia, odynophagia, weight loss, GI bleeding, persistent vomiting, or unexplained iron deficiency anemia.

(Strong recommendation)

- No alarm symptoms but BE risk factors:
  - Family history of BE or esophageal adenocarcinoma.
  - GERD plus another risk factor (50 years, male sex, white race, smoking, or obesity).

(Conditional recommendation)

- In infants and children with suggestive symptoms:
  - Poor weight gain.
  - Unexplained anemia.
  - Concern for GI bleeding.
  - Recurrent pneumonia.
  - Regurgitation and/or vomiting.

(Conditional recommendation)

Endoscopy post Sleeve Gastrectomy (SG)

Recommendation #1b:

- In patients who had SG with reflux symptoms.
- For patients with SG who are asymptomatic at 3 years after SG and then every 5 years thereafter.
- If BE is detected, follow-up according to existing BE surveillance guidelines.

(Conditional recommendation)

Endoscopy Post Peroral Endoscopic Myotomy (POEM) and Reflux Symptoms

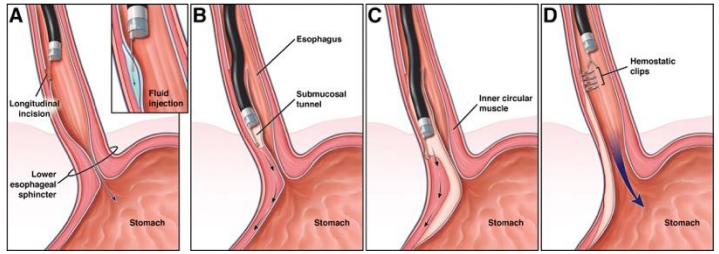
Recommendation #1c:

- In patients who had POEM and have symptomatic GERD.

(Conditional recommendation)

Best Practice Advice

- In patients who have undergone POEM:
  - Endoscopists should be aware of the high rate of GERD following the procedure.
  - Periodic endoscopic evaluation should be considered even in asymptomatic patients.



POEM Figure. Khashab MA, et al. Gastroenterology. 2019 Nov;157(5):1184-1189.

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High Quality Endoscopy Procedure and Reporting Criteria

Recommendation #2:

- Careful endoscopic evaluation, reporting and photo-documentation of:

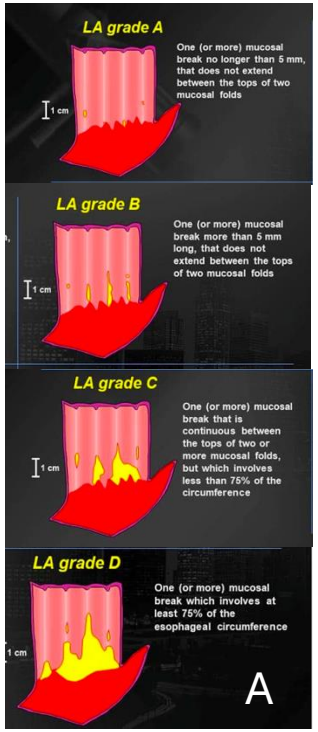
<u>Objective GERD findings, when present:</u>

- ➢Erosive esophagitis (using the Los Angeles [LA] grading system).
- ➢BE (using the Prague classification).
- ➢Peptic stricture.

<u>Gastroesophageal junction landmarks and integrity:</u>

- ➢Hiatal hernia (HH) dimensions using Hill grading or American Foregut Society grading in forward view and retroflexion.
- ➢Location of top of gastric folds, Z line, diaphragmatic impression.
- ➢Fundoplication description (if present).

(Strong recommendation)



Only Los Angeles Grades C and D esophagitis provide objective evidence of GERD.

Proton Pump Inhibitors (PPIs) in Patients with GERD

Recommendation #4:

- In patients with symptomatic and confirmed GERD with predominant heartburn symptoms:
  - ➢ Recommends medical management with PPIs at the lowest possible dose for the shortest possible period of time.
  - ➢ At the same time initiate discussion about long-term management options.

(Strong recommendation)

- In patients with suboptimal clinical response to PPI therapy:
  - ➢ Suggests testing CYP2C19 polymorphism.
  - ➢ Adjusting PPI dosage and/or selection accordingly.

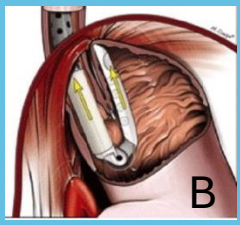
(Conditional recommendation)

Transoral Incisionless Fundoplication (TIF) in Persistent GERD

Recommendation #5a:

- As an alternative to chronic medical management in patients with confirmed GERD and a small HH (≤2 cm) and Hill grade 1 or 2 who meet any of the following criteria:
  - ➢ Chronic GERD (≥6 months).
  - ➢ Chronic PPI use (≥6 months) for management for GERD symptoms.
  - ➢ Refractory GERD.
  - ➢ Regurgitation-predominant GERD.
  - ➢ Patient preference for avoidance of long-term PPI use.

(Conditional recommendation)



Hiatal Hernia Repair Combined with TIF for GERD Management

Recommendation #5b:

- Suggests evaluation for combined HH repair and TIF (cTIF) in a multidisciplinary review in patients with confirmed GERD and a large HH (>2 cm) and Hill grade III or IV.

(Conditional recommendation)

Lifestyle Interventions Should Be Recommended to Reduce GERD symptoms

Recommendation #3:

- ➢ Weight loss for patients who with overweight or obesity.
- ➢ Smoking cessation.
- ➢ Elevating the head of the bed.
- ➢ Avoiding meals within 3 hours of bedtime.
- ➢ Reduced intake of certain foods and beverages showed no conclusive benefit in improving GERD symptoms.

(Strong recommendation)

Best Practice Advice

- Patients who have been on chronic PPI therapy (>6 months) should be considered for optimization and de-escalation of medical management.
- Providers should carefully consider the risks, benefits, and alternatives of PPI use for patients with GERD.
- Providers prescribing PPI therapy should be aware that adverse events from PPIs in prospective data have been limited to a modest increased risk of enteric infections.

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A. LA grading for erosive esophagitis. (Lundell L, et al. Gut 1999;45:172-80.)
B. Pearl (et al. Surg Endosc 31, 3783–3790 (2017))

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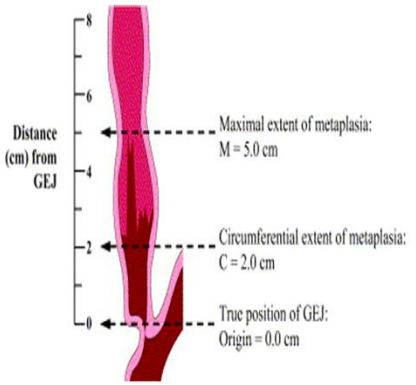
Radiofrequency Energy to the Lower Esophageal Sphincter for Persistent GERD

Best Practice Advice

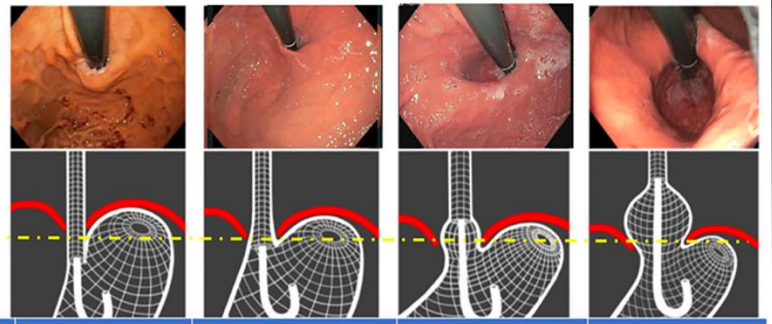
- In patients with confirmed GERD, a small HH (<2 cm), and Hill grade I or II, radiofrequency energy to the lower esophageal sphincter can be considered when other alternatives (endoscopic/surgical fundoplication) are not available or feasible.

- Hill grading is focused mainly on flap valve compared to the more comprehensive AFS grading.



A

Hill Grading & AFS Hiatus Grade



AFS Hiatus Grade	1	2	3	4
Hiatal axial Length, cm (L)	None (0 cm)	None (0 cm)	0-2 cm	>2 cm
Hiatal aperture, cm (D)	Snug to scope 1 cm	Loose 1-2 cm	Open 2-3 cm	Wide open >3 cm
Flap valve (F)	Present, full lip with Omega shape (F+)	Absent, thinning & flattening valve lip (F-)	Absent (F-)	Absent (F-)
LDF components	L0, D1, F+	L0, D1-2, F-	L0-2, D2-3, F-	L>2, D>3, F-

B

A, Prague classification for Barrett's esophagus. (Sharma P, et al. Gastroenterology 2006;131:1392-9.)
B, AFS classification for integrity of the antireflux barrier. (Nguyen N, et al. Foregut 2022;2:339-48.)

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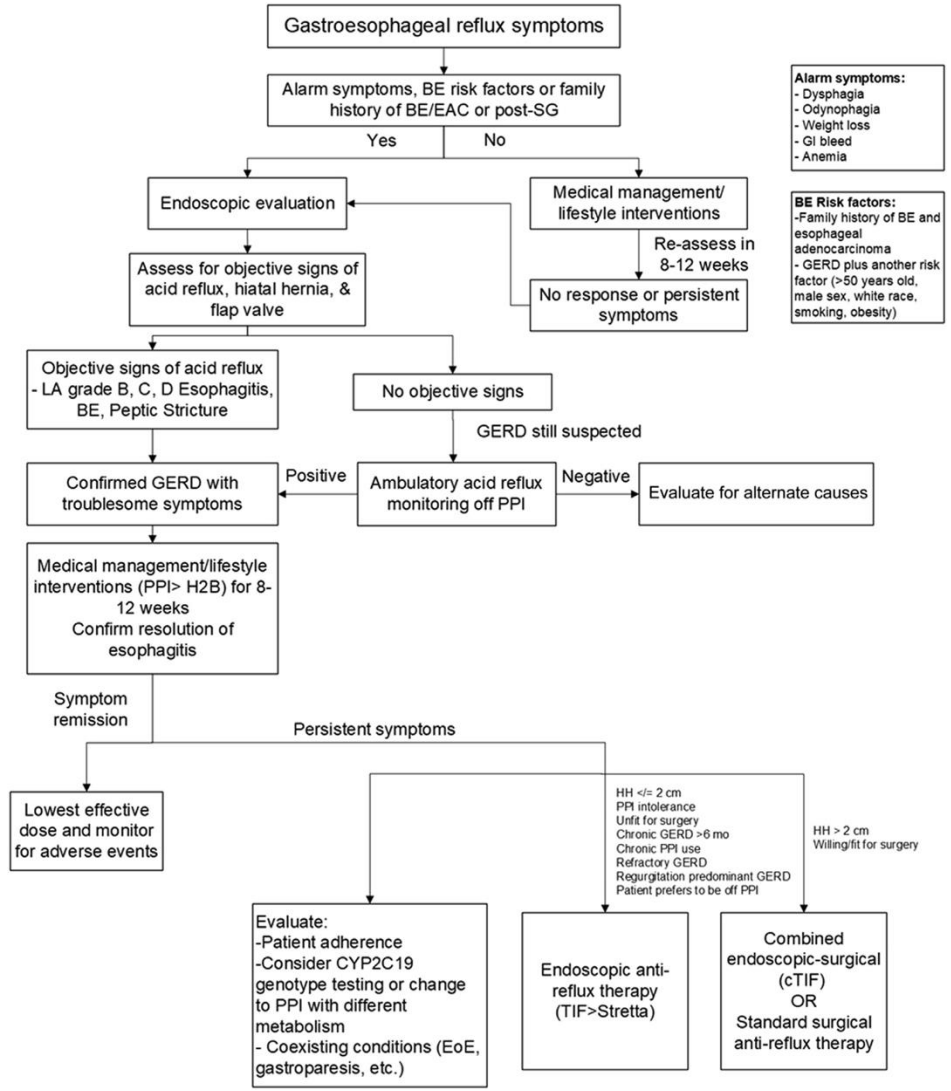
Simplified Algorithm of Recommendation



BE, Barrett's esophagus; EAC, esophageal adenocarcinoma; SG, sleeve gastrectomy; LA, Los Angeles classification; PPI, proton pump inhibitor; H2B, histamine-2 receptor antagonists/blockers; HH, hiatal hernia; TIF, transoral incisionless fundoplication; cTIF, combined TIF and hiatal hernia surgery; EoE, eosinophilic esophagitis.