Best Practice Guideline

GERD

Diagnosis and Screening

Patients with symptoms consistent with GERD should be questioned about GERD-provoking behaviors, educated about GERD lifestyle modifications, and started on acid suppression trial

Treatment and Management

- Favor starting with PPI when acid suppression given – increased likelihood that first line antacids or H2RA will fail – daily H2RA therapy impacted by tachyphylaxis. Start with PPI doses like omeprazole or pantoprazole 20- 40mg/day or lansoprazole 15-30mg/day. Plan to taper after 2-3 months of therapy once symptoms have improved

- Patients with advanced age (50 often used as threshold), chronic symptoms (5 years often used as threshold), and/or alarm symptoms (dysphagia/vomiting/bleeding/weight loss, etc.) should get referred to GI for EGD

- Patients without advanced age/chronic symptoms/alarm symptoms should get referred to GI for EGD if they fail to respond to GERD lifestyle modifications/acid suppression (i.e. persistent symptoms) after 6-8 weeks of continued therapy.

Surveillance and Follow Up

- If patients fail to respond to PPI daily X 8 weeks reasonable to try another PPI or keep same PPI and increase dose to twice daily while waiting for Endoscopic evaluation

- If no improvement with Twice daily Max dosing regimen after 6-8 weeks then consider Bravo Ph with or without impedance testing vs Baclofen therapy vs surgical interventions (i.e. Nissen fundoplication)

References:

Philip O. Katz, Lauren B. Gerson and Marcelo F. Vela
Am J Gastroenterol 2013; 108:308–328; doi: 10.1038/ajg.2012.444

The role of endoscopy in the management of GERD
Gastrointest Endosc 2015;81:1305–1310

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