Update on GERD: New Guidelines From the ACG

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The American College of Gastroenterology (ACG’s) last update to its gastroesophageal reflux disease (GERD) guideline was published in 2005, so February’s publication of Katz (Einstein-Philadelphia), Gerson (Stanford), and Vela’s (Baylor) synthesis of more current treatment standards is welcome—this is the ACG’s new guideline.¹ Here’s what’s new compared with the 2005 guideline:

1. **Lifestyle recommendations:** Weight loss is recommended as an effective lifestyle approach to the treatment of GERD (“moderate level of evidence”). In the context of our continuing obesity epidemic and parallel increases in GERD, this comes as no surprise. Head of bed elevation for patients with nocturnal GERD symptoms was also recommended, but note that the authors cited only “low level of evidence.” As for the other key lifestyle modification often recommended, the group did not recommend avoidance of foods conventionally thought to provoke reflux—this is not routinely advised for most GERD patients because of the lack of an evidence base.

2. **Helicobacter pylori testing and treatment?** Routine screening and treatment for infection are not recommended—evidence is insufficient to support the expectation that testing and treatment will affect GERD symptoms. This despite a European recommendation in favor of testing in this group because of concerns about the risk of atrophic gastritis in infected patients; the current US guideline committee considered the evidence in favor of testing to be weak and based on a single flawed study.

3. **Biopsy the distal and mid-esophagus for eosinophilic esophagitis (EoE) if your index of suspicion is high:** The guideline continues to advise against routine biopsies of the distal esophagus to diagnose GERD. But the recommendation shifts when EoE is suspected (for example, in patients with GERD and dysphagia or patients with refractory GERD). EoE has become more common since the publication of previous guidelines (or awareness of it has increased—the authors cannot distinguish based on current evidence).

4. **Safety of long-term proton pump inhibitors (PPIs):** This has been a crucial question because PPIs remain the mainstay of therapy for GERD.
   a. **Fracture risk with long-term PPIs?** The current guideline downplays the likelihood that PPIs are associated with fractures (citing “strong evidence” against avoidance of PPIs), but the group noted one exception: patients with other risk factors for hip fracture. This is consistent with 2012 findings from the Canadian Multicentre Osteoporosis Study reviewed in ConsultantLive.
   b. **Risk of cardiovascular events in patients using PPIs and clopidogrel?** The group did not find strong evidence for increased risk.
   c. **Clostridium difficile infection:** PPI therapy does appear to be a risk factor (“moderate level of evidence”).

   Given their effectiveness and lack of evidence suggesting long-term risk for most of the serious side effects, PPIs remain the mainstay of therapy for GERD. Maintenance therapy is appropriate for patients with GERD-associated complications. There is no evidence for superiority of any of the currently available products—they can be considered equivalent and all should be used in the lowest effective dose for patients who require long-term therapy, with consideration of on-demand or intermittent use.

5. **Extra-esophageal symptoms:** GERD is a co-factor in patients with cough, laryngitis, and
asthma. While a PPI trial can be recommended in patients who also have typical GERD symptoms, reflux monitoring should be considered before a PPI trial in patients without GERD symptoms. Evaluation for non-GERD causes should occur in all patients.

6. **Endoscopic therapy is not recommended for GERD.**

7. **Obese patients with GERD should consider gastric bypass surgery as treatment for heartburn symptoms.**

   Given the realities of the obesity epidemic, GERD will increase in prevalence with the aging of the baby boomers. Appropriate and cost-effective use of PPIs will continue to be major tasks for primary care clinicians.

**Reference**


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