

Suggested Guidelines for Endoscopies for Gastroesophageal Reflux Disease (GERD)

**Provided By Massachusetts Medical Society and its
Expert Panel of Gastrointestinal (GI) Specialists**

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The MMS worked in collaboration with Blue Cross Blue Shield of Massachusetts, who provided Network Data on utilization, specific to endoscopies with the diagnosis of GERD.

Goals

- Share suggested guidelines with gastrointestinal (GI) specialists and primary care physicians.
- Share guidelines with Blue Cross Blue Shield of Massachusetts and track changes over 2 years.
- Reduce unnecessary repeat endoscopy (reduce variability in endoscopy and endoscopy with biopsy), and encourage cost-effective quality care.

Background

- Initial meeting with GI specialists and primary care physicians to hear from BCBSMA about tremendous variation in their network regarding utilization of endoscopies for GERD. Follow-up meetings with advisory group of GI specialists and the chairs of the Committee on the Quality of Medical Practice to develop suggested guidelines.

The expert panel proposed the following.

Definition

Heartburn: Typically an intermittent, ascending burning sensation in the chest usually caused by regurgitation of gastric contents. This should be distinguished from functional dyspepsia, which usually consists of symptoms of epigastric pain or a burning sensation that lasts for hours and is often associated with bloating, nausea, or both.

Patients with GERD should be managed by their primary care doctors with various treatment strategies, including H2 blockers and lifestyle changes (avoid chocolate, peppermint, alcohol, coffee, other caffeinated beverages, no food ingestion within 3

hours of going to bed, elevation of the head of the bed 3-6 inches). Additionally, if needed, a proton pump inhibitor (PPI) should be taken in lieu of the H2 blocker and should be administered 20-30 minutes before the first meal of the day, with an increasing dose (twice a day; second dose before dinner) as needed to control symptoms.

1. *Warning signs*
 - a. Weight loss
 - b. GI bleeding reported or found (e.g., melena, guaiac-positive stool)
 - c. Anemia
 - d. Dysphagia/odynophagia
2. *Appropriate medical therapy*
 - a. Correct medication regimen (e.g., a proton-pump inhibitor, once daily in the majority of patients). Prescribed appropriately (i.e., first dose before breakfast, containing an acid stimulant such as milk).
 - b. Patient adheres to regimen.
 - c. Patients with GERD requiring H2 blocker or PPI therapy. It is imperative that PPIs, regardless of the specific formulation employed, be taken 20 to 30 minutes before the first meal of the day, although the medication can also be administered with a glass of milk or with yogurt. For PPIs to be maximally effective, patients must consume a meal or a liquid that stimulates acid secretion by alkalinizing the stomach. If a patient continues to have symptoms after taking a standard, or an increased dose of PPI before the initial daily meal for a specified and reasonable period determined by the physician (generally 2-6 weeks), he or she should be referred to a gastroenterologist for further evaluation.
3. *Stable symptoms*
 - a. Not waking up at night with heartburn
 - b. Not having to stop work or activities because of heartburn
 - c. No warning signs
4. *Extra-intestinal manifestations of GERD*
 - a. Non-cardiac chest pain (NCCP)
 - b. Hoarseness and other voice disturbances
 - c. Coughing, wheezing

Guidelines for performing endoscopy

1. For a diagnosis of GERD:
 - a. Routine endoscopy is not indicated unless there are *warning signs* to evaluate a patient for the diagnosis of acute GERD.
 - b. Routine endoscopy is not indicated unless the patient has failed to note improvement with appropriate medical therapy administered for a specified

and reasonable time period determined by the physician, as discussed in detail above.

2. For the evaluation of a patient with chronic GERD (one goal is to reduce unnecessary repeat endoscopies) :
 - a. It is appropriate to perform endoscopy in adult patients (both men and women) regardless of age who have chronic stable GERD without *alarm symptoms* if the patient has not undergone a prior endoscopy.
 - b. It is reasonable to obtain biopsies of the lower end of the esophagus even if the appearance is normal on the first endoscopy in a patient with chronic GERD.
3. If a patient with chronic GERD has undergone a prior endoscopy, repeat endoscopy is not indicated unless:
 - a. Symptoms are not stable with *appropriate medical therapy*.
 - b. The patient develops *warning symptoms*.
 - c. The patient has *Barrett's esophagus*
4. Prior to performing a repeat endoscopy in a patient with chronic GERD who does not have *stable symptoms* with *appropriate medical therapy* and who has undergone a prior endoscopy:
 - a. The primary care physician should see the patient and confirm that correct medications for control are prescribed and are being taken appropriately (i.e., before a breakfast consisting of food, such as milk, that stimulates acid secretion).
 - b. If symptoms persist with correct medical management, referral to a GI specialist for evaluation is appropriate to determine whether any changes in management, including repeat endoscopy, are indicated.
5. In a patient with GERD who has erosive esophagitis (e.g., ulceration) found during the initial endoscopy, mucosal architectural distortion due to the inflammatory process could obscure and prevent an accurate diagnosis of Barrett's metaplasia or dysplasia. It is thus reasonable to perform repeat endoscopy after a minimum of 8 weeks of *appropriate medical therapy* for the purpose of performing biopsies to determine the presence of Barrett's esophagus.

Note:

If there is doubt about the diagnosis of Barrett's metaplasia or dysplasia associated with Barrett's, the slides should be reviewed by an expert GI pathologist.
For patients with routine GERD who have never used a PPI, consider the use of a generic PPI.

These suggested guidelines do not address the management of Barrett's esophagus. The management of Barrett's esophagus and the role of endoscopy are outside the scope of clinical guidelines that address the role of endoscopy in uncomplicated GERD.

References

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These guidelines are available online at www.massmed.org/GERD