

## **Asia Pacific Consensus on GERD**

**Kwong-Ming Fock**

**Clinical Professor, Faculty of Medicine, National University of Singapore**

The third consensus on GERD in the Asia Pacific Region continues to clarify the investigation and treatment of gastro-oesophageal reflux disease which has been rising in incidence throughout the region. In the past two decades, much of the current knowledge is based on Western data as the West has seen a rise in GERD earlier. Since 2003, researchers have steadily build up experience in investigating and treating the disease. The report shows that there are similarities and differences within the region and the West

Epidemiological data throughout the region showed that the prevalence of symptomatic GERD in the community is rising in the Asia Pacific Region although within each country there are regional differences. Data on reflux esophagitis in asymptomatic subjects undergoing health screening have shown a similar trend. However, the severity of erosive esophagitis remains mild. The contributing factors that have caused the increase in GERD is overweight and obesity and the odds ratio for BMI  $\geq 25$  was 1.3 in Korea, and in a study in Taiwan BMI  $\geq 30$  had a odds ratio of 3.8 for erosive esophagitis.

Patients who have been treated with PPI for 8 weeks and have persistent troublesome GERD symptoms are deemed to be PPI. The causes of failure to respond to PPI fall into 3 categories:

- 1) GERD related – due to insufficient inhibitor of gastric acid secretion or on-going non-acid reflux
- 2) Non-GERD related
- 3) Reflux sensitivity

GERD related causes include wrong dosing (particularly before evening meals and not at bedtime), inadequate doses of PPI which may be contributed by CYP2C19 polymorphism, overweight and obesity. Changing to another PPI, correct dosing or increasing the dose of PPI and weight reduction are measures that would help the patient.

As for non-GERD causes, oesophageal motility disorders, achalasia, scleroderma, pill oesophagitis need to be considered. For patients with extra-oesophageal symptoms it is particularly important to review the diagnosis with other specialists – cardiologists, respiratory physicians etc. before further investigation. Upper GI endoscopy (if not already performed), is performed to exclude upper GI pathology (tumour, eosinophilic oesophagitis, pH oesophagitis). If the endoscopic features are in keeping with GERD (erosive or non-erosive oesophagitis) optimizing PPI therapy or changing to a new PPI would benefit a subset of patients. Addition of prokinetics, H<sub>2</sub> blockers at bedtime, alginates or antacids could improve control of reflux symptoms in some patients. Further investigations are indicated in individuals with persistent symptoms such as ambulatory pH monitoring and pH-impedance study, and if all tests are negative it can be

considered as functional heartburn. Tricyclic anti-depressants, SSRIs have been used but response is variable.

In regions where such tests are unavailable, a therapeutic trial of pain modulators is an useful alternative. Surgery in experienced hands is a treatment option for individuals with refractory reflux symptoms. It is however not recommended in patients with normal oesophageal / pH / impedance studies and no response to PPI. Endoscopic therapy should be performed in the context of a clinical trial.

The prevalence of Barrett's oesophagus in Asia Pacific region remains low and the most common type is short segment. Excluding ultrashort segment Barrett's oesophagus (<1cm) the prevalence in Japan are comparable to the rest of Asia. Ethnicity is a factor for Barrett's oesophagus, together with older age, weak gender and long duration of reflux symptoms. In this third consensus, the criteria for diagnosis of Barrett's oesophagus is replacement of the distal squamous epithelium limp by columnar epithelium. This must be clearly viable endoscopically ( $\geq$  1cm above GEJ) and confirmed by histology. Intestinal metaplasia is not required as it takes 8 biopsies to diagnose IM with a yield of 67.9%. Moreover, non-goblet columnar metaplasia has similar neoplastic potential as IM. The consensus further states that there is no value for screening for Barrett's oesophagus in Asia Pacific region. In the absence of dysplasia, there is no proven benefit in endoscopic surveillance of Barrett's oesophagus. Advanced endoscopic imaging including NBI can increase the risk of detection of dysplasia.