

Introduction

Gastroesophageal reflux disease (GERD) is among the most common disorders encountered in primary care. Endoscopy, ambulatory pH monitoring, and effective antisecretory and surgical therapy have enhanced our ability to manage this disorder.

However, despite its familiarity and apparent simplicity, GERD challenges the clinician's ability to discriminate patients who can be safely managed with reassurance, lifestyle measures, and patient-controlled therapy from patients who require aggressive antisecretory therapy or referral for diagnostic procedures.

In this issue of **Clinical Cornerstone**[®], we present an update on the diagnosis and treatment of GERD and its complications. Our goal is to provide an understanding of GERD that will help the primary care clinician make the potentially critical decisions about short- and long-term management. Although new data and insights better define the issues involved, those decisions still rest on the judgment of the primary care clinician.

First, Ronnie Fass, MD, FACP, FACG, and I consider the major subtypes of GERD: erosive esophagitis, Barrett's esophagus, and nonerosive reflux disease. These subtypes are clinically relevant because they differ in pathophysiology, clinical presentation, diagnosis, and therapy.

Next, Ronnie Fass, MD, FACP, FACG, Jimmy Bautista, MD, and Sailajah Janarthanan, MD, review current therapeutic modalities for GERD. Unless there are complications, the authors argue that symptom relief is the goal of therapy. Furthermore, GERD is a chronic, recurrent disease, so continuous maintenance therapy is often indicated. Some patients who have mild symptoms or who have flares only during stressful periods do well with as-needed therapy. The primary care clinician must decide whether symptom severity warrants starting with a proton pump inhibitor (PPI), or whether the patient will be satisfied and adequately treated with lifestyle measures and an H₂-receptor blocker.

Michael Vaezi, MD, PhD, provides an overview of the extraesophageal manifestations of GERD, which include laryngitis, asthma, cough, and noncardiac chest pain. Diagnosis of these extraesophageal manifestations requires a high level of suspicion because most patients do not have heartburn or regurgitation to indicate underlying GERD.

Stuart Spechler, MD, discusses the esophageal complications of GERD. The complications related to erosive disease can be effectively managed with PPI therapy, but there is no evidence that medical or surgical therapy prevents progression to esophageal adenocarcinoma. In patients with longstanding GERD, there remains no alternative other than endoscopy to detect Barrett's intestinal metaplasia. In patients with Barrett's, only periodic endoscopy can detect dysplasia or early adenocarcinoma. One unexplained factor with important clinical implications is the strong predilection of these complications for white males. When are the data compelling enough to warrant focusing surveillance on this at-risk population?

Radu Tutuian, MD, and Donald O. Castell, MD, consider the natural history of GERD and examine long-term medical and surgical outcomes. They highlight a challenging problem: esophageal acid reflux explains only 20% of GERD-like symptoms refractory to PPI therapy. What proportion of refractory symptoms is due to nonacid reflux that might benefit from surgery? What proportion is due to extraesophageal mechanisms? New diagnostic modalities have promise to answer these questions.

One consistent theme is that although current data are scant and do not delineate treatment guidelines, refractory GERD requires thoughtful assessment and treatment, integrating both biomedical and psychosocial modalities, to meet the challenge these patients face.

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