Dr Bernard Chin, Gastroenterologist

Interpreting oesophageal pH & manometry for GPs, Part 1

As you are aware, access to a modern oesophageal testing lab has been available through our private rooms for well over 6 months. This has assisted us in diagnosing problematic patients who are thought to have “reflux” but have not followed the script in terms of response to conventional medications. This update will help GPs interpret the results which, at times, can be quite technical.

Patient 1 : Typical reflux symptoms responsive to PPIs

This patient had typical acid reflux symptoms but required high doses of PPI, sometimes with concurrent antacids or prokinetic agents, to help with breakthrough symptoms. An oesophageal study was performed to reveal normal manometry (ruling out dysmotility conditions, which are a contraindication to anti-reflux surgery). A Bravo capsule was deployed endoscopically (a pH sensor within a disposable capsule that is attached to the lower oesophageal mucosa with a pin and detaches within a few days). This captures significant reflux episodes with GOOD CORRELATION with patient symptoms. This patient was referred for a fundoplication and achieved excellent symptomatic relief with only occasional use of PPIs.

Patient 2: Typical acid reflux symptoms unresponsive to PPIs+ prokinetic agents

Oesophageal testing is very important for these patients as they have had no response to maximal medical therapy for reflux. Oesophageal manometry was normal. Oesophageal pH did not show significant reflux episodes and there was no correlation with patient symptoms. These patients most likely have “hypersensitive oesophagus” – that is they experience typical symptoms of acid reflux without the prerequisite stimulus of a low enough pH. These patients can be very difficult to treat and respond poorly to fundoplication and therefore should not be pushed down the surgical pathway. They are probably best treated as “chronic pain” patients with CBT, lifestyle modifications (essentially weight loss if BMI is over 25), food elimination (if a food diary is useful for symptom production), and a trial of pain modulators such as Tricyclic Antidepressants (TCA) - like Nortriptyline.

Next Episode: Laryngopharyngeal Reflux (LPR) and volume reflux.

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About Dr Bernard Chin

Dr Chin graduated from the University of Adelaide and completed his Gastroenterology training in Sydney. He has an interest in the latest endoscopic obesity treatments and bowel cancer screening. He is the founder and principal of Cairns Gastroenterology since 2007, operating at both Cairns Private Hospital and Cairns Day Surgery.

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