Dr Bernard Chin, Gastroenterologist

Interpreting oesophageal lab tests for GPs, Part 2

Laryngo-pharyngeal reflux (LPR)

LPR is a difficult medical entity from both the diagnostic and the therapeutic points of view. Patients usually present with aero-digestive symptoms of dysphonia, chronic cough, globus, throat clearing and excessive throat mucous. Whether they are referred to an ENT specialist, Respiratory Physician or Gastroenterologist really depends on the predominant symptoms. There are no solid diagnostic features but a normal spirometry, corroborating nasendoscopic findings of laryngeal reflux and erosive oesophagitis on gastroscopy, are helpful if present. Often, tests are normal and one is left with the option to treat empirically. Some patients may respond quickly to standard doses of PPIs, but a sizeable minority may be recalcitrant even with high dose PPIs + Domperidone.

An oesophageal pH study could be helpful here. If it shows suggestive parameters of reflux (see the previous article on interpreting oesophageal pH studies), then the diagnosis is clearer. One very important fact is that patients with ONLY LPR symptoms without typical reflux symptoms, have a response rate to fundoplication of <30%. Even with typical reflux symptoms, the reflux symptoms may respond about 60% of the time but the LPR symptoms may persist after fundoplication. Most experienced fundoplication surgeons are usually reluctant to operate on patients with predominantly LPR symptoms. Unfortunately, the diagnosis and management of LPR remains unrewarding in a minority of patients.

Volume reflux

Patients may complain of regurgitation of intra-gastric content with or without typical reflux symptoms. Response to PPIs are mixed, as some patients may have grossly abnormal Lower Oesophageal Sphincter (LOS) function. Domperidone and other prokinetics may be particularly useful adjuncts to PPIs in these patients. It is important to perform oesophageal pH studies to confirm the diagnosis of acid reflux and oesophageal manometry to exclude unsuspected diagnoses such as oesophageal dysmotility and achalasia.

Once reflux is confirmed, these patients are ***particularly*** responsive to fundoplication, which is great news for our patients. Again, fundoplication should only be reserved as a final option when high dose PPIs are required or due to patient preference.

Complications of fundoplication

- Fundoplications are usually performed slightly tight rather than slightly loose. This is because re-do fundoplications are far less effective. A slightly tight fundoplication causing mild dysphagia can be gently endoscopically dilated periodically to provide good relief.
- Fundoplications generally last between 7-10 years if they work. This is due to normal tissue stretching. As symptoms of reflux tend to decrease from age 50, I generally discourage medication responsive patients from seeking surgery until they are in their 40's.
- Fundoplication can also make endoscopic surveillance of Barrett's mucosa tricky ("*hidden Barrett's*"), so this has to be balanced out against the potential positive effect it has on acid exposure and possible reduction of risk of progression to malignancy

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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 bowel cancer screening and prevention. 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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