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Summary

Gastro-oesophageal reflux disease diagnosis and how to avoid them

Sabine Roman

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Endoscopy | Nurses | Small Intestine & Nutrition | Oesophagus | Surgery

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Two common diagnostic pitfalls in GERD evaluation include labeling patients as having refractory GERD without first proving GERD exists off PPI, and failing to recognize misplaced pH probes that yield falsely elevated acid exposure readings.

KEY POINTS

- The speaker emphasized that the term refractory GERD should only be used after GERD has been objectively proven off PPI (via endoscopy showing LA grade B-D esophagitis, Barrett's, or peptic stricture, or reflux monitoring showing acid exposure time above 6 percent) and then documented to persist on PPI therapy.
- In the first case presented, a 25-year-old woman with persistent regurgitation on PPI therapy and normal endoscopy underwent pH impedance monitoring off PPI showing normal acid exposure (1 percent) and 70 reflux episodes; postprandial manometry with impedance revealed the diagnosis was rumination syndrome, not refractory GERD.
- The speaker reported a second case with pH monitoring showing 72 percent acid exposure time, but careful review of the tracing revealed the pH probe was misplaced in a hiatal hernia, yielding a gastric rather than esophageal pH recording.
- The speaker stated that manometry should be performed before pH catheter placement to properly localize the esophagogastric junction and avoid probe misplacement, and that pH tracings must be carefully reviewed when acid exposure is very high.
- In the discussion, the speaker recommended stopping PPI for four weeks before diagnostic testing if possible, and described performing postprandial manometry by having patients eat a symptom-triggering meal after standard manometry, observing for 10 to 60 minutes to detect rumination or meal-related motility disorders.

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