



GASTRO-OESOPHAGEAL DISEASE (GORD)

DEFINITION

Reflux of acid from the stomach into the lower oesophagus due to an incompetent lower oesophageal sphincter (L.O.S.)

NATURE

The stomach secretes a strong concentration of Hydrochloric acid for digestive purposes. The acid is meant to stay in the stomach and is neutralised by the alkaline bile in the duodenum. The lining of the oesophagus is different to that of the stomach and cannot cope with acid which leads to mucosal inflammation (oesophagitis).

L.O.S. incompetence occurs to some degree in 20 to 30% of adults, and maybe asymptomatic. The incompetence may be associated with a hiatal hernia, which tends to aggravate the reflux.

OESOPHAGITIS

Inflammation of the oesophagus occurs as a result of G.O.R., and is quantified and staged according to various classifications: Savary-Millar, 1977, Grade I to IV, Armstrong, 1996 (Los Angeles classification), graded from "minimal change", progressing through Grades A to D. The severity of the oesophagitis is also assessed with biopsy and histology. This is important to reveal dysplasia, a premalignant condition of the oesophageal mucosa.

HIATAL HERNIA

Herniation of part of the stomach through the oesophageal opening of the diaphragm into the chest. The diaphragm is a large flat musculo-tendinous structure separating the abdomen from the chest anatomically. At the level of the oesophago-gastric junction, the diaphragm has a "pinch-cock" effect, assisting the L.O.S. to prevent reflux. Herniation of the stomach into the chest will render the diaphragm useless in this role, and aggravate G.O.R.

BARRETT'S OESOPHAGUS

An acquired change of the inner lining (mucosa) of the oesophagus (metaplasia) replacing the normal squamous lining with gastric (stomach) mucosa. Occurs in 10 to 15% of all patients with oesophagitis and represents a more virulent form of reflux. Associated with an increased risk of oesophageal malignancy, and also of benign stricture formation. Requires long term endoscopic follow up with four quadrant biopsies performed over every 2 cm of the affected oesophagus. The scopes are performed every two years, to assess for the development of dysplasia (pre-malignant changes).

CLINICAL PRESENTATION

A spectrum of symptoms may occur: asymptomatic, heartburn, difficulty in swallowing, fluid “build up” in the throat (waterbrash), coughing and respiratory symptoms especially at night.

TREATMENT OF G.O.R.D.

Avoid foods and beverages that weaken the L.O.S. These include alcohol, caffeine and chocolate. Weight reduction, avoid “heavy” evening meals. Slight elevation of the head of the bed may reduce G.O.R. at night by gravity effect. Medications include simple antacids, H2 blockers, and Proton pump inhibitors.

SURGICAL TREATMENT

Surgery is very seldom required in the management of G.O.R.D. The indications for surgery have remained unchanged for four decades and include the following: intractable symptoms despite an adequate course of medical therapy; a Barrett’s oesophagus with dysplasia and inadequate response to therapy; persistent stricture of the oesophagus.

The choice surgical procedure is a Nissen Fundoplication, performed laparoscopically. Dr Curren does not perform this surgery and would refer patients to the appropriate specialist should surgical intervention be required.