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MODERN VISION IN REFRACTORY GASTROESOPHAGEAL REFLUX DISEASE

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Introduction. Refractory gastroesophageal reflux disease (rGERD) is defined as the persistence of typical symptoms that do not respond to stable, twice-daily proton pump inhibitors (PPI) dosing during at least 12 weeks of treatment. Up to 30% of GERD patients experience rGERD. The factors that can cause rGERD are many and vary in incidence, clinical importance, symptom severity and frequency.

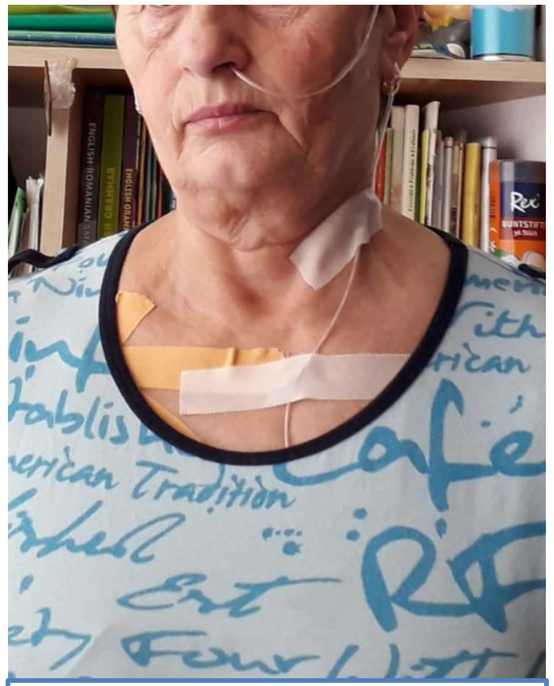
Purpose. The assessment of the patient with rGERD must be careful, detailed and should be done step by step, considering that rGERD probable does not have a single underlying cause and may actually describe several disease states.

Material and methods. A standard evaluation of rGERD symptoms should include a thorough symptom evaluation, a structural and a functional evaluation of the upper gastrointestinal tract. The symptom assessment include the determination of persistent signs, aggravating factors and presence of alarm symptoms. The instrumental work-up consists in barium swallow, upper GI endoscopy, esophageal 24h pH- and impedance monitoring, esophageal Bilitec test and high-resolution manometry (HRM).

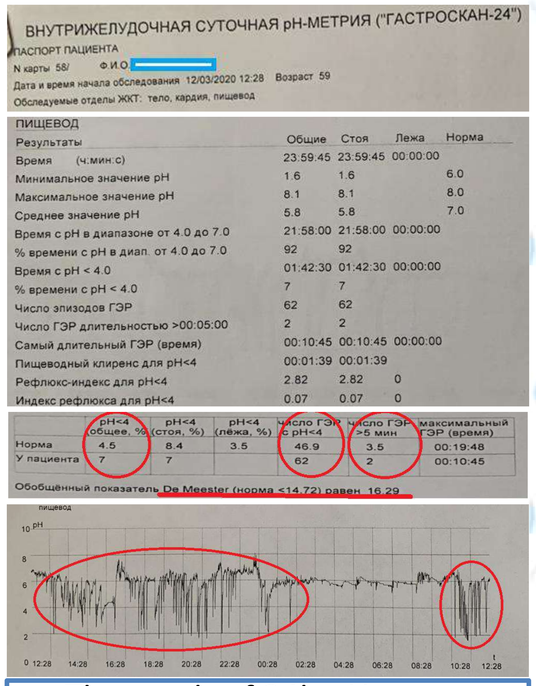
Results. The therapeutic approach of the patient with rGERD must be complex and target several pathogenetic mechanisms. There are a myriad of potential therapies that vary in efficacy, invasiveness and accessibility. Lifestyle modifications, such as elevation of the head of the bed at night, weight loss and special diet remain to be recommended as a first-line therapy for rGERD. Pharmacologic treatments include optimization of PPI and associated with other medication, like as H2-blokers, antacids, motility agents, antidepressants, reflux inhibitors, bile acid binder. In some situation, we reccomend various endoscopic procedures or surgeries, such as laparoscopic fundoplication. Nonpharmacologic interventions used in treatment of rGERD include divers therapies: cognitive behavioral therapy, hypnotherapy, biofeedback, alternative and complementary treatments, such as acupuncture, herbal treatments (Rikkunshito) and transcutaneous electrical acustimulation.

Conclusion. Management of patients with rGERD is a major clinical challenge for the gastroenterologist, and the multitude of potential therapies that vary in efficacy, invasiveness, and accessibility need to be individualized for each patient.

Causes of rGERD	Unrelated causes of rGERD
• PPI adherence and compliance • Functional esophageal disorders (functional heart burn, esophageal hypersensitivity, Irritable bowel sundrome, psychological comorbidity) • Weakly acidic or nonacid reflux (weakly acid reflux, duodenogastroesophageal reflux) • Residual acid (nocturnal acid breakthrough, acid pocket) • Delayed gastric emptying • Rapid PPI metabolism • Eosinophilic esophagitis • *Helicobacter pylori* status	• Achalasia • Zollinger–Ellison syndrome • Pill-induced esophagitis • Autoimmune skin diseases with esophageal manifestations • Rumination syndrome • Infectious esophagitis • Esophageal cancer • Nonsteroidal antiinflammatory drug use • Radiation-induced esophagitis • Caustic agent ingestion



Pacient X with rGERD, 59 y, 24h pH-metry monitoring



The result of 24h pH-metry demonstrating the presence of rGERD at this pacient

Keywords. rGERD, not respond, PPI