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A pragmatic symptom-based approach

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Symptoms are the main cause of morbidity and a significant impairment of quality of life in reflux disease. The majority of patients report their symptoms to primary care physicians, and do not have objective evidence of reflux oesophagitis. Thus symptom evaluation is the primary method of diagnosis, assessment of severity, and determining the choice of therapy. Symptoms are not currently judged to cause reflux disease until they occur on at least two days a week; at this level, they lead to significant impairment of quality of life. Heartburn and regurgitation and general considered to be the cardinal symptoms of reflux. However, these often occur in the setting of other upper gastrointestinal symptoms, particularly epigastric pain, which patients often have difficulty in distinguishing from heartburn. Questionnaires have been developed in order to standardise and improve symptom-based diagnosis, and perform as well as primary care clinicians. These have yet to become mainstream practise but offer great potential.

Introduction

Gastro-oesophageal reflux disease is common. It is estimated that up to 10–20% of people in Western societies experience troublesome reflux symptoms [1]. The prevalence in Asian countries is lower, 5–10%, but is increasing. Symptoms are the main cause of morbidity and a significant impairment of quality of life, and endoscopic findings such as erosions or Barrett's oesophagus have little additional impact [2]. The majority of patients report their symptoms to primary care physicians who do not have immediate access to diagnostic testing. Moreover, the majority of patients with reflux symptoms in the primary care setting do not have objective evidence of reflux oesophagitis [3]. Thus symptom evaluation is the primary method of diagnosis, assessment of severity, and determining the choice of therapy.

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Assessment of response to reflux treatment also relies heavily on symptom evaluation, especially in non-erosive disease where there is no objective treatment endpoint. In recent years, the concept of 'complete remission' (endoscopic and symptomatic resolution) [4] has become more widely accepted as the optimal treatment goal, making symptoms an integral part of evaluation of treatment. In comparison with endoscopy, however, evaluation of the accuracy of symptoms for the diagnosis of reflux disease has received relatively little attention, perhaps in part because of the lack of a gold standard for reflux disease. Symptoms are also a guide to the need for early endoscopy in patients in whom there is uncertainty regarding the diagnosis or concern about complications such as malignancy.

Symptom analysis takes place during the first encounter between the patient and the clinician and is therefore time-efficient and highly cost-effective. However, the lack of standardisation between the persons taking the history, and patient's ability to provide the necessary information can reduce the accuracy of symptom-based diagnosis. Much effort has therefore been devoted to improve the former, through the use of structured questionnaires.

Symptoms of gastro-oesophageal reflux Fig. 1 are common in the community. The prevalence of heartburn and acid regurgitation within the past 12 months has been reported to be up to 45% and frequent (at least weekly) by 20%. However, symptoms are not currently judged to cause reflux disease until they occur on at least two days a week [5,6]. At this level, they lead to significant impairment of quality of life, [2,7] and clinical trials have shown that patient's willingness to accept their level of reflux symptoms falls markedly above this level [8]. Agreement between clinicians and patients in their assessments of the severity of reflux symptoms is poor, particularly before treatment and for more severe symptoms [9]. Therefore, in clinical practise, the patient should determine if their reflux symptoms are troublesome [10].

Symptom patterns and classification of reflux disease

The current Montreal definition and classification of reflux disease divides oesophageal symptoms into two major groupings: esophageal syndromes and extra-oesophageal syndrome [10]. Esophageal syndromes include typical symptoms such as heartburn and regurgitation, as well as the less typical non-cardiac chest pain. Extra-oesophageal syndromes include symptoms such as cough, hoarseness, asthma, dental erosions, as well as more tenuous associations such as pharyngitis, sinusitis and otitis media.

Symptoms of reflux disease are not completely specific and often co-exist with other gastrointestinal symptoms. Identification of the dominant symptom by either the patient of clinician may be difficult. Thus careful evaluation of symptoms and symptom patterns is important in the symptomatic diagnosis of reflux disease.

Heartburn and regurgitation

Heartburn and regurgitation are generally considered to be the characteristic symptoms of reflux. The prompt induction of heartburn by oesophageal acid infusion, and the impact of acid suppression on heartburn in clinical trials support reflux as being the predominant cause [11]. The precise accuracy of

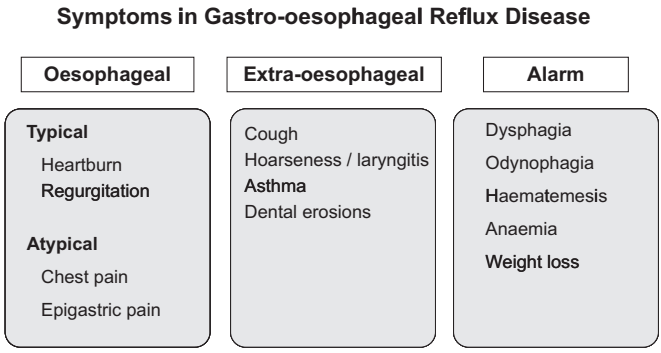

Fig. 1. Symptoms attributable to gastro-oesophageal reflux diease.