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GUEST EDITORIAL

Complacency in GERD an Imminent Disaster

Jibran Umar Ayub Khan, Azhar Zahir Shah, Ayesha Qaiser

Department of Medicine, Kabir Medical College, Peshawar[1]
Department of Surgery, Kabir Medical College Peshawar[2]
Department of Physiology, Khyber Medical College Peshawar[3]

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Gastroesphageal reflux disease is one of the most common gastrointestinal disorders which is mainly characterized by problems with esophageal peristalsis responsible for propelling the food from the esophagus into the stomach or dysfunctional or weaker lower esophageal sphincter preventing the reflux to stomach contents.[1] Typical symptoms involve heartburn, regurgitation of food, sore taste in the mouth and sometimes atypical symptoms like chest pain, signs of dental erosion and even breathlessness at night time bothering the patients.[2]

While it is the bread and butter of most clinicians in Pakistan where a large no of their clinical consultations are GERD patients, the symptoms can be misleading. There is a general concept amongst the public to have proton pump inhibitors for months and even years without realizing that they have their own devastating side effects including the risk of pernicious anemia, atrophic gastritis and even gastric carcinoma if used indefinitely.[3]

The old-style measures of sticking to strict dietary measures have been the main stay of treatment.[4] There has been a debate among the gastroenterologists about the choice of appropriate proton pump inhibitors for GERD. Most of them use omprazole for such patients, a drug that has been widely used with fewer side effects. The standard duration of treatment is 8 weeks with some physicians tapering the dose slowly and gradually with an intention to stop it in next few months.[5] The availability of such medications over the counter without prescription by some specialists lead to disaster in the long run with masking of symptoms. The self-prescription by the patients does lead to failure of treatment.[6] Some of them try herbal medications without any proper literature which have their own side effects and should not be used in the first place. The irresistible urge to use these medications by the patients not only create misery for them but also for the attending physicians.

There is also a trend of testing for helicobacter pylori in GERD patients which is absolutely not recommended at all as there is no evidence that eradication therapy will ease off the symptoms.[7] Instead it has added to widespread antimicrobial resistance with physicians using them which is otherwise a futile exercise. There is emerging data about the use of antibiotics having cardiovascular side effects with FDA warning against the use of clarithomycin and quinolones as they enhances risk of myocardial infarction and cardiac arrhythmias.[8]

A large cohort study in Hong Kong has further substantiated this and has reported that that there is three times more risk of cardiac arrhythmias with clarithomycin based regimen and there is resultant increase in inpatient mortality. There is already rising antibiotic resistance throughout the world that has worried the microbiologists. This was based on the CLARICOR trial from

Denmark. Patients with heart disease were randomized to clarithromycin 500 mg a day or placebo for 2 weeks. All-cause and cardiac mortality at 2 years were higher in the clarithromycin group. One shouldn't wait for alarm symptoms. The resistance to proton pump inhibitors is strong enough reason for the referral to gastroenterologist.

When symptoms are resistant to proton pump inhibitors, there is a need for endoscopy which most of general practioners missed. Unfortunately some of the patients come for gastroenterology advice when they develop alarm symptoms like dysphagia and weight loss in addition to hematemesis or malena.[9] When such patients are scoped, mostly we find a growth obstructing the lumen of esophagus leading to difficulty in swallowing. The damage is greater if the growth is not localized which means not feasible for surgery i.e. stage 3 or 4 and therefore having poor prognosis. What we forget that Barrets esophagus is a risk factor for esophageal carcinoma and that is an outcome of long-term gastroesophageal reflux disease.[10] Its better to be scoped on time than to be at a time when it's too late.

There is no need of trying different proton pump inhibitors for long time when there is no improvement of symptoms. The physicians in general practice should rather be generous in referring such patients on time to gastroenterology experts as the treatment needs to be multidisciplinary and one should not be silent on sinister signs and symptoms if they are present. Endoscopy is already a safer option to screen such patients which will suffice for the reassurance of the patients.

CONCLUSION

Therefore, to summarize, one should always remember that complacency in treatment for any disease is road map for imminent disaster and GERG is no different.

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Corresponding Author:
Jibran Umar Ayub Khan
Assistant Professor
Department of Medicine, Kabir Medical College, Peshawar
Email address: jibranumarayubkhan@gmail.com