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Evaluation of Upper GI Symptoms: an update

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Common symptoms

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- Dyspepsia
- GORD
- Dysphagia
- Nausea & vomiting
- Abdominal pain

Red flag symptoms: onset, weight loss, haematemesis, anaemia or melaena etc.

Dyspepsia

- BSG defines dyspepsia as group of symptoms attributed to Upper GI tract by a doctor
- Dyspepsia is not a disease
- Incidence ranges from 14-41% of the UK population
- Symptoms typically lasts for 4 or more weeks
- Risk factors

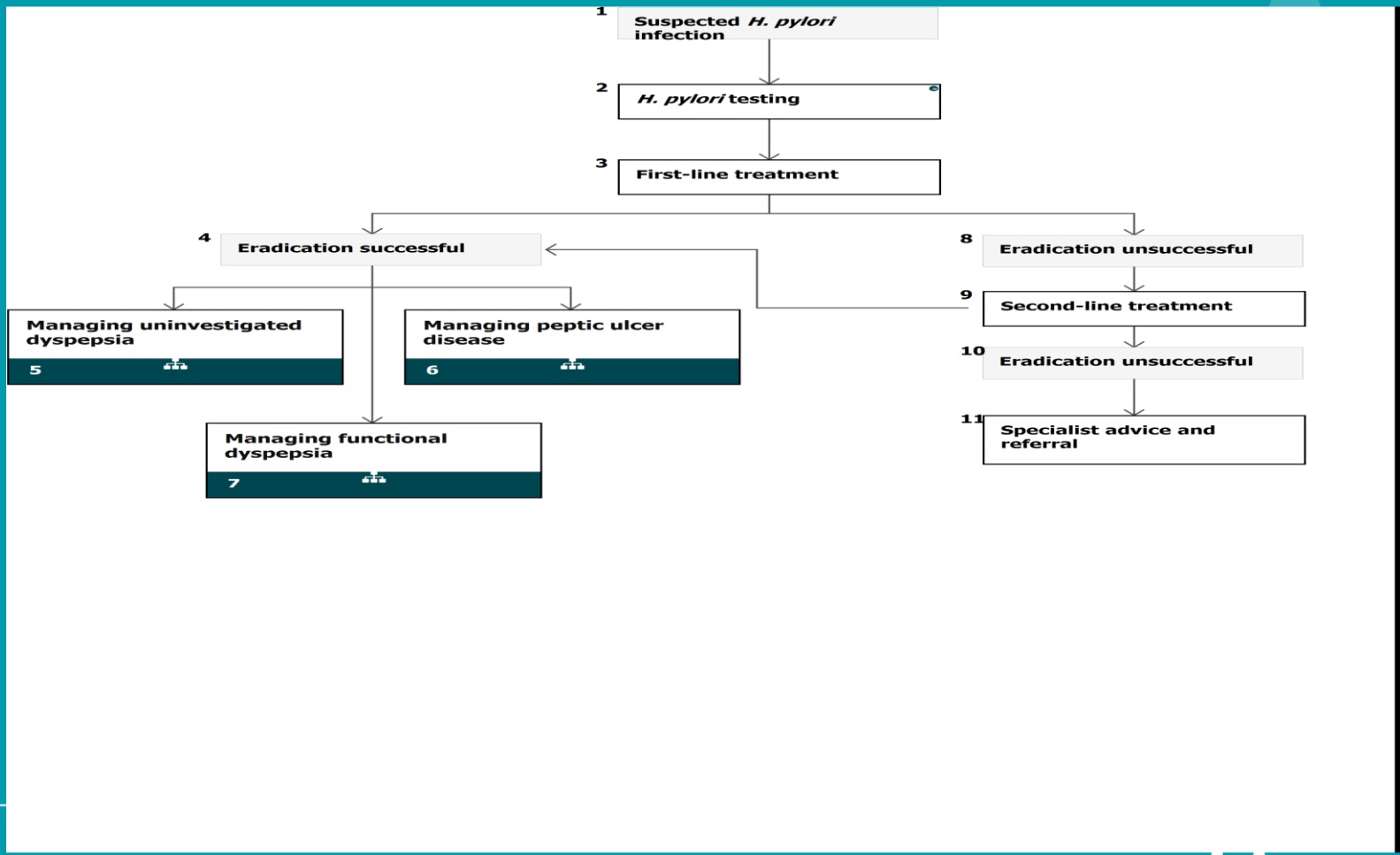
Smoking	Lower socioeconomic
Obesity	Age
ETOH	

H.Pylori Eradication

- Prevalence 40% (high prevalence in Japan and South America 80%)
- Associated with peptic dyspepsia and GI malignancy
- Eradication is associated with reduced incidence of malignancy in deprivate

Li W-Q et al. Effects of Helicobacter pylori treatment and vitamin and garlic supplementation on gastric cancer incidence and mortality,BMJ 2019;366:15016.

H.Pylori Eradication (NICE April 2019)



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H. Pylori Eradication

- First line treatment
- Success rate
- Relevance of breath test
- Indications for specialist referral
  - Refractory infection
  - Red flag symptoms
  - Functional dyspepsia

GORD

- Definition
- Etiology
- Risk factors
- Initial management
- Indications for specialist referral
- Indications for surgery

GORD (LINX Procedure)

- NICE approved procedure
- Lack of long term results (introduced in 2007)
- Minimally invasive
- Associated with lower incidence of gas bloat
- Day case surgery
- Improved eructation, vomiting rate compared to fundoplication

Investigating GORD

- Thorough history
- Endoscopy
- High resolution manometry
- 24 hour or wireless capsule ph monitoring
- Barium swallow

Oesophageal HRM

- Aids in diagnosis of motility disorders
- Evidence of LES dysfunction
- Predicted outcome of surgery
- Mandatory before surgery

24 hour vs Baravo (wireless pH monitoring)

- 24 hour monitoring is sufficient in majority cases
- 24 hour may not be long enough
- Tube hanging from nose for 24 hours
- Bravo requires endoscopy to place wireless chip
- Assessment over 96 hours
- Less intrusive (no tubes dangling from nose)

Pitfalls in managing GORD

- Life style
- Delay in investigating
  - Complications
  - Underlying Type III or IV hiatus hernia
  - Dysmotility
- Poor selection for surgery
  - Failing to establish benefits of surgery
  - Extra oesophageal symptoms
- Patient assessment

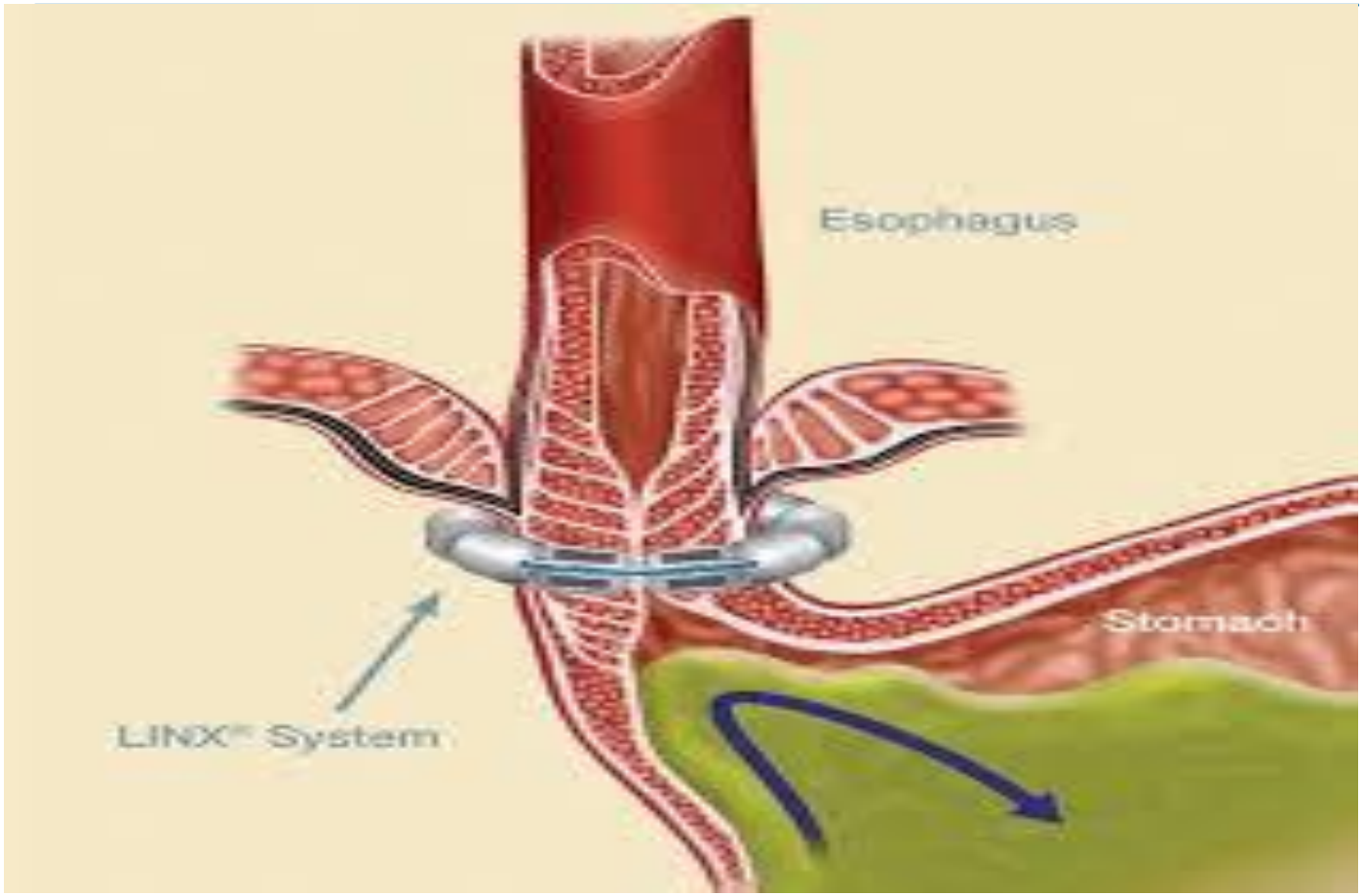
Indications for Surgery

- Patients choice
- Side effects of medical management
- Failed conservative management
- ?? Barretts (without dysplasia)
- PPI and H2RA are ineffective in long term control of symptoms
- Presence of risk factors
  - Large hiatus hernia
  - Barretts (no dysplasia)
  - Side effects of PPI/H2RA

Patient selection for surgery

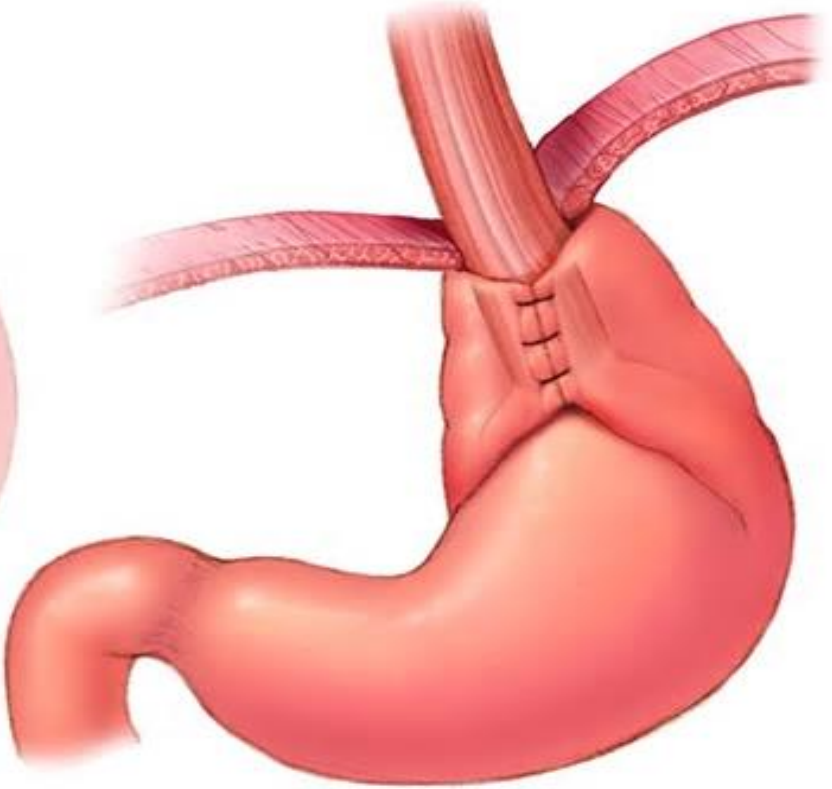
- Evidence of reflux
  - 24 hour/ BRAVO ph monitoring
  - Biopsies
  - Endoscopic evidence of damage from reflux
- No evidence of dysmotility on HRM
- Patient is fit for GA
- Evidence based counselling

LINX Procedure



Laparoscopic Fundoplication

A. The fundus is wrapped around the back side of the esophagus



B. The wrap is secured with sutures to anchor lower esophagus below diaphragm

PPI vs Laparoscopic Fundoplication (RCT)

- 70 patients (surgery; PPI 31 ;39)
- 2 year follow up
- Improvement in Reflux symptom index, cough, mucous and throat clearing significantly improved after surgery
- Both groups responded to treatment however QOL was better after surgery (P= 0.004)

Zhang et al, Nissen fundoplication vs proton pump inhibitors for laryngopharyngeal reflux based on pH-monitoring and symptom-scale.World J Gastroenterol. 2017 May 21;23(19):3546-3555.

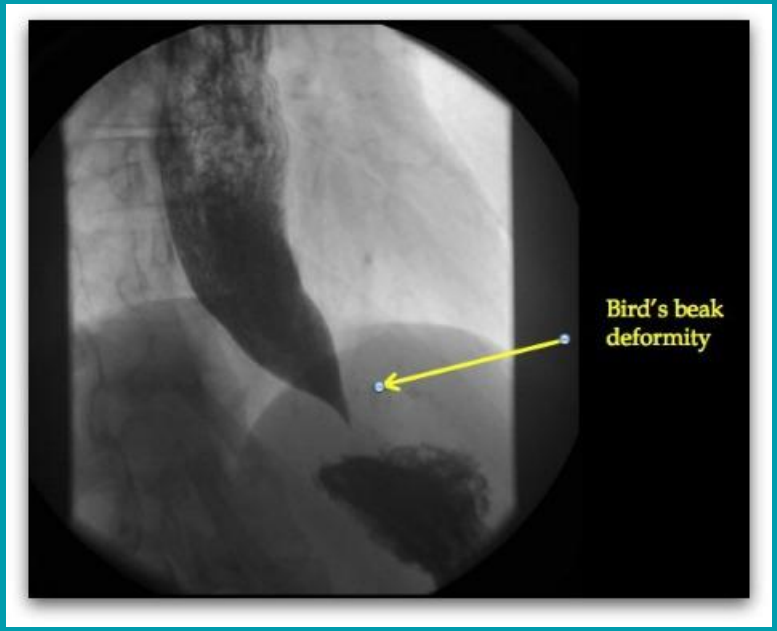
Barretts Oesophagus

- Diagnosis
- Management
- Surveillance
  - Presence of dysplasia
  - Individual preference
  - Risk factors
    - Male gender
    - Age
    - Degree of dysplasia

Dysphagia

- D/D
  - Functional
  - Dysmotility
  - Mechanical
    - Benign
    - Maliganancy
- Investigations
  - OGD
  - Barium swallow
  - HRM
- Management
- Pitfalls

Achalasia



Management

- Usually mismanaged
- Careful history
- Endoscopy
- Barium swallow
- HRM- diangnostic
- Differential diagnosis
  - Absent peristalsis
  - Pseudo achalasia

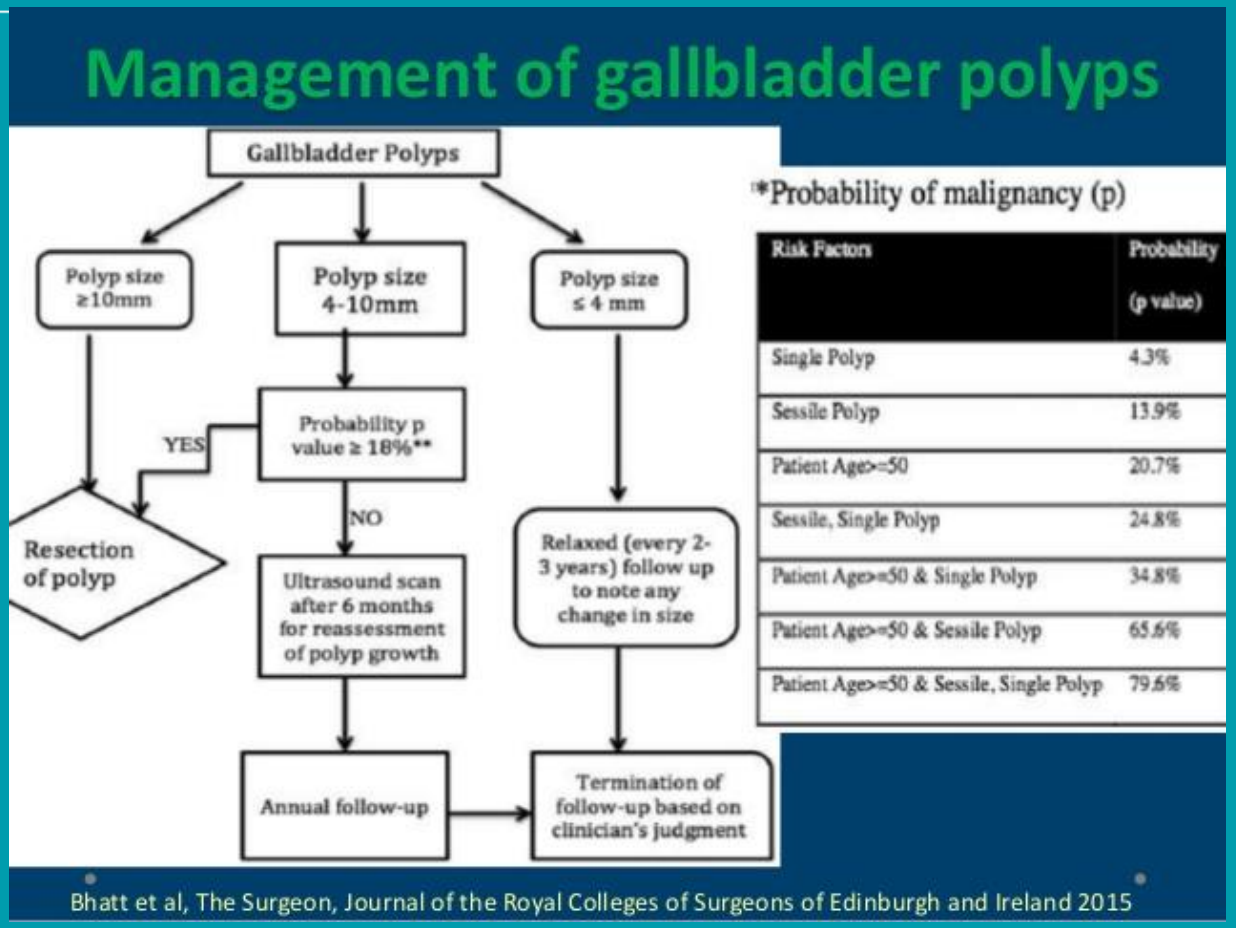
Management

- Balloon dilatation
- Botox injection
- Heller's cardiomyotomy (+/- anti reflux surgery)
- Endoscopic myotomy

Gallbladder Polyps

- Usually an incident finding
- Only Level 1 or 2 evidence
- Offer surgery if the polyp size is >10 mm
- Investigations
  - U/S
  - MRCP
  - Consider EUS

Systematic Review: Bhatt et al



Bhatt et al, The Surgeon, Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland 2015

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