[MUSIC PLAYING]

WILSON TSAI: When people talk about gastroesophageal reflux disease, many people actually talk about only the symptoms of the disease without recognizing that this is a true disease entity. So what I mean by that is for example, many people talk about heartburn as one of the symptoms of disease. And unfortunately they confuse that with the actual disease process known as gastroesophageal reflux disease.

Because of this, this has really propelled this disease to be treated primarily by medications. And we see all these commercials on the television promoting medications for the treatment of symptoms of reflux, which is essentially heartburn. These medications are designed to decrease the acidity of the stomach, which in turn reduces the symptoms of gastroesophageal reflux disease.

Unfortunately, many people don't only have heartburn as a symptom. They actually have true reflux or regurgitation of the contents of the stomach, which could injure the esophagus despite maximal medical treatment. Because of this, there's been many studies, one study that actually studied 502 patients with heartburn, which showed that the number one reason or the number one prognostic indicator causing Barrett's esophagus, pre-cancerous esophageal lesions, is actually the presence of bile in the refluxate. And bile, as we all know, cannot be controlled simply by taking medications, which are only designed to decrease the acidity of the gastric contents.

What I believe in patients with heartburn or gastroesophageal reflux disease is this, and this is my algorithm for recommendations for patients with this symptom. I recommend, of course, medical treatment to see if that does help alleviate the symptoms. I feel these patients should be on medical treatment for about two weeks to one month where these patients would stop the medical treatment to see if the symptoms resume, or the symptoms go away.

The most common reason for reflux in many patients in this country is the presence of a hiatal hernia. What a hiatal hernia is, is essentially a defect in the diaphragm where part of the stomach herniates up into the chest cavity. Because of this, this causes a disruption of the lower esophageal sphincter. This is not a true dysfunction of the sphincter.

All this simply means is that the esophagus that should be in the abdominal cavity has been displaced into the chest cavity. So simply taking these medications unfortunately may not help these patients in the prevention of the development of Barrett's esophagus.

So I do recommend an endoscopy with an evaluation of the presence of any anatomical derangements that causes the reflux. I recommend biopsies of the esophagus. And I definitely recommend, of course, informed consent with the patient. I recommend that all patients understand what the cause of their reflux is. And therefore there are two major schools of treatment, or major principles of treatment options.

One include continued medical therapy with PPIs or H2 blockers with endoscopies as surveillance, if there is proof that these patients have reflux. The endoscopies, if a patient has no Barrett's esophagus, I recommend once every five years. If they do have the presence of Barrett's esophagus, then I do recommend endoscopy every three years until we can confirm that the Barrett's esophagus is stable.

If these patients have large defects of the diaphragm causing the stomach to herniate up into the chest cavity, then I definitely think that part of the informed consent for these patients should include an option to treat these patients from a surgical correction standpoint. There are many different options for these treatments, which include laparoscopic Nissen fundoplications.

There are newer technologies on the market such as the LINX magnetic ring. But I do think that part of that discussion should be had with every patient individually. Not every patient needs surgery, but every patient needs to be educated. I thank everyone for their time today.

[MUSIC PLAYING]