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A CASE OF EROSIVE GASTROESOPHAGEAL REFLUX DISEASE

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Introduction

An interest in gastroesophageal reflux disease (GERD) is primarily determined by its high prevalence and the continuing increase in morbidity. GERD was recognized as an independent disease in October 1997 (Genval, Belgium) [1].

GERD is one of the most common diseases of digestive system that may cause such complications as esophagitis, esophageal strictures, ulcers, perforation, bleeding, Barrett's esophagus, esophageal adenocarcinoma. According to the "Map of Digestive Disorders and Diseases" (MDD), published by the World Gastroenterological organization in April 2008, the prevalence of GERD ranges from 7% in Brazil and China to 38.8% in Malaysia [2]. In Western Europe, this figure ranges from 15 to 30%; in the USA in 2007, its prevalence was 15% [3]. In Ukraine, the statistics data on the prevalence of GERD are few in number and scattered. According to the first population-based study in Ukraine, complaints of heartburn and belching with acidic content typical for GERD were present in 38.9% of persons in the general population [4]. Such contradictory prevalence rates indicate the absence of a focused examination of patients with relevant complaints and, as a result, a significant number of undiagnosed cases of GERD.

Further, we present our own clinical observation, demonstrating the need for timely diagnosis and treatment of this pathology.

Clinical Case

A 48-year-old woman complains of heartburn; sour belching, aggravated in a horizontal position and leaning forward after eating.

History of Disease

These symptoms appeared very rarely (once a two-three months) five years ago, were self-limiting and did not significantly affect the patient's quality of life. Approximately three months ago above mentioned symptoms began to bother much more often, almost daily, they did not disappear spontaneously; the patient forced to take baking soda occasionally for symptom relief. In connection with symptoms, aggravation patient sought medical help. She was not previously examined.

Smokes 8–10 cigarettes a day during 28 years, consumes alcohol in minimal quantities.

Anamnesis Vitae

Has one pregnancy with one delivery. Denies tuberculosis, diabetes, sexually transmitted infections, viral hepatitis. Allergic anamnesis is negative. Family history for oncology, cardiovascular diseases, and diabetes mellitus is negative. Denies surgical interventions and traumas.

Physical Examination

Patient condition is relatively satisfactory. BMI — 32 kg/m^2. The skin is clean, normal color. In the lungs vesicular breathing, no wheezing. Muffled heart sounds, regular rhythm, no murmurs. Heart rate (HR) — 72 beats per minute, blood pressure — 120/78 mm Hg. The abdomen is soft, painless to palpation. Liver and spleen are not palpable. The sign of tapping on the lumbar area is negative. Defecation and urination are normal.

Results of Laboratory and Instrumental Diagnosis

Laboratory tests (complete blood count, fasting blood glucose, urine analysis, liver and kidney function tests, fecal occult

blood test) are within normal ranges. ECG: sinus rhythm, HR 72 beats per minute, horizontal position of electric axis of heart, as a variant of norm. Fibroesophagogastroduodenoscopy (FEGDS): multiple areas of hyperemia of mucous membrane and separate non-eroding erosions of distal part of esophagus up to 5 mm in diameter.

On the basis of the patient's complaints of heartburn and sour belching after eating, aggravated in a horizontal position and by leaning forward the diagnosis of "gastroesophageal reflux disease" was made.

The diagnosis of "reflux esophagitis grade A" was made on the basis of FEGDS data according to the Los Angeles classification system (1997) [5]. This is the most validated classification system. In addition, it has been consistent in predicting the results of acid reflux therapy, correlates well with other acid reflux tests such as 24-hour pH monitoring and it was the most reproducible and practical when compared with other classification systems. Grade A of esophagitis corresponds to one (or more) mucosal break no longer than 5 mm that does not extend between the tops of two mucosal folds.

The diagnosis of "obesity" was based on inspection data (the presence of a BMI of more than 30 kg/m^2), Grade I of obesity corresponds to the value of BMI of 32 kg/m^2 [6].

Clinical Diagnosis

Main diagnosis: Erosive gastroesophageal reflux disease. Reflux esophagitis grade A.

Concomitant disease: Obesity constitutional-alimentary type, grade I.

Recommendations

We recommended X-ray examination of the esophagus, stomach (to identify possible pathological changes in the esophagus, hernia of the esophageal hiatus of the diaphragm); tests for determining the presence of Helicobacter pylori if long-lasting therapy with proton pump inhibitor is necessary. In the presence of refractory to treatment reflux 24-hour intra-esophageal pH-metry (to determine the number and duration of reflux per day, pH value) could be recommended.

Treatment of GERD is carried out in accordance with the Unified Clinical Protocol for primary and secondary care (Order of the Ministry of Health of Ukraine No. 943 of October 31, 2013). Patient management consists of life style modification and drug treatment.

Life style modification includes diet, smoking cessation and weight loss. Patient should exclude large amounts of food, eat small frequent meals, eat food with a low fat content and high protein content, avoid taking foods that cause irritant effect on the gastric mucosa or increase acid, such as coffee or decrease lower esophageal sphincter pressure, such as cigarettes, alcohol. Weight loss and elevation of the head of the bed on 15 cm blocks can be helpful.

Drug treatment. We recommend therapy on demand — taking alginates or antacids (e. g. Aluminum phosphate) to prevent irritation of esophageal mucosa by acid reflux and fast heartburn relief [7]. Alginates are medications that work through an alternative mechanism by displacing the postprandial gastric acid pocket. Alginates are preferred over antacids because they have been shown to be more effective than placebo or even antacids for treating GERD symptoms [8].

A proton pump inhibitor (PPI) to suppress the synthesis of hydrochloric acid should be prescribed for 4–8 weeks. Pantoprazole is a drug of choice in acid-suppressive therapy of GERD. According to pharmacokinetic properties (pH-selectivity, molecular mechanisms of blockage of H^+/K^+-ATPase, minimal risk of drug-drug interaction), it has sufficient efficiency with minimal risk of side effects. Pantoprazole in the standard (40 mg) and double standard dose (80 mg) according to the data of gastro-pH monitoring has a sufficient acid-suppressive effect both at the beginning of treatment and in its dynamics [9].

PPI may be used in combination with a prokinetic agent to stimulate the motility of the gastrointestinal tract, restore the normal physiological condition of the esophagus (e. g. Itopride hydrochloride). Some clinical studies support the fact that PPI combination with prokinetics have a beneficiary effect in comparison with monotherapy [10].

In case of positive Helicobacter test result standard triple 14-days therapy for HP eradication (Maastricht-3) should be prescribed.

Conclusion

The example of this clinical case shows the importance of early diagnosis of GERD in the absence of significant clinical manifestations which allows timely treatment of erosive gastroesophageal reflux disease and can prevent its severe complications. Untimely diagnosed manifestations of reflux esophagitis lead to the formation of complications such as peptic ulcers of the esophagus, stenosis of the esophagus and Barrett's esophagus.

Ключові слова: гастроезофагеальна рефлюксна хвороба, печія, клінічний випадок, діагностика, лікування.

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ВИПАДОК ЕРОЗИВНОЇ ГАСТРОЕЗОФАГЕАЛЬНОЇ РЕФЛЮКСНОЇ ХВОРОБИ

У статті розглядається проблема гастроезофагеальної рефлюксної хвороби на прикладі клінічного випадку. Наведені літературні дані про епідеміологію та медико-соціальну значущість цього захворювання. У статті висвітлено покроковий підхід до діагностики та лікування ерозивної гастроезофагеальної рефлюксної хвороби у пацієнта з відносно мізерними клінічними проявами. Підкреслюється значення модифікації способу життя.

Ключові слова: гастроезофагеальна рефлюксна хвороба, печія, клінічний випадок, діагностика, лікування.

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A CASE OF EROSIVE GASTROESOPHAGEAL REFLUX DISEASE

The problem of gastroesophageal reflux disease on the example of clinical case is examined in the article. Literature data about epidemiology and medical-social importance of this disease are presented. The article deals with a staged approach to diagnostics and treatment of erosive gastroesophageal reflux disease in patient with the relatively minimal clinical signs. The life style modification is underlined.

Key words: gastroesophageal reflux disease, heartburn, clinical case, diagnosis, treatment.

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ЗНАЧЕННЯ ІНІЦІАЛЬНИХ КЛІНІКО-ЛАБОРАТОРНИХ ПОКАЗНИКІВ У ПРОГНОЗІ ВІДПОВІДІ НА ТЕРАПІЮ НІЛОТИНІБОМ У ПАЦІЄНТІВ З ХРОНІЧНОЮ ФАЗОЮ ХРОНІЧНОЇ МІЄЛОЇДНОЇ ЛЕЙКЕМІЇ, У ЯКИХ ТЕРАПІЯ ІМАТИНІБОМ БУЛА НЕЕФЕКТИВНОЮ

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Вступ

Поява інгібіторів тирозинкіназ (ІТК) драматично змінила результати терапії хронічної мієлоїдної лейкемії (ХМЛ). Згідно з висновками міжнародного рандомізованого дослідження IRIS, у пацієнтів, які отримували іматиніб, 10-річна загальна виживаність сягала 83,3 % [1]. Проте у тому ж дослідженні зазначено, що тільки половина пацієнтів (48,3 %) залишилися на терапії іматинібом [1]. Решта 51,7 % хворих були змушені припинити лікування з