ACP Publishes Recommendations on Upper Endoscopy for Gastroesophageal Reflux Disease

Guideline source: American College of Physicians

Evidence rating system used? No

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

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Endoscopy has revolutionized the diagnosis and management of gastrointestinal illness. However, inappropriate use results in increased costs with no benefits. Data suggest that upper endoscopy in patients with symptoms of gastroesophageal reflux disease (GERD) is useful only in certain situations. To help physicians avoid the overuse of interventions that have little effect on health outcomes, the American College of Physicians (ACP) recently published recommendations on the appropriate use of upper endoscopy in patients with GERD symptoms.

Upper endoscopy is indicated in patients with heartburn and alarm symptoms (e.g., dysphagia, bleeding, anemia, weight loss, recurrent vomiting). However, it is not an appropriate first step in most patients with GERD, and is indicated only when empiric therapy with proton pump inhibitors (PPIs) taken twice daily for four to eight weeks does not control symptoms.

Endoscopy is also indicated in patients with a history of esophageal stricture who have recurrent dysphagia symptoms, and in those with severe erosive esophagitis who have completed a two-month course of PPI therapy to assess healing and rule out Barrett esophagus. Recurrent endoscopy after this follow-up examination is not indicated in the absence of Barrett esophagus.

Upper endoscopy may be indicated to detect Barrett esophagus and esophageal adenocarcinoma in men older than 50 years who have had symptoms for more than five years, and who have additional risk factors (e.g., nocturnal reflux, hiatal hernia, elevated body mass index, tobacco use, intra-abdominal body fat distribution). It may also be indicated for surveillance in men and women with a history of Barrett esophagus. If no dysplasia is detected, serial endoscopy should occur no more frequently than every three to five years. If dysplasia is present, more frequent intervals are recommended because of the higher risk of progression to cancer.

Multiple cohort studies have shown that upper endoscopy does not often detect Barrett esophagus or esophageal adenocarcinoma in patients who are not found to have these conditions on initial examination. In addition, frequent endoscopic evaluation of patients with nondysplastic Barrett esophagus shows a low rate of malignant transformation. Unnecessary endoscopy exposes patients to preventable harms, such as complications related to sedation, perforation, bleeding, and pulmonary aspiration. Misdiagnosis and subsequent inappropriate aggressive therapy are also possible, as are financial problems from increased insurance costs after a diagnosis of Barrett esophagus.

When discussing the use of upper endoscopy with patients who have GERD, physicians should emphasize that the risk of esophageal cancer in persons with heartburn is low, and that patients do not need to be evaluated for GERD at regular intervals as they do for other chronic diseases. Patients should be told that even in persons with severe esophageal irritation, acid suppressive therapy is the preferred treatment, and that endoscopy usually does not change treatment plans. Physicians should explain to patients with Barrett esophagus that endoscopy performed more often than every three to five years does not prevent more cancers than screening less frequently.

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