Fine-Tuning the Surgical Management of GERD

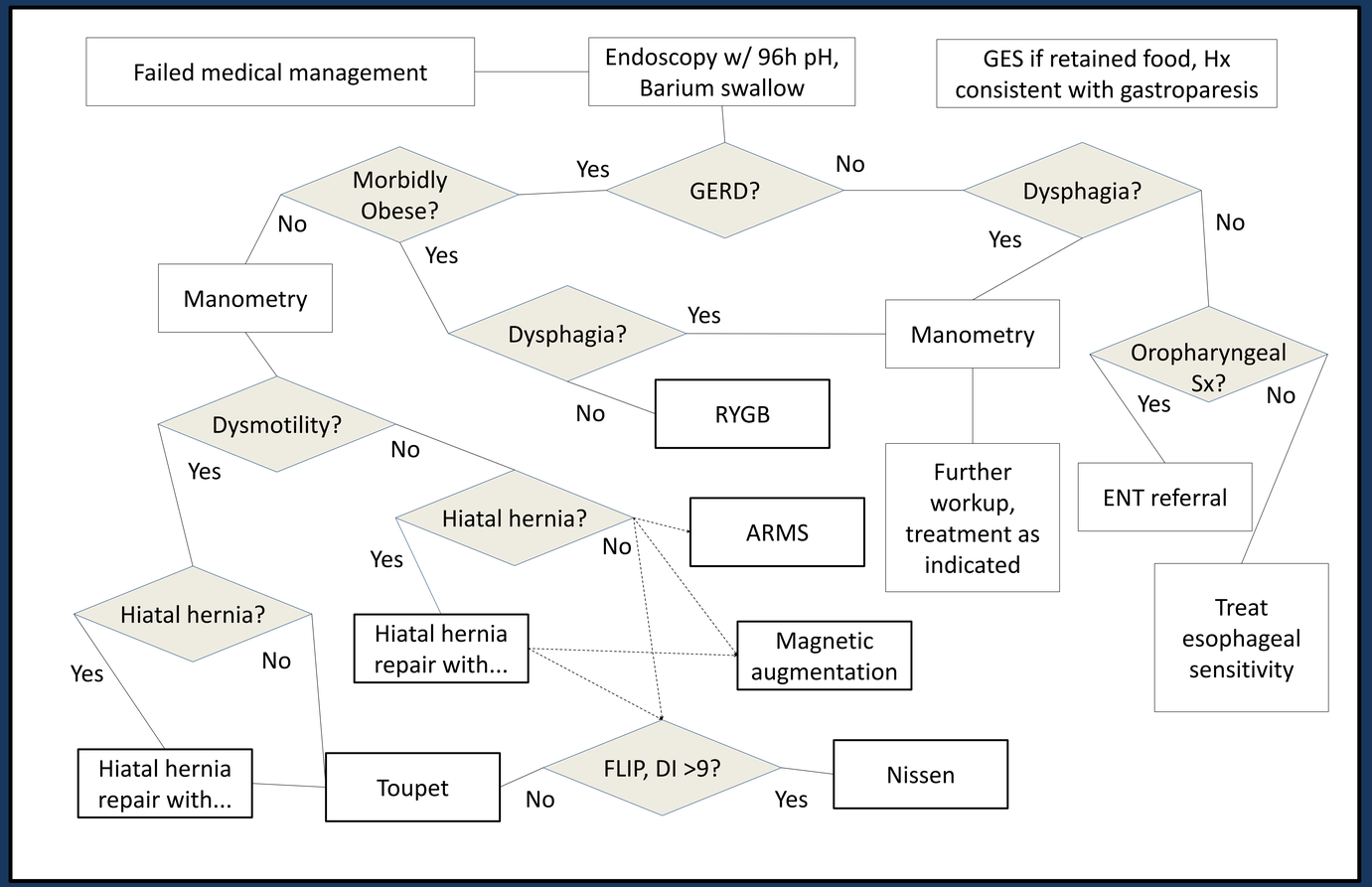
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Introduction

- Gastroesophageal reflux disease (GERD) affects approximately 15-20% of individuals in the US
- 10-40% of those treated medically do not achieve adequate symptom relief
- Laparoscopic approaches and refined diagnostic tools have revolutionized antireflux surgery
- We present a comprehensive algorithm for the surgical approach to GERD based on a 12 year experience and prospectively collected database with >600 anti-reflux procedures

Workup

- Endoscopy with 96h ambulatory pH testing is recommended for all patients
- Barium swallow to further evaluate anatomy
- Manometry is required to rule out occult motility disorder
- Manometry may be waived if a patient is morbidly obese, does not have dysphagia, and is amenable to gastric bypass



Algorithm for GERD (gastroesophageal reflux disease). RYGB - roux-en-y gastric bypass; ARMS - anti-reflux mucosectomy; FLIP - functional luminal imaging probe; DI - distensibility index
Dotted lines indicate decision per informed patient preference

Rationale

- The primary goal of antireflux surgery is to improve quality of life: address bothersome symptoms while avoiding side effects of dysphagia, bloating, and flatulence
- Patients without significant hiatal hernia, and without esophageal dysmotility, are candidates for anti-reflux mucosectomy, an endoscopic anti-reflux procedure
- Patients with normal esophageal motility and hiatal hernia primarily need normal anatomy restored, and may be considered for fundoplication or magnetic sphincter augmentation following hernia repiar
- We use intraoperative impedance planimetry to determine Nissen vs Toupet fundoplication based on lower esophageal sphincter distensiblility index
- All patients with esophageal dysmotility are recommended Toupet fundoplication