Sydney Heartburn Clinic

Comprehensive diagnosis and management of reflux disease.

An initial consultation is expedited by telephone and then a plan of investigation is arranged to confirm diagnosis, often advantageous for remote patients.

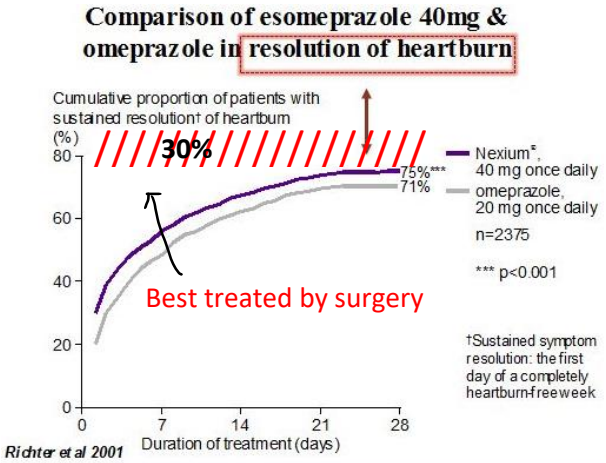

Figure 1 Graph depicting the remaining 29-25% of patients with unresolved heartburn from PPIs (surgical group).

Typical reflux disease

30% of patients treated for *heartburn and regurgitation* with PPI will not be adequately managed by medication. Quality of life is best established through minimally invasive surgery after appropriate physiological diagnosis, especially nocturnal and postural symptoms, regurgitation and choking.

Reflux cough and pulmonary microaspiration

Atypical reflux disease, where there is an absence of heartburn, can largely cause this problem. Extra oesophageal aspiration scanning confirms the diagnosis and gastrointestinal specialised testing allows management tailored to the causative abnormalities (PPI largely useless). (O'Hara et al., 2021).

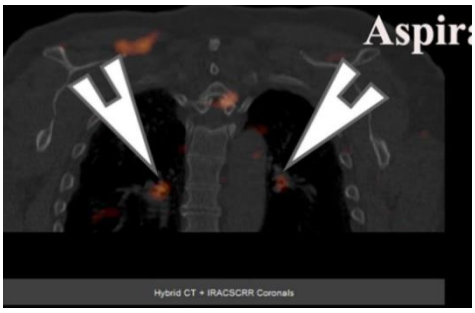

Figure 2 Reflux scan – silent lung aspiration

Throat symptoms and Laryngopharyngeal reflux disease (LPR)

LPR is caused by aerosol reflux contamination of structures outside the oesophagus in the throat and sinuses. Normal diagnostic studies, extra oesophageal reflux scanning and motility studies can elucidate the causation of disease and allow targeted therapy (PPI is largely useless) (O'Hara et al., 2021).

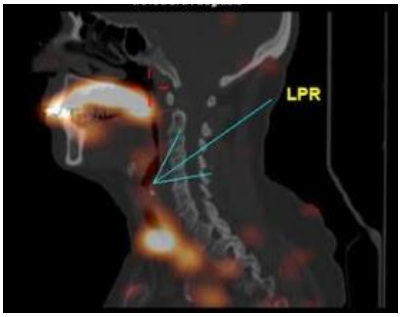

Figure 3 Scintigraphy reflux study demonstrating contamination of refluxate in the laryngopharyngeal.

Reflux lung disease

Episodes of pulmonary aspiration and episodes of silent aspiration often cause multiple different lung diseases, likely resulting in coughing and choking at night, SOB, recurrent chest infection, late-onset respiratory symptoms, late-onset 'so-called asthma', cough-predominant asthma, bronchiectasis, and recurrent atypical pneumonia. Pulmonary Microaspiration scanning is of great assistance. PPI does not stop the aerosol, and damage does not stop. 'Barrier' methods are better.

Figure 4 Chest X-Ray showing interstitial lung disease basal pulmonary fibrosis.

Very large hiatus hernia (LHH)

LHH identified on chest x-ray or incidental CT (not usually well seen on endoscopy) causes cardiorespiratory-like symptoms along with occasional typical reflux but does carry a risk of strangulation. Adequate anatomical testing and advice can be given. Dyspnoea and chest pain are common and concerning.

Figure 5 CT of patient with a massive hiatus hernia

Symptoms following previous gastric surgery

Patients may complain of reflux disease, pulmonary, and GI symptoms following surgery on the stomach. Bariatric surgery may worsen the reflux disease and anti-reflux surgery may fail. Appropriate investigation with modern testing is necessary to advise regarding management.

Treatment

Physiological testing and identification of the abnormalities are crucial so that management congruent to the problem may be instituted. Usually, a form of medical therapy is offered for Atypical reflux disease, PPI is not usually effective. Minimally invasive surgical care is indicated in some situations

Research

Substantial research has been performed on these topics enabling state-of-the-art management not generally available in other services. 5000+ patients treated, see attached hyperlink for more information.

https://www.gregoryfalk.com.au/

https://www.researchgate.net/profile/Gregory-Falk-2

https://scholar.google.com.au/citations?user=_bS3cG0AAAAJ&hl=en

Physiological Investigation

- Novel extra oesophageal pulmonary reflux aspiration scanning (limited availability).
- Multichannel 24-hour pH studies.
- Multichannel impedance reflux studies, including pharynx.
- New technology solid gastric emptying scanning.

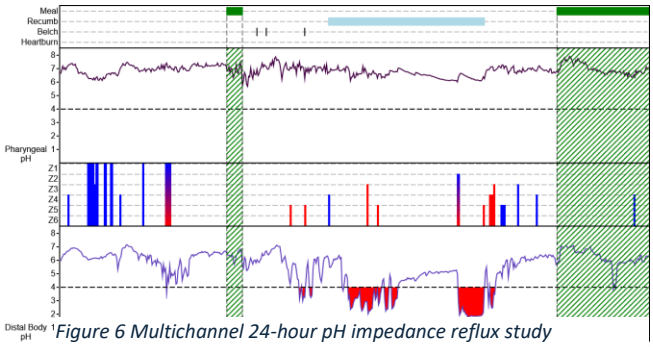

Figure 6 Multichannel 24-hour pH impedance reflux study

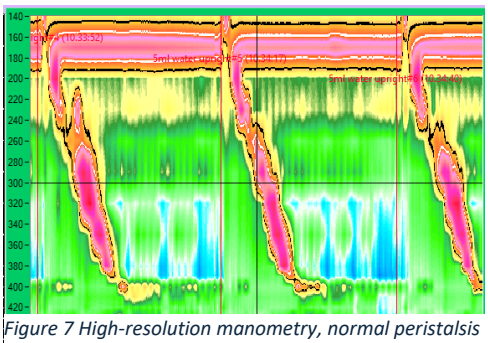

Figure 7 High-resolution manometry, normal peristalsis with hiatus hernia