GERD

Definition

Recurrent reflex of gastric contents into the distal esophagus d/t mechanical or functional abnormality of the lower esophageal sphincter (LES)

Normal protectant factors of the esophagus

Gravity, LES tone, esophageal motility, salivary flow, gastric emptying, tissue resistance

What can chronic reflux cause?

Barrett's esophagitis (replacement of normal squamous epithelium with metaplastic columnar epithelium)

Barrett's esophagitis can predispose

Malignancy

Clinical Features

Heartburn (worse after meals + lying down), hoarseness, halitosis, cough, hiccuping, atypical chest pain

Sx of more severe GERD

Occurs spontaneously when supine, sign of severe impairment of lower esophageal sphincter tone

Sx of less severe disease

Pattern of heartburn following meals, but no PM sx

Lab Studies

Clinical usually, can do endoscopy, EKG r/o MI if needed,

When is endoscopy indicated?

>45 yo w/ new onset of sx, long-standing or frequent sx and failure to respond to therapy, anemia, dysphagia, or recurrent vomiting

Treatment

Lifestyle modifications, antacids, H2-blockers 1st line, PPI most powerful, surgery/endoscopy available last resort

Mallory-Weiss Tear

Definition

Linear mucosal tear in the esophagus, generally at the gastroesophageal junction, that occurs with forceful vomiting, causing hematemesis

Most commonly associated with

Alcohol use but should be considered in all cases of upper GI bleeding

Diagnosis

Endoscopy

Treatment

Most cases resolve on their own, but may need endoscopic injx of epinephrine or thermal coagulation

Infectious Esophagitis

Seen in what patient population?

Rare except in immunocompromised

Etiology

Fungal: Candida, Viral: CMV and HSV, other (HIC, M. tuberculosis, EBV)

Clinical Features

Odynophagia (painful swallowing), or *dysphagia* (difficulty swallowing) in an immunocompromised patient

Lab Findings

Endoscopy shows large deep ulcers (CMV, HIV), or multiple shallow ulcers (HSV), or white plaques (Candida)

What is needed for definitive dx?

Cytology or culture from endoscopic brushings

Treatment

Candida-->fluconazole, HSV-->acyclovir, CMV-->ganciclovir

Esophageal Varices

Definition

Dilations of the veins of the esophagus, usually at the distal end

Etiology

Underlying portal HTN, most commonly from cirrhosis (EtOH abuse or chronic viral hepatitis); NSAIDs can exacerbate bleeding

Budd-Chiari Syndrome

May cause thrombosis of the portal vein, leading to esophageal varicose

Diagnosis

Patient with signs of cirrhosis + hematemesis (varicose can be asymptomatic until they bleed at which time they can be life-threatening)

Treatment

Hemodynamic support w/ high-volume fluid replacement, vasopressors, immediate control of bleeding! (Bleeding = high mortality). Preferred therapies: endoscopic therapy + pharm. vasoconstriction (i.e. octreotide)

Esophageal Neoplasms

Most common types

SCC and adenocarcinomas

Barrett's esophagitis associated with

Adenocarcinoma in the distal 1/3 of the esophagus

Squamous cell lesions associated with

Proximal 2/3 of the esophagus

Why is local spread to the mediastinum common

Esophagus has no serosa

Risk factors esophageal cancer

Smoking, EtOH, exposures (HPV, poor dental hygiene)

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Esophageal Neoplasms (cont)

Clinical Features

> Progressive dysphagia for solid foods assoc. w/ weight loss (also heartburn, hoarseness, vomiting)

Best initial lab test to visualize

> Biphasic barium esophagram

Best lab test to diagnose

> Endoscopy with brushings

Treatment

> *Surgical*

Esophageal Dysmotility

Definition

> Inclues neurogenic dysphagia, Zenker's diverticulum, esophageal stenosis, achalasia, diffuse esophageal spasm, scleroderma

Etiology

> Neurologic factors, intrinsic or external blockage, malfunction of esophageal peristalsis

Clinical features

> *Dysmotility* most common

Lab Findings

> Barium swallow, can show *achalasia* (parrot-beak)

Treatment

> Benign strictures-->dilation, Malignant strictures-->resection

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