

ENTITLEMENT ELIGIBILITY GUIDELINES GASTROESOPHAGEAL REFLUX DISEASE

MPC 00911
ICD-9 530.1

DEFINITION

Gastroesophageal Reflux Disease (GERD) is the reflux of gastric (stomach) contents into the esophagus. GERD results from interference in the function of the lower esophageal sphincter.

Esophagitis is a complication of reflux and it develops when the mucosal defenses that normally counteract the effect of injurious agents on the esophageal mucosa succumb to the refluxed acid pepsin or bile. It is classified as peptic, bile or alkaline esophagitis, in accordance with the composition of the reflux contents.

DIAGNOSTIC STANDARD

Diagnosis by a qualified medical practitioner is required.

In the case of esophagitis, reports of appropriate investigations are to be submitted because the diagnosis cannot generally be made on clinical grounds alone.

Investigations may include, but are not limited to, upper gastrointestinal investigation (UGI), x-rays, barium swallow and/or gastroscopic examination with or without mucosal biopsy.

Persons will often self treat, and often for a period of years, prior to a medical assessment.

ANATOMY AND PHYSIOLOGY

The normal anti-reflux mechanisms consist of the lower esophageal sphincter (LES) and the anatomic configuration of the gastroesophageal junction. Reflux occurs only when the LES-gastric pressure gradient is lost. It can be caused by increased intragastric pressure or a transient or sustained decrease in the sphincter tone itself.

Abnormal activity of the diaphragmatic crural muscle which surrounds the esophageal hiatus in the diaphragm and changes the anatomic configuration of the esophagogastric junction, as in hiatus hernia, also predisposes to gastroesophageal reflux.

CLINICAL FEATURES

Clinically, symptoms could include, but are not limited to, difficulty swallowing, pain with swallowing, heartburn, chest pain or pressure, cramping, and regurgitation of esophageal contents to the mouth.

Severe reflux which reaches the pharynx and mouth may result in laryngitis, morning hoarseness, and pulmonary aspiration.

Symptoms are often exacerbated by being recumbent and increased abdominal pressure. Symptoms will often improve by returning to an upright position.

Complications of reflux esophagitis include dysphagia (difficulty swallowing), odynophagia (pain with swallowing), erosions, stricture, ulceration, iron deficiency anemia (from occult bleeding), Barrett's esophagitis and in some cases esophageal cancer. Aspiration may cause cough, dyspnea or pneumonitis.

PENSION CONSIDERATIONS

A. CAUSES AND/OR AGGRAVATION

THE TIMELINES CITED BELOW ARE NOT BINDING. EACH CASE SHOULD BE ADJUDICATED ON THE EVIDENCE PROVIDED AND ITS OWN MERITS.

1. Suffering from hiatus hernia at the time of clinical onset only

Hiatus hernia means a herniation of part of the stomach into the thoracic cavity through the esophageal hiatus in the diaphragm.

2. Undergoing an intra-abdominal surgical procedure in the area of the lower esophageal sphincter within several days of clinical onset or aggravation

The area of the lower esophageal sphincter means the region immediately surrounding the intra-abdominal esophagus and the diaphragmatic crura.

Interference with the lower esophageal sphincter during certain surgical procedures, such as vagotomy, partial or total gastrectomy, lower esophageal resection, and esophageal dilation may play a role in the development of reflux esophagitis. If the symptoms are due to the surgical procedure the symptoms should occur within approximately the first month after the operation.

3. Suffering from scleroderma at time of clinical onset or aggravation

Scleroderma is a multisystem disorder characterized by the association of vascular abnormalities, connective tissue sclerosis and atrophy, and auto-immune changes.

4. Suffering from increased intra-abdominal pressure at time of clinical onset or aggravation

Increased intra-abdominal pressure may result from, but is not limited to:

- obesity

5. Suffering from decreased lower esophageal sphincter (LES) gastric pressure at time of clinical onset or aggravation

Decreased LES pressure can result from many factors. Common factors include:

- anticholinergic, calcium channel blocker, Beta adrenergic stimulant, nitrate, Diazepam and aminophylline medications
- fat
- chocolate
- peppermint
- chronic alcohol dependancy or abuse

6. Inability to obtain appropriate clinical management

B. MEDICAL CONDITIONS WHICH ARE TO BE INCLUDED IN ENTITLEMENT/ASSESSMENT

- Hiatus hernia
- Esophageal erosions, ulcerations and stricture formation
- Barrett's esophagus (columnar metaplasia)
- Esophageal dysplasia

C. COMMON MEDICAL CONDITIONS WHICH MAY RESULT IN WHOLE OR IN PART FROM GASTROESOPHAGEAL REFLUX DISEASE AND/OR ITS TREATMENT

- Asthma
- Bronchiectasis
- Esophageal adenocarcinoma

REFERENCES FOR GASTROESOPHAGEAL REFLUX DISEASE

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