GERD: What Should an Endoscopist Do?

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Today’s Talk

• Will focus on diagnosis in the patient being scoped for GERD symptoms
• I will make several points
The Esophagus is Not a Conduit to the Stomach: Take the time to look at the entire tube
The Exam begins with the vocal cords and MUST include careful retroflexion
Uniform reports are imperative (and missing today)

And should include photographs as in colonoscopy
Why we currently do endoscopy in GERD?

1. Continued symptoms – heartburn, regurg
2. Screening desired for Barrett’s with subsequent surveillance
3. Any GERD symptom accompanied by dysphagia irrespective of age

*** I believe we are scoping too late in many circumstances.
Vast Majority of Patients Only Need One Scope
My keys to a thorough exam

• Identify the GEJ, SCJ (note distance from teeth and photo)
• Use LA grading (A-D or normal): Mild or severe esophagitis is not acceptable
• Look for signs of EoE if dysphagia
• Retroflex carefully
• An accurate description and photos of the columnar segment if present is mandatory
What I want us to do in relative to diagnosis of Barretts

- Underbiopsy the GE junction
- Aggressive biopsy the columnar-lined esophagus
- Do not biopsy the cardia
- Agree on a common reporting system so someone else will know what you saw
The Key is to define the end of the tube

• Above which you should biopsy
• Below which represents the cardia
  – I do not believe this should be biopsied as part of the process of looking for Barrett’s
Some would say these vessels can only come from the bottom of esophagus

Too controversial a concept than identifying the top of the gastric folds
Barretts
Barretts nodule with adeno Ca
Barretts nodule with adeno ca
• Once the decision has been made that the esophagus is columnar-lined we need ways to describe what we are looking at and subsequently make decisions about biopsy
Based on Available Data I suggest we use the Prague Classification.
Should We Biopsy at Index Endoscopy

- If you are comfortable that your patient has had adequate anti-secretory therapy prior to the endoscopy ---- biopsy
- If in unique position that your patient has not yet seen a PPI ... consider 8 weeks tx and then repeat EGD
• If we can agree upon a common reporting system with careful description of GEJ, columnar lining (Prague) and take good photos, patients will be better served than they are today