

## Laryngo-pharyngeal reflux: final remarks

C.A. LEONE, F. MOSCA

Laryngo-pharyngeal reflux (LPR) is a major cause of laryngeal inflammation and presents with a constellation of symptoms different from the classic gastro-oesophageal reflux disease (GERD).

During gastro-oesophageal reflux, the acidic stomach contents may reflux all the way up the oesophagus, beyond the upper oesophageal sphincter and into the back of the throat and, possibly, even the back of the nasal airway. This is known as laryngo-pharyngeal reflux, which can affect anyone. Adults with LPR often complain that the back of their throat has a bitter taste, a sensation of burning, or of something being “stuck”. Some may also have difficulty in breathing if the voice box is affected.

There is no pathognomonic symptom or finding, but characteristic symptoms and laryngoscopic findings provide the basis for validated assessment instruments.

In our experience globus, dysphonia, cough, only when all associated, strongly correlate with LPR.

We refer to them as RISK “Reflux Infernal Serial Killers”.

The Otolaryngologist, in present times, is more often tempted first to suspect LPR, to recognize instrumental findings and to proceed with medical treatment of the condition. In many cases, LPR may only be suspected when not all the frequent symptoms are present and when video-laryngoscopy does not indicate a clear posterior commissure finding.

In these cases, treatment with proton pump inhibitor is useful as a diagnostic tool of LPR.

It is necessary to start a prolonged treatment period of 8 weeks using a double dosage, followed by a second ENT follow-up. In this second examination, the clinician may, or may not, find an improvement in the signs and symptoms.

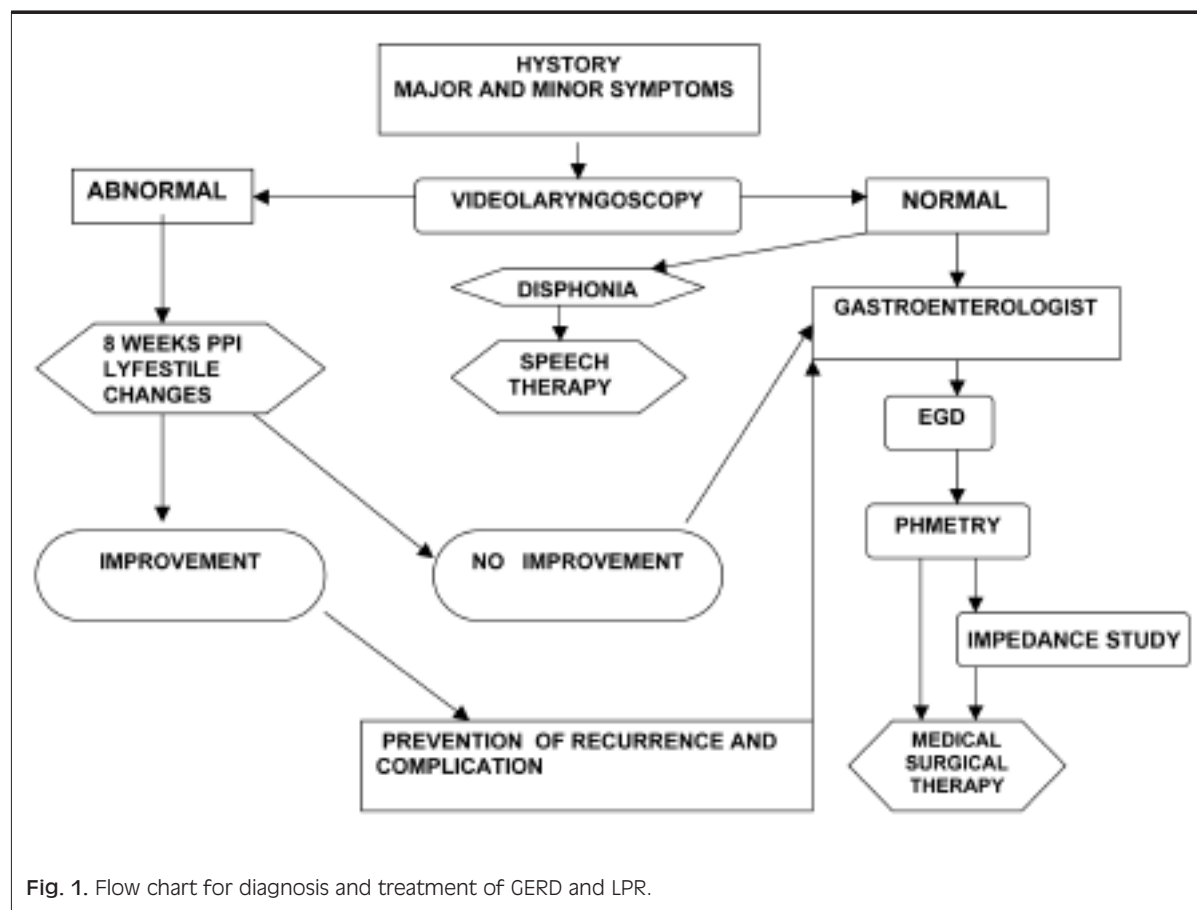


Fig. 1. Flow chart for diagnosis and treatment of GERD and LPR.

In the first case, diagnosis is confirmed with the therapeutic goal. In the second case, the patient must be referred to a gastroenterologist.

Oesophago-gastroduodenoscopy, dual-probe 24-hour pH monitoring or impedance study are often employed to better evaluate these patients.

Referral is also useful to avoid the frequent recurrence of illness.

But the ENT examination is useful for gastroenterologist also when the patient presents only typical or digestive symptoms: in fact, the specialist with great experience in the use of the diagnostic tools for GERD and LPR, can identify and cure many upper respiratory disorders, including also severe lesions (such as carcinoma) that may be prevented or treated. Males, females, infants, and children can all have

GERD or LPR. Unfortunately, GERD and LPR are often overlooked in infants and children leading to repeated vomiting; most infants grow out of GERD or LPR by the end of their first year; however, the problems resulting from GERD or LPR may persist. Children and adults who fail to respond to medical treatment or present anatomical abnormalities may require surgery which includes fundoplication, a procedure where part of the stomach is wrapped around the lower oesophagus to restrict the lower oesophageal sphincter (LES), and endoscopy, where sutures and radiofrequency energy ablation are used to make the LES diameter tighter.

We propose the following flow chart (Fig. 1) to define a possible procedure to diagnose and treat such patients.