

Gastroesophageal reflux disease is frequently present in patients with laryngeal and voice disorders

To the Editor

In a recent paper, Makhadoom et al¹ explored one aspect of the intriguing issue of extra-esophageal manifestations of gastroesophageal reflux disease (GERD). The authors reported their experience regarding the prevalence of GERD in 30 patients with laryngeal and voice disorders. By employing upper gastrointestinal (GI) endoscopy, they found "GERD with hiatus hernia in 63.3% of patients, GERD with acute gastritis and duodenitis in 10%, incompetent lower esophagus in 6.67% and normal in 20%". Furthermore, the sense of hyperacidity was present in 63.3% (19 out of 30).¹ We found these data very interesting and in agreement with the current literature.² However, another aspect may be highlighted. As considered in 1999 by the Genval Workshop group, the term GERD includes subjects with esophageal mucosal breaks as well as those without these features on endoscopy.³ Upper GI endoscopy represents the gold standard to detect esophageal injuries, but results may be biased by a condition called NERD (non erosive reflux disease) that represents 60% of those referred for this procedure, and may lead to underestimation (with false negative).⁴ On the contrary, "minimal mucosal lesions", such as edema and erythema, are not specific for GERD.⁵ To solve conflicts arising from the poor inter-observer reproducibility as well as from the multitude of classification schemes with various grading ranges, a scheme, termed "The Los Angeles (LA) classification system", has been proposed.⁶ In the LA system, minimal changes, such as erythema, edema, and friability have been removed and focus has been put on mucosal breaks. The fact that strictures, hiatal hernia, or Barrett's esophagus has not been included must also be considered. This grading scheme has good reproducibility and good correlation with esophageal acid exposure and healing after therapy. Therefore, the LA system is recommended when reporting esophagitis severity.⁶ In their paper, Makhadoom et al¹ did not mention the definition of endoscopic GERD employed, and did not clarify how they would manage the subset of patients with GERD symptoms but without esophageal lesions (by esophageal pH monitoring?). These details would have enriched the work.

Rinaldo Pellicano
Department of Gastro-Hepatology, Molinette Hospital
Sharmila Fagoonee
Department of Biology, Biochemistry and Genetics
University of Turin
Turin, Italy

Reply from the Author

We thank Drs. Pellicano and Fagoonee for their comments. Nicely, they suggested the use of "The Los Angeles (LA) classification system", to classify our patients with GERD; however, we would like to mention that we considered another classification system that considers minimal changes such as erythema and edema, before developing the mucosal breaks, which is mentioned in the LA - class A even. So, the grading system we used is as follow: Grade I = erythema and edema of the mucosa of the lower end of the esophagus. Grade II = esophageal ulcerations or mucosal breaks of less than 75% of the circumference of the esophagus. Grade III = esophageal ulcerations or mucosal breaks of more than 75% of the circumference of the esophagus. Grade IV = represents strictures and scarring of the esophagus. Also, we would like to mention that we believe that esophageal PH monitoring is an excellent tool to deal with the subset of patients with GERD symptoms, but without esophageal lesions, however, unfortunately such a tool is not available in our center, and this is why we depend on the response of GERD symptoms to empirical therapy with proton pump inhibitors in those patients.

Hassan A. Bokhary
Department of Medicine
Al-Noor Specialist Hospital
Makkah
Kingdom of Saudi Arabia

References

1. Makhadoom N, Abouloyoun A, Bokhary HA, Dhafar KO, Gazzaz ZJ, Azab BA. Prevalence of gastroesophageal reflux disease in patients with laryngeal and voice disorders. *Saudi Med J* 2007; 28: 1068-1071.
2. Ciorba A, Bianchini C, Pelucchi S, Pastore A. Gastroesophageal reflux and its possible role in the pathogenesis of upper aerodigestive tract disorders. *Minerva Gastroenterol Dietol* 2007; 53: 171-180.
3. An evidence-based appraisal of reflux disease management – the Genval Workshop Report. *Gut* 1999; 44 (Suppl 2): S1-16.
4. Fass R. Erosive esophagitis and nonerosive reflux disease (NERD): comparison of epidemiologic, physiologic, and therapeutic characteristics. *J Clin Gastroenterol* 2007; 41: 131-137.
5. Dughera L, Navino M, Cassolino P, Pellicano R. The diagnosis of gastroesophageal reflux disease. *Minerva Gastroenterol Dietol* 2007; 53: 143-152.
6. Lundell LR, Dent J, Bennett JR, Blum AL, Armstrong D, Galmiche JP, et al. Endoscopic assessment of oesophagitis: clinical and functional correlates and further validation of the Los Angeles classification. *Gut* 1999; 45: 172-180.