Symptom Check: Is It GERD?

ABSTRACT
Despite the vast number of individuals living with gastroesophageal reflux disease (GERD), establishing a diagnosis can be difficult. Detailed patient history and symptom review are critical. Nurses can play an integral role in gathering information that may lead to a definitive diagnosis. In addition to the classic symptoms of GERD—acid reflux and heartburn—several atypical conditions may also be present. Understanding the diverse and subtle nature of presenting symptoms can assist in establishing a GERD diagnosis. This column examines the atypical presentations of GERD, including laryngopharyngeal symptoms, chronic cough, asthma, and dental erosions.

LARYNGOPHARYNGEAL SYMPTOMS
According to Ahuja, Yencha, and Lassen (1999), 20% to 60% of patients with GERD have head and neck symptoms but no appreciable heartburn. Reflux is a contributory factor in hoarseness, chronic laryngitis, sore throat, and globus sensation (“lump in the throat”). Heidelbaugh, Gill, Van Harrison, and Nostrant (2008) have reported that “reflux is the cause of 10 percent of hoarseness, up to 60 percent of chronic laryngitis and refractory sore throat, and 25 to 50 percent of globus sensation in patients presenting with ENT symptoms” (p. 485). Patients with classic GERD symptoms typically have dysfunction of the lower esophageal sphincter and patients with head and neck symptoms have dysfunction in the upper esophageal sphincter. The most common symptom of individuals with laryngopharyngeal reflux is the feeling of a lump in the throat (Ahuja et al.).

CHRONIC COUGH
Chronic cough in the absence of classic GERD symptoms may in fact be caused by GERD. According to Makkar and Sachdev (2003), “GERD is the third most common cause of chronic unexplained cough after bronchial asthma and postnasal drip.” Chronic cough related to GERD could be caused by microaspiration of esophageal contents or a vagally mediated esophageal-tracheobronchial cough reflex due to acid in the distal esophagus. Individuals with reflux-associated cough usually have exacerbations first thing in the morning, nocturnally, while lying down, or immediately following exercise (Makkar & Sachdev).

ASTHMA
The exact relationship between asthma and GERD is unclear. However, patients with asthma are more likely to have GERD. According to Sheerin (2007), “As many as 70% of patients with asthma have GERD compared to 20% to 30% of the general population.” For patients with both GERD and asthma, it is difficult to establish which condition is the primary diagnosis, because either condition can induce the other. Asthma can be triggered by microaspiration of stomach contents into the trachea and bronchial tree; the resulting chronic irritation and inflammation can increase symptomatic asthma. Asthma can lead to GERD due to...
the increased negative pressure in the chest, which in turn increases the incidence of reflux. It has also been speculated that bronchodilators used to treat asthma can increase reflux. Some cues that can help establish the diagnosis of GERD-induced asthma are asthma symptoms that worsen after eating, drinking alcohol, or lying down or asthma that is refractory to medical therapy (Heidelbaugh et al., 2008).

**DENTAL EROSIONS**

When the acidic contents of the stomach are refluxed into the oral cavity, erosions of tooth enamel can result. Documentation from as early as 1971 associates dental erosions with reflux. Although some patients will have accompanying GERD symptoms, dental erosions can be one of the first signs of GERD. According to Ali, Brown, Rodriguez, Moody, and Nasr (2002), “Dental erosion of the posterior teeth is an important finding with respect to the diagnosis of gastroesophageal reflux disease” (p. 734). Although there are additional causes of dental erosion, when the definitive cause is unknown, it is wise to pursue medical diagnosis to indicate or eliminate the presence of GERD (Ali et al.).

**CONCLUSION**

GERD is a common problem affecting 10% to 30% of the Western world, with an annual estimated cost of more than 10 billion dollars in the United States (Ali & Miner, 2008). The National Ambulatory Medical Care Survey found that 38.53 million annual adult outpatient visits were related to GERD; despite this number, up to 90% of affected patients self-diagnose and 50% self-medicate (Heidelbaugh et al., 2007). Given the diverse and subtle nature of presenting symptoms and the absence of a gold standard test for GERD, definitive diagnosis and treatment are especially challenging. Detailed patient history and symptom review are critical. Nurses frequently play an integral role in obtaining accurate and detailed patient assessments. Thorough multisystem nursing assessment may reveal undiagnosed symptoms or even uncover a patient’s self-diagnosis of GERD. Understanding the classic symptoms as well as the atypical presentations of GERD can assist in establishing a definitive diagnosis.

**REFERENCES**


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