Government of **Western Australia**
Department of **Health**

Enhanced Access Community Pharmacy Pilot

Gastro-oesophageal reflux and gastro-oesophageal reflux disease

Clinical practice guideline

Service restricted to patients aged 18 to 55 years.

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

Contents

Guideline overview

Meet service and professional obligations

- Initial patient eligibility and suitability for management within the scope of the service
- Patient informed consent (including consent for communication with other health practitioners if relevant)

Patient history and assessment

- Patient history:
  - presenting signs and symptoms
- Examination:
  - vital signs

Develop management plan

- Non-pharmacological measures
  - dietary and lifestyle modification
- Pharmacotherapy

Confirm management is appropriate

- Contraindications, precautions, and interactions
- Pregnancy and lactation

Communicate agreed management plan

- Medication counselling
- General advice and patient information
- When to seek further care/treatment
- Communication with other health practitioners

Clinical review

- Response to treatment
- Continue, modify, or stop treatment
- Communication with other health practitioners

Refer when

- The patient is aged below 18 or above 55 years (does not preclude a patient from accessing usual pharmacy care)
- Unclear diagnosis
- Chest pain as the primary symptom
- Symptoms of anaemia, including fatigue, shortness of breath, weakness, dizziness, or an irregular heartbeat
- Difficulty or painful swallowing
- Prolonged or recurrent vomiting (longer than 24 to 48 hours)
- Jaundice
- Haematemesis or melaena
- Unexplained weight loss
- Severe, frequent, or changing symptoms
- Inadequate response to optimal treatment (8 weeks of PPI therapy at the standard dose).

Treat and concurrently refer

- Patient is on a medication that can precipitate reflux.

Key points

- The fundamental signs of gastro-oesophageal reflux are heartburn and regurgitation[1, 2, 3].
- The Therapeutic Guidelines defines gastro-oesophageal reflux disease (GORD) as gastro-oesophageal reflux symptoms that are frequent (2 or more episodes per week) or severe enough to significantly impair quality of life, or if complications of gastro-oesophageal reflux are present[3].
- The causes of gastro-oesophageal reflux and GORD are multifactorial and may involve dysfunctional peristalsis, delayed gastric emptying, and impaired or transient relaxation of lower oesophageal sphincter resting tone[1, 4].
- The presumptive clinical diagnosis of gastro-oesophageal reflux and GORD are primarily based on patient reported symptoms[3, 4]. However, response to a trial of proton pump inhibitors (PPIs) can help to confirm a diagnosis of GORD[2, 3]. A trial of high dose PPIs has a sensitivity of 80 per cent as a diagnostic test for GORD[1].
- The initial management of gastro-oesophageal reflux and GORD is based on the severity of symptoms; with symptom control the aim for most patients[3]. Mild intermittent symptoms may be managed with diet and lifestyle modification only. However, on-demand (when required) drug therapy may also be used if symptoms are significantly troublesome[3].
- Approximately one third of patients with symptoms of reflux have some form of mucosal damage, ranging from minor erosions to circumferential ulceration or metaplasia (e.g. Barrett's oesophagus)[3]. GORD may lead to oesophageal strictures in a minority of patients or on rare occasions, malignancy[3].

Refer when

Refer the patient to an appropriate healthcare provider (including emergency services, if required) in the following situations:

- the patient is aged below 18 or above 55 years (does not preclude a patient from accessing usual pharmacy care)
- unclear diagnosis
- chest pain as the primary symptom
- symptoms of anaemia, including fatigue, shortness of breath, weakness, dizziness, or an irregular heartbeat
- difficulty or painful swallowing
- prolonged or recurrent vomiting (longer than 24 to 48 hours)
- jaundice
- haematemesis or melaena
- unexplained weight loss
- severe, frequent, or changing symptoms
- inadequate response to optimal treatment (8 weeks of PPI therapy at the standard dose).

Treat (if clinically appropriate) and concurrently refer

- Patient is on a medication that can precipitate reflux.

Patient history and assessment

Presenting signs and symptoms

The clinical symptoms of GORD are common to multiple other conditions but can often be differentiated using the patient's history.

In addition to the cardinal signs of heartburn and regurgitation other atypical symptoms attributed to reflux include:

- belching
- epigastric pain
- dyspepsia
- acid brash (saliva mixing with stomach acid in the mouth)[1, 2].

Extra-oesophageal symptoms that are associated with, but not specific to gastro-oesophageal reflux, may include:

- tooth sensitivity, enamel erosion (particularly on palatal surface of upper incisors), and halitosis
- pharyngeal and laryngeal signs and symptoms such as hoarseness and throat clearing, persistent cough, sore throat, pharyngitis, and sinusitis
- chest pain
- sleep disturbance
- nausea
- asthma-like symptoms (cough, wheeze, shortness of breath)
- early post-prandial satiety[3, 4, 5].

Conditions to exclude

Table 1: Some conditions with symptoms similar to gastro-oesophageal reflux[6]

Condition*	Differentiating features*
• Gallstones	• Nausea and vomiting • Intense epigastric or right upper quadrant pain, which may radiate to the back, shoulder, or arm
• Peptic ulcer disease/ gastritis/*Helicobacter pylori* infection	• Abdominal pain • Nausea • Unintentional weight loss • Melena
• Myocardial infarction	• Nausea • Pressure, tightness, pain, or aching sensation in chest or arms that may spread to neck, jaw, or back • Shortness of breath • Cold sweats • Fatigue

*This table does not list all possible conditions or features. Consult specialised references for further information.

Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- weight
- pregnancy and lactation status (if applicable)
- nature, severity, and frequency of symptoms (typical, atypical, and extra-oesophageal), including signs and symptoms that may indicate the need for referral
- onset and duration of symptoms
- precipitating and relieving factors
- underlying medical conditions and conditions that may complicate diagnosis e.g. coronary heart disease and asthma
- dietary patterns or changes
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- allergies/adverse drug reactions
- pharmacological and non-pharmacological (dietary and lifestyle) strategies tried to treat current symptoms
- alcohol and drug history
- smoking status.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Examination

- Where appropriate, conduct assessment of vital signs.

Develop management plan

Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.

The initial management of gastro-oesophageal reflux and GORD is based on the severity of symptoms; symptom control is the aim for most patients[3].

Pharmacist management of gastro-oesophageal reflux and GORD involves:

- **non-pharmacological measures:**
  - advice regarding dietary and lifestyle modification as per the Therapeutic Guidelines: Diet and lifestyle modification for the management of gastro-oesophageal reflux in adults[3]
- **pharmacotherapy** [NB1,2]**:**
  - as per the Therapeutic Guidelines: Gastrointestinal (Gastro-oesophageal reflux in adults)[3].

NB1: The efficacy and availability of PPIs has led to overuse. Long-term regular PPI therapy is only recommended for a limited number of indications and should be reviewed regularly[3, 7].

NB2: Where regular drug therapy is required, consider referral to an appropriate healthcare provider[3].

Confirm management is appropriate

Consult the *Therapeutic Guidelines, Australian Medicines Handbook* and other resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- individual medicine use e.g. initial dosing, maintenance, and step-down therapy
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment
- when to return for follow-up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and/or parents/caregivers), and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

General advice

At the time of initial consultation, patients (and/or parents/caregivers) should be advised to see an appropriate healthcare provider if:

- the condition does not improve with recommended treatment (e.g. within 8 weeks of starting treatment with a PPI)
- ongoing maintenance treatment with a PPI is required
- the patient's condition worsens, including developing systemic signs and symptoms
- the patient develops new or changed signs or symptoms
- adverse effects of treatment cannot be managed in the pharmacy setting.

Patient resources

- Gastroenterological Society of Australia (GESA) Patient Resources: Information about Reflux

Clinical review

Clinical review with the pharmacist (or the patient's chosen healthcare provider) should occur in line with recommendations in the Therapeutic Guidelines.

- Patients should return for a follow up consultation 4 to 8 weeks after initiation of a new therapy to assess:
  - adherence to pharmacotherapy and non-pharmacological management strategies
  - response to treatment and if changes to the treatment plan are required (continue, modify, stop, and/or refer).

For patients continuing therapy, the frequency of further follow up appointments for maintenance and step-down therapy should be individualised to the patient's clinical presentation, response to treatment, and therapeutic goals, and based on recommendations in the Therapeutic Guidelines.

Pharmacists should prescribe a quantity of medicine (including repeats), that aligns with the expected duration of therapy, ensuring sufficient supply until the patient's next review. The total quantity prescribed should not exceed 12 months' supply (including repeats).

Pharmacist resources

- Therapeutic Guidelines: Gastrointestinal
  - Oesophageal disorders
  - Functional gastrointestinal disorders
- Australian Medicines Handbook:
  - Drugs for dyspepsia, reflux and peptic ulcers
- Australian Pharmaceutical Formulary and Handbook (APF): Treatment guideline for pharmacists (Gastro-oesophageal reflux)
- Australian Prescriber: The management of gastro-oesophageal reflux disease
- Pharmaceutical Society of Australia: Heartburn and indigestion 'Self-care' patient information card.
- Gastroenterological Society of Australia (GESA) Patient Resources: Information about Reflux
- Clinician Assist WA: Dyspepsia and Heartburn/GORD

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Feedback

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