



Foreword

Endoscopic therapy for gastroesophageal
reflux disease



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Therapeutic gastrointestinal endoscopy has thrived in areas previously claimed by more invasive surgical procedures. Colonoscopic polypectomy, endoscopic retrograde cholangio-pancreatography with sphincterotomy, and endoscopic therapy for upper gastrointestinal bleeding from peptic ulcer are prime examples. Now we are witnessing a major endoscopic offensive into an arena contested not only by surgery but also by medical pharmacological therapy—gastroesophageal reflux disease (GERD).

The stakes are high. Millions of Americans have symptomatic GERD. The market for pharmacological agents both over the counter and by prescription can be calculated in billions of dollars. The success of the proton pump inhibitor class of medications for GERD is one of the great pharmaceutical achievements of the current era, with an outstanding record of efficacy and safety.

In a minority of patients in whom proton pump inhibitor therapy is not successful and the cost of drug therapy becomes an economic burden, surgical therapy is an alternative. Laparoscopic fundoplication (with technical variations) has emerged as the clear winner in terms of the surgical management of GERD. There are certainly problems in a small number of patients who are left with uncomfortable postoperative symptoms. Furthermore, there are accumulating data indicating that as years go by, a majority of patients who have surgery resume taking antacid medications.

Can endoscopic therapy become another option for GERD patients to medical or surgical therapy? There are at least three types of approaches to endoscopic

therapy: (1) tightening the esophago-gastric junction with sutures, staples, or rivets; (2) sclerosing the esophago-gastric junction with deep radio-frequency ablation; and (3) narrowing the esophago-gastric junction by the injection of inert materials under the mucosa. These approaches are all in an early stage of development, although suturing (EndoCinch) and sclerosing (Stretta[®]) are already approved by the US Food and Drug Administration for clinical use. Will these treatments be useful in patients with large hiatal hernias and severe GERD, or only in those with mild forms of the disease? Safety, efficacy, repeatability, and reversibility are all important considerations in these treatments.

It seems an appropriate time to review the state-of-the-art of endoscopic therapy for GERD—I am delighted that Dr. Richard Rothstein agreed to take on the task. Dr. Rothstein was one of the earliest investigators in this field and has maintained an objective point of view and an open mind, promoting rigorous clinical research and demanding the hard data needed. He has assembled expert and pioneering authors in each of the endoscopic treatment methods for GERD, anchoring their articles with others indicating how the endoscopic therapies might correct the patho-physiologic abnormalities involved in the disease.

Is the endoscopic treatment of GERD the next big thing for gastrointestinal endoscopy? It could be. Which, if any, of the current treatments will prevail? Read this issue of the *Gastrointestinal Endoscopy Clinics of North America* and judge for yourself.

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