

ENT NEWS

A Service of the Ear, Nose, & Throat Center, PLLC

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Quarterly Newsletter

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LARYNGOPHARYNGEAL REFLUX

Laryngopharyngeal reflux (LPR) is a very common problem seen in medical practice and is quite difficult to resolve. Patients with LPR present with more than a dozen symptoms to ENT doctors and the same patients initially will present to their primary care physicians office. In addition to the typical LPR symptoms multiple reflux induced respiratory symptoms are common. The association between asthma and LPR has been well documented.

It is very likely that gastroesophageal reflux disease (GERD) was recognized in antiquity, however, LPR that is GERD that affects the larynx and pharynx was described in 1968. The pattern and mechanism of GERD and LPR are different. Analysis of pH probes in the distal esophagus and pharynx revealed that the LPR patients had reflux in the upright positions and the GERD patients had reflux while supine. The mechanisms may be quite different. The gastroenterology model of reflux doesn't seem to apply to patient with LPR. Other terms such as atypical reflux, laryngeal reflux, reflux laryngitis and others have been used. The prevalence of GERD and LPR is not known exactly but it is estimated that at least 10% of patients with laryngeal and voice disorders have LPR. One study has shown that 50% of patients with voice disorders had pH documented reflux.

Laryngopharyngeal reflux is somewhat controversial since that symptoms and physical findings are not always clean cut. The diagnosis of LPR depends on symptoms, laryngeal findings and the results of pH monitoring.

SYMPTOMS

Chronic dysphonia	Chronic cough
Intermittent dysphonia	Dysphagia
Vocal fatigue	Glomus sensation
Voice breaks	Airway obstruction
Chronic throat clearing	Pharyngeal/laryngeal spasm
Excessive throat mucous	Wheezing
Post nasal drip	

Findings on an ENT exam might include edema of the undersurface of the vocal cords, edema of the ventricle behind the true and false cords, vocal cord edema, erythema or hyperemia of the larynx, posterior commissure hypertrophy, thick mucous on the vocal cords, or granulomas on the vocal cords. More serious problems can occur secondary to LPR. Not only can it cause voice disorder but subglottic stenosis can occur. Rarely cancer of the larynx in nonsmokers is thought to be contributed to by LPR.

Evaluation can include a complete laryngeal exam with either a mirror or a flexible laryngoscope. Occasionally video laryngeal stroboscopy, pH probe, esophagoscopy or esophageal manometrics are done.

The treatment of LPR is not always the same as the treatment for GERD. LPR acid must be suppressed around the clock since the larynx is more susceptible to injury than the distal esophagus. The reflux may also occur when the patient is upright in contrast to supine in bed with GERD.

Proton pump inhibitors (PPIs) are much more effective than H₂ receptor antagonist. Some studies have demonstrated a significant failure rate with once daily dosing with a PPI. The medicine may need to be given more often. The LPR symptoms do not resolve quickly and may take months of therapy to resolve. The goals of therapy are to arrest the inflammatory process in the larynx and also to reconstitute the bodies' normal antireflux mechanisms if possible. Also decreasing weight, dietary changes and smoking cessation may help. If all fails, fundoplication may be helpful and highly successful.

The MOST important thing to remember is if laryngeal symptoms fail to resolve with treatment, the larynx has to be evaluated and visualized by an ENT doctor.

REMINDERS

- Our Grandville office has moved to 2373 64th St., SW, Byron Center, MI 49315 located near Byron Center Rd. and M-6
- After 31 years in practice, Dr. Robert Petroelje has retired from practice as of 7/11/08
- We welcome Dr. Chad Afman to our office