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**MORE CONVERSATIONS WITH THE DOCTOR: GERD AND ITS RELATIONSHIP TO ASTHMA**

*Air it Out* continues our discussions with Dr. William Howland, MD, Board certified in Internal Medicine & Allergy and Immunology, Allergy & Asthma Center of Austin, (512-345-7635) [www.nosneezes.com](http://www.nosneezes.com) concerning some difficult patient inquiries.

\* **AIO:** GERD (Gastroesophageal Reflux Disease) is linked to so many respiratory illnesses – asthma, allergies, food allergies, vocal cord dysfunction, chronic cough, COPD, Chronic Bronchitis to name a few. What exactly is GERD?

\* **Dr. Howland:** GERD (Gastro = stomach, Esophageal = swallowing tube) Reflux Disease is more commonly known as **heartburn or indigestion**. Reflux occurs when stomach acid and digestive juices flow back up the swallowing tube (esophagus) and irritate or damage the membrane lining the esophagus. GERD patients may experience a burning or gnawing pain in the upper stomach or lower chest. Some people have a sour or acidic taste when the reflux contents actually reach the back of the mouth. A **weakness of the muscle** at the bottom of the esophagus as it passes through the diaphragm (muscle under the lungs which aids in breathing) **is the usual cause**. Some people have a “hiatal hernia” which is a small part of the stomach herniated through the diaphragm into the chest cavity. With a **hiatal hernia**, acid reflux occurs because the diaphragm is no longer aiding the esophageal muscle in keeping stomach contents in the stomach. Over a long period of time, **GERD** can result in **damage to the esophagus** causing swallowing difficulties, **narrowing of the esophagus**, or in rare cases, changes in the cells leading to cancer.

\* **AIO:** Which comes first, the chicken or the egg? In other words, does having GERD provoke respiratory illnesses like asthma or do these respiratory illnesses cause GERD?

\* **Dr. Howland:** GERD is **common** in people **with asthma**, affecting as many as 60%. It can **worsen asthma** in a number of ways. When stomach contents reflux into the lower esophagus, reflex cough and broncho-spasm can occur leading to asthma symptoms or exacerbation. Cough and heavy breathing associated with asthma can actually increase reflux which can increase asthma and cough resulting in a self perpetuating process. GERD is often worse when a person is lying down; stomach contents can more easily move up into the esophagus, a reason that asthma can flare at night while a patient is in bed. **Reflux** should be suspected for the **asthma patient who wakes suddenly** with a choking cough.

\* Sometimes a patient will have spasm of the vocal cords as the body tries to protect the windpipe. The patient may feel tight in the throat or upper chest, feel they can't get a breath, or note wheezy sounds while trying to breathe in. The acute symptoms may pass in a few minutes but may be followed by asthma problems lasting minutes to hours. Reflux associated asthma and cough symptoms are worse if the underlying asthma is not under good control.

\* *GERD should be suspected in any asthma patient who is not well controlled with usual medications.* If **cough** and **wheezing** are prominent symptoms, **GERD** may be a **factor**. To make things even more complicated, many asthma patients with GERD do not have heartburn or indigestion and are unaware that GERD is playing a role in their asthma. Theophylline, a popular pill which was used extensively in the US for asthma control until the 1990s, can actually make reflux worse. **LPR** or laryngopharyngeal (laryngo = vocal cords and pharyngeal = throat) reflux is a recently recognized condition of **acid reflux into the throat**. As many as 75% of people with LPR have no heartburn and don't know they are refluxing. LPR can trigger asthma and cough, especially if any of the stomach acid and digestive juices get past the vocal cords and into the windpipe. More often **patients have severe coughing spasms**, sometimes leading to gagging or even vomiting. LPR **can mimic asthma** causing wheezing, cough, shortness of breath and tight chest even though lung function is not affected. A common pattern of symptoms with LPR is throat clearing, the sensation of past nasal drip or something sticking in the throat, dry cough and hoarseness. These symptoms don't respond to the usual treatments for allergy and asthma and can be very frustrating until the cause is determined and appropriate treatment is started.

\* **AIO:** How is GERD detected then controlled so that its impact on respiratory disease is reduced or eliminated?

\* **Dr. Howland:** Unfortunately, there are **no simple tests** to diagnose reflux. A **barium x-ray** may show a hiatal hernia or reflux or, it can be normal. An **EGD** (esophago-gastro-duodenoscopy) or looking down the esophagus with a fiberoptic scope can assess esophageal health and show secondary signs of reflux. An EGD is important in people with chronic reflux to rule out changes in the esophagus lining which may be precursors of cancer. A **pH probe** can be inserted through the nose to record acid levels in the esophagus over a 24 hour period. Except for barium swallow, these are invasive and expensive tests. The simplest and least expensive test can be a 2 month trial of reflux medications. Reflux **can be treated** with diet, life style changes and medications. *Reducing caffeine, not smoking and avoiding spicy and acidic food helps.* Patients with reflux should not eat within 2 hours of bedtime. Losing weight helps. Some people respond to tilting the entire bed at night so the head is 4 to 6 inches higher than the feet. This can be done by putting books or bricks under the frame at the head of the bed. Propping the head up on pillows is less helpful. Medications for reflux include antacids (Maalox, Mylanta, Tums, Rolaids, etc), H2 blockers (Zantac, Tagamet et al, which are available OTC) or prescription drugs (Nexium, Prevacid, Aciphex et al) which tend to be the most effective. For LPR, higher and twice daily dosing may be required. In severe cases surgery (fundoplication) can significantly lessen reflux.

**Upcoming Free AAFA-TX Programs:** 1) June 7 “Diagnosing & Managing Asthma 2008” LaQuinta Inn, Arlington, a CME symposium for physicians, nurse practitioners, physician assistants, nurses and respiratory therapists worth 4 cat. 1 CME, 4 CE for nurses. William Lumry, MD, Robert Rogers, MD, Eric Schmitt, MD, William A. Neaville, MD, faculty, Gerald Moore, MD, moderator, Rebecca Gruchalla, MD, program director. Pre-registration required by email [info@aafatexas.org](mailto:info@aafatexas.org). For more info, see [aafatexas.org](http://aafatexas.org) or email [info@aafatexas.org](mailto:info@aafatexas.org).

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