OMNIA HEALTH · NEWNAN, GEORGIA

Your Reflux and GERD Decision Guide

Why the pill stops being the answer, which four tests actually decide your treatment, how the operations really compare, and what to do about Barrett's esophagus.

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START HERE

A pill treats the acid. It does not treat the valve.

If you have taken omeprazole for years and still have symptoms, that is not a dosing problem. It usually means the thing causing your reflux was never something a pill could reach.

Reflux happens when the barrier between your esophagus and your stomach stops holding. Two structures do that job: the lower esophageal sphincter, a ring of muscle, and the diaphragm, which grips around the esophagus and keeps the stomach below it. A hiatal hernia means the stomach has slid up through that opening, and once it does, the valve geometry is gone.

A proton pump inhibitor such as omeprazole or pantoprazole reduces how much acid your stomach makes. That is genuinely useful, and for many people it is enough. But it does not move the stomach back down or tighten anything. Reflux still happens; it is just less acidic. That is why some patients feel better on the pill and still have esophageal damage, and why non-acid reflux, regurgitation, cough and hoarseness often do not respond to acid suppression at all.

> **THE DISTINCTION THAT CHANGES YOUR TREATMENT**
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> If your problem is acid production, medication is the treatment. If your problem is a mechanical barrier that has failed, medication manages a symptom while the cause continues. Sorting out which one you have is what the testing on the next page is for, and it is the step most often skipped.

SYMPTOMS THAT ARE REFLUX, BUT DO NOT FEEL LIKE HEARTBURN

- Chronic cough, throat clearing, hoarseness, or a voice that is worst in the morning.
- The feeling of a lump in the throat, or of food sticking.
- Chest pain that has been worked up by cardiology and cleared.
- Dental erosion, or a persistently sour or bitter taste.
- Waking at night choking or coughing, or needing to sleep propped up on pillows.
- Adult-onset asthma that does not behave like ordinary asthma.

SYMPTOMS THAT SHOULD BE EVALUATED PROMPTLY, NOT MANAGED AT HOME

- Difficulty swallowing, or food that genuinely will not pass.
- Unintended weight loss.
- Vomiting blood, or black stools.
- New symptoms after age 50, or reflux symptoms lasting more than five years without ever having had an endoscopy.

BEFORE ANY OPERATION

Four tests, four completely different answers

No reputable surgeon should offer you a reflux operation without these. Each one answers a question the others cannot, and together they determine which procedure is safe for you.

TEST	WHAT IT ANSWERS	WHY IT CHANGES THE PLAN
Upper endoscopy with biopsies	Is there visible damage, a hiatal hernia, or Barrett's esophagus? Biopsies find what the eye misses.	Grade C or D esophagitis or Barrett's confirms the diagnosis outright and changes which operation is appropriate.
pH study, off medication	How much acid actually reaches your esophagus, measured over 24 to 48 hours, and whether it lines up with your symptoms.	This is what proves reflux rather than assuming it. It can be skipped only when endoscopy already shows severe esophagitis or Barrett's.
Esophageal manometry	Does your esophagus squeeze normally, and does the sphincter relax properly?	Not a formality. Weak or absent motility makes a full wrap unsafe, and it can reveal achalasia masquerading as reflux.
Contrast esophagram	The shape of things: hernia size and type, and how a swallow actually moves.	Sizes the hernia and identifies a paraesophageal hernia that needs repair regardless of symptoms.

WHY WE INSIST ON MANOMETRY

Choosing a reflux operation without knowing how your esophagus moves is the most common way a technically perfect operation produces a miserable patient. A full wrap in someone with poor motility leaves them unable to swallow comfortably. The test takes about 20 minutes and it prevents that.

WHAT THE RESULTS ACTUALLY DECIDE

- Whether you have reflux at all, or a motility disorder that looks like it.
- Whether a full wrap, a partial wrap, or a different approach is right.
- Whether a hiatal hernia needs repair, and how large a repair.
- Whether you need surveillance for Barrett's rather than an operation right now.
- Whether medication remains the better option for you, which is a legitimate outcome.

COMPARE

What each procedure does, and its honest trade-off

Every one of these has a patient it is right for. The mistake is a practice that offers only one and finds a reason it fits everybody.

PROCEDURE	WHAT IT DOES	USUALLY CHOSEN WHEN	TRADE-OFF
Hiatal hernia repair	Brings the stomach back below the diaphragm and closes the enlarged opening. Almost always done together with one of the procedures below.	A hernia is present, which is very common in significant reflux.	Rarely sufficient by itself. The valve usually needs rebuilding too.
Nissen or Toupet fundoplication	Wraps the top of the stomach around the lower esophagus to rebuild the valve. Nissen is a full wrap; Toupet is a partial wrap.	The definitive repair, and our default for durable control. Toupet when motility is borderline.	Some early difficulty swallowing and gas bloating, usually settling over weeks. Requires normal or near-normal motility for a full wrap.
TIF (transoral incisionless fundoplication)	Builds a partial valve from inside, through the mouth, with no incisions.	Smaller hernias and patients who want an endoscopic option.	Less durable than a surgical wrap, and not suitable for larger hernias. Often needs a hernia repair alongside it.
Magnetic sphincter augmentation	A ring of magnetic beads placed around the esophagus that opens to swallow and closes afterward. Now offered here.	Selected patients who want to avoid a wrap, with the right anatomy and motility.	A device, with a real removal and recurrence rate. We will usually steer you to a proper fundoplication when both are options.

WHAT THEY HAVE IN COMMON

- Laparoscopic or robotic through small incisions, except TIF which is endoscopic.
- Typically one night in the hospital, then a soft diet for two to four weeks.
- Desk work in one to two weeks; lifting restricted longer to protect the repair.
- The goal is getting off daily acid medication. Most patients do. We do not promise it, because some still need something.

THE QUESTION TO ASK

"Which of these do you perform, how many a year, and which would you recommend against for me?" A surgeon who offers all of them and can argue against each is giving you an assessment. A surgeon with one answer is giving you their inventory.

TWO SITUATIONS WORTH THEIR OWN PAGE

When reflux has already changed something, and when surgery caused it

BARRETT'S ESOPHAGUS

Years of acid exposure can change the lining of the lower esophagus to a type more like intestinal lining. That is Barrett's esophagus, and it matters because it is the recognised precursor to esophageal adenocarcinoma. The nuance is proportion: the great majority of people with Barrett's never develop cancer, and the annual risk for any one patient is low. It is a reason to be in a surveillance program, not a reason to panic.

- Diagnosed by biopsy, not appearance. An endoscopy without biopsies is an incomplete answer.
- Its presence is objective evidence of significant reflux, and it changes which operation is appropriate.
- Surveillance intervals depend on dysplasia, which is treated rather than just watched.
- Controlling reflux does not reverse established Barrett's, so surveillance continues after treatment.

REFLUX AFTER A GASTRIC SLEEVE

Common and under-discussed. Among patients with no reflux symptoms before a sleeve gastrectomy, roughly 45% develop them afterward, and long-term studies show symptoms, erosive esophagitis, hiatal hernia and acid medication use all rising substantially.[1,2] It is mechanical: removing the fundus flattens the natural angle at the esophagus, divides the fibres that help the sphincter close, and leaves a narrow, high-pressure tube.[3]

THE TWO THINGS A POST-SLEEVE PATIENT NEEDS TO KNOW

First: a fundoplication is not possible after a sleeve. The fundus used to build the wrap is the part that was removed, so any clinic offering you one has not read your operative report. The standard definitive repair is conversion to a Roux-en-Y gastric bypass. Second: current guidance recommends a screening endoscopy in every patient three or more years after a sleeve, symptoms or not.[4] Most patients have never been told this.

Conversion works well but is not a guarantee: published series report roughly 80 to 92% meaningful improvement, though many patients still need some acid medication, and revisional surgery carries more risk than a first operation.[5,6] Individual results vary.

If you are still deciding on a sleeve, have your reflux assessed first. Routine endoscopy before every bariatric operation is debated, reasonably: across more than 10,000 patients about 56% of preoperative scopes were entirely normal.[7] But with real reflux symptoms, a scope beforehand is how you avoid choosing the one operation most likely to make your worst symptom permanent.

BRING THIS WITH YOU

Twelve questions worth asking before you agree to anything

1. Which reflux operations do you personally perform, and how many a year?
2. Will you order manometry and a pH study before deciding, and why or why not?
3. Do I have a hiatal hernia, and how large is it?
4. Based on my motility, is a full wrap safe for me, or do I need a partial one?
5. Do I have Barrett's esophagus, and was a biopsy taken rather than just a look?
6. If I have Barrett's, what is my surveillance schedule after treatment?
7. What is the realistic chance I get off acid medication completely?
8. What side effects come in the first three months, and which ones last?
9. What is your reoperation rate if the repair fails later?
10. If I have had a sleeve, why is conversion to bypass the recommendation?
11. What happens if I do nothing, in my specific case?
12. Would you recommend against any of these options for me, and which?

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> **Important.** General medical education, not medical advice, and it does not create a doctor patient relationship. Individual results vary: the figures above are population averages, not predictions about you. Reported rates for Barrett's esophagus after sleeve gastrectomy vary widely between studies and no single figure is definitive. Both surgical and medical treatment carry risks to be discussed with a physician who has reviewed your testing.

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