

Laryngopharyngeal reflux (LPR)

Answers to frequently asked questions

How can I have reflux if I don't feel it, taste it, and never have heartburn?

LPR is different from GERD. One of the hallmarks of this condition is its subtle presentation and lack of the more typical symptoms one thinks of when they hear the word "reflux". Many patients have never had a "stomach problem" of any kind.

Shouldn't some type of test be performed before treatment is started?

Currently, the best diagnostic test to confirm LPR is response to a proper course of treatment. LPR is usually suspected by listening to a patient's symptoms and careful examination of the nose, throat and larynx. Endoscopy, barium swallow, pH monitoring, manometry, can all be helpful in certain circumstances, but generally are not sensitive enough to detect many cases of LPR.

What if I have already been taking an antacid without improvement?

The nature of LPR requires aggressive therapy for 2-6 months before improvement is noticed. This aggressive regimen usually requires a strong antacid (Nexium, Prevacid, Zegerid, etc.) taken as often as 2-3 times per day. Also, the antireflux diet and lifestyle changes are absolutely pivotal, and if not followed strictly, patients often fail to improve.

C'mon, how can anyone strictly follow such a restrictive diet?

Admittedly, the antireflux diet is strict and does, at least temporarily, eliminate many popular foods and drinks. Unfortunately, the diet is the stumbling block for most patients, and many do not improve until the final remaining favorites have been completely eliminated. Many reluctant and skeptical patients find that their favorites are not missed as much as they thought, and that the improvement of chronic ear, nose, and throat problems has been more than worth their sacrifice.

Why is the diet so important?

Each item on the list of dietary restrictions is either acidic itself, promotes acid production, or promotes reflux by causing belching or relaxation of muscles that normally prevent backwash of stomach juices.

How can I have LPR if my gastroenterologist disputes it or my esophagoscopy was normal?

LPR was formally described in 1991, and has been poorly understood. Fortunately, as more research is done, we gain better understanding and the condition becomes more widely known and accepted. Still, it remains controversial in the minds of some.

The esophagus is a relatively durable and resilient structure. A certain amount of exposure to acid and digestive enzymes can be well tolerated without damage. An endoscopy may therefore be "normal". However, the same amount of reflux may cause terrible problems for the more delicate tissues of the throat, larynx, nasal passages, etc.

Could I have LPR if I had a "normal" pH study?

Yes. LPR is an intermittent phenomenon and a patient may not have an event during the test. Studies have shown that pH tests are only about 60% sensitive for detection of LPR. Also, there is no consensus regarding the normal ranges of reflux entering the upper esophagus and throat. Some specialists use the DeMeester scale for evaluating pH studies, however this scale was designed for traditional GERD and is not appropriate for analysis of LPR (proximal reflux).

Will I always require treatment for LPR?

Hopefully, patients with LPR can be weaned off of treatment. However, many will have to manage their LPR in some fashion, or "co-exist" with some of their symptoms.

Am I at risk for cancer or more serious problems?

LPR symptoms can sometimes indicate the presence of problems involving the esophagus (including cancer). Therefore, if the LPR is chronic or severe, endoscopy to evaluate the esophagus is important.

Can LPR run in families?

Yes, but it is also under the influence of age, weight, dietary and lifestyle habits, stress levels, hormonal changes, medication side effect, prior treatment with radiation or surgery, hydration, certain rheumatology disorders, pregnancy, etc.

Can children have LPR?

Yes, it can affect all ages.