GP Resource

One size fits all? An update on surgical management for reflux

At least 10-20% of people suffer from reflux weekly. Whilst for many it is only mild and can be treated with effective medical therapy, for some it is persistent. Ongoing reflux can progress to Barrett's oesophagus and then further to malignancy. Approximately 10-40% of patients will continue to have significant symptoms of reflux despite maximal PPI therapy. For these patients, many of whom may also have a hiatus hernia, surgical management should be considered.

A fundoplication is a surgical option to treat reflux and hiatus hernia repair. This procedure takes approximately 1-2 hours. It involves dissecting the oesophagus free around the abdominal hiatus and into the mediastinum. After ensuring that at least 2-3cm of the oesophagus and all of the stomach is below the hiatus (i.e. reducing any hiatal hernia or paraoesophageal hernia), the crura of the hiatus are reapproximated. Part of the fundus of the stomach is then wrapped around the oesophagus at this level to reinforce the repair and act as an anti-reflux mechanism.

There are many immediate and long-term benefits to having a fundoplication, which have been well documented in the literature. These include:

- Improved quality of life – the vast majority of patients state they are happy they had the procedure.
- Decreased chance of developing Barrett's oesophagus and malignancy statistics.
- Elimination of medication.

Along with these general benefits, long term follow up from a randomised controlled trial has shown that the differing types of fundoplication have a different long-term quality of life profile (Hopkins et al., 2020).

- A Total 360° (Nissen) fundoplication involves a complete wrap around the oesophagus. It is very effective in relieving the symptoms of severe reflux but can also result in dysphagia, gas bloating, flatulence and difficulty vomiting.
- Partial fundoplication, which involves a lesser wrap, still yields excellent anti-reflux results but results is less dysphagia and less odynophagia, as well as less flatulence and gas bloating.

The literature indicates that the benefits last years post surgery, but despite this, we know that 25-30% of patients are restarted on reflux medication. Objective endoscopic studies have shown only 25% of those restarted on medication (so 5-6% of total patients) actually have evidence of ongoing reflux. Therefore, if a patient complains of recurrent reflux following fundoplication, it should warrant a surgical review including endoscopy.

The positive immediate and long-term benefits of having a fundoplication indicate that it is the preferred option for those who have not responded to maximal PPI therapy, or those who have been identified as having a hernia. Considering the differing degrees of surgical fundoplication yield different long-term side-effect profiles, the best patient results are achieved when the fundoplication is tailored to the needs of the individual. That is, the surgeon and patient together need to delicately balance the severity of the reflux, the patient's quality of life and the potential side effects, to achieve the best overall outcome for the individual. It is also important for the surgeon to communicate the type of fundoplication that has been performed on the patient to be able to monitor for potential related side effects.

Hopkins RJ, Irvine T, Jamieson GG, Devitt PG, Watson DI. Long-term follow-up of two randomized trials comparing laparoscopic Nissen 360° with anterior 90° partial fundoplication. British Journal of Surgery. 2020;107(1):56-63. doi: 10.1002/bjs.11327

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