
PEDIATRIC GASTROESOPHAGEAL REFLUX DISEASE (GERD)

Acid reflux occurs when acidic stomach contents flow back into the esophagus, the swallowing tube that leads from the back of the throat to the stomach. In some children, when reflux happens so frequently and is so severe that it causes complications, it is known as pediatric gastroesophageal reflux disease (GERD). An estimated five to eight percent of children have pediatric GERD. In babies, reflux is called spit up, and is normal and expected. In older children, the signs of reflux can be burping, stomach aches, and heartburn.

Complications include failure to gain weight, bleeding, breathing problems, hoarseness, and/or inflammation of the esophagus, known as esophagitis. Researchers have found that one in 10 infants younger than 12 months with GERD develop significant complications, but as infants grow their improved muscle control and the ability to sit up often resolves many instances of GERD.

WHAT ARE THE SYMPTOMS OF PEDIATRIC GERD?

GERD is common in adults, but children have a harder time describing this sensation. They may complain of stomach aches or chest discomfort, particularly after meals. Other symptoms include:

- Crying or irritability
- Poor appetite, or feeding and swallowing problems
- Weight loss or poor weight gain
- Wet burps or vomiting, or regurgitation
- Stomach aches
- Abdominal and/or chest pain
- Sore throat
- Hoarseness
- Asthma or wheezing
- Chronic coughing and throat clearing

- Chronic sinusitis
- Ear infections and/or fluid in the ear
- Tooth decay

WHAT CAUSES PEDIATRIC GERD?

GERD occurs when a valve at the lower end of the esophagus doesn't work properly. Normally, this muscle closes to keep acid in the stomach and out of the esophagus. During the first year, infants frequently spit up. This is called laryngopharyngeal reflux (LPR), when stomach acid travels up the esophagus and spills into the throat or voice box. However, in most infants, it's a normal occurrence caused by the immaturity of both the upper and lower esophageal valves, the shorter distance from the stomach to the throat, and the greater amount of time infants spend lying on their backs.

But repeated exposure to acidic stomach contents may cause long-term airway problems, such as a narrowing of the area below the vocal cords, hoarseness, and possibly eustachian tube dysfunction with ear or sinus infections and hearing loss. Infants who have breathing-related symptoms or feeding problems should be seen by an ENT (ear, nose, and throat) specialist, or otolaryngologist.

WHAT ARE THE TREATMENT OPTIONS?

Treatment of reflux in infants is intended to lessen symptoms, not to relieve the underlying problem, as this will often correct itself over time. Lifestyle changes are often recommended, such as smaller and more frequent feedings, burping more throughout the feeding, avoiding tight diapers and waistbands, and keeping the baby upright after feeding.

You can also help older children make certain lifestyle changes. Pay attention to what they eat, avoiding chocolate, carbonated drinks, caffeine, tomato products, peppermint, and other acidic foods like citrus juices.

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Fried foods and spicy foods can aggravate GERD symptoms. Have your child eat smaller, more frequent meals instead of large amounts of food at one sitting. Avoid eating right before they go to bed or lie down; let two or three hours pass.

Taking a walk or a warm bath after eating can help your child, as well as losing excess weight or dressing in loose-fitting clothing. You can also try raising the head of your child's bed about 30 degrees.

Most medications prescribed to treat GERD break down or lessen intestinal gas, decrease or neutralize stomach acid, or improve intestinal coordination. A trial of medications including H2 blockers or proton pump inhibitors may be advised by your child's primary care physician, but it's rare for children with GERD to require surgical intervention.

WHAT QUESTIONS SHOULD I ASK MY DOCTOR?

1. What's the difference between GERD, LPR, and normal pediatric regurgitation?
2. What long-term damage might be done to my child's development?
3. Do you recommend medication or other more intensive forms of treatment?