The changing face of treatment for hiatus hernia and gastro-oesophageal reflux

It is paradoxical that recently the number of operations for gastro-oesophageal reflux and hiatus hernia has increased dramatically even though extremely effective medication for these conditions is now available in many, if not all, Western countries. The traditional indications for antireflux surgery still exist but they have been impacted upon by cultural factors, cost, and associated serious disease; so why do more people require surgery?

The most common indication for surgery used to be the failure of medical treatment in severely symptomatic disease; however, so effective are proton pump inhibitors (PPIs) at controlling the major symptom of reflux—namely, heartburn, that this is a less common reason for performing surgery today. Indeed, the failure of a patient to get some degree of symptomatic relief from an adequate dosage of PPIs should alert the surgeon to other problems—for example, bile reflux, irritable colon, functional dyspepsia, or gallstones. Yet, successful medical treatment is often indefinite in duration and many patients do not wish to be on medication for the rest of their lives; such patients are often considered for surgery. Lifelong medication is also costly, and surgery may be the cheaper option in the long term.1

Stricture formation used to be another common indication for surgery, but PPI treatment has proved so successful that this is now rarely seen. Many patients are elderly and their predominant problem is dysphagia, which is usually effectively treated with PPIs and dilatation. A further indication for surgery—that is, regurgitation or high volume reflux, is now seen more often. It is possible that the successful treatment of heartburn through the use of PPIs has decreased awareness of reflux and the patient has thus allowed more fluid to regurgitate; as a consequence more patients are presenting with volume regurgitation as their main problem.

Surgery as a result of patient and/or physician directed choice has also become more common since the introduction of laparoscopic surgery because patients no longer face long and painful incisions with prolonged hospital stays and time off work. There are reports of antireflux surgery performed as a day case procedure, with most patients out of hospital in two or three days and back at work within a few weeks of the operation.2

A new, more controversial indication is the relation between reflux, columnar lined oesophagus, and adenocarcinoma. There is an argument that fundoplication should be considered at an earlier stage in the management of patients with reflux, so that the complications of Barrett’s oesophagus and its evolution into an adenocarcinoma of the distal oesophagus can be prevented. This hypothesis is based on evidence that the development of Barrett’s oesophagus is caused by the influence of duodenoesophageal reflux, which is not effectively controlled by antisecretory medication. Although earlier fundoplication has obvious appeal to surgeons, this hypothesis is, as yet, unsupported; in our opinion, the possible prevention of Barrett’s oesophagus and adenocarcinoma of the oesophagus is not yet an acceptable indication for surgery.

The reduction in morbidity resulting from laparoscopic antireflux surgery has been most noticeable in the treatment of giant hiatus hernias (intrathoracic stomach). These hernias can strangulate, cause anaemia or overt bleeding, and other symptoms such as chest pain or breathlessness after meals. Previously, surgery for giant hiatus hernias has been controversial because many patients with this condition are very old. However, because the majority of such hernias can be treated with a relatively straightforward laparoscopic procedure,4 a greater number of patients with this condition are now being referred for surgery before the hernia grows too large.

Laparoscopy for antireflux surgery was first reported in 1991.5 The development phase allowed instrumentation and techniques to be refined, operating times to be shortened, and learning curve problems to be recognised and overcome; laparoscopic surgery for reflux has since become commonplace. In some centres, follow up extends for up to five years, and prospectively evaluated single centre experiences of more than 300 procedures have been reported.6 The published results of laparoscopic antireflux surgery, irrespective of the type of fundoplication, confirm the efficiency of the laparoscopic approach.7 8 Furthermore, in comparison with an open approach, laparoscopy controls reflux symptoms well, and medium term outcomes have not been compromised.9 10 Moreover, the overall incidence of perioperative complications has been reduced, and the length of hospital stay shortened to two or three days. These outcomes have also been confirmed in randomised trials of open versus laparoscopic Nissen fundoplication.11 12

Nevertheless, complications can occur following laparoscopic antireflux surgery. Mostly minor, such complications resolve rapidly and do not impact on the long term outcome of surgery. The risk of acute postoperative para-oesophageal hiatus herniation and acute dysphagia has been highlighted,13 14 but standardisation of surgical technique with routine hiatal repair, improved surgeon

Abbreviations used in the paper: PPI, proton pump inhibitor.
awareness of potential complications, and better apprecia-
tion of laparoscopic anatomy have all contributed to a sig-
ificant reduction in postoperative problems.1

The risk of postoperative dysphagia creates considerable
anxiety for surgeons, gastroenterologists, and patients. It
occurs almost universally in the early postoperative period,
but only affects a minority of patients beyond the first
year after operation, and in these patients dysphagia is usu-
ally mild.8,19 The long term incidence is about 5%, although
this rate varies depending on whether the follow up data are
collected by the operating surgeon or by an independent
investigator. Additionally, the postoperative incidence of
dysphagia should be compared with the incidence of dys-
phagia in patients with reflux who are awaiting surgery; the preop-
ervative rate has been reported to be up to 40%.8,19

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than good results after surgery, making it easy to overlook
the fact that more than 90% of patients who have surgery
for reflux are happy with the outcome. Much of the debate
over technique is centred around comparisons between
uncontrolled case series. However, evidence from prospec-
tive randomised trials has recently become available.

Although trials which compare Nissen with partial
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