Reflux

Gatekeeper reflux repair system; a mechanistic reflux hypothesis

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The Gatekeeper reflux repair system is the fifth endoluminal therapy for GORD to gain regulatory approval and, akin to its predecessors, still faces many questions regarding its place in clinical practice.

Although there can clearly be an argument regarding the threshold at which it becomes a disease, gastro-oesophageal reflux disease (GORD) is ultimately the result of excessive gastro-oesophageal reflux and the associated consequences of that. It then seems rather straightforward that therapeutic interventions should seek to reduce or eliminate gastro-oesophageal reflux. The paradox is that the dominant medical interventions do not; rather, they alter the content of the refluxate (by inhibiting gastric acid secretion) so as to make it less noxious to the oesophageal epithelium. This, in a nutshell, summarises the decades old argument regarding the relative merits of medical versus surgical therapy for GORD. Or so it was, until the dawn of the era of endoluminal therapies for GORD a few short years ago. Now it seems that physicians have assumed some attributes of their surgical colleagues as they experiment with therapies that target the reflux itself.

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The Gatekeeper reflux repair system is the fifth endoluminal therapy for GORD to gain regulatory approval either in the European Union or in the USA (Stretta, EsophyX, Endocinch, Enteryx, and NDO Plicator). As detailed by Cicale and colleagues1 in this issue of Gut (see page 183) and by Fockens et al in a recent summary report of a multicentre study,2 the concept behind Gatekeeper is to restrict the luminal dimensions of the distal oesophagus by the submucosal implantation of a relatively biocompatible hydrogel material. The intended consequence of this is not necessarily to alter lower oesophageal sphincter (LOS) pressure, length, or relaxation characteristics, but to restrict the aperture through which gastro-oesophageal refluxate must flow. Flow through a tube, be it round or elliptical, is highly dependent on both the cross sectional area of the tube and the viscosity of the fluid flowing through it.3,4 Thus to use the example of transient LOS relaxation, the effect of the Gatekeeper procedure would not be to alter the frequency with which these occur but to change the consequences of their occurrence. Whereas prior to implantation the opening dimensions during transient LOS relaxations allow for voluminous reflux of gas or gastric juice, afterwards reflux is relatively restricted to gas (owing to its viscosity being 55-fold less than water). In essence, the effect of the Gatekeeper implantation is to reverse the oesophagogastric junction opening anormalies recently described in GORD patients compared with normals.5

So, are the data presented herein consistent with the above mechanistic hypothesis? Cicale and colleagues1 investigated the effect of the Gatekeeper treatment in nine patients on pH data, oesophageal manometry, and GORD-health related quality of life scores. pH data were obtained at 5 cm above the manometrically identified LOS and both 3 and 10 cm below the upper oesophageal sphincter prior to treatment and six months afterwards. They found that the distal acid exposure time was unchanged (quite possibly due to a type 2 error given the small number of subjects studied). However, reflux detected by both more proximally positioned sensors decreased substantially. Conceptually, reflux was still occurring but at a slower flow rate and, hence, with less proximal migration. Given that existing physiological data support the notion that an important determinant of reflux symptom generation is the proximal extent of mucosal acidification,6,7 this observation offers a mechanistic explanation for the observed therapeutic effect of Gatekeeper. Similarly, in the Fockens study2 of 68 patients (49 of whom were followed for six months), the treatment resulted in less oesophageal acid exposure and less regurgitation. In both studies, these effects were associated with substantial symptom reduction, albeit with an uncontrolled study design. So, yes, these data do argue for a relevant therapeutic effect. Given the above data, does this now mean that the Gatekeeper treatment is ready for widespread application? Clearly, not yet. There are many aspects to a treatment modality that define its optimal utilisation. With respect to an endoluminal therapy for GORD, one must consider: (1) safety, (2) efficacy, (3) cost, (4) durability, and (5) reversibility. In terms of safety and reversibility, the data on Gatekeeper are encouraging. The few complications reported in the multicentre study were easily remedied by removing the implants.8 Cost has yet to be determined but, as with other endoscopic therapies, will likely be somewhere between that of chronic proton pump inhibitor use and surgical fundoplication. Thus the dominant unresolved questions are of efficacy and durability, and much remains to be learned in these domains. Fockens et al reported that 70.4% of prostheses were retained at six months.9 These authors also found a statistical correlation between the number of retained prostheses and the quality of the clinical response. However, major issues remain to be addressed. Who are the ideal patients to treat? Is oesophagitis or hiatus hernia a relative contraindication? Where is the optimal implant location? What is the optimal number of implants per treatment? Is this number the same for every patient or is it dependent on other variables? How long will the implants remain in place? Is retreatment feasible? How much of the observed treatment effect is a placebo response? These and a myriad of other questions can only be answered by further studies and it is imperative that such studies utilise appropriate controls in their design. Encouragingly, one such study has recently been initiated. Hopefully, that ongoing, multicentred, randomised, sham controlled study of GORD patients with mild or absent oesophagitis will shed light on the most fundamental question of all: the magnitude of the Gatekeeper treatment effect.

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Granulomas may be more than diagnostic tools and could be significant in the biology and clinical course of Crohn’s disease

O ur immunological and molecular knowledge base1 in idiopathic chronic inflammatory bowel disease (IBD) has seen a tremendous increase over the past few years. Laboratory application of sophisticated new methodologies has revealed a plethora of agonistic and antagonistic factors involved in the pathogenesis of both ulcerative colitis and Crohn’s disease. Proinflammatory and Th2 derived anti-inflammatory cytokines are secreted by and act on various different cell types forming a complex network of interdigitating molecular pathways with profound effects on epithelial cells, lymphocytes, endothelial cells, and monocytes. This multilayered interplay of humoral factors and various cells at different stages of differentiation appears similar to a symphony where the end result is perfect yet the role of various single instruments remains obscure to the casual listener. Some of the newly discovered pathways have been utilised to develop new therapeutic strategies2 and molecular genetic studies in particular have provided fascinating new insights into the problems of genetic host susceptibility. Polymorphisms or mutations in the NOD2 gene3 are coding for proteins involved in the recognition of different pathogen associated molecular patterns and different bacteria, ultimately resulting in the activation of nuclear factor-kB. Other members of the innate immune system such as Toll-like receptors appear to be involved in Crohn’s disease.1,4

Histopathological features of IBD are well defined and little if any changes have occurred during the past few years. Any modern textbook on the subject of IBD will certainly contain a single chapter on histopathology but only the diagnostic role of histopathology in IBD is emphasised. While this remains especially true for the differential diagnosis of Crohn’s disease versus ulcerative colitis, the problem of dysplasia, and issues of inter- and intraobserver variability, attempts to correlate morphological and molecular mechanisms are rarely found. Granulomas for example are seen as diagnostic tools but their potential role in disease biology is neglected. This is contrasted by numerous basic research publications on IBD in which the authors do not mention granulomas at all and where it remains doubtful whether they have ever seen such lesions. There have been only a few recent reports on the frequency of granulomas in endoscopic and surgical specimens of patients with Crohn’s disease and prospective population based studies are lacking. The article of Heresbach and colleagues7 in this issue of Gut carefully defines the histomorphological features of epithelioid cell granulomas, microgranulomas, and isolated giant cells (see page 223). Correlating the morphological findings with treatment data and clinical outcome revealed that epithelioid cell granulomas might indicate a more aggressive clinical course. The article by Pierik and colleagues,7 also in this issue of Gut, compares the occurrence of epithelioid cell granulomas with some of the most important genetic variants of the innate immune system (CARD15/NOD2 and Toll-like receptor 4) in a well defined cohort of patients with Crohn’s disease (see page 223). The lack of significant correlations between the prevalence of epithelioid cell granulomas and immune system variants is disappointing but other findings, such as a higher frequency of granulomas in distal portions of the intestine and in younger patients, are of interest. Sampling error may have influenced the detection rate of epithelioid cell granulomas in both studies but the morphological and molecular data are well presented and prospectively correlated. This is especially important as most of the basic science in IBD research generates functional data from in vitro experiments or laboratory animal models. Epithelioid granulomas seen in Crohn’s disease show a specific geographical arrangement with multinuclear giant cells and T lymphocytes, similar to granulomas observed in many infectious diseases. Specific disease phenotypes may provide insights towards answering the question of whether a phenomenon is causative in Crohn’s disease or ulcerative colitis, or simply reflects secondary inflammatory reactions. Both articles contribute to this question by stressing the significance of epithelioid cell granulomas in the biology and clinical course of the disease. Tremendous progress in the understanding of complex immunological networks and genetic susceptibility provides a new stimulus to re-evaluate certain morphological features of disease. Granulomas may in fact contain previously unsuspected biological information that goes beyond their established role as a diagnostic tool.
Inflammatory bowel disease

Value of MR colonography for assessment of inflammatory bowel disease? Believe what you see—see what you believe

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Should magnetic resonance colonography be used to assess colonic inflammation in known inflammatory bowel disease or for assessment of inflammatory bowel disease?

**REFERENCES**


analysis by not taking biopsies from normal appearing tissue (although this is recommended in their national guidelines).⁶ ⁷ Thereby, their analyses were limited to endoscopically and histologically inflamed segments in a series of active colitis patients. Lastly, the report is unclear on the method of histological grading, on the rational and procedures for developing the radiological score of inflammation, and on the numerical results in the IBD population.

The histological features of Crohn’s disease differ from ulcerative colitis. Therefore, a single histological grading system as a gold standard of inflammation is questionable. The mismatch between endoscopic disease activity and histopathology has been known for several years. Specifically in Crohn’s disease, physicians are facing a multidimensional dilemma: clinical activity correlates poorly with endoscopic activity or histopathology. In fact, most endoscopic studies failed to demonstrate a relationship between disease activity, disease severity, endoscopic findings, or the degree of inflammation in biopsies (reviewed by Geboes and Dalle⁶). With regard to the novel MRI based score for quantification of bowel inflammation, two independent groups of IBD patients should have been studied: one for establishing and another for validating this score.

The Regensburg group³ avoided such selection bias by enrolling consecutive IBD patients, regardless of IBD subtype, Crohn’s disease location (including non-colonic Crohn’s disease), or disease activity. Thereby, they appropriately mimicked the true clinical situation and tested MR colonoscopy rigorously against conventional colonoscopy. However, they could have improved their sensitivity in two ways: firstly, by studying the normal cut off values in a healthy population, and secondly, by using quantitative measures for the contrast to noise ratio and contrast enhancement.

When critically interpreting the findings from Essen,³ MR colonoscopy was able to reliably depict inflamed bowel segments in patients with known and systematically active colitis, a conclusion that is quite similar to that of the Regensburg group.³ In addition, MR colonoscopy is certainly useful in identifying extraluminal disease complications, such as fistulae, enlarged mesenteric lymph nodes, or abscesses, with the advantage of a non-invasive and radiation free examination.

Will MR colonography replace colonoscopy in the future? We do not believe so. However, it is human nature that men willingly believe what they wish. So too does the group from Essen, by blaming colonoscopy and biopsy as sources of bowel perforation in IBD.³ The fact is that bowel perforation is a rare complication that occurs in approximately 0.045% of patients undergoing diagnostic colonoscopy⁶ and is not related to biopsy of inflamed and thickening bowel walls. On the other hand, the technique and spatial resolution of MR colonoscopy will be further advanced in the future and thus successfully used in IBD patients. Instead of replacing colonoscopy in the future however, we believe that MR colonoscopy will be complementary, similar to the situation with MR cholangiography and ERCP.

REFERENCES