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Laryngopharyngeal Reflux (LPR)

LPR is hard to diagnose because symptoms often mimic other ailments:

Many people recognizer heartburn, gastric distress or a foul taste in their month as the typical and classic symptoms of gastroesophageal reflux disease (GERD), a condition in which gastric contents such as acid and bile pass up into the esophagus. However, many of us don't realize that a feeling of "drainage" in the throat, a "lump" sensation in the throat, frequent throat clearing, intermittent hoarseness and sometimes mild difficulty in swallowing are hallmark signs of a different type of refll1x. The culprit behind this set of symptoms is **Laryngopharyngeal Reflux (LPR),** a disease that occurs when gastric contents travel up the esophagus and into the upper throat and voice box.

Diagnosis of LPR:

Often, these atypical reflux symptoms occur in the absence of the classic symptoms. Therefore, they are mistaken for another disease process such as post-nasal drainage from either allergies or sinus problems. Because 75 percent of the patients with LPR symptoms do not report having heartburn, the diagnosis of reflux is often overlooked. As a result, patients with LPT may be treated for chronic sinonasal problems unsuccessfully for long periods of time. LPR is different from, GERD is many ways. While GERD tends to occur while lying down, after meals and more often in obese people, LPR can happen while upright, intermittently throughout the day, especially during exercise. It can be just as common in thin as obese people. The lower esophagus more resistant to acid exposure than the delicate lining found in the vocal foIds and upper throat. Therefore, even a small, infrequent exposure to acid can become a problem in the laryngopharynx. Looking for excessive mucus from the nose and examination of the laryngeal area for signs of irritation from reflux can be extremely helpful in diagnosis. Fiberoptic laryngoscopy (endoscopy of the larynx and throat) looking for actual acid exposure can help in the diagnosis. The particular teclu1ique used in performing this test and how the results are inte1preted are important and can vary between clinicians. Collaboration between otolaryngologist (ear, nose and throat physician) and a gastroenterologist is common in diagnosing reflux and associated swallowing disorders.

Requires aggressive treatment:

Treatment of LPR requires a more aggressive approach than GERD. Because LPR happens intermittently throughout the day, reflux medications are often dosed twice daily rather than the traditional once a day dosing. In addition, reflux medications are typically trialed for three to six months at minimum before changing or adding other medications. This adds significant expense to medication costs for patients, but symptoms may not be controlled unless this more aggressive treatment regimen is followed. Because the fundamental problem in reflux is a relaxation of the nah1ral "valve" at the end of the esophagus that is supposed to prevent stomach contents from refluxing into the esophagus, surgery to "wrap" the stomach tighter around the esophagus is an option. In most cases, this is considered after failure of medications. Laryngopharyngeal reflux can be a frustrating disease for both doctor and patient alike. It can be very difficult to properly diagnose and can be equally troublesome to control. In severe cases, it can cause chronic hoarseness, benign growths on the vocal folds and life-threatening narrowing of the breathing passages (tracheal stenosis). Proper diagnosis and adherence to a more aggressive treatment regimen are the keys to threating LPR.