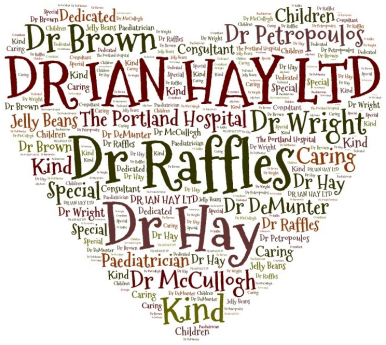

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PATIENT INFORMATION SHEET: GASTRO-OESOPHAGEAL REFLUX (GOR) IN BABIES

We are diagnosing an increasing number of babies suffering from what appears to be gastro-oesophageal reflux. The symptoms usually start in the first weeks of life with discomfort especially during and after feeds, arching of the back, excess flatulence and, usually, some posseting/vomiting. Unlike so called “colic” the symptoms are not confined to the late afternoon and evening.

GOR is a physiological event in most babies. It usually manifests in some mild posseting and does not require any treatment. It is due to immaturity of the circular muscle around the top of the stomach which in later life prevents regurgitation of the stomach contents up into the oesophagus (gullet). While the stomach lining is protected from the effects of acid, the oesophagus is not; this causes irritation of the lining and causes pain in the baby. This is the type of discomfort that so many women have in pregnancy (“Heartburn”).

Moderate reflux produces the symptoms outlined above, but the baby’s weight gain remains good and feeding is not severely affected. The most severe form of reflux is called Gastro-Oesophageal Reflux Disease (GORD) and is associated with weight falloff and significant feeding difficulty.

Treatment of the mildest forms consists of holding the baby in an upright position for 15-20 minutes after a feed and possibly the addition of an acid neutraliser such as Gaviscon, or the thickening of the feeds in a bottle-fed baby. If the symptoms are not relieved, many doctors would then recommend using an acid-blocking agent, usually starting with Ranitidine and, if not successful, Omeprazole or Lansoprazole. These measures are not always successful as there is some evidence that in some babies, it is the refluxed milk rather than the acid content that causes symptoms. Very occasionally some of us try Domperidone which is said to tighten up the muscle band at the top of the stomach and allow the stomach to empty faster.

A significant proportion of babies with reflux have evidence of intolerance to cow’s milk, and if the above treatment is unsuccessful, a trial of dairy produce avoidance in breast feeding mothers or a change to a non-dairy milk (e.g. Nutramigen/Neocate/Pepti) in bottle fed or in breast fed babies who require a formula top-up may be needed.

There is light at the end of the tunnel, as the vast majority of babies with GOR will be better by a year of age and, in most, there is a gradual improvement during the second 6 months of life.

Dr Raymond Brown