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Reflux with chest pain (non-cardiac chest pain)

A Practical Guide For Patients

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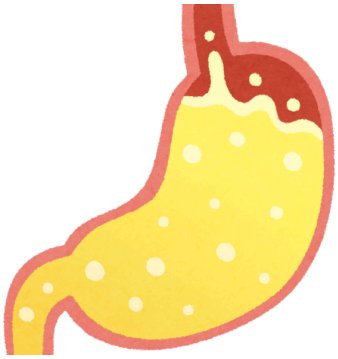
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Introduction: Reflux with chest pain (non-cardiac chest pain)

Gastroesophageal reflux disease (GERD) can sometimes cause chest pain in addition to the more familiar symptoms of heartburn and regurgitation. Reflux-related chest pain may feel like burning, pressure, squeezing, or discomfort behind the breastbone and can sometimes be difficult to distinguish from pain caused by the heart.



The term non-cardiac chest pain should be used only after an appropriate evaluation has excluded a cardiac cause. The American College of Gastroenterology specifically recommends that patients with chest pain undergo appropriate evaluation for heart disease before the pain is attributed to GERD.

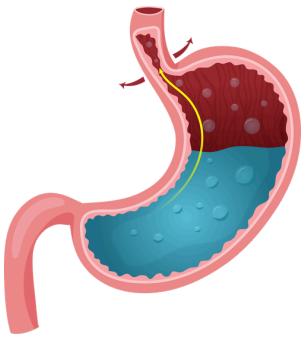
Key Takeaways

- GERD can cause chest pain that may resemble cardiac chest pain.
- Chest pain should not be assumed to be acid reflux before a cardiac cause has been appropriately excluded.
- Typical GERD symptoms include heartburn and regurgitation, but chest pain may sometimes be the main symptom.
- Reflux-related discomfort commonly occurs behind the breastbone and may be associated with meals or lying down.
- Objective testing for GERD is recommended when chest pain occurs after heart disease has been excluded, particularly when typical reflux symptoms are absent or the diagnosis remains uncertain.
- Upper endoscopy can identify reflux esophagitis and other structural or mucosal disorders.
- Ambulatory pH or impedance-pH monitoring can determine whether reflux episodes correlate with symptoms.

What Causes Reflux with chest pain (non-cardiac chest pain)

Known Causes

- Gastroesophageal reflux disease: Acid or other stomach contents entering the esophagus can cause substernal burning or chest pain.
- Lower esophageal sphincter dysfunction: A weak or inappropriately relaxing sphincter allows gastric contents to reflux upward more easily.
- Hiatal hernia: Anatomical disruption around the esophagus and diaphragm may impair the normal antireflux barrier in some patients.
- Reflux esophagitis: Repeated reflux can inflame and injure the lining of the esophagus, producing heartburn or pain.
- Esophageal hypersensitivity: Some patients perceive normal or relatively small reflux events as painful because the esophagus is unusually sensitive.
- Reflux hypersensitivity: Symptoms may correlate with reflux episodes even when overall esophageal acid exposure is within the normal range. Impedance-pH testing can help characterize this pattern.
- Delayed gastric emptying: In selected patients, impaired stomach emptying may contribute to reflux physiology, although routine gastric-emptying testing is not required for typical GERD.



Common Signs & Symptoms

Reflux-related chest discomfort is commonly felt behind the breastbone. Some patients describe it as burning, while others experience pressure, tightness, aching, or discomfort that can be difficult to distinguish from cardiac pain. The presence of heartburn or regurgitation increases suspicion for GERD but does not by itself prove that the chest pain is reflux-related.

Core Symptoms Include:



- **Substernal chest pain**: Pain or discomfort behind the breastbone may occur with GERD.
- **Heartburn:** A burning sensation in the middle of the chest that may rise toward the throat.
- **Regurgitation:** Stomach contents or acidic fluid may rise into the throat or mouth.

Severe cases can also cause:



- Persistent or progressively worsening chest pain
- Difficulty swallowing food
- Pain with swallowing
- Persistent vomiting
- Vomiting blood or material resembling coffee grounds
- Black or tarry stools
- Unexplained weight loss

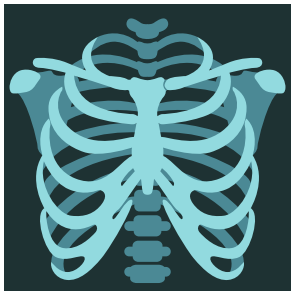
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Diagnosis & Medical Testing

The first diagnostic priority with unexplained chest pain is determining whether it could be cardiac. Current chest-pain guidance emphasizes early evaluation of potentially life-threatening causes rather than assuming that burning chest discomfort is gastrointestinal.Once an adequate cardiac assessment has excluded heart disease, the gastrointestinal evaluation focuses on determining whether GERD.

Diagnostic Tools

- **Medical history:** Reviews the quality, duration, location, timing, and triggers of chest discomfort and whether heartburn, regurgitation, swallowing problems, meals, or body position are associated with symptoms.
- **Cardiac evaluation:** Acute or suspicious chest pain may require ECG, blood testing such as cardiac troponin, and other cardiac assessment according to the clinical situation.
- **Upper endoscopy (EGD):** Examines the esophagus, stomach, and duodenum and can identify erosive esophagitis, strictures, Barrett's esophagus, or alternative conditions. Biopsies can be obtained when needed.
- **Ambulatory pH monitoring:** Measures acid exposure in the esophagus and helps determine whether symptoms correlate with reflux.
- **Wireless Bravo pH monitoring:** A temporary capsule attached to the esophagus measures acid exposure over an extended period without a nasal catheter.
- **Catheter-based pH monitoring:** A thin nasal catheter records esophageal acid exposure.



Diet

There is no universal “acid reflux diet” that every patient must follow. ACG recommends focusing on individual trigger foods and eating behaviors, because evidence for eliminating broad categories of foods is variable.

Key Insights

- Avoid eating within approximately 2–3 hours of bedtime if nighttime reflux occurs.
- Consider smaller meals if large meals consistently provoke reflux.
- Identify and avoid foods that reliably trigger your own symptoms rather than automatically eliminating numerous foods.
- High-fat meals can worsen reflux in some patients and may be worth reducing when they are a clear trigger.
- Carbonated beverages may aggravate symptoms in some patients.
- Citrus, tomato-based foods, chocolate, peppermint, coffee, spicy foods, or alcohol may trigger symptoms in some people, but routine universal avoidance is not strongly supported; individual response matters.
- Weight loss is recommended for people who are overweight or have obesity when GERD symptoms are present.
- Avoid lying down immediately after eating.
- Stop smoking or using tobacco products if applicable.
- For nighttime symptoms, raising the head of the bed may reduce reflux.

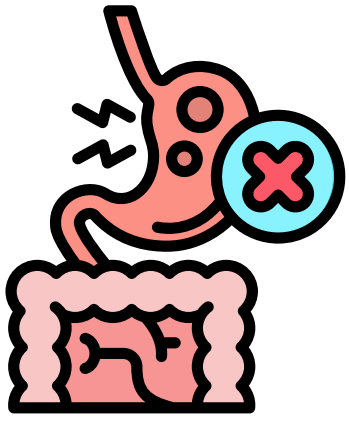
Medications & Treatment Options

Medication treatment is appropriate after the clinical picture supports GERD. Chest pain alone should not lead to indefinite acid-suppressing medication without considering other causes, especially if cardiac evaluation has not been completed or symptoms fail to respond as expected.

Treatment Options

- **Antacids:** Can provide short-term relief of mild, occasional reflux symptoms by neutralizing stomach acid. They are not intended as the sole daily treatment for severe or persistent GERD without medical guidance.
- **H2-receptor blockers:** Reduce stomach acid production and may help selected patients with mild or intermittent symptoms.
- **Proton pump inhibitors (PPIs):** Medications such as omeprazole or pantoprazole suppress gastric acid and are the principal medical treatment for GERD. Correct PPI timing: ACG recommends taking a PPI approximately 30–60 minutes before a meal, rather than at bedtime, for optimal GERD symptom control.
- **PPI trial:** For troublesome heartburn, regurgitation, or appropriately evaluated non-cardiac chest pain without alarm features, AGA advises a 4–8 week single-dose PPI trial, followed by reassessment.



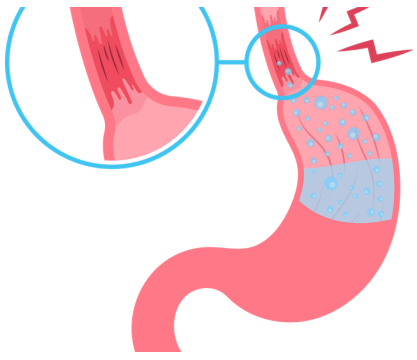


Advanced Therapies & Procedures

Most patients with GERD-related chest symptoms are managed without surgery. Invasive treatments are generally considered only when objective evidence confirms GERD and the patient's symptoms and anatomy make a procedure appropriate.

Therapy Options

- **Upper endoscopy with biopsy:** Helps diagnose esophagitis, strictures, Barrett's esophagus, eosinophilic esophagitis, and other disorders when appropriate.
- **Prolonged reflux monitoring:** Helps confirm whether abnormal reflux is present when the diagnosis remains uncertain.
- **High-resolution manometry:** Helps exclude achalasia and major esophageal motility disorders and is recommended before antireflux surgery or endoscopic intervention.
- **Laparoscopic fundoplication:** Surgically reinforces the antireflux barrier and may be appropriate for selected patients with objectively confirmed GERD.
- **Magnetic sphincter augmentation:** May be considered for selected patients with objectively documented GERD, depending on anatomy and clinical circumstances.



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Coping With Reflux with chest pain (non-cardiac chest pain)

Recurrent chest discomfort can understandably be difficult to interpret because reflux and cardiac pain may overlap in location and sensation. The safest approach is not to assume that every recurrent episode is "just reflux," particularly when the pattern changes.

Once cardiac disease has been appropriately excluded and reflux has been diagnosed.

Practical Strategies

- Record when chest discomfort occurs.
- Note whether symptoms develop before, during, or after meals.
- Record whether lying down worsens symptoms.
- Track heartburn or acid regurgitation occurring with the pain.
- Identify foods or beverages that repeatedly provoke symptoms.
- Avoid meals within 2–3 hours of bedtime when nighttime reflux is a problem.
- Elevate the head of the bed when nighttime reflux is persistent.
- Work toward appropriate weight reduction if overweight or obesity is contributing to GERD.
- Stop smoking or tobacco use.
- Take PPIs at the prescribed time, generally 30–60 minutes before a meal.
- Record whether prescribed reflux treatment actually reduces the chest discomfort.

FAQS About

Reflux with chest pain (non-cardiac chest pain)



Q1: Can acid reflux really cause chest pain?
A: Yes. GERD can cause chest pain behind the breastbone, and ACG notes that reflux-related chest pain may be indistinguishable from cardiac pain based on symptoms alone. For that reason, a heart-related cause should be appropriately excluded before chest pain is labeled non-cardiac or reflux.

Q2: How can I tell reflux chest pain from a heart attack?
A: You cannot reliably make that distinction based solely on how the pain feels. Heart attack symptoms can include pressure, squeezing, fullness, burning, or pain in the chest and may occur with shortness of breath, nausea, sweating, light-headedness, or pain involving the arm, shoulder, jaw, neck, back, or stomach.

Q3: How is reflux-related non-cardiac chest pain diagnosed?
A: After an appropriate cardiac evaluation has excluded heart disease, a gastroenterologist may use upper endoscopy and/or ambulatory reflux monitoring to determine whether GERD is present. Esophageal manometry may be added when a motility disorder is suspected.

Q4: What if chest pain continues despite taking a PPI?
A: Persistent symptoms should prompt reassessment. The clinician may confirm that the PPI is being taken correctly, perform endoscopy or reflux monitoring, and consider other causes such as achalasia, other motility disorders, reflux hypersensitivity, eosinophilic esophagitis, or chest pain.

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Take Action

Repeated chest discomfort associated with heartburn, regurgitation, meals, or lying down may be related to GERD, but chest pain should never automatically be labeled reflux based on symptoms alone. ACG recommends adequate evaluation to exclude heart disease before investigating chest pain as a GERD manifestation.

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