Update on gastroesophageal reflux disease (GERD): diagnosis

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1. Should patients with heartburn and endoscopic examination without upper esophageal erosions be submitted to esophageal pH-metry to confirm the diagnosis?

a. Abnormal pH-metry defines the diagnosis with 50% certainty.
b. Normal pH-metry excludes the diagnosis with 95% certainty.
c. In these patients, pH-metry has a sensitivity of 65%.
d. In these patients, pH-metry has a specificity of 100%.

2. Is the wireless capsule for esophageal pH monitoring better than conventional esophageal pH-metry to diagnose GERD?

a. Although the capsule is less invasive, the level of discomfort is the same.
b. The capsule records a higher number of reflux episodes.
c. Interference in daily life is higher with the capsule.
d. The number of diagnoses is similar between the two procedures.

3. Should all patients with atypical manifestation undergo esophageal pH-metry?

a. The prevalence of GERD in patients with atypical symptoms is 63.4%.
b. In patients with chronic cough, most symptoms depend on the reflux.
c. Acid reflux is associated with more atypical symptoms.
d. Globus sensation can only be investigated with dual-channel pH-metry.

4. Should patients with refractory GERD undergo esophageal biopsy?

a. The diameter of intercellular spaces in GERD is half the normal.
b. The recovery of the intercellular space is similar to the recovery of symptoms.
c. Sensitivity and specificity of biopsy are 98% and 99%, respectively.
d. Biopsy allows the diagnosis of GERD non-responsive to treatment.

5. Should patients with asthma be investigated for GERD?

a. Pantoprazole 40 mg twice daily for 1 week improves asthma symptoms.
b. The use of omeprazole 20 mg twice daily does not affect asthma symptoms.
c. In asthmatic patients with reflux symptoms, normal pH-metry predicts therapeutic unresponsiveness.
d. Symptoms of reflux in pulmonary fibrosis are less frequent than a positive-test result for GERD.

Responses to clinical scenario: update on childhood asthma: drug treatment

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1. Comparison with oral administration showed that the action of inhaled BDL is faster and has fewer side effects (**Alternative A**).
2. The inhalation route is preferably recommended for the use of β-adrenergic in asthma attack (**Alternative C**).
3. There is similar efficacy between the use of high-dose inhaled corticosteroids and systemic corticosteroids (**Alternative A**).
4. Aminophylline has a narrow therapeutic safety margin and may cause poisoning and side effects (**Alternative D**).
5. Continuous treatment with corticosteroids is associated with decreased rates of hospitalization (**Alternative B**).