Management of symptomatic reflux in pharmacy in South Africa

A report from a FIP insight board

September 2024

Colophon

International Pharmaceutical Federation (FIP)
Andries Bickerweg 5
2517 JP The Hague
The Netherlands
www.fip.org

Authors:
Sherly Meilianti, FIP Data and Intelligence Specialist
Ruben Viegas, FIP Humanitarian and Sustainability Programme Manager
Genuine Desireh, FIP Educational Partnerships and Project Manager

Reviewers:
Dalia Bajis, FIP Senior Programme Lead
Catherine Duggan, FIP Chief Executive Officer

Cover image:
Drazen Zigic | istock

Recommended citation
International Pharmaceutical Federation (FIP). Management of symptomatic reflux in pharmacy in South Africa. The Hague: International Pharmaceutical Federation; 2024.

Contents

Acknowledgements

FIP expresses gratitude and appreciation to all the insight board participants. A list of participants can be found in the participants' section.

The insight board and report were supported through unconditional funding from Reckitt.

1 Background

Reflux symptoms are frequently encountered in community pharmacies, where pharmacists serve as the first point of contact for many patients and the public. Various lifestyle factors, such as diet, excessive alcohol consumption, insufficient exercise, stress, and excess body weight, can influence these symptoms.[1] Many individuals may unknowingly live with reflux disease, making it a condition that is both common and underdiagnosed.[2]

Despite the prevalence of reflux disease across all communities, it remains poorly understood and under-researched, especially in the African region.[3] The scarcity of region-specific studies makes it difficult to identify the root causes of the disease within Africa. In other regions, increased urbanisation and lifestyle factors are leading contributors to this condition,[4] so it could be considered likely that similar trends are occurring across the African continent as well. However, with differences in diet, cultural practices, and healthcare access, the factors driving reflux in Africa may differ from those observed globally. Further, it is uncertain whether the lockdown countermeasures may have exacerbated and worsened reflux disease symptoms following the COVID-19 pandemic.[5] Beyond the direct impact of COVID-19 on reflux-like symptoms,[6] the countermeasures implemented during the pandemic, such as mask-wearing and mobility restrictions, could have influenced how these symptoms manifested and were managed.[7] During the pandemic, many patients turned to over-the-counter (OTC) medications as a more convenient and cost-effective way to manage their symptoms, a trend that has continued post-pandemic.

Pharmacists play a critical role in the management of symptomatic reflux, not just by offering medication but by identifying and addressing the lifestyle factors that contribute to the condition and helping patients avoid incorrect self-treatment.[8] While pharmacological non-prescription medicines, such as Proton Pump Inhibitor (PPI) therapy, are commonly used to treat the acid component of reflux, lifestyle modifications are often overlooked in symptom management and treatment. It is essential to develop a more holistic approach to treating reflux, especially in regions like South Africa, where unique challenges exist alongside diverse populations and a lack of gastroenterologists in the healthcare systems.[9]

The International Pharmaceutical Federation (FIP) has developed several resources to support pharmacists in managing reflux disease. A handbook titled "Empowering Self-Care: A Handbook for Pharmacists"[10] was launched in 2022 and includes a chapter on managing gastrointestinal complaints, including reflux-like symptoms. To build on the insights from this resource, FIP convened insight board meetings in November 2022 to explore the role of pharmacists in reflux management across different countries, gathering insights on the strategies and challenges pharmacists face.[11] From these discussions, it became clear that barriers to greater involvement of pharmacists in this area, included a need for specific education and training, as well as the lack of professional guidelines and protocols to support pharmacists in providing services.

In light of these findings, FIP organised a follow-up insight board meeting during the 82nd FIP World Congress in Cape Town, South Africa, on Monday, 2 September 2024. The primary objective of the insight board was to develop a series of consensus statements to guide pharmacists in South Africa in managing symptomatic reflux, addressing not only acid suppression therapy but also emphasising the importance of lifestyle modifications. The objectives of the discussion included:

1. Exploring the underlying causes, symptoms and potential red flags associated with symptomatic reflux, considering that 70% of endoscopies show no visible disease and patients only report reflux symptoms.
2. Discussing the role of lifestyle modifications and non-prescription medicines in the effective management of symptomatic reflux.
3. Identifying and sharing best practices, including OTC medicines most suitable for treating simple symptomatic reflux (disease), to optimise pharmacists' involvement in patient-centred reflux disease management.

2 Insight board participants

Moderator and facilitator (FIP team)	
Genuine Desireh	FIP Educational partnerships and projects manager
Rúben Viegas	FIP Humanitarian and Sustainability Programme Manager

Note-takers and researchers (FIP team)	
Sherly Meilianti	FIP Data and Intelligence Specialist
Sinalo Khulakade	FIP Volunteer

Insight board participants – South Africa	
Douwleen Conradie	South African Pharmaceutical Student Federation
Elmien Bronkhorst	South African Society of Clinical Pharmacy
Esther Shuping	Young Pharmacists' Group
Gravesham Jagarnath	Newkwa Pharmacy
Paché Oranje	Young Pharmacists' Group
Mehboob Cassiem	Director – ICPA
Pieter Jacobus Kobus Le Roux	Kleinmond Pharmacy
Stacey Kundiona	South African Pharmaceutical Student Federation

Observers	
Adrian Shephard	Reckitt
Trevor Gore	Maestro Consulting

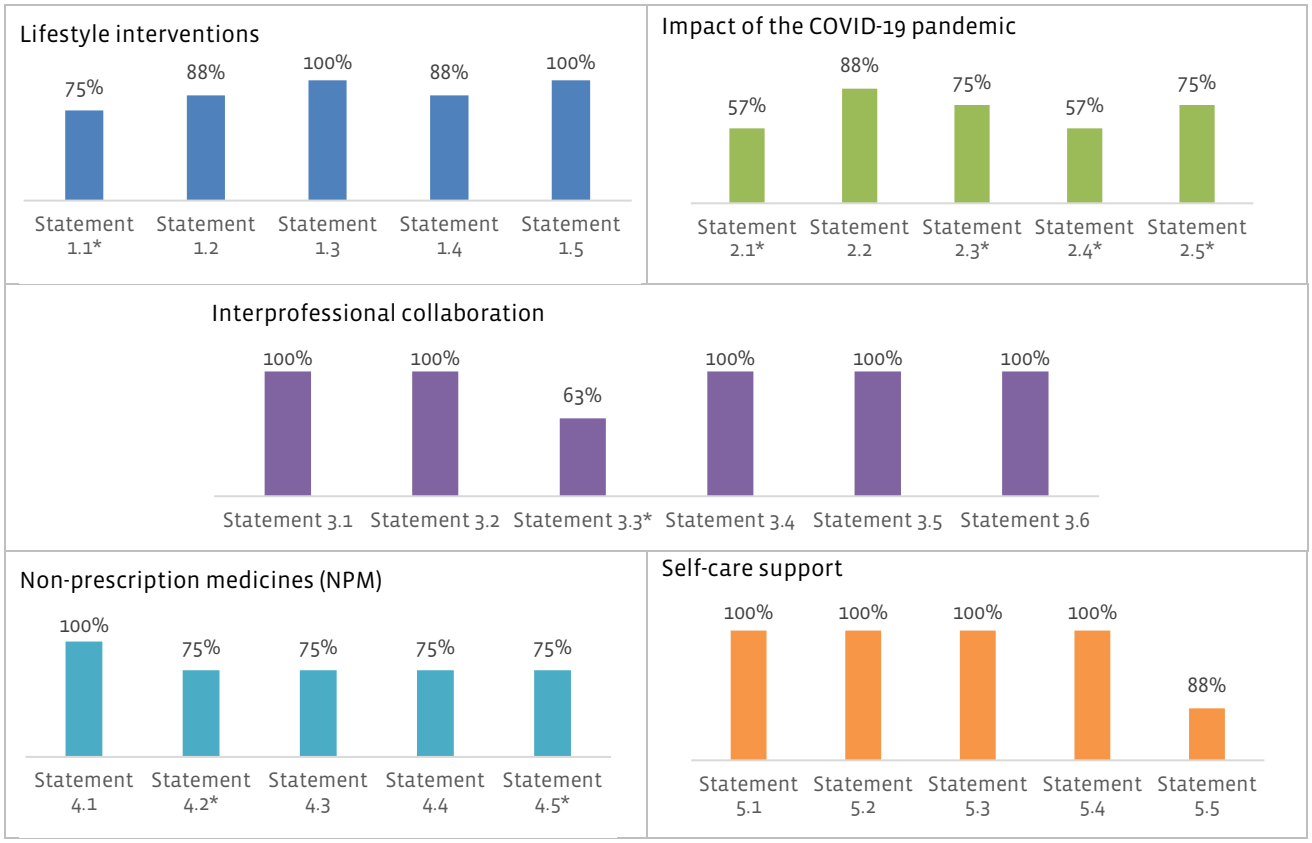
3 Consensus development approach

The FIP team initially developed draft recommendations for managing reflux disease based on peer-reviewed resources.[12-21] These recommendations were organised into five key areas, with each section elaborated in the subsequent chapters. The five key areas are:

1) Lifestyle interventions;
2) Impact of the COVID-19 pandemic;
3) Interprofessional collaboration;
4) Non prescription medicines (NPM);
5) Self-care support.

Prior to the meeting, participants of the insight board were invited to rate their level of agreement with each recommendation using a five-point Likert scale, ranging from 1 (Strongly disagree) to 5 (Strongly agree). They were also encouraged to provide comments on the relevance and applicability of the recommendations within the South African practice context. A total of eight responses were collected before the meeting. The consensus process stipulated that a recommendation would be adopted if at least 70% of respondents selected "Agree" or "Strongly agree." Recommendations that received comments or disagreements were discussed in detail during the insight board meeting, where concerns were addressed, and the statements were refined accordingly. The results of each statement are shown in Figure 1, and the final list of recommendations is presented in chapter 9 - Final recommendations.

Figure 1: Participants' agreement with the original statements



Note: The percentage represents the proportion of respondents who agreed or strongly agreed to the statement. The asterisk (*) shows that at least one participant expressed disagreement with the statement.

Through this consensus-building process, the goal was to ensure that the recommendations not only reflect the best available evidence but are also tailored to the practical realities faced by pharmacists in South Africa. By doing so, these recommendations will help pharmacists manage reflux disease more effectively within their community settings in this region.

4 Lifestyle interventions

4.1 Main discussion points

The discussion highlighted the importance of combining lifestyle interventions with pharmacological treatments in managing reflux, especially in severe cases that affect all elements of quality of life. Effective communication is key, as patients often perceive symptom severity differently from healthcare providers, and cultural and language barriers, especially in South Africa and across Africa, can complicate this. Pharmacists should educate patients on the distinctions between reflux and heartburn, using localised terminology to ensure clarity. A detailed patient history is essential for evaluating the severity of symptoms, while visual aids and patient education about dietary changes, exercise, and stress management can encourage better symptom control. Stress was identified as a major contributor to reflux exacerbation, and raising awareness of its impact may motivate patients to adopt healthier lifestyle habits. Community outreach and access to healthcare professionals are critical, especially in lower-income areas with limited access to specialised care (Figure 2).

"If the symptoms are not that severe, then we can implement lifestyle modifications. But if the symptoms are severe and the patient's quality of life is compromised, you cannot simply send them back."

"I think it's very important to take a thorough patient history. From there, as a pharmacist or healthcare professional, you can decide whether to treat the patient or refer them to a specialist"

"Exercise doesn't have to be extreme. Doing the dishes after a meal, can help prevent people from lying flat soon after eating food. So just telling them to sit or take a walk, even to walk the dog, can make a difference"

"I have seen that some of the cases of reflux are missed because patients self-treat. So having something as simple as a poster asking, 'Do you have this or that symptom?' can help start a conversation."

Figure 2: Main discussion points about lifestyle interventions

4.2 Modification of statements

During the discussion, some key recommendations emerged based on participant feedback. Table 1 summarises the original statements and the revised versions that incorporated insights from the discussions. Additionally, specific suggestions, such as the use of visual aids and community outreach programmes, were highlighted to address challenges specific to the South African context.

Table 1. Statement modifications according to participants' feedback (related to lifestyle interventions)

ID	Original statement	Revised statement	Participant insights and recommendation
1.1	Lifestyle interventions should be the first-line management for patients with symptomatic reflux, regardless of the severity of symptoms.[14]	Pharmacists should support patients with lifestyle interventions as a first-line management for patients with symptomatic reflux. In cases where symptoms are severe and impair quality of life, lifestyle modifications should be combined with pharmacological interventions.	Participants emphasised that while lifestyle interventions are important, severe cases may require a combination of lifestyle changes and medication. Patient history is crucial for assessing severity.
1.2	Weight loss should always be encouraged as a primary intervention in overweight or obese patients experiencing reflux symptoms.[12, 20]	Pharmacists should encourage weight loss as a primary intervention in overweight or obese patients experiencing reflux symptoms, but recommendations should be tailored to the patient's readiness for change.	Weight management remains important, but participants stressed that recommendations should be practical, patient-centred, and consider the individual's readiness to make lifestyle changes.
1.3	Patients should be advised by pharmacists to avoid specific dietary triggers, such as caffeine, alcohol, spicy foods, and large meals, to reduce reflux symptoms.[19]	Pharmacists should advise patients to avoid specific dietary triggers, such as caffeine, alcohol, spicy foods, and large meals. An individualised dietary assessment should be conducted to identify individual triggers.	A dietary assessment was highlighted as crucial, ensuring that recommendations align with the patient's cultural context and individual eating habits.
1.4	Pharmacists should always nudge patients to engage in gentle post-meal activities, such as walking, as it can help facilitate digestion and reduce the risk of reflux.[16]	Pharmacists should encourage patients to engage in gentle post-meal activities, such as walking or remaining upright, while cautioning against strenuous activities immediately after eating.	Participants agreed that gentle activities like walking should be promoted, but strenuous exercise should be avoided. This recommendation should be part of patient education.
1.5	Stress and anxiety can worsen reflux symptoms, so pharmacists should encourage patients to practice stress-reducing techniques such as mindfulness, relaxation exercises, or yoga.[13, 17]	Pharmacists should inform patients about the link between stress and reflux, encouraging stress-reduction techniques. with an initial focus on raising awareness before offering specific solutions.	Awareness about the link between stress and reflux should come first, followed by guidance on stress-reducing techniques like mindfulness or relaxation exercises.

5 Impact of the COVID-19 pandemic

5.1 Main discussion points

During the pandemic, patients increasingly self-medicated and overused supplements such as high doses of vitamins, which sometimes resulted in gastrointestinal issues, including reflux. In the post-pandemic landscape, patients have become more proactive about health, adopting lifestyle changes that improved reflux management – a trend that pharmacists should continue to encourage. While telehealth proved useful during the pandemic, it also posed challenges, including patient discomfort due to the lack of interaction and privacy, and limited access for those in lower-income areas, making in-person consultations more effective for some, especially with long-term medication management. Mental health emerged as a key factor in managing reflux, particularly as pandemic-related stress exacerbated symptoms. Concerns about COVID-19 vaccine side effects were prevalent, prompting pharmacists to reassure patients (Figure 3).

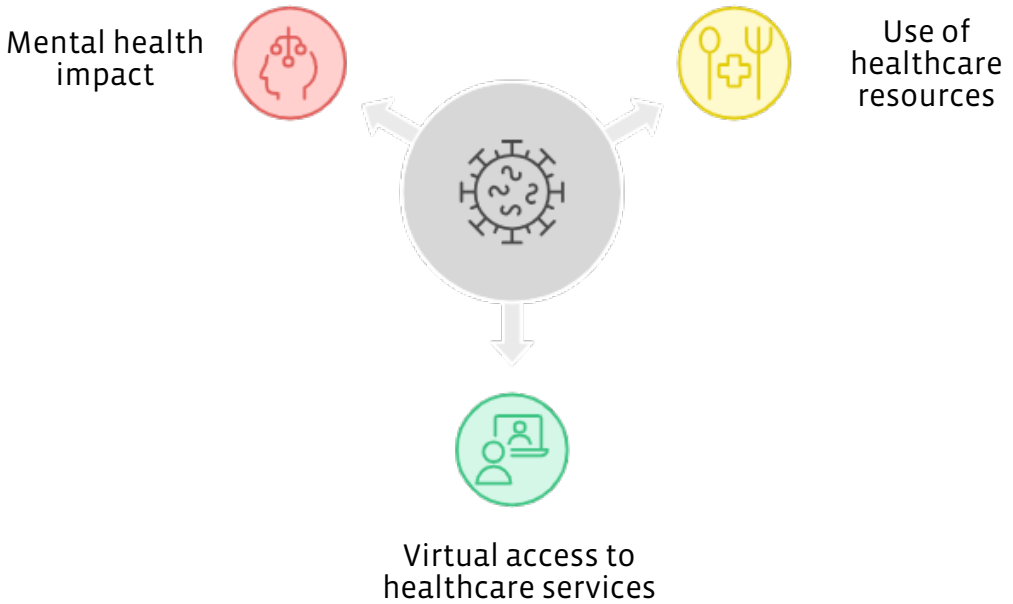
"People were taking super high doses of vitamins, especially effervescent vitamin C, and then they would throw in an antihistamine as well. (…). it was like a flu cocktail."

"In South Africa, we must also consider that the majority of our patients do not have access to the internet."

"The vaccine can't cause any of those issues. It might be some other condition or other medication that you are taking that leads to those symptoms."

"I think COVID-19 changed people's perceptions – not specifically about reflux, but in terms of lifestyle changes. We are seeing a lot more people becoming more active, asking more questions and trying to lead healthier lives."

Figure 3: Main discussion points about the COVID-19 pandemic effects on reflux management



5.2 Modification of statements

Based on the discussions, some of the original statements were revised to reflect participant feedback. Table 2 summarises the original statements and the revised versions, incorporating insights from the discussions, such as the role of telehealth, the emphasis on lifestyle changes, and addressing vaccine-related concerns.

Table 2. Statement modifications according to participants' feedback (related to COVID-19)

ID	Original statement	Revised statement	Participant insights and recommendation
2.1	Patients experiencing reflux symptoms during or after COVID-19 should be assessed for potential gastrointestinal manifestations related to the virus, not just acid reflux.[5, 6]	Pharmacists should assess patients experiencing reflux symptoms during or after COVID-19 for potential gastrointestinal manifestations, including those caused by self-medication with high doses of vitamins or supplements.	Participants highlighted the importance of considering gastrointestinal damage caused by self-medication during the pandemic, such as high doses of vitamin C, which may contribute to reflux.
2.2	The potential impact of COVID-19 on mental health should be considered, as stress and anxiety can exacerbate reflux symptoms.[6]	Pharmacists should consider the potential impact of COVID-19 on mental health, as stress and anxiety are known to exacerbate reflux symptoms. Mental health support should be considered for reflux management.	Participants emphasised that heightened stress during the pandemic exacerbated reflux, and addressing mental health should be considered as a component of reflux management post-pandemic.
2.3	Telehealth consultations should be optimised for managing reflux in patients reluctant to visit healthcare facilities due to COVID-19 concerns.[21]	Pharmacists can advise on the usefulness of telehealth consultations for managing reflux, but this should not replace in-person visits, especially in places with difficulties in accessing the internet.	Participants noted that telehealth consultations, while helpful, are challenging for some patients and cannot replace in-person visits, particularly for those requiring long-term management or specialist referrals.
2.4	COVID-19 vaccination should be discussed with reflux patients, addressing any concerns about potential gastrointestinal side effects.	Pharmacists may discuss COVID-19 vaccination with reflux patients, with reassurance that the vaccine does not typically cause reflux or gastrointestinal side effects.	Participants reported that patients expressed concerns about gastrointestinal side effects from the vaccine. Pharmacists should reassure patients that reflux is unlikely to be a side effect of the vaccine.
2.5	COVID-19 has highlighted the importance of promoting lifestyle changes, such as improved diet and exercise, to enhance overall health, including reflux management.[7]	Pharmacists should continue to promote lifestyle changes, such as diet and exercise, for overall health, including reflux management to support post-pandemic long-term health.	Participants agreed that patients are more engaged in lifestyle changes post-pandemic. Pharmacists should build on this momentum to encourage healthier habits and better reflux management.

6 Interprofessional collaboration

6.1 Main discussion points

Participants highlighted that true collaboration in healthcare requires shared goals and active cooperation; yet pharmacists are often excluded from decision-making processes, particularly in South Africa, where doctors hold central authority. The lack of direct communication between pharmacists and doctors limits cooperation and negatively affects patient care, especially in managing long-term conditions like reflux. While patients often trust pharmacists and share important information with them, this information is not always communicated to general practitioners (GPs) and specialists, creating gaps in care. To improve collaboration, pharmacists should proactively build professional relationships with doctors, assert their expertise, and establish structured collaboration protocols, particularly in community settings where cooperation is often informal or absent (Figure 4).

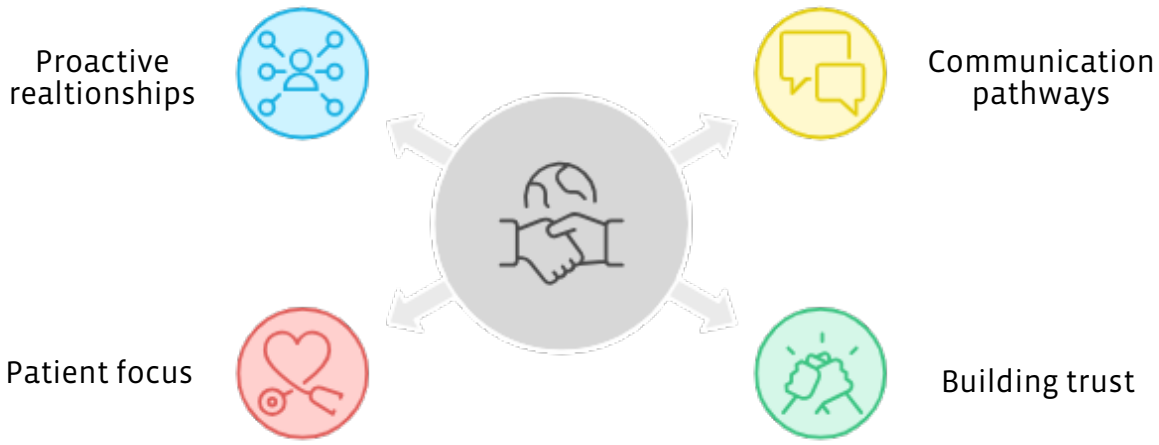
"They're too busy to speak to the pharmacist about their patient because, ultimately, it is our patient. But they [doctors] have more authority over the patient than what we do."

"So, you call the GP and say,'Look, I'm having a wellness day; our patients are going to be there. Come and join us, maybe with a 5 minute talk.' This way, the GP becomes more open to having that kind of discussion."

"There is no collaboration, from what I've seen, and it's kind of crippling as a pharmacist. Patients often feel more comfortable talking to us, which can help identify issues that the doctor might have overlooked."

" In my experience in hospital pharmacy, the collaboration has been much better, particularly with specialists than with GPs. Over the last 15 years, I've noticed that the partnership between specialists and pharmacists in the hospital sector is much better than in the community setting."

Figure 4: Main discussion points about interprofessional collaboration



6.2 Modification of statements

Based on the discussion, some of the original statements were revised to reflect participant feedback, particularly regarding the barriers to collaboration and the need for more structured communication between pharmacists and medical doctors. Table 3 summarises the original statements and the revised versions, incorporating the suggestions from the discussions.

Table 3. Statement modifications according to participants' feedback (related to interprofessional collaboration)

ID	Original statement	Revised statement	Participant insights and recommendation
3.1	Pharmacists and GPs should work together to identify patients on long-term PPI therapy and evaluate the need for deprescribing when appropriate.[15]	Pharmacists and GPs should collaborate to regularly review patients on long-term PPI therapy, assessing the need for deprescribing and ensuring appropriate therapy adjustments. Regular communication should be established between pharmacists and GPs.	Participants noted that direct collaboration between pharmacists and GPs is limited. Regular communication and periodic reviews are essential to ensure appropriate care.
3.2	Written action plans should be provided to patients by GPs and pharmacists, outlining both lifestyle modifications and medication use for symptom control.[15, 18]	Pharmacists should collaboratively develop written action plans with GPs, outlining both lifestyle modifications and medication use for symptom control. These plans should be discussed with the patient to ensure understanding.	The importance of collaboration in developing and explaining action plans to patients was emphasised, as patients often misunderstand healthcare advice without proper guidance.
3.3	Patients with persistent symptoms despite lifestyle modifications and appropriate medication use should be considered for referral to a dietitian for personalised dietary advice.[15]	Pharmacists should refer patients with persistent symptoms, despite lifestyle modifications and appropriate medication use, to a dietitian for personalised dietary advice, where available. Pharmacists should actively participate in identifying and referring patients who require specialist care.	Pharmacists play a key role in identifying patients who may need specialist care. Collaboration between GPs and pharmacists is essential for successful referrals.
3.4	Referral to a gastroenterologist should be considered for patients with refractory symptoms or complications such as Barrett's oesophagus.[18]	Pharmacists should consider referral to a gastroenterologist for patients with refractory symptoms or complications such as Barrett's oesophagus.	Participants noted that referrals to specialists are often delayed, which negatively affects patient outcomes. Pharmacists should be empowered to facilitate timely referrals.
3.5	Pharmacists and GPs should collaborate on developing a protocol for periodic reviews of patients on long-term reflux therapy to ensure optimal management.[15]	Pharmacists and GPs should collaborate on developing a protocol for periodic reviews of patients on long-term reflux therapy. This protocol should include regular reassessments and clear communication between pharmacists and GPs.	Establishing formal collaboration protocols is key to improving long-term reflux management. Regular reassessments and clear communication channels are critical.
3.6	Pharmacists and GPs should collaborate to educate patients on the role of lifestyle factors in managing reflux symptoms.[15]	Pharmacists and GPs should collaborate to educate patients on the role of lifestyle factors in managing reflux symptoms, ensuring clear and consistent messaging from both providers.	Participants noted that patients often receive inconsistent advice from different providers. Collaboration is essential to ensure consistent messaging about lifestyle changes.

7 Non-prescription medicines (NPMs)

7.1 Main discussion points

Participants highlighted the importance of educating patients on drug-drug interactions, especially for those on multiple medications for chronic conditions such as hypertension or diabetes. In South Africa, public sector pharmacists face challenges due to limited medication options and frequent shortages, often leaving patients reliant on lifestyle interventions and unable to afford non-prescription medications (NPMs). In contrast, private-sector pharmacists have more flexibility in treatment options, enabling them to tailor care based on symptom severity. Concerns were raised about the self-medication of PPIs, leading to potential overuse. The disparity between public and private sector treatment options underscores the need for advocacy to expand public access to more effective, evidence-based medicines (Figure 5).

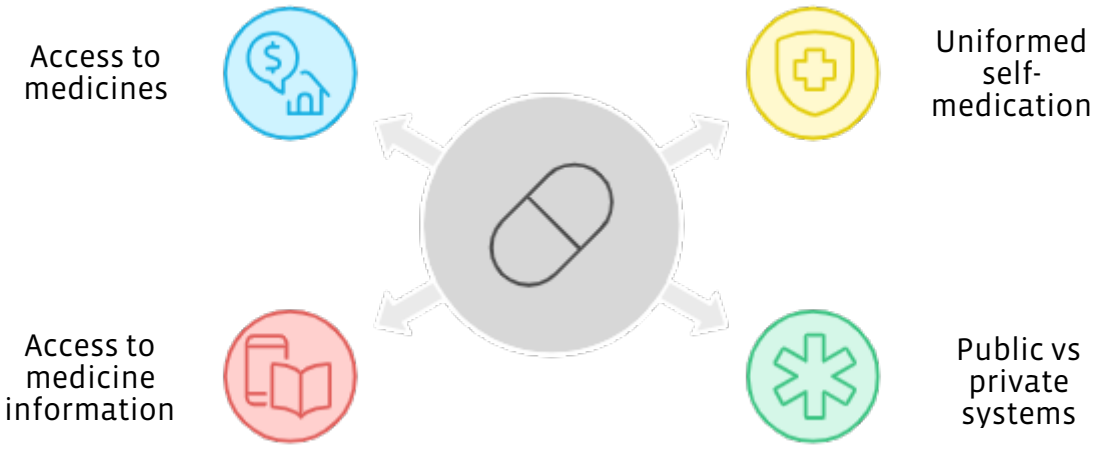
"For me, it depends on the severity of the symptoms and how often the person presents with the symptoms. As first line, I would recommend OTC antacids and assess if the patient is not responding well to that."

"Currently, due to cost constraints in the hospital, the only medicines available for treating reflux are calcium as an antacid, and our PPIs are limited, specifically in the maternity ward where omeprazole is the preferred option."

"In South Africa, pantoprazole is available over the counter and has fewer side effects and drug interactions, so I would opt for that."

"I think we need to distinguish between the two sectors. In the private sector, we have more leeway. I would suggest using support algorithms to interact with the patient. In the public sector, the interaction between the pharmacists and patients is restricted to the prescription."

Figure 5: Main discussion points about non-prescription medicines



7.2 Modification of statements

Based on the discussion, several of the original statements were revised to reflect participant feedback. Table 4 summarises the original statements and the revised versions, incorporating suggestions regarding patient education and the challenges in both the public and private sectors.

Table 4. Statement modifications according to participants' feedback (related to NPMs)

ID	Original statement	Revised statement	Participant insights and recommendation
4.1	PPIs should be prescribed at the lowest effective dose and duration, with regular reviews for possible step-down or discontinuation.[18, 22]	Pharmacists should consider that PPIs should be prescribed at the lowest effective dose and duration, with regular reviews for possible step-down or discontinuation. Pharmacists should actively review patient medications and advocate for appropriate PPI use to minimise overuse and side effects.	Participants emphasised the importance of regular reviews to ensure PPIs are not overused and that pharmacists should play a role in deprescribing when necessary.
4.2	H2 receptor antagonists or antacids should be considered as alternatives or adjuncts to PPIs in patients with mild or intermittent symptoms.[18, 22]	Pharmacists should consider that H2 receptor antagonists or antacids should be considered as alternatives or adjuncts to PPIs in patients with mild or intermittent symptoms. Pharmacists should guide patients in choosing the most appropriate treatment based on symptom severity and the availability of medicines.	Participants discussed the importance of establishing a treatment hierarchy based on symptom severity, starting with lifestyle modifications and antacids before progressing to PPIs.
4.3	NPM antacids, such as calcium carbonate and magnesium hydroxide, should only be considered for immediate relief of mild and infrequent reflux symptoms.[18, 22]	Pharmacists should consider that NPM antacids, such as calcium carbonate and magnesium hydroxide, should only be considered for immediate relief of mild and infrequent reflux symptoms. Pharmacists should guide patients on lifestyle modifications when medication availability is limited.	Given the frequent medication shortages in the public sector, participants stressed the need for pharmacists to focus on lifestyle interventions when medications are not available.
4.4	H2 receptor antagonists are appropriate NPM options for patients with more frequent symptoms or those requiring longer-lasting relief.[18, 22]	Pharmacists should consider that H2 receptor antagonists are appropriate NPM options for patients with more frequent symptoms or those requiring longer-lasting relief. However, pharmacists should assess the risk of side effects and interactions with other medications.	Participants raised concerns about the potential side effects of long-term PPI use and stressed the importance of careful patient assessment before recommending H2 receptor antagonists.
4.5	Combination NPM products, such as antacids with alginates, should be recommended for patients with postprandial reflux.[18, 22]	Pharmacists should consider that combination NPM products, such as antacids with alginates, should be recommended for patients with postprandial reflux. Pharmacists should educate patients about the correct use of these products and the importance of following lifestyle modifications.	Participants emphasised that pharmacists should ensure patients understand how to use combination products correctly and encourage lifestyle changes to support symptom relief.

8 Self-care support

8.1 Main discussion points

Participants emphasised the importance of promoting health literacy and obtaining a comprehensive medication history from patients, particularly since many visit multiple healthcare providers and lack electronic health records to track medications across different sectors. To improve care, pharmacists should request a full overview of both prescription and non-prescription medications. The need for a centralised patient registration system was also highlighted to facilitate better record-keeping and medication history tracking. A holistic approach to reflux management was encouraged, addressing related conditions like weight and stress while collaborating with GPs. Pharmacists were urged to prioritise evidence-based self-care interventions, recommending only scientifically proven treatments (Figure 6).

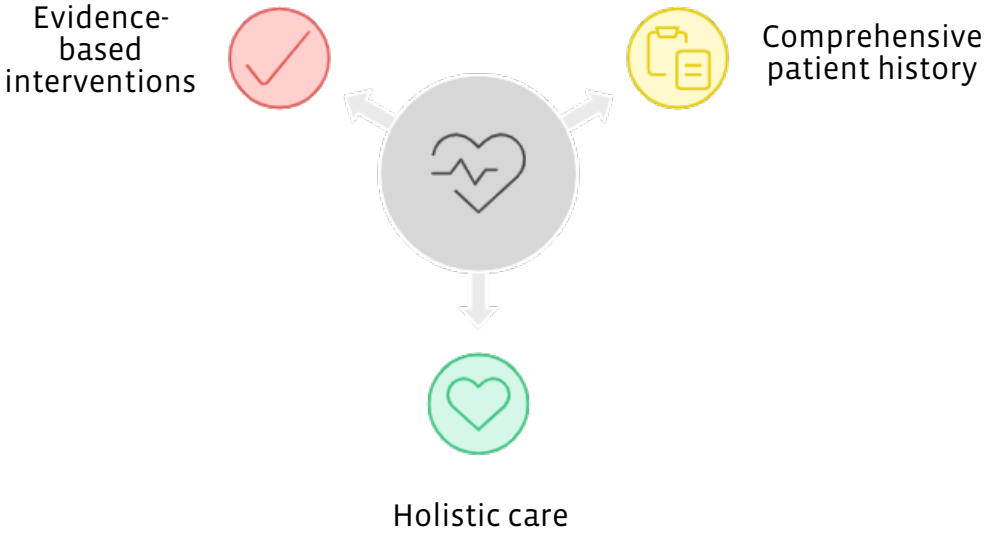
"The problem we face without electronic health records is significant. I think [the government] will attempt to address this, as it would allow for one patient file. For instance, patients who receive their PPI from me in the private sector might also be visiting the public sector, but I have no way of knowing what other medications they are taking."

"Regarding self-care support, I believe pharmacists are ideally positioned to provide this guidance."

"In my year of experience in a pharmacy, I've found that an empiric approach works better for short-term heartburn, but reflux requires a more comprehensive strategy that often takes longer than just six months to manage effectively."

"The problem is finding the time to engage with patients. When they come in every month to collect their PPIs, we should sit down with them and ask, 'Do you really know how you are feeling? Have you had any episodes, and is it under control?' This kind of dialogue empowers the patient"

Figure 6: Main discussion points about self-care support



8.2 Modification of statements

Based on the discussion, several of the original statements were revised to reflect participant feedback. Table 5 summarises the original statements and the revised versions, incorporating insights regarding health literacy, patient registration, and the importance of holistic care.

Table 5. Statement modifications according to participants' feedback (related to self-care support)

ID	Original statement	Revised statement	Participant insights and recommendation
5.1	Patients should be empowered with self-management strategies, including recognising early symptoms and making lifestyle adjustments accordingly.[15]	Pharmacists should empower patients with self-management strategies, including recognising early symptoms and making lifestyle adjustments. Pharmacists should ensure that patients provide a full medication history to offer comprehensive care.	Participants emphasised the need for patients to share their full medication history with pharmacists to enable better management of their conditions.
5.2	Mindfulness-based interventions, such as stress management and relaxation techniques, should be explored as part of a holistic approach to reflux management.[15, 18]	Pharmacists should consider evidence-based mindfulness-based interventions, such as stress management and relaxation techniques, and should explore these as part of a holistic approach to reflux management.	Participants stressed that self-care interventions should be rooted in evidence-based practice and tailored to individual patient needs.
5.3	Regular follow-up and reassessment of reflux management plans should be standard practice, especially after initiating lifestyle modifications, self-care interventions or changes in medication.[15, 18]	Pharmacists should regularly follow-up and reassess reflux management plans as standard practice, especially after initiating lifestyle modifications or changes in medication. Pharmacists should engage patients in ongoing conversations about their condition to ensure effective care.	Regular follow-ups are essential for tracking patient progress and ensuring that any necessary adjustments to treatment plans are made in a timely manner.
5.4	Pharmacists should be actively involved in monitoring patient adherence to lifestyle recommendations, self-care interventions, and medication regimens.[15]	Pharmacists should be actively involved in monitoring patient adherence to lifestyle recommendations, self-care interventions, and medication regimens. This includes educating patients on the differences between reflux and heartburn and addressing any misconceptions.	Participants noted the importance of educating patients to ensure they understand their condition and the appropriate treatments.
5.5	Regular follow-up and reassessment of NPM use are essential to prevent long-term reliance and ensure appropriate management of simple symptomatic reflux.[15]	Pharmacists should conduct regular follow-up and reassessment of NPM use to prevent long-term reliance and ensure appropriate management of simple symptomatic reflux. They should also ensure that self-care strategies are aligned with a holistic approach, addressing related symptoms and lifestyle factors.	A holistic approach was emphasised as crucial to effective reflux management, with pharmacists playing a key role in coordinating care.

9 Final recommendations

A summary of the recommendations following the meeting in Cape Town regarding the management of symptomatic reflux in pharmacies and pharmacists in South Africa is presented below in Table 6.

Table 6. List of final recommendations on the management of symptomatic reflux in pharmacy in South Africa

1	**Lifestyle interventions**
1.1	Pharmacists should support patients with lifestyle interventions as a first-line management for patients with symptomatic reflux. In cases where symptoms are severe and impair quality of life, lifestyle modifications should be combined with pharmacological interventions.
1.2	Pharmacists should encourage weight loss as a primary intervention in overweight or obese patients experiencing reflux symptoms, but recommendations should be tailored to the patient's readiness for change.
1.3	Pharmacists should advise patients to avoid specific dietary triggers, such as caffeine, alcohol, spicy foods, and large meals. An individualised dietary assessment should be conducted to identify individual triggers.
1.4	Pharmacists should encourage patients to engage in gentle post-meal activities, such as walking or remaining upright, while cautioning against strenuous activities immediately after eating.
1.5	Pharmacists should inform patients about the link between stress and reflux, encouraging stress-reduction techniques with an initial focus on raising awareness before offering specific solutions.
2	**Impact of the COVID-19 pandemic**
2.1	Pharmacists should assess patients experiencing reflux symptoms during or after COVID-19 for potential gastrointestinal manifestations, including those caused by self-medication with high doses of vitamins or supplements.
2.2	Pharmacists should consider the potential impact of COVID-19 on mental health, as stress and anxiety are known to exacerbate reflux symptoms. Mental health support should be considered for reflux management.
2.3	Pharmacists can advise on the usefulness of telehealth consultations for managing reflux, but should not replace in-person visits, especially in places with difficulties in accessing the internet.
2.4	Pharmacists may discuss COVID-19 vaccination with reflux patients, with reassurance that the vaccine does not typically cause reflux or gastrointestinal side effects.
2.5	Pharmacists should continue to promote lifestyle changes, such as diet and exercise, for overall health, including reflux management to support post-pandemic long-term health.
3	**Interprofessional collaboration**
3.1	Pharmacists and GPs should collaborate to regularly review patients on long-term PPI therapy, assessing the need for deprescribing and ensuring appropriate therapy adjustments. Regular communication should be established between pharmacists and GPs.
3.2	Pharmacists should collaboratively develop written action plans with GPs, outlining both lifestyle modifications and medication use for symptom control. These plans should be discussed with the patient to ensure understanding.
3.3	Pharmacists should refer patients with persistent symptoms, despite lifestyle modifications and appropriate medication use, to a dietitian for personalised dietary advice, where available. Pharmacists should actively participate in identifying and referring patients who require specialist care.

3.4	Pharmacists should consider referral to a gastroenterologist for patients with refractory symptoms or complications such as Barrett's oesophagus.
3.5	Pharmacists and GPs should collaborate on developing a protocol for periodic reviews of patients on long-term reflux therapy. This protocol should include regular reassessments and clear communication between pharmacists and GPs.
3.6	Pharmacists and GPs should collaborate to educate patients on the role of lifestyle factors in managing reflux symptoms, ensuring clear and consistent messaging from both providers.
4	**Non-prescription medicines (NPM)**
4.1	Pharmacists should consider that PPIs should be prescribed at the lowest effective dose and duration, with regular reviews for possible step-down or discontinuation. Pharmacists should actively review patient medications and advocate for appropriate PPI use to minimise overuse and side effects.
4.2	Pharmacists should consider that H2 receptor antagonists or antacids should be considered as alternatives or adjuncts to PPIs in patients with mild or intermittent symptoms. Pharmacists should guide patients in choosing the most appropriate treatment based on symptom severity and the availability of medicines.
4.3	Pharmacists should consider that NPM antacids, such as calcium carbonate and magnesium hydroxide, should only be considered for immediate relief of mild and infrequent reflux symptoms. Pharmacists should guide patients on lifestyle modifications when medication availability is limited.
4.4	Pharmacists should consider that H2 receptor antagonists are appropriate NPM options for patients with more frequent symptoms or those requiring longer-lasting relief. However, pharmacists should assess the risk of side effects and interactions with other medications.
4.5	Pharmacists should consider that combination NPM products, such as antacids with alginates, should be recommended for patients with postprandial reflux. Pharmacists should educate patients about the correct use of these products and the importance of following lifestyle modifications.
5	**Self-care support**
5.1	Pharmacists should empower patients with self-management strategies, including recognising early symptoms and making lifestyle adjustments. Pharmacists should ensure that patients provide a full medication history to offer comprehensive care.
5.2	Pharmacists should consider evidence-based mindfulness-based interventions, such as stress management and relaxation techniques, and should explore these as part of a holistic approach to reflux management.
5.3	Pharmacists should regularly follow-up and reassess reflux management plans as standard practice, especially after initiating lifestyle modifications or changes in medication. Pharmacists should engage patients in ongoing conversations about their condition to ensure effective care.
5.4	Pharmacists should be actively involved in monitoring patient adherence to lifestyle recommendations, self-care interventions, and medication regimens. This includes educating patients on the differences between reflux and heartburn and addressing any misconceptions.
5.5	Pharmacists should conduct regular follow-up and reassessment of NPM use to prevent long-term reliance and ensure appropriate management of simple symptomatic reflux. They should also ensure that self-care strategies are aligned with a holistic approach, addressing related symptoms and lifestyle factors.

10 Summary and conclusions

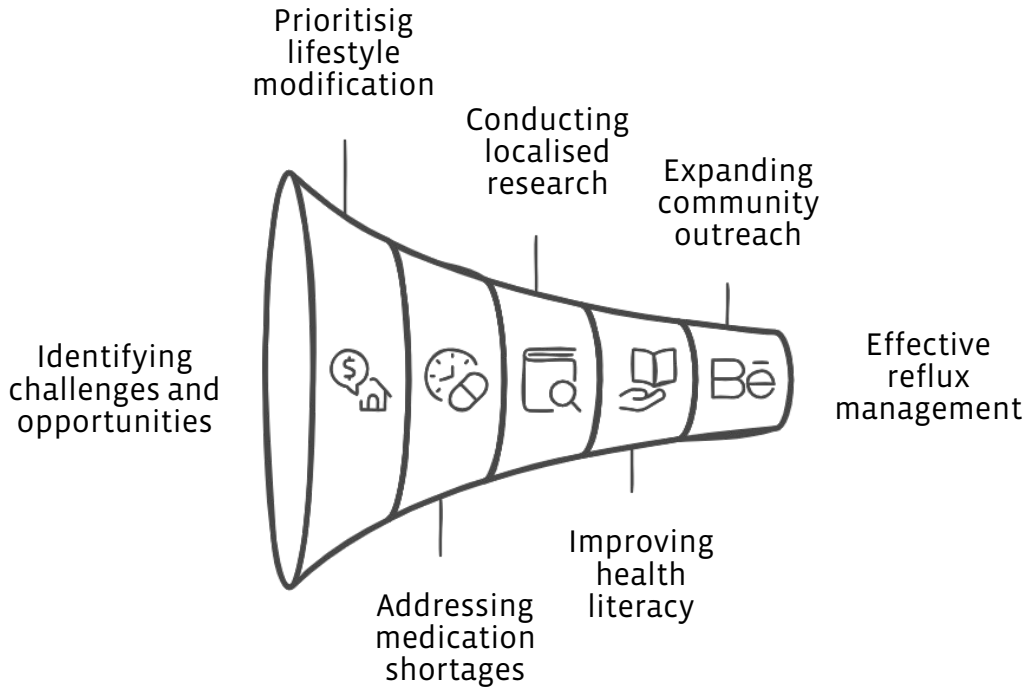
The focus of this report is to explore the management of symptomatic reflux in the pharmacy setting within South Africa. Insights from the discussions revealed key challenges and opportunities for pharmacists in managing reflux, highlighting the need for greater collaboration between healthcare professionals, especially in light of the pandemic's impact on patient behaviour and healthcare accessibility (Figure 7).

Participants stressed that while PPIs are commonly used for symptom relief, lifestyle modifications should be prioritised as part of a holistic treatment approach. Pharmacists are well-positioned to guide patients through self-care strategies and ensure proper use of medications, especillay given the rise of self-medication during the pandemic. The discussions also underscored the limitations in the public healthcare sector, where medication shortages often restrict treatment options. In contrast, private sector pharmacists have more flexibility, enabling them to tailor treatment recommendations based on the severity of symptoms.

The report identifies gaps in the current management of symptomatic reflux, particularly within the African context, where region-specific research is scarce. There is a pressing need for localised studies and evaluation to better understand the root causes of reflux, such as differences in diet, lifestyle, and healthcare access, which may result in unique disease patterns. Further research is also needed to explore the long-term impact of COVID-19 on reflux symptoms, self-medication trends, and the role of mental health in exacerbating symptoms. To address these gaps, more focus should be placed on improving health literacy and expanding community outreach programmes to enhance access to dietitians and other healthcare professionals in underserved areas. By addressing these research and infrastructure needs, pharmacists will be better equipped to manage reflux effectively in the post-pandemic era.

Further work on the area of reflux management may include understanding how these recommendations might be adopted and adapted in other regions and countries across the globe. This report can be used by colleagues globally as an example of the work under the area of self-care and as a practical tool to understand how pharmacists can proactively engage in supporting patients in the management of their reflux conditions.

Figure 7: Report conclusions



11 References

1. Maret-Ouda J, Markar SR, Lagergren J. Gastroesophageal Reflux Disease: A Review. JAMA. 2020;324(24):2536-47. [Accessed: Available at: https://www.ncbi.nlm.nih.gov/pubmed/33351048.

2. Hershcovici T, Fass R. Nonerosive Reflux Disease (NERD) - An Update. J Neurogastroenterol Motil. 2010;16(1):8-21. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20535321.

3. El-Serag HB, Sweet S, Winchester CC et al. Update on the epidemiology of gastro-oesophageal reflux disease: a systematic review. Gut. 2014;63(6):871-80. [Accessed: 30 September 2024]. Available at: https://pubmed.ncbi.nlm.nih.gov/23853213/.

4. Eusebi LH, Ratnakumaran R, Yuan Y et al. Global prevalence of, and risk factors for, gastro-oesophageal reflux symptoms: a meta-analysis. Gut. 2018;67(3):430-40. [Accessed: Available at: https://www.ncbi.nlm.nih.gov/pubmed/28232473.

5. Al-Momani H, Balawi DA, Almasri M et al. Gastroesophageal reflux in lockdown. Future Sci OA. 2023;9(6):FSO863. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/37228859.

6. Al-Momani H, Aolymat I, Al Haj Mahmoud S. Critical appraisal of how COVID-19 infection and imposed lockdowns have impacted gastroesophageal reflux: A review. Medicine (Baltimore). 2024;103(19):e38074. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/38728518.

7. Fauzi A, Simadibrata DM, Friska D et al. COVID-19 Pandemic is Associated With Increased Prevalence of GERD and Decreased GERD-related Quality of Life: Analysis From 9800 Participants in the Indonesian GERD-Q Study. J Clin Gastroenterol. 2024;58(4):324-9. [Accessed: Available at: https://www.ncbi.nlm.nih.gov/pubmed/37983734.

8. Armstrong D, Nakhla N. Non-prescription proton-pump inhibitors for self-treating frequent heartburn: the role of the Canadian pharmacist. Pharmacy Practice (Granada). 2016;14(4). [Accessed: 30 September 2024]. Available at: https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1885-642X2016000400010.

9. Van Rensburg CJ, Kulich KR, Carlsson J et al. What is the burden of illness in patients with reflux disease in South Africa? : research article. South African Gastroenterology Review. 2005;3(3):16-21. [Accessed: 30 September 2024]. Available at: https://journals.co.za/doi/abs/10.10520/EJC71898.

10. International Pharmaceutical Federation (FIP). Empowering Self-Care: A Handbook for Pharmacists. The Hague: [Internet]. 2022. [Accessed: 30 September 2024]. Available at: https://www.fip.org/file/5111.

11. International Pharmaceutical Federation (FIP). The role of pharmacists in managing reflux-like symptoms: Report from an international insight board The Hague: International Pharmaceutical Federation; 2022. Available at: https://www.fip.org/file/5395.

12. El-Serag H. The association between obesity and GERD: a review of the epidemiological evidence. Dig Dis Sci. 2008;53(9):2307-12. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/18651221.

13. Hungin AP, Yadlapati R, Anastasiou F et al. Management advice for patients with reflux-like symptoms: an evidence-based consensus. Eur J Gastroenterol Hepatol. 2024;36(1):13-25. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/38006602.

14. Hunt R, Armstrong D, Katelaris P et al. World Gastroenterology Organisation Global Guidelines: GERD Global Perspective on Gastroesophageal Reflux Disease. J Clin Gastroenterol. 2017;51(6):467-78. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28591069.

15. Kahrilas PJ, Anastasiou F, Barrett K et al. Assessment and treatment of reflux-like symptoms in the community: a multidisciplinary perspective. Br J Gen Pract. 2024;74(742):232-5. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/38664044.

16. Karim S, Jafri W, Faryal A et al. Regular post dinner walk; can be a useful lifestyle modification for gastroesophageal reflux. J Pak Med Assoc. 2011;61(6):526-30. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22204202.

17. Kessing BF, Bredenoord AJ, Saleh CM et al. Effects of anxiety and depression in patients with gastroesophageal reflux disease. Clin Gastroenterol Hepatol. 2015;13(6):1089-95 e1. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25496817.

18. MacFarlane B. Management of gastroesophageal reflux disease in adults: a pharmacist's perspective. Integr Pharm Res Pract. 2018;7:41-52. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29892570.

19. Newberry C, Lynch K. The role of diet in the development and management of gastroesophageal reflux disease: why we feel the burn. J Thorac Dis. 2019;11(Suppl 12):S1594-S601. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31489226.

20. Singh M, Lee J, Gupta N et al. Weight loss can lead to resolution of gastroesophageal reflux disease symptoms: a prospective intervention trial. Obesity (Silver Spring). 2013;21(2):284-90. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23532991.

21. Tang Z, Dubois S, Soon C et al. A model for the pandemic and beyond: Telemedicine for all outpatient gastroenterology referrals reduces unnecessary clinic visits. J Telemed Telecare. 2022;28(8):577-82. [Accessed: 30 September 2024]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/32954940.

22. International Pharmaceutical Federation. Managing reflux symptoms in the community pharmacy: Quick reference guide for pharmacists. The Hague: [Internet]. 2023. [Accessed: 30 September 2024]. Available at: https://www.fip.org/file/5436.

International
Pharmaceutical
Federation

Fédération
Internationale
Pharmaceutique

Andries Bickerweg 5
2517 JP The Hague
The Netherlands
-
T +31 (0)70 302 19 70
F +31 (0)70 302 19 99
fip@fip.org
-
www.fip.org

10/2024 | Reflux SA