

위식도역류증과 인후두이상감증과의 상관관계

엄재욱·한태희

The Relationships between Gastroesophageal Reflux and Globus Pharyngeus

Jae Wook Eom, MD, PhD and Tae Hee Han, MD

*Department of Otorhinolaryngology-Head and Neck Surgery, College of Medicine, Inje University,
Pusan Paik Hospital, Busan, Korea*

-ABSTRACT-

Background and Objectives : Globus pharyngeus is a choking sensation, as of a lump in the throat. Although otolaryngologists are often confronted with this condition, they still do not completely understand the etiologies of globus pharyngeus. Recently researchers have come to believe that gastroesophageal reflux (GER) are the most important etiologic factor causing globus pharyngeus. In an attempt to verify this current belief, the authors performed a prospective study in patient who complained of globus sensation in the throat. **Materials and Method** : All 30 patients with globus symptoms met the Rome II criteria. They underwent telelaryngoscopy, gastroesophagoscopy and ambulatory 24 hr pH monitoring. **Result** : GER was diagnosed in 20% of the tested patient. On telelaryngoscope, Reflux finding score (RFS) was 2.83 in GER patients and 4.0 in non-GER patients. On gastroesophagoscope, the number of patients were decreased along the LA Classification grade. On ambulatory 24 hr pH monitoring, the number of patients were decreased along the %time. These results consequently suggest globus pharyngeus does not correlate with GER. **Conclusion** : In contrast to the current belief, GER should be regarded as just one of the possible etiologic factor, and it is necessary to evaluate the further etiologic factors. (J Clinical Otolaryngol 2005;16:253-257)

KEY WORDS : Gastroesophageal reflux · Globus pharyngeus.

서론

가 24% 가 53% 가 40%
1) 2)

: 2005 9 14

: 2005 10 14

: , 614 - 735

2 633 - 165

: (051) 890 - 6379 · : (051) 892 - 3831 E - mail : sinus4@pusanpaik.or.kr

(telaryngoscope),
 (ambulatory 24 - hour double - probe pH monitoring),
 (esophageal manometry),
 (gastroesophagoscopy)
 가 가
 가
 가

방 법

Belafsky⁵⁾
 reflux finding score(RFS)
 (Table 2).

LA LA Grade A,
 B, C, D (Table 3).

24

2

2 cm

대상 및 방법

대 상

2000 4 2004 4
 1) Rome II Criteria
 2)

3)

30
 24
 30 가 20 (66.6%), 가 10 (33.3%)
 39.4 (24~65)
 19 (12~48) 가
 7 (23.3%), 가 23 (76.6%) (Table 1).
 1

24

Table 1. Patient's characteristics

Patient	N=30
Mean age (yrs)	39.4 (24 - 65)
Sex	M/F=1/2
Duration of symptoms (months)	19 (12 - 48)
Non-smoker	23
Smoker	7

Table 2. Modified Components of the reflux finding score (RFS)

Telaryngoscopic finding	RFS
Subglottic edema (stenosis)	Present=2 Absent=0
Erythema/Hyperremia	Arytenoid medial wall=2 Diffuse=4
True Vocal Cord edema	Mild=1 Moderate=2 Severe=3
Posterior commissure hypertrophy (interarytenoid bar)	Mild=1 Moderate=2 Severe=3

Table 3. The Los Angeles classification of esophagitis

Grade A	One (or more) mucosal break no longer than 5 mm, that does not extend between the tops of two mucosal folds
Grade B	One (or more) mucosal break more than 5 mm long that does not extend between the tops of two mucosal folds
Grade C	One (or more) mucosal break that is continuous between the tops of two or more mucosal folds but which involves less than 75% of the circumference
Grade D	One (or more) mucosal break which involves at least 75% of the esophageal circumference

Table 4. Results of telearyngoscopy

Reflux finding score	No. of patients (%)
1	1 (3)
2	6 (20)
3	5 (17)
4	13 (43)
5	1 (3)
6	2 (6)
7	1 (3)
8	0 (0)
9	1 (3)
Total	30 (100)

Table 5. Results of gastroesophagoscopy

LA Classification	No. of patients (%)
Grade A	7 (23.5)
Grade B	4 (13.5)
Grade C	3 (10.0)
Grade D	1 (3.5)
Total	15 (50.0)

Table 6. Results of ambulatory 24-hour pH monitoring

%time*	No. of patients (%)
<0.5	8 (27)
0.5 - 1.5	8 (27)
1.5 - 2.5	5 (17)
2.5 - 3.5	2 (7)
3.5 - 4.5	1 (3)
>4.5	6 (20)
Total	30 (100)

*%time: Percent total time which pH on lower esophageal sphincter is less than 4.

cm , 24
 가 4
 (%time)
 4.5%time
 , Bowmann Gray
 1 가 4
결 과
 가
 23 (77%) 가 RFS 4 가
 13 45% RFS
 가
 24
 2.83 , 가

4.0 RFS
 가 (Table 4).
 15 (50%)
 24
 6
 5 1 LA Grade B
 LA Classification Grade가 가
 가
 가
 (Table 5).
 24 30
 %time 4.5 %time
 가 6 (20%) , %time
 가 가 %time
 (Table 6).
 6 1
 가
 24
 가

고찰

가

Koufman⁹⁾

가 , Lorenz¹⁰⁾ 67%
Batch¹¹⁾¹²⁾ 65%,
Kang¹³⁾ 42.2%
Wilson¹⁴⁾ 47
24 15%, Son¹⁵⁾
가 . 33 21.1%

(globus histericus)

24 20%
1940 Son

가
1) 1968 Malcomson⁶⁾ Koufmann⁹⁾ 24
23% Jacob¹⁶⁾
24
가

가 6
7) 1 가 가
8) 가 가 가
(micro - aspiration)
가 Lorenz¹⁰⁾ 51
(vagus nerve - mediated reflex)
가 가 70.6%
Hsu¹⁹⁾ 25
1 (4%)
15 (50%) , LA Cla-
ssification
24 Belafsky⁵⁾
24 가 RFS 24

17 가 RFS Hill 20)

가 RFS

가 RFS

24

가

24

가

결 론

30

24

중심 단어 :

2003

REFERENCES

- 1) Jang TY, Lee SC, Park IY, Kim GR, Jang HS. *Globus syndrome: Clinical aspects and Video-esophagogram. Korean J Otolaryngol* 1988;31:321-6.
- 2) Yoo CS, Kim DS, Lee SK, Lee BD, Chang HS, Kang JW. *A study for causative diseases of globus pharyngeus patients who have no pathologic conditions in laryngopharynx. Korean J Otolaryngol* 1998;41:1573-8.
- 3) Postma GN, Belafsky PC, Aviv JE, Koufman JA. *Laryngo-*

pharyngeal reflux testing. Ear Nose Throat J 2002;81:14-8.

- 4) Johnson PE, Koufman JA, Nowak LJ. *Ambulatory 24-hour double-probe pH monitoring: The importance of manometry. Laryngoscope* 2001;111:1970-5.
- 5) Belafsky PC, Postma GN, Koufman JA. *The validity and reliability of the reflux finding score (RFS). Laryngoscope* 2001;111:1313-7.
- 6) Bradley PJ, Narula A. *Clinical aspects of pseudodysphagia. J Laryngol Otol* 1987;101:689-94.
- 7) Koufman JA. *Gastroesophageal reflux disease. In: Cummings CW, Fredrickson JM, Harker LA, Krause CJ, Richardson MA, Schuller DE. Otolaryngology-Head and Neck Surgery. 3rd ed. St Louis: Mosby year book;1998. p.2411.*
- 8) Ohman L, Olofsson J, Tibbling L, Ericsson G. *Esophageal dysfunction in patients with contact ulcer of the larynx. Ann Otol Rhinol Laryngol* 1983;92:228-30.
- 9) Koufman JA. *The otolaryngologic manifestation of gastroesophageal reflux disease: Clinical study of 225 patients using ambulatory 24-hr pH monitoring and an experimental investigation of the role of acid and pepsin in the development of laryngeal injury. Laryngoscope* 1991;101:1-28.
- 10) Lorenz R, Jorysz G, Clasen M. *The globus syndrome: Value of flexible endoscopy of the upper gastrointestinal tract. J Laryngol Otol* 1993;107:535-7.
- 11) Bacht AJG. *Globus pharyngeus. Part I. J Laryngol Otol* 1988;102:152-8.
- 12) Bacht AJG. *Globus pharyngeus. Part II. J Laryngol Otol* 1988;102:227-30.
- 13) Kang YW, Han CY, Park SK. *Esophageal motility disorder in patients with globus senses in throat or anterior chest. Korean J Gastroenterol* 1993;25:251-7.
- 14) Wilson JA, Heading RC, Maran AGD, Pryde A, Pirus J, Allan PLR. *Globus sensation is not due to gastroesophageal reflux. Clin Otolaryngol* 1987;12:271-5.
- 15) Son YI, Kwon JK, Rhee PL, Lee HY, Ryu BH, Kim JH. *Importance of psychological factors and organic factors in globus pharyngeus. Korean J Otolaryngol* 1998;41:381-4.
- 16) Jacob P, Kahrilas PJ, Herzon G. *Proximal esophageal pH-metry in patients with reflux esophagitis. Gastroenterology* 1991;100:305-10.
- 17) Frank M, komisar A. *Ambulatory pH monitoring in the management of reflux. Ann Otol Rhinol Laryngol* 1993;102:243-6.
- 18) Woo P, Noordzij P, Ross JA. *Association of esophageal reflux and globus symptom: Comparison of laryngoscopy and 24-hour pH manometry. Otolaryngol Head Neck Surg* 1996;115:502-7.
- 19) Hsu CC, Wan SJ, Chou KS, Hwang SY. *Globus hystericus-reports on 25 ENT cases and literature review. Zhonghua Yi Xue Za Zhi (Taipei)* 1989;43:213-6.
- 20) Hill RH, Simpson CB, Velazquez R, Larson N. *Pachydermia is not diagnostic of active laryngopharyngeal reflux disease. Laryngoscope* 2004;114:1557-61.