

Letter to the Editor

In Response to *The Dubai Definition and Diagnostic Criteria of Laryngopharyngeal Reflux: The IFOS Consensus*

Dear Editor

We appreciate Dr. Li's reading of the IFOS Consensus¹ and the dialogue² on diagnostic criteria for laryngopharyngeal reflux (LPR). The topic is complicated. A robust discussion may help move our field closer to a shared understanding of these issues.

Dr. Li points out that an LPR event is different than having LPR-disease.² We agree that having physiologic hypopharyngeal reflux events (HREs) does not equate to an LPR diagnosis,¹ however, in our article, we are using the acronym LPR to mean LPR-disease (and present it as such). We clarify that the term "laryngopharyngeal reflux" is not completely correct when describing what the hypopharyngeal-esophageal multichannel-intraluminal impedance-pH monitoring (HEMII-pH) test is actually reporting. Anatomic reflux events into the pharynx from the esophagus, more correctly called "HRE" correctly describe reflux events that do not necessarily make it into the larynx.^{1,3} Thus, the term "laryngopharyngeal reflux" is a commonly offered shorthand,^{4,5} often used in the literature to represent the disease state of LPR,^{4,5} and describes the related histopathological consequences, for example, laryngopharyngeal findings.⁴

Despite Hoppo *et al.* describing the finding of ≥ 1 HRE being outside HEMII-pH normative values, there is no evidence that one HRE should be accepted as the cause of the patient's symptoms.⁶ In the Dubai consensus, experts proposed the diagnosis for >1 HRE based on a systematic review of normative data.³ In this review, the 95th percentile values of HREs ranged from 0 to 10.7. Some authors reported that the 95th percentile values of acid/weakly acid/alkaline HREs were 0/0/2 in asymptomatic individuals, respectively,³ while others observed a 75th percentile value of one HRE.³

Dr. Li reminds us of some studies that choose not to split the "non-acid" events into either weakly acid or alkaline events.² The findings of the aforementioned review,³ reinforced the importance of considering weakly acid and non-acid HREs when discussing LPR, both being more prevalent than acid HREs.^{1,7-9} HEMII-pH software

parameters may be tailored to detect weakly acid and alkaline events. The differentiation of weakly/non-acid HREs is important regarding the several degrees of enzyme activity within gastroduodenal contents as they affect the upper aerodigestive tract mucosa at differing pH levels.^{9,10} Interestingly, clinical differences were observed between patients with acid, weakly acid, and alkaline reflux.¹¹ Finally, we agree that the statement "*The LPR diagnosis can be based on symptoms or finding only but requires >1 HRE...*" could be clearer regarding the practical management of suspected LPR patients. We tried to express that the patient history and/or examination alone are not LPR diagnostic, but rather supported by more objective HEMII-pH-based evidence. In a real-world setting, a response to empiric therapy may also be considered diagnostic. Empiric treatment as a diagnostic tool was therefore included in our flow chart.

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