

NGN NCLEX 2026 • CLINICAL JUDGMENT SERIES

Gastroesophageal Reflux *Disease*

A chronic GI disorder where the lower esophageal sphincter (LES) fails to close properly, allowing gastric acid to reflux upward into the esophagus — damaging the mucosa and producing the hallmark burn.

GI / DIGESTIVE SYSTEM

PHARMACOLOGY

PRIORITY CARE

PATIENT TEACHING

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Definition & Overview

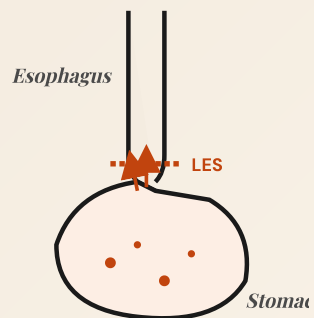
WHAT IT IS • WHY IT MATTERS

The Core Problem

Backflow of gastric contents (HCl acid + pepsin) into the esophagus through an incompetent lower esophageal sphincter (LES). The esophagus lacks the protective mucosal lining of the stomach, so acid exposure causes inflammation (esophagitis) and pain.

Why It Matters

Untreated GERD leads to esophageal strictures, Barrett's esophagus (precancerous metaplasia), and increased risk of esophageal adenocarcinoma. Chronic nighttime reflux can also cause aspiration pneumonia and asthma-like respiratory symptoms.



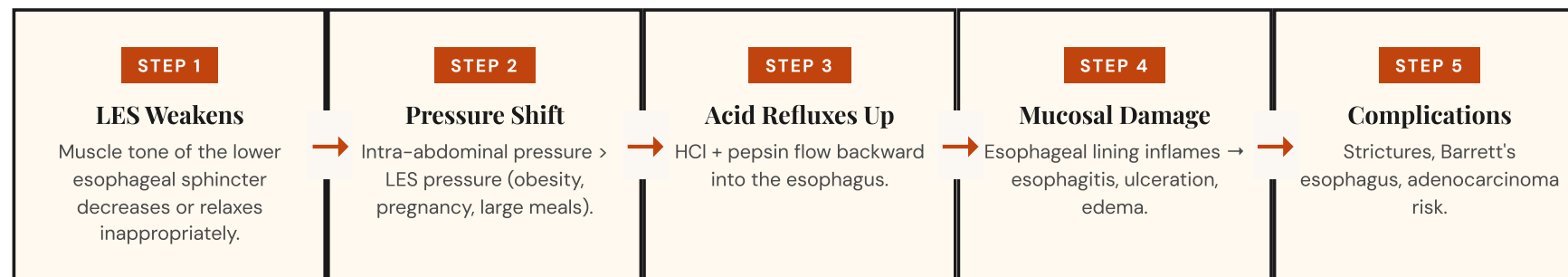
The Reflux Pathway

When the **LES** weakens or relaxes inappropriately, gastric acid splashes upward into the esophagus. Because the esophageal lining has **no protective mucus barrier**, every reflux episode burns the tissue — producing pyrosis (heartburn) and, over time, chronic inflammation.

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Pathophysiology

STEP-BY-STEP MECHANISM



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Signs & Symptoms

MILD PRESENTATION · SEVERE / COMPLICATION FINDINGS

Mild / Classic

- ▶ **Pyrosis (heartburn)** — burning retrosternal pain, worse after meals & lying down
- ▶ **Regurgitation** — sour/bitter taste in mouth
- ▶ Dyspepsia (indigestion)
- ▶ Belching, bloating, early satiety
- ▶ Water brash (hypersalivation)
- ▶ Symptoms worsen when *bending, lying supine, or after large meals*

Severe / Atypical

- ▶ **Dysphagia** — difficulty swallowing (possible stricture)
- ▶ **Odynophagia** — painful swallowing
- ▶ Chronic dry cough, hoarseness, laryngitis
- ▶ Nocturnal wheezing / asthma-like symptoms
- ▶ Chest pain mimicking MI — *always rule out cardiac first*
- ▶ Dental erosion (enamel loss from acid)

RED FLAG FINDINGS — NOTIFY HCP

Unintentional weight loss · Hematemesis or melena (GI bleed) · Persistent dysphagia (possible stricture or Barrett's) · Chest pain not relieved by antacids (cardiac cause?) · Symptoms refractory to PPI therapy.

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Priority Nursing Interventions

ABCS · SAFETY · NCLEX PRIORITIZATION

A · AIRWAY & ASPIRATION FIRST

Assess

Position & Safety

Administer & Monitor

- ✓ Airway patency; auscultate lungs (aspiration risk)
- ✓ Pain: quality, timing, relationship to meals
- ✓ Weight loss, dysphagia, hemoglobin/hematocrit
- ✓ Rule out cardiac cause of chest pain — obtain ECG if ordered
- ✓ Review medications contributing to reflux (CCBs, nitrates, anticholinergics)

- ✓ **Elevate HOB 30°–45°** at all times (reverse Trendelenburg at night)
- ✓ Keep upright 1–2 hours after meals
- ✓ Never lay patient flat immediately after eating
- ✓ Assess aspiration risk — suction at bedside if high risk
- ✓ Monitor for respiratory distress, wheezing

- ✓ Give antacids 1–3 hours after meals & at bedtime
- ✓ PPIs 30–60 min before breakfast on empty stomach
- ✓ H2 blockers at bedtime for nocturnal reflux
- ✓ Monitor for med side effects (see Pharm)
- ✓ Assess pain relief & reflux frequency

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Pharmacology

DRUG CLASSES · MECHANISMS · NURSING IMPLICATIONS

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
PPIs –prazole	Block H ⁺ /K ⁺ ATPase pump → profoundly ↓ acid secretion. Most potent suppressors.	Headache, diarrhea, ↑ fracture risk, hypomagnesemia, C. diff infection, rebound acid on withdrawal, B12 deficiency (long-term)	Give 30–60 min before breakfast on empty stomach. Do NOT crush delayed-release capsules. Long-term: monitor Mg, Ca, B12. Examples: omeprazole, pantoprazole, esomeprazole
H2 Blockers –tidine	Block histamine H2 receptors on parietal cells → ↓ acid secretion (less potent than PPIs).	Headache, dizziness, confusion in elderly (cimetidine). Cimetidine → gynecomastia, many drug interactions.	Give at bedtime for nocturnal reflux. Famotidine preferred over cimetidine (fewer interactions). Examples: famotidine, ranitidine (withdrawn), cimetidine, nizatidine
Antacids Tums, Maalox, Mylanta	Neutralize existing gastric acid. Rapid onset, short duration.	Al-based: constipation. Mg-based: diarrhea. Na-based: fluid retention	Give 1–3 hours after meals and at bedtime . Separate from other meds by 1–

		(avoid in HF/HTN). Ca-based: rebound acid, kidney stones.	2 hrs (↓ absorption). Shake liquid forms well.
Sucralfate Carafate	Forms a protective barrier over ulcerated mucosa — does NOT reduce acid.	Constipation (most common). Can bind other meds and ↓ their absorption.	Give on empty stomach — 1 hour before meals & at bedtime . Separate from other meds by 2 hrs. Needs acidic environment — do not give with antacids at same time.
Prokinetics metoclopramide	↑ LES tone and ↑ gastric emptying → less reflux opportunity.	Extrapyramidal symptoms (EPS), tardive dyskinesia (black box), drowsiness, restlessness.	Monitor for involuntary movements. Limit to < 12 weeks. Avoid in Parkinson's and bowel obstruction.

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NCLEX Test Traps

COMMON CONFUSIONS · PRIORITY PITFALLS



PPI vs H2 Blocker Timing

PPIs go **30–60 min BEFORE breakfast** (empty stomach). H2 blockers are commonly given **at bedtime** for nighttime symptoms. Students mix these up — timing is a testable detail.



Antacid vs Sucralfate

Antacids = **AFTER meals** (neutralize existing acid). Sucralfate = **BEFORE meals on empty stomach** (needs acid to coat the ulcer). Opposite schedules — don't confuse.



GERD Chest Pain vs MI

GERD can mimic cardiac chest pain exactly. **Always rule out MI first** — obtain ECG, cardiac enzymes. NCLEX will present "burning chest pain" and the priority answer is cardiac assessment, NOT antacid.



"Lie Down After Eating"

Biggest teaching trap. Patients say "I rest after meals" — wrong. Remain **upright for at least 1–2 hours** after eating. Flat positioning worsens reflux dramatically.



Milk Makes It Worse



Don't Stop PPI Abruptly

Patients often drink milk for heartburn. Milk initially soothes but causes **rebound acid secretion**. Teach: avoid milk as a remedy.

Sudden PPI withdrawal causes **rebound hyperacidity**. Teach patients to taper under HCP guidance, not stop cold-turkey even if feeling better.

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Patient Education

LIFESTYLE MODIFICATIONS • DIETARY GUIDANCE

Do This

- Eat **small, frequent meals** (4–6 per day) instead of 3 large ones
- Remain **upright 1–2 hours** after eating — no lying down, no reclining
- Elevate head of bed **6–8 inches on blocks** (pillows alone don't work — they bend the waist)
- Stop eating **2–3 hours before bedtime**
- Lose weight if overweight (reduces abdominal pressure)
- Quit smoking — nicotine relaxes the LES
- Wear loose-fitting clothing around waist and abdomen
- Chew food thoroughly; eat slowly in an upright position
- Report weight loss, black stools, vomiting blood, or worsening dysphagia

Avoid These Triggers

Foods & habits that **relax the LES** or ↑ acid:

- Caffeine
- Chocolate
- Garlic · Onion
- Tomato products
- Spicy foods
- Citrus
- Whole milk · Dairy fat
- Fried / fatty foods
- Alcohol
- Peppermint
- Carbonated drinks
- Smoking

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Memory Boosters

MNEMONICS · PATTERN RECOGNITION

GERD

SYMPTOM MNEMONIC

G Gurgling / regurgitation — sour taste in mouth

E Eructation (belching) & epigastric pain

R Reflux of acid → burning pyrosis

D Dysphagia — late finding (stricture warning)

BURN

AVOID-THESE TRIGGERS

B Big meals & bedtime eating

U Upward pressure — tight clothing, obesity, pregnancy

R Reclining after eating

N Nicotine, caffeine, alcohol, spicy/fatty foods

QUICK PATTERN RECOGNITION

"-prazole" = PPIs (before breakfast) · "-tidine" = H2 blockers (at bedtime) · Antacids = AFTER meals · Sucralfate = BEFORE meals · HOB up, weight down, meals small, upright always.

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NCJMM Clinical Judgment Framework

NEXT GENERATION NCLEX · CLINICAL JUDGMENT MEASUREMENT MODEL

STEP 1

Recognize Cues

Burning retrosternal pain after meals, sour regurgitation, worse when lying down, relief with antacids. Note dysphagia, weight loss, hematemesis as *red flag* cues needing escalation.

STEP 2

Analyze Cues

Differentiate GERD pain from MI — always rule out cardiac. Connect risk factors (obesity, pregnancy, hiatal hernia, tobacco) to LES incompetence. Identify medication contributors (CCBs, nitrates).

STEP 3

Prioritize Hypotheses

Priority: airway / aspiration risk > tissue damage from acid exposure > pain > nutrition. In new chest pain → cardiac cause is top hypothesis until proven otherwise.

STEP 4

Generate Solutions

Elevate HOB, upright after meals, small frequent low-fat meals, weight loss, smoking cessation, PPI/H2 blocker/antacid timing, avoid triggers, monitor for complications.

STEP 5

Take Action

Administer PPI 30–60 min before breakfast; antacid 1–3 hr after meals; position upright 30°–45°; teach lifestyle modifications; assess response to therapy.

STEP 6

Evaluate Outcomes

↓ frequency of heartburn; no nocturnal symptoms; maintained/gained weight; no dysphagia progression; no signs of bleeding. If no improvement in 4–8 wks → reassess / further workup.

CLINICAL JUDGMENT PEARL

Priority Setting for GERD

Always apply **ABCs first** — GERD complications include aspiration pneumonia and laryngospasm. Chest pain with reflux history must first be evaluated as **cardiac**. Only after ruling out life-threatening causes do you address comfort and lifestyle teaching.

— End of GERD NGN NCLEX 2026 Infographic —