Watchful waiting no longer recommended for some high-risk Barrett's esophagus patients

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Endoscopic removal of pre-cancerous cells in patients with confirmed, high-risk Barrett's esophagus is recommended rather than surveillance, according to a new "Medical Position Statement on the Management of Barrett's Esophagus," published by the American Gastroenterological Association (AGA) Institute. The medical position statement was published in *Gastroenterology*, the official journal of the AGA Institute.

In patients with Barrett's esophagus, the normal cells lining the esophagus are replaced with tissue that is similar to the lining of the intestine. The goal of endoscopic eradication therapy is to permanently eliminate all intestinal-type cells in the esophagus. A small number of people with Barrett's esophagus develop a rare, but often deadly, type of cancer of the esophagus.

"The AGA's recommendations for the treatment of patients with Barrett's esophagus are based on the best data currently available within the medical literature," said John M. Inadomi, MD, AGAF, chair of the AGA Clinical Practice & Quality Management Committee. "When considering whether surveillance or endoscopic eradication therapy is the preferred management option for patients with Barrett's esophagus, the AGA strongly supports the concept of shared decision-making between the treating physician and patient."

The AGA recommends endoscopic eradication therapy with radiofrequency ablation (RFA), photodynamic therapy (PDT) or endoscopic mucosal resection (EMR), as follows for various patient

groups:

- Patients with confirmed high-grade dysplasia (advanced pre-cancerous cells): endoscopic eradication therapy is recommended.
- Patients with confirmed low-grade dysplasia (beginning pre-cancerous cells): endoscopic eradication therapy is a treatment option and should be discussed with patients as such.
- Patients with Barrett's esophagus without abnormal cells: endoscopic eradication therapy is not recommended.

If eradication therapy is not indicated, is not available or is declined by a patient with Barrett's esophagus, surveillance by endoscopy should be performed every three months in patients with high-grade dysplasia, every six to 12 months in patients with low-grade dysplasia, and every three to five years in patients with no dysplasia.

"The recommendations in the medical position statement were made under the assumption that a patient's diagnosis and the presence or absence of low and high grade dysplasia would be accurate to the highest degree possible using the best current standards of practice," according to Stuart J. Spechler, MD, AGAF, a member of the AGA Institute Medical Position Panel. High grade dysplasia is an abnormal growth that has a high risk for cancer development.

Most patients (70 to 80 percent) with high-grade dysplasia can be successfully treated with endoscopic eradication therapy. Esophagectomy (surgical removal of all or part of the esophagus) in patients with high-grade dysplasia is an alternative; however, current evidence suggests that there is less morbidity with ablative therapy.

Other findings of the medical position statement on the management of Barrett's esophagus include:

- In patients with multiple risk factors associated with esophageal cancer (age ≥50 years, male gender, Caucasian, chronic gastroesophageal reflux disease [GERD], hiatal hernia, elevated body mass index and intra-abdominal distribution of body fat), AGA suggests screening for Barrett's esophagus. We recommend against screening the general population with GERD for Barrett's esophagus.

- The diagnosis of dysplasia in Barrett's esophagus should be confirmed by at least one additional pathologist, preferably one who is an expert in esophageal histopathology.

- For patients with Barrett's esophagus, GERD therapy with medication effective to treat GERD symptoms and to heal reflux is clearly indicated, as it is for patients without Barrett's esophagus. However, evidence to support the use of acid-reducing agents, specifically proton pump inhibitors, in patients with Barrett's esophagus solely to reduce the risk of progression to dysplasia or cancer is indirect and has not been proven in a long-term controlled trial.

- Given that cardiovascular deaths are more common than deaths from esophageal cancer among patients with Barrett's esophagus, screening for cardiovascular risk factors and interventions is warranted.

It is expected that, each year, every one in 200 patients diagnosed with Barrett's esophagus will develop esophageal cancer, which is a devastating disease. For advanced esophageal cancers, the current

treatment options are limited and odds of survival remain low; it is nearly universally terminal. However, while patients diagnosed with Barrett's esophagus, especially those with pre-cancerous cells, feel an increased level of anxiety and emotional burden, the actual risk of death from esophageal cancer remains low. Patients with Barrett's esophagus appear to have an increased risk of death from cardiovascular disease, perhaps due to an association with obesity.

The conclusions of the medical position statement are based on the best available evidence (as the technical review discusses), or in the absence of quality evidence, the expert opinions of the medical position panel convened to critique the technical review and structure the medical position statement.

To develop the guidelines, a set of 10 broad questions were identified by experts in the field to encapsulate the most common management questions faced by clinicians. To review recommendations and grades, view the American Gastroenterological Association Medical Position Statement on the Management of Barrett's Esophagus.

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