Barrett's Guidelines Tweak Screening Justification

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ORLANDO — Strategies for screening and treatment approaches for Barrett's esophagus, which were addressed in clinical practice guidelines released by the American College of Gastroenterology earlier this year, continued to trigger discussion during the college's annual meeting.

Screening of the general population for Barrett's esophagus is not recommended, nor is there sufficient evidence to support selective screening of higher-risk populations, according to the updated recommendations on diagnosis, surveillance, and treatment of Barrett's esophagus (Am. J. Gastroenterol. 2008;103:788-97).

Previous guidelines, issued in 2002, said people with chronic gastroesophageal reflux disease (GERD) symptoms should undergo upper endoscopy because of their increased risk of Barrett's esophagus.

"You would end up having more serious adverse events from the very safe upper endoscopy—perforations, cardiac collapse, death—than the number of cancers detected if we were to screen everyone with chronic GERD symptoms," Dr. Nicholas J. Shaheen of the departments of medicine and epidemiology at the University of North Carolina at Chapel Hill commented during the meeting. Current screening and surveillance practices in Barrett's esophagus are limited by poor risk stratification, he said.

The guideline committee noted that the highest screening yield for Barrett's esophagus would be among Caucasian men older than 50 years with longstanding heartburn, though even in this group, efficacy has not been proven and the screening yield has been low, said Dr. Shaheen, who is on the speakers bureau and is a consultant for AstraZeneca PLC and TAP Pharmaceutical Products Inc. He has received grant support from BÂRRX Medical Inc., CSA Medical Inc., and Procter & Gamble Co.

Another criticism came from Dr. Joel Richter, a gastroenterologist who is chairman of the department of medicine at Temple University, Philadelphia. "They did not distinguish long-segment versus short-segment Barrett's. There is a higher chance of cancer with increasing length," he said during a media briefing.

The guideline does not distinguish long-segment versus short-segment Barrett's.

DR. RICHTER

The guidelines state that patients who undergo endoscopic mucosal resection require long-term surveillance for cancer recurrence "for life, at least once a year or more," Dr. Richter noted.

The grade of dysplasia determines the recommended surveillance interval, according to the guidelines. Low-grade dysplasia, for example, warrants a follow-up endoscopy within 6 months to rule out development of high-grade dysplasia. If that procedure yields a negative finding, annual endoscopy is recommended until two consecutive assessments reveal no dysplasia.

The guidelines suggest that physicians prescribe proton pump inhibitors (PPIs) for patients on long-term surveillance. PPIs suppress acid and lower inflammation, thus permitting better visualization and pathologic interpretation of tissue, but other potential benefits are less clear. "There is no randomized, controlled trial that shows a person randomized to a PPI with Barrett's will live longer than someone without a PPI," said Dr. Yvonne Romero of the department of medicine at the Mayo Clinic, Rochester, Minn.

Some experts have suggested that capsule endoscopy could be used to screen for Barrett's esophagus. One study found a sensitivity of 100% and specificity of 80%, Dr. Shaheen said (Aliment. Pharmacol. Ther. 2004;20:1083-9), though subsequent studies "were less compelling." The guidelines state this technique cannot yet be recommended.

In regard to detection of Barrett's esophagus using biomarkers, the guidelines state that "no biomarkers or panel is currently ready for routine clinical use." They also state that esophagectomy is no longer required for all people with high-grade dysplasia. "This is a paradigm shift—that we'll more selectively use surgery," Dr. Richter said. ■