New guideline: Barrett's esophagus precedes esophageal cancer, but not all patients need abnormal cell removal

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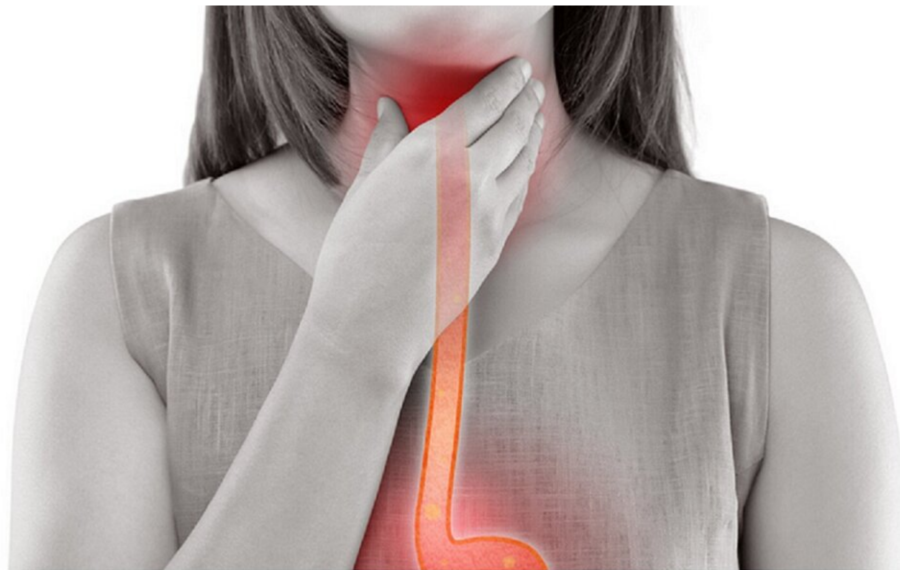

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The American Gastroenterological Association's (AGA) new evidence-based Clinical Practice Guideline on Endoscopic Eradication Therapy of Barrett's Esophagus and Related Neoplasia, published today in *Gastroenterology*, establishes updated guidance for Barrett's esophagus patients.

A precursor to esophageal cancer, Barrett's esophagus is a condition in

which the cells in the esophagus have been replaced with non-cancerous abnormal cells. These cells can progress to a condition called dysplasia, which may in turn become cancer. Dysplasia is considered low-grade or high-grade, depending on the degree of cellular change.

"While the benefit is clear for patients with high-grade dysplasia, we suggest considering endoscopic eradication therapy for patients with low-grade dysplasia after clearly discussing the risks and benefits of endoscopic therapy," said guideline author Dr. Tarek Sawas, assistant professor in the department of internal medicine at UT Southwestern.

"A patient-centered approach ensures that treatment decision is made collaboratively, taking into account both the medical evidence and the patient's preferences and values. Surveillance is a reasonable option for patients who place a higher value on harms and a lower value on the uncertain benefits regarding reduction of esophageal cancer mortality"

Endoscopic eradication therapy consists of minimally invasive procedures such as endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD), followed by ablation (burning or freezing) techniques.

Key guideline takeaways:

- For patients with low-grade dysplasia, it may be appropriate to either remove or monitor the cells. This is a decision doctors and patients should make together after discussing the risks and benefits of treatment.
- For patients with high-grade dysplasia, AGA recommends endoscopic therapy to remove the abnormal pre-cancerous cells.
- Most patients undergoing endoscopic eradication can be safely treated with EMR, which has a lower risk of adverse events. Patients who undergo ESD can face an increased risk of

strictures and perforation. AGA recommends reserving ESD primarily for lesions suspected of harboring cancers invading more deeply into the wall of the esophagus or those who have failed EMR.
- Patients with Barrett's esophagus (dysplasia or early cancer) should be treated and monitored by expert endoscopists and pathologists who have experience in Barrett's neoplasia.

"We need to have a conversation with patients in clinic prior to when they show up in the endoscopy unit on a gurney. Patients need to be fully aware of the risks and benefits, both in the short term but also in the long run, to decide which treatment approach is best for them. This decision often comes down to personal factors and values," added guideline author Dr. Joel Rubenstein, who is the director of the Barrett's Esophagus Program at the University of Michigan.

The guideline provides the following general implementation considerations:

- Tobacco use and obesity are risk factors for esophageal adenocarcinoma, so counseling patients to abstain from tobacco use and to lose weight can help improve outcomes.
- In patients with Barrett's esophagus, reflux control should be optimized with both medication and lifestyle modifications.

More information: American Gastroenterological Association Clinical Practice Guideline: Endoscopic Eradication Therapy of Barrett's Esophagus and Related Neoplasia, *Gastroenterology* (2024). DOI: 10.1053/j.gastro.2024.03.019

Guideline:
https://www.gastrojournal.org/article/S0016-5085(24)00302-0/fulltext

Medical Xpress

Clinical decision support tool:
https://www.gastrojournal.org/article/S0016-5085(24)00432-3/fulltext

Spotlight (infographic):
https://www.gastrojournal.org/article/S0016-5085(24)00433-5/fulltext

Provided by American Gastroenterological Association

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