Guidelines for management of Barrett's Oesophagus

The recommendations from the Lothian Combined Upper GI Group, Dec 1999.

Definition
- Oesophagus lined by metaplastic columnar epithelium for a variable length above the GOJ
- Careful documentation of the following endoscopic landmarks is essential –
  1. Gastro-oesophageal junction is represented by the position of the proximal margin of the gastric folds in the deflated oesophagus.
  2. Columnar-lined oesophagus is the portion occurring between landmarks 1 and 2.
  3. The proximal extent of the Barrett's is defined here as the most proximal tip of the tongues of columnar mucosa.

Where to Look for Barrett’s
- Distal oesophagus should be examined in all patients undergoing OGD
- Especially those with longstanding reflux symptoms
- Endoscopic screening for Barrett's is not currently indicated

Diagnosis
- Requires systematic biopsy to document intestinal metaplasia and detect dysplasia
- Lack of goblet cells on biopsy does not rule out BO - discuss with pathologist if uncertain.

Dye Stain (See dye stain chart)
- These should be available for use in selected cases but are not routinely indicated.

Appropriate Number of Biopsies
A minimum of 6 biopsies should be taken
- 1 from GOJ.
- 4 from columnar mucosa.
- 1 from squamous-columnar junction.

Any endoscopically visible lesion should be documented, biopsied and sent separately.

Classification of Dysplasia
- No dysplasia
- Indeterminate for dysplasia
- Low grade dysplasia (LGD)
- High grade dysplasia (HGD)

Specific Therapy for Barrett’s
- Treat symptoms of GORD
- Consider anti-reflux surgery in appropriate patients
- No treatment if asymptomatic

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**Surveillance** (See Algorithm for the management of Barrett’s Oesophagus)

- No dysplasia – 2 - 3 years
- Indeterminate dysplasia - repeat after PPI
- LGD - 6 months then yearly
- HGD or carcinoma in situ* - repeat & review by 2nd pathologist
- Invasive carcinoma* - staging tests
- Short segment BO (<3cm) - surveillance recommended as per standard Barrett’s

**Note:**
- No age limit – in general we consider survey if ASA Grade < 3 in all patients; but we consult with patients and GP if surveillance is appropriate for patients over 75.
- * discuss at weekly Upper GI Meeting

**ASA Grades**

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<thead>
<tr>
<th>ASA Grade</th>
<th>Definition</th>
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<tbody>
<tr>
<td>1</td>
<td>Patient has no organic, physiological, biochemical or psychiatric disturbance. Pathological process for which operation is to be performed is localised and does not entail a systematic disturbance.</td>
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<tr>
<td>2</td>
<td>Mild to moderate systemic disturbance caused by either the condition to be treated surgically or by other patho-physiological processes.</td>
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<tr>
<td>3</td>
<td>Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.</td>
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<tr>
<td>4</td>
<td>Severe systemic disorders that are already life threatening, not always correctable by operation.</td>
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<tr>
<td>5</td>
<td>The moribund patient who has little chance of survival but is submitted to operation in desperation.</td>
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**Members of the Combined Lothian Upper GI Group**

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