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Managing Esophageal Cancer From the Onset

Managing Esophageal Cancer From The Endoscopic Therapy

You are listening to ReachMD XM 160, The Channel For Medical Professionals. Welcome to GI Insight, where we cover the latest clinical issues, trends, and technologies in gastroenterological practice. GI Insight is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals, North America. Your host for GI Insights is professor of medicine and director of the Digestive Disease Center at the Medical University of South Carolina, Dr. Mark Delegge.

Endoscopy can be used to detect the development of dysplasia in the Barrett's Esophagus patient, but can it also help us to help treat early stage esophageal cancer. Joining us to discuss managing esophageal cancer from the onset is endoscopic therapy finally here is Dr. Prateek Sharma, Professor of Medicine in the Division of Gastroenterology and Hepatology at the University of Kansas School Of Medicine in Kansas City.

DR. MARK DELEGGE:

Welcome Dr. Sharma.

DR. PRATEEK SHARMA:

Thank you Dr. Delegge it's a pleasure to be here.

DR. MARK DELEGGE:

Prateek I find this is a fascinating topic and I know it's come a long ways and I know that you are leader in this area, I want to ask you how should we as a gastroenterologist approach a patient who we think has a cancer or neoplasia in side of Barrett's esophagus, meaning we look for that, but how do we approach when we think that there is a cancer their.

DR. PRATEEK SHARMA:

That's an excellent question Mark and the reason I think it's important is because of the dismal survival of esophageal cancer when it's detected at a later stage and unfortunately still the majority of the esophageal adenocarcinomas that we detect are late stage cancers, I

think its very crucial that we detect neoplasia in Barrett's at an early stage. It starts right from your surveillance endoscopy, I think just like we have now realized that spending more time during a colonoscopy makes us detect more colon polyps, I think the same holds true for detecting dysplasia and early cancer in Barrett's esophagus, so the key that I tell people is to spend enough time in the distal esophagus examining the Barrett's segment very carefully before you start taking your biopsies. Now we do have very good high resolution and even high definition endoscopes, which are available. So starting from the gastroesophageal junction and doing a gradual pull back examining the Barrett's area carefully would be my first recommendation, so look for any subtle lumps, bumps, erosions, basically looking for anything that is not flat regular mucosa and any of those areas should be targeted first for biopsies and after that is done then you can start taking your 4 quadrant biopsies every 2 cm. So I think Mark if you do that we will have high accuracy for the detection of neoplasia and Barrett's, of course we do have a number of these upcoming new technologies available and we can discuss those later as well.

DR. MARK DELEGGE:

So, Prateek what I am hearing from you is when you face one of these Barrett's patients, you are not simply going and taking a bite here and taking bite there and then going home.

DR. PRATEEK SHARMA:

Exactly, and for the first time we actually do have some data albeit from retrospective study from the UK, which clearly showed that in patient's who had undergone a systematic biopsy protocol, had increased detection of both low-grade dysplasia and high-grade dysplasia as compared to what you just said, you know biopsy here and there.

DR. MARK DELEGGE:

Many times you mentioned the lumps and bumps that we see and frankly we have heard a lot about flat polyps in the colon and even gastric nodules, but with the esophagus itself, with these lumps and bumps, you know when I did my training, some times we just basically went by them and some times we biopsied and sometimes we didn't. It sounds like this is becoming more and more important. Is this simply just biopsying those areas or are there some endoscopic imaging techniques that are now available that could help you.

DR. PRATEEK SHARMA:

Yes Mark there are number of new emerging techniques that are available just to name a few, I mean you could do simple things such as spraying or dyeing the esophagus, you know just to enhance the contrast between the lesion and the Barrett's segment then you have other technologies such as you know optical chromoendoscopy technique such as narrow band imaging, _____ the eye scan, which basically you know you don't have to use the dye that you used for chromoendoscopy and to get even further along those techniques for further characterization you have confocal endo microscopy, optical coherence tomography, spectroscopy, so a number of these new technologies are out there and number of them like the narrowband imaging in the _____ and the confocal microscopy are also commercially available. The preliminary studies that have been done Mark using all these techniques have had, you know, good results in terms of characterizing the type of lesion that you see with the Barrett's and I know of a number of ongoing multi center randomized trials, which hopefully will give us some better estimates of which one of these techniques would be useful, but if you have any of these special instruments available and you have expertise in that then I think you can definitely use them because they are available to you and they will all help increase your detection rates of high-grade dysplasia in early cancer, which then can be subjected to endoscopic treatment.

DR. MARK DELEGGE:

Prateek if you are sitting at Community Center and you are looking at an endoscopy and saw some lumps and biopsied them and they came back as we say esophagitis or chronic inflammation. Would you refer a patient like that to tertiary institution if one was available who had some of these technologies?

DR. PRATEEK SHARMA:

Well I mean, Mark, if the biopsies came back as inflammation and esophagitis, I think that would not be of concern to me, but if the biopsies from these lumps and bumps showed, you know, so-called "atypia" or if the pathologist they read it out as high-grade dysplasia cannot rule out cancer or cannot determine the grade of dysplasia or something like that, then I think it would be of concern and I mean I agree with you I mean that would be a patient that needs further regress evaluation.

DR. MARK DELEGGE:

If you are just tuning in, you are listening to GI Insights on ReachMD, The Channel for Medical Professionals. I am your host, Dr. Mark Delegge and joining me today to discuss managing esophageal cancer from the outset "is endoscopic therapy finally here" is Dr. Prateek Sharma, Professor of Medicine in to Division of Gastroenterology and Hepatology at the University of Kansas school of medicine in beautiful Kansas City.

Well, Prateek lets move right on to therapy here. If we find or if we see some one who has Barrett's esophagus and we get a biopsy back that says high-grade dysplasia or perhaps early adenocarcinoma what do we do?

DR. PRATEEK SHARMA:

Mark, I can tell you what happens at our institution and how we approach these patients because we do get referrals exactly of patient's that you just mentioned, I mean we will start off first by standard white light endoscopy that we will do at our unit and we will do the examination that I just mentioned with a standard high resolution high-definition white light endoscope, we will locate where the gastroesophageal junction is, we will grade the Barrett's segment using the Prague criteria and for, you know, those of I think the majority of our listeners are but those of them who are not aware of these Prague criteria, these are criteria, which measure the circumferential and the maximal extent of Barrett's esophagus, so for example if somebody has 5-cm Barrett's esophagus in which the distal 3 cm is circumferential, then the patient is classified as having a Barrett's Prague C3 in which the C stands for circumferential and M5 in which the M stands for the maximal limit and it becomes important about the circumferential extent and the therapy can be decided based on that and I will come to that in a minute, so we will start off with that. We will grade it accurately, we look for these lumps and bumps that I just mention to you Mark and then we will use some of these advanced imaging techniques that we have available at our endoscopy unit and again the goal for doing that is to determine which are the bad areas, the irregular areas that need further interrogation. Then, if we see a lump or bump or if we see an irregular area or an abnormal area with any of our techniques, then what we do is we do a diagnostic EMR or endoscopic mucosal resection of that area and the reason to do that is you can easily imagine Mark that now your pathologist has almost like 2-cm specimen to look and make a diagnosis of is it low grade, is it high grade, is it intramucosal cancer, is it invasive cancer as compared to like a 3-mm biopsy that you may have sent. It also changes, I mean there are bunch of studies including a meta-analysis, which have shown that as compared to simple biopsy once you've done an EMR, you change the diagnosis with the EMR in 40% of the cases. So that is the huge change, so you may have a patient who on biopsy may have been called as high grade dysplasia and after the EMR your pathologist may say well it is not high-grade dysplasia, it is actually only low grade dysplasia in which case the patient may not need any further endoscopic therapy. For cancer it is crucial because your pathologist will be able to tell you whether the cancer is just in the mucosa in which case it is early cancer and is still amenable to endoscopic therapy or your pathologist will be able to tell you that well its cancer which is going in to the submucosa in which case the patient no longer is a candidate for endoscopic therapy with a curative intent. So that is the key step right there Mark.

DR. MARK DELEGGE:

I would like to thank my guest from University of Kansas School Of Medicine, Dr. Prateek Sharma, for an awesome review of Barrett's esophagus and early stage esophageal cancer. Dr. Sharma, thank you very much for being our guest this week on GI Insight.

DR. PRATEEK SHARMA:

Thank you very much Mark it was my pleasure.

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Now it's your turn, the ReachMD poll wants your opinion on matters of clinical importance to the medical community practicing primary care physician Kevin Pho shared insights from his popular medical blog kevinmd.com and we asked you to voice your opinion and vote.

What were the most significant events of 2008 that will continue to effect practicing physicians. Here there are 3 to top my list. First is the Medicare's institution of never event where payment is denied for certain medical errors. In addition, the uncontroversial event like operating on a wrong patient Medicare has included conditions where total prevention is impossible like patient falls, hospital-acquired infections. Hospitals will now be motivated to increase the amount of preadmission testing to ensure that any complication the patient acquires preexisting and doctors would now think twice about admitting or performing procedures on the chronically ill or the elderly, the patients most at risks and complications. Next is the recession impact on healthcare. These difficult economic times prevent patients from undergoing routine exams and seeing the doctor regularly. The increasing volume at both physician offices and hospitals. In our _____ system, doctors will be under more physical pressure then ever to break even. Finally, the election of Barack Obama along with a democrat-controlled congress, this represents a best chance in a generation to meaningful health reform legislation. Expect the focus on supporting primary care, the decreasing the number of uninsured patient, reforming the physician payment system and potentially _____ negotiation with the pharmaceutical and health insurance industries. I don't see any way the physician practice environment cannot change with the dramatic shift in the political climate in 2008. That's my take. If I have not covered the issue that's on your mind, you can add it by going to my blog at kevinmd.com in light to get it or calling to ReachMD listener line and phoning it in for broadcast. Tell us what and why. For the ReachMD poll, Kevin Pho don't forget to vote.

Now it's your turn, read Kevin's poll blog at kevinmd.com and post your comment. Download the podcasts at reachmd.com and vote at either site, you can also record your comment for air by calling ReachMD at 888-639-6157.