Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/top-screening-strategies-barretts-esophagus/12811/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Top Screening Strategies for Barrett's Esophagus

Dr. Nandi:
We recognize that chronic GERD patients may develop Barrett's esophagus. Screening and prevention are key. But who should we screen? How do we screen? And how vigilant must we be in order to prevent progression to malignancy?

Joining me today is Dr. Gary Falk, Professor of Medicine at the University of Pennsylvania in the Division of Gastroenterology and Hepatology. Dr. Falk is the Director of the Esophagology and Swallowing Center. Indeed, he's an esophagologist extraordinare.

Gary, we are very delighted to have you on our program today. Welcome to *GI Insights*.

Dr. Falk:
Well, thank you very much for that kind introduction.

Dr. Nandi:
Absolutely. This is a common hot topic, we talk about this at every CME symposium, GERD and Barrett's and how do we remain vigilant? Who should we be screening for Barrett's esophagus? And more importantly perhaps, who should we not?

Dr. Falk:
Well, it's a great question. The whole issue of screening of Barrett's is really based on expert opinion, and all the guidelines around the world hedge on it. So you have things like suggest, consider, risk stratify, or consider. But the common theme seems to be longstanding reflux symptoms with additional risk factors. And the key risk factors are age greater than 50, male gender, obesity, especially central obesity, and smoking, as well as a first-degree relative. And actually, the ASGE in 2019 suggested recommending it only in people with a positive family history and suggests that it may benefit for those with GERD and one or more risk factors and do not recommend it for low-risk individuals, who's everybody else.

So it's usually based on GERD symptoms plus other criteria. The problem with it is that threshold for screening doesn't work very well. And when you look at the performance characteristics of these guidelines in a sample population, it really is not that good. So we've got to do better.

And unfortunately, the other part of the problem is that it's well known that about 40% of people with esophageal cancer don't ever remember having reflux-type symptoms. So this is what we do right now because endoscopy is the only tool that we have. That may change in the future when we have different, less invasive tools, whether it's going to be things like the sponge on a string, the Cytosponge, or the swallowed capsule device that is being made too. So lots of less invasive options. Even screening for volatile organic acids. And if any of those have good poor performance characteristics, of the Cytosponge, certainly in work by Rebecca Fitzgerald does, we may do a lot better, and we may be able to broaden the screening population in the future.

Dr. Nandi:
That brings me to how often do we give patients an inaccurate diagnosis of Barrett's esophagus? How often can this be a false diagnosis?

Dr. Falk:
Well again, that's a great question. And that gets into how do you make the diagnosis? And unfortunately right now, we have an epidemic of false diagnosis because for reasons that remain unclear, the normal Z-line seems to be having with it attached an invitation to biopsy, when all guidelines all over the world emphasize that that should not be the case. How to change that habit on the part of the GI community is something I'm not quite sure how we do. But I think one of the problems when you label someone with Barrett's is that

they then have their life insurance premiums changed, their quality of life has altered, their worry for developing esophageal cancer increases. And then they start looking for things that may hurt them, such as unnecessary endoscopic eradication therapy for a condition that doesn't exist. So unfortunately, there are many, many people who have a diagnosis of Barrett's who don't have it. And lot of us are in what we call the delabeling business.

Dr. Nandi:
Gary, what are your opinions about biopsying for Barrett's when you see esophagitis when you actually see some form of ulceration at the Z-line? Should we be biopsying that?

Dr. Falk:
So I think that's a great question. The one caveat about the normal Z-line is that one should not biopsy normal Z-line if it looks totally normal. But if there are any mucosal abnormalities, no matter how subtle, they should be biopsied. Not all ulcers or inflammatory changes have the same flavor. So obviously if you have a normal Z-line with nodularity, with mucosal irregularity, that does at least merit a biopsy or two. Again, if there's a potential for an underlying neoplastic lesion, you don't want to do too much because that may make it difficult to do a resection in the future. But in the setting of a normal Z-line, you shouldn't. One needs to inspect very carefully to make sure there are no mucosal abnormalities.

In a setting of ongoing reflux esophagitis, it's become a little bit controversial. Most people think that that is really an invitation to get a diagnosis of indefinite for dysplasia. So I think it's best not to biopsy in the setting of active inflammation. And always live to fight another day and have that inflammation calm down with appropriate anti-secretory therapy. However, if there is an ulcer that looks unusual, you know, saying it doesn't look like classic LA A, B, C, or D esophagitis, that's a different story.

There's another side to that coin is that if you have LA C or D esophagitis, you really do need to get that healed up to see if underneath that there is Barrett's esophagus. So I agree esophagitis does need to be healed and repeated endoscopy. A and B, esophagitis is less clear-cut that one needs to repeat it endoscopy to sort out whether there's Barrett's or not.

Dr. Nandi:
For those just tuning in, you're listening to *GI Insights* on ReachMD, and I've been speaking with Dr. Gary Falk about Barrett's esophagus; who should we be screening? Who shouldn't we not be screening? And how can we best characterize it?

Speaking of characterization, Dr. Falk, optics have come a long way with HD scopes, zoom, and all these little nifty gadgets that we have literally at our fingers' disposal. How can we best characterize Barrett's esophagus? What do you do that we should be doing better when we're actually scoping a patient in terms of light filter? And I'm hoping you'll also review how we can characterize it in terms of Prague classification.

Dr. Falk:
Thank you. I think that's a great question. And I think that's something that doesn't require any expensive capital outlay to do. I think that in the world of Barrett's esophagus, the single biggest thing that's changed diagnostics, and in fact, to a certain extent therapeutics, is our ability to see much better. So we can see so much better now with high-definition endoscopes. And the key principle of Barrett's esophagus surveillance and detection is a high-quality examination. You need to clear the surface, first of all, of any debris, you need to spend some time looking at the involved area. Typically, you should go up and down with high-definition white light first, and then I usually switch to narrowband imaging because of the scope that I have. But there are many other instruments that have electronic chromoendoscopy that work quite well. And if you do a high-definition white light exam followed by an electronic or conventional, in this case, acetic acid chromoendoscopy exam, by definition, you're doubling the inspection time. And there are suggestions that the more carefully and the longer you look, the more you find. That that is a little bit flawed, but there is consensus in the Barrett's esophagus community that one of the critical aspects of Barrett's esophagus is a high-quality examination.

So the key things to do clean, look carefully, look antegrade and retrograde, varying your degrees of insufflation, and then define your landmarks. It's just like the LA classification, the Paris classification, the Prague classification, define where the diaphragmatic pinch is, define where the top of the gastric folds is with partial insufflation, define the circumferential extent, the so-called C, to the maximal extent of the tongues of the Barrett's. And that gives you a clear language.

One shouldn't be doing biopsies, if there's less than 1 centimeter of Barrett's because there's poor interobserver variability. The blind spot of the Prague classification are islands. So there may be islands above the squamocolumnar junction. And that's not part of the Prague classification. But I do advocate biopsies of those islands.

So it's really taking a little bit of time and looking very carefully at things. And then, of course getting systematic biopsies.

Dr. Nandi:

Acetic acid, is that something that we can learn to do out in the community? Or is that something that has to be done at a center?

Dr. Falk:
Anybody can do it. It's inexpensive, but it's probably also inconvenient. So while it has met the ASGE PIVI criteria for rigor, it's not really used. And I don't think it's really necessary in the setting of electronic chromoendoscopy. It is used in Europe and South America. It works. But I think that from a practical perspective where in North America every scope has got the capability of electronic chromoendoscopy, it's one less thing I think you should worry about. If you don't have electronic chromoendoscopy, it's a different story. It's inexpensive, and I don't think there's enough time to get into it today, but it does work. But I think that electronic chromoendoscopy is a much simpler application here.

Dr. Nandi:
And I think that's a practical point. So I'm glad you answered that question that we have already very sophisticated tools that we can use. And I think you said it earlier, you said look right, take your time inspecting and looking, don't rush by, do a quality job. It doesn't take long, right? Endoscopy's a relatively easy procedure for endoscopists to perform. So just looking can help you make the diagnosis.

Dr. Falk:
Now the one thing I would add in that has no evidence for it other than it's been embraced in the Barrett's community that at least in the surveillance of known dysplastic patients, adding a distal cap to the scope allows you to isolate areas and allows you to use your electronic zoom and look more carefully. It's not necessary for the routine examination in someone where you're not sure if there's Barrett's or not. In terms of the delabeling, you may want to consider it. It's not terribly expensive. It's not necessarily a routine surveillance. And after all, most people with Barrett's esophagus are never going to develop dysplasia or cancer. So most Barrett's surveillance is routine.

Dr. Nandi:
That's very important. And I think the cap, like you said, it's not routine, it is inexpensive, and I've used that in my practice. And it's been very helpful. Such a little simple tool that has actually helped me kind of pin down the tissue and get a better look than I would have otherwise.

Dr. Falk:
I think what you said about pinning it down, it really helps you compensate if there's a lot of inspiration expiration, if there's an area that's really subtle that you want to look at, you can pull out and just put a cap on it; it makes it so much easier. But like I said, it's not necessary for the routine, run-of-the-mill non-dysplastic case.

Dr. Nandi:
Absolutely. Now let's say we do due diligence, we characterize, we screen, we due diligence, and then we have our pathologists return a diagnosis suggestive of Barrett's. What should be our first reflex with that Barrett's diagnosis? Should we talk to that pathologist? Should we get a second opinion pathologist? When should we entertain that?

Dr. Falk:
Well, I think before we go to the pathologist, it's important to make sure that we've provided them adequate samples. Again, despite being advocated and having evidence for a long time that it works, that the Seattle protocol which has been out there from before the age of high-definition endoscopy, allows a systematic biopsy, a biopsy of the Barrett's segment. The more biopsies that you do and the more you adhere to it, the more dysplasia you find. So before we get things to the pathologist, we want to obtain the tissue in the right way. Again, this is something that has been difficult to have the community embrace, but I think that there's good evidence that it works nicely.

As far as pathology communication, you're looking for certain descriptions. If there is no dysplasia, I think that you're basically okay in terms of columnar epithelium intestinal metaplasia. If there is dysplasia though, that should result in an automatic trigger for at least a consensus review or ideally a review with someone with expertise in GI pathology. So how you define expertise, it's hard to say because there's no agreement. But there's general pathology, and then there's GI pathology. So you'd like to get it reviewed by a GI pathologist. And certainly, all guidelines in this country will state that any diagnosis of dysplasia merits review by a second pathologist, preferably with expertise in GI pathology.

I think that that's going to change in the future, too. There ways of scanning slides and having that sent. Whether those systems take off or not, it's hard to say. But I think that the key thing here is anybody in definite low-grade high-grade, that needs to be reviewed, intramucosal or cancer, that needs to be reviewed. And anybody who doesn't use accepted terminology such as moderate dysplasia, severe dysplasia, that is not adhering to the correct linguistics. So I would certainly want those slides reviewed, if they're not using the normal terminology.

Dr. Nandi:
So I think the highlights of what you just said were make sure you get adequate samples, make sure you've given good tissue for the pathologist to work with. And then you kind of raise some alarm language, alarm words or buzzwords that we should be thoughtful and thinking that perhaps our pathologists may be using outdated terminology. And maybe that would be a reasonable question to review the pathology. So that's actually a great tip right there too.

Dr. Falk, you kind of hit a lot of great points. You reviewed in a very high-yield fashion, the high-risk factors that are obvious for developing chronic reflux and Barrett's but a key take-home that I will not forget is that 40% of those esophageal cancer patients never had symptoms. So perhaps that every GI visit that I have, for a patient with reflux, I'm going to be very thoughtful and continue to be detailed in my screening questionnaire, if you will, for those chronic reflux patients, making sure I'm not missing any subtle symptoms of esophageal or extraesophageal reflux.

Dr. Falk:
The other thing to point out is that there is active development of risk prediction tools that can be used in electronic medical records. They are being looked at in various centers around the world. And they have reasonable but not perfect performance characteristics, where you can place in some of these risk factors, such as sex, smoking, BMI, reflux, family history, and they are very, very promising for the future.

Dr. Nandi:
This was some great information you shared with us, Gary. Before we close, do you have any last closing remarks?

Dr. Falk:
Well, first of all, again, I want to thank you for giving me this opportunity. I think that the most important thing in our Barrett's patients is to emphasize that if the diagnosis is made correctly, and surveillance is done well, they're playing with house money. The risk for cancer in a given patient is 0.1 to 0.3% per year. The highest risk is in that initial time period, especially if the initial exam is not meticulous. Once you're out there, even though the risk never zeroes out, most people with non-dysplastic Barrett's esophagus will never develop cancer. Again, 90% of people with esophageal cancer have never had a diagnosis of Barrett's esophagus. And that's the whole conundrum that we have with esophageal cancer in Barrett's programs today.

Dr. Nandi:
Thank you, Dr. Falk. The research must go on, but today we're going to be doing better in screening our patients for Barrett's esophagus. Thank you so much. For ReachMD, I'm Dr. Neil Nandi. To access this episode and others from *GI Insights*, please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.