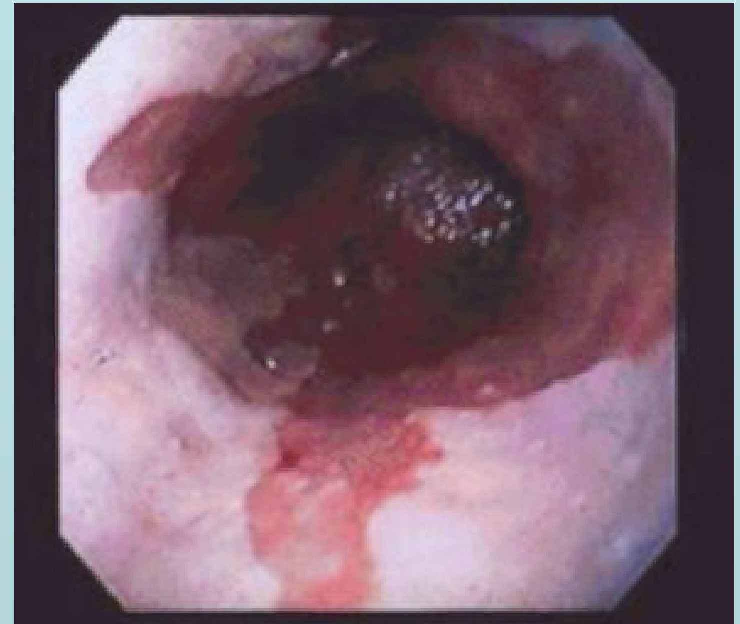
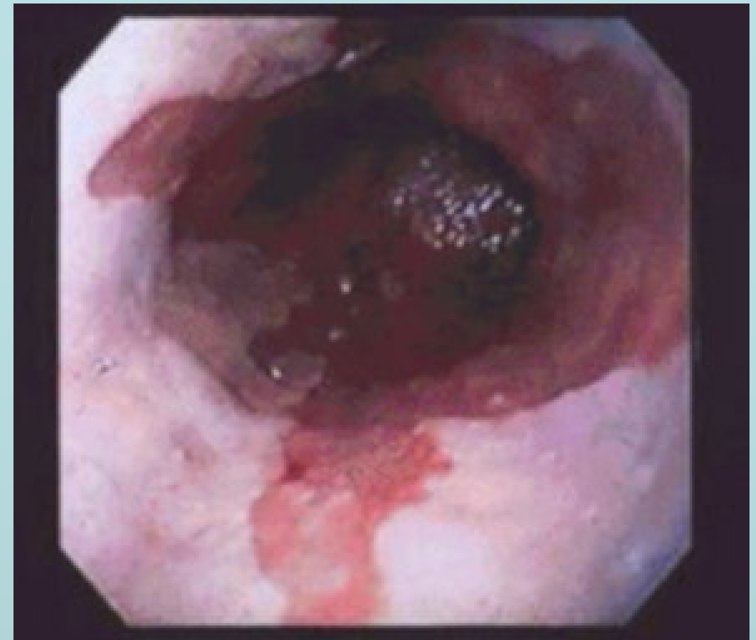


2009
Retningslinier
Barretts øsophagus

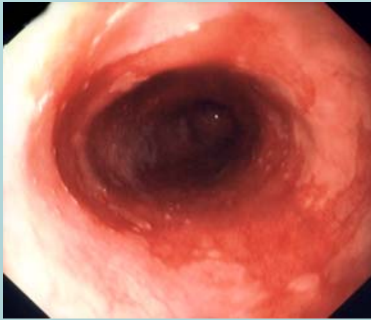
PVA DECV
Lars Bo Svendsen

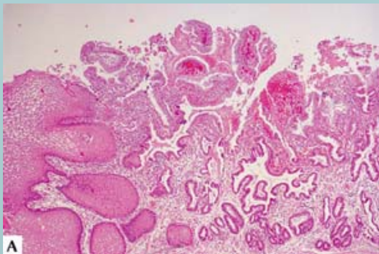


2009 Retningslinier Barretts øsophagus

1. DECV gruppen
2. DKS / DGS guideline gruppen

Diagnose
Endoskopi + Histologi





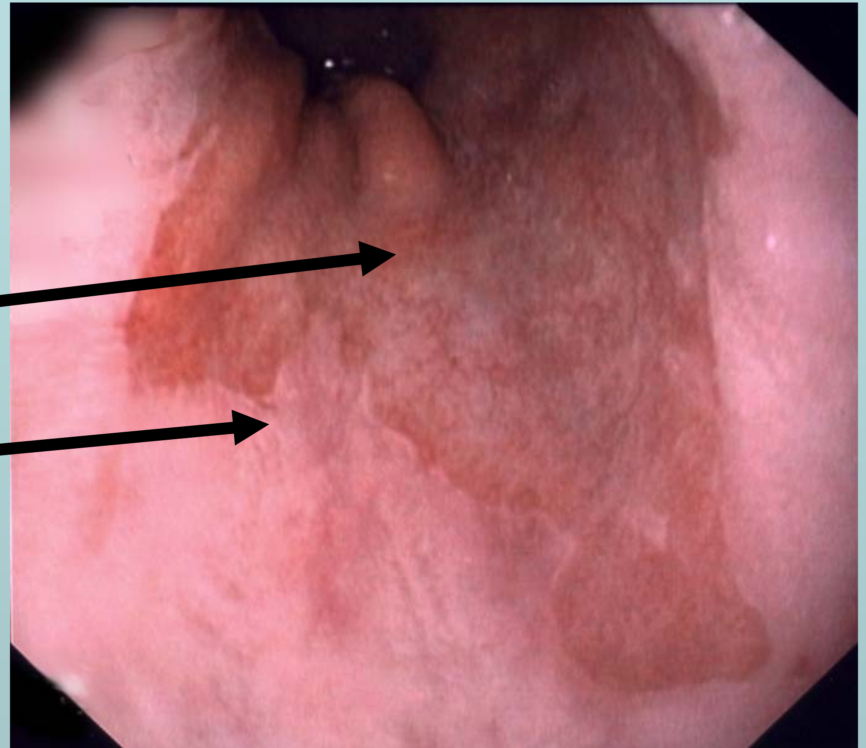
- Makroskoskopisk synlig intestinalt metaplastisk cylinderepithel (B)
- *Mere end 1 cm oralt for gastro-esophageale overgang* (C)
- Bekræftet histologisk ved tilstedeværelsen af intestinal metaplasi med bægerceller (B)

Endoskopi

To landemærker:

1. Gastro-øsofageale overgang

2. Z-linien

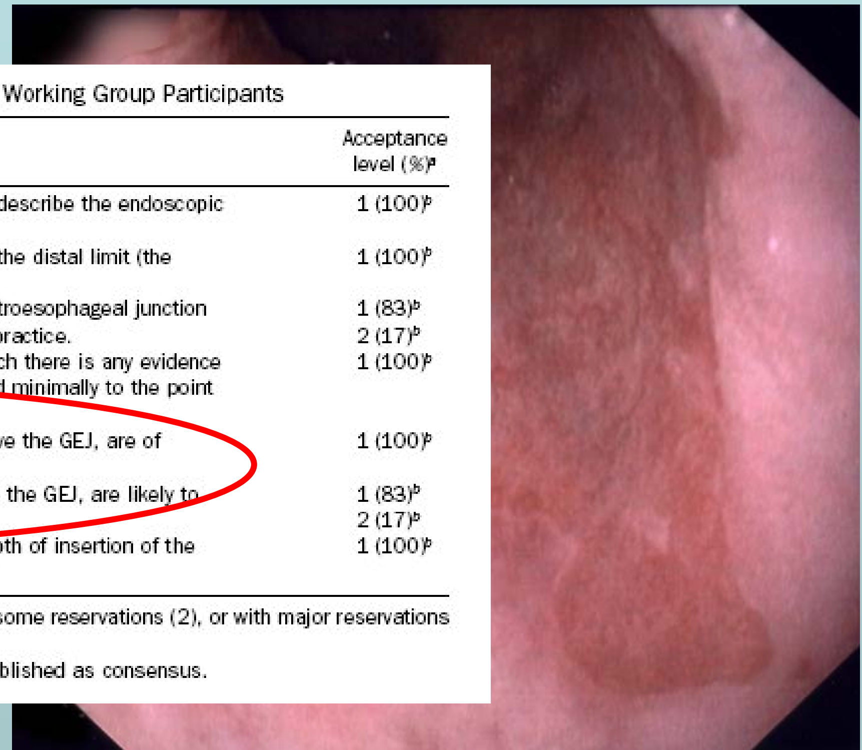


Endoskopi

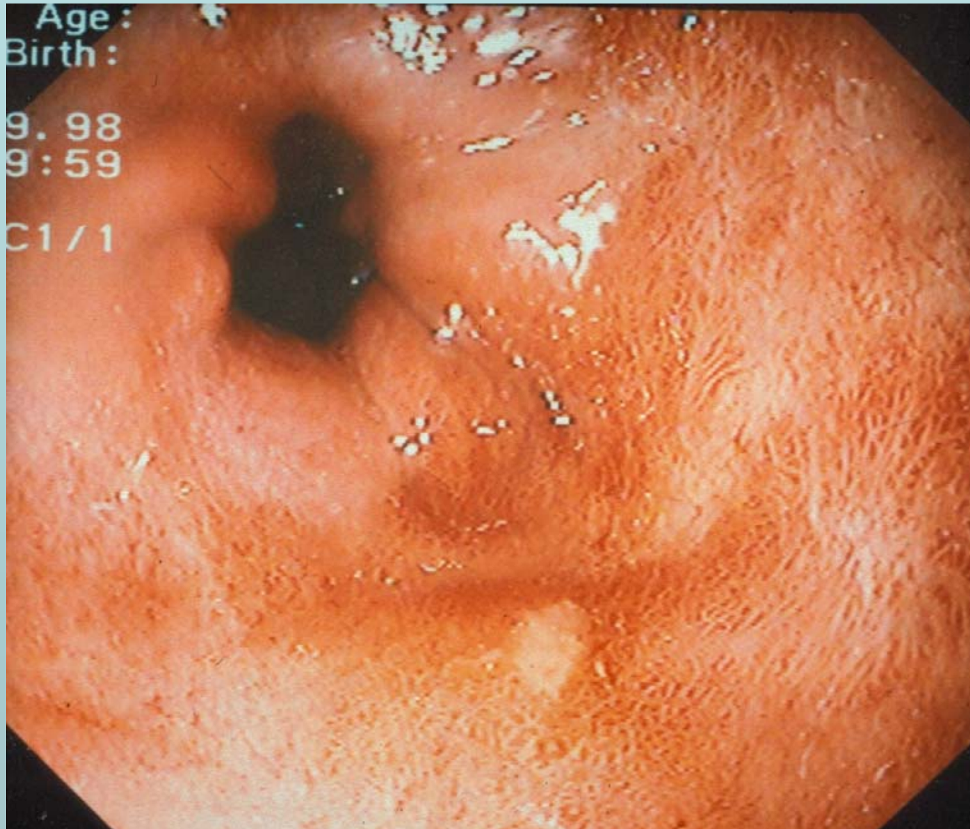
Table 1. Key Propositions and Acceptance Levels Among the Barrett's Esophagus Working Group Participants

Proposition and level of acceptance	Acceptance level (%)[a]
"Barrett's esophagus," qualified by a descriptor of its extent, is the most pragmatic term to describe the endoscopic appearances suggestive of columnar-lined esophagus.	1 (100)[b]
Measurement of the nearest and farthest proximal limits of Barrett's esophagus, relative to the distal limit (the GEJ), is a reasonable assessment of its extent.	1 (100)[b]
The proximal limit of linear gastric mucosal folds is the most practicable indicator of the gastroesophageal junction (GEJ) in the presence of suspected Barrett's esophagus in routine diagnostic endoscopic practice.	1 (83)[b] 2 (17)[b]
The proximal limit of gastric mucosal folds is defined best as the most proximal point at which there is any evidence of a linear fold of gastric mucosa. This is best visualized when the esophagus is distended minimally to the point that the proximal ends of the gastric folds appear.	1 (100)[b]
Endoscopic changes suggestive of columnar-lined esophagus, extending less than 1 cm above the GEJ, are of uncertain value for the diagnosis of Barrett's esophagus.	1 (100)[b]
Endoscopic changes suggestive of columnar-lined esophagus, extending at least 1 cm above the GEJ, are likely to predict the presence of Barrett's esophagus.	1 (83)[b] 2 (17)[b]
Assessment of the extent of Barrett's esophagus should be conducted by measuring the depth of insertion of the endoscope relative to the bite block.	1 (100)[b]

[a] Workshop participants voted on whether they accepted the proposition completely (1), with some reservations (2), or with major reservations (3), or rejected the propositions with reservations (4), or completely (5).
[b] Greater than 70% of votes cast in agreement or disagreement of each proposition was established as consensus.

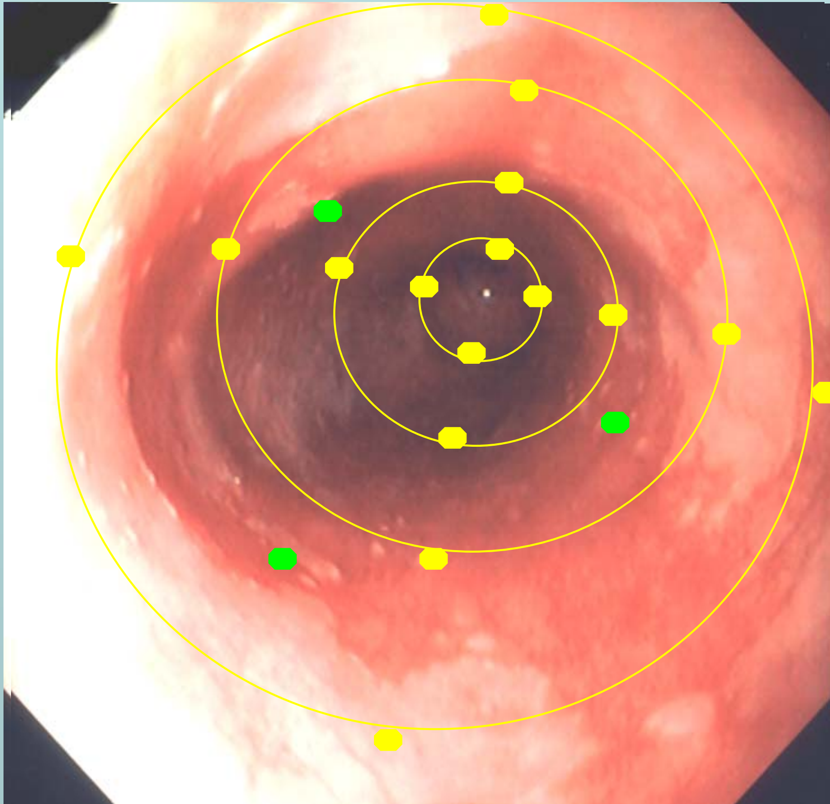


Hvor skal biopsierne tages?



Målrettet biopteret ?

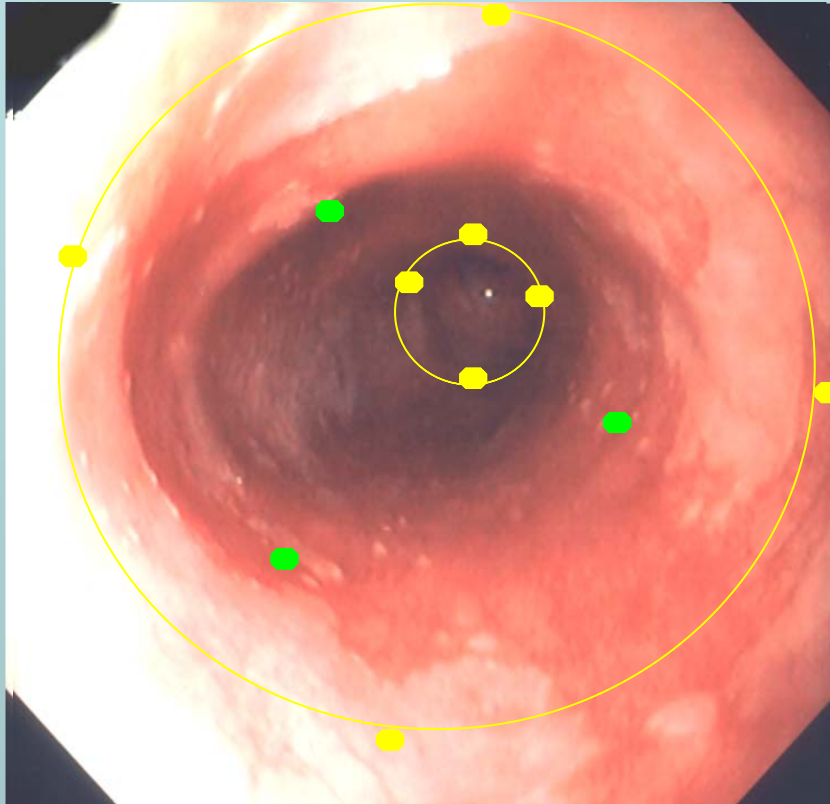
Anbefalet biopteret



<u>'Seattle – biopterering':</u>

Kvadrantbiopsier for hver 2 cm
og fra fokale læsioner (B)

Anbefalet biopterering DGS/DKS



<u>"Dansk metode":</u>

Kvadrantbiopsier i top og bund og fra fokale læsioner

Hvis segmentet længere end 5 cm - også i midten (C)

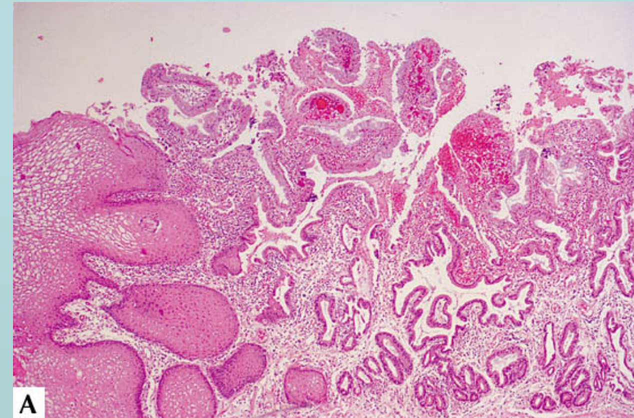
Beskrivelse af Barrett

GASTROENTEROLOGY 2006;131:1392–1399

The Development and Validation of an Endoscopic Grading System for Barrett's Esophagus: The Prague C & M Criteria

PRATEEK SHARMA,* JOHN DENT,‡ DAVID ARMSTRONG,§ JACQUES J. G. H. M. BERGMAN,¶ LIEBWIN GOSSNER,‖ YOSHIO HOSHIHARA,# JANUSZ A. JANKOWSKI,** OLA JUNGHARD,‡‡ LARS LUNDELL,§§ GUIDO N. J. TYTGAT,§ and MICHAEL VIETH¶¶

*Department of Veterans Affairs Medical Center, University of Kansas School of Medicine, Kansas City, Missouri; ‡Department of Gastroenterology, Hepatology, and General Medicine, Royal Adelaide Hospital, Adelaide, Australia; §Division of Gastroenterology, McMaster University, Hamilton, Ontario, Canada; ¶Department of Gastroenterology and Hepatology, Academic Medical Centre, University of Amsterdam, The Netherlands; ‖Second Department of Internal Medicine, HSK-Kliniken, Wiesbaden, Germany; #Department of Gastroenterology, Toranomon Hospital, Tokyo, Japan; **Department of Clinical Pharmacology, University of Oxford, Oxford, United Kingdom; ‡‡AstraZeneca R&D, Mölndal, Sweden; §§Division of Surgery, Karolinska University Hospital, Stockholm, Sweden; and ¶¶Institute of Pathology, Otto-von-Guericke University, Magdeburg, Germany



Beskrives ud fra Prag klassifikationen (B)

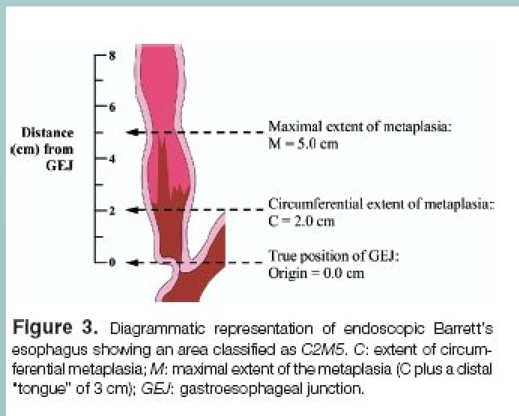


Figure 3. Diagrammatic representation of endoscopic Barrett's esophagus showing an area classified as *C2M5*. *C*: extent of circumferential metaplasia; *M*: maximal extent of the metaplasia (C plus a distal "tongue" of 3 cm); *GEJ*: gastroesophageal junction.

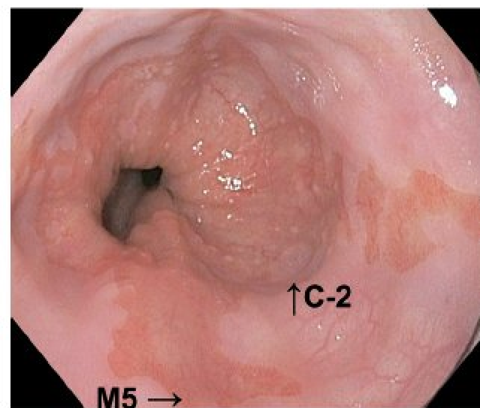


Figure 4. Video still of endoscopic Barrett's esophagus showing an area classified as *C2M5*. *C*: extent of circumferential metaplasia; *M*: maximal extent of the metaplasia (C plus a distal "tongue" of 3 cm).

Husk øér

Skal vi screene "raske" for Barrett

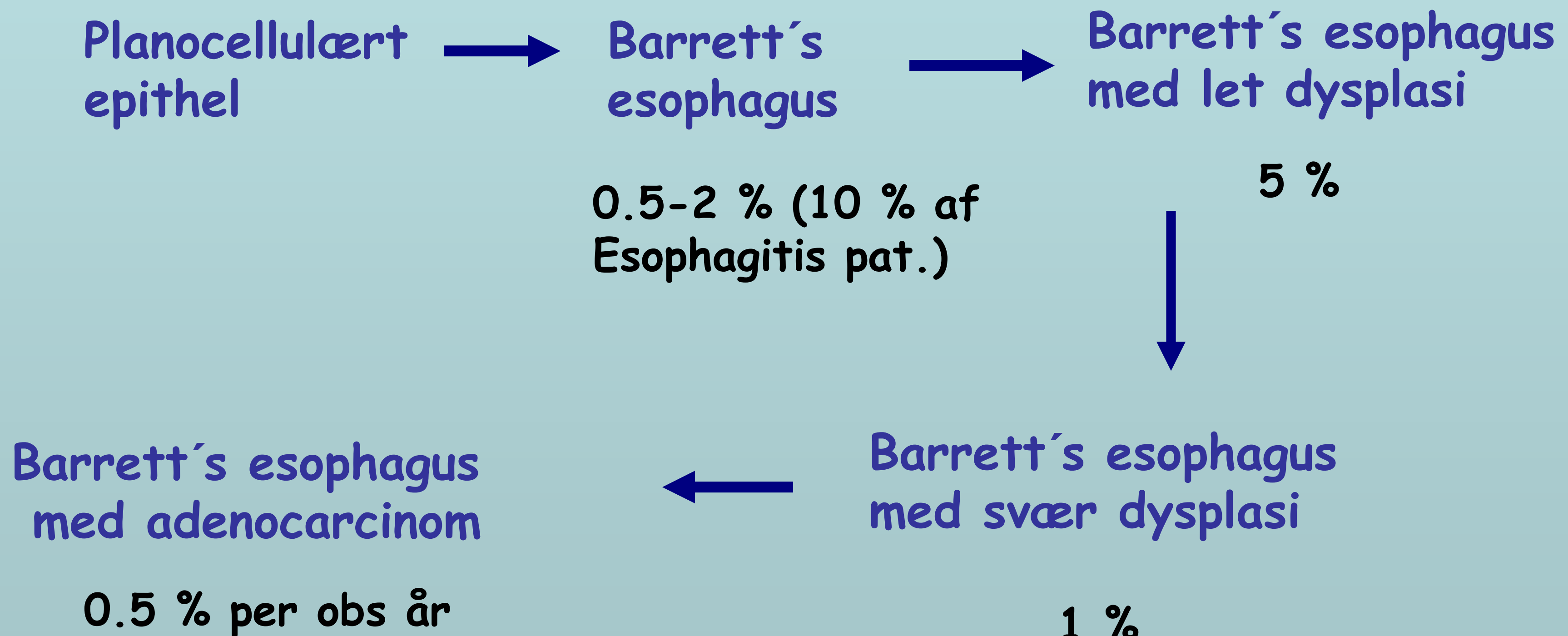
1. Patienter med sværesophagitis skal re-skoperes under behandling med PPI !! (B)

   Dobbelt dosis PPI og 4 uger

2. *"Once in a life-time" endoskopi til mænd over 50 år med langvarig svær reflux (C)*

3. Øvrig screening anbefales ikke (B)

Barrett´s esophagus



Kontrol programmer

Kontrolprogram (NDBE) *

Patienter i overvågning synes at overleve bedre (III)

Bør udføres efter individuel vurdering (B)

* Alle bør gastroskoperes efter 6 mdr fra diagnosetidspunktet for at sikre mod samplingerror ved biopteringen

Kontrolprogrammet

Table 1 Clinical risk factors predisposing to Barrett's adenocarcinoma

	Highest Risk	Lowest Risk	Categories of evidence for recommendations for surveillance
Gender	Male	Female	B
Age	> 45 years	< 40 years	B
Length of BM	> 8cm	< 3 cm	B
Severity of reflux symptoms	Severe and Frequent (>3 times / week)	Mild and Infrequent (< 1 time/week)	B
Chronicity	> 10 years	< 1 year	B
Race	White	Black	B
Body Mass Index	Obesity	Normal weight	B
Family history	Gastric cancer	None	B
Drug therapy	Nitrates, benzodiazines Anticholinergics, theophyllines	Non-steroidal anti-inflammatory drugs	C
Helicobacter	absent	present	C
Cigarette smoking	Heavy smokers	Non-smoker	C
Mucosal damage	Ulceration or stricture in Barrett's metaplasia	Intact mucosa	B
Duodeno-gastro-oesophageal reflux	Markedly present(high Bilitec levels)	Mild or absent	B

August 2005 BSG Guidelines in Gastroenterology

Hvis man finder overvågning indiceret, bør det være hvert 2 år (3 ?) (B)

Kontrolprogram (LGDBE)

Hvis patologerne er enige progression i 40-80 % af LGD (II)
Skacel AJG 2000

27 % progression over 8 år overfor kontrolgruppe (II)
Lim Endoscopy 2007

Skal kontrolleres (B)

Gastroskopi efter :

3 mdr og derefter hver 6. måned (C)

Efter 2 år uden dysplasi følges programmet for NDBE

Kontrolprogram (HGDBE)

HGDBE skal ikke kontrolleres, men behandles (B) (højt specialiseret enhed)

Risiko for samtidig adenocarcinom og HGD

- 30 % (II)

Risiko udvikling af adenocarcinom ved HGD

- 30 % (II)

Tidsrammen 24 mdr (6-43 mdr)

Husk at HGD er multifocal og patologerne er IKKE sjældent uenige

Så: flere patologer og kontrol endoskopi med biopsi

Behandling af Barrett

Alle skal behandles med relevant livslang antireflux behandling

Kirurgi eller medicinsk (B)

NDBE:
2 daglige doser PPI (standard dosering eller optimeret til symptomfrihed)

LGDBE:
2 daglige doser PPI (standard dosering eller optimeret til symptomfrihed) *DGS/DKS dobbelt standard dosis*

Barrett´s esophagus og kirurgi

Metaanalyse I:
Bammer 2001: adenocarcinom hos 1: 145 med. beh. vs. 1: 294 kir. Beh (NS)
Metaanalyse II:
Corey 2003: adenocarcinom 5,3 per 1000 pat.år med. beh vs. 3,8 per 1000 kir. beh. (NS)
Metaanalyse III:
Chang 2007: Adenocarcinom 6,5 per 1000 pat.år med. beh. vs. 4,8 per 1000 kir.beh. (NS RCT)

Anbefaling: Antireflux procedurer er ikke forskellig fra medicinsk behandling til BE uden dysplasi (A) i RCT

Behandling af HGDBE

1. Esophagektomi (B) (multifokal HGD*, nodularitet*, lange segmenter, operabel tilstand)
   (BSG 2005, SSAT 2007)

3. Endoskopisk ablativ behandling (EMR/fotodynamisk/ RF) (C) synes ligeværdig i retrospektive serier (ACG 2008)
   Skal foregå i protokolleret regi

*EMR skal i denne forbindelse bruges til at få makrobiopsi

Behandling af Barrett´s esophagus

NDBE:

1. PPI eller antirefluxkirurgi og samtidig ablation i protokol

LGDBE::

PPI og ablation i protokol

HGDBE::

EMR +

1. Esophagektomi BSG 2005, SSAT 2007
2. Kontrol og ablation ??

Samlede anbefalinger

Diagnose

- Makroskoskopisk synlig intestinalt metaplastisk cylinderepithel (B)
- *Mere end 1 cm oralt for gastro-esophageale overgang* (C)
- Bekræftet histologisk ved tilstedeværelsen af intestinal metaplasi med bægerceller (B)
- Alle bør gastroskoperes efter 6 mdr fra diagnosetidspunktet for at sikre mod sampling-error ved biopteringen

Biopsi

- *Kvadrantbiopsier i top og bund og fra fokale læsioner (> 5 cm segment så også fra midten (C))*

Beskrivelse

- Beskrives ud fra Prag klassifikationen (B)

Screening

- Patienter med svær esophagitis skal re-skoperes under behandling med PPI !! (B) (Dobbelt dosis PPI og 4 uger)
- *"Once in a life-time" endoskopi til mænd over 50 år (C)*
- Øvrig screening anbefales ikke (B)

Kontrol regimer

- **NDBE**: Hvis man efter individuel vurdering finder overvågning indiceret, bør det være hvert 3 år (B)
- **LGDBE**: Gastroskopi hver 6 måned (B), Efter 2 år uden dysplasi følges program for NDBE
- **HGDBE**: ikke kontrol, men behandling (B) (HSE)

Behandling

- **NDBE/ LGDBE**: Effektiv antireflux behandling (A)
- **HGDBE**: Esophagectomi (B), evt tæt kontrol i effektiv antireflux behandling (C)