A Review of Barrett's Esophagus

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Barrett’s Esophagus is a premalignant condition that predisposes patients to the development of esophageal adenocarcinoma. Esophageal adenocarcinoma dramatically rising over several decades; survival rates of less than 15% in a five-year period. Appropriate endoscopic surveillance intervals for biopsies 12 months after the receiving RFA. Early treatment in Barrett’s Esophagus is a chronic reflux of stomach acids into the lower esophagus, inducing a premalignant condition in which normal squamous epithelial lining of the esophagus is replaced with columnar epithelium and goblet cells, known as intestinal metaplasia. Dysplastic change occurs during the sequence of epithelial transition predisposing to the development of EAC. Risk factors for the dysplastic transitions in BE and EAC include advanced age, hiatal hernia, GERD, ethnicity, smoking, poor dietary intake of fruits and vegetables, the type of dysplasia and length of the BE segment. Pathological expert reviews ensure the progression of cellular changes in BE is inconsistent, but Gastrointestinal endoscopy criteria are applied. In adults patients with complete eradication of Barrett’s esophagus continue to evolve, now expanding the use of radiofrequency ablation (RFA) for the treatment of low grade dysplasia BE, previously observed with endoscopic surveillance until advancement to high grade dysplasia. Risk factors associated with the development of Barrett’s esophagus need to be studied due to the increasing burden of conditions associated with the progression to esophageal adenocarcinoma. More studies are needed to evaluate the long-term efficacy and durability of early endoscopic surveillance and the appropriate surveillance intervals to further determine the successful treatment of dysplastic BE and reduction of EAC. Applicable to Clinical Practice

Primary care providers need to consistently identify risk factors such as age, race, diet, tobacco, obesity and duration of GERD symptoms when determining candidates for early endoscopic screening for BE. Factors that predict the progression of non-dysplastic BE to EAC include the initial dysplasia histology and the length of the BE segment. Counsel and teach patients regarding control of modifiable risk factors with emphasis of tobacco cessation and management of GERD. A diagnosis of EAC has poor survival rates. Risk stratification can help patients make and maintain good decisions for a better overall health outcome. Establish a trusting provider to patient relationship so facts regarding BE and the risks of progression to EAC can be clearly shared and communicated. Endoscopic therapy with radiofrequency ablation is now the standard of care for treatment of dysplastic BE. It has high rates of success and durability when used alone or in combination with other therapeutic strategies. Follow-up should be individualized, and treatment decisions should reflect consideration of current guidelines. Lifestyle modification should be exhausted before ablative therapy is decided.

References


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