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Strategies for monitoring patients with Barrett's esophagus

Abstract: Barrett-Adeno-Cancer (AC) diagnosed after patients suffer from typical symptoms (dysphagia, weight loss, bleeding) have an advanced disease in more than 50 % which is associated with a bad long-term prognosis: less than 10 % in 5 years. In case of mucosal early AC treated by local endoscopic resection the 5-year-survival rate increases significantly (80 to 98 %) (1, 2). Compared to surgery endoscopic resection is the method of choice in case of mucosal AC because of a highly significant lower rate of complications and deaths and a preserved function of the esophago-gastric junction (3).

Intestinal metaplasia of the distal esophagus (Barrett-Esophagus, BE) is strongly associated with reflux disease , a proven premalignant condition and the most important risk factor for development of Barrett-Adeno-Cancer (AC). AC is a increasing tumor entity of the Western World, and also in Asia. The individual risk for progress from low.grade intraepithelial neoplasia (BE) to AC ranges from 0,1 to 1,0 % per year and is increased for male gender, white ethnicity, adiposity, smoking and long-term history of reflux disease. Thus, persons on risk for BE and AC can be identified easily.

Methods and strategies for screening and surveillance of BE will be demonstrated and discussed during presentation as well as therapeutic strategies in case of low-grade or high-grade intraepithelial neoplasia and early mucosal AC (4).

Screening for BE and surveillance of BE is a recommended standard nowadays (ESGE guideline 2023; 4), while concrete recommendations for patient selection, technical performance und time periods for controls differ a little from country to country. The aim of screening upper GI endoscopy is to identify individuals on risk. This is easily done by a one-in-a-lifetime gastroscopy. Patients without BE do not need follow-up examinations. Once BE is diagnosed and preexisting AC is ruled out, recommendations for surveillance depend on length of the Barrett segment and other risk factors. Acid suppression therapy (PPI, reflux-surgery) is mostly recommended to reduce inflammation, symptoms and transformation pressure to malignant disease. Prophylactic interventions for non-malignant BE are not recommended outside of studies.

According to the experience based on thousands of patients with BE and AC in a single Center and other institutions, a so-called Index-endoscopy finds not only patients with BE for future surveillance but also patients who already have AC (5, 6). Indeed, from all cases of AC we had treated in Wiesbaden two-thirds were diagnosed during Index-endoscopy and one third during surveillance. Early detection of AC leads to a significant improvement of survival, since many have early tumor stages and can be successfully treated by endoscopic or surgical resection. In case of endoscopic therapy, the following lifetime expectancy is even similar to adjusted normal people without malignant diseases. Screening and surveillance of BE seem to be cost efficient as well, even if randomized studies are lacking.

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Biography: Prof. Thomas Rabenstein is a prominent medical professional based at the Diakonissen-Stiftungs-Krankenhaus in Speyer, Germany. He holds the position of Chief Physician for Internal Medicine and Gastroenterology at the hospital, where he has contributed significantly to the field of oncology and internal medicine. Prof. Rabenstein has an extensive background, having served in various leadership roles, including as the Deputy Head and later the Head of the Oncology Center in Speyer. With a career that spans many years, he has been involved in numerous clinical and academic endeavors. He holds an Extraordinary Professorship for Internal Medicine at Friedrich-Alexander University Erlangen-Nuremberg and is widely recognized for his expertise in gastroenterology, especially in oncological gastroenterology. Prof. Rabenstein is also a member of multiple professional associations and contributes to research and ethics counseling within his field.

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