

Barrett's oesophagus – small group work

Group A notes – Chaired by Tim Stokes, Notes by Adelle McGill

Population

- Should cover patients with intermucosal cancer and high grade dysplasia.
- Patients with low grade dysplasia should not be covered as there isn't a great deal of effectiveness for using ablative therapies in this area, and it is not practiced much in the UK. This should possibly be suggested as a topic for NICE in the future when more evidence becomes available.

Ablative therapies

- Endoscopic mucosal resection (EMR) should be included in the list of therapies, not just as a comparator. This is because EMR is often used as a complement to Radiofrequency Ablation (RFA) in between 50-75% of cases. The EMR would be used to remove specific nodules and then circumferential RFA would be done.
- Cryotherapy should not be considered as it is not part of UK practice.

Clinical management and outcomes?

- Depth of injury is an issue but this should come out in the evidence.
- It is likely that an indirect comparison will need to be done. There is quite a bit of data on RFA (most common) and PDT vs. sham, but the group didn't identify any direct comparisons between ablative therapies.

Health economics

- A number of members of the group volunteered that they would have some information on costs of therapies

GDG composition

This should include

- Gastroenterologists
- Upper GI surgeons
- GI nurse specialist
- Pathologist
- Patient/carer reps

Group B notes – Chaired by Damien Longson, Notes by Beth Shaw

Population:

Adults with BO with HGD

- Needs more detail
- Include early cancer/cancer
- Early cancer is in the same pathway
- Low grade with surveillance – why not treat early and eliminate doubt (RCT to publish)
- BO with high grade/early cancer (incontrovertially cancer), with low grade variation is huge (intra/inter), no dysplasia – no invasion (ie benign Barrett's)

Include early cancer

- biopsies may find dysplasia on top of a cancer which will change intervention? So need dysplasia assessed with rigorous exclusion of underlying cancer
- need to include early cancer identified through BP surveillance if surgery not appropriate
- definition? mucosal cancer? Mucosal to surgery (dep on age)

Ablative therapies

- should include EMR?
- The use only in those who were unfit for surgery – no longer true – but some people still consider surgery best (surveillance is not then

needed, though new BO can develop post surgery) – patients preference with informed choice

- With ablative treatment surveillance is needed
- Contraindications – increase in strictures – ulcers – bleeding – submucosal invasion - ????

Clinical management and outcomes

- Now staging is increasingly acceptable – then ablative therapy have had more use as do new surgical techniques
- Need to add staging of high grade dysplasia (with inter rater variation?)
- Argon plasma coagulation (widely used 20-30)
- Photodynamic therapy (old, on way out as increased a/es, 1-2)
- Laser ablation (used in a few places, old, increased a/es)
- Multipolar electrocoagulation (few, as tedious)
- Radio frequency ablation (10-12 people, little evidence, research only)
- Cryotherapy (? Used in the UK)
- EMR (20-30, surgery?, valid comparator? Last stage of staging – first steps of treatment)
- Comparators – chemotreatment, for BO, dysplasia)

Outcomes

- Effective ablation of high grade dysplasia and BO
- Risk of progression – curable/incurable
- Risk of recurrence of Barrett's of any grade of dysplasia

Other

- No RCTs

GDG composition

- Upper GI surgeons (2)
- Intervention endoscopist (2, diagnostic staging/therapeutic)
- Pathologist (conventional, molecular – co-opted)
- GI radiologists (1)

- Genetics/biomarkers expert (co-opted)
- GP/primary care, GP with special interests (co-opted?)
- General gastroenterologist (overall picture)
- Epidemiologist?