2018 surveillance of Barrett's oesophagus: ablative therapy (NICE guideline CG106)

Surveillance report
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Survveillance decision

We will update the guideline on Barrett's oesophagus.

The scope will be extended to incorporate management of low-grade dysplasia.

We considered this guideline alongside the following related guidelines that will not be updated:

- Gastro-oesophageal reflux disease in children and young people: diagnosis and management (NICE guideline NG1).
- Acute upper gastrointestinal bleeding in over 16s: management (NICE guideline CG141).

See the webpages for each guideline for the surveillance decisions for these guidelines.

The following table gives an overview of how evidence identified in surveillance might affect each area of the guideline, including any proposed new areas.

<table>
<thead>
<tr>
<th>Section of the guideline</th>
<th>New evidence identified</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirming diagnosis of high-grade dysplasia or intramucosal cancer</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Key principles of care</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Offering endoscopic therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Endoscopic therapies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiofrequency ablation after endoscopic resection</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiofrequency ablation and cryotherapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient and carer support and information</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Areas not currently covered in the guideline – low-grade dysplasia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Reasons for the decision

This section provides a summary of the areas that will be updated and the reasons for the decision to update.
Offering endoscopic therapy

The guideline recommends considering endoscopic therapy, particularly for those in whom surgery is unsuitable or who do not wish to undergo surgery. Clinical practice has progressed since the publication of the guideline, with evidence suggesting that most people who have treatment have endoscopic therapy, with surgery used only in a minority of patients.

Rates of complete eradication in the UK have increased in the years after the guideline published. However, there appears to be inconsistency in the management of Barrett’s oesophagus across the UK. The evidence mainly consists of observational studies and small randomised controlled trials, which is similar to the limited evidence available when developing the current guideline. Nevertheless, there is a need to update the guideline so that it remains relevant to clinical practice in the UK.

Endoscopic therapies

The guideline currently recommends considering endoscopic mucosal resection alone or ablative therapy alone (radiofrequency ablation or photodynamic therapy). However, evidence on the use of radiofrequency ablation after endoscopic mucosal resection suggests that combination treatment may be more effective than either treatment alone. The 2018 UK National Oesophageal-Gastric Cancer Audit indicates that about a third of people who have endoscopic resection have subsequent radiofrequency ablation. The update should consider whether a single-treatment strategy remains appropriate.

Low-grade dysplasia

The scope of the guideline on Barrett’s oesophagus specifically excluded the management of low-grade dysplasia. Since the guideline was published, the evidence base on treating low-grade dysplasia to prevent progression to high-grade dysplasia or cancer has grown. UK audit data also indicate a clinical need for the guideline to cover treatment of low-grade dysplasia.

NICE has issued interventional procedures guidance on endoscopic radiofrequency ablation for Barrett’s oesophagus with low-grade dysplasia or no dysplasia (IPG496). This recommends that radiofrequency ablation for low-grade dysplasia may be performed with normal arrangements for clinical governance, consent and audit or research. Topic experts noted gastroenterology guidelines produced by other organisations now address management of low-grade dysplasia.

Additionally, a large randomised controlled trial suggested that treatment with high-dose proton pump inhibitors plus aspirin may reduce progression or death in people with low-grade dysplasia.
However, all comparator groups in this study received drug treatments. It is therefore difficult to ascertain the effects on progression from low-grade dysplasia to high-grade dysplasia compared with endoscopic therapies or with surveillance.

The 2018 UK National Oesophageal-Gastric Cancer Audit showed that about one-third of people diagnosed with high-grade dysplasia in the UK then receive a diagnosis of oesophageal or junction cancer within a year. This indicates a need for earlier intervention; therefore the update to the guideline should consider management of low-grade dysplasia.

For further details and a summary of all evidence identified in surveillance, see appendix A.
Overview of 2018 surveillance methods

NICE's surveillance team checked whether recommendations in Barrett's oesophagus: ablative therapy (NICE guideline CG106) remain up to date.

The surveillance process consisted of:

- Initial feedback from topic experts via a questionnaire.
- Input from stakeholders on known variations in practice and policy priorities.
- Literature searches to identify relevant evidence.
- Assessing the new evidence against current recommendations and deciding whether or not to update sections of the guideline, or the whole guideline.
- Consulting on the decision with stakeholders, except if we propose to update and replace the whole guideline.
- Considering comments received during consultation and making any necessary changes to the decision.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We searched for new evidence related to the whole guideline.

We found 36 studies in a search for randomised controlled trials and systematic reviews published between 1 May 2009 and 21 June 2018.

We also included 3 relevant studies from a total of 5 identified by topic experts.

From all sources, we considered 39 studies to be relevant to the guideline.

See appendix A: summary of evidence from surveillance for details of all evidence considered, and
Ongoing research

We checked for relevant ongoing research; of the ongoing studies identified, 2 studies were assessed as having the potential to change recommendations; therefore we plan to regularly check whether these studies have published results, and evaluate the impact of the results on current recommendations as quickly as possible. These studies are:

- A trial of a new GP-based test for patients with heartburn symptoms (BEST3).
- Randomised controlled trial of surveillance and no surveillance for patients with Barrett’s oesophagus (BOSS).

Intelligence gathered during surveillance

Views of topic experts

We sent questionnaires to 5 topic experts and received 2 responses. The topic experts were recruited to the NICE Centre for Guidelines Expert Advisers Panel to represent their specialty.

Topic experts indicated that the guideline was out of date and no longer reflected clinical practice in the UK. Areas of interest included treatment of low-grade dysplasia and early stage oesophageal cancer.

Other sources of information

We considered all other correspondence received since the guideline was published. This included a suggestion the guideline should address treatment of low-grade dysplasia.

Views of stakeholders

Stakeholders are consulted on all surveillance proposals except if the whole guideline will be updated and replaced. Because this surveillance decision was to fully update the guideline, we did not consult on the decision.

See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual for more details on our consultation processes.
Equalities

No equalities issues were identified during the surveillance process.

Overall decision

After considering all evidence and other intelligence and the impact on current recommendations, we decided that a full update is necessary.

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