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Titel des Beitrags:
The Munich Barrett follow up study:
suspicion of Barrett’s oesophagus
based on either endoscopy or
histology only--what is the clinical
significance?

Abstract:
BACKGROUND: The incidence of
distal oesophageal adenocarcinoma is
rising, with chronic reflux and Barrett's
oesophagus being considered risk
factors. Reliable detection of Barrett's
oesophagus during upper endoscopy
is therefore mandatory but requires
both endoscopy and histology for
confirmation. Appropriate
management of patients with
endoscopic suspicion but negative on
histology, or vice versa, or of patients
with no endoscopic suspicion but with
a biopsy diagnosis of intestinal
metaplasia at the gastro-oesophageal
junction, has not yet been studied
prospectively. PATIENTS AND
METHODS: In a prospective
multicentre study, 929 patients (51%
males, mean age 50 years) referred for
upper gastrointestinal endoscopy were
included; 59% had reflux symptoms.
The endoscopic aspect of the Z line
and any suspicion of Barrett's
oesophagus were noted, and biopsies
were taken in all patients from the Z
line (n = 4), gastric cardia (n = 2), and
body and antrum (n = 2 each).
Biopsies positive for specialised
intestinal metaplasia (SIM) were
reviewed by a reference pathologist
for a final Barrett's oesophagus
diagnosis. All patients with endoscopic
and/or histological suspicion of
Barrett's oesophagus were invited for
a follow up endoscopy; the remaining
cases (no endoscopic or histological
suspicion of Barrett's oesophagus)
were followed clinically. RESULTS: Of 235 patients positive for Barrett's oesophagus on endoscopy and/or histology, 63% agreed to undergo repeat endoscopy (mean follow up period 30.5 months). 46% of patients with an endoscopic Barrett's oesophagus diagnosis but no histological confirmation (group A) showed the same distribution, a further 42% did not have Barrett's oesophagus, and 11% had confirmed Barrett's oesophagus on both endoscopy and biopsy on follow up. In the group with a histological Barrett's oesophagus diagnosis but negative on initial endoscopy (group B), follow up showed the same in 26% whereas 46% had no Barrett's oesophagus, and confirmed Barrett's oesophagus (endoscopy plus histology) was diagnosed in 17%. Of the study population, 16 patients had Barrett's oesophagus on initial endoscopy confirmed by histology which remained constant in 70% at follow up (group C). Of the remaining patients without an initial Barrett's oesophagus diagnosis on either endoscopy or histology (group D) and only clinical follow up (mean follow up period 38 months), one confirmed Barrett's oesophagus case was found among 100 patients re-endoscoped outside of the study protocol. However, no single case of dysplasia or cancer of the distal oesophagus was detected in any patient during the study period. CONCLUSIONS: Even in a specialised gastroenterology setting, reproducibility of presumptive endoscopic or histological diagnoses of Barrett's oesophagus at follow up were poor. Only 10-20% of cases with either endoscopic or histological suspicion of Barrett's oesophagus had established Barrett's oesophagus after 2.5 years of follow up. The risk of dysplasia in this population was very low and hence meticulous follow up may not be required.