Royal Cornwall Hospitals
NHS Trust

Endoscopy Barrett's Surveillance Service Standard Operating Procedure

V1.0

September 2025

Table of Contents

1. Introduction 3
2. Purpose of this Standard Operating Procedure 4
3. Ownership and Responsibilities 4
3.1. Role of the Senior Clinical Endoscopist Managers 4
3.2. Role of the Clinical Endoscopist 4
3.3. Role of Gastroenterology Consultant 5
3.4. Role of Administrators 5
4. Standards and Practice 5
4.1. BO Telephone Clinic 5
4.2. Reasons for appointment rejection 6
4.5. Microsoft One Note database 7
4.6. Procedural standards for Acetic Acid Chromoendoscopy (Appendix 7) 9
4.7. Abbreviations 10
4.8. Training 10
5. Dissemination and Implementation 11
6. Monitoring compliance and effectiveness 11
7. Updating and Review 11
8. Equality and Diversity 11
Appendix 1. Governance Information 12
Appendix 2. Equality Impact Assessment 14
Appendix 3. BSG guidelines on the diagnosis and management of Barrett's Oesophagus 17
Appendix 4. Diagnosis and Management of Barrett's Esophagus: European Society of Gastrointestinal Endoscopy (ESGE) Guideline 2023 18
Appendix 5. Vetting instruction for Barrett's Oesophagus clinic referrals 19
Appendix 6. Instruction for retrieving monthly RADAR report for One Note database and reviewing each patient 20
Appendix 7. Procedure for the administration of Acetic Acid 21
Appendix 8. Training and competency of Registered Healthcare Professionals 22

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. This document outlines the local standards for maintaining a safe practice whilst managing the care of patients with Barrett's Oesophagus (BO) within gastroenterology at Royal Cornwall Hospitals Trust (RCHT) as per the British Society of Gastroenterology (BSG) and the European Society of Gastrointestinal Endoscopy (ESGE) guidelines on the diagnosis and management of BO.

1.2. BO is defined as an oesophagus in which the normal distal squamous epithelial lining has been replaced by metaplastic columnar epithelium, which is clearly visible endoscopically >1cm, above the gastro oesophageal junction (GOJ) and confirmed histopathologically with intestinal metaplasia (BSG, 2013).

1.3. Rationale for surveillance is based on the poor survival rate for oesophageal cancer of <13% survival at five 5 years. The incidence of oesophageal cancer in non-dysplastic BO is estimated at <1% (0.33%) (BSG, 2013).

1.4. Following a diagnosis of BO the patient will be offered a telephone clinic appointment with a Clinical Endoscopist (CE) to discuss the condition, define the meaning of surveillance, agree on the interval of surveillance and explain histology results. Patients will also have the opportunity to ask questions and have them answered.

1.5. All known patients with BO diagnosed from January 2021 are recorded on a Microsoft One Note database to enable their condition to be appropriately monitored. This includes details of all relevant past medical history, medications and historical endoscopy reports to inform surveillance interval. To ensure information governance compliance, the One Note database is registered as a Trust asset with access limited to the CE via TR11 shared drive. In the event of IT failure and inability to access the One Note database the MAXIMS business continuity plan would be followed.

2. Purpose of this Standard Operating Procedure

2.1. The aim of this Standard Operating Procedure (SOP) is to:

2.2. Adhere to the BSG and ESGE guidelines, offering surveillance gastroscopy every six months to five years depending on histology results, length of the BO and fitness of the patient. Ceasing surveillance should be determined based on an estimate of the likelihood of cancer progression, patient preference, fitness for repeat endoscopy and subsequent treatment modalities (BSG, 2013, ESGE, 2023).

2.3. The risk of cancer progression correlates significantly with:

- The length of BO segment. Less than 3cm segments have a lower cancer incidence.
- Dysplasia – non-dysplastic BO may be at least 10 times more likely to die from an unrelated cause than to develop oesophageal cancer (BSG, 2013).

2.4. Standardise a safe and effective BO Service ensuring patients are referred for appropriate surveillance in a timely, informed manner.

2.5. Standardise the process of endoscopic surveillance including the use of acetic acid (AA) in addition to the Seattle biopsy protocol (Appendix 4), to increase the detection of dysplasia or cancer as recommended by BSG and ESGE.

2.6. Identify the standards required by all staff involved with the BO service.

3. Ownership and Responsibilities

3.1. Role of the Senior Clinical Endoscopist Managers

Are responsible for:

- Roster Clinical Endoscopists (CE's).
- Telephone clinic.
- Vetting of maxims referrals.
- Populate One Note database with new patients.

3.2. Role of the Clinical Endoscopist

- To be JAG (Joint Advisory Group) Accredited in Upper GI Endoscopy.
- Hold telephone clinics to review BO patients.
- Vet BO clinic referrals for appropriateness for telephone clinic appointment.
- Update One Note database, ensuring the patient is referred and monitored appropriately.

- Where appropriate, refer for Gastroenterology outpatient appointment via Maxims.
- Write to GP, patient and gastroenterologist, summarising clinic appointment and histology outcomes.
- Will refer for a surveillance gastroscopy under 'BARRETTS (Louise Moffitt)'.
- The rostered CE will retrieve a report from RADAR to populate the months data of new patients.
- Will review each patient from the RADAR report.
- Will check histology results.
- Will check each tab of the One Note database weekly.
- Where necessary, will refer to UGI (Upper Gastro-Intestinal) MDT (Multi-Disciplinary Team).
- Referral to Derriford for treatment.
- Review patient fitness when patient has reached the age of 80 to determine if surveillance is required.

3.3. Role of Gastroenterology Consultant

Responsible for:

- Review patients with complex conditions.
- Refer BO patients to the nurse led BO service.

3.4. Role of Administrators

- Book telephone clinic appointments.
- Will check the referred nurse led BO clinic patients to allocate to the pending list.
- Will ensure that all clinics are fully utilised.
- Will ensure patients are booked in a timely manner.
- Complete an 'inter provider referral' to Derriford as required and add the most recent gastroscopy report with images included.

4. Standards and Practice

4.1. BO Telephone Clinic

The BO clinic referrals are vetted weekly, by the rostered CE who is trained in Upper GI Endoscopy, BO patients are identified via MAXIMS - Appendix 5:

Vetting instruction for Barrett's Oesophagus clinic referrals.

4.2. Reasons for appointment rejection

- Biopsies taken from inflamed area. Await repeat, following increase in PPI and reassess with biopsies to confirm Barrett's
- There is documentation that the patient has had a previous discussion about BO in Gastroenterology or BO Clinic.
- The patient has a medical or surgical conditions for which they are being investigated by a Gastroenterologist or an Upper GI Surgeon that supersedes their need to discuss BO surveillance.

4.3. Patients will be contacted to discuss BO and will be advised of the appropriate surveillance interval.

4.4. Existing patients will be contacted if:

- There have been any documented changes to their health.
- They are aged 75 or over.
- There is no documentation to demonstrate that BO has previously been discussed.

Patients who require a telephone clinic appointment will be booked by the administration team.

The telephone clinic is held twice a month. The CE holding the clinic is allocated by a senior CE in advance.

4.4.1. New patients whose condition is complex or have a complicated medical history will need further guidance from a gastroenterologist. In this case the CE will refer the patient for a gastroenterology outpatient clinic appointment.

4.4.2. The CE holding the telephone clinic will have the patient's information available on the Microsoft One Note database; the CE will update the database to ensure the patient is referred and monitored appropriately. This will include:

- Update medications.
- Update medical history.
- Ensure their procedure is documented.
- Ensure the histology results are checked and documented in the relevant section.
- Document the month and year that their next surveillance procedure is due.

4.4.3. The CE will write a letter to the patient and GP summarising the appointment, using the Dragon Workforce system. If applicable the named Gastroenterology Consultant will be copied into the letter.

4.4.4. The CE will refer for a surveillance gastroscopy on Maxims within six months to five years as per BSG guidelines (Appendix 3). The CE will use BSG guidelines in conjunction with clinical judgement. Taking into consideration the likelihood of cancer progression, patient fitness for repeat gastroscopies and patients' preference to determine surveillance interval.

New patients will have their surveillance gastroscopy booked ensuring results are returned to 'BARRETTS (Louise Moffitt)'.

4.4.5. Histology results from the previous procedure will be marked as checked on Maxims and actioned appropriately.

4.5. Microsoft One Note database

4.5.1. The One Note document is in the shared drive TR11, - Clinical Endoscopist - Barrett's, Metaplasia - Barrett's surveillance – Admin.

4.5.2. The CE rostered for that month by a senior CE will retrieve a report from RADAR at the beginning of each month which contains the previous month's data. The CE will add the patient's full name and CR number to the admin 'to sort' tab on the One Note database (Appendix 6).

4.5.3. The CEs will check each tab on One Note database weekly to ensure the appropriate actions are performed promptly.

Tabs:

- Derriford/ cancer.
- B to action.
- B await histopathology.
- B awaiting clinic.

4.5.4. **New diagnosis of BO**:

- Clinicians can refer to the nurse led BO service by making a referral on Maxims, where a telephone appointment will be offered to the patient by the Endoscopy Administration team.
- The central booking office checks this pool of patients and adds to the Patient Administration System (PAS) pending list with the correct urgency (routine or urgent) and add any booking instructions if necessary.
- The pending lists are then booked in chronological order by the booking office.

- Vacant slots for the MOFLO/BAR clinic are managed via the clinic companion report on Radar to ensure all clinics are fully utilised.

- This is managed by the booking office with the Deputy Performance and Operations Manager checking on clinic utilisation and long waiting patients to ensure patients are booked in a timely manner.

- The CE holding the clinic will take responsibility for any new patients they speak to during their dedicated telephone clinic by:

  - Booking any surveillance gastroscopies required and ensuring histology is allocated to 'BARRETTS (Louise Moffitt).'

  - Ensuring they write letters and action histology when reported.

If any further treatment is required due to the histopathology, the steps below will be followed.

4.5.5. **Histology Results:**

- Existing patients who do not need a clinic appointment will have a surveillance gastroscopy booked by the CE, via Maxims referral. The CE will also send a letter outlining histology results and surveillance interval.

- The CE will mark histology result as checked on Maxims and the patient's details will be filed under the 'due' tabs on the One Note Database.

- The CE will write a letter to all patients, explaining the histology result.

4.5.6. Histology reported as: Intestinal Metaplasia.

- Surveillance gastroscopy interval will be booked by CE as per the BSG guidelines. Appendix 3.

4.5.7. Histology reported as: Indefinite for Dysplasia:

- The CE will book a surveillance gastroscopy in six months using Acetic Acid Chromoendoscopy (AAC).

- If this is the second result of 'Indefinite for dysplasia', the CE will refer the patient to the upper GI MDT.

4.5.8. Histology reported as: Low Grade Dysplasia (LGD).

The CE will refer patient to the upper GI MDT and book a gastroscopy using AAC via Maxims, six months after their last gastroscopy.

In cases where the Multidisciplinary Team (MDT) decision is for the patient to be referred to Derriford for Radio Frequency Ablation (RFA) treatment, the CE will make the referral by:

- A letter will be written using DRAGON to (currently) Dr Sean Cochrane at University Hospitals Plymouth NHS Trust.
- The letter will include a brief medical history and current medications.
- The history of endoscopic surveillance of the LGD seen, the exact measurements and relevant biopsies taken.
- A note will be added to DRAGON for attention of the gastroenterology secretaries asking them to add the most recent gastroscopy report from maxims, including images.
- The secretaries will complete an 'inter provider referral'.

4.5.9. Histology reported as: High Grade Dysplasia (HGD):

- The CE will book an urgent non Two Week Wait (2WW) gastroscopy using AAC and near focus imaging via Maxims, indicating number of points required for the procedure from the drop-down menu. As per maxims referral a segment less than 2cm will be allocated one point. Above 2cm will be allocated two points. When using AA an extra point will be allocated to allow time for the AA to work.
- The CE will refer patient to the upper GI MDT.
- In cases where the MDT decision is for the patient to be referred to Derriford for RFA, the CE will action the referral by:
- A letter will be written using DRAGON to (currently) Dr Sean Cochrane at University Hospitals Plymouth NHS Trust.
- The letter will include a brief medical history and current medications.
- The history of endoscopic surveillance of the HGD seen, the exact measurements and relevant biopsies taken.
- A note will be added to DRAGON for attention of the gastroenterology secretaries asking them to add the most recent gastroscopy report from maxims, including images.
- The secretaries will complete an 'inter provider referral'.

4.5.10. **Discharging from BO service:**

The CE, using clinical knowledge and judgement, will cease surveillance if the patient has multiple debilitating co morbidities or they reach the age of 80. If the patient is age 80 at the time of the planned surveillance the CE will have a discussion with the patient to assess fitness and quality of life.

4.6. Procedural standards for Acetic Acid Chromoendoscopy (Appendix 7)

4.6.1. AAC is shown to have a higher dysplasia yield in BO surveillance (BSG) AAC is an additional diagnostic tool recommended by ESGE, used to detect BO neoplasia. The diluted AA helps to identify neoplasia by a process known as aceto-whitening reaction, where tissue absorbs the AA and turns white for a brief period and then slowly reverts to normal colour.

4.6.2. AAC will be carried out in patients with Barrett's > five cm and in all patients where neoplastic lesions are suspected (including in those patients with < five cm of Barrett's). Seattle protocol biopsies will be taken during the procedure. (Appendix 4).

4.7. Abbreviations

2WW	Two weeks wait.
AA	Acetic acid.
AAC	Acetic Acid Chromoendoscopy.
BO	Barrett's Oesophagus.
BSG	British Society of Gastroenterology.
CE	Clinical Endoscopist.
ESGE	European Society of Gastrointestinal Endoscopy.
GI	Gastrointestinal.
GOJ	Gastro-oesophageal junction.
GORD	Gastroesophageal reflux disease.
GP	General Practitioner.
HGD	High grade dysplasia.
LGD	Low grade dysplasia.
MDT	Multi-disciplinary team.
NBI	Narrow band imaging.
NHS	National Health Service.
PAS	Patient Administration System.
RFA	Radio frequency ablation.
SOP	Standard operating procedure.
UGI	Upper Gastro-Intestinal

4.8. Training

4.8.1. CEs involved with the Barrett's service and performing gastroscopies using AAC should be familiar with this SOP.

4.8.2. All clinicians performing BO surveillance and using AAC will observe a competent practitioner completing BO surveillance with AA, with instruction on recognition of dysplasia. They must then be observed using AAC for BO surveillance by a competent practitioner and deemed competent to practice independently.

5. Dissemination and Implementation

5.1. There will be a hard copy of document available stored in the Clinical Endoscopist office.

5.2. There will be a hard copy of document available stored in the Clinical Endoscopist office.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Training Compliance.
Lead	Louise Moffitt.
Tool	Personnel Records.
Frequency	Ongoing monitoring through localised Business and Governance.
Reporting arrangements	Any recommendations/ changes to this SOP will be reported in Endomax.
Acting on recommendations and Lead(s)	Rebecca Carruthers.
Change in practice and lessons to be shared	Required changes to practice will be identified and carried out within one month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This SOP will be reviewed every three years or earlier depending upon the guidelines changing.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Endoscopy Barrett's Surveillance Service Standard Operating Procedure V1.0
This document replaces (exact title of previous version):	New Document.
Date Issued/Approved:	April 2025.
Date Valid From:	September 2025.
Date Valid To:	September 2028.
Author/Owner:	Rebecca Carruthers, Senior Advanced Clinical Endoscopist.
Contact details:	01872 255482 (office number). 01872 253247 (endoscopy recovery).
Brief summary of contents:	Appropriate standards for monitoring patients with Barrett's oesophagus.
Suggested Keywords:	Barrett's, Surveillance, Acetic Acid.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Gastroenterology Governance Meeting. Senior Management Team Meeting. Care Board Meeting.
Manager confirming approval processes:	Ian Moyle-Browning, Head of Nursing (HoN), Specialist Services and Surgery.
Name of Governance Lead confirming consultation and ratification:	Michele Reed.
Links to key external standards:	None.
Related Documents:	None required.
Training Need Identified:	Yes, documented in SOP.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Endoscopy.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
September 2025	V1.0	Initial issue.	Rebecca Carruthers, Senior Advanced Clinical Endoscopist.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Endoscopy Barrett's Surveillance Service Standard Operating Procedure V1.0.
Department and Service Area:	Specialist Services and Surgery (SSS). Endoscopy.
Is this a new or existing document?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Rebecca Carruthers, Senior Advanced Clinical Endoscopist.
Contact details:	01872 255482 (office number). 01872 253247 (endoscopy recovery).

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Clinical endoscopist team and support colleagues involved in the clinical pathway of patients with a diagnosis of Barrett's Oesophagus.
2. Policy Objectives	To ensure all staff are aware of the process and standards for patients with a diagnosis of Barrett's Oesophagus.
3. Policy Intended Outcomes	Safe and appropriate surveillance and timely discussion of new diagnosis and results of patients with a diagnosis of Barrett's Oesophagus. Ensuring all staff are aware of the standards for Barrett's Surveillance service.
4. How will you measure each outcome?	Audit surveillance outcomes as per standard/rota.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	Staff involved in the clinical pathway of patients with a diagnosis of Barrett's Oesophagus. Patients with a diagnosis of Barrett's Oesophagus.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Endoscopists and endoscopy colleagues.
6c. What was the outcome of the consultation?	Advised and agreed on standards.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

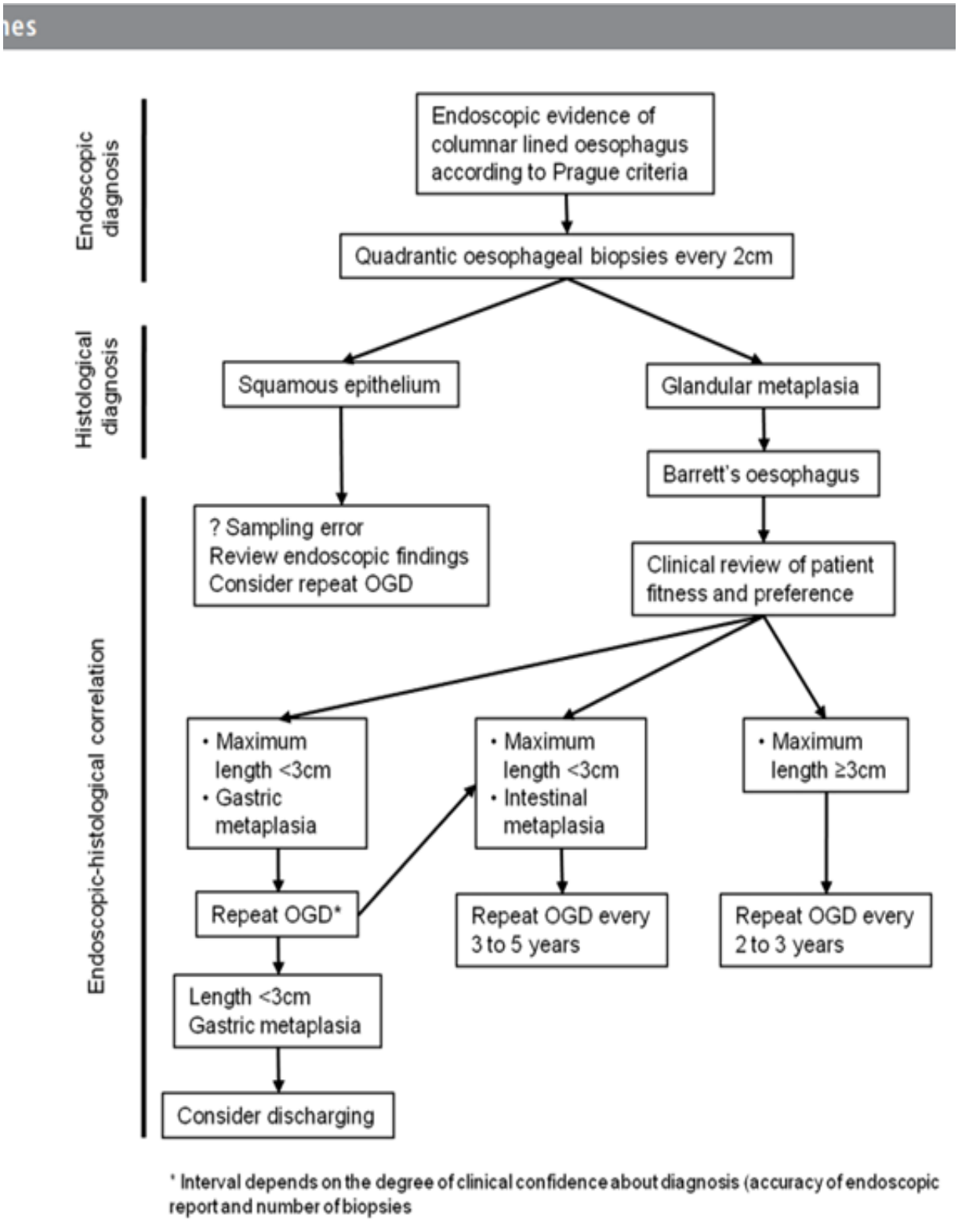
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

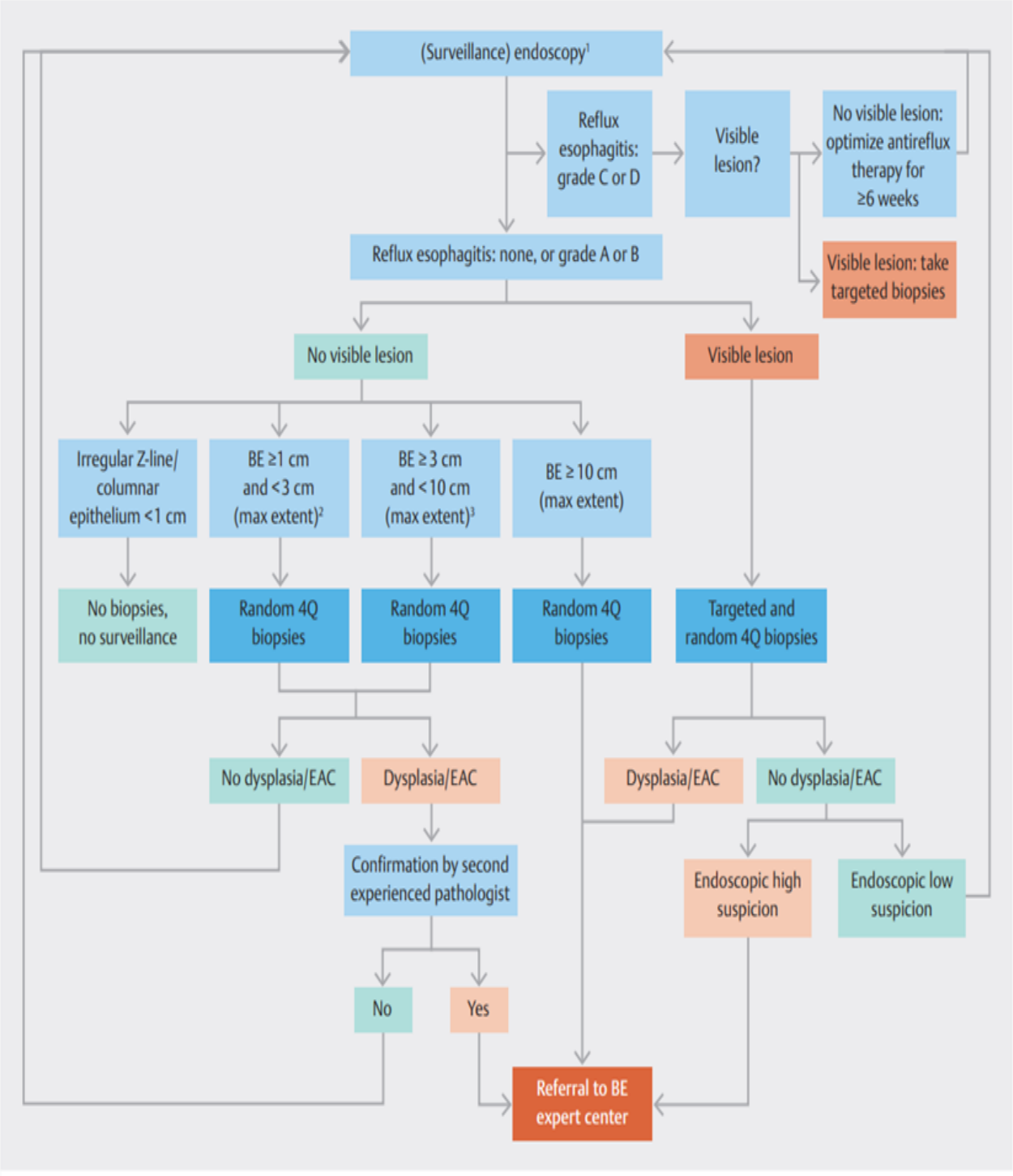
Name of person confirming result of initial impact assessment: Rebecca Carruthers, Senior Advanced Clinical Endoscopist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

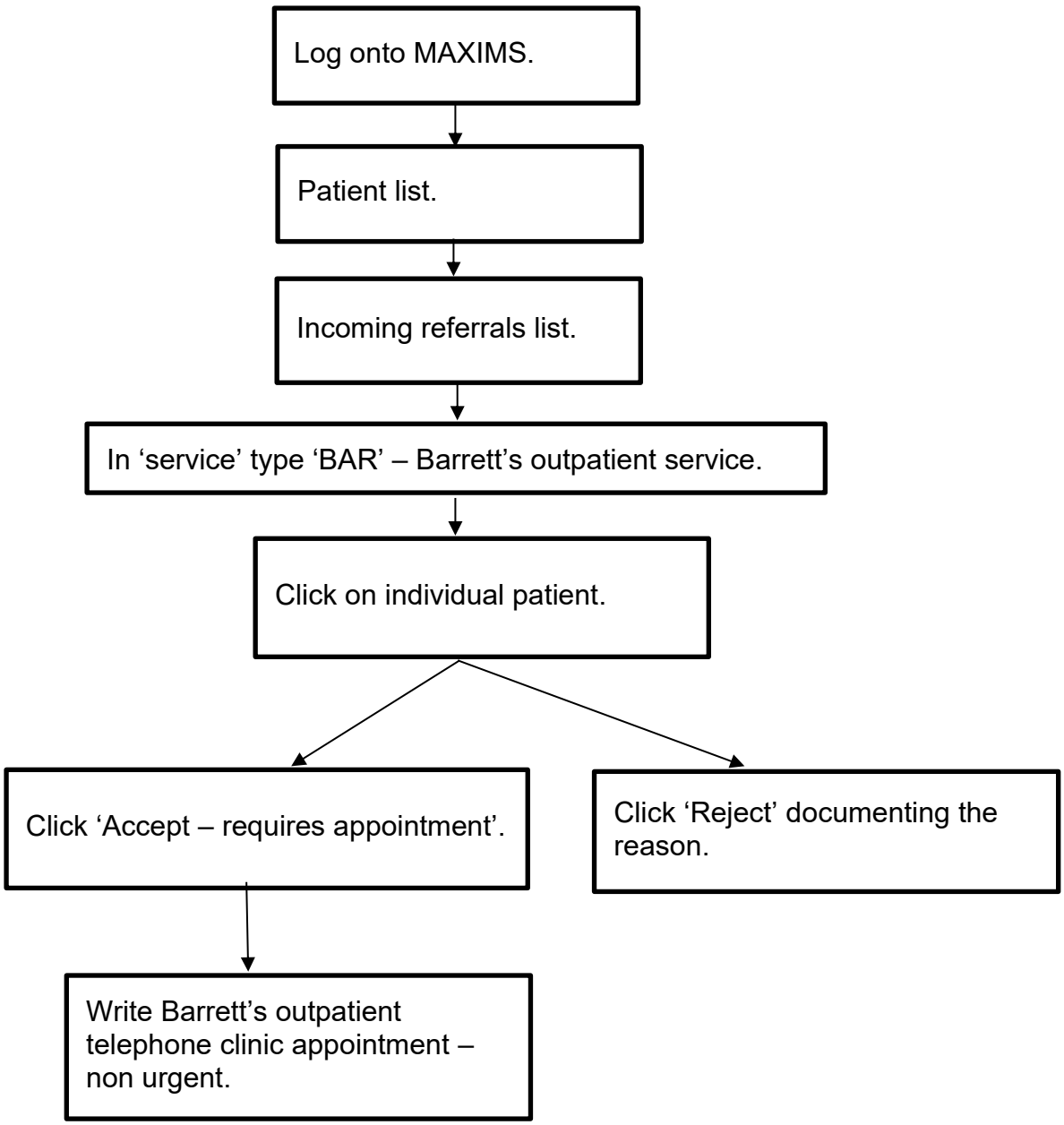
Appendix 3. BSG guidelines on the diagnosis and management of Barrett's Oesophagus



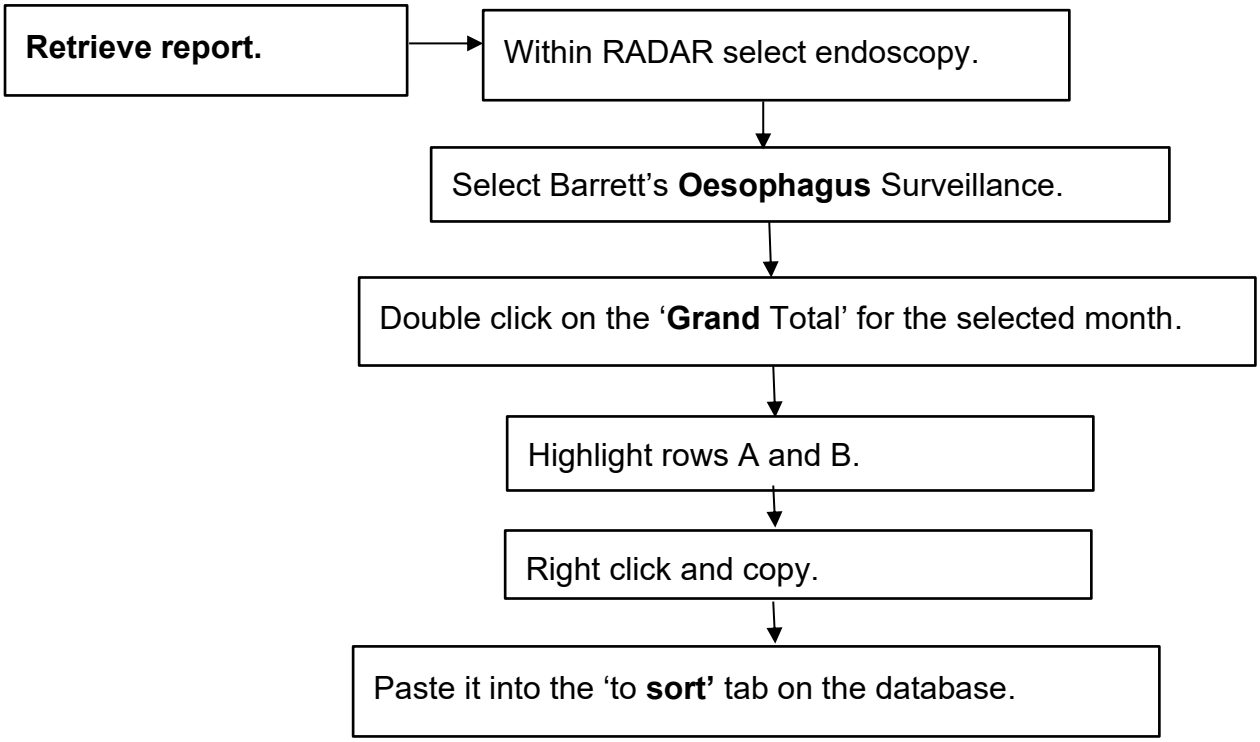
Appendix 4. Diagnosis and Management of Barrett's Esophagus: European Society of Gastrointestinal Endoscopy (ESGE) Guideline 2023

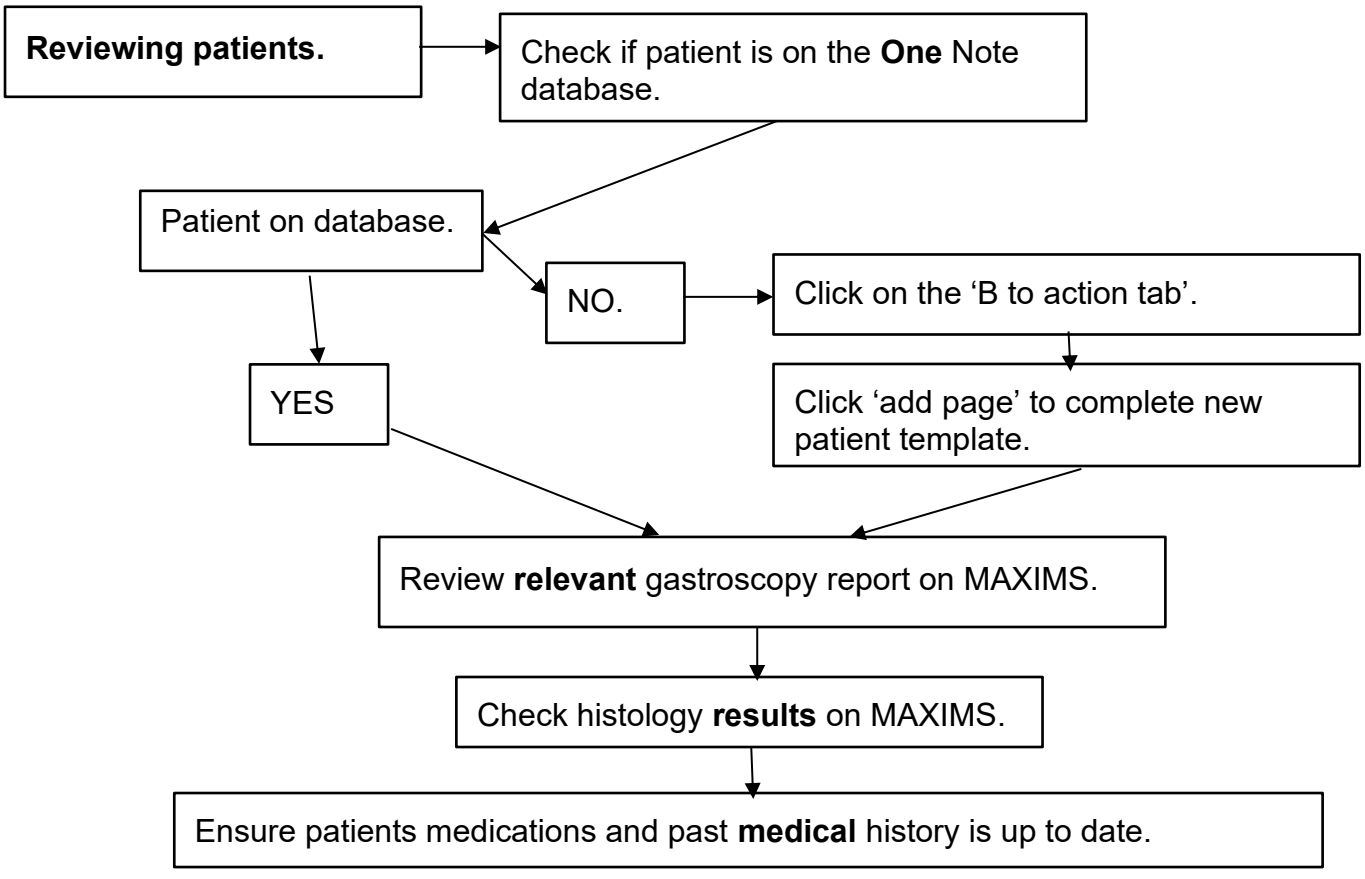


Appendix 5. Vetting instruction for Barrett's Oesophagus clinic referrals



Appendix 6. Instruction for retrieving monthly RADAR report for One Note database and reviewing each patient





Appendix 7. Procedure for the administration of Acetic Acid

7.1. **Equipment:**

- 5% Acetic acid.
- 20ml Luer-lock syringe x two minimum.
- 50ml syringe.
- PPE: Gloves and apron.
- Spray catheter.
- Infacol (Simeticone 40mg/ml).
- Sterile water 1L bottle.

7.2. Prepare patient first by washing the oesophagus with sterile water and infacol using a 50ml syringe by:

- Wash your hands.
- Put on gloves.
- Open infacol and write date of opening on bottle when opening new bottle.
- Prepare the flush solution on a blue medication tray.
- Open 1L bottle of sterile water, dispense 22mls of infacol into the bottle, replace the cap and gently agitate the bottle.
- Pour approximately 200ml of solution into the bowl provided in the scope tray.
- Draw up solution into a 50ml syringe (44mg Simeticone) ready to flush through to increase mucosal views up to 150ml (132mg Simeticone).

7.3. Draw up 10ml 5% Acetic acid and 10ml Sterile water into a 20ml Luer-lock syringe (prepare at least two syringes) with the capacity to draw up more.

7.4. Use a spray catheter to spray the solution in a circular motion starting from the distal end of the oesophagus up to the proximal end of the Barrett's.

7.5. Leave for two minutes to allow the solution to highlight appropriate areas.

7.6. Take any targeted biopsies, then proceed with the standard quadratic samples as per the Seattle protocol.

Appendix 8. Training and competency of Registered Healthcare Professionals

Training	Requirements of registered health professionals working under this SOP
Qualifications and professional registration.	Knowledge of the interaction of acetic acid with other medications. Be JAG accredited in Upper GI Endoscopy.
Competency assessment.	Be assessed as competent to practice by a competent practitioner.
Ongoing training and competency.	Keep up to date in the recognition in dysplasia using AAC by attending online and face to face conferences and study days as appropriate.

Clinical Condition

Clinical condition or situation to which this applies.	Patients attending for a surveillance gastroscopy with Barrett's > 5cm and in all patients where neoplastic lesions are suspected (including in those patients with < 5cm of Barrett's).
Inclusion criteria.	All patients with Barrett's Oesophagus >5cm or those where neoplastic lesions are suspected.
Exclusion criteria.	Oesophagitis.
Cautions (Including any relevant action to be taken).	Nil.
Arrangements for referral for medical advice.	Allergic reaction (very rare) refers to ED.
Action to be taken if patient excluded.	Gastroscopy will be performed using NBI or to be rebooked once treated if oesophagitis is found.
Action to be taken if patient declines treatment.	Gastroscopy will be performed using NBI if acetic acid is declined. If the Gastroscopy is declined, the patient will be referred to a Barrett's telephone clinic.