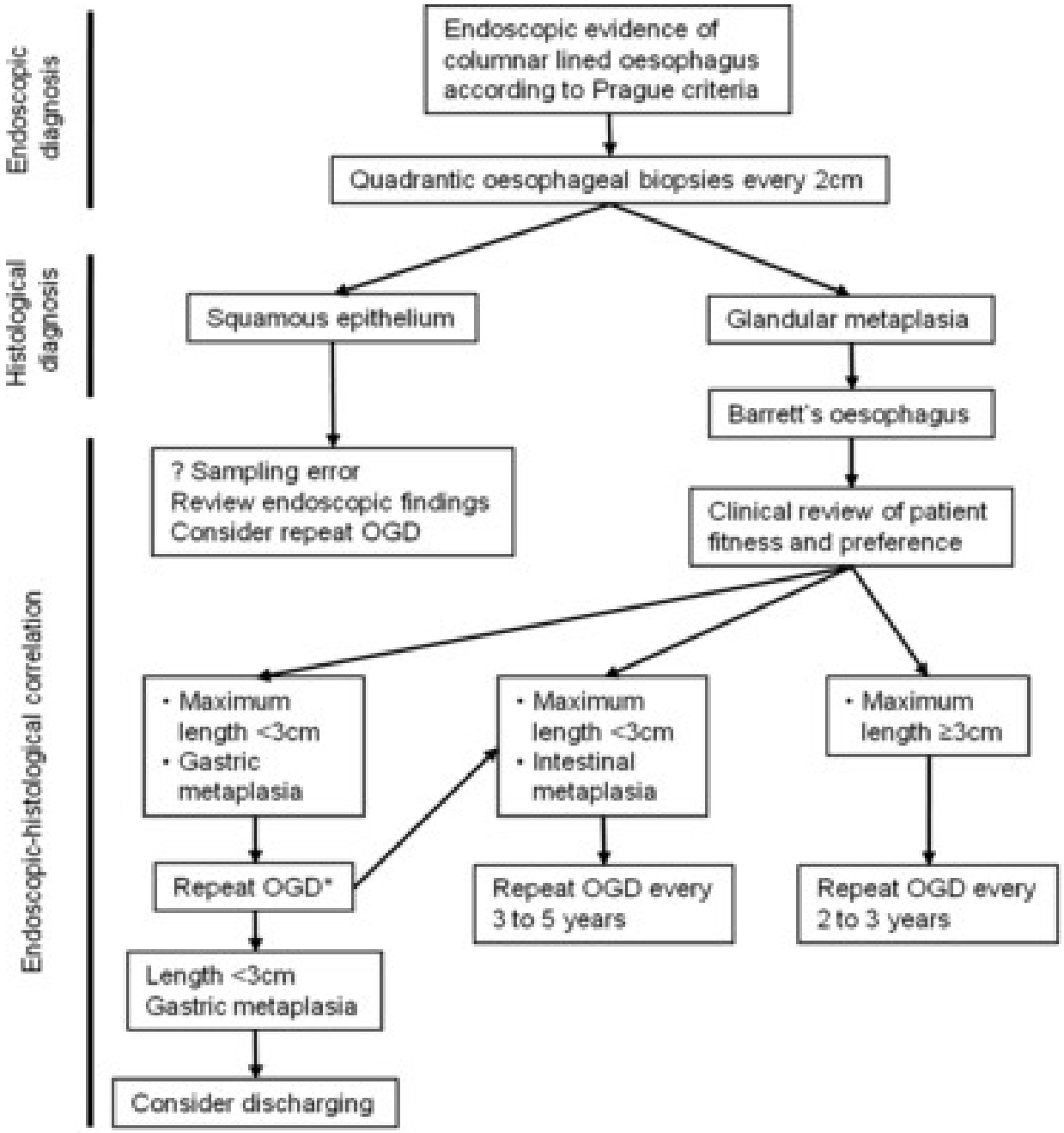
Royal Cornwall Hospitals
NHS Trust

Management of Barrett's Oesophagus Clinical Guideline

V3.0

October 2023

Summary



Patients with Low Grade Dysplasia (LGD) should have a repeat endoscopy in 6 months. If LGD is found in any of the follow up Oesophagogastro Duodenoscopy's (OGD) and is confirmed by an expert Gastrointestinal (GI) pathologist, the patient should be offered endoscopic ablation therapy after clinical review and specialist Multi-Disciplinary Team (MDT) discussion. If ablation is not undertaken, 6- monthly surveillance is recommended.

- **It is the responsibility of the referring clinician to request follow up endoscopy.**
- **It is the responsibility of the referring clinician to refer dysplasia to the MDT.**

1. Aim/Purpose of this Guideline

1.1. This guideline applies to all patients with a histological diagnosis of Barrett's oesophagus and is relevant to all clinicians referring patients for upper gastrointestinal endoscopy.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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

2. The Guidance

2.1. Although RCHT data are lacking, given the evidence from the published studies that surveillance correlates with earlier stage and improved survival from oesophageal cancer, endoscopic surveillance of Barrett's oesophagus is generally recommended.

2.2. Endoscopic monitoring with histopathological assessment of dysplasia is the only current method of surveillance with sufficient evidence to be recommended.

2.3. There is no current role for endoscopic screening for Barrett's. Cases will be diagnosed incidentally.

2.4. **Endoscopic Assessment**

Barrett's oesophagus is defined as an oesophagus in which any portion of the normal distal squamous epithelial lining has been replaced by metaplastic columnar epithelium, which is clearly visible endoscopically (≥1 cm) above the GOJ and confirmed histopathologically from oesophageal biopsies. The proximal limit of the longitudinal gastric folds with minimal air insufflation is the easiest landmark to delineate the GOJ and is the suggested minimum requirement.

2.5. Biopsy protocol

The Seattle biopsy protocol (four-quadrant random biopsies every 2 cm in addition to targeted biopsies on macroscopically visible lesions) is recommended at the time of diagnosis and at subsequent. Targeted biopsy samples from visible lesions should be taken before random biopsies. Distal areas should be biopsied first starting 1–2 cm above the GOJ and advancing proximally to minimise obscured view from bleeding. **Each quadrant biopsies (4) should be labelled at precise distance and collected in separate pots.**

2.6. Photographic Images

A digital record should be made of the oesophagus and suspicious lesions. These should be recorded on endoscribe and annotated detailing the area and abnormality seen.

2.7. If a patient is unable to tolerate this procedure at the initial diagnostic OGD the patient is brought back at the earliest opportunity for further evaluation.

2.8. Report

Endoscopic reports should be standardised:

Finding	Reporting system	Nomenclature
Barrett's oesophagus length	Prague classification	C*n*M*n* (where n is length in cm)
Barrett's islands	Describe distance from the incisors and length in cm	Descriptive in the text
Hiatus hernia	Distance between diaphragmatic pinch and GOJ	yes/no; cm
Visible lesions	Number and distance from incisors	yes/no; cm
Classification of visible lesions	Paris classification	0-Ip, protruded pedunculated
		0-Is, protruded sessile
		0-IIa, superficial elevated
		0-IIb, flat
		0-IIc, superficial depressed
		0-III, excavated
Biopsies	Location and number of samples taken	*n* cm (distance from incisors) X*n*

GOJ - gastro-oesophageal junction

It is imperative to carefully describe, biopsy and photograph focal abnormalities for the histopathologist.

2.9. Histological assessment

Should be by a specialist in upper GI histopathology. Any dysplasia should be reviewed independently by another expert histopathologist.

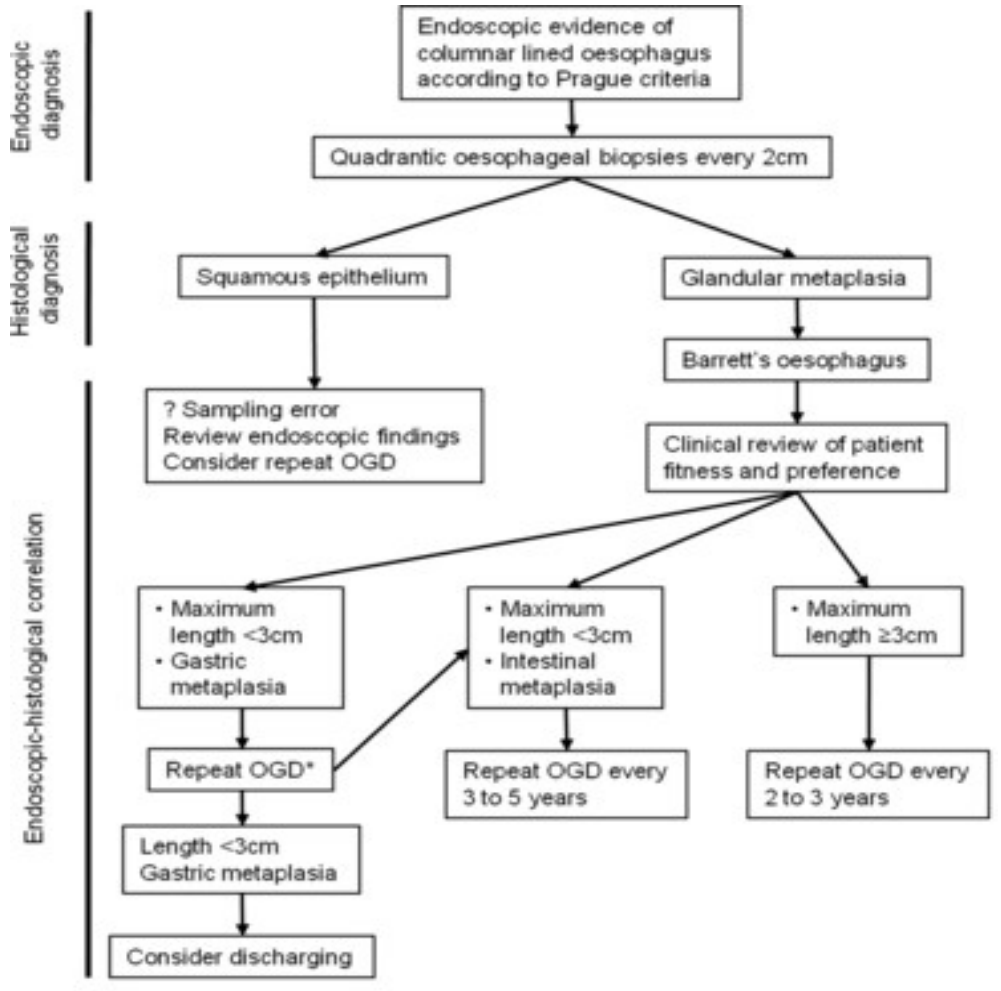
2.10. Patient Information

Patients should have early access to an outpatient clinic to be informed about a new diagnosis of Barrett's oesophagus and to have an initial discussion about the pros and cons of surveillance with written information provided. For a given patient, whether or not surveillance is indicated should be determined on the basis of an estimate of the likelihood of cancer progression and patient fitness for repeat endoscopies, as well as patient preference. Information should be provided from: http://patient.info/health/barretts-oesophagus-leaflet http://www.nhs.uk/Conditions/Gastroesophageal-reflux-disease/Pages/Complications.aspx

2.11. Drug therapy

Patients should be maintained on proton pump inhibitor. Barrett's alone is not an indication for Anti-reflux surgery.

2.12. Management Of Barrett's oesophagus



* Interval depends on the degree of clinical confidence about diagnosis (accuracy of endoscopic report and number of biopsies

2.13. Management of dysplasia

2.13.1. All cases of dysplasia should be discussed at the upper GI cancer MDT.

2.13.2. It is the responsibility of the referring clinician to ensure the case is discussed.

2.13.3. A weekly data base check for oesophageal dysplasia will be performed by pathology and cases referred to cancer services for cross checking.

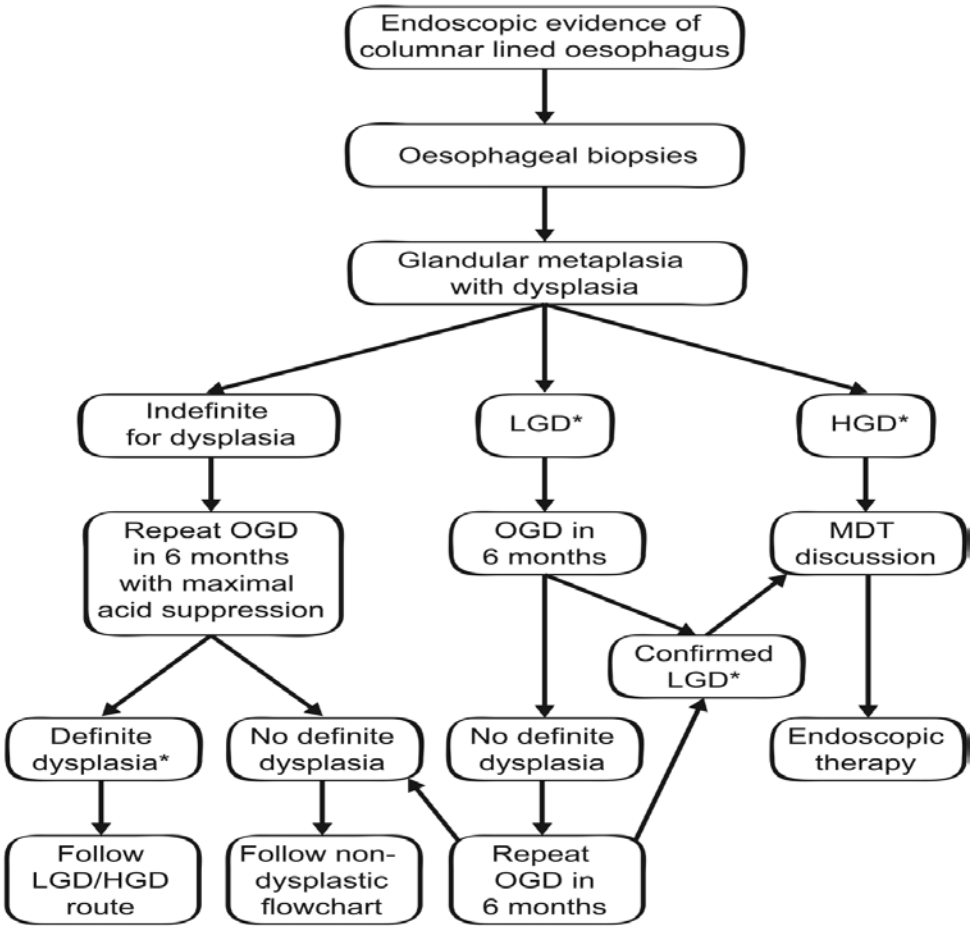
2.13.4. All histological cases should be double reported by a second specialist histopathologist.

2.13.5. Outcome from MDT will be summarised and recorded by cancer services.

2.13.6. The treatment plan will be discussed with the patient.

2.14. Management of Barrett's Dysplasia

Updated flow chart for the management of dysplastic Barrett's oesophagus:



* dysplasia needs to be confirmed by 2 independent GI pathologists

2.15. A pathological finding of indefinite for dysplasia does not exclude the presence of dysplasia; therefore, a 6-month follow-up is warranted. Endoscopic follow-up

in 6 months is recommended for LGD. If LGD is also found at follow-up endoscopy, even if not consecutive, provided that the diagnosis of dysplasia on two occasions is confirmed by two independent GI pathologists (ideally from a different institution), endoscopic ablation should be considered. A diagnosis of high-grade dysplasia (HGD) also needs to be confirmed by a second GI pathologist. Patients with dysplasia should be offered endoscopic therapy following discussion within MDT setting.

2.16. Dedicated Barrett's Endoscopy Lists

In cases of focal abnormality, a repeat OGD is frequently requested on the advice of the MDT. These cases should:

1. Be performed by an operator experienced in the assessment of Barrett's.
2. Access to HD zoom scope.
3. Access to acetic acid.
4. Access to Lugoli's iodine.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Identification and outcomes for cases of dysplasia will be audited annually
Lead	Governance and Endoscopy lead.
Tool	1. Pathology data base weekly review. 2. MDT records. 3. Standardised endoscopic reporting – Scorpio electronic reporting system.
Frequency	1. Annual outcomes audit 2. Quarterly scorpio audit (JAG review) 3. Monthly pathology /cancer services
Reporting arrangements	Reported to: 1. Gastroenterology Governance meeting 2. Endoscopy users group Reports will be discussed in a clinical forum and recommendations made. Each meeting is minuted.
Acting on recommendations and Lead(s)	1. Responsibility of the gastroenterology management team (service lead, clinical lead and governance lead) to act on recommendations. 2. Report back to specialty Business and Governance Meeting
Change in practice and lessons to be shared	1. Actions will be implemented by the clinical leads in each area: • Governance • Endoscopy. 2. Changes in practice and lessons learned will be discussed at the Gastroenterology Governance Meeting and the Endoscopy users Group

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Management of Barrett's Oesophagus Clinical Guideline V3.0
This document replaces (exact title of previous version):	Management of Barrett's Oesophagus Clinical Guideline V2.0
Date Issued/Approved:	24 October 2023
Date Valid From:	October 2023
Date Valid To:	October 2026
Directorate / Department responsible (author/owner):	Dr N Michell, Department of Gastroenterology
Contact details:	01872 252074
Brief summary of contents:	Standardised identification of Barrett's oesophagus, biopsy protocol, histological assessment and management plan
Suggested Keywords:	Barrett's oesophagus, high grade dysplasia, low grade dysplasia
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	• Gastroenterology Business and Governance Meeting. • Care Group Governance Meeting.
Manager confirming approval processes:	Roz Davies
Name of Governance Lead confirming consultation and ratification:	Maria Lane
Links to key external standards:	None required
Related Documents:	None required
Training Need Identified?	No

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

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
21 Nov 2017	V1.0	New	Nick Michell, Consultant Gastroenterology
12 Oct 2020	V2.0	Revised – No changes to content and transposed to latest Trust template	Nick Michell, Consultant Gastroenterology
24 October 2023	V3.0	Reviewed – No Changes Transposed to latest trust template	Nick Michell Consultant Gastroenterologist

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:	Management of Barrett's Oesophagus Clinical Guideline V3.0
Directorate and service area:	Gastroenterology, Specialist Services and Surgery
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Nick Michell, Consultant Gastroenterologist
Contact details:	01872 252074

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)	This guideline applies to all patients with a histological diagnosis of Barrett's oesophagus and is relevant to all clinicians referring patients for upper gastrointestinal endoscopy.
2. Policy Objectives	To ensure that all patients undergoing endoscopic procedures have correct management of their condition.
3. Policy Intended Outcomes	All patients being referred for endoscopy have an evidence based plan created.
4. How will you measure each outcome?	Auditing numbers of referrals without such a management plan and also those where the plan is deemed inappropriate.
5. Who is intended to benefit from the policy?	All patients with Barretts Oesophagus undergoing endoscopy.

Information Category	Detailed Information
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:** • Gastroenterology Governance Meeting • Care Group Governance Meeting
6c. What was the outcome of the consultation?	Agreed
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	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
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: Dr Nick Michell, Consultant Gastroenterologist.

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