Motion – All patients with GERD should be offered once in a lifetime endoscopy: Arguments for the motion

David Armstrong MA FRCP(UK) FRCPC

Proton pump inhibitor therapy is so successful at relieving reflux-related symptoms and healing esophageal erosions that it has supplanted formal diagnostic techniques, such as endoscopy and esophageal pH monitoring, for the initial management of gastroesophageal reflux disease. The response to antisecretory therapy is not indicative, however, of Barrett’s esophagus or esophageal adenocarcinoma. Patients with prolonged and severe reflux symptoms, especially if they are over the age of 60 years, are at risk of these complications. For them, endoscopy is the only appropriate investigation for detecting Barrett’s esophagus and dysplasia or cancer. Because of the difficulty in distinguishing dysplasia from inflammatory and regenerative changes, endoscopy should be undertaken while the patient is on effective antisecretory therapy. Endoscopy should be offered only to patients who are suitable for further therapy (especially esophagectomy), and only if they understand the implications of abnormal findings. The published evidence suggests that the application of clear guidelines would not overwhelm health care resources, and that fewer than 20% of patients with Barrett’s esophagus would eventually undergo endoscopic surveillance.

Key Words: Barrett’s esophagus; Endoscopy; Esophageal adenocarcinoma; Gastroesophageal reflux disease

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Division of Gastroenterology, McMaster University, Hamilton, Ontario
Correspondence: Dr David Armstrong, Division of Gastroenterology, HSC-4W8, McMaster University Medical Centre, 1200 Main Street West, Hamilton, Ontario L8N 3T5. Telephone 905-521-2100 ext 76404, fax 905-521-4958, e-mail armstro@mcmaster.ca
THE ROLE OF ENDOSCOPY IN GASTROESOPHAGEAL REFUX DISEASE

Since its introduction, endoscopy has been crucial to the management of gastroesophageal reflux disease (GERD), although its specific role has continued to evolve as understanding of the disease has changed over the years. Fibreoptic endoscopy allows safe, detailed inspection of the upper gastrointestinal tract and accurate identification of distal esophageal erosions, which are the most typical lesions of reflux esophagitis (1).

The identification of esophageal erosions and their healing in response to treatment were the basis of many of the seminal trials in GERD, shifting the emphasis from symptomatic therapy to the healing of esophageal erosions. For many physicians, erosive esophagitis has become synonymous with GERD, and endoscopy has, therefore, been the investigation of choice for the diagnosis of GERD. Endoscopy has also improved the opportunities to identify and, on occasion, treat complications of reflux disease, such as hemorrhage, ulceration, strictureing and Barrett’s esophagus (BE) (1,2). With these developments, greater emphasis has been placed on refining the diagnosis of GERD, so that therapy can be tailored to disease severity and to facilitate the management of the acute complications of reflux disease. Even though it is increasingly apparent that BE is a premalignant lesion, the identification of this abnormality was not the primary aim of endoscopic examination.

Endoscopy continues to have a major role in the investigation of patients with alarm features, such as dysphagia, odynophagia, bleeding, weight loss, severe atypical symptoms or failure to respond to optimal medical therapy. It has recently been recognized, however, that endoscopy-negative reflux disease (ENRD) accounts for a large proportion (over one-half in some studies) of patients with GERD (3). Moreover, esophageal pH monitoring has not lived up to its diagnostic promise, particularly in patients with ENRD. Increasingly, GERD is diagnosed based on the presence of typical reflux symptoms (heartburn and regurgitation) that resolve with acid-suppression therapy. A number of consensus panels have endorsed this approach, and the use of empirical therapy for patients with typical symptoms and no alarm features (4,5).

SCREENING FOR BE

Recent guidelines from the American College of Gastroenterology recommend endoscopy for patients over the age of 50 years who have long-standing symptomatic gastroesophageal reflux (21), but there are limited outcomes data to support this policy. The significance of short-segment BE (less than 3 cm) and of small intestinal metaplasia at the esophagogastric junction remains unclear. These lesions appear to be much more prevalent than classical long-segment BE (6%) for short-segment BE, 5.6% for small intestinal metaplasia at the esophagogastric junction and 1.6% for long-segment BE) (22). Some investigators have suggested that patients with short-segment BE could be followed expectantly. Although dysplasia and cancer are more prevalent in patients with long-segment BE (31%), they are not rare among cases of short-segment BE (10%) or esophagogastric junction-specialized intestinal metaplasia (6.4%) (22).

In accordance with principles outlined by the World Health Organization, surveillance is predicated on the availability of suitable therapy for the disease in question or its precursor (23). For a patient who is otherwise fit, esophagectomy offers the possibility of improved long term survival or even cure for patients with high-grade dysplasia or early cancer. Although diagnosis and treatment are far from ideal, improved diagnostic techniques (such as photodynamic therapy and laser ablation) offer new promise.
Endoscopy is the technique of choice for identifying esophagitis, while the diagnosis of BE requires (targeted) biopsy to identify areas of intestinal metaplasia (5). Because inflammation and mucosal regeneration can induce changes that are difficult to distinguish histologically from dysplasia, endoscopy and biopsy should be performed while the patient is taking sufficient antiresecretory medication to relieve symptoms and minimize esophageal damage (21).

Some physicians have argued that cancer surveillance is too costly to be applied to all patients with GERD. Nevertheless, unless early indicators of possible malignancy are sought, all endoscopic evaluations for reflux disease might as well be avoided until alarm features develop, with the knowledge that most malignancies will, by then, be incurable. Even though the presence of severe reflux symptoms has been identified as a risk factor for EAC (8), endoscopy with biopsies is the only available means of determining whether an individual patient has an increased risk of esophageal malignancy and merits long-term follow-up.

CONCLUSIONS
‘Once in a lifetime’ endoscopy should be the standard of care for patients over 60 years of age who have severe, prolonged, frequent GERD symptoms and who are willing to proceed with surgery, if necessary. Endoscopy should be undertaken earlier if clinically warranted, for example, if alarm symptoms or diagnostic confusion are present. The endoscopic appearances should be fully recorded, and biopsies should be taken if BE is suspected endoscopically. It should be emphasized that ‘once in a lifetime’ endoscopy is not synonymous with either ‘surveillance endoscopy’ for BE, which depends on additional criteria, or ‘screening endoscopy’, which would be used to look for BE in the general population. According to published guidelines (24,25), surveillance should be undertaken in patients whose risk of developing malignancy is greater than 0.5% per year.

REFERENCES
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