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Endoscopic resection for oesophageal mucosal adenocarcinoma

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Endoscopic therapy should be the standard of care for OmAC

This prospective study,¹ by some margin the largest of its kind, demonstrates emphatically the safety and efficacy of endoscopic therapy for Barrett's oesophageal mucosal adenocarcinoma (OmAC).

The association between Barrett's oesophagus (BO) and oesophageal cancer has been recognised since the 1970s. Treatment options for Barrett's neoplastic lesions include surgical oesophageal resection, endoscopic resection (ER) alone and ER combined with ablative therapy. Society guidelines exhibit variance with regard to management of OmAC. Furthermore, data are limited to small studies, with short follow-up, with high grade dysplasia (HGD) and OmAC included as one entity. This study aimed to clarify the safety and efficacy of endoscopic therapy for OmAC and to investigate the associations of treatment failure.

Data were collected prospectively from all patients referred to a single tertiary centre in Germany for endoscopic therapy of suspected Barrett's intraepithelial neoplasia (IN) or early adenocarcinoma over a 15-year period. All patients diagnosed with submucosal or more advanced disease at the time of the first study endoscopy were excluded, as were those with low grade dysplasia or HGD. All patients with suspected OmAC underwent ER with curative intent. Initially, ablative therapy (argon photo-coagulation (APC)) was coadministered to the neoplastic lesion. Later, the protocol was amended to sole ER therapy reflecting changing best practice that acknowledges the importance of ER specimens as diagnostic gold standard. High dose proton pump inhibitor (PPI) was given postprocedure.

The remaining non-neoplastic Barrett's segment was ablated with APC that is known to decrease metachronous lesions in follow-up.² Follow-up endoscopies were planned for 1–3, 6, 9, 12 months, then every 6 months until 5 years, and every 2 years thereafter. ER was performed if OmAC recurred. The two primary endpoints were complete remission from IN and OmAC and tumour associated death at 5 years.

In all, 1000 patients (median age 69.1; 861 men) with OmAC entered the study. Complete remission from neoplasia was achieved in 96.3% of patients. There were two tumour associated deaths (0.2%) and 111 non-tumour related deaths. Recurrence of neoplasia occurred in 14.5% of patients at a median of 26.5 months, and retreatment was successful in 82.1% of cases; 14.9% of neoplastic recurrence was after 5 years. Treatment failure occurred in 37 patients, most commonly due to incorrect initial diagnosis. Other causes of treatment failure were poor wound healing (despite PPI) and scarring from previous ER. The only positive association with treatment failure was a long segment of BO. There were 14 cases of major complications (1.4%), all successfully managed endoscopically.

The authors acknowledge a number of study weaknesses including possible referral bias; the change of protocol during the study; and the fact that the study predates or partly predates the Prague and Paris classifications respectively.

The study concludes that ER for Barrett's OmAC is safe and effective and compares favourably with published data for mortality and morbidity following surgical resection. Other conclusions include the necessity for surveillance beyond

5 years given the ongoing possibility of recurrence, and the need for close follow-up of those with long-segment BO.

Comment

This clearly written and thorough article detailing a well-designed prospective study adds significantly to the evidence base for the use of ER as sole agent therapy for OmAC, and for its inclusion as such in society guidelines. The large patient number and long follow-up outweigh the study weaknesses outlined above. It is interesting to consider that patients were 50 times more likely to die from unrelated causes than from tumour related disease, mirroring the efficacy of the treatment and comorbidities of this elderly cohort. The authors acknowledge that the 14 endoscopies performed on each patient over the first 5 years may be too aggressive for this elderly population. It is critical, therefore, to take patient factors (frailty, comorbidities, etc) and informed patient wishes into consideration when discussing endoscopic follow-up regimes.

Competing interests None.

Provenance and peer review

Commissioned; internally peer reviewed.

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