NHS
Royal Devon
University Healthcare
NHS Foundation Trust

# Barrett's oesophagus

**The gastro-intestinal tract (digestive system)**

**(Eastern services)**

## Other formats

If you need this leaflet in another format such as Braille, large print, high contrast, British Sign Language or translated into another language, contact the Patient Advice and Liaison Service:

- 01392 402093 (for Mid Devon, East Devon and Exeter services)
- 01271 314090 (for North Devon services)
- rduh.pals@nhs.net

## What is Barrett's oesophagus?

Acid is present in the stomach to help digest food. Gastro-oesophageal reflux (GORD) occurs when digestive juices containing acid actually rise into the oesophagus (gullet), the tube which carries food from the mouth to the stomach.

The lining of the oesophagus is different from the stomach, so when it is exposed to the acid it may become inflamed and painful, causing damage to the lining. The oesophagus usually heals with time and the lining returns to normal, but sometimes it heals in a different way and the lining changes to being like the lining of the stomach or intestine. This change is known as "Barrett's oesophagus" (after the doctor who first described this).

## Diagnosis

Barrett's oesophagus is diagnosed by gastroscopy or cytosponge tests. A gastroscopy is a test in which a clinician (endoscopist) uses an instrument called a gastroscope to look directly at the lining of the oesophagus, stomach and duodenum (first part of the intestine). A gastroscope is a long flexible tube, thinner than your little finger, which transmits a picture to a video monitor. During the procedure the endoscopist will usually take very small pieces of tissue (biopsies) for analysis in the laboratory.

Cytosponge is a test that is available in some areas of the UK. Cytosponge requires a small capsule with a sponge inside it to be swallowed, which is attached to a piece of thread. The capsule dissolves in the stomach within about seven minutes of being swallowed, releasing the sponge inside. A nurse will then gently pull the thread to remove the sponge – the sponge collects cells from the lining of the oesophagus on the way out. These cells are then analysed in the laboratory to see if there are any cell changes. If

there are cell changes, you may be asked to attend for a gastroscopy to confirm if Barrett's oesophagus is present.

## Complications of Barrett's oesophagus

Of every 1000 patients who have Barrett's oesophagus, approximately three to six of them develop cancer in their oesophagus each year. The longer someone has Barrett's oesophagus, the higher their lifetime risk of cancer. Cancer of the oesophagus may cause few or even no symptoms until it is advanced and usually incurable.

Patients with Barrett's oesophagus will often receive gastroscopies at regular intervals (e.g. every three years), to help pick up oesophageal cancer, or pre-cancer (dysplasia) before it causes physical symptoms. Catching cancers earlier, may mean that the opportunity to provide curative treatments is increased.

As well as GORD, there are other risk factors that can lead to Barrett's oesophagus, including older age, family history, obesity, smoking, or a hiatus hernia. Barrett's oesophagus can affect both men and women, though it is significantly more common in white men.

## Treatment for Barrett's oesophagus

You will usually be advised to take regular acid-reducing medication, such as proton pump inhibitors (PPIs). The names of these include omeprazole, esomeprazole, lansoprazole, pantoprazole and rabeprazole. The aim is to relieve symptoms and heal any soreness in the oesophagus. Recent evidence suggests that high-doses of these medications may reduce the risk of cancer and the pre-cancerous changes described above, though they don't remove it completely. You may also be advised to take a very small dose of aspirin with your PPI, as this may reduce the risk further.

## Barrett's oesophagus without dysplasia

Occasionally, cells within a Barrett's segment which have already changed due to acid reflux, start to develop more worrying changes. These changes in cells are known as dysplasia. Whilst dysplasia is not cancer, it is often occurs before the development of oesophageal cancer. Therefore, if we detect dysplasia, we may consider a different treatment approach or monitor it more closely.

A patient **without** dysplasia would be considered low risk. There are certain exceptions that may warrant treatment (very long segment of Barrett's or a strong family history of cancer) but these need to be discussed with a specialist. Patients without dysplasia may be treated with the medications listed above, although it must be noted that these medications do not remove the Barrett's oesophagus and therefore, do not eradicate the risk of developing oesophageal cancer. Monitoring Barrett's oesophagus is a vital part of management, because even if there is no dysplasia initially, that doesn't mean that someone will never develop dysplasia or cancer in the future.

Surveillance is usually carried out by gastroscopy or cytosponge every two to five years – the frequency of surveillance varies from person to person and is based on the type and length of Barrett's oesophagus seen.

## Barrett's oesophagus with dysplasia (abnormal cells)

Minimally invasive endoscopic therapy has been introduced in recent years to remove or treat the segment of Barrett's oesophagus with dysplasia. The procedure is selected based on a variety of factors, including the stage and location of the affected cells:

## Endoscopic mucosal resection (EMR)

This is a technique used to remove small polyps or growths from the lining of the oesophagus, enabling the endoscopist to remove a larger area of tissue than is possible with a simple biopsy. It treats the area by removing the pre-cancerous or cancerous cells, without the need for major surgery. It also allows better assessment of the abnormal Barrett's tissue than that of a standard biopsy, so it gives more information about the right treatment for you.

When EMR is performed, there is approximately a one in 50 risk of bleeding. If bleeding does occur it usually stops on its own, but observation and further treatment in hospital may be necessary. Rarely (approximately one in 200 cases) a small hole (perforation) in the lining of the area can develop. If this were to happen, it would mean a stay in hospital for antibiotics and artificial feeding, and possibly an operation to repair any damage. After treating the abnormal area with EMR, a scar will form as it heals – it is quite common to get some chest discomfort and pain on swallowing for the first two to three days. If this continues and you develop any problems with swallowing, it may be that the scar has caused a narrowing in the oesophagus (this occurs in approximately one in 20 patients), and can be treated with an endoscopy to stretch the scar.

## Radiofrequency ablation (RFA)

This is a technique that allows the endoscopist to burn away the abnormal cells. It is carried out under sedation and is very safe and effective. This technique is often also referred to as HALO®, RFA or Barrx® (after the manufacturers of the device). Your doctor will decide which is best to use depending on various factors, such as how much of the lining of the oesophagus is affected. It is not unusual for patients to need more than one treatment to remove the Barrett's segment entirely.

Radiofrequency ablation is now recommended as the preferred technique in the UK for high grade dysplasia, and has been approved by NICE for low grade dysplasia as well.

## How to reduce gastro-oesophageal reflux symptoms

In addition to taking medication, the following measures may help your symptoms of reflux:

- Avoid late evening meals: your last meal should be at least four hours before lying down.
- Avoid bending or stooping just after meals.

- Avoid tight clothing around the waist.
- Lose weight, if necessary.
- Stop smoking.
- Stopping or considerably reducing alcohol intake, which should only be consumed on occasion and in moderation
- Avoid foods that could irritate your condition (coffee, citrus foods, fatty foods, chocolate).
- Eat small, regular meals.
- You may find it helpful to elevate the head of the bed at least 8-12 inches.

## Symptoms to look out for

If you have Barrett's oesophagus and develop any symptoms between your surveillance procedures, such as persistent reflux despite your medication, difficulty swallowing or food sticking on the way down, unexplained weight loss, bringing up blood or a change in your voice, please let us know and don't just wait for your next endoscopy - just because you have had a surveillance endoscopy doesn't mean you won't develop changes prior to your next scope.

## Further information

For more information, please contact the Endoscopy Unit on 01392 402400.

## Your notes

---

---

---

---

---

---

---

---

---

---

---

## PALS

The Patient Advice and Liaison Service (PALS) ensures that the NHS listens to patients, relatives, carers and friends, answers questions and resolves concerns as quickly as possible. If you have a query or concern, please contact PALS:

- 01392 402093 (for Mid Devon, East Devon and Exeter services)
- 01271 314090 (for North Devon services)
- rduh.pals@nhs.net

## Have your say

Royal Devon University Healthcare NHS Foundation Trust aims to provide high quality services. However, please tell us when something could be improved. If you have a comment or compliment about a service or treatment, please raise your comments with a member of staff or the PALS team in the first instance.

You can also share your feedback on the Care Opinion website at www.careopinion.org.uk or freephone 0800 122 3135.

Scan the QR code to visit the Care Opinion website →

Royal Devon University Healthcare NHS Foundation Trust
www.royaldevon.nhs.uk

---

The Trust cannot accept any responsibility for the accuracy of the information given if the leaflet is not used by Royal Devon staff undertaking procedures at the Royal Devon sites or in community settings.



www.royaldevon.nhs.uk/get-in-touch