REBELLIOUS MEDIC · GASTROENTEROLOGY ALGORITHM SERIES

Barrett's Esophagus

Diagnosis, screening, surveillance intervals, and medical/endoscopic therapy for Barrett's esophagus.

2022 ACG Clinical Guideline
Diagnosis and Management of Barrett's Esophagus
Shaheen et al. · Am J Gastroenterol 2022;117:559–587

GRADE — Strong Rec | Conditional Rec | No Recommendation Reached

1 Diagnosis

STATEMENT	GRADE
Diagnosis requires **intestinal metaplasia** in the tubular esophagus, with **columnar mucosa ≥1 cm** in length	2 · Conditional
Normal or irregular Z line (<1 cm proximal displacement), no visible lesion: **no routine biopsies**	2 · Conditional
≥8 biopsies at screening exam with possible BE; **Seattle protocol** for segments >4 cm	2 · Conditional
Any-grade dysplasia on biopsy must be **confirmed by a 2nd GI pathologist**	1 · Strong

2 Screening

STATEMENT	GRADE
Single screening endoscopy for **chronic GERD + ≥3 risk factors** (male, age >50, White race, smoking, obesity, family history of BE/EAC)	2 · Conditional
Swallowable capsule device + biomarker is an acceptable alternative to endoscopy for screening	2 · Conditional
Against repeat screening after an initial negative screening endoscopy	2 · Conditional

3 Surveillance

STATEMENT	GRADE
White light endoscopy + chromoendoscopy for surveillance	1 · Strong
Structured biopsy protocol to minimize detection bias	1 · Strong
Surveillance interval dictated by **degree of dysplasia** on prior biopsies	2 · Conditional
BE segment length factors into interval; longer intervals for segments < 3 cm	1 · Strong
Wide-area transepithelial sampling (WATS-3D) as adjunct: no recommendation	No Rec Reached
Predictive biomarkers (p53 IHC, TissueCypher) as adjunct: no recommendation	No Rec Reached

4 Medical & Endoscopic Treatment

STATEMENT	GRADE
At least **once-daily PPI** in BE without contraindication	2 · Conditional
ASA + PPI combination therapy: no recommendation	No Rec Reached
Against antireflux surgery as an antineoplastic measure	2 · Conditional
Endoscopic eradication therapy (EET) for BE with **HGD or intramucosal cancer**	1 · Strong
EET for BE with LGD to reduce progression risk, vs close surveillance	2 · Conditional
Resect visible lesions before ablative therapy	2 · Conditional
EET performed at **high-volume centers**	2 · Conditional
Endoscopic surveillance program after successful EET	1 · Strong

5 Baseline Surveillance Intervals

FINDING	SUGGESTED INTERVAL
NDBE, < 3 cm	EGD every 5 yr
NDBE, ≥3 cm	EGD every 3 yr
Indefinite for dysplasia	Repeat EGD in 6 mo after uptitrating PPI to BID → then follow NDBE/LGD algorithm, or annual EGD if still indefinite
LGD (2nd pathologist-confirmed, surveillance chosen)	EGD at 6 mo → 12 mo → annually thereafter

6 Post-EET Surveillance (After Complete Eradication of IM)

WORST PRETREATMENT HISTOLOGY	SUGGESTED INTERVAL FOLLOWING CEIM
Low-grade dysplasia	1 yr → 3 yr → every 2 yr thereafter
High-grade dysplasia	3 mo → 6 mo → 12 mo → annually thereafter
Intramucosal carcinoma	3 mo → 6 mo → 12 mo → annually thereafter

KEY Post-CEIM biopsy protocol: careful inspection of the **GEJ and neosquamous epithelium** with high-resolution white light + virtual chromoendoscopy, then biopsies from the **GEJ** (separate bottle) and **distal 2–5 cm** of neosquamous esophagus (separate bottle). **>90% of recurrences** are successfully retreated endoscopically; cessation of surveillance after CEIM is not recommended unless dictated by overall medical status.

Shaheen NJ, Falk GW, Iyer PG, et al. American College of Gastroenterology Clinical Guideline: Diagnosis and Management of Barrett's Esophagus. *Am J Gastroenterol.* 2022;117(4):559–587.