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To err is human: it is time to look forward in the management of Barrett's esophagus

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Dear Editor,

We read with great interest the review article by Vicente Munitiz et al. on Barrett's esophagus (BE) (1). We were perplexed by the superficial nature of the literature review and wish to highlight the serious bias and conflict of interest. The authors have been objective in communicating their previous work and have neglected seminal papers on the topic. A useful review must critically appraise the significant developments in the field, identifying the areas of controversy and highlighting the research gaps to the readers. Unfortunately, the review failed to uphold these principles and in the realm of evidence-based medicine, this paper should be re-classified as an expert opinion rather than a detailed systematic review.

First, the use of terminologies such as esophagologist is inconsistent, as such a subspecialty does not exist. Second, the authors only focused on selected risk factors and did not represent the importance of other risk factors (2). We wish to highlight that only one-third of BE patients have gastroesophageal reflux disease (GERD) (3,4) and most BE are sporadic (5). Third, the familial clustering of BE has only been reported in small series and unlike the risk quoted by the authors (0.5%), the actual rate of progression to adenocarcinoma is not well known. Fourth, there are substantial data showing that proton pump inhibitors (PPI)

reduce the risk of esophageal adenocarcinoma (EAC) by 71% in BE (6). It is also clear from a meta-analysis that anti-reflux surgery offers no superior benefit compared to PPI in the reduction of EAC rates (7).

The final nail in the coffin is the lack of emphasis on endoscopic therapies by the authors. The major societies in Europe and North America have systematically summarized the available data and published clinical practice guidelines on BE to minimize treatment variation and assist physicians (2,8). They strongly recommend endoscopic resection of the visible dysplastic lesion and propose endoscopic ablative therapy of the remaining BE segment, based on high-quality evidence.

Several advances in endoscopy have occurred in the last decade. These simplify BE screening, enhance detection of dysplasia, treat dysplasia effectively and even resect superficial cancers with a low risk of complications and achieve a cure. It is time that we move forward and embrace the change to provide our patients with the best possible clinical outcome. As to err now may not be human.

We sincerely hope that *The Spanish Journal of Gastroenterology (Revista Española de Enfermedades Digestivas)* publishes an updated review with a clear focus and provides an unbiased point of view for the readers on this subject.

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