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COMPLETE BARRETT'S ESOPHAGUS ERADICATION BY ENDOSCOPIC TECHNIQUES: REMISSION OR CURE?

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The prevalence of Barrett's esophagus has been estimated to be 1 % to 2 % of all patients referred for upper gastrointestinal endoscopy, and up to 15% amongst patients with chronic gastroesophageal reflux symptoms (1).

The significance of this condition lies in its premalignant nature. Indeed, the annual incidence of esophageal adenocarcinoma in patients with Barrett's esophagus without dysplasia is 0.33 %, in those with low-grade dysplasia is 0.76 %, and in those with high-grade dysplasia ranges from 7 % to 19 % (2).

The management of patients with Barrett's esophagus has changed over the past ten years. Today, the natural history of this condition can be modified with endoscopic treatment, and progression to adenocarcinoma may be averted in patients with dysplasia. Among these endoscopic techniques radiofrequency ablation is most commonly used, and has proven itself in completely eradicating metaplasia in 80 % of cases with a low rate of complications, and in reducing the risk for adenocarcinoma (3).

However, once Barrett's esophagus has been completely eradicated concerns arise on its potential recurrence as well as on the need for endoscopic monitoring of these patients.

First of all, there is no consensus definition of recurrence, which usually encompasses both the recurrence of intestinal metaplasia and the recurrence of dysplasia. However, these two recurrences do not occur with the same frequency, and do not have the same impact on the management and clinical course of these patients. There is a moderate risk of recurrence of intestinal metaplasia, with a rate of 20 % and 33 % at one and two years, respectively, according to reported series (4). The risk for recurrent dysplasia is low, with an annual incidence of 0.9 % in cases of mild dysplasia, and of 4.3 % when severe dysplasia was present (5). It is the purpose of patient follow-up after eradication to provide an early identification of recurrence so that it may be effectively retreated using endoscopic techniques.

On the other hand, the limitations of available imaging techniques and random biopsies for the identification of recurrence, at times "buried" recurrence, must be borne in mind. Indeed, some study using an optical coherence tomography system described the presence of metaplasia under the newly developed squamous epithelium of the esophagus in up to 63 % of previously treated patients (6). Even so, despite the fact that "buried" adenocarcinomas have been reported over a previously treated Barrett's esophagus (7), this is an uncommon condition and the significance of "subsquamous" metaplasia in clinical practice remains to be clearly established. Long-term follow-up studies describe the most common sites of recurrence at the gastroesophageal junction (74 %) and, concerning "visible" lesions, the distal portion of the previously treated esophagus (26 %) (5), not underneath the new squamous epithelium, a site hardly accessible by conventional endoscopic biopsy systems.

Lastly, the distribution of recurrences over time has not yet been clearly established. Although some authors have observed that recurrence primarily develop within the first year after treatment (8), other studies report a progressive increase with follow-up length (5). Therefore, it seems advisable that endoscopic monitoring be carried on indefinitely and, as is established for colonic adenoma, any decision to discontinue follow-up should rest on an assessment of

patient life expectancy rather than time since eradication.

Because of all the above, the potential for recurrence, and the recommendation to protract endoscopic follow-up once complete eradication of the metaplasia has been achieved, some authors suggest the use of “remission” rather than “cure” as the right term (9).

In the present issue of *Revista Española de Enfermedades Digestivas* an international team of experts in the subject matter review the scientific evidence available concerning the follow-up of patients with Barrett’s esophagus after complete eradication of intestinal metaplasia; based on their experience and opinions they have developed a number of recommendations that will undoubtedly be useful for the management of these patients (10).

To conclude, in patients with Barrett’s esophagus endoscopic treatment is effective to eradicate both metaplasia and dysplasia. However, the available evidence does not suffice to recommend follow-up discontinuation, and monitoring should involve careful examinations in order to provide an early diagnosis of recurrence.

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