Ordine dei Medici Chirurghi e degli Odontoiatri della provincia di Belluno

FNOMCeO
Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri

REGIONE DEL VENETO
ULSS 1 DOLOMITI

GASTROENTEROLOGIA BELLUNO

LA SORVEGLIANZA DELLE CONDIZIONI E DELLE LESIONI PRECANCEROSE IN GASTROENTEROLOGIA

Esofago di Barrett

Dr.ssa Nunzia Russo
U.O. Gastroenterologia Belluno

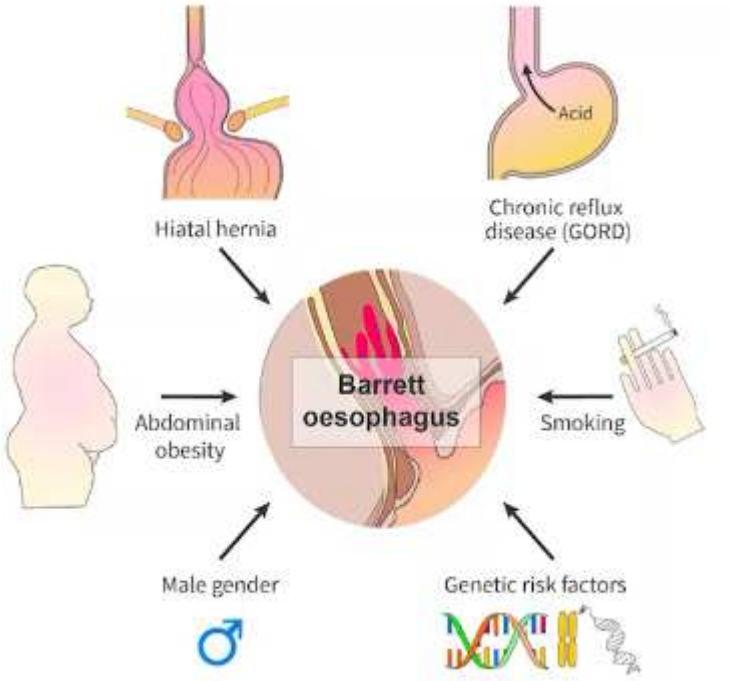
Esofago di Barrett

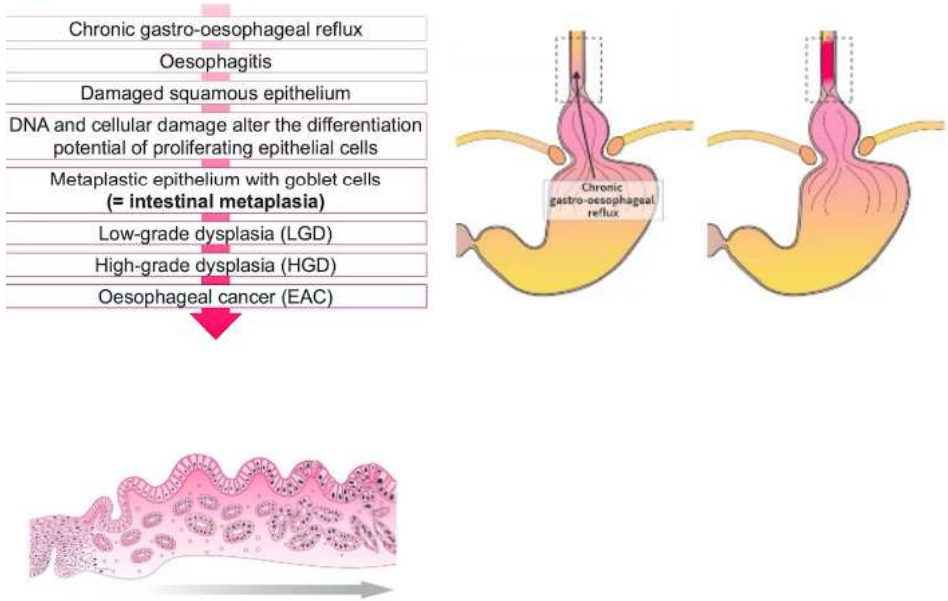
Presenza a livello dell'esofago distale di epitelio colonnare esteso per almeno 10 mm e con presenza di metaplasia intestinale all'esame istologico

Prevalenza 1-2% nella popolazione generale,
fino a 8-13% nei paziente con MRGE

Ronkainen J, Prevalence of Barrett's esophagus in the general population: an endoscopic study. Gastroenterology.2005

Fattori di rischio per lo sviluppo di Esofago di Barrett



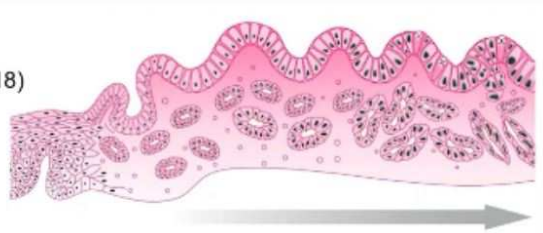


Barrett's esophagus. The New England journal of medicine. 2014

L’esofago di Barrett è una condizione che predispone allo sviluppo di adenocarcinoma

Basso rischio di progressione da displasia (HGD) ad adenocarcinoma (EAC): 0,3% - 0,8% per anno

- Risk factors for malignant progression[8,10]
  - Confirmed LGD (HR 2.42)
  - Longer Barrett segment in cm (HR ± 1.18)
  - Older age at first endoscopy (HR ± 1.06)
  - Male gender
  - Smoking



ProBar-Study Group. Impact of surveillance for Barrett's oesophagus on tumour stage and survival of patients with neoplastic progression. Gut. 2016

Factors Associated With Progression of Barrett’s Esophagus: A Systematic Review and Meta-analysis. Clinical Gastroenterology and Hepatology. 2018

Guideline

Thieme

Diagnosis and management of Barrett esophagus: European Society of Gastrointestinal Endoscopy (ESGE) Guideline

Authors

Bas L. A. M. Weusten[1,2], Raf Bisschops[3], Mario Dinis-Ribeiro[4], Massimiliano di Pietro[5], Oliver Pech[6], Manon C. W. Spaander[7], Francisco Baldaque-Silva[8,9], Maximilien Barret[10], Emmanuel Coron[11,12], Glòria Fernández-Esparrach[13], Rebecca C. Fitzgerald[5], Marnix Jansen[14], Manol Jovani[15], Ines Marques-de-Sa[4], Arti Rattan[16], W. Keith Tan[5], Eva P. D. Verheij[17], Pauline A. Zellenrath[7], Konstantinos Triantafyllou[18], Roos E. Pouw[17]

A chi consigliare uno screening?

RECOMMENDATION 2

a ESGE recommends against screening for BE in an unselected population.
Strong recommendation, low quality of evidence.

b ESGE suggests that case finding for BE could be considered in a select population, consisting of patients ≥ 50 years of age with a history of chronic GERD symptoms, and at least one of the following risk factors (white ethnicity, male sex, obesity, smoking, having a first-degree relative with BE or EAC).
Weak recommendation, low quality of evidence.

Prevalenza BE:
- 23% pazienti con familiarità
- 6,8% sesso maschile
- 6,1% età > 50 anni
- 2,3% sintomi cronici da reflusso
- 12,2% MRGE + altro fattore rischio
- 1,9 % obesità

Qumseya BJ, Systematic review and meta-analysis of prevalence and risk factors for Barrett's esophagus. Gastrointest Endosc. 2019

Screening e sorveglianza endoscopica

Esame di Qualità

- endoscopi ad alta definizione

- cromoendoscopia virtuale e/o con acido acetico

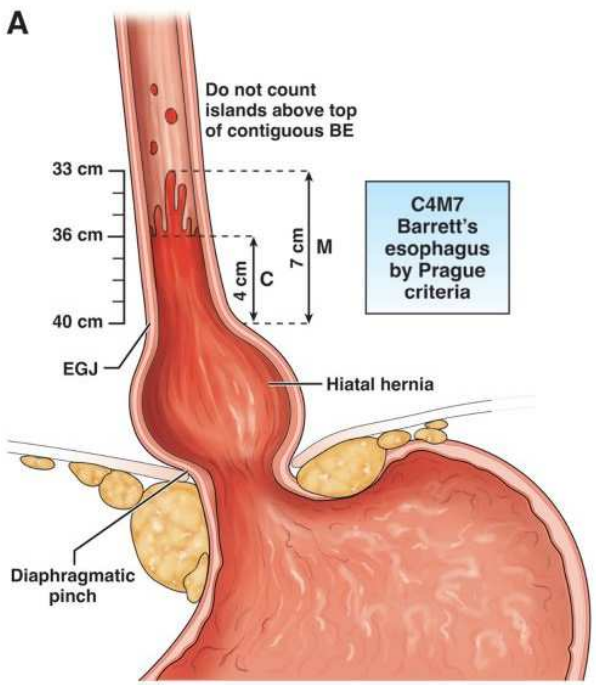
- tempo adeguato di ispezione (almeno un 1min. per ogni cm di BE) e retroversione

- documentazione fotografica

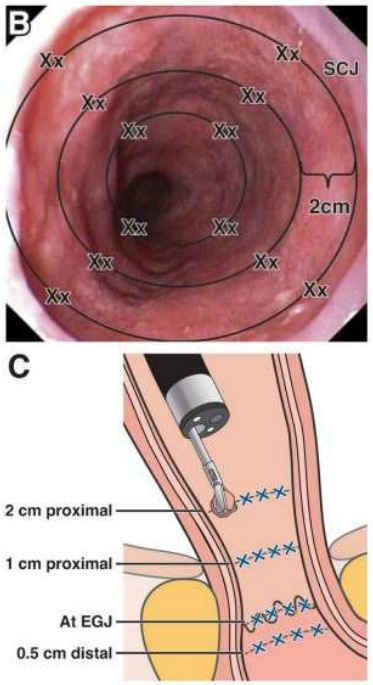
- utilizzo della Classificazione di Praga

- utilizzo della classificazione di Parigi se presenti lesioni visibili

- biopsie secondo Protocollo di Seattle e su lesioni visibili



Classificazione di Praga



Protocollo di Seattle

Diagnosis and management of Barrett esophagus: European Society of Gastrointestinal Endoscopy (ESGE) Guideline. Endoscopy. 2023
AGA Clinical Practice Update on New Technology and Innovation for Surveillance and Screening in Barrett's Esophagus. 2022

ORIGINAL ARTICLE – CLINICAL ONCOLOGY

Do proton pump inhibitors prevent Barrett's esophagus progression to high-grade dysplasia and esophageal adenocarcinoma? An updated meta-analysis

Yue Chen[1] · Chenyu Sun[2] · Yile Wu[3] · Xin Chen[3] · Sujatha Kailas[4] · Zeid Karadsheh[4] · Guangyuan Li[5] · Zhichun Guo[6] · Hongru Yang[6] · Lei Hu[1] · Qin Zhou[7]

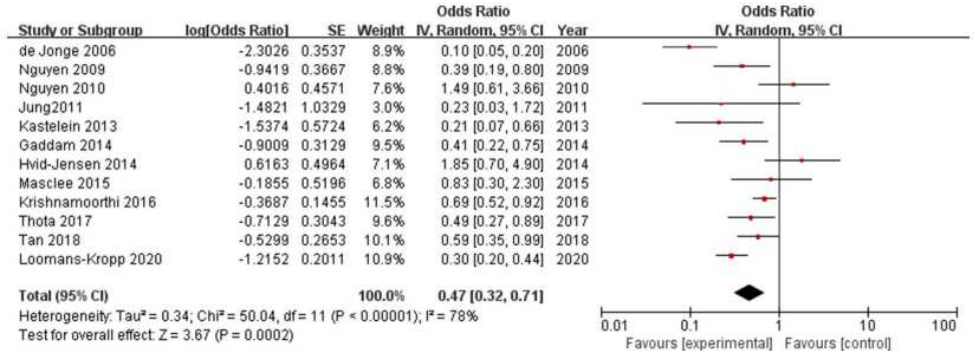


Fig. 2 Forrest plot: Association between proton pump inhibitor (PPI) use and the risk of progression to high-grade dysplasia (HGD)/esophageal adenocarcinoma

20 studi
155,769 pazienti

PPI riducono il rischio di progressione/anno di BE a HGD/EAC

Terapia medica

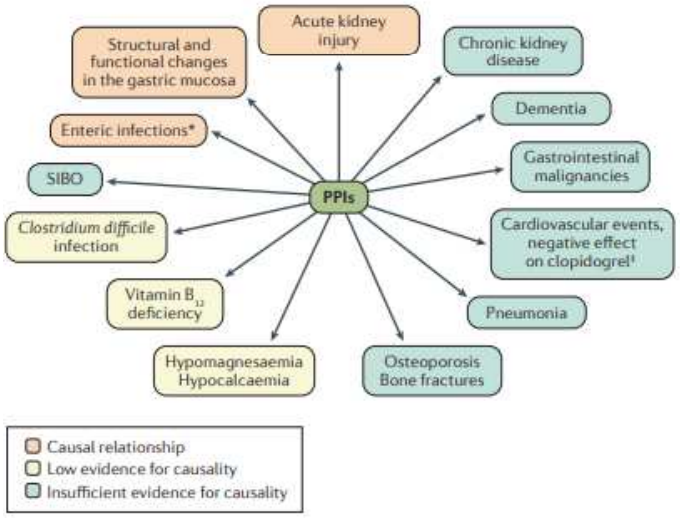
RECOMMENDATION 1

a ESGE suggests a proton pump inhibitor (standard dose* once daily) for chemoprevention in patients with BE.

Weak recommendation, moderate quality of evidence.

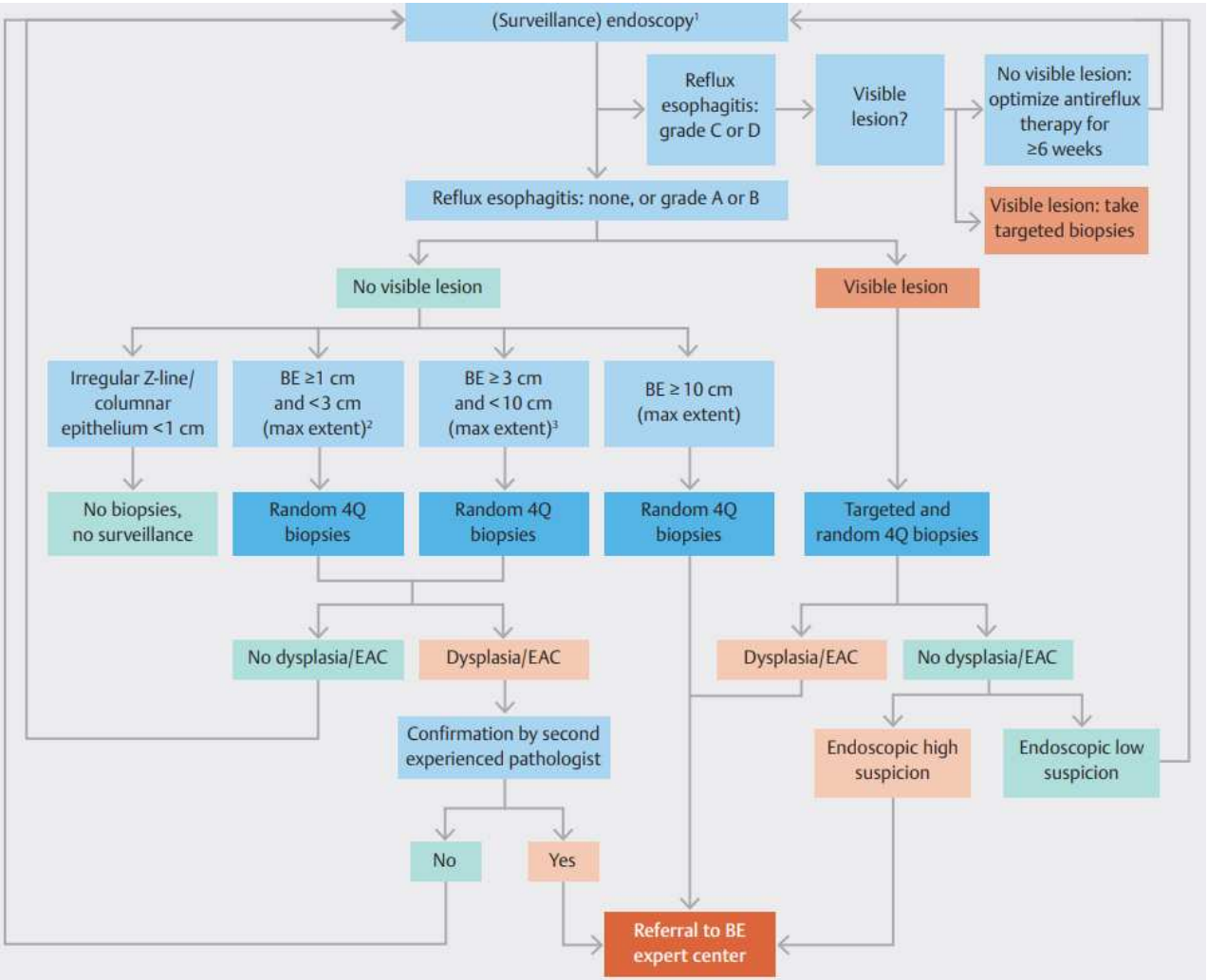
* Standard PPI dose for the indication "severe esophagitis" is omeprazole 40 mg or its dose equivalent (pantoprazole 40 mg, esomeprazole 40 mg, rabeprazole 20 mg, or lansoprazole 30 mg) [14].

Sicurezza dei PPI?



Malfertheiner P. Proton-pump inhibitors: understanding the complications and risks. Nat Rev Gastroenterol Hepatol. 2017

Sorveglianza



► **Fig. 1** Flowchart of the recommended surveillance for patients with Barret esophagus (BE).
4Q, four quadrant; EAC, esophageal adenocarcinoma.
[1] Consider stopping surveillance if a patient has reached the age of 75 at the time of the last surveillance endoscopy.
[2] Surveillance interval 5 years.
[3] Surveillance interval 3 years.

L'intervallo di sorveglianza viene stratificato in relazione alla lunghezza del Barrett e la presenza o meno di displasia

Sorveglianza

Indefinito per displasia	Conferma da patologo esperto →	Ottimizzazione della terapia antireflusso e rivalutazione a 6 mesi. Se la rivalutazione negativa per displasia o nuovamente “indefinito per displasia”, prosegue follow-up per Barrett non displastico
Displasia di basso grado	Conferma da patologo esperto →	In assenza di lesioni visibili, sorveglianza a 6 mesi: - se non confermata, dilazionare l’intervallo di sorveglianza a 1 anno. Dopo due reperti consecutivi negativi, seguire follow-up per Barrett non displastico - se confermata: ablazione endoscopica

Trattamento endoscopico

RECOMMENDATION 11
ESGE recommends offering endoscopic eradication therapy using ablation to patients with BE and low grade dysplasia (LGD), on at least two separate endoscopies, both confirmed by a second experienced pathologist.
Strong recommendation, high level of evidence.

RECOMMENDATION 12
ESGE recommends endoscopic ablation treatment for BE with confirmed HGD without visible lesions, to prevent progression to invasive cancer.
Strong recommendation, high level of evidence.

9,2% - 13,4% rischio di progressione per anno
da LGD a HGD/EAC

Low-grade dysplasia | High-grade dysplasia | Carcinoma

Qumseya BJ, et al. Disease Progression in Barrett's Low-Grade Dysplasia With Radiofrequency Ablation Compared With Surveillance: Systematic Review and Meta-Analysis. Am J Gastroenterol. 2017
Curvers WL et al. Low-grade dysplasia in Barrett's esophagus: overdiagnosed and underestimated. Am J Gastroenterol.

Radiofrequenza

Metodica ampiamente diffusa

Buon profilo di sicurezza (sanguinamento 2%; stenosi 0-15%; perforazione 0,2%)

Riduzione del rischio di progressione di LGD a HGD/EAC

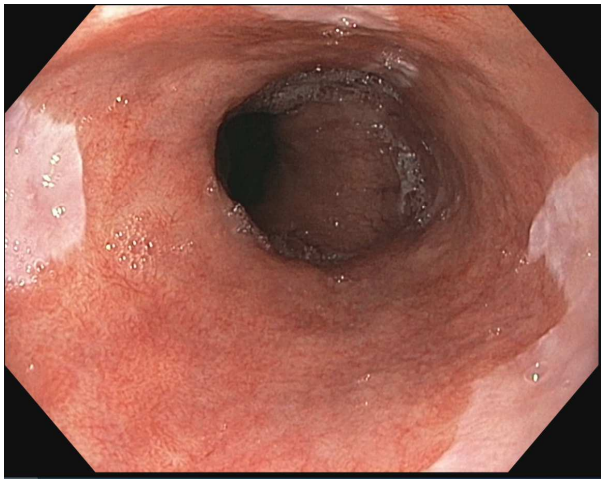
Completa eradicazione di:
- metaplasia intestinale: 54-100%
- displasia: 80-100%

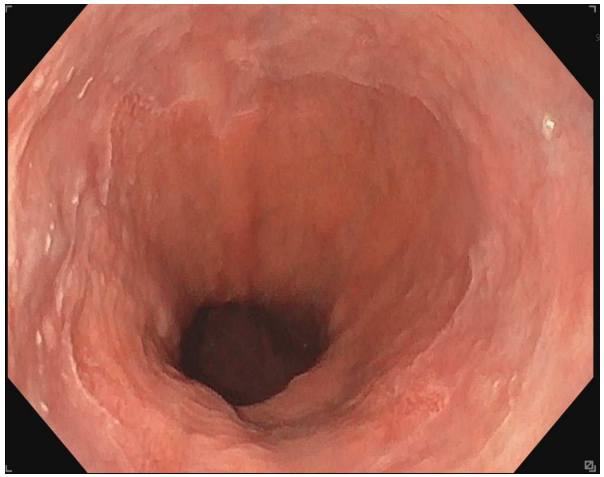
Completa eradicazione a lungo termine di
- metaplasia fino a 91%
- displasia fino a 96%

Pouw RE et al. Radiofrequency ablation for low-grade dysplasia in Barrett's esophagus: long-term outcome of a randomized trial. Gastrointest Endosc. 2020

Nieuwenhuis EA, et al. Radiofrequency Ablation of Barrett's Epithelium. Gastroint. and Pancreatico-Biliary Diseases: Advanced Diagnostic and Therapeutic Endoscopy.2022

Trattamento con RFA



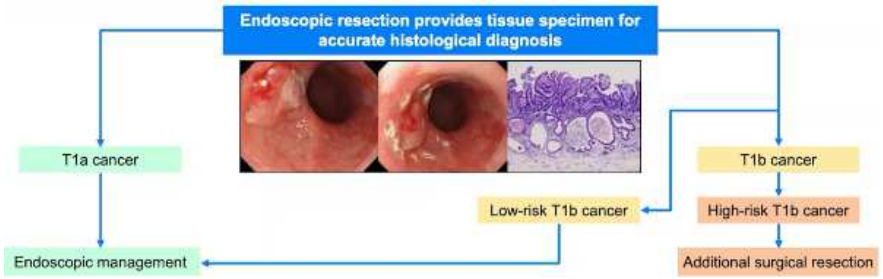


Se lesioni visibili?

RECOMMENDATION 14

a ESGE recommends the use of endoscopic mucosal resection (EMR) for ≤20-mm visible lesions with low probability of submucosal invasion (Paris type 0-IIa, 0-IIb) and for larger or multifocal benign (dysplastic) lesions.
Strong recommendation, high quality evidence.

b ESGE suggests the use of endoscopic submucosal dissection (ESD) for lesions suspicious for submucosal invasion (Paris type 0-Is, 0-IIc), for malignant lesions of >20 mm, and for lesions in scarred/fibrotic areas.
Weak recommendation, low quality of evidence.



Dopo l'asportazione di lesioni visibili?

Tasso di ricorrenza o lesioni metacrone con HGD e/o EAC fino al 20-35% dopo resezione endoscopica

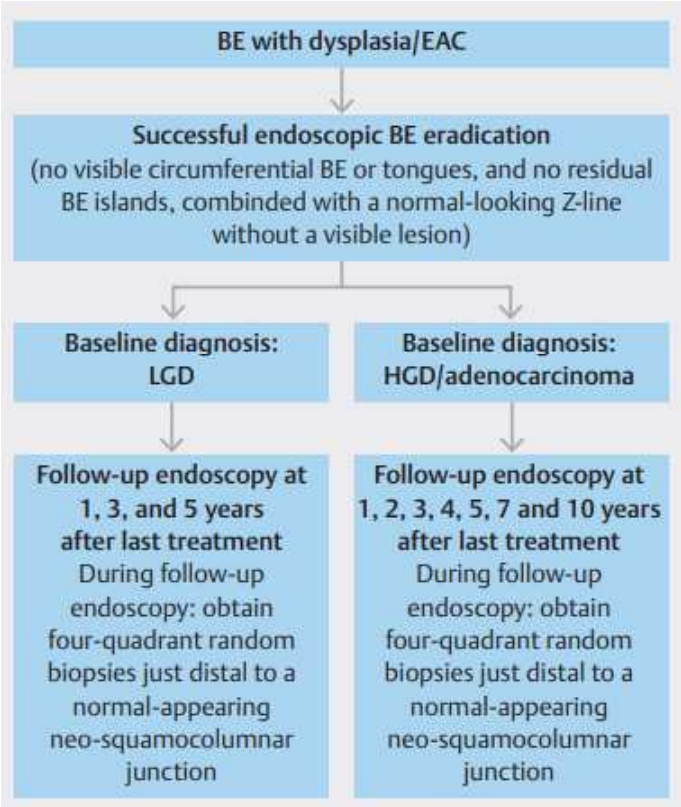
RECOMMENDATION 13

ESGE recommends offering complete eradication of all remaining Barrett epithelium by ablation after endoscopic resection of visible abnormalities containing any degree of dysplasia or EAC.
Strong recommendation, moderate quality of evidence.

Endoscopic submucosal dissection for superficial gastrointestinal lesions: European Society of Gastrointestinal Endoscopy (ESGE). Endoscopy. 2022

Phoa KN, et al. Multimodality endoscopic eradication for neoplastic Barrett oesophagus: results of an European multicentre study (EURO-II). Gut. 2016

Sorveglianza dopo trattamento



Non interrompere la terapia con inibitore della pompa protonica

RECOMMENDATION 19

ESGE recommends adequate acid suppression treatment during and after endoscopic eradication therapy of BE. Strong recommendation, very low quality of evidence.

Quando interrompere la sorveglianza?

RECOMMENDATION 10

ESGE suggests that, if a patient has reached 75 years of age at the time of the last surveillance endoscopy and/or the patient's life expectancy is less than 5 years, the discontinuation of further surveillance endoscopies can be considered.

Weak recommendation, very low quality of evidence.

Cut-off arbitrario di 75 anni in relazione all'aspettativa media di vita
In alcuni casi selezionati si potrebbe decidere di estendere il follow-up fino a 80 anni

Quando interrompere la sorveglianza?

Ragionevole interrompere la sorveglianza in pazienti non più ‘fit’ a sottoporsi a controlli endoscopici o eventuali trattamenti

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Acalasia
Ingestione caustici
Altre condizioni che non richiedono sorveglianza

Dr.ssa Nunzia Russo
U.O. Gastroenterologia Belluno

Condizioni esofagee che richiedono sorveglianza

Acalasia

Ingestione di caustici

Esofagite grado C e D
sec. Los Angeles

Acalasia

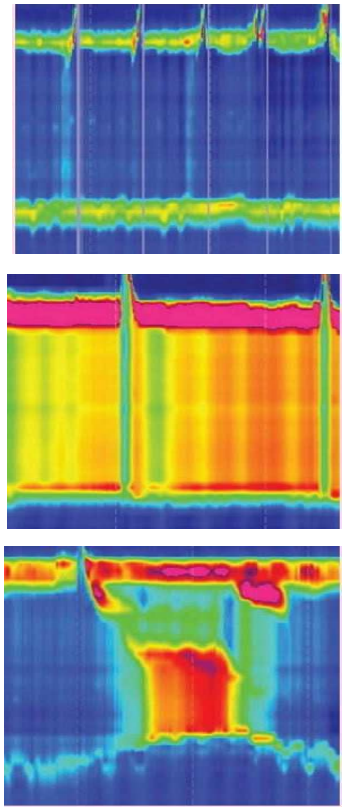
Disordine motorio primitivo dell'esofago caratterizzato da ipertono dello sfintere esofageo inferiore e assenza di peristalsi del corpo esofageo

Eziopatogenesi non nota

Incidenza: 1.07-2.2 per 100,000
Prevalenza: 10-15.7 per 100,000

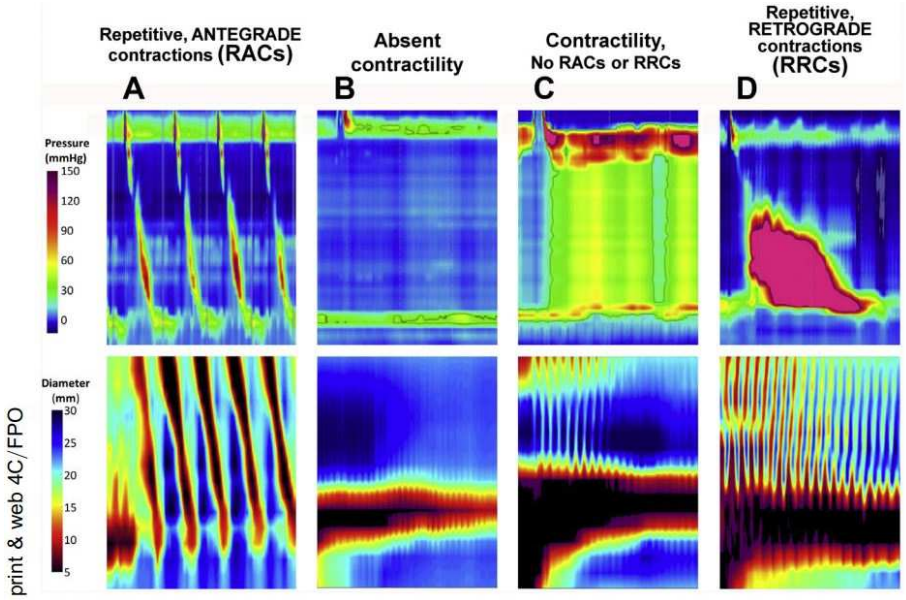
Sintomi: disfagia, calo ponderale, pirosi

Lo sviluppo di neoplasia esofagea (carcinoma a cellule squamose, adenocarinoma) rimane una complicanza a lungo termine



Oude Nijhuis Rab et al. European guidelines on achalasia: United European Gastroenterology and European Society of Neurogastroenterology and Motility recommendations. United European Gastroenterol J. 2020

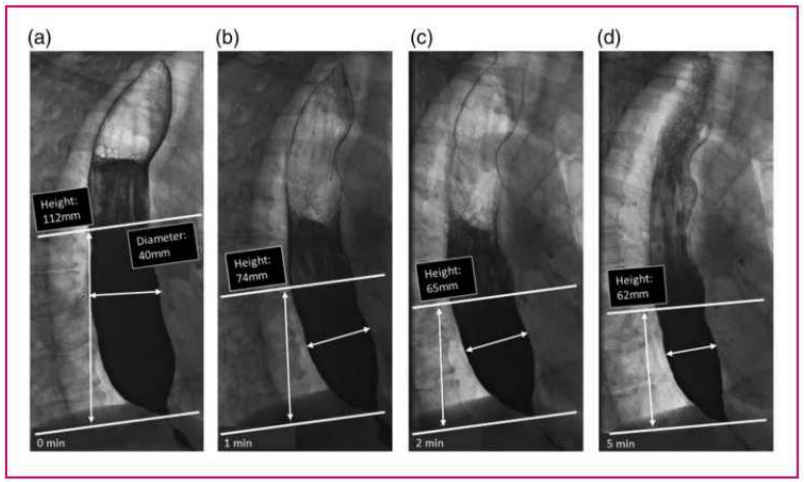
Diagnosi



Manometria Esofagea HR

Endo FLIP

RX Esofagogramma

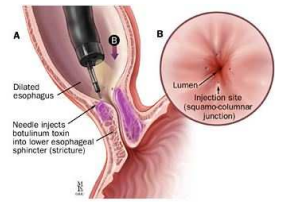


Donnan EN. EndoFLIP in the Esophagus: Assessing Sphincter Function, Wall Stiffness, and Motility to Guide Treatment. Gastroenterol Clin North Am. 2020

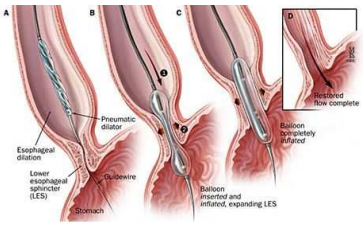
Oude Nijhuis. European guidelines on achalasia: United European Gastroenterology and European Society of Neurogastroenterology and Motility recommendations. United Europan Gastroenterol J. 2020

Trattamento

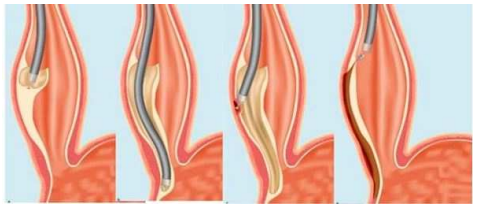
- Iniezione di tossina botulinica



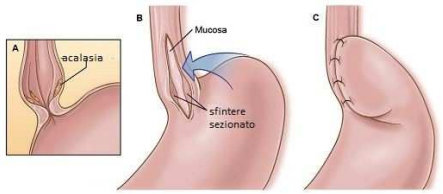
- Dilatazione pneumatica



- Miotomia Perorale Endoscopica (POEM)



- Miotomia chirurgica sec. Heller con plastica antireflusso



European guidelines on achalasia: United European Gastroenterology and European Society of Neurogastroenterology and Motility recommendations. United European Gastroenterol J. 2020

Fattori correlati all'aumentato rischio di sviluppo di neoplasia dell'esofago

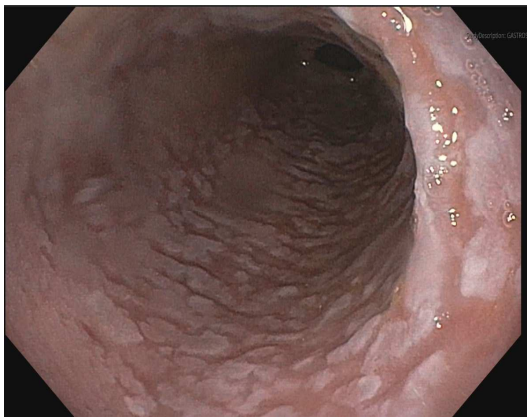
- inadeguata clearance

- sovracrescita batterica

- irritazione chimica

- infiammazione cronica, che può favorire modificazioni displastiche delle cellule epiteliali

- aumentata eposizione all'acido nei pazienti trattati può favorire lo sviluppo di esofago di Barrett



Pajecki et al. Larger amounts of nitrite and nitrate reducing bacteria in megaesophagus of Chagas' disease than in controls. J Gastrointest Surg 2007

European guidelines on achalasia: United European Gastroenterology and European Society of Neurogastroenterology and Motility recommendations. United European Gastroenterol J. 2020

Rischio di sviluppare neoplasia esofagea?

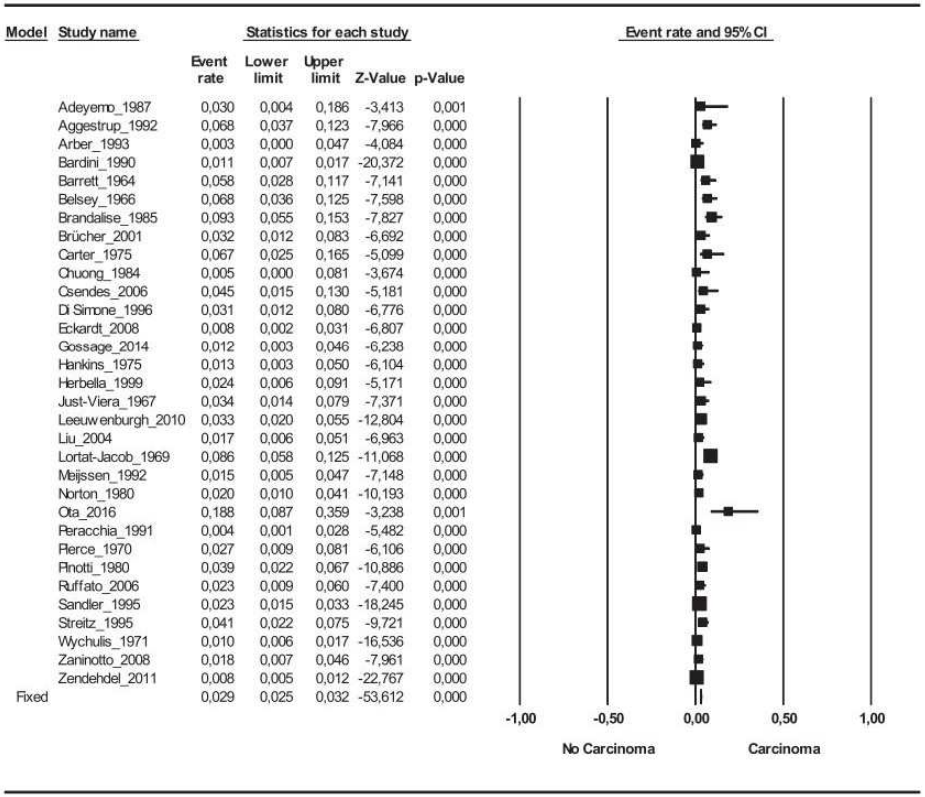


Fig. 2 The prevalence of esophageal carcinoma in esophageal achalasia patients (number of carcinoma cases among achalasia patients) ($n = 11,899$).

42 studi

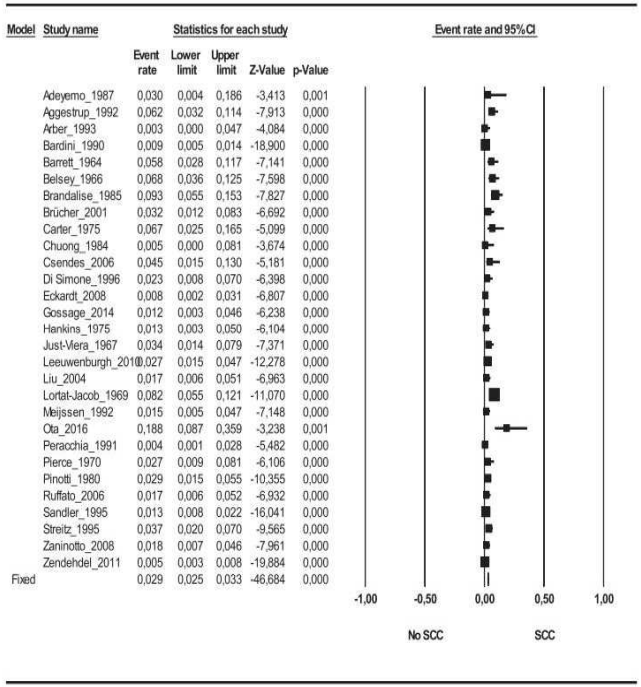
11,978 pz.

follow-up 3,3-23,2 anni

28 carcinoma
cases per 1,000 achalasia patients on random effect model (CI 95% 2, 39; n = 11,899) and
29 on fixed effect model (CI 95% 25, 32; n = 11,899)

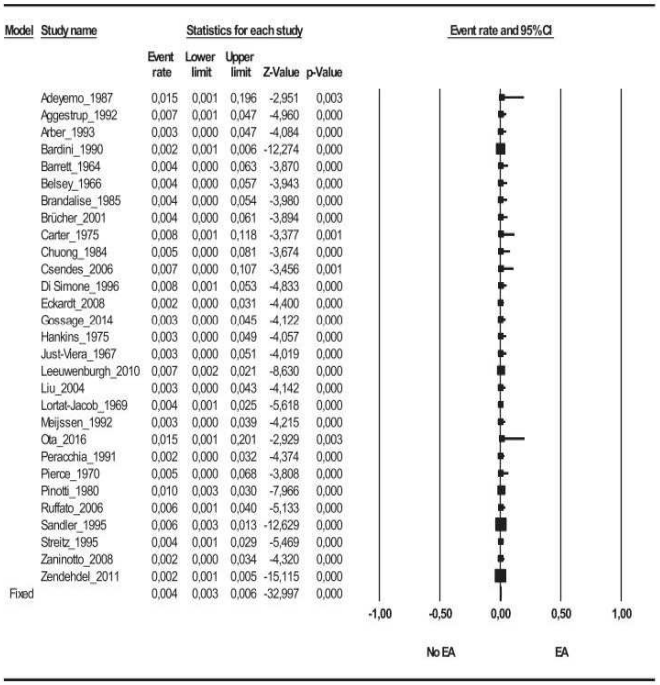
Tustumi F, et al.. Esophageal achalasia: a risk factor for carcinoma. A systematic review and meta-analysis. Dis Esophagus. 2017

Rischio di sviluppare neoplasia esofagea?



Model	Study name	Event rate	Lower limit	Upper limit	Z-Value	p-Value
	Adeyemo_1987	0,030	0,004	0,186	-3,413	0,001
	Aggestrup_1992	0,062	0,032	0,114	-7,913	0,000
	Arber_1993	0,003	0,000	0,047	-4,084	0,000
	Bardini_1990	0,009	0,005	0,014	-18,900	0,000
	Barrett_1964	0,058	0,028	0,117	-7,141	0,000
	Belsey_1966	0,068	0,036	0,125	-7,598	0,000
	Brandalise_1985	0,093	0,055	0,153	-7,827	0,000
	Brücher_2001	0,032	0,012	0,083	-6,692	0,000
	Carter_1975	0,067	0,025	0,165	-5,099	0,000
	Chuong_1984	0,005	0,000	0,081	-3,674	0,000
	Csendes_2006	0,045	0,015	0,130	-5,181	0,000
	Di Simone_1996	0,023	0,008	0,070	-6,398	0,000
	Eckardt_2008	0,008	0,002	0,031	-6,807	0,000
	Gossage_2014	0,012	0,003	0,046	-6,238	0,000
	Hankins_1975	0,013	0,003	0,050	-6,104	0,000
	Just-Viera_1967	0,034	0,014	0,079	-7,371	0,000
	Leeuwenburgh_2010	0,027	0,015	0,047	-12,278	0,000
	Liu_2004	0,017	0,006	0,051	-6,963	0,000
	Lortat-Jacob_1969	0,082	0,055	0,121	-11,070	0,000
	Meijssen_1992	0,015	0,005	0,047	-7,148	0,000
	Ota_2016	0,188	0,087	0,359	-3,238	0,001
	Peracchia_1991	0,004	0,001	0,028	-5,482	0,000
	Pierce_1970	0,027	0,009	0,081	-6,106	0,000
	Pinotti_1980	0,029	0,015	0,055	-10,355	0,000
	Ruffato_2006	0,017	0,006	0,052	-6,932	0,000
	Sandler_1995	0,013	0,008	0,022	-16,041	0,000
	Streitz_1995	0,037	0,020	0,070	-9,565	0,000
	Zaninotto_2008	0,018	0,007	0,046	-7,961	0,000
	Zendehdel_2011	0,005	0,003	0,008	-19,884	0,000
Fixed		0,029	0,025	0,033	-46,684	0,000

Fig. 3 The in prevalence of SCC (squamous cell carcinoma) in esophageal achalasia patients (number of SCC cases among achalasia patients) ($n = 10,148$).



Model	Study name	Event rate	Lower limit	Upper limit	Z-Value	p-Value
	Adeyemo_1987	0,015	0,001	0,196	-2,951	0,003
	Aggestrup_1992	0,007	0,001	0,047	-4,960	0,000
	Arber_1993	0,003	0,000	0,047	-4,084	0,000
	Bardini_1990	0,002	0,001	0,006	-12,274	0,000
	Barrett_1964	0,004	0,000	0,063	-3,870	0,000
	Belsey_1966	0,004	0,000	0,057	-3,943	0,000
	Brandalise_1985	0,004	0,000	0,054	-3,980	0,000
	Brücher_2001	0,004	0,000	0,061	-3,894	0,000
	Carter_1975	0,008	0,001	0,118	-3,377	0,001
	Chuong_1984	0,005	0,000	0,081	-3,674	0,000
	Csendes_2006	0,007	0,000	0,107	-3,456	0,001
	Di Simone_1996	0,008	0,001	0,053	-4,833	0,000
	Eckardt_2008	0,002	0,000	0,031	-4,400	0,000
	Gossage_2014	0,003	0,000	0,045	-4,122	0,000
	Hankins_1975	0,003	0,000	0,049	-4,057	0,000
	Just-Viera_1967	0,003	0,000	0,051	-4,019	0,000
	Leeuwenburgh_2010	0,007	0,002	0,021	-8,630	0,000
	Liu_2004	0,003	0,000	0,043	-4,142	0,000
	Lortat-Jacob_1969	0,004	0,001	0,025	-5,618	0,000
	Meijssen_1992	0,003	0,000	0,039	-4,215	0,000
	Ota_2016	0,015	0,001	0,201	-2,929	0,003
	Peracchia_1991	0,002	0,000	0,032	-4,374	0,000
	Pierce_1970	0,005	0,000	0,068	-3,808	0,000
	Pinotti_1980	0,010	0,003	0,030	-7,966	0,000
	Ruffato_2006	0,006	0,001	0,040	-5,133	0,000
	Sandler_1995	0,006	0,003	0,013	-12,629	0,000
	Streitz_1995	0,004	0,001	0,029	-5,469	0,000
	Zaninotto_2008	0,002	0,000	0,034	-4,320	0,000
	Zendehdel_2011	0,002	0,001	0,005	-15,115	0,000
Fixed		0,004	0,003	0,006	-32,997	0,000

Fig. 4 The prevalence of esophageal adenocarcinoma (EA) in achalasia patients (number of EA among achalasia patients) ($n = 10,158$).

Tustumi F, et al. Esophageal achalasia: a risk factor for carcinoma. A systematic review and meta-analysis. Dis Esophagus. 2017

Acalasia

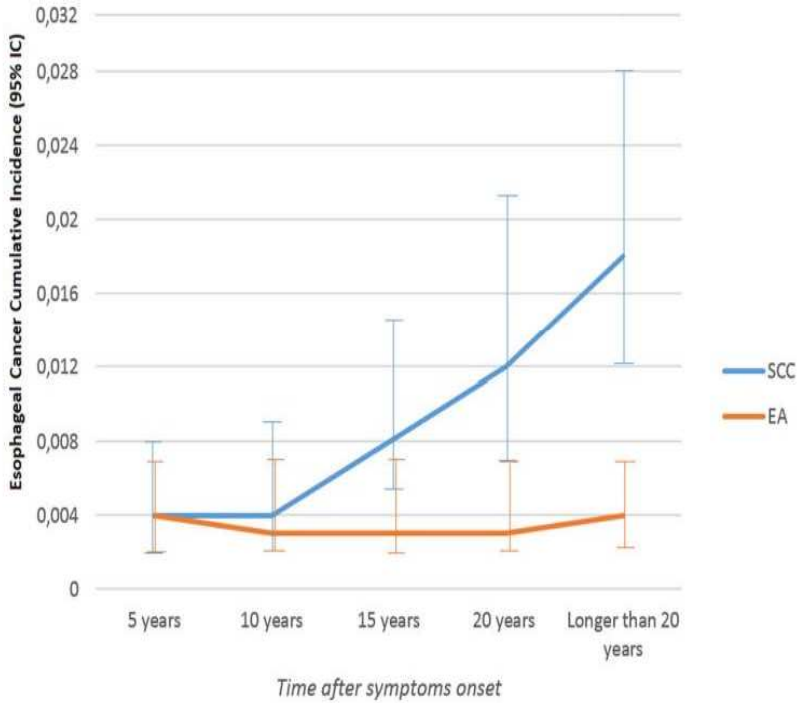


Fig. 5 Esophageal cancer cumulative incidence (carcinoma cases over achalasia patients): 95% confidence interval by time after achalasia symptoms onset. The prevalence of squamous cell carcinoma (SCC) and esophageal adenocarcinoma (EA) increase over the time in curves with different slopes.

Dopo trattamento?

Valutare se presente MRGE

- 10-31% dopo dilatazione pneumatica

- 5-35% dopo miotomia secondo Heller con plastica antireflusso

- 60% nei pazienti sottoposti a POEM

Recommendation 3.3

a. We suggest follow-up endoscopy to screen for GORD in patients treated with myotomy without anti-reflux procedure.

b. In case of reflux symptoms in absence of reflux oesophagitis, TBE, empiric PPI therapy, and/or 24-h oesophageal pH-(impedance)monitoring can be considered.

c. Proton pump inhibitors are the first line treatment of GORD after achalasia treatment. We recommend lifelong PPI therapy in patients with oesophagitis > grade A (LA classification).

Oude Nijhuis RAB, et al. European guidelines on achalasia: United European Gastroenterology and European Society of Neurogastroenterology and Motility recommendations. United European Gastroenterol J. 2020

Follow-up?

L’esatto livello di rischio resta ad oggi molto controverso

Mancano dati che dimostrino una efficacia della sorveglianza endoscopica
(400 EGDS per diagnosticare una neoplaia)

Sandler RS, et al. The risk of esophageal cancer in patients with achalasia. Apopulation-based study.

1. Approximately how many patients with a diagnosis of achalasia are seen in your practice?
   a) 0 patients
   b) 1 to 10 patients
   c) 10 to 20 patients
   d) 20 to 50 patients
   e) More than 50 patients

2. Once a diagnosis of achalasia is established, provided the patient is relatively young and has no significant comorbidities, which therapeutic treatment option do you typically first perform?
   a) Endoscopic dilation utilizing a 18 to 20 mm TTS balloon
   b) Endoscopic dilation utilizing a 18 to 20 mm Savary dilator
   c) Endoscopic Botox injection to the distal esophagus
   d) Pneumatic dilation with a 30 mmHg Rigiflex balloon
   e) Pneumatic dilation with a 35 mmHg Rigiflex balloon
   f) Pneumatic dilation with a 40 mmHg Rigiflex balloon
   g) Refer to a thoracic surgeon for Heller myotomy with partial fundoplication
   h) Refer for peroral endoscopic myotomy

3. How often do you recommend patients with achalasia be seen by a gastroenterologist following treatment?
   a) Only as needed, I do not recommend routine follow up
   b) Roughly every 3 months
   c) Every 6 months
   d) Annually
   e) Every 2 years
   f) Every 5 years

4. Do you routinely screen for esophageal cancer in patients with achalasia?
   a) Yes
   b) No

If answering No to question 4, please skip to question 10

5. Which patients require screening for esophageal cancer?
   a) Type 1 achalasia
   b) Type 2 achalasia
   c) Type 3 achalasia
   d) Type 1 or 2 achalasia
   e) Type 1 or 3 achalasia
   f) Type 2 or 3 achalasia
   g) Type 1, 2, or 3 achalasia
   h) I do not use the Chicago classification of achalasia to determine the need for screening

6. Which patients require screening for esophageal cancer?
   a) Those with an esophageal diameter >3 cm
   b) Those with an esophageal diameter >4 cm
   c) Those with an esophageal diameter >5 cm
   d) Those with an esophageal diameter >6 cm
   e) I do not use esophageal diameter to determine the need for screening

7. How long after onset of symptoms should screening for esophageal cancer begin?
   a) At the time of diagnosis
   b) 1 year after symptom onset
   c) 5 years after symptom onset
   d) 10 years after symptom onset
   e) 15 years after symptom onset
   f) 20 years after symptom onset

8. Once initiated, how often should screening be performed?
   a) Annually
   b) Every 2 years
   c) Every 3 years
   d) Every 5 years
   e) Every 10 years

9. What modalities do you utilize for screening?
   a) EGD
   b) Esophagram
   c) CT scan
   d) EGD with esophagram
   e) EGD with CT scan
   f) Esophagram with CT scan
   g) EGD with esophagram and CT scan

10. When counselling patients with achalasia, what do you tell them the risk of cancer is?
    a) The same as the general population
    b) 0.1 to 0.5% over their lifetime
    c) 0.5% to 1% over their lifetime
    d) 1 to 2% over their lifetime

Fig. 1 Study survey. CT, computed tomography; EGD, esophagogastroduodenoscopy.

Diseases of the Esophagus (2015) **28**, 299–304
DOI: 10.1111/dote.12196

DISEASES OF THE ESOPHAGUS

Original article

Esophageal cancer screening in achalasia: is there a consensus?

K. Ravi, D. M. Geno, D. A. Katzka

Division of Gastroenterology and Hepatology, Mayo Clinic College of Medicine, Rochester, Minnesota, USA

Table 2 Esophageal cancer screening practice in achalasia

Expert	Region	Screening	Chicago classification considered	Esophageal diameter considered	Screening initiation after diagnosis	Screening interval	Screening modality	Lifetime risk of cancer (%)
1	Europe/Australia	Yes	No	No	5 years	3 years	EGD	0.1–0.5
2	Europe/Australia	Yes	No	No	1 year	3 years	EGD	0.5–1
3	United States	No	N/A	N/A	N/A	N/A	N/A	0.1–0.5
4	Asia	Yes	No	No response	5 years	5 years	EGD	Not increased
5	United States	Yes	No	No	No response	2 years	EGD	3–5
6	Europe/Australia	No	N/A	N/A	N/A	N/A	N/A	Not increased
7	United States	No	N/A	N/A	N/A	N/A	N/A	Not increased
8	Europe/Australia	Yes	No	No	10 years	2 years	EGD/esophagram	0.1–0.5
9	Europe/Australia	No	N/A	N/A	N/A	N/A	N/A	1–2
10	United States	Yes	No	No	5 years		EGD	0.1–0.5
11	Europe/Australia	Yes	No	No	10 years	3 years	EGD	0.5–1
12	Asia	Yes	No	No	At diagnosis	2 years	EGD	0.1–0.5
13	Europe/Australia	No	N/A	N/A	N/A	N/A	N/A	0.1–0.5
14	United States	Yes	No	Yes	10 years	2 years	EGD	0.1–0.5
15	United States	No	N/A	N/A	N/A	N/A	N/A	0.1–0.5
16	United States	No	N/A	N/A	N/A	N/A	N/A	1–2
17	Europe/Australia	No	N/A	N/A	N/A	N/A	N/A	0.5–1

EGD, esophagogastroduodenoscopy; N/A, not applicable.

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Am J Gastroenterol. 2020 September ; 115(9): 1393–1411. doi:10.14309/ajg.0000000000000731.

ACG Clinical Guidelines: Diagnosis and Management of Achalasia

Recommendation

21. We recommend against routine endoscopic surveillance for esophageal carcinoma in patients with achalasia.

UNITED EUROPEAN GASTROENTEROLOGY ueg journal

Review Article

United European Gastroenterology Journal
2020, Vol. 8(1) 13–34


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European Guideline on Achalasia – UEG and ESNM recommendations

RAB Oude Nijhuis[1], G Zaninotto[2], S Roman[3], GE Boeckxstaens[4], P Fockens[1], MW Langendam[5], AA Plumb[6], AJPM Smout[1], EM Targarona[7], AS Trukhmanov[8], BLAM Weusten[9] and AJ Bredenoord[1]

Recommendation 3.4

We suggest against performing systematic screening for dysplasia and carcinoma. However, the threshold of upper GI endoscopy should be low in patients with recurrent symptoms and longstanding achalasia.

Conditional recommendation, low certainty of evidence

Condizioni esofagee che richiedono sorveglianza

Acalasia

Ingestione di caustici

Esofagite grado C e D
sec. Los Angeles

Ingestione di caustici

EGDS fondamentale per avere informazioni relative al danno e prognosi

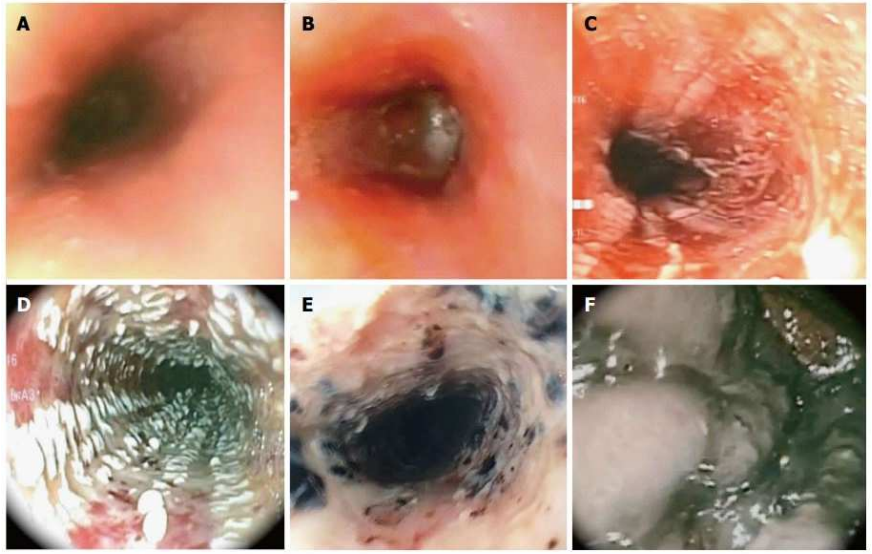


Figure 1 Endoscopic pictures of Zargar classification 0 to ⅢB. A: Zargar Grade 0: Normal mucosa; B: Zargar Grade Ⅰ: Edema and erythema of the mucosa; C: Zargar Grade ⅡA: Hemorrhage, erosions, blisters, superficial ulcers; D: Zargar Grade ⅡB: Circumferential bleeding, ulcers. Exudates; E: Zargar Grade ⅢB: Focal necrosis, deep gray or brownish black ulcers; F: Zargar Grade ⅢB: Extensive necrosis, deep gray or brownish black ulcers.

Due picchi di età:
- 80% dei casi tra 1-5 anni (ingestione accidentale)

- adolescenti e giovani adulti (scopo autolesivo)

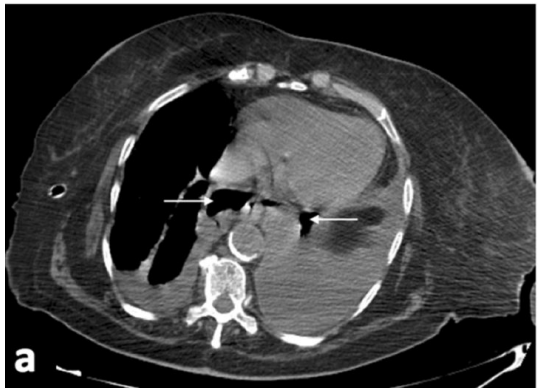
La severità del danno dipende da:
- pH della sostanza ingerita
- concentrazione
- tempo di esposizione della mucosa
- quantità ingerita

De Lusong MAA, et al. Management of esophageal caustic injury. World J Gastrointest Pharmacol Ther. 2017

Complicanze

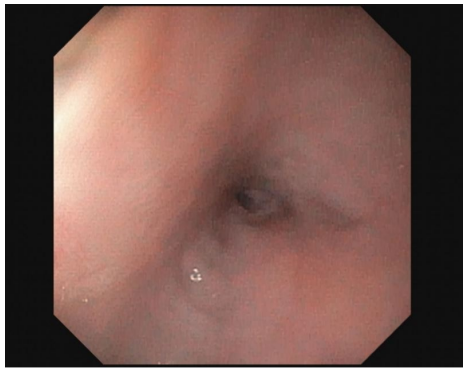
Immediate (acute/subacute):

- perforazione (tra la II° e III° settimana)
- sanguinamento
- fistole esofagee
- mediastinite/ascessi mediastinici
- decesso



Tardive:

- stenosi (dopo la V°-VI° settimana)
- ostacolato svuotamento gastrico
- carcinoma esofageo



De Lusong MAA, et al. Management of esophageal caustic injury. W J Gastrointest Ph.l Ther. 2017

Cutaia G et al. Caustic ingestion: CT findings of esophageal injuries and thoracic complications. Emerg Radiol. 2021

Carcinoma esofageo come complicanza tardiva nell'ingestione di caustici

- rischio 1.000-3.000 volte più elevato rispetto alla popolazione di età simile
- colpisce dal 2% - 30% dei pazienti
- più giovani rispetto a coloro che non hanno anamnesi di ingestione di caustici
- periodo di insorgenza variabile da 1 anno a diverse decadi
- insorge più frequentemente su tessuto fibrotico (scar carcinoma)
- fattori favorenti: danno chimico, infiammazione cronica, ripetute dilatazioni, danno chimico da stasi
- sembra correlato ad una prognosi migliore rispetto ad altre neoplasie esofagee

Contini S, Scarpignato C. Caustic injury of the upper gastrointestinal tract: a comprehensive review. W J Gastroenterol. 2013

Ruol A, et al. (2010) Caustic ingestion and oesophageal cancer: intra- and peri-tumoral fibrosis is associated with a better prognosis.

Follow-up?

Consigliata una EGDS ogni 2-3 anni di follow-up a partire da 20 anni dopo l'ingestione di caustici

Se sintomi? → EGDS

De Lusong MA et al. Management of esophageal caustic injury. W J Gastrointest Ther. 2017

Condizioni esofagee che non richiedono sorveglianza

Isole di ectopia gastrica in esofago (Inlet patch)

Esofagite grado A e B sec. Los Angeles

< 10 mm di mucosa colonnare

Papilloma esofageo

› Endoscopy. 2020 Jun;52(6):491-497. doi: 10.1055/a-1137-4721. Epub 2020 Apr 14.

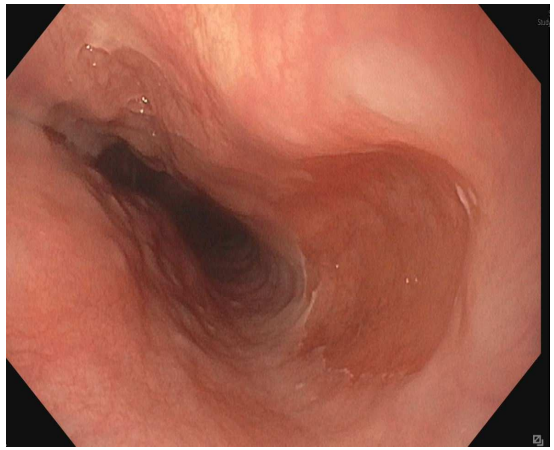
Position statement

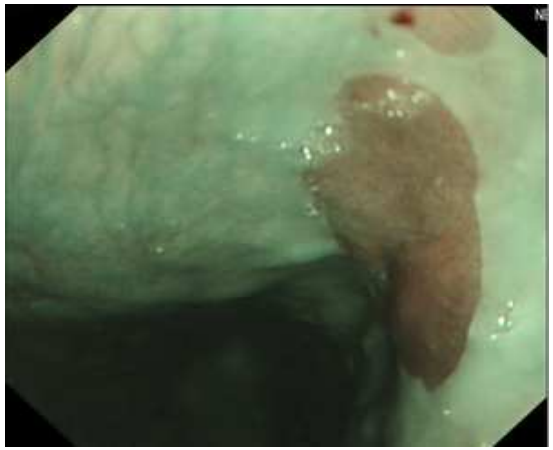
Thieme

Digestive findings that do not require endoscopic surveillance – Reducing the burden of care: European Society of Gastrointestinal Endoscopy (ESGE) Position Statement

Authors
Enrique Rodríguez-de-Santiago[*1], Leonardo Frazzoni[*2], Lorenzo Fuccio[2], Jeanin E van Hooft[3], Thierry Ponchon[4], Cesare Hassan[5], Mário Dinis-Ribeiro[6,7]

Mucosa gastrica ectopica in esofago





STATEMENT
ESGE recommends against routine endoscopic surveillance of inlet patches.

Presenza di isole di mucosa gastrica ectopica nell'esofago prossimale

Prevalenza: 0.1% - 12%

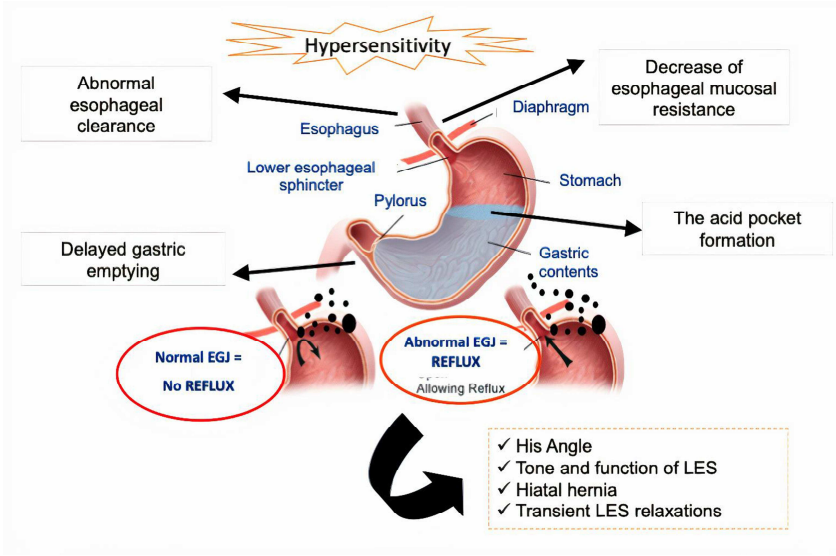
Progressione neoplastica estremamente rara

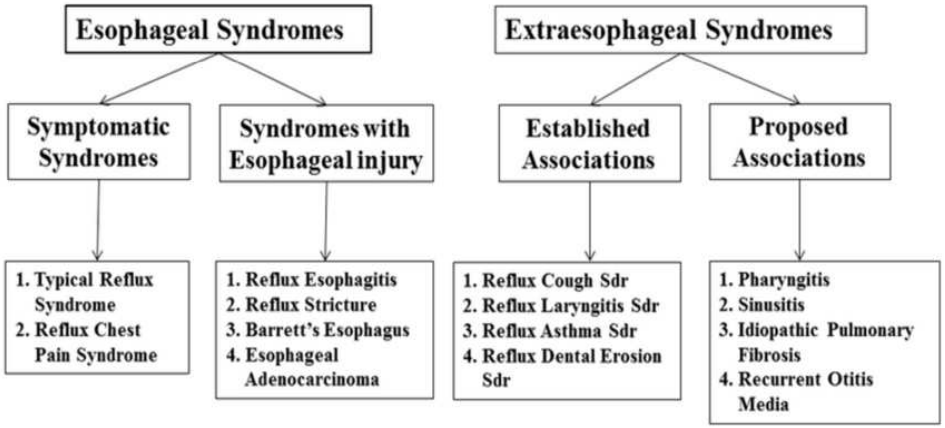
Non raccomandate biopsie di routine se non su aree di irregolarità della mucosa

Peitz U, et al. The prevalence of gastric heterotopia of the proximal esophagus is underestimated, but preneoplasia is rare– correlation with Barrett's esophagus. BMC Gastroenterol 2017

Esofagite erosiva

Una delle più comuni malattie del tratto gastrointestinale superiore





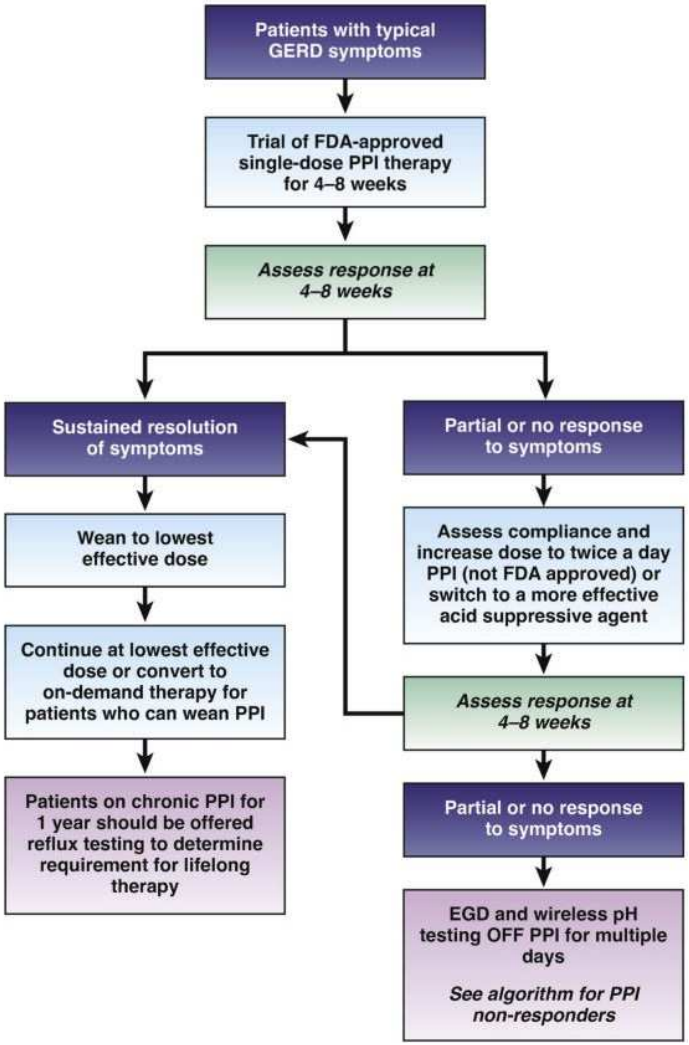
The Montreal Classification 2006

Savarino V. et al. Pharmacological Management of Gastro-Esophageal Reflux Disease: An Update of the State-of-the-Art. Drug Des Devel Ther. 2021

Diagnosi

Sintomi tipici e senza sintomi di allarme: PPI test

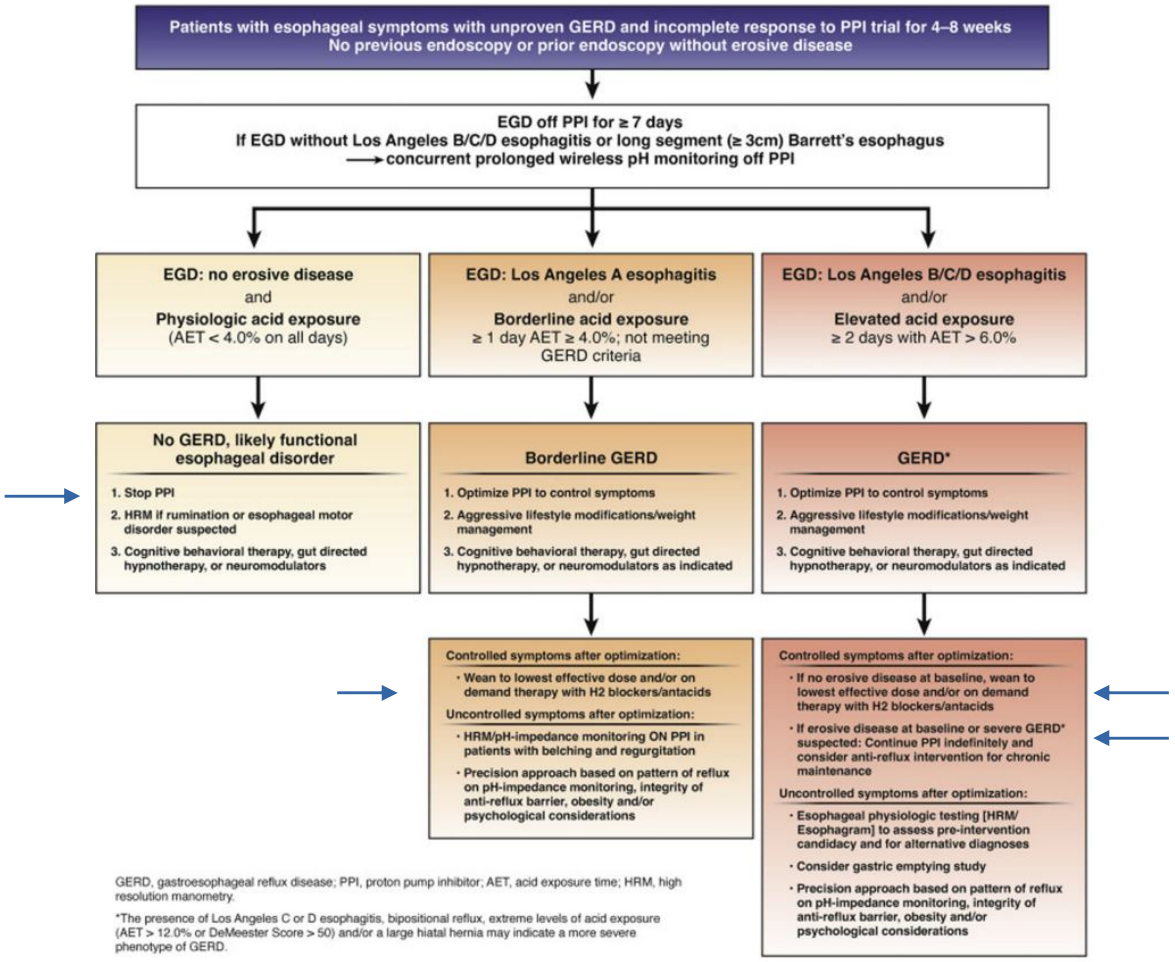
Se sintomi d'allarme (disfagia, odinofagia, calo ponderale, anemia) o solo sintomi atipici: EGDS



Gyawali CP, et al. Updates to the modern diagnosis of GERD: Lyon consensus 2.0. Gut. 2023

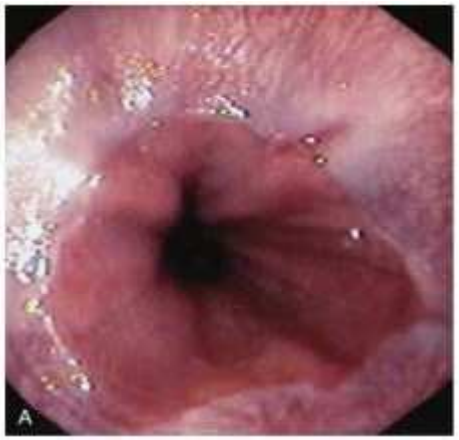
AGA Clinical Practice Update on the Personalized Approach to the Evaluation and Management of GERD: Expert Review. Clin Gastroenterol Hepatol. 2022

Diagnosi



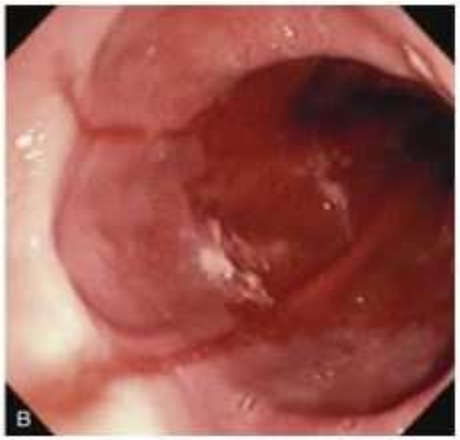
AGA Clinical Practice Update on the Personalized Approach to the Evaluation and Management of GERD. Clin Gastroenterol Hepatol. 2022

Esofagite erosiva



Grado A

Una o più lesione della mucosa, non superiori a 5 mm, che non si estendono tra gli apici di due pliche mucose



Grado B

Una o più lesione della mucosa, superiori a 5 mm, che non si estendono tra gli apici di due pliche mucose

Prevalenza 11%

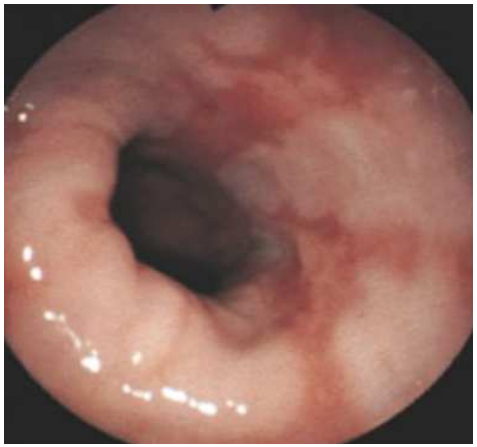
LA grado A nel 5% - 7% dei paziente asintomatici per MRGE

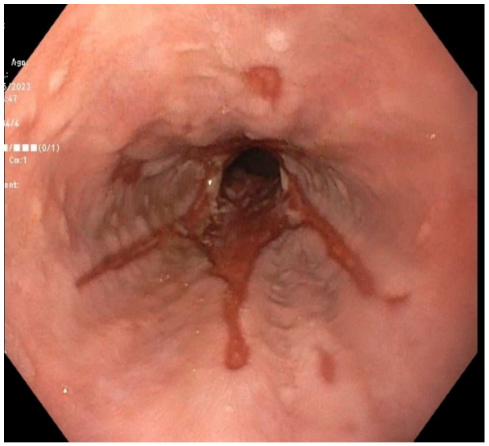
0% - 9% di rischio di esofago di Barrett sottostante

STATEMENT

ESGE recommends against routine endoscopic surveillance of Los Angeles (LA) grade A or B erosive esophagitis.

Esofagite erosiva





Grado C

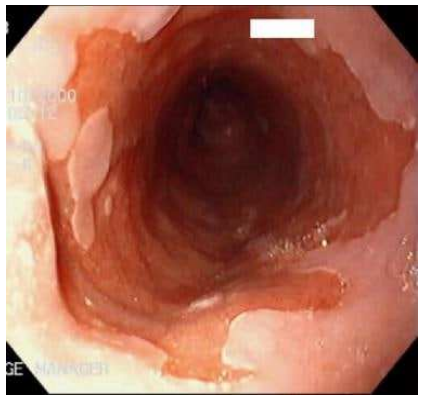
Una o più lesione della mucosa, continue tra gli apici di due o più pliche mucose, ma che si estendono per meno del 75% della circonferenza.

Grado D

Una o più lesione della mucosa, che si estendono per almeno il 75% della circonferenza.

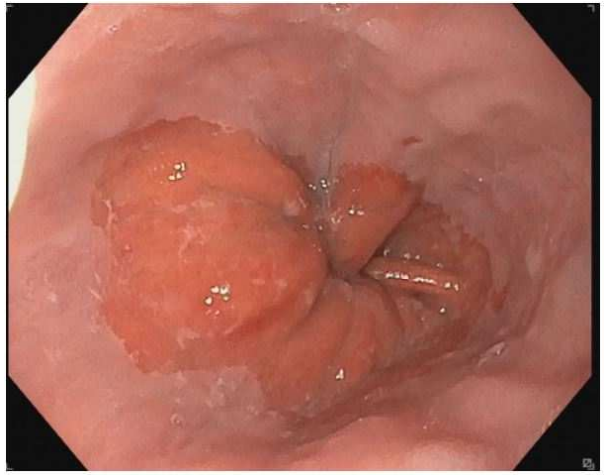
Circa il 12% dei pazienti presentano un Barrett sottostante

Raccomandata la ripetizione della EGDS dopo 8 settimane di terapia con PPI



Hanna S, et al. Detection of Barrett's esophagus after endoscopic healing of erosive esophagitis. Am J Gastroenterol. 2006
Katz PO, et al .Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol. 2013

Presenza di epitelio colonnare per < 10 mm



Si riscontra in > 10% delle EGDS

Non si associa ad aumentato rischio di carcinoma indipendentemente dalla presenza di metaplasia

STATEMENT

ESGE recommends against endoscopic surveillance for individuals with < 1 cm columnar-lined esophagus.

Itskoviz D, et al. Risk of neoplastic progression among patients with an irregular Z line on long-term follow-up. Dig Dis Sci 2018
Voutilainen M, et al. Specialized columnar epithelium of the esophagogastric junction: prevalence and associations. Am J Gastroenterol 1999

Papilloma esofageo o Papilloma a cellule squamose

Lesione benigna di piccole dimensioni

Incidenza 0.01 – 0.45%
Prevalenza 0.006 – 0.04 %

Eziopatogenesi non completamente nota, probabilmente correlata a:
- infiammazione cronica (MRGE)
- HPV, riscontrato nel 20 – 50 % dei casi, anche se l'evidenzia di HPV quale agente eziologico principale e causa di progressione in SCC resta molto controverso

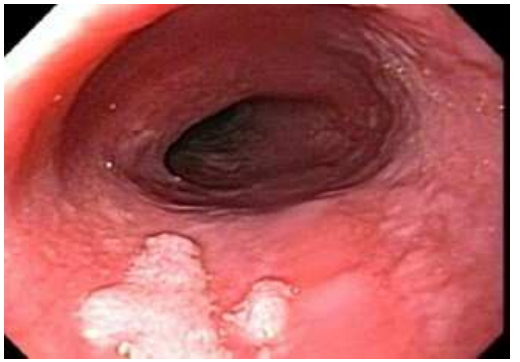
Rajendra S, Human papillomavirus infection in esophageal squamous cell carcinoma and esophageal adenocarcinoma: a concise review. 2020

Papilloma esofageo o Papilloma a cellule squamose

Rari casi di progressione in SCC

Raccomandata comunque la rimozione endoscopica

Scarse evidenze relative alla ricorrenza, pertanto al momento non è raccomandato un follow-up



Tsai SJ, et al. Benign esophageal lesions: endoscopic and pathologic features. W J Gastroenterol. 2015

Ordine dei Medici Chirurghi e degli Odontoiatri della provincia di Belluno

REGIONE DEL VENETO

ULSS 1 DOLOMITI

GASTROENTEROLOGIA BELLUNO

GRAZIE PER L'ATTENZIONE