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Summary

Barrett's oesophagus: Surveillance gastroscopy detects high-grade dysplasia – what's next, and when tissue is the issue

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High-quality endoscopic inspection with adequate preparation and sufficient time, combined with appropriate tissue sampling and expert histopathology review including p53 immunochemistry, are essential for detecting dysplasia and early adenocarcinoma in Barrett's oesophagus surveillance.

KEY POINTS

- The speaker demonstrated that Barrett's inspection time correlates with detection rates for high grade dysplasia and early adenocarcinoma, similar to colonoscopy withdrawal time, and adequate oesophageal cleanliness scores are associated with higher lesion detection.
- Endoscopic mucosal resection is performed for visible lesions to provide adequate tissue for histopathology, while endoscopic submucosal dissection is used when submucosal invasion is suspected to achieve en bloc resection.
- The speaker reported that a randomised controlled trial showed hybrid argon plasma coagulation is as effective as radiofrequency ablation for flat Barrett's after focal lesion resection but with fewer strictures.
- European guidelines and upcoming BSG guidelines now require intestinal metaplasia for Barrett's oesophagus diagnosis, aligning pathology standards across regions, though sampling variability means it may not appear in all biopsies.
- The speaker stated that p53 immunochemistry is a useful adjunct that can improve reproducibility of dysplasia diagnosis, but morphology and H&E assessment remain the gold standard, and difficult cases should be reviewed by a second pathologist.
- After ablation therapy, European guidance indicates biopsies just below the new squamocolumnar junction combined with targeted biopsies of visible abnormalities have the greatest yield, while routine four-quadrant sampling is probably not helpful.

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