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Summary

Video case: Oesophagus under the scope - diagnosing squamous and Barrett’s neoplasia

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Oesophagus | Endoscopy | Digestive Oncology

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High-quality endoscopy techniques for detecting Barrett's and squamous neoplasia can prevent missed cancers, which occur in 5-11% of upper GI cancers and lead to worse outcomes in nearly half of affected patients.

KEY POINTS

- The speaker stated that endoscopists spending at least seven minutes on gastroscopy are three times more likely to detect neoplasia than those performing rapid examinations.
- For Barrett's surveillance, the speaker recommends spending one minute per centimetre of Barrett's segment, performing examination without a cap first, and completing Seattle Protocol biopsies only after thorough visual inspection to avoid bleeding that obscures lesions.
- In 80% of cases where high grade dysplasia is found on random Barrett's biopsy, a visible lesion can be identified on careful re-examination, according to the speaker.
- The speaker teaches that intrapapillary capillary loop patterns in squamous lesions predict depth of invasion, with type B3 large dilated vessels indicating deep invasion and types A/B1 small loops representing up to M2 invasion within curative criteria.
- Essential quality steps emphasized by the speaker include thorough mucosal cleaning with mucolytic agents, adequate time and patient sedation, attention to hotspots (cardia, upper oesophagus, and gastroesophageal junction at 12-3 o'clock in Barrett's), and systematic use of virtual chromoendoscopy during withdrawal.

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