Introduction:

➢ Surveillance of Barrett’s Esophagus (BE) depends on degree of dysplasia, which is separated into low-grade dysplasia (LGD) or high-grade dysplasia (HGD).

➢ For confirmed LGD, radiofrequency ablation (RFA) is the procedure of choice, with over 90% successful eradication at two-year follow up.

➢ Reports of progression of LGD to esophageal adenocarcinoma (EAC) after RFA treatment is as low as 0.25%.

➢ BE with LGD was treated with RFA → CEIM with aggressive endoscopic follow up, but nonetheless had an unlikely progression to EAC requiring esophagectomy.

➢ A meta-analysis demonstrated recurrence of dysplasia carried a 0.9% risk and development to EAC carried a risk of 0.7% at 1.5 years.

➢ For patients with baseline LGD, it has been proposed that surveillance intervals be lengthened to 1, 3, and 5 years after CEIM.

➢ However, our case suggests surveillance guidelines should continue to be aggressive for LGD post RFA, especially in the case of long-segment BE.

Case:

➢ 63-year-old male was found to have long-segment, non-dysplastic, BE; classified as C8-M10 (Image 1).

➢ EGD #2, demonstrated the same degree of mucosal findings; however, biopsies now revealed LGD (Figure 1).

➢ EGD #3, the entire area of intestinal metaplasia was treated with RFA.

➢ EGD #4, BE now measuring C4-M9, requiring the 2nd RFA.

➢ EGD #5, one significant island of columnar mucosa identified requiring a 3rd round of RFA.

➢ EGD #6, near complete eradication of BE with intestinal metaplasia, no dysplasia.

➢ EGD #7, two tiny islands of columnar mucosa with no dysplasia.

Case Continued:

➢ EGD #8, no evidence of BE and biopsies revealed complete eradication of intestinal metaplasia (CEIM).

➢ Patient was instructed to follow up for repeat EGD in 6 months, but he returned 1.5 years later for EGD #9.

➢ EGD #9, a small island of BE with foci indefinite for dysplasia.

➢ EGD #10, a new 2cm nodule (Image 2).

➢ Biopsy revealed invasive well-differentiated adenocarcinoma, requiring neoadjuvant chemotherapy with proximal esophageal resection.

Discussion:

➢ BE with LGD was treated with RFA → CEIM with aggressive endoscopic follow up, but nonetheless had an unlikely progression to EAC requiring esophagectomy.

➢ A meta-analysis demonstrated recurrence of dysplasia carried a 0.9% risk and development to EAC carried a risk of 0.7% at 1.5 years.

➢ For patients with baseline LGD, it has been proposed that surveillance intervals be lengthened to 1, 3, and 5 years after CEIM.

➢ However, our case suggests surveillance guidelines should continue to be aggressive for LGD post RFA, especially in the case of long-segment BE.

References attached in online abstract.