

*“How to approach a patient with
a long segment Barrett’s
esophagus and HGIN located at
the level of a proximal reflux
stenosis?”*

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Case

A 60 year old patient presented with a long segment Barrett's esophagus (C7M8) and a reflux stenosis at 29cm. The patient was prescribed high-dose proton-pump inhibitors and was rescheduled for endoscopy 6 weeks later.

Histology

Biopsies from the stenosed area, at the 12 o'clock position, showed high-grade intraepithelial neoplasia.

Endoscopy

To get an impression of the lesion and its accessibility for endoscopic resection, it was tested if the mucosa could be suctioned into an ER-cap. This proved to be no problem.

However, the fibrotic ring may make impede with the endoscopic resection procedure. In addition, scarring after an endoscopic resection in this area may result in a more severe stricture, which may make subsequent circumferential ablation with the Barrx360 system very difficult.

What would be the best treatment strategy
for this patient?

Endoscopic resection or
radiofrequency ablation?

It may be advisable to perform stepwise dilatation to 18 mm and wait for any laceration to heal.

Then, RFA and endoscopic resection can be performed in the same treatment session.

For this, the lesion first needs to be delineated with nicely visible electrocoagulation marks. After marking the lesion, RFA can be performed as usual, using the 18-mm wide Barrx³⁶⁰ catheter.

Since the patient was dilatated to 18 mm, no sizing procedure is necessary, since this could only increase the risk of lacerations during the procedure.

Immediately after the RFA procedure, the electrocoagulation marks still visible, and they can guide an endoscopic resection of the suspicious area, using either multiband mucosectomy or the ER-cap technique with submucosal lifting.

The superficial layers of the mucosa may be damaged by the RFA procedure, yet the true staging information of the endoscopic resection: invasive cancer, differentiation grade, vertical resection margins, sm-invasion and vascular invasion, can still be assessed

By performing RFA and endoscopic resection in the same session, after dilatation of the stricture, you prevent that the stenosis becomes worse after the endoscopic resection and that subsequent RFA is more difficult.