Barrett's Oesophagus Surveillance and Acetic Acid Chromoendoscopy (AAC) Adult - Summary Clinical Guideline

Reference No: CG-CLIN/3044/24

Please note, this service is a consultant lead service at QHB

At RDH, the service is lead by the CNS

Referral to Nicola Stevens via Letter/endoscopy report/histology form/GP correspondence/SRS

Email address for referral - **uhdb.gastroenterologynursespecialistupper@nhs.net**

CNS will triage new patients with Barrett's oesophagus to clinic, review histology, and plan further surveillance as appropriate. Plan ongoing Barrett's surveillance for existing patients. Discuss cessation of surveillance in clinic.

Surveillance criteria

- Surveillance is determined on an estimate of the likelihood of cancer progression and patient fitness for repeat endoscopies and patient preference.
- Endoscopic screening can be considered in patients with chronic GORD and multiple risk factors (at least 3 of age 50 years or older, white race, male sex, obesity). The threshold of multiple risk factors should be lowered in the presence of family history including at least one first degree relative with Barrett's or Oesophageal adenocarcinoma (OAC)
- Surveillance is not generally recommended in patients with Intestinal metaplasia (IM) at the cardia or in those with an irregular z line regardless of the presence of IM.

BSG guidelines on the diagnosis and management of Barrett's oesophagus - The British Society of Gastroenterology

Recommended surveillance intervals

Long segment > 3cm with or without IM

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Repeat OGD & biopsies 2-3 yearly.

Short segment < 3cm with IM

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Repeat OGD & biopsies 3-5 yearly.

Short segment < 3cm without IM

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Repeat OGD & biopsies in 6 months.

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Still no IM, discharge

Low Grade Dysplasia/Indefinite for Dysplasia

High dose PPI to reduce inflammation - Repeat gastroscopy & biopsies in 6 months

No Dysplasia return to standard surveillance.

Where low grade dysplasia persists refer to **upper GI MDT**

High grade dysplasia (HGD)

Refer straight to MDT.

Upper GI MDT Via CITO form or dhft.uppergimdt@nhs.net

Patients post Endoscopic Mucosal Resection (EMR) undergoing HALO Radio Frequency Ablation (RFA)/Argon plasma Coagulation (APC)

3 month follow up gastroscopy with APC/RFA until complete ablation of the Barrett's segment.

Yearly gastroscopy surveillance thereafter

Endoscopist criterion for performing Barrett's surveillance.

- Double slot (2-point Listing) with a gastroscope (trans nasal endoscope not suitable)
- Endoscopist to visualise Barrett's segment with Pentax Iscan Tone Enhancement mode (TE)/Acetic Acid chromoendoscopy (AAC) to improve dysplasia detection. AAC protocol evidenced below.
- The Barrett's segment should be carefully photographed after washing and after chromoendoscopy.
- Seattle biopsy protocol. Four quadratic biopsies every 2cm, in addition to targeted biopsies on visible lesions
- Endoscopic reporting should include the length of the Barrett's, using the Prague criteria (circumferential extent (C), maximal extent (M) of endoscopically visible columnar-lined oesophagus in centimetres and any separate islands above the main columnar lined segment noted)
- The hiatus hernia landmarks should be recorded - i.e., top of gastric folds to diaphragm pinch point.

Barrett's Oesophagus – Acetic Acid Chromoendoscopy Guideline

Introduction:

This evidence-based guideline seeks to provide guidance on how to improve dysplasia detection within Barrett's oesophagus by using acetic acid chromoendoscopy (AAC).

Aim and Purpose:

This guidance applies to all endoscopists performing upper GI endoscopy and nurses who prepare the acetic acid solution and assist the endoscopist.

Equipment required:

100ml water	*2.5% Acetic Acid (AA)
Drawing up needle	2ml Acetylcysteine (200g/ml)
20ml slip tip syringe	Spray catheter
Infacol with dropper	0.9% sodium chloride ampoules.

Mix 100mls of water with 2mls Acetylcysteine and 4 droppers full of Infacol and use this solution to flush the oesophagus to clear the mucosa prior to AAC.

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Draw up 20mls of 2.5% AA in a 20ml slip tip syringe. If the stock on hand is 5%, draw up 10mls of 5% AA and dilute it with 10mls of 0.9% sodium chloride using a 20mls slip tip syringe.

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Insert the spray catheter into the biopsy channel and spray the solution onto the Barrett's Mucosa.

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When the AA is sprayed onto the Barrett's mucosa, there is an "acetowhitening" reaction caused by masking of the submucosal capillaries and increasing opacity of the mucosal surface. Areas with absence or rapid loss of acetowhitening are likely to be dysplastic and need to be biopsied and placed in a separate pot.

Documentation Controls

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Version / Amendment History	Version	Date	Author	Reason
	3	Dec 2023	Nicola Stevens, Nurse Practitioner Endoscopist	Review and merging of Burton and Derby versions
Intended Recipients: State who the Clinical Guideline is aimed at – staff groups etc.				
Training and Dissemination: How will you implement the Clinical Guideline, cascade the information and address training				
Development of Guideline: Genesis Sollano, Nurse Practitioner Endoscopist. Revised by Nicola Stevens Nurse Practitioner Endoscopist **Job Title:**				
Consultation with: Dr Cole, Dr Din, Dr Hearing, Dr Chilkunda, Nicola Stevens, Genesis Sollano				
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Business Unit Sign Off			**Group:Endoscopy user group** **Date: 18/7/23**	
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Review Date			July 2027	
Contact for Review			Genesis Sollano, Nurse Practitioner Endoscopist. Nicola Stevens, Nurse Practitioner Endoscopist.	

Previously: **Reference no: CG- GASTRO/2015/007 CG- ENDO/2018/011**