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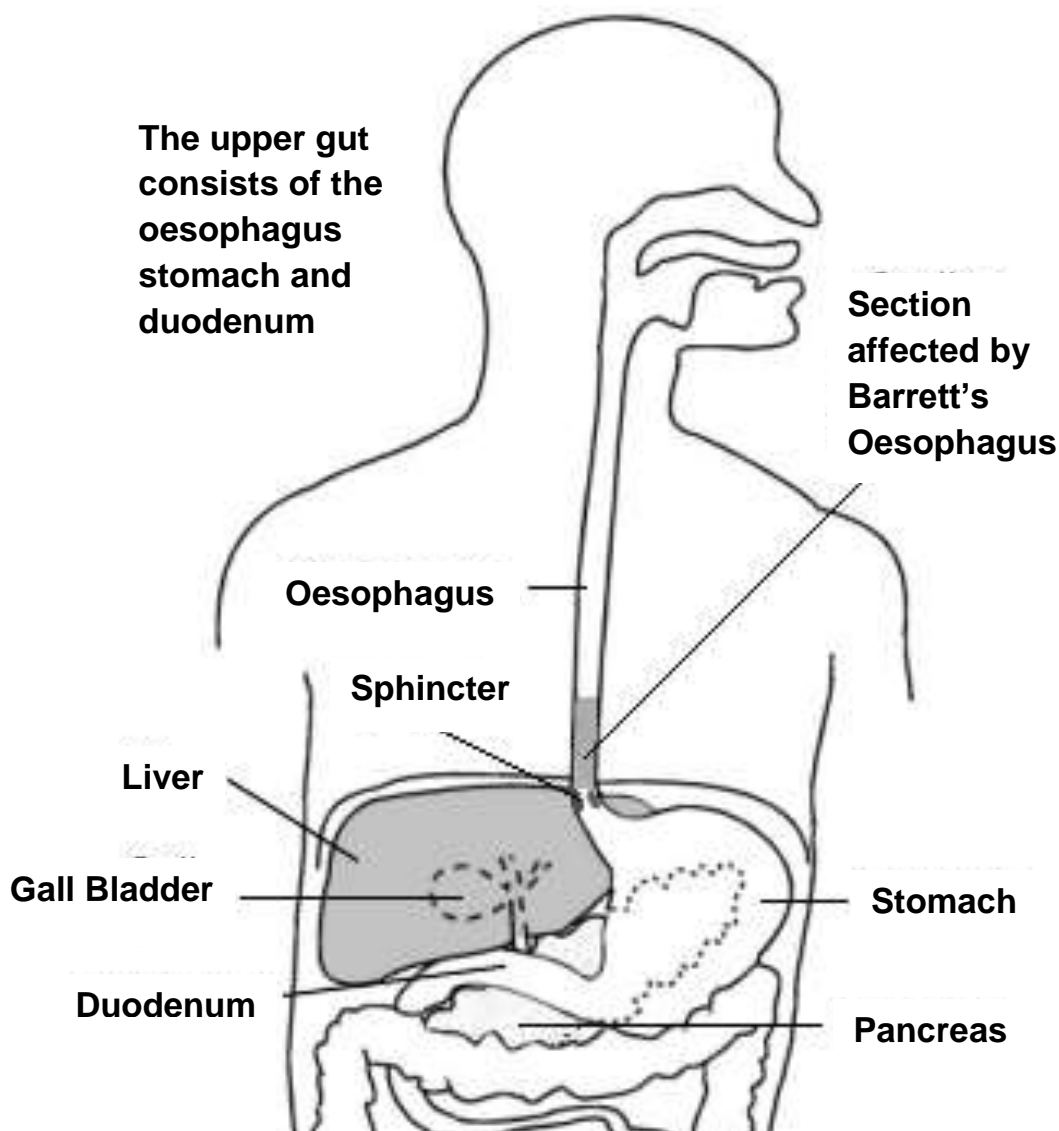
The Royal Liverpool
and Broadgreen
University Hospitals
NHS Trust

Patient information

Barrett's Oesophagus

Digestive Diseases Care Group

When we eat food passes down the oesophagus (gullet) into the stomach. Cells in the lining of the stomach make acid and other chemicals which help to digest food. Stomach cells also produce a mucus which protects it against the damaging effects of the acid. The cells on the inside of the oesophagus are different and have no protection from acid.



There is a circular band of muscle (a 'sphincter') at the junction between the oesophagus and stomach. This relaxes to allow food down, but normally tightens up and stops food and acid leaking back up (refluxing) into the oesophagus. In effect, the sphincter acts like a valve.

What is Barrett's Oesophagus?

Barrett's oesophagus is a condition which affects the lower oesophagus. It is named after the doctor who first described it.

In Barrett's oesophagus, the cells that line the affected area of oesophagus become changed.

The cells of the inner lining (epithelium) of a normal oesophagus are pinkish-white, flat cells (squamous cells). The cells of the inner lining of the area affected by Barrett's oesophagus are tall, red cells (columnar cells).

The columnar cells are similar to the cells that line the stomach. Another name sometimes used by doctors for Barrett's oesophagus is columnar-lined oesophagus (CLO).

Is Barrett's oesophagus harmful?

The changed cells at the lower end of the oesophagus are not cancerous. However, these cells have an increased risk (compared to normal oesophagus cells) of turning cancerous in time. The changed cells in Barrett's oesophagus can develop something called dysplasia. A cell with dysplasia is an abnormal cell. It is not cancerous, but is more likely to develop into cancer than other cells. It is often called a pre-cancerous cell.

In Barrett's oesophagus, there are various degrees of dysplasia from low-grade dysplasia to high-grade (severe) dysplasia. Cells that are classed as high-grade dysplasia have a high risk of turning cancerous at some point in the future.

About 1 in 20 people with Barrett's oesophagus develop dysplasia. In those who develop low-grade dysplasia, between one to five in ten people will go on to develop high-grade dysplasia or cancer of the oesophagus over the next two to five years.

The good news is the research tells us that people with Barrett's oesophagus live just as long as anyone else.

What causes Barrett's oesophagus and how common is it?

The cause in most cases is thought to be due to long-term reflux of acid into the oesophagus from the stomach. The acid irritates the lining of the lower oesophagus and causes inflammation (oesophagitis). With persistent reflux, eventually the epithelial (lining) cells change to those described above.

It is thought that about 1 in 100 people who have recurring acid reflux eventually develop Barrett's oesophagus. The risk is mainly in people who have had severe acid reflux for many years. However, some people who have had fairly mild symptoms of reflux 'on and off' for years can develop Barrett's oesophagus.

Barrett's oesophagus seems to be more common in men than women and it typically affects men between the ages of 50 and 70 years. Other risk factors for Barrett's oesophagus that have been suggested include smoking and being overweight (particularly if you carry excess weight around your middle).

What are the symptoms of acid reflux and oesophagitis?

Heartburn is the main symptom. It is a burning feeling that rises from the upper abdomen or lower chest up towards the neck. (This can be confusing as it has nothing to do with the heart.)

Other common symptoms include: pain in the upper abdomen and chest, feeling sick, an acid taste in the mouth, bloating, belching, and a burning pain when you swallow hot drinks. Like heartburn, these symptoms tend to come and go, and tend to be worse after a meal.

People with Barrett's oesophagus will usually have (or will have had in the past) the symptoms associated with acid reflux and oesophagitis.

What causes acid reflux and who does it affect?

Problems occur if the sphincter does not work very well. This is common, but in most cases it is not known why it does not work so well. However, having a hiatus hernia makes you more prone to reflux. A hiatus hernia is when part of your stomach protrudes through the diaphragm into the lower chest.

Most people have heartburn at some time, perhaps after a large meal. However, about one in three adults have some heartburn every few days, and nearly one in ten adults have heartburn at least once a day. In many cases it is mild and soon passes.

The sphincter at the bottom of the oesophagus normally prevents acid reflux. However, it is quite common for symptoms to be frequent or severe enough to affect quality of life. It is people who have severe and long-standing reflux who are more likely to develop Barrett's oesophagus.

How is acid reflux treated?

A medicine which prevents your stomach from making acid is a common treatment and usually works well. Some people take short courses of treatment when symptoms flare up. Some people need long-term daily treatment to keep symptoms away. An operation to 'tighten' the sphincter muscle is an option in severe cases which do not respond to medication, or where full dose medication is needed every day to control symptoms.

There are also various things that you can try to change in your lifestyle that may help to treat your acid reflux. These include losing weight if you are overweight, stopping smoking if you are a smoker and reducing your alcohol intake.

How is Barrett's oesophagus diagnosed?

Barrett's oesophagus itself usually causes no symptoms. However, you are likely to have, or have had, the symptoms of longstanding or severe reflux disease described earlier.

Endoscopy (gastroscopy)

You may have an endoscopy if you have severe or persistent symptoms of acid reflux. For this test, a thin, flexible telescope is inserted into the mouth, passed down the oesophagus into the stomach, all of which takes only a few minutes. This allows a doctor or nurse to look inside.

This test can usually help to diagnose Barrett's oesophagus. The change in colour of the lining of the lower oesophagus from its normal pale white to a red colour strongly suggests that Barrett's oesophagus has developed.

If Barrett's oesophagus is suspected during endoscopy, then several small samples (biopsies) are taken of the lining of the oesophagus during the endoscopy. This involves biopsy forceps being inserted into the endoscope through a channel. The biopsies taken are approximately two to three mm in size. These are sent to the lab to be looked at under the microscope to confirm the diagnosis. The cells are also examined to see if they have any signs of dysplasia (see above).

What is the treatment for Barrett's oesophagus?

Treatment of acid reflux

This treatment is as described. You are likely to be advised to take acid-suppressing medication for the rest of your life.

It is unclear as to whether treating the acid reflux helps to treat or reverse your Barrett's oesophagus and studies are ongoing. However, this treatment should help any symptoms that you may have.

Surveillance

When you have been diagnosed with Barrett's oesophagus, you may be advised to have an endoscopy and biopsy at regular intervals to monitor the condition. This is called 'surveillance'. The biopsy samples aim to detect whether dysplasia has developed in the cells, in particular if high-grade dysplasia has developed.

The exact time period between each endoscopy and biopsy sample can vary from person to person. It may be every two to three years if there are no dysplasia cells detected. Once dysplasia cells are found, the check may be advised every three to six months or so. If high-grade dysplasia develops, you may be offered an operation to remove the oesophagus. This is a major operation and it carries risks. Your specialist will advise on the pros and cons of such a big operation.

However, there is debate as to the value of surveillance, and if it is done, how often it should be done. Briefly, some doctors argue that most people with Barrett's oesophagus do not develop cancer. Many people would need to have regular endoscopies to detect the very few who develop high-grade dysplasia.

In addition, complications are likely to occur in a small number of people who have endoscopy. And, even if you develop high-grade dysplasia and have an operation to remove the oesophagus, there is about a 1 in 20 chance that you would die from the operation itself (it is a big operation).

So, in effect, there is a debate as to the benefit versus the risk of surveillance. Your specialist will advise what is best for your particular circumstances.

Newer treatments being investigated

Ways of removing just the abnormal cells from the lining of the oesophagus are being studied.

If you are diagnosed with Barrett's oesophagus, your specialist will be able to give you up-to-date information on the pros and cons of surveillance, and the current situation about newer treatments.

A further note

If you have Barrett's oesophagus and you develop any new symptoms such as unexplained weight loss, vomiting blood or difficulty swallowing, it is important that you see a doctor urgently. These are some of the symptoms that you might get from complications of gastro-oesophageal reflux and Barrett's oesophagus. These complications are rare but can include an ulcer or cancer of the oesophagus.

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Following your discharge from hospital or attendance at your outpatient appointment you will receive a text asking if you would recommend our service to others. Please take the time to text back, you will not be charged for the text and can opt out at any point. Your co-operation is greatly appreciated.

Further information

If you have any questions or queries, please contact:

Upper GI Nurse Specialists

Tel: 0151 706 2653

Text phone number: 18001 0151 706 2653

Or

The Endoscopy Unit during the following hours

Monday – Thursday	0800 – 2100 hrs
Friday	0800 – 1700 hrs
Saturday/Sunday/BH	0800 – 1600 hrs

Tel: 0151 706 2656

Text phone number: 18001 0151 706 2656

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Review Date: February 2022

All Trust approved information is available on request in alternative formats, including other languages, easy read, large print, audio, Braille, moon and electronically.

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