

Barrett's Esophagus and Adenocarcinoma of Esophagus

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Barrett's esophagus is a premalignant lesion detected in the majority of patients with esophageal and gastroesophageal adenocarcinoma, which are associated with a low rate of survival (5-year survival rate, 15 to 20%) [1]. The annual incidence of esophageal cancer for the general population of patients with Barrett's esophagus is approximately 0.5% per year [2]. In the past, the incidence of gastroesophageal reflux disease (gastroesophageal reflux disease, GERD) in Western countries is much higher than Asian countries, which is about 2-4 times. But in recent decades statistics have found that the incidence of GERD in Asian countries has significantly increased. In Singapore, the prevalence of GERD increased from 4.3% to 10% between 1992 to 2001, in South Korea from 1.8% to become 9.1% (10 years period), in Taiwan from 5% to 12.6% between 1995 to 2002. And the prevalence was increased up to 25% in taiwan (between 2008 and 2009). Chronic GERD is the major risk factor of Barrett's esophagus [3]. Endoscopic surveillance has become the standard of practice for patients with Barrett's esophagus based on the unproven assumption that the practice will reduce deaths from esophageal adenocarcinoma and thereby prolong survival. The patients with Barrett's esophagus who are most likely to benefit from endoscopic eradication therapy are those with esophageal adenocarcinoma limited to the mucosa and those with high-grade dysplasia [1].

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Societal guidelines generally have recommended endoscopic surveillance for patients with Barrett's esophagus at intervals that vary with grade of dysplasia found in the metaplastic epithelium. Intervals of 3 to 5 years have been suggested for patients who have no dysplasia, 6 to 12 months for those found to have low-grade dysplasia, and every 3 months for patients with high-grade dysplasia who receive no ablation therapy. Endoscopic mucosal resection has been used for both diagnostic and therapeutic purposes.

Conflict-of-interest: None

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