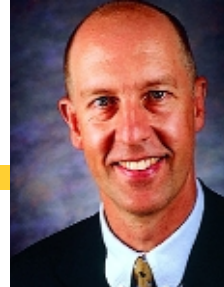
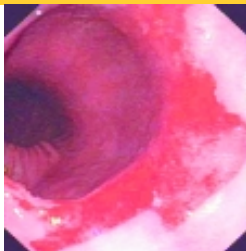


# Barrett's Oesophagus - Now What?



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Endoscopic photograph of  
Barrett's oesophagus

The rising incidence of oesophageal adenocarcinoma in Australia and its links to Barrett's

oesophagus serve to raise the level of anxiety when an endoscopy heralds its discovery in one of your patients. Chances are it's a totally unexpected finding, and the brevity of the report, which often arrives without concurrent specialist consultation, can leave the primary practitioner with a dilemma about how to respond. Thankfully, formal surveillance programs are becoming available and the following guidelines would represent general consensus.

Firstly, unless the Barrett's (columnar lined oesophagus) extends for 3 cm or more above the oesophago-gastric junction there may be no need for ongoing follow-up, and unless intestinal metaplasia is present the patient is not at increased risk of oesophageal cancer.

Otherwise, routine surveillance endoscopies are recommended at two-yearly intervals.

If the biopsies show that the intestinal metaplasia has low-grade (mild) dysplasia then your patient has progressed along the genetic pathway toward the development of

carcinoma (by hypermethylation of p16 gene, loss of p53 tumour suppressor gene, and other molecular biological changes).

Repeat endoscopies and biopsies are then recommended every six months.

The real difficulty arises when the biopsies reveal high-grade (severe) dysplasia. This finding is synonymous with intra-epithelial carcinoma and should initiate an intensive hunt for cancer with repeated biopsies often sent to independent laboratories for confirmation.

In fact, approximately one-third with high-grade dysplasia will harbour an underlying cancer; between 15% and 60% will progress to carcinoma within one to four years. With such alarming odds, if the diagnosis of high-grade dysplasia is confirmed then referral for consideration of an oesophagectomy is in order.

Ideally an oesophago-gastric specialist will be available to assist you and your patient in this momentous decision, and will be very aware of all the competing issues in the risk-benefit equation such as the patient's typically advanced age and sometimes questionable fitness for surgery.

If the advice does not favour curative surgery, experimental procedures are on the horizon

that may offer an alternative means to ablate the unstable mucosa.

Argon beam coagulation, endoscopic mucosal resection and photodynamic therapy are undergoing trials, but unfortunately are not yet of proven value for diminishing the risk of future malignancy. At the very least, ongoing screening should be on the agenda.

Not all the emerging data contains such depressing news however. It seems that unifocal high-grade dysplasia has a lower cancer risk than multifocal disease and happily, the highest chance of discovering any malignancy is on the first endoscopy after diagnosis of Barrett's oesophagus, after which the detection rate drops off considerably.

The minefield of Barrett's screening and the necessary decision-making is much simplified with the emergence of surveillance programs along similar lines to those available for bowel or breast cancer.

*Ed. A new Barrett's screening service is based co-operatively at Flinders Medical Centre, the Repatriation General Hospital, and Southern Gastrointestinal Services.*

## Is "Super vision" possible with laser surgery?

Dr Stephen Siebert FRACS, FRACO is available to discuss any aspect of your patient's eye care by phoning the Clinic on the 24 hour number 8431 9991.



The average person in the community does not have perfect vision.

Every eye has some optical imperfections that prevent the eye from reaching the theoretically best possible acuity limit.

These imperfections are termed "aberrations".

Aberrations can be high order or low order and can be present at different levels in different patients.

In general patients will not notice any problem until the total aberrations result in a drop in their visual acuity below 6/6.

At this stage they will seek help, generally with glasses. This may then result in a marked gain of acuity and very often they will exceed the average uncorrected acuity in the population.

Glasses can correct only part of the aberrations present in the eye. These are the spherical and astigmatic component but they do not correct the other aberrations present and these may limit the best vision achieved.

The total aberrations uncorrected by glasses fall into the category of "irregular errors".

Clinically these can be quantified by measuring the "wavefront" deviations in the eye. These errors can then be programmed into a suitable laser system to correct them.

These aberrations have the greatest impact on low light vision and significantly better low light visual performance can be achieved with

wavefront-based treatments. This is of particular importance with tasks such as night driving.

Not all laser systems can correct aberrations and only the latest generations of equipment can achieve satisfactory results.

The Bausch and Lomb "Zyoptix" wavefront based treatment system we employ at Laser Focus has been shown by multi centered trials to achieve significantly better overall visual performance compared to standard treatments. Over three years of clinical trials support this claim by B&L. It is the most widely used wavefront system in the world.

We now have over two years' clinical experience with the system and benchmark our results internationally.

Can it achieve "super vision"?

No, but every effort should be made to aim for this goal.

A tradesman is only as good as his tools and this is certainly the case with laservision correction, the clinical evidence supports the Bausch and Lomb system as being among the "best tools" available today.

Clinical data comparing different treatment systems can be reviewed at [www.fda.gov](http://www.fda.gov) and the Bausch and Lomb web site. We can also supply this data if requested by phone or fax.

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[www.laserfocus.com.au](http://www.laserfocus.com.au)

