Barrett esophagus: Definition, treatment

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To the Editor: In a well-written and informative article in the November 2019 issue, Singh et al reviewed the current management of Barrett esophagus and esophageal adenocarcinoma.[1] Here, I would like to discuss some concepts not addressed in their article.

First, the broad definition of Barrett esophagus is that metaplastic columnar epithelium replaces normal stratified squamous epithelium of the distal esophagus.[2] The broad definition is different from the traditional definition, which requires the presence of intestinal metaplasia and goblet cells. If we use the broad definition, more patients will match the diagnosis of Barrett esophagus and will have a chance to receive appropriate treatment and endoscopic surveillance to prevent esophageal dysplasia and adenocarcinoma.

Second, the American Gastroenterological Association[3] recommends that patients with Barrett esophagus receive a proton pump inhibitor once daily, but does not mention what duration of proton pump inhibitor therapy is needed. Based on the findings of available studies, continuous use of proton pump inhibitors for 1 year or longer is needed for patients with Barrett esophagus to prevent esophageal dysplasia and adenocarcinoma.[4]

Third, a cohort study revealed that statin use after the diagnosis of esophageal cancer was associated with a lower risk of esophageal cancer death than nonuse (hazard ratio for adenocarcinoma 0.79; 95% confidence interval 0.71–0.98).[5] Studies have shown that statins might have biologic effects on cancer and thus on outcomes, but the effects depend on the cancer cell type and on the statin used, with different agents having various antitumor potential.[6] These findings indicate a direction for research into chemoprevention of esophageal cancer. Well-designed randomized controlled trials are needed to clarify the association between statin use and the risk of esophageal cancer death.

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In reply: Dr. Lai points out that the broader definition of Barrett esophagus can include the presence of metaplastic columnar epithelium that replaces the normal stratified squamous epithelium in the distal esophagus. Guidelines of both the American College of Gastroenterology[1] and the American Gastroenterological Association[2] require the presence of intestinal mucosa for the diagnosis of Barrett esophagus, as only intestinal metaplasia is associated with the risk of malignant transformation. Therefore, we recommend using the same standard definition.

The second point concerns the duration of therapy in Barrett esophagus. We recommend therapy with proton pump inhibitors indefinitely.

Lastly, we agree that use of statins has shown improved outcomes in patients with esophageal cancer,[3] but the existing data on this topic are limited, and a specific recommendation regarding use of statins for this

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indication cannot be made with the available data. Randomized controlled trials are certainly needed to determine the association between statins and decreased mortality risk from esophageal cancer.

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