# GERD News!

## Minimally Invasive Procedure to Treat Barrett's Esophagus Reduces Risk of Esophageal Cancer

By: Roxanne Jones

La Quinta resident Ginger Engle, here with daughter Kristi, husband Jim an

La Quinta resident Ginger Engle, here with daughter Kristi, husband Jim and son Jimmy, has what's called gastroesophageal reflux disease, or GERD.

"I'd had indigestion for years," says La Quinta resident Ginger Engle. "It probably started when I was in my thirties, and foods like coffee, chocolate and spicy foods would make it worse. I lived on antacids and would eat a bland diet until it passed."

Engle has what's called gastroesophageal reflux disease, or GERD. It's a digestive disorder that occurs when a muscle at the end of the esophagus (the tube that carries food from mouth to stomach) doesn't close properly. This allows stomach contents to leak back — or reflux — into the esophagus and irritate it.

This can cause a burning sensation in the chest or throat often referred to as heartburn. Sometimes, people will taste stomach fluid in the back of the mouth. When these symptoms occur more than

twice a week, it's likely to be GERD. Some people can also have GERD without having heartburn. Their symptoms can include a dry cough, asthma symptoms or trouble swallowing.

Engle's heartburn symptoms became so severe that she ended up going to the hospital emergency department more than once, thinking she was having a heart attack.

"They told me that they see this in the emergency department all the time, that GERD can mimic a heart attack," she says. "I do have heart problems, so they told me if I ever have any chest pain, it's best to go to the emergency department so they can figure out what's causing it.

"The last episode was pretty bad, so I went in for an endoscopy," Engle continues, referring to an esophagogastroduodenoscopy (EGD), a procedure that uses a lighted, flexible "scope" to look inside the esophagus, stomach and duodenum (the first part of the small intestine).

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The procedure — performed by James Conti, MD, a Board Certified Gastroenterologist at Eisenhower Medical Center — revealed that not only did the 67-year-old have GERD, but she also had Barrett's esophagus. This is a condition in which the tissue that lines the esophagus is replaced by tissue that's similar to the intestinal lining, a process called intestinal metaplasia. It can occur as a result of the refluxed stomach acid that touches the lining of the esophagus — especially the lower part — damaging the cells.

Of the estimated 20 percent of Americans who have chronic GERD, like Engle, 10 to 15 percent will develop Barrett's esophagus. This is concerning because Barrett's is a premalignant (precancerous) condition that increases the risk of developing esophageal adenocarcinoma, a type of cancer that's increasing faster than any other in the United States today. It's also one of the most deadly cancers, with only a 15 percent survival rate after five years. And individuals with Barrett's have a 44 to 220 times greater chance of developing esophageal cancer than the general population.

"The lifetime risk of esophageal adenocarcinoma for someone with Barrett's esophagus is on the order of three to five percent for every ten years they have Barrett's," says Dr. Conti. "Without Barrett's, the chance of having esophageal cancer is extremely rare."

"I had never heard of Barrett's before," Engle admits. "Learning all this was a little scary."

The good news, however, is that today there is a minimally invasive procedure called radiofrequency ablation (RFA) that not only removes the abnormal cells of Barrett's but also allows normal cells to regrow. Using the BARRX™ RF Ablation System, doctors can remove the Barrett's tissue in an outpatient endoscopic procedure that generally takes less than 30 minutes. Eisenhower is the only hospital in the valley to offer this non-surgical treatment that has a nearly 100 percent success rate in eradicating Barrett's esophagus tissue.

"Before this treatment became available, patients with Barrett's esophagus were followed on a surveillance protocol, or 'watchful waiting,'" Dr. Conti explains. "After their initial diagnosis, we'd repeat their EGD a year later and biopsy their esophagus for abnormal cells to see if there was any advancement to lowgrade dysplasia."

Dysplasia refers to unusual changes in the cells that are pre-cancerous. Lowgrade dysplasia is when these changes do not involve most of the cells. High-grade dysplasia is the most advanced stage of dysplasia with unusual changes in many of the cells and a very abnormal, distorted growth pattern.

The problem with surveillance and biopsy, however, is undersampling. Because it's not feasible to biopsy the entire esophagus, abnormal cells could be missed. "It's like having a driveway with 1,000 paver stones and choosing only 10 to examine," says Dr. Conti.

"If there was advancement, then we'd do more intense monitoring every six months to a year until it progressed to high-grade dysplasia," he continues. "In these cases, the only treatment we could offer was esophagectomy, a surgical procedure to remove the esophagus, which resulted in extremely poor quality of life."

With the RFA treatment, however, the abnormal cells can be eradicated, preventing progression from low-grade to high-grade dysplasia, or from highgrade dysplasia to esophageal cancer — results that have been documented in clinical studies.

Engle has Barrett's esophagus with lowgrade dysplasia. She has undergone two RFA treatments so far and will have a third procedure in November (most patients require two to three treatments).

"We're seeing significant regression of the abnormal cells — 90 percent — after her first two treatments," says Dr. Conti.

"The procedure wasn't bad," reports Engle. "I had some chest discomfort and difficulty swallowing for a couple of days afterward, but nothing I hadn't experienced before [with GERD]. So I just consumed liquids and took some pain medication for a few days, which alleviated any discomfort."

Engle also is taking a prescription medication called a proton pump inhibitor (PPI) that suppresses the production of stomach acid to keep her GERD symptoms under control.

Dr. Conti urges anyone over age 50 who has chronic GERD symptoms to have a baseline endoscopy to screen for Barrett's esophagus.

"There's a big percentage of the population who are self-diagnosing their GERD and taking over-the-counter PPIs on their own," he says. "Within this group are people with significant reflux who aren't getting appropriate management. They really should talk to their doctor about having a screening endoscopy."

"You have to be very careful, because when Barrett's tissue changes the lining of the esophagus to mimic stomach cells, sometimes people may not feel the symptoms of reflux," cautions Dr. Conti. "So it's really important to get screened."

Are You a Candidate for RFA Treatment?

You are a likely candidate for this non-surgical treatment if:

- You have a history of Barrett's esophagus
- You have long-segment Barrett's esophagus (a greater than 3 centimeter segment of the esophagus is affected)
- You have had the condition for several years

You are at greatest risk of Barrett's progressing to esophageal cancer if you are/have:

- Male
- Caucasian
- Obese
- Smoke
- Hiatal hernia
- Family history of Barrett's or esophageal cancer

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