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Surveillance Post Oesophageal EMR/ESD for High Risk Barrett's Adenocarcinoma

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WHICH PROGRAMME / PATHWAY BOARD / GROUP HAS PRODUCED THIS DOCUMENT (IF APPLICABLE)	GM OG Pathway Board, GM OG Endoscopy Subgroup
WHAT CONSULTATION HAS TAKEN PLACE?	*The document has been developed during an endoscopy subgroup meeting which consistent of representation from gastroenterologists across the GM System from every provider. The document has been sent to the GM Endoscopy Network for review.*
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Oesophageal Surveillance Post EMR/ESD of High Risk Barrett's Adenocarcinoma

High Risk T1a/T1b

- **Definition**: High risk lesions have one or more of the following; >SM1 depth, lymphatic invasion, vascular invasion, poor differentiation, positive deep margin.
- **At present we should still be recommending HR T1a and T1b patients have adjunctive treatment (Surgery / CRT)**
- Some patients may decide against adjunctive treatment at that stage OR the risks and benefits are finely balanced
- These patients need careful counselling re
    - Risk of Surgery or CRT
    - Risk of LN metastasis / local recurrence
    - What active intensive surveillance involves
- This surveillance protocol is a recommended optimal pathway (PREFER study protocol) and should only be used in patients fit enough for adjunctive treatment down the line.
- The aim of this surveillance protocol is to catch disease recurrence / nodal disease at a curative stage.
- Residual Barrett's eradication via RFA therapy should also be considering in this cohort.

Year	Investigation	Frequency
Year 1	OGD and EUS CT PET	Every 3 months At 12 months
Year 2	OGD and EUS	Every 3 months
Year 3	OGD and EUS	Every 6 months
Year 4	OGD and EUS	Every 6 months
Year 5	OGD and EUS	Once a year

- Should the patient wish to reduce the level of intensity of this pathway, the recommendation is to alternate EUS with CT.