



Barrets Oesophagus and Sleeve Gastrectomy

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The gastro-oesophageal junction (GOJ) is by definition the uppermost border of the gastric fold(s). In a normal situation, the squamo-columnar transition-zone ('z-line') and the GOJ are at the same level, both situated at the level of the diaphragm [1, 2]. If the GOJ is above the diaphragm (pragmatically defined as more than 2 cm) this is called a hiatal hernia [3].

Visible mucosal breaks at the distal oesophagus is indicative of oesophagitis, and according to the length and circumferential extension of these breaks, the oesophagitis is classified as grade A, B, C or D. A higher grade is indicative of more severe reflux [4, 5].

If a salmon-pink mucosa appears in a length of ≥ 1 cm above the GOJ, and if histology from such an area confirms columnar epithelium (metaplasia) this has been called Barret's oesophagus [2]. The clinical significance of Barret's oesophagus is dependent upon the orad circumferential and tongue-like extension (Prague C and M criteria) and the type of columnar cells. With gastric type of cells (gastric metaplasia) only, the risk for transformation to dysplasia is negligible, while the presence of intestinal metaplasia is a marker of higher risk and surveillance is recommended. Furthermore, intestinal metaplasia is a common finding at the GOJ in patients with reflux symptoms even without columnar lined distal oesophagus (i.e. the GOJ and the z-line at the same level) [6]. Recent guidelines from the European Society of Gastrointestinal Endoscopy as well as from other societies defines the presence of columnar epithelium with a minimum length of ≥ 1 cm above the GOJ containing intestinal metaplasia as Barret's oesophagus [7, 8].

In a recent publication by Sebastinelly et al., it is stated that 'the diagnosis of Barret's oesophagus was made if the distal oesophagus was lined with columnar epithelium with a

minimal length of 1 cm (tongues or circular) containing specialised intestinal metaplasia at histological examination [9]'. However, when presenting the study at the first international consensus conference on reflux and bariatric surgery in Montpellier, France, on the 28th of June, it was presented as gastric metaplasia only, and all areas less than 3 cm. If this is correct, it is open for discussion whether Barrets was found or not. I will encourage the authors to clear up their findings and present them in this journal.

Compliance with Ethical Standards

Conflict of Interest The author declares that he has no conflict of interest.

Ethical Approval Statement This article does not contain any studies with human participants or animals performed by the author.

Informed Consent Statement Does not apply.

References

1. Sharma P, Dent J, Armstrong D, et al. The development and validation of an endoscopic grading system for Barrett's esophagus: the Prague C & M criteria. *Gastroenterology*. 2006;131(5):1392–9.
2. Bennett C, Moayyedi P, Corley DA, et al. BOB CAT: A large-scale review and delphi consensus for management of Barrett's esophagus with no dysplasia, indefinite for, or low-grade dysplasia. *Am J Gastroenterol*. 2015;110(5):662–82. quiz 83
3. Kahrilas PJ, Kim HC, Pandolfino JE. Approaches to the diagnosis and grading of hiatal hernia. *Best Pract Res Clin Gastroenterol*. 2008;22(4):601–16.
4. Lundell LR, Dent J, Bennett JR, et al. Endoscopic assessment of oesophagitis: clinical and functional correlates and further validation of the Los Angeles classification. *Gut*. 1999;45(2):172–80.
5. Gyawali CP, Kahrilas PJ, Savarino E, et al. Modern diagnosis of GERD: the Lyon Consensus. *Gut*. 2018;67(7):1351–62.
6. Byrne JP, Bhatnagar S, Hamid B, et al. Comparative study of intestinal metaplasia and mucin staining at the cardia and esophagogastric junction in 225 symptomatic patients presenting for diagnostic open-access gastroscopy. *Am J Gastroenterol*. 1999;94(1):98–103.

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7. Weusten B, Bisschops R, Coron E, et al. Endoscopic management of Barrett's esophagus: European Society of Gastrointestinal Endoscopy (ESGE) Position Statement. *Endoscopy*. 2017;49(2): 191–8.
8. Clermont M, Falk GW. Clinical guidelines update on the diagnosis and management of Barrett's esophagus. *Dig Dis Sci*. 2018;63(8): 2122–8.
9. Sebastianelli L, Benois M, Vanbiervliet G, et al. Systematic endoscopy 5 years after sleeve gastrectomy results in a high rate of Barrett's esophagus: results of a multicenter study. *Obes Surg*. 2019;29(5):1462–9.

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