This Clinical Practice Guideline (CPG) and accompanying patient education were developed by a multidisciplinary team, under the leadership of Nebraska Health Network’s Gastroenterology Workgroup.

Based on national guidelines and emerging evidence and shaped by expert local opinion, this CPG provides practical strategies for early recognition, diagnosis and effective treatment of Barrett’s Esophagus.

**Overview**

Barrett’s Esophagus occurs in 5 to 15 percent of patients seeking medical care for Gastroesophageal Reflux Disease (GERD), although a large subgroup of patients with Barrett’s Esophagus have no symptoms.¹ Men develop Barrett’s Esophagus twice as often as women, and Caucasian men develop this condition more often than men of other races. The average age at diagnosis is 55.²

Barrett’s epithelium is a major risk factor for adenocarcinoma of the Esophagus and is readily detected endoscopically, due to proximal displacement of the squamocolumnar junction.³ The risk of esophageal adenocarcinoma in people with Barrett’s Esophagus is about 0.5 % per year.³ Treatment options for Barrett’s Esophagus depend on the severity of the disease and the presence of dysplasia. Treatment options include medicines for GERD, endoscopic ablative therapies, endoscopic mucosal resection and surgery.³

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Nebraska Health Network (NHN) Clinical Practice Guidelines (CPG) are developed to assist clinicians by providing an analytical framework for the evaluation and treatment of selected common problems encountered in patients. They are not intended to establish a protocol for all patients with a particular condition. Clinicians must exercise independent judgment and make decisions based upon the clinical presentation. While great care has been taken to assure the accuracy of the information presented, NHN cannot be responsible for continued currency of the information, for any errors or omissions in this guideline, or for any consequences arising from its use. This CPG should not be used or reprinted without written consent from the Nebraska Health Network.
The “Triple Aim” of the Nebraska Health Network (NHN) is to improve the quality and safety of our patient care, improve the patient experience and enhance affordability. NHN’s clinical integration goal is to standardize treatment across our health systems and providers to meet the Triple Aim. Clinical Practice Guidelines (CPGs) are developed by NHN workgroups to implement evidence-based care and best practice standards within our network. CPGs may include an algorithm for appropriate care, and ideally support the practice of all clinicians providing care for a certain condition with patient support tools.

**Team Roles:** Patient-centered teams work more efficiently and effectively to provide high quality care known to improve health outcomes and patient satisfaction. All team members should educate themselves on the best practice guidelines to achieve the Triple Aim.

**Team Resources:** Team members interacting with patients should review the following key points to answer patient questions, or initiate conversation to facilitate shared decision making. Team members should familiarize themselves with strategies to increase patient understanding of condition management and ensure adequate patient education, with the goal being self-management of the patient’s health.

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**BARRETT’S ESOPHAGUS (BE)**

Screen male patients with:
Chronic (>5 years) and/or frequent (weekly +) symptoms of GERD
AND
> 3 risk factors

**EGD and Biopsy**

**BARRETT’S ESOPHAGUS CONFIRMED?**

- **NO**
  - Symptom management

- **YES**
  - **DYSPHASIA PRESENT?**
    - **NO**
      - Repeat EGD and biopsy every 3 years
    - **YES**
      - Refer to Gastroenterologist

**Risk Factors:**
- Age > 50 years
- Caucasian race
- Central obesity
- History of smoking (current or past)
- Family history of BE or EAC in 1° relative

**Future dysplasia present**
Effective patient-provider communication is essential for improving health behaviors and overall health outcomes. Effective patient education requires an understanding of the patient’s current knowledge about their condition, as well as resources to manage their health. Patient learning preferences should drive decisions about methods of education. All patient education should cover these basic priorities for improved quality of care:

1. Simplify communication and confirm understanding (teach-back)
2. Support patients’ efforts to improve their health (shared decision making)

**SUGGESTED TEACHING RESOURCES:**

**StayWell Healthsheets:**
- What is Barrett Esophagus?
- Understanding Radiofrequency Ablation (RFA) for Barrett’s Esophagus

**ExitCare Education Leaflets:**
- Barrett’s Esophagus
- Radiofrequency Ablation for Barrett’s Esophagus
- Radiofrequency Ablation for Barrett’s Esophagus, Care After

**Additional Resources:**
- Barrett’s Esophagus
  
  https://www.niddk.nih.gov/health-information/health-topics/digestive-diseases/barretts-esophagus/Pages/overview.aspx

**Definition:**
Barrett’s Esophagus is a condition in which tissue that is similar to the lining of the intestine replaces the tissue lining the esophagus. People with Barrett’s Esophagus may develop a rare type of cancer called esophageal adenocarcinoma.

**Risk Factors:**
Experts are unsure about the exact cause of Barrett’s Esophagus. However, gastroesophageal reflux disease (GERD) increases the patient’s chance of developing the condition.

Other risk factors include:
- Advancing age (>50 years)
- Male gender
- Caucasian race
- Central obesity
- Tobacco use (current or past)
- First-degree relatives with known Barrett’s Esophagus

**Signs and Symptoms:**
Barrett’s Esophagus may not cause symptoms, but some people may report trouble swallowing, blood in vomit, or pain under the sternum where the esophagus meets the stomach. Many people with Barrett’s Esophagus have GERD symptoms.

GERD symptoms may include:
- Heartburn
- Chronic dry cough
- Hoarseness
- Bad breath
- Ear aches
- Increase in saliva
- Acid taste in mouth

**Diagnosis and Treatment:**
Doctors diagnose Barrett’s Esophagus with an upper gastrointestinal (GI) endoscopy and a biopsy. Doctors may diagnose Barrett’s Esophagus while performing tests to find the cause of a patient’s GERD symptoms.

In an upper GI endoscopy, a gastroenterologist, surgeon or other trained health care provider uses an endoscope to view the upper GI tract, most often under sedation. The doctor performs a biopsy with the endoscope by taking a small piece of tissue from the lining of the esophagus. There is no pain during the biopsy.

A pathologist examines the tissue in a lab to determine whether there are Barrett’s Esophagus cells. Sometimes, the doctor takes biopsy samples from different areas of the lining of the esophagus since Barrett’s may not be in all areas of the esophagus.

The doctor will recommend the best treatment options based on the patient’s results and overall health. Treatment options include medicines for GERD, endoscopic ablative therapies, endoscopic mucosal resection and surgery.

**Prevention and Lifestyle Modification:**
While many of the risk factors for Barrett’s Esophagus are unavoidable, patients may be able to reduce their risk by:
- Stopping use of tobacco products
- Losing weight, especially belly fat

Researchers have not found that diet and nutrition play an important role in causing or preventing Barrett’s Esophagus. If a patient has GERD, they can prevent or relieve symptoms by changing their diet. Dietary changes that can help reduce symptoms include:
- Decreasing fatty foods
- Eating small, frequent meals instead of three large meals
REFERENCES & RESOURCES


