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COMMENTARY

Radiofrequency ablation for nondysplastic Barrett's esophagus: Should we do it, because we can?

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The treatment of patients with Barrett's esophagus has been a topic of intense investigation for the last several decades. Although it is well recognized that Barrett's esophagus may develop into dysplasia and then progress to invasive esophageal cancer, initial studies comparing fundoplication surgery and the best medical management available demonstrated no difference in either regression of the Barrett's esophagus or diminution of cancer risk.¹ More modern randomized, controlled trials that investigated laparoscopic fundoplication or long-term proton pump inhibitor use also did not demonstrate any regression of Barrett's esophagus with either strategy² after 5 years of follow-up. In fact, the American Gastroenterological Association does not currently recommend routine surgery (fundoplication) to treat Barrett's esophagus.³ Strategies to eradicate Barrett's esophagus by means of radiofrequency ablation in patients with high-grade dysplasia, however, have

demonstrated efficacy in preventing the progression to esophageal cancer.⁴

In the accompanying article in this issue of the *Journal*, Korst and colleagues⁵ have extended the application of radiofrequency ablation technology in a phase 2 trial of patients with Barrett's esophagus without evidence of dysplasia (72% of patients enrolled). This study demonstrated efficacy in eradicating Barrett's esophagus in 78% of treated patients. Patients with large hiatal hernias were found to be at risk for impaired healing of the esophageal lining after radiofrequency ablation. This study provides valuable information on the intensity of follow-up and treatment necessary to treat Barrett's esophagus with radiofrequency ablation technology. There is considerable variation with respect to the number of radiofrequency ablation treatments needed, with as many as 5 treatments needed for patients with less than 2 cm Barrett's esophagus and as many as 8 treatments needed for patients with greater than 5 cm of Barrett's esophagus. Treatments were done at 2-month intervals. Although the study patients have undergone careful endoscopic follow-up, the long-term efficacy of the strategy remains unclear. Korst and colleagues⁵ are unable to provide long-term follow-up data, and the rate of recurrent Barrett's esophagus is unknown. In addition, there is no assessment for potential buried islands of Barrett's esophagus. Furthermore, given the low rate of progression of nondysplastic Barrett's esophagus to cancer, the utility of the intervention, even if successful, is unclear.

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Routine endoscopic screening for Barrett's esophagus in the general population is currently not recommended.³ For patients with Barrett's esophagus without dysplasia, follow-up surveillance endoscopy is only recommended every 3 to 5 years, in recognition of the relatively low risk of progression to more advanced dysplasia. More intense surveillance and possibly surgical resection or ablation is recommended if more advanced dysplasia is discovered.

In light of the ambiguity of the natural history of Barrett's esophagus without dysplasia, radiofrequency ablation should currently only be done in the context of a clinical trial. Although this article by Korst and colleagues⁵ brings up intriguing possibilities, routine radiofrequency ablation for nondysplastic Barrett's esophagus should not be considered the standard of care. Further work allowing risk stratification of subjects at increased likelihood for progression to high-grade dysplasia and

cancer will be necessary for better targeting of this intervention in low-risk populations.

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