

Barrett's oesophagus

What is Barrett's oesophagus?

The oesophagus (gullet) is the tube that carries food from the mouth to the stomach and is lined by cells like those that form the skin (squamous cells). In Barrett's oesophagus the lining at the lower end of the gullet is found to have changed from being skin-like to being like the lining of the stomach. It was first identified in the early 1950's by a surgeon called Norman Barrett. The more scientific name is columnar-lined oesophagus (CLO).

What causes Barrett's oesophagus?

The cause of the condition is not known, but it is believed to be linked to gastro oesophageal reflux disease (GORD) where digestive juices from the stomach reflux up into the oesophagus. Acid is present in the stomach to help digest food. Unlike the stomach, the oesophagus does not have a protective lining, so when it is repeatedly exposed to acid it may become inflamed and painful (oesophagitis). Sometimes bile from the duodenum (the first part of the intestine), may also reflux and mix with acid from the stomach, which is even more damaging to the oesophagus. The oesophagus usually heals with time and the lining returns to normal, but sometimes, and particularly if bile is present, it heals in a different way and the lining changes to appear more like the lining of the stomach or small intestine. How or why the change occurs is not known.

The condition appears to be more common in men, and people who are overweight. It has also been shown that smoking can accelerate changes to Barrett's oesophagus.

What are the symptoms?

Barrett's oesophagus is often symptomless, most people diagnosed will have been examined because of symptoms associated with gastro-oesophageal reflux, which causes heartburn (a burning pain in the gullet, usually following a meal or when bending or lying down). Other symptoms may include a salty taste at the back of the mouth (termed water brash), hoarseness due to acid damaging the vocal cords and chest pains.

The majority of people who have Barrett's oesophagus have no serious consequences, while a minority will develop complications such as ulcers in the oesophagus, bleeding, difficulty in swallowing due to a narrowing of the oesophagus (stricture), and occasionally cancer.

How is Barrett's oesophagus diagnosed?

The diagnosis is made by means of an endoscopy. A small sample is usually taken (biopsy) for examination to confirm the diagnosis and also highlight any complications that may be developing.

What is the treatment for Barrett's oesophagus?

Barrett's oesophagus can be managed in different ways. The aim of the treatment is to reduce reflux, control symptoms and prevent cancer.

- Medical treatment aims mainly to suppress the production of acid in the stomach reducing the amount of acid to reflux into the oesophagus. You may be prescribed a medicine known as proton pump inhibitor (PPI).

- If the cells are becoming very abnormal, they are sometimes removed by specialised endoscopic treatment.
- Occasionally surgery to strengthen the valve at the lower end of the oesophagus can also be used, but this is not suitable for most cases.

Making lifestyle changes can reduce the amount of acid in your stomach, which may include:

- Losing weight, if necessary.
- Eating small meals at regular intervals.
- Allowing time for food to be digested before going to bed.
- Avoiding tight clothes and bending down after meals.
- Stopping smoking.

Does the condition need to be monitored?

Monitoring at regular intervals called surveillance, is advised. A gastroscopy and biopsies can identify any further changes in the oesophagus and the cells that might cause complications.

The changed cells in Barrett's oesophagus can develop something called dysplasia. A cell with dysplasia is an abnormal cell. It is not cancerous but is more likely than other cells to develop into cancer.

There are various degrees of dysplasia - from low-grade dysplasia to high-grade (severe) dysplasia. Cells that are classed as high-grade dysplasia have a high risk of turning cancerous at some point in the future. The biopsy samples aim to detect whether dysplasia has developed in the cells, in particular we are looking to see if high-grade dysplasia has developed.

The exact time period between each gastroscopy and biopsy sample can vary from person to person. It may be every three to five years if there are no dysplasia cells detected. Once dysplasia cells are found, the check may be advised every three to six months or so. If high-grade dysplasia develops, you may be offered treatment to remove the affected cells from the oesophagus.

However, there is debate as to the benefit of surveillance versus risk of surveillance. Some doctors argue that most people with Barrett's oesophagus do not develop cancer. Many people would need to have regular gastroscopies to detect the very few who develop high-grade dysplasia. Complications are likely to occur in a small number of people who have gastroscopy. And, even if you develop high-grade dysplasia and have treatment, there is a risk of developing complications from treatment. Your specialist will advise what is best for your particular circumstances.

New symptoms, such as difficulty in swallowing, vomiting blood or weight loss, require urgent medical attention.

Sources of information

www.nhs.uk & www.patient.co.uk

[BSG guidelines on the diagnosis and management of Barrett's oesophagus - The British Society of Gastroenterology](#)

Important information

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

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After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

Reference

The following clinicians have been consulted and agreed this patient information:

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Responsible clinician/author: JAG Lead Nurse T.L. Holmes-Ling

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