Barrett's oesophagus scope stakeholder workshop breakout group discussions **Date: 11 November 2020 Time: 10:00 – 12:30**	

3.1 Population:
Groups that will be covered:
Adults with Barrett's oesophagus and stage 1 oesophageal adenocarcinoma.
 	
Specific consideration will be given to the following subgroups:
• No dysplasia
• Low-grade dysplasia
• High-grade dysplasia
• Stage I oesophageal adenocarcinoma.
	• The group discussed the inclusion of the non-dysplasia group.
	  ○ It was raised that this group won't currently get endotherapy in the UK currently and so it was queried as to whether we really want to include them. It was highlighted that their inclusion will make the guideline much bigger. It was suggested that the guideline could potentially focus on endotherapy for Barrett's with dysplasia and remove medical management and surveillance.
	  ○ It was also raised that in other countries they do sometimes do endoscopy in this group and that it would be good to look at the evidence even if the conclusion is that they shouldn't receive it.
	  ○ Following discussion, the group concluded it should be included and the guideline needed a bigger remit than just endo therapy so that the guideline covers the whole of Barrett's management
	• The group wanted clarity on how the new guideline will fit with existing NICE guidance for example the IPG guidance
	  ○ NICE noted that IPGs are updated if there is new evidence or if they are sequenced.
	• It was highlighted that there is a group 'indefinite dysplasia' not currently mentioned
	• It was suggested that T1A adenocarcinoma should be groups with high-grade dysplasia ad T1B adenocarcinoma should be a separate subgroup
	• It was highlighted that people who have had treatment should perhaps be a separate subgroup
	
	• One group queried whether there were there other categories that are used elsewhere, such as quality of endoscopy itself and the length of segment.

	• It was noted that low grade dysplasia can be misreported and definition needs to be agreed to ensure how these studies will be picked up in searches.
3.3 Key areas that will be covered in the update: 1 Medical management: – Antacid medications, including alginate – Aspirin – H2 receptor antagonists – Proton pump inhibitors. 2 Endoscopic treatment, including endoscopic mucosal resection (also referred as endoscopic resection), endoscopic submucosal dissection (ESD), radiofrequency ablation (RFA), argon plasma coagulation (APC) and cryoablation alone or in combination. 3 Oesophagectomy for stage 1 adenocarcinoma. 4 Antireflux surgery for progression of Barrett's oesophagus and in people undergoing endoscopic ablation with poor response. 5 Follow up after diagnosis and treatment.	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? • Surveillance for dysplasia in people with a Barrett's diagnosis without dysplasia was highlighted as a crucial issue o Guidance for identifying dysplasia / dysplasia diagnosis should be included o This should include looking at surveillance techniques o It was noted that different imaging modalities would be covered • Currently there appears to be a gap in scope between medical management in primary care and specialist care in tertiary • Referral between secondary care and tertiary care endotherapy centres important • Workup of people referred for endotherapy was also highlighted as an area currently not covered – step between medical treatment and endotherapy o Might do endoscopy as part of workup even before do endotherapy o It was noted that practice will vary greatly and there are lots of different approaches to ruling out nodal disease – may be too much for the guideline o It was noted that there may not be good evidence for what to do in this area and so may be challenging to look at • It was queried whether EndoRotor should be included as it has emerging data o The group said only small case series available currently but all techniques with evidence will be considered

6 Information and support for patients and their families/carers.
 	
Key clinical issues that will not be covered:
 	
• Investigation and management of gastro-oesophageal reflux in the absence of Barrett's oesophagus
• Screening for and diagnosis of Barrett's oesophagus
• Oesophagectomy techniques
	• The question was asked about whether for reviewing purposes endoscopic treatment and oesophagectomy should looked at together
	  ○ It was noted this is a tricky area and not really covered in other guidelines
	  ○ It was noted that it may be that it is looked at alone for some groups but together for others
	  ○ there is wide variation in how manage T1 people.
	• It was highlighted that antireflux surgery is used for people where medical management fails to control symptoms (before endoscopy) and so should be also higher up in list
	  ○ It was noted that guideline doesn't aim to look at managing reflux but Barrett's and this question is about the latter
	• The group discussed whether the guideline should cover follow-up after oesophagectomy as often there is not much currently
	  ○ It was suggested that what to do in these people if there is a recurrence should be included – they should perhaps be a separate subgroup
	• It was suggested that we are touching on diagnosis if looking at imaging
	  ○ It was clarified that it means we are not looking at screening or initial diagnosis of Barrett's – we are looking at surveillance and dysplasia identification i.e. monitoring of know Barret's not when to give an endoscopy to confirm Barrett's
	  ○ No one disagreed with this approach
	
	• The group considered that maintenance therapy was crucial and that when patients are treated for Barrett's and how we treat them long term is important.
	• There are other modalities of treatment for refractory Barrett's - endoscopic therapies for example.
	• People with reflux is a very large population and it is NICE's intention not to redo some of the reflux information already included in other NICE guidance. The

	group agreed that there was not much evidence that would change this at the moment. The group suggested more should be done around anti reflux assessment and treatment as some ppl don't respond to PPI. • Trials at the moment around anti reflux treatment - ASPECT trial which looks at the use of PPI with or without aspirin is the biggest trial on Barrett's at the moment. • Terminology of diagnosis and screening/surveillance needs clarification – how we further define the dysplasia's and how the diagnoses are being made is important. • Need to differentiate between short and long segment of Barrett's (1-2 cm vs 8-10cm of Barrett's), low and high grade equally important. **Medical management** • The group agreed with this section. **Endoscopic treatment** • Currently very broad **Anti reflux surgery** • Need to make recommendations on everybody, should say where it is and isn't appropriate • Different techniques are used in different countries and there is also different availability in England according to services and skills available • Endotherapy not available in all institutions • Recognise that detail from individual papers will be specified and discussed by the committee **Follow up and diagnosis** • Frequency of recommended surveillance

	• People need personal follow up • Relevant to all of the pop, but assumption is that frequency is likely to vary • Putting patient first, continual information and care for patient • Patient perspective very important here, the group don't want to miss progression in Barrett's but patients having frequent endoscopies find this extremely unpleasant. How frequently and for how long should these patients be surveilled? • The groups suggested that a population that isn't explicitly mentioned in the scope is patients who have been treated but have Barrett's again when followed up – need to make it clearer this population is included. • Patients need reassurance. • The group agreed that dedicated surveillance lists and dedicated gastroenterologists was the ideal way forwards. • Resources for endoscopy, hospitals can get overwhelmed with colonoscopies. Screening for and diagnosis of Barrett's seems a broad sweeping statement (in exclusion list). The group agreed that it was important that patients are further screened and under surveillance. It is the intention that follow up and repeat endoscopy etc is included, agreed that the terminology being used needs reviewing to ensure key areas are clearly included.

Specific probes for key clinical issues:	• The group looked at the draft clinical questions
	  ○ It was suggested that medical management for stage 1 adenocarcinoma has has no role and could be removed from question
	  ○ It was suggested that the questions are separated for Barrett's and stage 1 adenocarcinoma
	  ○ It was suggested that a question should be added relating to workup (as raised in key areas section)
	  ○ It was raised that some of the questions presuppose the answers to other questions e.g. to assess different interventions you need to know what follow-up there will be as it will affect the costs
	
	• The group reviewed the list of outcomes
	  ○ It was suggested that recurrence should be added
	  ○ It was discussed how people who don't have a treatment success will be captured but it was noted this would come under the regression outcome i.e. if they don't achieve regression, they will be a non-responder.

Any comments on guideline committee membership?
 	
• 1-2 Upper Gastrointestinal Surgeons
• Advanced Nurse Practitioner
• 2 Gastroenterologists
• Consultant Pathologist
• Oncologist
• GP with special interest
• Radiologist with a special interest in upper GI cancer
• 2 Lay member
	• The following suggestions were made:
	  ○ add nuclear medicine PET specialist
	  ○ need gastroenterologists who:
	  ▪ Manage Barrett's in the community
	  ▪ Do endotherapy
	  ▪ Do staging
	  ○ This may require 3 gastroenterologists although not necessarily as there may be overlap in last two, or may be covered by other people
	  ○ Someone should have experience in endoscopic ultrasound
	  ○ Add endoscopic nurse as they do a lot of surveillance (although it was noted that there may be cross over with nurse practitioner)
	  ○ Two surgeons were required for balance as there may be strong alternative views from different individuals

	○ Two surgeons could be 1 interested in upper GI cancer and 1 with an interest in reflux surgery ○ Add public health / clinical epidemiologist ○ Add pharmacist due to issues around long terms PPI use and new meds • Clinical rather than medical oncologist • Important not to exclude surgeons- in some places they do endoscopies • Gastroenterologists need variety of expertise and settings • Radiologist - role of PET in assessment in early stages disease • Dietician patients commonly ask in follow up about what they should eat Discussion on whether pharmacist required but general agreement that medicines available are common medicines
Further Questions:	
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?	
Not covered	
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?	
Not covered	
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?	
Not covered	
4. Which area of the scope is likely to have the most marked or biggest health implications for patients?	
Not covered	
5. Which practices will have the most marked/**biggest cost** implications for the NHS?	
Not covered	
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?	
Not covered	
7. If you had to delete (or de prioritise) two areas from the Scope what would they be?	
Not covered	
8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?	
Not covered	

9. What are the top 5 outcomes?
Not covered
10. Are there any areas that you think should be included for the purposes of the quality standard? Are there any service delivery or service configuration issues that you think are important?
Not covered
11. Other issues raised during subgroup discussion for noting:
• The national Barret's registry is not running anymore