Upper endoscopy may be indicated to detect Barrett esophagus and esophageal adenocarcinoma in men older than 50 years who have had symptoms for more than five years, and who have additional risk factors (e.g., nocturnal reflux, hiatal hernia, elevated body mass index, tobacco use, intra-abdominal body fat distribution). It may also be indicated for surveillance in men and women with a history of Barrett esophagus. If no dysplasia is detected, serial endoscopy should occur no more frequently than every three to five years. If dysplasia is present, more frequent intervals are recommended because of the higher risk of progression to cancer.

Multiple cohort studies have shown that upper endoscopy does not often detect Barrett esophagus or esophageal adenocarcinoma in patients who are not found to have these conditions on initial examination. In addition, frequent endoscopic evaluation of patients with nondysplastic Barrett esophagus shows a low rate of malignant transformation. Unnecessary endoscopy exposes patients to preventable harms, such as complications related to sedation, perforation, bleeding, and pulmonary aspiration. Misdiagnosis and subsequent inappropriate aggressive therapy are also possible, as are financial problems from increased insurance costs after a diagnosis of Barrett esophagus.

When discussing the use of upper endoscopy with patients who have GERD, physicians should emphasize that the risk of esophageal cancer in persons with heartburn is low, and that patients do not need to be evaluated for GERD at regular intervals as they do for other chronic diseases. Patients should be told that even in persons with severe esophageal irritation, acid suppressive therapy is the preferred treatment, and that endoscopy usually does not change treatment plans. Physicians should explain to patients with Barrett esophagus that endoscopy performed more often than every three to five years does not prevent more cancers than screening less frequently.

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