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# Low-grade dysplasia on Barrett's esophagus: visible or not ?



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Current management of Barrett's esophagus (BE) relies on endoscopic follow-up of non-dysplastic BE, endoscopic resection of visible lesions, and ablation of flat dysplastic or residual BE. Indeed, so-called "visible lesions" arising in BE, mainly consisting of Paris 0-IIa and 0-IIb lesions, harbor early adenocarcinoma in 57% to 63% of cases, justifying endoscopic resection for adequate tumor staging [1,2]. While high-grade dysplasia (HGD) without any visible lesion is exceedingly rare, low-grade dysplasia (LGD) has long been considered endoscopically indistinguishable from non-dysplastic BE. Actually, LGD is observed in 7% to 8% of endoscopic resection specimens [1,2], suggesting that a certain proportion of BE with low-grade dysplasia is actually visible.

In this issue of Endoscopy International Open, Tony He et al. investigated the frequency of visible LGD among patients with dysplastic BE referred to an expert center in Melbourne, and sought to describe the endoscopic features of BE with LGD [3]. In their retrospective analysis of 135 patients with confirmed LGD, they observed a visible lesion in 50% of the patients (68/135). Among these, 18% (24/153) had Paris 0-IIa lesions, and 33% (44/135) had Paris 0-IIb lesions, with only pit pattern and vascular pattern abnormalities. Interestingly, 87% of the patients (58/67) without visible lesions only had a single, small focus of LGD on the Seattle biopsy protocol, suggesting that visible LGD could be at higher risk of neoplastic progression because of more numerous, larger, and deeper foci of dysplasia.

The 50% rate of visible LGD reported by He et al. is much higher than the 6% to 19% reported in other Barrett's expert centers. It can be explained by the systematic use of a cap to analyze the Barrett's segment, the specific expertise of the group in analyzing the Barrett's mucosa, demonstrated by the description in 2019 of the diffuse endoscopically visible LGD in BE or DEVLB [4], and the performances in diagnostic endoscopy of the community centers involved. However, the fact that LGD is endoscopically invisible in half of the cases, even to experts specifically seeking it, reminds us that random biopsies following the Seattle protocol are still needed in 2023.

Conflicting data have been reported on the benefit of treating BE with LGD using radiofrequency ablation [5,6]. If, like He et al., we manage to identify the 50% of patients with visible LGD on BE, possibly picking up the half of patients with the highest risk of neoplastic progression, and treat them with endoscopic resection and ablation of the residual BE, we might safely offer annual endoscopic follow-up to the other half of patients with BE and LGD.

## Conflict of Interest

Olympus, Fujifilm, Pentax, Medtronic, Sanofi, Dr Falk Pharma, Norgine.

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