INTRODUCTION

Transnasal gastroscopy is a far more acceptable form of gastroscopy to the patient, with benefits including reduced gagging, ability to communicate during the procedure, greater flexibility of endoscope allowing easier visualisation of difficult areas and closer inspection of the larynx. (1)

Due to the smaller working channel, 2.0mm as compared with 2.8mm of a standard oral gastroscope, the biopsy forceps used in transnasal gastroscopy are smaller, leading to questions about the suitability of transnasal gastroscopy for Barrett’s surveillance.

As an early adopter of transnasal gastroscopy, Braintree community hospital endoscopy service has performed many thousands of diagnostic transnasal gastroscopies including Barrett’s surveillance.

This study compares the dysplasia and malignancy rate of transnasal gastroscopy biopsies and oral gastroscopy biopsies.

RESULTS

In the three year period there were a total of 1282 patients who underwent Barrett’s surveillance.

Of these, 905 (70.6%) chose to have transnasal gastroscopy, the remainder, 377 (29.4%) chose to have oral gastroscopy.

Of the transnasal series, 12 (1.3%) had LGD, 5 (0.6%) had HGD, 3 (0.3%) had ACA and 9 (1%) were indefinite for dysplasia.

Of the oral series, 7 (1.8%) had LGD, 0 (0%) had HGD, 2 (0.5%) had ACA and 7 (1.8%) were indefinite for dysplasia.

The overall dysplasia and malignancy rate in the transnasal group versus the oral group was 2.2% versus 2.4%. (p=0.4048)

CONCLUSION

Our series at Braintree community hospital shows that there is not a significant difference in the dysplasia and malignancy rate found on transnasal biopsies as compared with oral gastroscopy biopsies.

REFERENCES


Disclosure of interest: None declared