**Brief guide to upper GI histological findings**

This is a brief guide to common histology diagnoses after upper GI endoscopy. It has been agreed at clinical senate that histology will return to the referring GP as, in summary, the clinician who has seen the patient is best able to understand the clinical context and histology is a routine aspect of upper GI endoscopy. This guide is to help GPs to interpret some statements from histopathology that they may not be familiar with, and suggest actions that are recommended following receipt of those reports.

It is not exhaustive but covers the most commonly encountered histological appearances.

Accurate interpretation of histology reports requires clinico-pathological correlation.

In any cases of clinical uncertainty you are advised to seek expert advice by a letter to a gastroenterologist or by referral if you feel that it is indicated.

**Oesophageal**

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| **Condition** | **Action** | **Referral** |
| Dysplasia – indefinite | Generally need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – low grade | Need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – high grade | Need urgent assessment and MDT review | Urgent |
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| Barrett’s with high grade dysplasia | Need urgent assessment and MDT review. MDT discussion will consider endoscopic therapy (either resection or ablation) or surgery | Urgent |
| Barrett’s with low grade dysplasia | Need acid suppression and reassessment. GI referral indicated. May be considered for ablation therapy. | Routine |
| Barrett’s with indefinite for dysplasia | Generally need acid suppression and reassessment. GI referral indicated | Routine |
| Barrett’s with intestinal metaplasia but no dysplasia | Need surveillance as per protocol. Please refer to the Barrett’s clinic | Routine  Barrett’s |
| Barrett’s without intestinal metaplasia and no dysplasia | There should be 2 endoscopies demonstrating an absence of intestinal metaplasia. Thereafter surveillance is not routinely indicated. |  |
| Barrett’s (general advice) | All patients should remain on life-long PPI therapy |  |
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| Adenomas | Most likely related to Barrett’s and need urgent assessment | Urgent |
| Eosinophilic oesophagitis | Benign condition which can cause dysphagia and/or food bolus obstruction. Routine GI referral indicated. | Routine |
| Fibrovascular polyps | Benign lesions which generally only need treatment when symptomatic |  |
| Glycogen acanthosis | Common benign lesions of uncertain aetiology. No treatment or follow up required. |  |
| Inlet patch | Benign condition which does not require treatment in the absence of complications (rare and clinically overt) |  |
| Oesophageal candida | Assess for underlying causes (HIV test recommended), check inhaler technique if on steroid inhalers, and treat with Fluconazole (beware drug-drug interactions). May be a sign of systemic illness – requires clinical correlation. |  |
| Oesophagitis dessicans superficialis | Can be associated with desquamating dermatitis, coeliac disease or bisphosphonate use. GI referral appropriate. | Routine |
| Oesophageal web | A thin non-circumferential mucosal fold. Benign. Can be dilated if patients experience dysphagia. May be associated with other conditions | Possible |
| Papillomas | Benign lesions with a small pre-malignant potential. Require non-urgent review in a GI clinic to consider resection | Routine |
| Reflux oesophagitis | Require acid suppression. Refer only if clinical concern or non-responsive to treatment. | Possible |
| Schatzki ring | Circumferential mucosal thickening. Benign. Can be dilated if patients experience dysphagia. No action needed if asymptomatic | Possible |

**Gastric**

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| **Condition** | **Action** | **Referral** |
| Dysplasia – indefinite | Generally need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – low grade | Need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – high grade | Need urgent assessment and MDT review | Urgent |
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| Carcinoid | Requires urgent review and MDT discussion | Urgent |
| GI stromal tumours (GIST) | These require formal assessment and MDT review. | Urgent |
| MALToma | Requires urgent review and MDT discussion | Urgent |
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| Adenomas (polyps) | These require resection and the patient should be referred to gastroenterology. | Routine |
| Cystic fundal polyps | These are benign lesions. They are commonly associated with PPI use. Their presence in patients under 40 may be an indicator of familial adenomatous polyposis. Patients under 40 should be referred for consideration of colonoscopy. For patients over 40 no further action is routinely required. | Possible |
| Hamartomatous polyps | These are rare polyps seen in the context of other diseases including FAP and Peutz-Jegher’s. All cases should be referred to gastroenterology. | Routine |
| Hyperplastic polyps | These are benign lesions with a small pre-malignant potential. Management is controversial but they may need resection or surveillance endoscopy. *H. pylori* should be eradicated if present. A non-urgent referral to gastroenterology is appropriate. | Routine |
| Inflammatory polyps | Do not confuse with inflammatory fibroid polyps. This is a commonly  used misnomer for hyperplastic polyps. Please refer to the hyperplastic polyps advice. | Routine |
| Inflammatory fibroid polyps | Do not confuse with inflammatory polyps. These are benign polyps without malignant potential but can be seen in atrophic gastritis. They may enlarge but only require treatment if symptomatic. | Possible |
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| Atrophic gastritis | *Helicobacter* should be eradicated where present. Routine GI referral is indicated.  There is no current UK consensus on the role for repeat endoscopy. Based on European and American guidelines it is reasonable to consider repeat endoscopy to assess the extent of atrophy. Atrophy confined to the antrum does not need follow up. Patients with extensive atrophy *may* be offered surveillance endoscopy if they have a family history of cancer or are of Asian heritage. | Routine |
| Autoimmune gastritis | A variation of atrophic gastritis, it should be managed in the same manner as atrophic gastritis. | Routine |
| Gastric intestinal metaplasia | *Helicobacter* should be eradicated where present. Routine GI referral is indicated. There is no current UK consensus on the role for repeat endoscopy. Based on European and American guidelines it is reasonable to consider repeat endoscopy to assess the extent of metaplasia. Metaplasia confined to the antrum does not need follow up. Patients with extensive metaplasia *may* be offered surveillance endoscopy if they have a family history of cancer or are of Asian heritage. | Routine |
| Gastric ulcers | Ensure on high dose PPI. Avoid ulcerogenic drugs where possible. All patients should have a repeat OGD in 6-8 weeks to ensure resolution. | Repeat OGD 8/52 |
| *Helicobacter* | *H. pylori*  should be eradicated in all patients with; ulcers, functional dyspepsia, intestinal metaplasia, iron deficiency anaemia, B12 deficiency, idiopathic thrombocytopaenic purpura, and for patients on long term PPI treatment and before NSAID use (as per Maastricht IV guidelines) |  |
| Lymphocytic gastritis | The clinical relevance of this condition is uncertain. It may be related to *H. pylori* and when present eradication is indicated. It may rarely be related to other GI conditions including lymphocytic colitis and Crohn’s disease and can be due to Olmesartan use. In the absence of symptoms it is not likely to need treatment. Routine GI referral is appropriate if symptomatic or further advice is needed. | Possible |
| Reflux (chemical) gastritis | Commonly seen with drugs (e.g. NSAIDs, iron, cocaine, alcohol, bowel preparation, bisphosphonates) and gastroduodenal reflux. Precipitants should be avoided where possible. Bile sequestrants can be trialled but evidence is limited. PPIs can be used for patients on NSAIDs/bisphosphonates. GI referral is not normally indicated. |  |

**Duodenum**

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| **Condition** | **Action** | **Referral** |
| Dysplasia – indefinite | Generally need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – low grade | Need acid suppression and reassessment. GI referral indicated | Routine |
| Dysplasia – high grade | Need urgent assessment and MDT review | Urgent |
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| Adenomas | These may require resection. Refer to gastroenterology. | Routine |
| Chronic non-specific duodenitis | Benign condition. Eradicate *H. pylori* when present. Test for coeliac disease. Treat symptomatically. Referral required when symptoms dictate. | Possible |
| Desmoid tumours | Can be seen in FAP. All cases should be referred to gastroenterology. | Routine |
| Eosinophilic duodenitis | There are multiple possible causes for this condition. The clinical relevance is unclear. All symptomatic cases should be referred routinely. | Possible |
| Gastric heterotropia | A benign condition. Does not routinely require treatment or referral. |  |
| Giardia | Should be treated. Refer to gastroenterology if advice needed. | Possible |
| Hamartomatous polyps | These are rare polyps seen in the context of other diseases including FAP and Peutz-Jegher’s. All cases should be referred to gastroenterology. | Routine |
| Lymphocytic duodenosis with normal villous structure | Can be seen with NSAIDs, *H. pylori*, coeliac disease, infection and many other conditions. Check coeliac screen and refer routinely to gastroenterology. | Routine |
| Villous atrophy with increased intraepithelial lymphoctyes | Confirms coeliac disease. Refer routinely to gastroenterology. | Routine |
| Whipple’s disease | Refer all cases. | Routine |