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LETTER TO THE EDITOR

Endoscopy campaigns in high-risk populations of gastric cancer in Chile

Campanas de endoscopia en poblaciones de alto riesgo de cancer gastrico en Chile

Dear Editor,

We would like to share our experience of conducting esophagogastroduodenoscopy (EGD) campaigns among symptomatic individuals in high-risk areas of gastric cancer (GC) in Chile. Our multi-disciplinary and multi-institutional efforts could inspire and serve as an example for colleagues in countries with low and middle burden of GC. Chile had an overall GC mortality rate of 18.7/100,000 population, representing the leading cause of cancer deaths among men, and the fourth in women.[1] The estimated incidence of GC in males is higher in the southern regions of the country, reaching up to 42/100,000 population in La Araucania.[2] Despite multiple public and private efforts, the high mortality trend has not significantly changed in the last 25 years.[3] In addition, *Helicobacter pylori* infection is common in Chile,[4] and resistance to antibiotics is a growing problem.[5] Public health initiatives included an increase in the total number of endoscopists, and an investment in new endoscopic equipment in high-risk GC areas. Additionally, specific public health policies were implemented, such as a ''fast track'' for patients with ''red flag'' symptoms, and better access to *H. pylori* eradication treatments. Potential limitations for the success of these initiatives have been the lack of coordinated networks between primary and tertiary health care systems, deficiencies in the quality of endoscopic procedures, absence of follow-up of patients with advanced preneoplastic lesions (particularly intestinal metaplasia), and the lack of retest of *H. pylori* infection after eradication treatment. More recently, the Ministry of Health also recommended EGD for all individuals over 40 years of age.[6]

As a response to this challenging situation, the Chilean Association of Digestive Endoscopy (ACHED), an affiliate of the Chilean Society of Gastroenterology, established an agenda aimed to provide some initial solutions and guide future public health initiatives. First, the ACHED brought together a panel of national experts, including gastroenterologists, endoscopists, and pathologists. This group generated a set of 24 evidence-based recommendations for primary and secondary prevention of GC (the ACHED Protocol).[7] The most important recommendations were: (*i*) a standardized endoscopic reporting for all EGD procedures, including digital photo-documentation, (*ii*) the adoption of the updated Sydney biopsy protocol in patients over 40 years of age or those with first-grade relatives with GC, (*iii*) the incorporation of the Operative Link on Gastritis and Intestinal metaplasia Assessment classifications (OLGA and OLGIM) into the pathological report, and (*iv*) endoscopic follow-up according to the estimated risk of GC. In addition, the ACHED protocol determined the benchmarks for the development of an adequate endoscopic follow-up program, including technical and training requirements for endoscopists.

As a second strategy, in 2016 the ACHED implemented an annual 4-to-6-week endoscopy campaign to reduce the patient waiting list in Nueva Imperial, a high GC risk rural area, with a waiting list of ∼4000 symptomatic patients (average waiting period of 4 years). To date, in four campaigns, a total of ∼3700 EGD procedures have been performed by ∼118 volunteer endoscopists (30% of the total in Chile). Annual endoscopic follow-up has been implemented for patients with severe stages of gastric atrophy (OLGA stages III/IV). An educational component was also included. Experienced international endoscopists participated as clinical consultants and contributed to improving the communication of the pathology report to endoscopists. Notably, in collaboration with national and international investigators, we have nested research projects, addressing risk factors for gastric intestinal metaplasia (GIM) and potential non-invasive biomarkers for GC risk stratification. As an example, we have confirmed the association between TFF3 levels and invasive GC, although the former's potential role as a biomarker for GIM require further investigation to confirm.[8] We hope that our clinical efforts not only contributed to reducing the growing EGD waiting list in Chile, but also provided an opportunity for the development of GC risk reduction strategies, including non-invasive testing approaches.

These campaigns did not directly address the optimal time interval for endoscopic surveillance of patients with advanced GIM. However, the new Endoscopic Cohort and Histological OLGA Staging (ECHOS), a prospective endoscopic study conducted in Chile,[9] together with novel approaches such as chromoendoscopy with targeted biopsies,[10] will help to shed light on this issue.

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