# key points

SELECTED BY

**Dr Peter Saul**
GP Wrexham and Associate GP Dean for North Wales, UK

**Oesophageal cancer rates are continuing to increase.** Oesophageal cancer is the thirteenth most common cancer in the UK, however, its outcome remains poor making it the fifth most common cause of cancer deaths. There are two main types; oesophageal squamous cell carcinoma (OSCC) and oesophageal adenocarcinoma (OAC). They have different pathogenesis but similar presentation. Both carry a very poor five-year survival of 17% compared with more common cancers such as colorectal (60%), prostate (88%) and breast cancer (86%). The UK has the highest incidence of OAC in Europe in females and the second highest in males.

**Oesophageal cancer is twice as common in men than** women with peak incidence at presentation in the 65-75 age group. Smoking is a major risk factor for oesophageal cancer and is linked to an estimated two-thirds of cases in the UK. Other risk factors include excess alcohol intake, chewing betel leaf, gastro-oesophageal reflux disease, obesity and Barrett's oesophagus.

**Oesophageal cancer commonly presents with dysphagia** or odynophagia and can be associated with weight loss and vomiting. Referral for urgent endoscopy should always be considered in the presence of dysphagia regardless of previous history or medication. Dysphagia, weight loss and age are strong positive predictors of cancer. In a study on symptom referral for rapid access endoscopy, 92% of patients with malignancy had either dysphagia, weight loss or were over the age of 55 with other alarm symptoms. NICE recommends urgent referral (within 2 weeks) for direct access for upper GI endoscopy in patients with dysphagia and those aged 55 years or over with weight loss and any of the following: upper abdominal pain, reflux, or dyspepsia.

**Once diagnosis has been confirmed, the staging process** enables patients and their doctors to choose appropriate treatments and avoid unnecessary surgery in those patients with advanced or incurable disease. Computed tomography of the neck, chest, abdomen and pelvis (whole body) is carried out initially to detect incurable disease. If the patient has no distant metastases or local invasion, a clinical assessment for curative treatment including surgery is carried out. Tumours that show local invasion or distant metastases are not amenable to curative treatment.

**The majority of patients with oesophageal cancer have** incurable metastases at diagnosis. Palliative combination chemotherapy is an option in advanced oesophageal cancer. Dysphagia is the predominant symptom in patients with oesophageal cancer and self-expanding metal stents can be used to relieve dysphagia and aid nutrition. Nutritional assessment and review by a dietitian should be offered before, during and after radical treatment or palliative treatment.