the outcome of this potentially curable cancer. Current evidence regarding available and appropriate treatment options are then reviewed.

‘The UK has the highest incidence of oesophageal adenocarcinoma in Europe’

RISK FACTORS
UK cancer registration statistics show a 2:1 male to female ratio for oesophageal cancer. Peak incidence at presentation is in the 65-75 age group, with 95% of cases presenting in those over the age of 50. Smoking is a major risk factor for both types of oesophageal cancer and is linked to an estimated 66% of cases in the UK. OSCC is linked to alcohol, smoking and chewing betel quid. OAC is associated with the presence of GORD and its duration and obesity (especially increased waist circumference).

Metaplastic change in the distal oesophagus from recurrent acid reflux damage, known as Barrett’s oesophagus, is a precursor and risk factor for OAC. The risk of developing OAC with Barrett’s oesophagus is currently 0.1-0.33% per year. Diagnosis of Barrett’s oesophagus generally triggers endoscopic surveillance to enable early diagnosis in the event of cancer developing which improves survival. GORD has been discussed in a previous review article in this journal.

SUSPICIOUS SYMPTOMS
Oesophageal cancer commonly presents with dysphagia or odynophagia (pain with swallowing). This can be associated with weight loss and vomiting. Other important causes of dysphagia are listed in table 1, below, but referral for urgent endoscopy should still be considered in the presence of dysphagia regardless of previous history or medication. The significance of dysphagic symptoms was highlighted in a recent study based on symptom referral for rapid access endoscopy. Dysphagia, weight loss and age were strong positive predictors for cancer. In this study, 92% of patients with malignancy had either dysphagia, weight loss or were over the age of 55 with other alarm symptoms (see table 2, opposite). Although involuntary or unintentional weight loss has been defined as greater than 5% of body weight in over six months, in clinical practice objective markers are rarely available therefore any subjective history of weight loss in the absence of any known illness should be considered given its importance.

‘Referral for urgent endoscopy for dysphagia should be considered regardless of previous history or medication’

Because of the elasticity of the oesophagus, advanced tumours can present without dysphagic symptoms. Anaemia (lesion bleeding), hoarse voice (early mediastinal invasion) or weight loss (metastatic spread) may manifest. At-risk or alarm symptoms for oesophago-gastric cancer have been identified in guidelines by NICE, SIGN and the British surgical and gastroenterological societies.

‘Advanced tumours can present without dysphagic symptoms’

The NICE recommendations for endoscopy referral to assess for suspected oesophageal cancer in their recently updated guidelines are shown in table 2, opposite. These guidelines differ slightly from other earlier guidelines regarding who to refer urgently or to consider for non urgent endoscopy. SIGN recommends early endoscopy for patients with dysphagia, recurrent vomiting, anorexia, weight loss or gastrointestinal (GI) blood loss regardless of age and the British surgical and gastroenterological societies recommend rapid access endoscopy for all patients over 55 with recent onset dyspepsia regardless of a response to treatment or all patients with alarm symptoms irrespective of age.