There are two main types of oesophageal cancer, oesophageal squamous cell carcinoma (OSCC) and oesophageal adenocarcinoma (OAC). Although their pathogenesis differs they present in the same manner. Both carry a very poor five-year survival of 16%. In the UK there is 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 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. OAC 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).

Oesophageal cancer commonly presents with dysphagia or odynophagia (pain with swallowing). This can be associated with weight loss and vomiting. All patients with recent onset dysphagia should be referred for rapid access endoscopy. Referral for urgent endoscopy should still be considered in the presence of dysphagia regardless of previous history or medication. Dysphagia is not always present; therefore all patients with alarm symptoms should be considered for endoscopy.

NICE recommends referral for urgent direct access upper GI endoscopy to assess for oesophageal cancer for: Dysphagia or Aged 55 and over with weight loss and any of the following: upper abdominal pain; reflux; dyspepsia. Non urgent direct access upper GI endoscopy should be considered for: Haematemesis; or Aged 55 or over with: treatment-resistant dyspepsia or upper abdominal pain with low haemoglobin levels or raised platelet count with any of the following: nausea; vomiting; weight loss; reflux; dyspepsia; upper abdominal pain or nausea or vomiting with any of the following: weight loss; reflux; dyspepsia; upper abdominal pain.

Patients over 55 with dyspepsia should be fully reviewed to assess for the ‘full’ response to treatment. Non urgent referral for endoscopy is acceptable when any clinical suspicion is raised, persisting upper GI symptoms are unexplained or proton pump inhibitor treatment is required long term (>6 weeks).

Patients deemed medically fit with non-metastatic or locally invasive tumours should be offered surgical resection to cure early cancers (Stage I-IIA) and chemotherapy (neoadjuvant) followed by surgical resection for higher stage tumours (Stage IIB+) as it improves long-term survival.

Most patients presenting with oesophageal cancer have incurable metastases at diagnosis. A palliative treatment plan should be considered. Palliative combination chemotherapy can be offered in advanced oesophageal cancer. Self-expanding metal stents can be used to aid dysphagia and nutrition.

Advances in endoscopic imaging now result in detection of early, non-ulcerating carcinomas at screening before dysphagia develops. In small nodular lesions < 2 cm, endoscopic mucosal resection may be considered to stage and treat early cancers and differentiates between high-grade dysplasia, Tla and Tlb lesions. Endoscopic removal may be complete and considered curative in Tla given the low incidence of lymph node metastases in this group (<5%), and avoids surgery.

Palliative treatment
Most patients presenting with oesophageal cancer have incurable metastases at diagnosis. A palliative treatment plan should be considered by the MDT, taking into account performance status and patient preference. Early direct involvement of the palliative care team, the cancer nurse specialists and diététiciens (all core members of the MDT) is essential.

Palliative combination chemotherapy can be offered in advanced oesophageal cancer. Trials have shown response to palliative chemotherapy in 37-48% of patients. Mean survival ranges from 8 to 15 months with better outcomes in OSCC groups. In patients with advanced OAC involving the upper stomach, endoscopic biopsies are assessed for HER-2 immunopositivity. The addition of trastuzumab can result in a statistically significant improvement in response rate and median overall survival (13.8 versus 11.1 months) in patients with HER-2 receptive tumours.

Dysphagia is the predominant symptom in patients with oesophageal cancer. Self-expanding metal stents (SEMS) can be used to aid dysphagia and nutrition. They can be placed endoscopically or radiologically in a single procedure. When SEMS are compared with other methods to help swallowing, such as endoscopy with argon photocoagulation debulking, they have similar outcomes on quality of life, but debulking requires multiple procedures so is avoided in those patients with limited life expectancy.

Complications of SEMS are stent migration, pain for up to ten days, blockage and stent overgrowth by tumour requiring further stents or endoscopy in one third of cases. Dilatation is rarely used because of the high risk of perforation and early recurrence and percutaneous endoscopic gastrostomy placement is only rarely used.

SUPPORT AND FOLLOW-UP
Diétetic review and cancer nurse specialist input has been demonstrated to contribute to improved quality of life. The cancer nurse specialist is central to patient care, consulting with multiple specialties including primary care to provide a co-ordinated approach and act as the patient’s advocate. Regular review of patients following therapy is required to manage post-treatment side effects such as dysphagia and post-surgical diarrhoea and pain. Regular access to cancer nurse specialists has been shown to be cost effective in supporting follow-up.

In the palliative setting these nurses can ensure close liaison with primary and secondary care and help avoid readmission for relief of pain, nutrition and dysphagia.

FUTURE DIRECTIONS
The assessment and evaluation of outcomes is fundamental in the management of oesophageal cancer. The National Oesophago-Gastric Cancer Audit has set high standards. With drivers like this it is encouraging to see cancer registries across Europe reporting gradual improvements in five-year survival rates, however, they are still generally poor and varied. The observed trends reflect the variations in alcohol consumption, smoking and obesity across European countries. With these remaining high we need to develop effective treatments with limited morbidity that minimise significant effects on quality of life and health service resources. Minimal access surgery and developments in endoscopy are encouraging.

Preventative strategies to improve rates of oesophageal cancer including smoking cessation and weight reduction are required in the UK. Increasing expertise and evidence for treating early lesions in Barrett’s oesophagus mean less invasive endoscopic techniques can be used to prevent cancer development.

Given the advanced stage of oesophageal cancer at presentation, waiting for patients to develop alarm symptoms before referring them for endoscopy would be unlikely to improve our five-year survival rates. There are currently very limited non-invasive biomarkers to detect or screen for early oesophageal cancer. Research to develop a novel approach to early diagnosis of Barrett’s oesophagus and dysplasia using a swallowed cell collection device (Cytosponge), coupled with molecular assays is in