key points

SELECTED BY
Dr Phillip Bland
GP, Dalton-in-Furness

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. 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).

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.