<u>Oesophageal cancer podcast outline</u>

Types: the 2 most common

Squamous cell carcinoma

Adenocarcinoma

Risk factors

Squamous cell Carcinoma

- smoking and alcohol
- longstanding achalasia
- human papillomavirus
- caustic injury
- diet: Low fruits and vegetables , high in nitrogenous compounds
- tylosis –rare Autosomal Dominant disease with hyperkeratosis of palms and soles

Adenocarcinoma

- Gastroesophageal reflux and Barret's oesophagus
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Clinical presentation

Typical
Mainly presents with Progressive dysphagia - Functional grading – Grades 1 -6

Anorexia and weight loss

Symptoms of local invasion
TOF - coughing, choking, and aspiration pneumonia.
Vocal cord palsy with RLN invasion

Asymptomatic pats
Identified on endoscopy (surveillance or other indications)

On exam
Severely wasted, dehydrated, pallor
Signs of metastases (i.e. tinge of jaundice, cervical LN etc.)

Differential diagnosis

Malignancy

Reflux stricture

Dysmotility disorders: Achalasia, Scleroderma

Investigations

Diagnosis
Barium swallow, initially - features of cancer, level and length of cancer
Endoscopy and biopsy

General
Routine bloods: U&E, FBC, LFT, no tumour markers
Imaging: Chest X-ray

Staging

Based on AJCC TNM classification

Staging modalities

- CX-ray and abdominal u/s
- CT scan – Chest abdomen pelvis – modality of choice
- Endoscopic ultrasound (EUS) for local staging

The most common sites of metastases are lymph nodes, lung, liver, bones, adrenal glands, brain and peritoneal surfaces

- (PET) scanning to assess whether distant masses are metabolically active

Management

Approach to management is based on

- patient factors - age , comorbidities and general health (cardiopulmonary reserve , nutritional status)
- extent of tumour staging and location(i.e. cervical tumours)

Based on tumour stage

- Confined to mucosa (T in situ, T1a) - consider with endoscopic treatment.
- Confined to the oesophagus (T1, T2 N0) – Surgical resection with adjacent lymph nodes
- Locally advanced (T1– 3, N1) resectable -multimodality approach in a surgically fit patient.
- Locally advanced irresectable T4b - palliation
- Disseminated cancer (M1, any T, any N) - Palliation of symptoms
- Cervical tumours – Definitive chemoradiotherapy

Surgical Approach

Esophagectomy - should only be considered if R0 resection can be achieved

Clinical staging of resectability

- Favourable factors – short and small tumour
- Unfavourable factors – long tumours (>8cm), nerve involvement, fistula, pleural effusion

Types of surgical resection - Trans-hiatal, Three-Stage, Two -stage

- Open or thoracoscopic laparoscopic

Palliation

Dysphagia Palliation – SEMS and or Radiation (brachytherapy or external beam), for OGJ tumours consider radiation over stent if feasible

Analgesia – morphine syrup

Conclusion

- Investigations: start with barium swallow, then endoscopy, followed by staging
- Determine Resectability
- Determine patient's operability