



Medicine for Managers

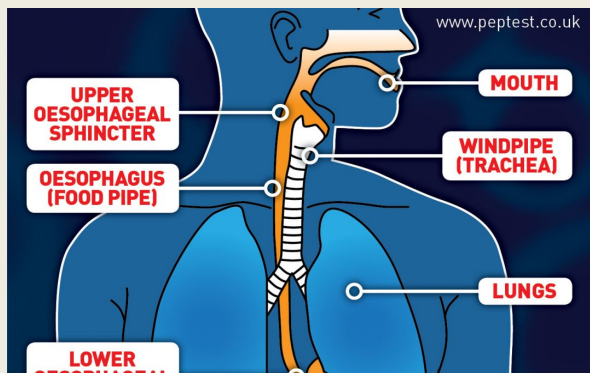
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Oesophageal Cancer

Over Christmas, the BBC showed repeats of programmes starring the late, great comedian and writer, Victoria Wood, CBE, who died in 2016 at the age of 62 from oesophageal cancer. Her panoply of comedic skills was considerable and her talent was lost too early. The UK has rates of oesophageal cancer that are higher than in most of Europe and it is unclear why this should be the case. About 9,300 new cases are diagnosed each year.

Data shows that, in the UK, there are about 14.2 cases of oesophageal cancer per 100,000 people and in Europe only the Netherlands is higher at 14.9 cases per hundred thousand people.

In Italy it is only 3.5, in France 7.0 and in Germany 7.7. About 9,300 patients are diagnosed each year and it is the 10th most common cancer in the world and the 14th most common in the UK. Of concern is the fact that fewer than 20% of people diagnosed with oesophageal cancer in the UK will survive for more than five years.



The oesophagus is essentially a muscular tube extending from the throat to the stomach.

It is protected at either end by sphincters (valves) which prevent food entering from the mouth when not required or regurgitated into the oesophagus from the stomach. It passes behind the trachea.

Oesophageal cancer develops as a result of proliferation of abnormal cells within the lining of the oesophagus.

It is believed to be associated with the development of some sort of genetic malformation resulting from damage to the cellular genetic structure.

Of every ten cases, about six develop in the lower oesophagus within the mucous glands, and four occur in the upper or middle part in the squamous cells which line it. It is more common in men than women.

Although there is no apparent reason in many cases why a patient should develop such a tumour, there are a number of risk factors which increase the odds of one developing.

It is primarily a disease of older people with 40% of cases occurring in people over the age of 75, although there are increasing numbers of cases in people below 50. Other factors include:

- Smoking (believed to be responsible for about one third of cases)
- Excessive alcohol consumption
- Diet. A high fat diet, and obesity increases the risk and about 1 in 4 cases is associated with obesity or overweight
- Persistent acid reflux from the stomach known as GORD (Gastro-Oesophageal Reflux Disease). A small number of people with GORD go on to develop a cancer.

Barrett's Oesophagitis occurs as a result of long-standing acid reflux with acid damage, resulting in the development of abnormal oesophageal cells. About 1 in every 200 Barrett's sufferers will develop cancer.

Symptoms

Typically, symptoms develop late in the disease and the first symptom is normally **dysphagia** (difficulty swallowing) as the tumour growth narrows the tube. Other symptoms include:

- Vomiting after eating
- Increased indigestion or heartburn
- Choking and vomiting
- Coughing, increased chest infections and hoarseness of voice
- Weight loss, loss of appetite and tiredness and lassitude

Diagnosis

Patients with symptoms will be referred by GPs for endoscopy and imaging investigations. A gastro-intestinal physician will arrange:

- Oesophago-gastroscopy to view directly the cavity of the oesophagus and the junction with and body of the stomach
- Barium swallow may sometimes be used. The patient swallows radio-opaque barium liquid which outlines the oesophageal cavity to identify any suspicious areas.

If any suspicion is raised a biopsy through an endoscopy is taken and sent to the laboratory to look for any cells suggestive of cancerous change.

- Ultrasound, MRI or CT scans and other types of scan may be used to identify the extent of the cancer (whether it is localised or has spread) so that a decision can be made on the most effective management.

Treatment

Depending on the location and spread of the disease, there are a number of options.

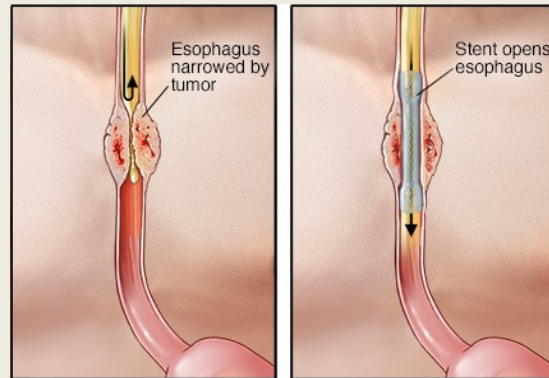
- **Surgery.** In localised cases, the tumour may be excised from within the oesophagus, removing some healthy surrounding tissue with it. In more extensive cases, part of the oesophagus may be removed together with other involved diseased tissue. Following removal of part of the oesophagus and part of the stomach, the remaining oesophagus may be joined directly to

the remaining stomach. The operation may be carried out endoscopically or through opening the chest.

Because the surgical area contains many structures, including major blood vessels, there is a significant risk of serious complications such as bleeding or infection.

- **Chemotherapy** using anti-cancer drugs, which may supplement the surgery or where the tumour has spread beyond the immediate area. It may be used to manage symptoms rather than to attempt to eradicate the disease and side effects include nausea and vomiting, fatigue, loss of appetite and weight loss
- **Radiotherapy**, which is often combined with chemotherapy to enhance effectiveness
- **Targeted Drug Therapy** uses medication which attacks specific chemicals in cancer cells. It is not an option in all cases. It may be combined with other therapies and can be effective.
- **Immunotherapy** is medication which helps the body's immune system to destroy cancer cells. Immunotherapy augments the ability of the immune system cells to find and kill cancer cells.

Sometimes, the tumour may grow to narrow or obstruct the oesophagus. A surgeon may be able to place a plastic or metal tube through the



tumour to hold the oesophagus open and allow the passage of food.

Survival rates with the disease are disappointing but, with earlier diagnosis, more skilled surgery and the introduction of targeted therapy and immunotherapy, the percentage of patients cured or treated to improve life expectancy, is increasing.

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