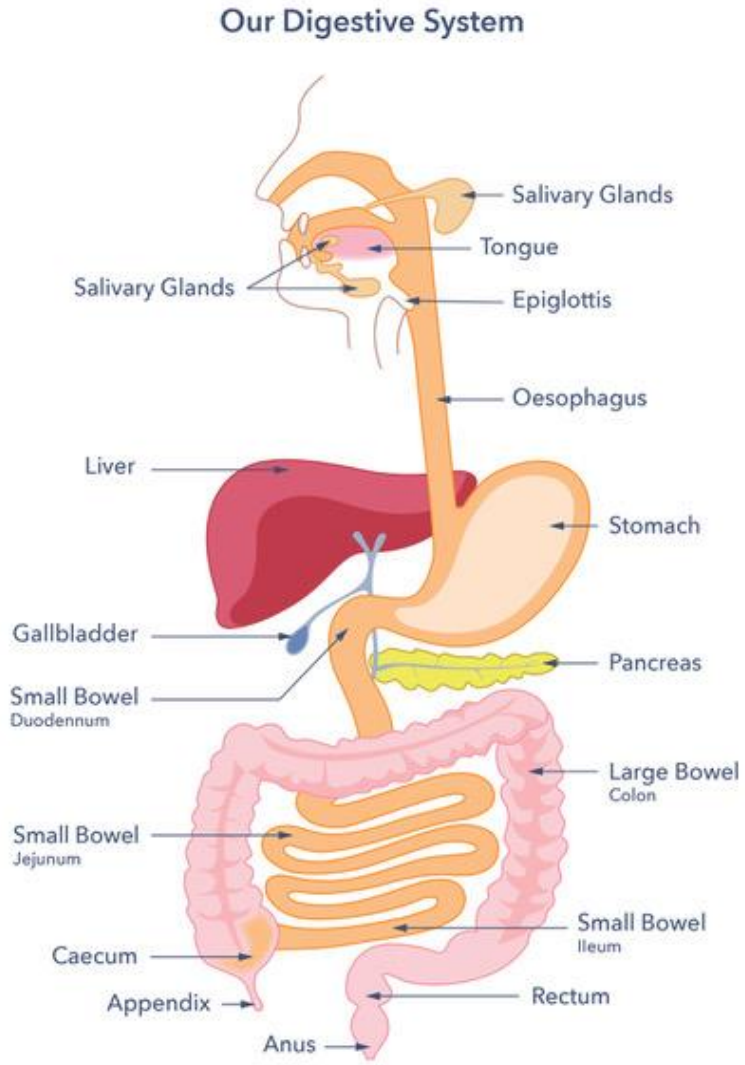
FUNDING RESEARCH TO FIGHT DISEASES OF THE GUT, LIVER & PANCREAS

THE DIGESTIVE SYSTEM



THIS FACTSHEET IS ABOUT CANCER OF THE OESOPHAGUS

The oesophagus (often known as the gullet) is a muscular tube that leads to the stomach. Food and drink pass from the back of the throat into the stomach through the oesophagus. When food is consumed the muscles at the top of the oesophagus contract, forcing food and fluid downwards into the stomach. At the lower end of the oesophagus there is a muscular valve (the sphincter), which prevents food and fluid being pushed upwards from the stomach.

Around 1 in 5 to 1 in 3 of the population appear to have a weakness of the lower oesophageal sphincter (valve), which allows acidic stomach contents to splash back up into the oesophagus, causing heartburn and regurgitation (reflux). One person in 10 people with reflux may develop a condition where the cells in the lining of the oesophagus change and this is called Barrett's oesophagus. (link to information on Barrett's oesophagus) People with Barrett's Oesophagus are at increased risk of developing adenocarcinoma of the oesophagus (see prevention.)

CAUSES

CAUSES OF CANCER OF THE OESOPHAGUS

This cancer is particularly common in some parts of Africa and China, and is likely to be partly caused by the local diet or the way that food is preserved and cooked. Important risk factors for cancer of the oesophagus include smoking cigarettes and drinking alcohol, particularly spirits.

A combination of both smoking and spirit-drinking considerably increases the risk. It also appears that the amount of acid reflux (see above) and the period of time over which the oesophagus has been exposed to this acid, are risk factors which may explain the recent increase in the number of cases of adenocarcinoma of the oesophagus. A rare disorder of the muscles of the gullet, known as achalasia, in which there is a failure of relaxation of the muscular valve at the bottom of the gullet, very occasionally leads to cancer.

SYMPTOMS

WHAT ARE THE USUAL SYMPTOMS OF CANCER OF THE OESOPHAGUS?

Oesophageal cancer may cause no symptoms until it begins to obstruct passage of food and fluids down the gullet, or to make swallowing painful. As the cancer develops, there is progressive difficulty in swallowing (dysphagia), at first with solids such as meat and bread, and then with softer foods, and eventually there is difficulty in getting liquids down. Some people might also report bringing up thick clear sectretions, which they might describe as 'vomiting'. People begin to lose weight and may have other symptoms, such as choking, coughing, unexplained chest infections or a hoarse voice. Although some people report long-standing heartburn before developing these symptoms, most people who develop oesophageal cancer have no symptoms of this kind before they experience dysphagia.

HOW IS OESOPHAGEAL CANCER DIAGNOSED?

Most people seek medical attention because of problems swallowing, and going to the doctor early when symptoms begin is important, to increase the chances of early diagnosis and effective treatment. The GP is likely to make a referral to a specialist for investigations. These are likely to include a barium swallow, which involves swallowing a white liquid containing barium, which shows up on X-ray, outlining the oesophagus and revealing any obstruction. Another test likely to be used is an endoscopy, in which a narrow, flexible telescope is passed gently into the gullet through the mouth, using a local anaesthetic throat spray. Changes in the lining of the gullet can be seen and samples taken (biopsy) for laboratory examination.

If cancer is diagnosed, other tests may be needed to see if it has spread. These include chest X-ray and ultrasound examinations of the chest, and other tests such as a CT scan or magnetic resonance imaging (MRI) scan. Sometimes it is necessary for a surgeon to look inside the abdomen using a special illuminated tube (laparoscopy).

TREATMENT

HOW IS OESOPHAGEAL CANCER TREATED?

Surgery: is the most common treatment in the United Kingdom, particularly if the cancer has not spread beyond the oesophagus. Depending on the position of the tumour the surgeon may need to enter the chest cavity, the abdomen or the neck, and will remove the affected part of the oesophagus with the surrounding lymph glands. A tube is then made out of the stomach, which is drawn up into the chest or neck where it is joined to the remainder of the oesophagus. This is called an oesophagectomy. Patients are usually cared for in an intensive care ward after this operation and after leaving hospital are able to eat normally, although may feel full rather quickly. This sensation usually improves over the next few months.

The surgery may result in a condition called dumping syndrome, which results in symptoms of dizzyness, diarrhoea and abdominal pain you can read more about dumping syndrome here:

Sometimes problems swallowing returns weeks or months after the operation. This may be because the cancer has returnedcurred, but often is due to scarring (known as a 'stricture') where the surgeon has made the join. These strictures can be easily stretched using an endoscope.

HOW CAN I PREPARE MYSELF FOR SURGERY?

Preoperative (before surgery) habilitation or PREHAB is a means of increasing fitness by improving activity, nutrition and wellbeing for people with cancer before surgery. PREHAB is becoming increasingly recognised for improving people's ability to cope with cancer treatment. Ask your doctor if this is available in your area.

Radiotherapy: also offers a potential cure, and it is particularly useful for people with early tumours, especially squamous cancer. Radiotherapy can be used in conjunction with surgery and is also often used as an alternative to surgical treatment, when the type and position of the tumour and the patient's general condition may influence the decision to operate. When radiotherapy is given in an attempt to cure the cancer it is known as radical radiotherapy. Oor, when the tumour cannot safely be removed by surgery, radiotherapy, sometimes with chemotherapy, is used in smaller doses and is known is palliative radiotherapy, intended to treat the symptoms caused by the cancer.Palliative radiotherapy is sometimes used with chemotherapy to treat the symptoms. Radiotherapy can be given as an external beam or on the inside of the gullet via an endoscope (brachytherapy).

Treatment of symptoms: If surgery is not possible, there are other ways to help to relieve difficulties in swallowing.

Endoscopic intubation: is usually done under sedation or anaesthetic in the endoscopy department. A tube (stent) is inserted into the gullet to keep it open, so that food and fluid can be swallowed without difficulty. These tubes are made of either plastic or springy metal coils. They can become blocked by large food particles so that specific instructions on diet are always provided. Sometimes these tubes cause troublesome heartburn and regurgitation, which can be helped considerably by taking acid suppressing medication. If you have had weight loss

and are struggling with eating ask for a referral to a dietitian from your consultant or GP.

Endoscopic laser treatment: is also possible, and a specialist endoscopist will use a laser to destroy any tumour that is growing into the gullet. In some ppeople atients laser treatment and intubation need to be combined.

Palliative care: is provided to people who have an illness that can't be cured. Palliative care practitioners are experts in managing symptoms from cancer and also symptoms from cancer treatments. Palliative care practitioners can provide significant improvements in quality of life for someone who has a life limiting diagnosis. Ask your doctor if you can be referred to a palliative care team.

Everyone with oesophageal cancer should have access to a dietitian to prevent weight loss and for advice with regards to diet changes that might be needed after treatment. Ask your consultant to refer you to one.

CAN OESPHAGEAL CANCER BE PREVENTED?

Where lifestyle factors are known to be a risk for developing oesophageal cancer reducing the risks are beneficial. Stopping smoking and reduction in alcohol consumption can reduce the risk of someone developing oesophageal cancer.

Check the amount of alcohol you drink here https://www.drinkaware.co.uk/ and if you drink heavily, it is best not to stop immediately, but ask your GP for a referral to local alcohol support services to help you reduce the amount you drink slowly with an aim to stop. You can find more information about what is available here Alcohol support - NHS (www.nhs.uk).

To stop smoking check the following link https://www.nhs.uk/better-health/quit-smoking/?WT.mc_ID=JanQuitSmokingPPC&gclid=CO7SoYGSme4CFQ7hGwodggoB1A

People with Barrett's Oesophagus are at increased risk of developing adenocarcinoma of the oesophagus. To try to prevent cancer developing, people diagnosed are required to undergo endoscopic surveillance – inspection of the oesophagus through an endoscope every one to two years – in an attempt to pick up pre-cancerous changes, known dysplasia, and prevent progression to cancer. A number of trials of endoscopic surveillance in Barrett's Oesophagus are still underway, and it is not known for certain how effective different patterns of surveillance are like to be.

Chemoprevention (preventing cancer by using drugs) is an exciting new idea in the prevention of oesophageal cancer, and trials are currently underway to

determine whether drugs, such as aspirin giving in conjunction with an acid suppressing agent, are capable of preventing the development of cancer of the oesophagus.

SUPPORT

DOES OESOPHAGEAL CANCER NEED TO BE MONITORED AND IF SO, HOW?

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WHAT TO ASK YOUR DOCTOR?

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For further information, visit gutscharity.org.uk