



Royal Berkshire
NHS Foundation Trust

Oesophageal cancer

Information for patients about
treatment options

This booklet will explain what is likely to happen if you have been diagnosed with a suspected cancer of the oesophagus.

The gullet (oesophagus) is a tube, which lets food and drink pass from the throat to the stomach. It is found in the centre of the chest (like an apple core in an apple) and has muscles that help food pass down it.

The reason you have been asked to see a surgeon at the Royal Berkshire Hospital is that you have either been shown to have a malignant tumour (cancer) or there is a high suspicion that this may be the problem with your swallowing – i.e. an obstruction in the gullet may be causing it to narrow or tighten.

This booklet has been developed to give you more information about treatment.

What investigations will I need?

You may have already had some of these tests but others may be ordered.

Barium swallow - This is a series of x-rays taken when you swallow some fluid, which will show up on the x-ray film. This allows us to see the part of the oesophagus, which has become tight and prevents you from swallowing. Some patients find the fluid they are given to drink unpleasant but the amount drunk is small. This test takes about half an hour.

Ultrasound scan - This test is completely painless. A listening probe and gel is applied to your abdomen (tummy) so the liver can be seen clearly. Pregnant women have a similar test (scan) to look at the unborn baby. The reason for this test is to show if the disease (cancer) has spread to the liver. The scan takes about 20 minutes.

CT scan - This is a series of special x-rays which view the body in thin slices. It involves you lying on a table, which slowly passes through a circular machine (like going through the hole of a mint!). The test takes a few minutes to set up and then the scan lasts about 2-5 minutes.

Oesophagoscopy - This is an investigation under sedation or local anaesthetic, when a surgeon will look down your oesophagus and perhaps take a small piece (biopsy) to send to the laboratory. This may have been performed before your admission to the Royal Berkshire Hospital.

Occasionally, at the same time, a bronchoscopy (look into the breathing tubes of the lungs) will be performed. This takes about half an hour.

Endoscopic ultrasound (EUS) - This test is carried out in a similar way to the oesophagoscopy. A scope with an ultrasound probe on the end is used to estimate the depth of your tumour through the oesophageal wall using sound waves. A similar test is used to look at unborn babies. It is also used to estimate the spread of tumour into local nodes and nearby structures. You may find you have a sore throat after the procedure. It takes about half an hour.

PET scan – This scan is similar to a CT scan. You will be given an injection of special glucose which passes in to rapidly dividing cells (tumour cells). When the scan is taken any areas of disease spread and the primary cancer will show up on the scan pictures.

This test is performed in Oxford. You will be contacted directly by them with the appointment and more details will be given at this time.

Laparoscopy - A look inside the abdomen (tummy) by putting a small camera through one or two holes about ½ inch long. The space around the liver and stomach can be seen. This test is also done under general anaesthetic and shows if the disease (cancer) has spread. This takes about half an hour to perform and you would

usually be able to go home on the same day.

Cardiopulmonary exercise (Cpex) test – This test is a basic fitness assessment. You will be asked to cycle on a type of exercise bicycle whilst machines monitor your heart and breathing.

The results of the test give the anaesthetist an accurate assessment of how well your heart and lungs work allowing them to predict more accurately the risk of surgery.

Will I need any other treatment?

Pre-operative chemotherapy

This treatment is given before the operation over a period of 4 - 9 weeks. You will be given two or three courses of strong drugs, either by intravenous injection (directly into the blood) or in tablets for you to take. These may make you feel unwell with nausea (sickness), vomiting and tiredness. The nausea and vomiting will be controlled with strong anti-sickness drugs. Your ability to fight infection may reduce but this returns to normal after the treatment. Occasionally, some people have some hair loss – but if this occurs, a wig can be provided. This treatment is being offered to patients following research, which shows some cancers get smaller after the drugs. In order to have this you must be fit and able to cope with the side effects. More details will be given when you see the specialist chemotherapy doctor (oncologist) at his/her outpatient clinic. After the surgery the doctors may suggest a further course of chemotherapy. The pro's and con's will be discussed with you, as not all patients are suitable for post operative chemotherapy or radiotherapy (x-ray treatment).

Operation

The reason for the operation is to allow you to swallow normally (most patients with cancer of the oesophagus have problems swallowing normal food, bread, potatoes and meat).

It is our philosophy not to perform major surgery on patients in whom the disease has already spread (seen on the scans). If this is the case, we shall not carry on with the big operation but to help your swallowing, a metal mesh tube can be put inside the oesophagus to keep it open and allow you to swallow more normally. This tube cannot be seen or felt.

If during the operation we find that the cancer has spread, again, we will not proceed and a stent (tube) will be put in place to help the oesophagus to stay open. You should then be able to eat more easily. More details about the tube will be given when it is used.

An operation to remove part or all of the oesophagus and part of the stomach is considered to be major surgery. It requires large incisions (cuts) to get to the area but these are sewn up with dissolvable sutures (stitches) or metal clips which have to be removed. Occasionally, we are able to perform part of this surgery using telescope instruments so only small incisions are then needed (keyhole surgery).

Assuming the operation goes according to plan, you will stay in hospital for about 10-14 days after the surgery.

What happens in the early post-operative days?

The first few days after the operation are spent in the intensive care unit (usually 1-2 nights) and then you will be transferred to a ward. Whilst in these areas you are carefully monitored by the nurses who are always close at hand.

During this time you will have a number of drains/tubes. The first you become aware of is the one that does your breathing for you; it goes through the mouth down the back of the throat into the lungs. When you are warm and stable, this tube is removed to be replaced with an oxygen mask over your nose and mouth to aid your breathing.

Other tubes stay in for up to seven days. These are:

Nasogastric tube - This goes through the nose into the stomach to keep it empty.

Central venous line - This is a drip into the side of your neck so we can give you fluids because you can't eat or drink for four or five days. We can also give drugs that you may need through this line.

Intercostal drain - This goes into the area around the lung to help it re-expand.

Jejunostomy tube – A curled tube on the tummy, which goes into the small intestine. We give you a liquid feed through here (not always used).

Catheter - This drains the urine so we can know accurately how much you are making. This helps us to decide the amount of fluid to give.

Epidural - This is a very thin plastic tube put into the area around the spine. Drugs are given down this to reduce your pain. It normally stays in place for five days. The anaesthetist will give you more details about this.

At the Churchill Hospital, Oxford there is a Pain Control Team who visit to make sure pain is under control at all times – there is no reason to have pain.

Most of these tubes and drains stay in place for five to seven days. At this time most patients have a barium swallow to check everything is all right. If it is, then you are allowed to drink freely. It is at this stage that these tubes are removed.

Throughout your stay you will receive physiotherapy and dietary advice.

Cancer is a big disease to come to terms with. If you want to receive specialist advice the hospital has a Clinical Nurse Specialist who will come and talk to you. This support can be arranged when you go home as well if you wish.

Are there any risks?

Patients and their relatives are understandably very anxious about the risks of surgery. What we say to you is that, with today's modern anaesthesia and monitoring, it is extremely unlikely that you will come to harm during your operation.

Some patients have other problems (angina, diabetes, chronic bronchitis, asthma, emphysema or hypertension – high blood pressure). We have seen that a combination of these factors is sometimes too much for the body to bear. Occasionally, we run into complications (problems) and sadly there are times when the patient dies.

In order to put this into perspective for you, we can tell you that this operation done by general surgeons in the United Kingdom has a mortality rate of between 7-10%. In our unit at the Royal Berkshire Hospital, over the last 3-4 years the mortality rate has been about 4-6%. These figures may well frighten you but they have to be set against the fact that if nothing is done for your disease then you will probably come to a situation where you are unable to swallow even your own saliva. We feel that the risks are fairly low and we do all in our power to minimise these.

We realise that the information in this booklet may be a little alarming and we would like you in the first instance to discuss problems with your GP. At the back are numbers to contact if you need further questions answered. When patients have had their first meeting and have read this booklet we arrange a second meeting with the surgeon to go over any worries.

After the operation there are some short term and longer term problems you may experience. These are:

1. The majority of patients notice a temporary disturbance of their taste. In particular, things like tea may taste extremely unpleasant. This usually returns to normal after 6 weeks.
2. You will never be able to eat three large meals a day and you will have to change your diet to take small meals often with snacks in between.
3. Something which may be affected is the feeling of hunger. Within about 5 –7 days of surgery, most patients are eating again. Usually soft food to start with, gradually building up to normal food. It is important to remember as time progresses and your sense of taste returns to normal, you will start to enjoy food again.

If anything is not clear or you still have questions, it may help to write them down and discuss them with the nurses or ourselves at clinic or when you next visit the hospital.

Support groups

Oesophageal Patients Association

22 Vulcan House

Vulcan Road

Solihull

West Midlands B91 2JY

Telephone: 0121 704 9860

www.opa.org.uk

Macmillan Cancer Support

89 Albert Embankment

London SE1 7UQ

Telephone: 0800 808 00 00

www.macmillan.org.uk

Upper GI Specialist Nurse

Royal Berkshire Hospital

London Road

Reading RG1 5AN

Telephone: 0118 322 7748

Reading Upper GI and Laparoscopic Surgical Partnership website

www.lapsurg.info/

Royal Berkshire NHS Foundation Trust
London Road
Reading RG1 5AN
0118 322 5111
www.royalberkshire.nhs.uk

This document can be made available in other languages
and formats upon request.

Written by Ruth Moxon. Revised September 2019
Review due: September 2021