

Optimal care pathway for people with oesophagogastric cancer

Quick reference guide



Please note that not all patients will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Prevention: Smoking cessation is associated with a reduced risk of oesophagogastric cancers.

Risk factors: There are very few people at high risk. People with the following risk factors are at increased risk:

Oesophageal adenocarcinoma	Male gender, obesity, gastro-oesophageal reflux, barrett's oesophagus, smoking, alcohol and age.
Oesophageal SCC	Heavy alcohol consumption, tobacco smoking, age, caustic injury and achalasia.
Gastric cancer	Age, <i>helicobacter pylori</i> (<i>H. pylori</i>) bacteria, previous partial gastrectomy, especially more than 20 years ago, tobacco smoking, pernicious anaemia and family history of gastric cancer.

Early detection: Awareness of risk factors and high-risk individuals can guide appropriate referral for specialist input and potentially surveillance.

Careful monitoring of Barrett's oesophagus may lead to early detection of cancer.

Step 2

Presentation, initial investigations and referral

Signs and symptoms:

- dysphagia (difficulty swallowing)
- persistent epigastric pain/dyspepsia
- pain on swallowing
- food bolus obstruction
- unexplained weight loss or anorexia
- haematemesis (vomiting blood) and/or melena
- early satiety
- unexplained nausea/bloatedness or anaemia.

The following symptoms require urgent consultation (within two weeks):

- new onset or rapidly progressive dysphagia
- progressive/new epigastric pain persisting for more than two weeks.

General/primary practitioner investigations: All people identified in high-risk categories should be referred for diagnostic endoscopy if presenting with symptoms.

Referral: Refer to an upper gastrointestinal (GI) surgeon with expertise in oesophagogastric cancer who is an active participant in an upper GI cancer multidisciplinary team (MDT).

Urgent referral by the specialist may also be required to allied health practitioners (particularly a dietitian) prior to an MDT meeting.

Communication – lead clinician to:

- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

Step 3

Diagnosis, staging and treatment planning

Diagnosis and staging: Biopsy material from a diagnostic endoscopy should be reviewed by an expert pathologist prior to MDT discussion.

Staging may include the following.

For oesophageal junction cancers:

- computed tomography (CT) scan of the thorax, abdomen and pelvis
- endoscopic ultrasound
- positron emission tomography (PET) scan
- endoscopic resection.

For gastric cancer:

- CT scan of the thorax, abdomen and pelvis
- focal endoscopic resection (in early lesions)

- laparoscopy (gastric/junctional cancer).

Treatment planning: All newly diagnosed patients should be discussed in an MDT meeting within four weeks of referral to agree treatment plan.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the MDT in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

1 Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment options: Given the poor prognosis of this cancer at present, for the majority of patients, treatment is often given with palliative rather than curative intent. Early specialist palliative care will be required.

Endoscopic treatments:

Suitable for high-grade dysplasia and selected cases of early cancer.

Surgery: Surgical resection is considered to offer the best long-term survival chance.

Palliative resection for late-stage disease is not recommended.

Chemotherapy or drug therapy:

This may be indicated for:

- locally advanced disease (pre- or postoperatively or as primary treatment)
- patients with HER2-positive advanced adenocarcinoma of the stomach, combined with targeted therapy (trastuzumab).

Radiation therapy: This may be indicated as part of:

- neoadjuvant therapy prior to surgery
- definitive chemoradiation (unresectable locally advanced disease) (oesophageal/ oesophagogastric cancers)
- symptom palliation.

Patients with metastatic disease should be assessed for suitability for chemoradiation, palliative chemotherapy and/ or targeted therapy, or other treatments such as radiation therapy or stent.

Palliative care: Review by a specialist palliative care team is essential. Early referral can improve quality of life.

Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as the risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

Step 5

Care after initial treatment and recovery

Treatment summary (provide a copy to the patient/carer and general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the patient/carer and general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)

- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Treatment of a recurrent, residual or metastatic oesophagogastric cancer is rarely curative.

Treatment: Where possible, refer the patient to the original MDT. For the majority of patients, cancer-directed treatment is often given with palliative rather than curative intent.

Palliative care: Review by a specialist palliative care team is essential. Referral should be based on need, not prognosis. Early referral can improve quality of life.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

Step 7

End-of-life care

Palliative care: Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient/carer
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.