Oesophageal and gastric cancers

Screening recommendations
Oesophageal Adenocarcinoma or Squamous Cell Carcinoma
No formal population-based screening programs
Careful monitoring of Barrett’s oesophagus may lead to early detection of cancer
- Regular surveillance – upper endoscopies or tissue biopsies
- Treatment of reflux symptoms
- Therapeutic intervention for high grade dysplasia

Gastric Cancer
No formal population-based screening programs

Summary statistics
- In Victoria 2018, there were 271 new cases of oesophageal cancer in males and 120 new cases in females. For gastric cancer, there were 393 new cases in males and 217 new cases in females
- The five-year survival for people with oesophageal cancer is 24%, and 32% for people with gastric cancer.

Risk factors
Oesophageal Adenocarcinoma or Squamous Cell Carcinoma
- Age
- Male gender
- Barrett’s oesophagus
- Smoking
- Obesity
- Gastric-oesophageal reflux
- Caustic injury
- Alcohol
- Achalasia.

Gastric Cancer
- Age
- Helicobacter pylori (H. pylori)
- Previous partial gastrectomy
- Smoking
- Pernicious anaemia
- Family history
- Race (Asian descent)

Prevention
- Offer all smokers advice on quitting
- Promote eating a healthy diet, including plenty of vegetables, fruit and wholegrains, while minimising intake of red and processed meat
- Encourage regular exercise
- Maintain a healthy body weight
- Avoid or limit alcohol intake.

Signs and symptoms
The following symptoms require urgent consultation within 2 weeks
- New onset or rapidly progressive dysphagia
- New onset or rapidly progressive epigastric pain (>2 weeks).

Other signs and symptoms
- Persistent epigastric pain/dyspepsia
- Pain on swallowing
- Food bolus obstruction
- Unexplained weight loss
- Haematemesis and/or melaena
- Early satiety
- Unexplained nausea/bloatedness or anaemia

Initial investigations
- Full blood count
- H. pylori (dyspepsia)
- Liver function test.
The Optimal Care Pathways were developed through consultation with a wide range of expert multidisciplinary teams, peak health organisations, consumers and carers. They are nationally endorsed by the National Cancer Expert Reference Group, Cancer Australia and Cancer Council Australia.

For more information on the Optimal Care Pathways please refer to www.cancervic.org.au/for-health-professionals/optimal-care-pathways

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### Figure 1: Risk assessment tool

<table>
<thead>
<tr>
<th>Low haemoglobin &lt;13g/dL</th>
<th>Raised platelets &gt;400 x10^9/L</th>
<th>Constipation</th>
<th>Chest pain</th>
<th>Abdominal pain</th>
<th>Nausea or vomiting</th>
<th>Dyspepsia</th>
<th>Epigastric pain</th>
<th>Reflux</th>
<th>Weight loss</th>
<th>Dysphagia</th>
<th>PPV as a single symptom</th>
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<td>PPV (%) or probability of Ca if Sx present</td>
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### Referral pathway

- Prior to referral, discuss the cost implications to enable patients to make an informed decision regarding their choice of specialist and health service, including out of pocket costs: for example, radiological tests and specialist appointments.
- People with symptoms suggestive of oesophageal or gastric cancer should be referred for urgent triage.
- Information should include:
  - Relevant psychosocial, medical and family history, current medications, allergies and results of clinical investigations (imaging and pathology reports).


### Patient resource checklist

- Arrange referral for behavioural support via Quitline [www.quit.org.au](http://www.quit.org.au) or individual/group stop smoking service Quitline 13 78 48
- For additional practical and emotional support, encourage patients to call Cancer Council 13 11 20 to speak with an experienced oncology nurse or visit [www.cancervic.org.au](http://www.cancervic.org.au) for more information about oesophageal and gastric cancers.
- For translator assistance call TIS on 13 14 50
- Download the ‘What to expect - Oesophagogastric cancer’ guide at [www.cancerpathways.org.au](http://www.cancerpathways.org.au)