

Oesophageal disorders and oesophageal cancer

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James talks to Dr Reginald Lord about oesophageal disorders and oesophageal cancer.

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About Dr Reginald Lord

Reginald Lord is a Gastrointestinal Surgeon at [St Vincent's Hospital](#) and [Macquarie University Hospital](#), Sydney. He is Professor and Head of [Surgery](#) at Notre Dame University School of Medicine and Head of Gastro-oesophageal cancer research program at the [St Vincent's Centre for Applied Medical Research](#).

Hard to Swallow - Oesophageal Disorders and Oesophageal Cancer

With Professor Reginald V. Lord, Upper GI Surgeon at St Vincent's Hospital, Head of Surgery at University of Notre Dame, School of Medicine, Sydney and Head of the Gastro-oesophageal Cancer Research Program at St Vincent's Centre for Applied Medical Research

Introduction

What is dysphagia? How does it differ from odynophagia?

Dysphagia

The sensation of difficulty in swallowing food or liquid from the mouth to the stomach. It is the most specific symptom of an oesophageal disorder and the goal of the history and examination is to either diagnose or exclude oesophageal cancer.

Odynophagia

Pain on swallowing usually due to an obstructive lesion or bolus of food and relieved by passage of the bolus. It often occurs with dysphagia. It is a less specific symptom and may also be indicative of a motility disorder.

Case 1

A 56-year-old obese man is sent in to the Emergency Department by his GP, complaining of being unable to completely swallow food. He says that a piece of food has been stuck in his chest since last night. On further questioning, he reveals this has been happening on and off for several months, but this is the first time he hasn't been able to clear it.

1. Initial priorities

- Have you attempted to relieve the obstruction? Uncarbonated Coca Cola, Pepsi, pineapple juice, papaw, glucagon
- Is the patient able to swallow their saliva? If not, they will require urgent endoscopy
- Does the patient have a cardiac history? Has an ECG been conducted?
- Any respiratory symptoms that might indicate a complication such as aspiration pneumonia? What are the oxygen saturations?

2. Outline your assessment approach by the bedside

- **History**
 - Dysphagia symptom assessment
 - Anatomy
 - Oropharyngeal ('transfer') dysphagia: difficulty transferring food from the oropharynx into the (cervical) oesophagus, usually in patients with neuromuscular disorders e.g. stroke
 - Oesophageal ('transport') dysphagia: difficulty transporting food through the tubular oesophagus in the thorax
 - Obstructive vs mechanical
 - Obstructive: due to a lesion, usually oesophageal cancer
 - Mechanical (non-obstructive): due to a motility disorder, usually achalasia
 - Any previous history of reflux?
 - Regular use of anti-reflux medications
 - Any improvement/worsening in symptoms?
 - Ever been diagnosed with Barrett's oesophagus? (precursor to oesophageal cancer)
 - Any symptoms of food as if it is getting stuck after swallowing? Do you have difficulty swallowing?
 - How long has this been occurring?
 - Solids only, or both solids and liquids?
 - Solids only: if progressive, suggests obstructive cause
 - Solids and liquids: motility disorder

- Dietary history (be aware that patients will subconsciously adjust their diet)
 - What did you have for dinner last night?
 - Can you eat rice/steak/bread/chops(large food bolus)? If not, when could you last eat these?
 - Can you eat soup (liquid bolus)?
- Weight loss?
- Past surgical history?
 - Reflux surgery (e.g. Nissen fundoplication) especially relevant
- Red flags
 - Progressive or solid food dysphagia
 - Bolus obstruction
 - Weight loss
 - Risk factors: male gender, obesity, middle-age
 - Back pain
- **Systems review**
 - Neurological: stroke risk factors
 - Cardiovascular: chest pain vs reflux symptom
 - Respiratory: laryngopharyngeal reflux symptoms e.g. adult-onset asthma
- **Examination**
 - Inspection: age, obesity, signs of malnourishment
 - Airway and respiratory examination: stridor, coughing, dysphonia (signs of reflux and/or local cancer invasion)
 - Cranial nerve examination: exclude neuromuscular causes e.g. stroke, brain stem tumour, multiple sclerosis, Parkinson's disease, pseudobulbar palsy
 - Swallow assessment
 - Abdominal examination

3. Investigations for oesophageal cancer?

- Bloods: FBC, EUC, CMP, LFTs (occult bleeding, electrolyte abnormalities or hypoalbuminaemia secondary to malnourishment)
- Endoscopy + biopsy + endoscopic ultrasound
- Swallow study
- Full cardiac and respiratory workup due to the high risk nature of surgery
- Bronchoscopy: airway symptoms suggesting either aspiration pneumonia or airway invasion
- CT-PET scan: more accurate for diagnosing lymph node involvement than regular CT

4. Management for inpatient with oesophageal cancer?

- Decide intent of treatment: curative (oesophagectomy), palliative (chemotherapy + radiation) or surveillance (endoscopic mucosal resection, ablation of the oesophagus)
- All patients with an oesophageal disorder e.g. adenocarcinoma, hiatus hernia, severe reflux have a high risk of aspiration, so be aware
- Nasogastric tube placement is safe, but the tumours are friable, so call for help early if having difficulty
- Postoperative complications: if the patient is not recovering as anticipated, assume anastomotic leak or ischaemic graft until proven otherwise; the patient will need an urgent endoscopy for diagnosis

Take home messages

- Call the surgical registrar early if the patient becomes unwell postoperatively
- Pay attention when patient complains of change in swallowing habit and organise a prompt endoscopy

References

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