Esophageal Cancer

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Note: Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center.

WORK UP
- History and physical
- Barium swallow (optional)
- Esophagogastroduodenoscopy (EGD) to visualize entire upper Gastrointestinal (GI) tract
- Biopsy confirmation and histologic subtyping
- CBC with differential and chemistry profile
- CT chest and abdomen with oral and IV contrast
- Bronchoscopy, if tumor is at or above the carina with no evidence of M1 disease
- Endoscopic ultrasound, if no evidence of M1 disease and tumor is at Gastroesophageal (GE) junction
- Biopsy confirmation of suspected metastatic disease
- PET/CT in absence of M1 disease
- MSA-H/dMMR in patients with locally advanced and metastatic cancer
- HER2-neu evaluation by immunohistochemistry (IHC) and PD-L1 in patients with advanced, metastatic cancer (not localized cancer)
- Additional biomarkers as clinically indicated
- Lifestyle risk assessment

CLINICAL STAGE
- cTis - cT1b
- cT2, N0

ADDITIONAL EVALUATION
- Multidisciplinary evaluation is required for all localized cases (not for metastatic patients)
- Diagnostic Endoscopic mucosal resection (EMR) when feasible/appropriate
- Nutritional assessment [for preoperative nutritional support, consider nasogastric or jejunostomy tube (J-tube); gastrostomy tube is not recommended]
- Barium enema or colonoscopy if colon interposition or bypass planned
- Consider arteriogram (optional) if performing colon interposition

PRIMARY TREATMENT
- cTis - cT1b
  - Yes: Esophagectomy
  - No: Definitive chemoradiation
- cT1b, Any N
  - cTis - cT1b: Medically operable? Yes → Surgery or combined modality therapy
  - cT2, N0: Definitive chemoradiation

STAGE IV
- Metastatic cancer
  - Preoperative chemoradiation preferred o Radiation therapy, 50-50.4 Gy plus concurrent chemotherapy o Consider preoperative or perioperative chemotheraphy

Palliative chemotherapy treatment or best supportive care as clinically indicated

Not medically operable or patient declining surgery
- Definitive chemoradiation
- Salvage surgery
- Surgery

Follow-up, See Page 2

Post-Surgical Treatment, See Page 2

Follow-up, See Page 3

Post-Surgical Treatment, See Page 2

Follow-up, See Page 3

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SURGICAL OUTCOMES AFTER ESOPHAGECTOMY

CLINICAL PATHOLOGIC FINDINGS

- Adenocarcinoma
- Squamous

Node negative?

Yes

- Tis, T1, N0
  - Observe as clinically indicated

- T2, N0
  - Observe or chemoradiation (fluoropyrimidine-based) for selected patients
  - Adjuvant chemotherapy if patient received chemotherapy preoperatively

- T3, N0
  - Chemoradiation (fluoropyrimidine-based)
  - Adjuvant chemotherapy if patient received chemotherapy preoperatively
  - Observe as clinically indicated

No

- Adenocarcinoma
- Squamous

- Proximal or mid esophagus
  - Observe or chemoradiation (fluoropyrimidine-based) for selected patients

- Distal esophagus, GE junction
  - Chemoradiation (fluoropyrimidine-based)
  - Adjuvant chemotherapy
  - Observe as clinically indicated

- Macroscopic residual cancer

- Chemoradiation (fluoropyrimidine-based) or palliative therapy or best supportive care

POST-OPERATIVE TREATMENT

Follow-up, See Page 3

1 Consider chemoradiation for patients with high-risk lower esophagus or esophagogastric junction (EGJ) adenocarcinoma. High-risk features include poorly differentiated or higher grade cancer, lymphovascular invasion (LVI), perineural invasion, or age < 50 years.

Note: Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center.
**FOLLOW-UP**

- If asymptomatic:
  - History and physical every 4 months for 1 year, every 6 months for 2 years, then annually
- Chemistry profile and CBC with differential, as clinically indicated
- CT chest and abdomen with oral and IV contrast as clinically indicated
- Upper GI as clinically indicated
- Nutritional counseling
- Vitamin D level check

**RECURRENCE**

- Local/regional only recurrence:
  - prior surgery, no prior chemoradiation

- Local/regional recurrence:
  - (prior chemoradiation, no prior surgery)

- Resectable and medically operable

- Yes → Salvage surgery
- No → Palliative therapy or best supportive care

- Metastatic cancer

**PALLIATIVE THERAPY**

- Concurrent chemoradiation (fluoropyrimidine-based) (preferred) or
- Surgery or
- Chemotherapy and/or
- Best supportive care

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1Patient with Tis or T1a who undergo EMR should have endoscopic surveillance every 3 months for one year, then annually

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SUGGESTED READINGS

PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR GASTROESOPHAGEAL CANCERS


PRINCIPLES OF SURGERY


Continued on next page
SUGGESTED READINGS - continued

PRINCIPLES OF SYSTEMIC THERAPY FOR ESOPHAGEAL OR GASTROESOPHAGEAL JUNCTION CANCER


Continued on next page
SUGGESTED READINGS - continued

PRINCIPLES OF SYSTEMIC THERAPY FOR ESOPHAGEAL OR GASTROESOPHAGEAL JUNCTION CANCER - continued


OTHER SUPPORTIVE READINGS


Esophageal Cancer

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