Survivorship - Esophageal Cancer

ELIGIBILITY

Esophageal cancer post-treatment and NED

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE — Status-post EMR/ESD or esophagectomy with or without neoadjuvant therapy **or** Treated with tri-modality therapy and did not require adjuvant nivolumab

MONITORING FOR LATE EFFECTS

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

See Page 2

Years 1 to 2:
- History and physical every 6 months
- Alternate PET/CT and CT chest and abdomen every 6 months
- EGD every 6 months for status-post EMR/ESD. EGD as clinically indicated for patients treated with esophagectomy with or without neoadjuvant therapy

Years 3 and up:
- History and physical annually
- CT chest and abdomen **or** PET/CT as clinically indicated
  - For squamous cell carcinoma (SCC) consider PET/CT or the addition of CT neck[1]
- Consider comprehensive metabolic panel, CBC, vitamin B12, vitamin D 25OH, calcium, folic acid, iron, and zinc as clinically indicated[2]
- Consider collection of standardized patient reported outcomes annually
- EGD for esophageal adenocarcinoma (EAC):
  - 3-5 years post-treatment: As clinically indicated
  - 5-10 years post-treatment: Consider every 2 years until 80 years old as per patient's performance status
  - Past 10 years post-treatment: As clinically indicated
- EGD for SCC:
  - 3-10 years post-treatment: Consider annually **or** every 2 years as clinically indicated until 80 years old as per patient's performance status
  - Past 10 years post-treatment: Consider every 2 years as clinically indicated until 80 years old as per patient's performance status

NED = no evidence of disease
EMR = endoscopic mucosal resection
ESD = endoscopic submucosal dissection
EGD = esophagogastroduodenoscopy

DISPOSITION

Abnormal findings[3]?

Yes → Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[4]

No → Continue survivorship monitoring

[1] Patients are at risk for secondary head and neck cancer. For abnormal scan, refer to or consult Head & Neck Surgery for examination and evaluation.

[2] Laboratory tests may be monitored by PCP

[3] Abnormal findings may include but are not limited to:
- Recurrent or metastatic disease
- Delayed gastric emptying
- Diaphragmatic hernia
- Severe reflux and aspiration
- Barrett's esophagus with or without dysplagia
- Moderate to severe stricture
- Moderate to severe anastomotic stricture
- Significant weight-loss (BMI < 20)

[4] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

Department of Clinical Effectiveness V5
Approved by the Executive Committee of the Medical Staff on 06/17/2025

Survivorship - Esophageal Cancer

ELIGIBILITY

Esophageal cancer post-treatment and NED (continued from previous page)

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Assess for:
- Fatigue
- Cardiovascular screening[1]
- Peripheral neuropathy
- Weight loss
- Pulmonary status
- GI disturbance
- Malnutrition/malabsorption

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[2]
- Cancer screening[3]
- Vaccinations[4] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Limit alcohol use

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress (see Distress Screening and Psychosocial Management algorithm)
- Depression
- Social support
- Financial stressors
- Access to primary health care

DISPOSITION

Refer or consult as indicated

[1] See Survivorship – Adult Cardiovascular Screening algorithm
[2] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[3] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[4] Based on American Society of Clinical Oncology (ASCO) guidelines

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

Continued on next page

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DEVELOPMENT CREDITS

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