## Esophageal Cancer

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### Work Up

- History and Physical
- Barium Swallow (optional)
- Esophagogastroduodenoscopy (EGD) to visualize entire upper GI tract
- Biopsy confirmation and histologic subtyping
- CBC & chemistry profile
- Chest/abdominal CT with 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
- HER2-neu evaluation by Immunohistochemistry (IHC) in patients with advanced, metastatic cancer (not localized cancer)

### Clinical Stage

- cTis to less than or equal to cT1b
  - Yes: Endoscopic mucosal resection (EMR) and/or Ablation or Esophagectomy
  - No: Medically Operable?

<table>
<thead>
<tr>
<th>Stage IV</th>
<th>Metastatic cancer</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>PRIMARY TREATMENT</td>
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<tr>
<td>cT1b-T2, N+</td>
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<tr>
<td>cT3-T4, N0-3</td>
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<tr>
<td>Medically operable</td>
<td></td>
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<tr>
<td>Preoperative chemoradiation RT, 50-50.4 Gy plus concurrent chemotherapy</td>
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<tr>
<td>Surgery4</td>
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<tr>
<td>Stage IV Metastatic cancer</td>
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<tr>
<td>Palliative treatment as clinically indicated</td>
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</tbody>
</table>

### Additional Evaluation

- Multidisciplinary evaluation is required for all localized cases (not for metastatic patients)
- Nutritional assessment (for preoperative nutritional support, consider nasogastric or J-tube [PEG is not recommended])
- Barium enema or colonoscopy if colon interposition or bypass planned
- Arteriogram (optional) consider if performing colon interposition

### PRIMARY TREATMENT

- Not medically operable or patient declining surgery
  - Definitive chemoradiation
    - Follow-up, See page 3

- Medically operable
  - Definitive chemoradiation
    - Salvage Surgery4

Note: Consider Clinical Trials as treatment options for eligible patients. Consider referral to a Comprehensive Cancer Center.
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**SURGICAL OUTCOMES AFTER ESOPHAGECTOMY**

**CLINICAL PATHOLOGIC FINDINGS**

- **Adenocarcinoma**
  - 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

- **Squamous**
  - Proximal or mid esophagus
    - Observe or chemoradiation (Fluoropyrimidine based) for selected patients
  - Distal esophagus, GE junction
    - Chemoradiation (Fluoropyrimidine based).
    - Adjuvant chemotherapy if patient received chemotherapy preoperatively
  - Observe as clinically indicated

- **Macroscopic residual cancer**
  - Chemoradiation (Fluoropyrimidine-based) or palliative therapy
**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, as clinically indicated
- Imaging as clinically indicated
- Upper GI as clinically indicated\(^1\)
- Dilatation for anastomotic stenosis
- Nutritional counseling
- Vitamin D level check

**RECURRENT**

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

Esophageal recurrence:
- (prior chemoradiation, no prior surgery)

Resectable and medically operable

Metastatic cancer

**PALLIATIVE THERAPY**

Concurrent chemoradiation (Fluoropyrimidine-based preferred and/or best supportive care or surgery or chemotherapy)

Yes
- Salvage surgery

No
- Palliative therapy

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\(^1\)Patient with Tis or T1a who undergo EMR should have endoscopic surveillance every 3 months for one year, then annually.
SUGGESTED READINGS

PRINCIPLES OF MULTIDISCIPLINARY TEAM APPROACH FOR GASTROESOPHAGEAL CANCERS


PRINCIPLES OF SURGERY


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**SUGGESTED READINGS - CONTINUED**

**PRINCIPLES OF SYSTEMIC THERAPY FOR ESOPHAGEAL OR GASTROESOPHAGEAL JUNCTION CANCER**


**OTHER SUPPORTIVE READINGS**

Esophageal Cancer

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Consider referral to a Comprehensive Cancer Center

DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Gastrointestinal Center Faculty at the University of Texas, MD Anderson Cancer Center. A multidisciplinary approach was used and included input from the following medical oncologists, radiation oncologists, surgical oncologists, and pathologists:

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