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
- cT1b, AnyN
- cT2, N0
- cT1b-T2, N+
- cT3-T4, N0-3
- Endoscopic mucosal resection (EMR) and/or Ablation or Esophagectomy
- Definitive chemoradiation
- Surgery or combined modality therapy
- Salivaage Surgery
- Preoperative chemoradiation
- Surgery

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
- Stage IV
- Metastatic cancer

PRIMARY TREATMENT

- Medically Operable?
- Yes
- Esophagectomy
- No
- Definitive chemoradiation
- Follow-up, See page 3

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

**SURGICAL OUTCOMES AFTER ESOPHAGECTOMY**

**CLINICAL PATHOLOGIC FINDINGS**

- Adenocarcinoma
  - Node negative?
    - Yes
      - Tis, T1, N0: Observe as clinically indicated
      - T2, N0: Observe or chemoradiation (Fluoropyrimidine based) for selected patients.
    - No
      - Distal esophagus, GE junction
        - Adenocarcinoma: Observe as clinically indicated
        - Squamous: Chemoradiation (Fluoropyrimidine-based) or palliative therapy
  - Observe or chemoradiation (Fluoropyrimidine based) for selected patients.
- Squamous
  - Proximal or mid esophagus
    - Observe or chemoradiation (Fluoropyrimidine based) for selected patients
  - Distal esophagus, GE junction
    - Adenocarcinoma: Observe as clinically indicated
    - Squamous: Observe as clinically indicated

**POSTOPERATIVE TREATMENT**

- Observe as clinically indicated
- Chemoradiation (Fluoropyrimidine based) or palliative therapy
- Adjuvant chemotherapy if patient received chemotherapy preoperatively
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#### 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
- Dilatation for anastomotic stenosis
- Nutritional counseling
- Vitamin D level check

#### RECURRENCE

<table>
<thead>
<tr>
<th>Local/regional only recurrence: prior surgery, no prior chemoradiation</th>
<th>Metastatic cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esophageal recurrence: (prior chemoradiation, no prior surgery)</td>
<td>Recomendable and medically operable</td>
</tr>
</tbody>
</table>

#### PALLIATIVE THERAPY

- Concurrent chemoradiation (Fluoropyrimidine-based preferred and/or best supportive care or surgery or chemotherapy)
- Salvage surgery (Yes)
- Palliative therapy (No)

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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.
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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


OTHER SUPPORTIVE READINGS

Esophageal Cancer

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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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