Oesophageal Tumours

Definition

Benign

- Leiomyomas - Most common.
- Often incidental/PM finding. Ulceration rare. Enucleation surgery if causing dysphagia.
- Others – Rare.
- Fibrovascular polyps, Lipomas, Granular cell tumours, and Squamous cell papillomas

Malignant

- Primary
    - Squamous carcinomas – used to be commonest.
    - Adenocarcinoma – increasing incidence esp dev nations ?due to overnutrition, ↑GORD/Barrett's oesophagus.
    - Others are rare but include: melanoma, lymphoma, carcinoid, leiomyosarcoma, small cell carcinoma, adenoid cystic carcinoma, plasmacytomas and pseudosarcoma.
    - GIT Kaposi's sarcoma is common in AIDS may be found in the oesophagus.
- Secondary
    - Most commonly breast

Carcinoma of the Oesophagus

Pathogenesis

Almost all are epithelial - squamous cell carcinoma (SCC) or adenocarcinoma (AC).

Epidemiology

Incidence

- Fifth most common malignant tumour in the developed world.
- ~10 per 100,000 pop (UK). Increasing incidence of AC now > SCC in UK.
- M>F for all tumours, particularly with AC (7M:1F)
- The median age at presentation >60 years.
- AC more common in Caucasians, SCC in Africans.

Risk factors

- Smoking & EtOH for both SCC and AC and in the later ↑risk ≥30yrs post giving up.
- Higher rates in China and Iran linked to the nitrosamine food preservation
- Obesity → ↑risk for AC (as ↑risk GORD) but ↓risk for SCC
- Chronic inflammation and stasis from any cause for SCC e.g. strictures due to caustic injury or achalasia.
- Tylosis and Plummer-Vinson syndrome for SCC.

Presentation

Oesophageal cancers often present late & unresectable.

- Dysphagia or odynophagia (>75%)
- Weight loss & anorexia (60%)
- Hoarseness or intractable hiccups
- Retrosternal pain
- Melaena or anaemia
- Lymphadenopathy

Investigations

- FBC
- CXR - looking for evidence of metastases
- Double contrast barium swallow
- Endoscopy - with brushings and biopsy of any lesion seen
- CT/MRI/Endoscopic/USS/PET - for staging

Differential diagnoses

- Oesophageal stricture from any cause
- External compression of the oesophagus
- Intramural benign tumours e.g. leiomyoma
- Metastatic tumours - most commonly from breast

Staging by TNM system.

Management

Palliative

- 50% patients present late with unresectable disease
- Radiotherapy or laser ablation may ↓tumour bulk
- Stents may aid swallowing in the short to mid-term
- Nutritional status maintained by liquid feeds, parenteral nutrition or PEG tubes.
- Analgesia

Therapy

- Photodynamic therapy (PDT) (photosensitising agent is injected and then activated by endoscopic low power laser).
- Preoperative chemo/radiotherapy no benefit over surgery alone for resectable tumours.
- Radiotherapy may have some benefit in SCC

Surgery

- Oesophagectomy for resectable tumours ± block dissection of LN. Mortality 2-23%.
- Thorascopic oesophagectomy to ↓post-op Cx, but may not get all tumour.

Complications

Metastasis: Initially locally to mediastinal tissues around the oesophagus. Subsequently downwards to the gastric glands and to the liver. Direct spread involves the bronchi, lungs, and pleura, but also the aorta. Perforation and local sepsis, result in tracheo-oesophageal or other fistulae, or mediastinitis.

Prognosis

The prognosis for oesophageal carcinoma varies depending on the stage at presentation:

- The overall 5 year survival rate for resectable tumours ranges from 10-25%.
- 5 year survival rates for stage I oesophageal cancer range from 80-94%
- 5 year survival rates for stage III are between 10-14%