Cambridge
Oncology Teaching

Upper GI Tumours

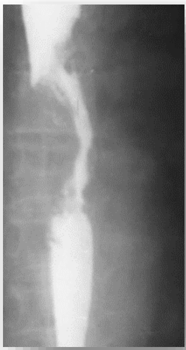
An Introduction to the Clinic

Both oesophageal and gastric cancer have a UK incidence of around 10,000 per year. Sadly, the outlook for most patients with these diseases remains bleak despite aggressive surgery, radiotherapy and chemotherapy treatment. Patients often present late in the disease history with weight loss and dysphagia. By this stage, it is common for the disease to have spread to loco-regional lymph nodes, or with metastases to the liver.

Oesophageal cancer

In general patients present with dysphagia and weight loss. Tumours tend to be squamous in the upper oesophagus and adeno distally. In general distal tumours without distant spread can be resected and patients often receive pre-operative neoadjuvant chemotherapy or triple modality treatment with neoadjuvant chemoRT then surgery. Higher oesophageal tumours without distant spread may be treated with definitive chemoradiation. Palliative chemotherapy is given for more advanced disease.

Barium swallow study showing a stricture related to an oesophageal malignancy. Most tumours in the upper oesophagus are squamous cell carcinomas, whilst lower oesophageal tumours are usually adenocarcinomas



Gastric cancer

We offer peri-operative chemotherapy for patients with resectable disease. Palliative chemotherapy is offered when disease is too advanced for surgery. A minority of patients have tumours with HER2 positivity and may be offered Herceptin to target this (See lecture 3).

65-80% of patients will have had Helicobacter pylori infection, yet only 2% of people with H pylori infection will go on to develop gastric cancer

In this Clinic

You should expect to learn:

- Examination of the neck.
- Appearances of primary tumours, lymph nodes and metastases on CT and PET-CT scans.

From patients you should hear about:

- History of their presentation.
- Toxicity of treatment.