Esophageal Cancer

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

WORK UP

- History and physical
- Barium swallow (optional)
- Esophagogastroduodenoscopy (EGD) to visualize entire upper Gastrointestinal (GI) tract
- Biopsy confirmation and histologic subtyping[1]
- CBC with differential and chemistry profile
- CT chest and abdomen with oral and IV 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 in absence of M1 disease
- MSA-H/dMMR in patients with locally advanced and metastatic cancer
- HER2-neu evaluation by immunohistochemistry (IHC)[2] and *PD-L1* in patients with advanced, metastatic cancer (not localized cancer)
- Additional biomarkers as clinically indicated[1,2]
- Lifestyle risk assessment[3]

CLINICAL STAGE

cTis – cT4, N0-1

ADDITIONAL EVALUATION

- Multidisciplinary evaluation is required for all localized cases (not for metastatic patients)
- Diagnostic Endoscopic mucosal resection (EMR) when feasible/ appropriate
- Nutritional assessment [for preoperative nutritional support, consider nasogastric or jejunostomy tube (J-tube); gastrostomy tube is not recommended]
- Barium enema or colonoscopy if colon interposition or bypass planned
- Consider arteriogram (optional) if performing colon interposition

PRIMARY TREATMENT

- cTis - cT1b[4] → EMR **and/or** ablation **or** esophagectomy[5] → Post-Surgical Treatment, See Page 2
- cT1b[4], Any N → Medically operable ?
  - Yes → Esophagectomy[5] → Post-Surgical Treatment, See Page 2
  - No → Definitive chemoradiation → Follow-up, See Page 3
- cT2, N0[4] → Surgery **or** combined modality therapy → Post-Surgical Treatment, See Page 2
- cT1b-T2, N+[6] cT3-T4, N0-3
  - Not medically operable or patient declining surgery → Definitive chemoradiation → Salvage surgery[7] → Follow-up, See Page 3
  - Medically operable → Preoperative chemoradiation preferred
    - Radiation therapy, 50-50.4 Gy plus concurrent chemotherapy
    - Consider preoperative or perioperative chemotherapy
    → Surgery[7] → Post-Surgical Treatment, See Page 2
- Stage IV Metastatic cancer → Palliative chemotherapy treatment or best supportive care as clinically indicated

[1] Confirmation should be completed on outside MD Anderson specimen and inside MD Anderson specimen
[2] Consider HER2-neu evaluation initially by IHC and if IHC score 2+, follow-up with FISH test. See MD Anderson approved biomarkers.
[3] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Consider diagnostic endoscopic mucosal resection (EMR) for all cT1b patients and T2N0 patients who have tumors < 2 cm in size with standardized uptake values (SUV) ≤ 3
[5] Preferred for non-cervical cT1b disease
[6] Whenever possible, N+ status in patients with limited depth of invasion should be confirmed histologically
[7] Patients who receive preoperative chemoradiation should be followed after surgery

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Esophageal Cancer

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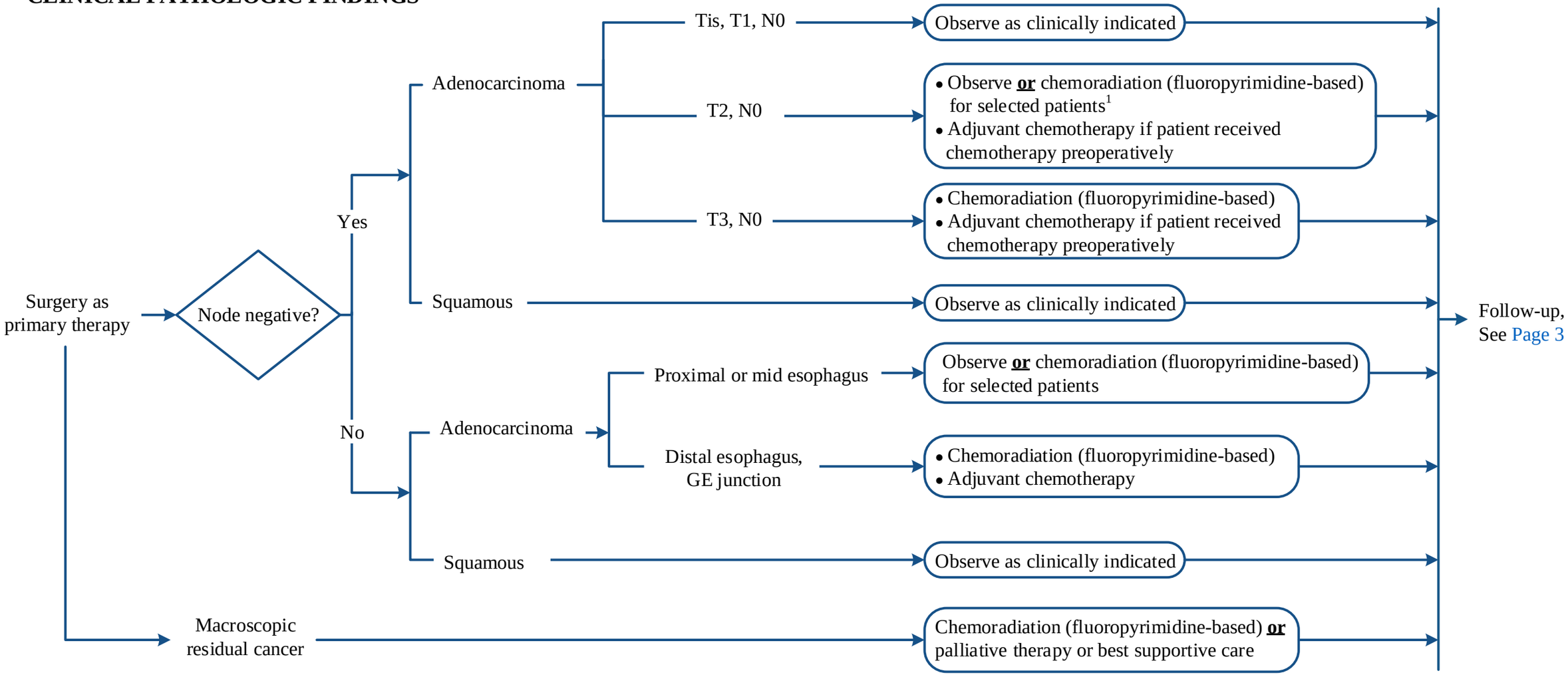
SURGICAL OUTCOMES AFTER ESOPHAGECTOMY CLINICAL PATHOLOGIC FINDINGS

POST-OPERATIVE TREATMENT



[1] Consider chemoradiation for patients with high-risk lower esophagus or esophagogastric junction (EGJ) adenocarcinoma. High-risk features include poorly differentiated or higher grade cancer, lymphovascular invasion (LVI), perineural invasion, or age < 50 years.

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Esophageal Cancer

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

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 with differential, as clinically indicated
- CT chest and abdomen with oral and IV contrast as clinically indicated
- Upper GI as clinically indicated[1]
- Dilatation for anastomotic stenosis
- Nutritional counseling
- Vitamin D level check

RECURRENCE

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

Local/regional recurrence: (prior chemoradiation, no prior surgery)

Resectable and medically operable

Yes

No

Metastatic cancer

PALLIATIVE THERAPY

- Concurrent chemoradiation (fluoropyrimidine-based) (preferred) **or**
- Surgery **or**
- Chemotherapy **and/or**
- Best supportive care

Salvage surgery

Palliative therapy or best supportive care

[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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