Optimal care pathway for people with oesophagogastric cancer

Quick reference guide

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with oesophagogastric cancer.*

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

Stopping smoking will reduce the risk of oesophagogastric cancer.

Risk factors

There are very few people at high risk. People with the following risk factors are at increased risk:

Oesophageal adenocarcinoma	**Male gender, obesity, gastro-oesophageal reflux, Barrett's oesophagus,** tobacco smoking, alcohol consumption and increasing age
Oesophageal squamous cell carcinoma	**Heavy alcohol consumption, tobacco smoking,** increasing age, caustic injury and achalasia
Gastric cancer	Increasing age, *Helicobacter pylori* bacteria, previous partial gastrectomy (especially more than 20 years ago), tobacco smoking, pernicious anaemia and family history of gastric cancer

* Most common risk factors are **bolded**.

Early detection

Being aware of the risk factors and who is at high risk can guide monitoring and referral to a specialist.

Careful monitoring of Barrett's oesophagus may lead to early detection.

Screening recommendations

There are no formal population-based screening programs for oesophagogastric cancer in Australia.

Checklist

- ❑ Recent weight changes discussed and weight recorded
- ❑ Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- ❑ Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- ❑ Physical activity recorded
- ❑ Referral to a dietitian considered
- ❑ Referral to a physiotherapist or exercise physiologist considered
- ❑ Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms included in the tables below are based on best available evidence on how patients may present to their general practitioner (GP) with oesophagogastric cancer.

Signs and symptoms

Patients presenting to their GP with the following signs and symptoms should be investigated. Signs and symptoms have been categorised by higher, moderate and lower risk, underpinned by primary care evidence. See referral and safety netting section for more detail on appropriate next steps.

Checklist

- ❑ Signs and symptoms recorded
- ❑ Patient referred for an endoscopy if symptomatic

SECOND EDITION

Australian Government
Cancer Australia

Cancer Council

Step 2: Presentation, initial investigations and referral continued

Higher-risk symptoms About 3-5 out of 100 people with this symptom are likely to have oesophagogastric cancer.	Dysphagia
Moderate-risk symptoms About 1-2 out of 100 people with one of these symptoms are likely to have oesophagogastric cancer	Appetite loss Dyspepsia Haematemesis Unexplained anaemia Unexplained weight loss
Lower-risk symptoms Less than one out of 100 people with one of these symptoms is likely to have oesophagogastric cancer	Abdominal pain Epigastric pain Nausea/vomiting Raised platelets*

* A raised platelet count of >400 x10^9/L is recognised as a predictor of undiagnosed cancer in primary care, linked to an increased risk of lung, colorectal, gastric, oesophageal, pancreatic, ovarian, uterine, bladder and kidney cancer.

Signs, symptoms and symptom combinations

Presenting to general practice with a combination of signs and symptoms may increase a patient's risk of having oesophagogastric cancer. This table demonstrates the single symptoms associated with oesophagogastric cancer, and how the risk changes when presenting with more than one symptom. Signs and symptoms have been categorised by highest, higher, moderate and lower risk, underpinned by primary care evidence. See referral and safety netting section for more detail on appropriate next steps. The same risk categories have been used, with an additional category highlighting symptom combinations that increase the risk of oesophagogastric cancer to above 5%.

	Single symptoms	Symptom combinations
Highest-risk symptom combinations About 5-10 out of 100 people presenting with this symptom combination are likely to have oesophagogastric cancer	N/A	• Dysphagia with any of the following: – abdominal pain – dyspepsia – epigastric pain – nausea/vomiting – raised platelets – reflux – unexplained weight loss or a repeat presentation of dysphagia
Higher-risk symptoms About 3-5 out of 100 people with these symptoms or combinations are likely to have oesophagogastric cancer	Dysphagia	• Unexplained weight loss with any of the following: – abdominal pain* – epigastric pain – reflux

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 2: Presentation, initial investigations and referral continued

	Single symptoms	Symptom combinations
Moderate-risk symptoms About 1-2 out of 100 people with these symptoms or combinations is likely to have oesophagogastric cancer	Appetite loss Dyspepsia Haematemesis Unexplained anaemia Unexplained weight loss	• Abdominal bloating with unexplained anaemia • Abdominal pain with any of the following: – raised platelets – unexplained anaemia – unexplained weight loss • Epigastric pain with any of the following: – constipation – dyspepsia – raised platelets – reflux – unexplained anaemia • Nausea/vomiting with any of the following: – epigastric pain – dyspepsia – reflux – raised platelets – unexplained weight loss • Raised platelets with any of the following: – dyspepsia – reflux – unexplained weight loss – Repeat presentations of either – dyspepsia – nausea/vomiting • Unexplained weight loss with any of the following: – chest pain – constipation – dyspepsia – unexplained anaemia
Lower-risk symptoms Less than one person out of 100 with one of these symptoms is likely to have oesophagogastric cancer	Abdominal pain Epigastric pain Nausea/vomiting Raised platelets	

* This symptom combination occurs in women and men; however, in the primary care evidence, only men under 60 with this symptom combination reach the 'higher-risk' threshold.

These recommendations are generated from evidence in populations primarily aged >40 years. The risk of an undiagnosed cancer increases with age for all signs and symptoms. Underlying risk factors outlined in Step 1 (e.g., known Barrett's oesophagus, family history of gastric cancer, previous partial gastrectomy) should be considered in the presence of signs and symptoms of oesophagogastric cancer and could be used to lower the threshold for initial investigation.

General practitioner investigations

Initial investigations should include:

- Detailed medical history (including risk factors for upper gastrointestinal (GI) cancer)
- Physical examination
- Full blood count and serum ferritin

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 2: Presentation, initial investigations and referral continued

Referral and safety netting

Patients with higher- and highest-risk symptoms and symptom combinations should be referred promptly for upper GI endoscopy. For patients with low-to-moderate-risk symptoms, further investigation to identify an underlying cause is appropriate. If symptoms do not resolve after 2–4 weeks of appropriate initial management, including lifestyle modification, empirical treatment (e.g. proton pump inhibitors (PPI) or H. pylori eradication), and/or basic investigations, referral for upper GI endoscopy should be arranged. All patients should be provided with safety-netting advice, including a planned timeframe for follow-up that is agreed with the patient, and the need for patient-initiated follow-up if new symptoms develop, if symptoms persist or worsen, or if the patient has further concerns.

The specialist may need to urgently refer the patient to allied health practitioners (particularly a dietitian) before a multidisciplinary meeting (MDM).

Referral options

At the referral stage, the patient's GP or other referring doctor should, where possible, advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/ or carer that they can contact Cancer Council on 13 11 20 for additional support.

Checklist continued

- ❏ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❏ Patient notified of support services such as Cancer Council 13 11 20
- ❏ Referral options discussed with the patient and/or carer including cost implications

Timeframe

Patients with concerning symptoms of oesophagogastric cancer should see their GP **within 2 weeks**. If oesophagogastric cancer is suspected, refer patients to a specialist for an endoscopy **within 2 weeks** of GP referral.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

An expert histopathologist should review the biopsy material from the endoscopy before the MDM.

Staging for oesophageal cancer may involve:

- CT scan of the neck, thorax, abdomen and pelvis
- endoscopic ultrasound
- PET scan
- endoscopic resection.

Staging for oesophagogastric junction cancer may involve:

- CT scan of the neck, thorax, abdomen and pelvis
- endoscopic ultrasound
- staging laparoscopy
- PET scan
- endoscopic resection.

Staging for gastric cancer may involve:

- CT scan of the neck, thorax, abdomen and pelvis
- endoscopic resection
- staging laparoscopy.

Genetic testing

Environmental factors are important in causing gastric cancer; inherited factors (i.e. genes) usually play a minor role. Occasionally gastric cancers are due to an inherited cancer predisposition.

Treatment planning

Discuss all newly diagnosed patients at an MDM **within 4 weeks** of GP referral.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Checklist

- ❏ Diagnosis confirmed
- ❏ Staging conducted and recorded in the patient's medical record
- ❏ Full histology obtained
- ❏ Performance status and comorbidities measured and recorded
- ❏ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ❏ Clinical trial enrolment considered
- ❏ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❏ Patient referred to support services (such as Cancer Council) as required
- ❏ Treatment costs discussed with the patient and/or carer

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 3: Diagnosis, staging and treatment planning continued

Communication

The lead clinician's[1] responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from MDMs.

Timeframe

Staging work-up needs to be complete for presentation at the MDM **within 2 weeks** of diagnosis and **within 4 weeks** of GP referral.

Step 4: Treatment

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation.

Treatment options

Given the poor prognosis of this cancer at present, for many patients, treatment is often given with palliative rather than curative intent. Early specialist palliative care may be required.

Endoscopic treatments are suitable for high-grade dysplasia and selected cases of early cancer.

Surgery

Surgical resection offers the best long-term survival chance in patients with locally advanced oesophageal or gastric cancer.

Palliative oesophageal resection for metastatic cancer is not recommended.

Radiation therapy may be indicated for oesophageal or oesophagogastric junction cancer as part of:

- neoadjuvant therapy before surgery
- definitive chemoradiation (unresectable locally advanced disease)
- symptom palliation.

Radiation therapy may be indicated for gastric cancer as part of:

- postoperative care in combination with chemotherapy in selected patients who have undergone a gastrectomy for locally advanced gastric cancer
- symptom palliation before or after chemotherapy.

Systemic therapy may be indicated for:

- locally advanced disease (pre- or postoperatively or as primary treatment)
- inoperable locally advanced oesophageal or gastro-oesophageal cancer.

Palliative care

Review by a specialist palliative care team is essential. Early referral to palliative care can improve quality of life and in some cases may prolong survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- ❑ Intent of treatment established
- ❑ Risks and benefits of treatments discussed with the patient and/or carer
- ❑ Treatment plan discussed with the patient and/or carer
- ❑ Treatment plan provided to the patient's GP
- ❑ Treating specialist has adequate qualifications, experience and expertise
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Early referral to palliative care considered
- ❑ Advance care planning discussed with the patient and/or carer

Timeframe

Begin treatment **within 2 weeks** of the MDM.

1 Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

- ❑ Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms.

Treatment

Evaluate each patient for referral to the original multidisciplinary team is appropriate. For most patients, treatment is often given with palliative rather than curative intent.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Review by a specialist palliative care team is essential. Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases may prolong survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- ❑ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Advance care planning discussed with the patient and/or carer
- ❑ Patient referred to palliative care if appropriate
- ❑ Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient referred to palliative care
- ❑ Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.

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