For health professionals
in England and Wales

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CANCER RESEARCH UK

Together we are beating cancer

Your guide to diagnosing oesophageal cancer early

Recognising and managing suspected oesophageal cancer can be challenging. In this guide, we provide information and practical tips to help you diagnose oesophageal cancer earlier – including signs and symptoms, safety netting, risk factors including Barrett's Oesophagus and a patient case study.

Why is early diagnosis of oesophageal cancer important?

Early diagnosis is vital to improving cancer survival. In England and Wales, less than 1 in 10 oesophageal cancers are diagnosed at the earliest stage. Oesophageal cancer survival is highly dependent on the stage at diagnosis [1]. Almost 55% of people diagnosed at stage 1 survive for 5 years or more, compared to 15% of people diagnosed at stage 3. Stage 4 data is not reported due to small numbers.

There is no screening programme for oesophageal cancer. GPs play a vital role in recognising oesophageal cancer with most cases diagnosed via a primary care route. A significant proportion are diagnosed via an emergency route (19%, England 2018) [1].

Acting as soon as there's a suspicion of oesophageal cancer can lead to better treatment options and outcomes for patients.

Recognition and referral of suspected oesophageal cancer

The **National Institute for Health and Care Excellence (NICE) NG12 guidelines** [2] recommend referring people using a suspected cancer pathway referral for oesophageal cancer in people:

- with dysphagia or
- aged 55 and over with weight loss and any of the following symptoms:
  - upper abdominal pain
  - reflux
  - dyspepsia

NICE NG12 also provides recommendations for symptoms that warrant non-urgent direct access endoscopy, such as haematemesis.

Guidance shouldn't override clinical judgement, based on patient history, examination, and gut feeling. Make sure you're aware of local guidance and pathways.

Who is most at risk?

Incidence of oesophageal cancer is highest in people aged over 75, men, those from a White ethnic background and those from more deprived areas of the UK [3].

Make sure to be aware of these groups, as well as key risk factors [4] including:
- alcohol consumption
- Barrett's oesophagus
- family history
- gastro-oesophageal reflux disease (GORD)
- high-fat diet
- obesity
- smoking

Barrett's oesophagus

Barrett's oesophagus is defined as changes to the lining of the oesophagus, usually due to GORD, and is associated with an increased risk of oesophageal cancer. Between 3–13% of people with Barrett's oesophagus in the UK will develop oesophageal cancer in their lifetime [5].

The British Society of Gastroenterology and **NICE** recommend surveillance for people diagnosed with Barrett's every 2–5 years, dependent on the severity of cell changes. Make sure you actively enquire whether the patients in your surgery who've been diagnosed with Barrett's oesophagus are receiving surveillance. If they're not, discuss the risks and benefits and refer to secondary care as appropriate.

You can refer your patients here for information on Barrett's oesophagus: **cruk.org/barretts-oesophagus**

Capsule sponge tests: 'pill on a string'

Capsule sponge tests (including Endosign and Cytosponge), are single-use devices which detect abnormalities in cells lining the oesophagus. They're currently being piloted across the UK to evaluate their role in surveillance of Barrett's oesophagus and oesophageal cancer diagnosis, including in non-hospital settings.

Your involvement is key

GPs play a vital role in identifying signs and symptoms of oesophageal cancer and promptly referring patients for tests.

Barriers to prompt referral

Many symptoms are non-specific, which can make recognising potential signs and symptoms of oesophageal cancer difficult for both patients and health professionals.

- Patients may use similar descriptions of reflux, indigestion and heartburn, making it more challenging to identify concerning symptoms and understand symptom duration [6]. Make sure you have an accurate understanding of your patient's symptoms.
- Symptoms such as reflux and indigestion are commonly attributed to personal or lifestyle factors and self-managed with over-the-counter medication, which may result in delayed help-seeking [6,7]. Actively enquire about your patients use of reflux medication, including duration.

Safety netting is crucial

Safety net patients until signs and symptoms are resolved.

Specify when patients should book another appointment if their symptoms persist, worsen or new symptoms develop. Check with your patient that they're clear about how and when to get back in touch if needed.

Case study

John is 65 years old and overweight. He presents to his GP with dyspepsia, which he's sometimes taken over-the-counter medication for over the last few years.

Would you order an urgent direct access endoscopy?

As per NG12 guidance, John would not meet the criteria for an urgent direct access endoscopy. John's GP prescribes anti-reflux medication and advises him to return if his symptoms don't resolve. It may be worth asking about family history and other risk factors at this point.

Two months later, John re-presents with treatment-resistant dyspepsia, as well as weight loss.

What could you do next?

John now would meet the NG12 criteria for an urgent, direct access endoscopy and should be referred along this pathway.

John's case highlights the importance of safety netting and being alert to people who've been taking over-the-counter reflux medication for a significant period of time.

If you have any comments or useful information about this guide, contact **SEinbox@cancer.org.uk**

1. Cancer Research UK. Early Diagnosis, 2023.
2. NICE. Suspected cancer: recognition and referral, 2015.
3. Cancer Research UK. Oesophageal cancer incidence statistics. Accessed January 2024
4. Franklin and Jankowski. Research, 2020.
5. Cancer Research UK. Barrett's oesophagus, 2023.
6. Humphrys et al. BJGP, 2020.
7. Lewis et al. Eur J Cancer Care, 2017.