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Document Title:

Oesophagectomy

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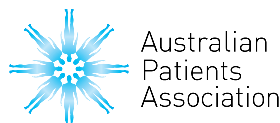

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What is oesophageal cancer?

Oesophageal cancer is a malignant growth that starts in the wall of your oesophagus (gullet), which usually makes it difficult for you to swallow. About 1,200 people develop oesophageal cancer every year in Australia. There are two main types of oesophageal cancer, squamous cell carcinoma and adenocarcinoma.

What is an oesophagectomy?

An oesophagectomy involves removing the cancer and part of your oesophagus (see figure 1).

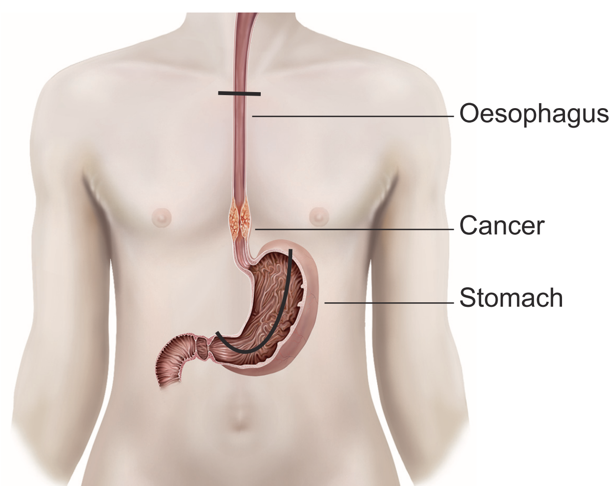

Figure 1

The limits of tissue to be removed

Your tests have shown that an oesophagectomy offers the best chance of you being free of oesophageal cancer. You may be recommended chemotherapy or chemo-radiation (a combination of chemotherapy and radiotherapy) before surgery to increase the chance of you being free of oesophageal cancer.

An oesophagectomy involves significant risks. It is your decision to go ahead with the operation or not.

This document will give you information about the benefits and risks to help you to make an informed decision. If you have any questions that this document does not answer, ask your surgeon or the healthcare team.

What are the benefits of surgery?

The aim is to remove all the cancer and your swallowing should improve.

Are there any alternatives to surgery?

Removing the cancer by surgery, along with chemotherapy and sometimes radiotherapy, usually gives the best chance of you being free of oesophageal cancer.

Chemotherapy or radiotherapy on their own will not lead to you being cured but can be used to shrink the cancer and so improve your quality of life. If you have squamous cell carcinoma, chemo-radiation may be as effective as surgery in giving you the best chance of being free of oesophageal cancer.

It is possible to have procedures to improve swallowing without treating the underlying cancer. These include inserting a stent (metal mesh tube) across the cancer to hold your oesophagus open, and laser treatment to make a hole in the cancer.

You should discuss the options carefully with your surgeon.

What will happen if I decide not to have the operation?

The healthcare team will arrange for you to have non-surgical treatment and will continue to be involved in your care.

What does the operation involve?

The healthcare team will carry out a number of checks to make sure you have the operation you came in for. You can help by confirming to your surgeon and the healthcare team your name and the operation you are having.

The operation is performed under a general anaesthetic and usually takes 4 to 6 hours. You may be given antibiotics during the operation to reduce the risk of infection.

Your surgeon will make cuts on your chest (thoracotomy) and usually on your abdomen (laparotomy). Sometimes they will need to make a cut on your neck. Your surgeon will tell you which cuts they will need to make.

It may be possible for your surgeon to perform some parts of the operation using keyhole surgery. Your surgeon will tell you if this is likely.

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The following are the main steps.

- Freeing up and removing the cancer and parts of your oesophagus.
- Removing the surrounding lymph nodes (glands) that may have cancer in them.
- Freeing up and reshaping your stomach to allow it to be pulled up into your chest.
- Joining your stomach to the remaining oesophagus either in your chest or in your neck (see figure 2).
- Inserting a temporary feeding tube into your abdomen, if you need one.

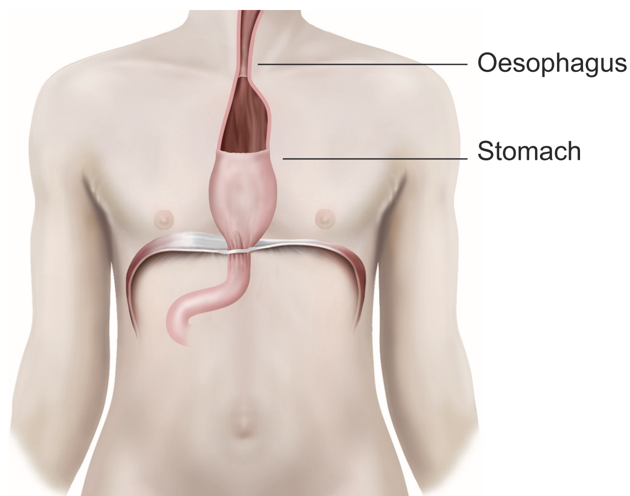

Figure 2
An oesophagectomy

Your surgeon may insert drains (tubes) in your chest to drain away air and fluid that can sometimes collect. They will close the cuts with stitches or clips.
The healthcare team will place a small tube in a vein in your arm (drip) and in your neck (called a central line). They will also place a catheter (tube) in your bladder to help you to pass urine.
All organs and tissues removed will be examined carefully for evidence of cancer and will be stored. They may be used in the future to help find new treatments for cancer. Let your surgeon know if you do not want your organs and tissues used in this way.

Will I need more treatment?

All the tissue and lymph nodes removed will be examined under a microscope. Your surgeon will know the results a few days later. Lymph nodes filter abnormal cells and can show if the cancer has spread. Your surgeon may recommend combining surgery with chemotherapy and sometimes radiotherapy to give the best chance of you being free of oesophageal cancer.
Chemotherapy and radiotherapy also have side effects and complications. Your surgeon and oncologist (doctor who specialises in treating cancer with medication and radiotherapy) will discuss the options with you and recommend the best treatment for you. It is your decision to have chemotherapy and radiotherapy as well as surgery.

What should I do about my medication?

Let your doctor know about all the medication you take and follow their advice. This includes all blood-thinning medication as well as herbal and complementary remedies, dietary supplements, and medication you can buy over the counter.

What can I do to help make the operation a success?

If you smoke, stopping smoking several weeks or more before the operation may reduce your risk of developing complications and will improve your long-term health.
Regular exercise should help to prepare you for the operation, help you to recover and improve your long-term health. Before you start exercising, ask the healthcare team or your GP for advice.
You can reduce your risk of infection in a surgical wound.

- In the week before the operation, do not shave or wax the area where a cut is likely to be made.
- Try to have a bath or shower either the day before or on the day of the operation.
- Keep warm around the time of the operation. Let the healthcare team know if you feel cold.

What complications can happen?

The healthcare team will try to make the operation as safe as possible. A team of doctors and nurses, who perform this operation regularly, will look after you. However, complications can happen. Some of these can be serious. You should ask your doctor if there is anything you do not understand.
Any numbers which relate to risk are from studies of people who have had this operation. Your doctor may be able to tell you if the risk of a complication is higher or lower for you.

1 Complications of anaesthesia

Your anaesthetist will be able to discuss with you the possible complications of having an anaesthetic.

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2 General complications of any operation

- Pain can be severe with this operation. The healthcare team will give you strong painkillers either by a nerve block or an epidural, or through the drip. It is important that you take the medication as you are told so you can move about and cough freely.
- Bleeding during or after the operation. This often needs a blood transfusion. You may need another operation to stop the bleeding.
- Infection of the surgical site (wound) (risk: 6 in 100). It is usually safe to shower after two days but you should check with the healthcare team. Let the healthcare team know if you get a high temperature, notice pus in your wound, or if your wound becomes red, sore or painful. An infection usually settles with antibiotics but you may need another operation.
- Unsightly scarring of your skin.
- Developing a hernia in the scar caused by the deep muscle layers failing to heal. This appears as a bulge or rupture called an incisional hernia. If this causes problems, you may need another operation.
- Blood clot in your leg (deep-vein thrombosis – DVT). This can cause pain, swelling or redness in your leg, or the veins near the surface of your leg to appear larger than normal. The healthcare team will assess your risk. They will encourage you to get out of bed soon after the operation and may give you injections, medication, or special stockings to wear. Let the healthcare team know straightaway if you think you might have a DVT.
- Blood clot in your lung (pulmonary embolus), if a blood clot moves through your bloodstream to your lungs. Let the healthcare team know straightaway if you become short of breath, feel pain in your chest or upper back, or if you cough up blood. If you are at home, call an ambulance or go immediately to your nearest Emergency department.

3 Specific complications of this operation

- Chest infection or fluid collecting in your chest (risk: 2 in 10). This is usually treated with antibiotics or a procedure to drain the fluid. The healthcare team will give you exercises to help reduce this risk.
- Continued bowel paralysis (ileus), where your bowel stops working for more than a few days, causing you to become bloated and to be sick.
- Anastomotic leak (risk: 8 in 100). This is a serious complication that may happen if the join (anastomosis) between your stomach and oesophagus fails to heal, leaving a hole. This often involves a long time without food by mouth. You may need another operation.
- Damage to structures in your chest or abdomen. Your oesophagus lies next to major structures in your chest and abdomen that can be damaged, particularly if the tumour is stuck to them.
- Chylothorax, where fluid called chyle leaks into your chest cavity (risk: 4 in 100). Chyle is normally absorbed from your small bowel and passes into the veins through the thoracic duct, which lies close to your oesophagus. During the operation, your surgeon will usually remove the thoracic duct and tie off the remaining end. If chyle leaks out, you may need another operation to repair the leak.
- Heart problems such as a heart attack (where part of the heart muscle dies) or abnormal heart rhythm (risk: 7 in 100). You may need treatment with medication.
- Change in your voice, if your surgeon needs to make a cut on your neck. There are nerves in your neck that supply your voice box and these can be damaged or stretched, leading to a hoarse or weak voice. Although this usually gets better within a few weeks, it may cause a permanent hoarse voice or difficulty in singing and shouting.
- Narrowing of the join (stricture). This is usually obvious about three months after the operation and makes it difficult for you to swallow. It does not mean the cancer has come back. If you have difficulty swallowing, let your surgeon know. You may need a dilatation, where the join is stretched using a flexible telescope (endoscope).
- Continued pain in your chest wound. Part of a rib needs to be removed to perform the operation. This often results in damage to the nerves in the area, causing pain. This may be permanent.
- Failure to remove the cancer (risk: 7 in 100). The cancer may be too far advanced for your surgeon to remove it safely. Your surgeon may need to insert a stent to improve swallowing. After the operation they will discuss with you other ways of treating the cancer.
- Death sometimes happens with an oesophagectomy (risk: 1 in 20). The risk is less the fitter you are.

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How soon will I recover?

• In hospital

After the operation you will be transferred to the intensive care unit or high dependency unit for a few days, so the healthcare team can monitor you more closely. You will then go to the ward.

You will usually not be able to eat and drink for at least 5 days. During this time you will be fed through the feeding tube, if this was fitted during the operation.

You will be given fluid through the drip. The healthcare team will use the central line to monitor the pressure of blood returning to your heart. This will help your doctor to know how much fluid to give you.

Your surgeon may recommend that you have an x-ray or an endoscopy to find out how well the join is healing, before allowing you to have food. You may be fed through the tube for a few weeks if you are having difficulty getting enough food by mouth.

The drains, drips and catheter will usually be removed after 2 to 5 days.

You should be able to go home after 8 to 14 days. However, your doctor may recommend that you stay a little longer.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

• Returning to normal activities

To reduce the risk of a blood clot, make sure you follow carefully the instructions of the healthcare team if you have been given medication or need to wear special stockings.

An oesophagectomy is a major operation and it will take you at least 3 to 6 months to recover fully.

You can expect to feel tired once you return home but you should gradually feel stronger and be able to do a bit more week by week.

You will be able to eat only small meals and should eat more often than before to try to keep your weight up. Sit upright when you eat and take a drink with your meal to help the food go down.

You may get acid reflux, where acid from your stomach travels up into your oesophagus. Your GP will be able to give you medication to control your symptoms.

Regular exercise should help you to return to normal activities as soon as possible. Before you start exercising, ask the healthcare team or your GP for advice. Do not drive until you are confident about controlling your vehicle and always check your insurance policy and with your doctor.

• The future

Unfortunately, the healthcare team cannot guarantee you will be cured even after the cancer is removed by surgery. Overall about 1 in 4 people will be cured. Your doctor will be able to give you a better idea of your chance of being cured once the cancer has been examined under a microscope. If the cancer is at an early stage with no lymph nodes affected, there is a higher chance of you being cured. An advanced cancer is likely to come back despite the best available treatment. Even if surgery does not lead to you being cured, you should survive longer and have a better quality of life than if you did not have surgery.

Summary

Oesophageal cancer is a serious condition. Your tests have shown that there is a good chance of you being free of oesophageal cancer if you have surgery. However, an oesophagectomy is a major operation and serious complications can happen. You need to know about them to help you to make an informed decision about surgery. Knowing about them will also help to detect and treat any problems early.

Keep this information leaflet. Use it to help you if you need to talk to the healthcare team.

Acknowledgements

Author: Mr Simon Parsons DM FRCS (Gen. Surg.)
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