# Who should stage upper gastrointestinal tract malignancy?

*John Mathew, Lloyd R Jenkinson*

***District general hospitals with trained upper gastrointestinal surgeons should undertake staging of patients with upper gastrointestinal cancers within their catchment areas. This could considerable reduce the workload at regional cancer centres.***

Upper gastrointestinal cancers represent 13.5% of all cancer deaths in England and Wales (Office of National Statistics, 1999). There are 16 000 deaths annually from oesophageal and gastric cancers (Office of National Statistics, 1999). Survival is related to the stage of the disease at presentation (Anonymous, 2000). The 5-year survival rates of oesophageal and gastric cancer are 9% and 12% respectively (Faivre et al, 1998). These survival rates are generally worse than those in other developed countries. For example, the 5-year survival rates for gastric cancer in Austria and Switzerland are 27% and 23% respectively (Faivre et al, 1998). Because of the comparatively poor results in the UK, centralization of upper gastrointestinal cancer services has been recommended (Anonymous, 2000).

Clinical Outcomes Group guidelines (National Cancer Guidance Steering Group, 2000) suggest that the district general hospital (DGH) is an upper gastrointestinal diagnostic centre, making the initial diagnosis only. They recommend that further staging of the cancer should be done at the regional cancer centre. It is not known what proportion of patients with oesophago-gastric cancer presenting to a DGH need extensive staging or how many benefit. This audit was conducted to assess how many patients presenting to a rural DGH need extensive staging and whether this could be done in a DGH.

## MATERIALS AND METHODS

Ysbyty Gwynedd is a DGH in North Wales serving a population of around 230 000. All patients with histologically-proven carcinoma of the oesophagus and stomach between September 1999 and September 2000 were identified from data collected from the pathology department. A retrospective review of the case notes was done with the help of the clinical governance support unit. Patients with gastrointestinal stromal tumours and gastrointestinal lymphomas were excluded from the study group as their management was significantly different from the rest of the group. X-ray of the chest and ultrasound of the abdomen were done as a preliminary staging investigation.

All the patients were discussed at the multidisciplinary meeting before extensive staging investigations, which included computed tomography (CT) scan, endoscopic ultrasound and laparoscopy.

## RESULTS

There were a total of 85 patients with a median age of 74 years (range 49–97 years). Male to female ratio was 2:1. There were 41 oesophageal cancers (26 adenocarcinomas and 15 squamous cell carcinomas) and 44 gastric adenocarcinomas. All patients were discussed at the multidisciplinary meeting. Thirty two patients were considered not suitable for operation because of their age and co-morbid factors and 12 patients were found to have metastasis on ultrasound of the abdomen and chest X-ray. Only 41 patients were fit for extensive staging investigations as shown in *Figure 1*. Seventeen patients were fit for surgery, of which two patients opted for radiotherapy.

Thirty-two patients (37.6%) were considered inoperable because of age and co-morbid factors (17 cardiovascular, six renal, five pulmonary, two associated cancers and two because of their age). Twenty-six patients were above the age of 80 years at the time of diagnosis. Twenty-eight patients (32.9%) had metastasis (liver 19, lungs four, adrenal glands one, nodal-paraaortic nodes two, coeliac nodes one, supraclavicular nodes one). Eight patients (9.4%) had locally advanced disease.

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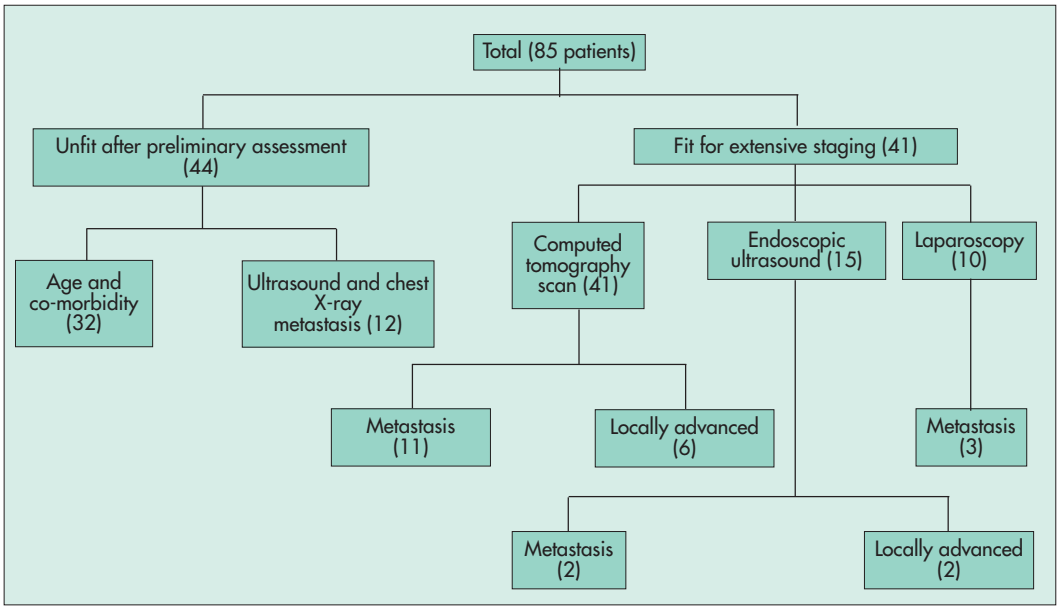


*Figure 1. Staging investigations and reason for inoperability in this audit.*

## DISCUSSION

The incidence of adenocarcinoma of the gastro-oesophageal junction is increasing (Office for National Statistics, 1999). It would put undue pressure on the specialist units if all the upper gastrointestinal cancers were to be staged at the regional cancer centre. If the GP recommendations are implemented, the regional cancer centre would need to perform 40+ CT scans, 15+ endoscopic ultrasound and 10+ laparoscopies for each referring DGH.

The majority of patients with upper gastrointestinal malignancy are over 70 years of age at the time of diagnosis (Office of National Statistics, 1999). This study has shown that in this hospital only 20% (17) of patients need or are fit enough for curative resection. If the patients are counselled and staged locally, this could considerably reduce the workload at the regional cancer centre.

The staging of most upper gastrointestinal cancers is no different from the many other cancers presenting at a DGH and it would create even more anxiety if the patients had to travel long distances to be staged. All DGHs have a CT scanner and this study has shown that all the 41 patients who were considered for extensive investigations had a CT scan done, and 17 (41.4%) of these patients were found to be inoperable as a result of metastasis and locally advanced disease.

To retain the skill, and to make use of the available resources at the DGH, a network multidisciplinary meeting is a viable option, especially with regard to newly appointed consultants. Cases could be discussed at the network multidisciplinary meeting, locally staged and taken to the cancer centre for operation where the consultant has a regular session.

## CONCLUSIONS

The number of patients with upper gastrointestinal cancers undergoing surgery in the authors' DGH is a minority. This is mostly because either their disease is too advanced following staging investigations or that they are not fit to undergo a major surgical procedure.

A significant number of patients with upper gastrointestinal cancers need extensive staging investigations. Cancer centres would be overwhelmed with patients requiring staging investigations if they are referred from DGHs soon after the initial diagnosis. In the authors' s view, DGHs with trained upper gastrointestinal surgeons should undertake staging of patients with upper gastrointestinal cancers. HM

*Conflict of interest: none.*

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### KEY POINTS

- Patients diagnosed with upper gastrointestinal cancer at the district general hospital could and should be staged there.
- District general hospitals with a trained upper gastrointestinal team could considerably reduce the workload at the regional cancer centre if the patients are staged at the district general hospital.