Esophageal Cancer and Palliation of Dysphagia

Sarah Massey, RN, BSN

Progressive dysphagia is the most common presenting symptom of esophageal cancer but also may occur as a side effect of treatment. Evaluation of patients’ dysphagia includes determining its cause and assessing the severity. Several palliative options are available for dysphagia; the clinical situation, local expertise, and cost effectiveness help determine the appropriate treatment modality.

Esophageal cancer is a highly aggressive upper gastrointestinal malignancy. According to the American Cancer Society ([ACS], 2010), 16,640 new cases of esophageal cancer were diagnosed in 2010, with 14,500 deaths caused by the disease. Most cases are diagnosed at stage III or IV (Edmondson & Schiech, 2008). The five-year survival rate is 17% for all stages of esophageal cancer (ACS, 2010); therefore, palliation is the goal for many patients. The two main types of esophageal cancer are squamous cell carcinoma and adenocarcinoma (Siersema, 2008) (see Figure 1). Each type has different risk factors. Squamous cell is associated with cigarette smoking and chronic, heavy alcohol consumption, whereas adenocarcinoma is linked to a history of gastroesophageal reflux disease, Barrett esophagus, and obesity. The risk of esophageal cancer increases with age, and men are three times more likely than women to acquire the disease (ACS, 2010).

Case Study

Mr. X, a 61-year-old African American, had a history of gastroesophageal reflux disease, a 40-pack-year history of smoking cigarettes, and hypertension. He was obese with a baseline weight of 210 lbs at 5’9” tall (body mass index = 31). Five months ago, Mr. X was experiencing dysphagia with solid foods such as sandwiches and meats. He modified his diet to avoid troublesome foods. His symptoms progressed over the next six weeks to dysphagia with liquids. At that time, Mr. X visited his primary care provider, who referred him for an esophagogastroduodenoscopy (EGD) to determine whether any structural blockage existed. An EGD procedure involves passing a flexible tube with a light and camera on the end down the throat to directly visualize the esophagus, stomach, and duodenum. A mass was found in the lower third of Mr. X’s esophagus; the pathology report revealed adenocarcinoma of distal esophagus with moderate differentiation.

Mr. X underwent computed tomography scans of the chest, abdomen, and pelvis, along with a positron emission tomography scan. The scans revealed metastatic disease in both lungs with multiple pulmonary nodules ranging in size from 9 mm to 2 cm. Mr. X was staged at IVb. He then underwent palliative chemotherapy with 5-fluorouracil and cisplatin and external beam radiation. After the completion of treatment, Mr. X was found to still have dysphagia to solids (grade 3). He was referred back to a gastroenterologist for additional interventions to palliate his dysphagia. The gastroenterologist performed an upper endoscopy and placed a self-expanding metal stent. Two days after the procedure, Mr. X was able to eat solid foods with only slight modifications to meats (grades 1–2). Mr. X tolerated the procedure well without any complications of bleeding, perforation, or severe pain.

Pathology

Dysphagia, or difficulty swallowing, has several possible causes in esophageal cancer. Progressive dysphagia is the most common presenting symptom of esophageal cancer (Javle et al., 2006). The esophagus lacks a serosal lining, allowing for unimpeded radial distention and swallowing despite progressive tumor growth. This delays dysphagia from occurring until the tumor occupies 80%–90% of esophageal circumference (Javle et al., 2006). Dysphagia also occurs as a result of treatment for esophageal cancer. Treatment modalities such as external beam radiation, ablation therapy, photodynamic therapy, and brachytherapy can cause esophagitis, fibrosis, and strictures resulting in dysphagia (Javle et al., 2006). Esophagectomy for tumor resection also can cause postoperative anastomotic strictures, creating dysphagia (Javle et al., 2006).

Evaluation

Evaluating dysphagia in patients with esophageal cancer includes determining the cause and assessing the severity, which can be done by grading the dysphagia (see Table 1). The grades range from 1 (normal...
Difficulty swallowing liquids

Normal swallowing

Difficulty swallowing liquids (1) to 5 (unable to swallow saliva) (Javle et al., 2006). The cause of dysphagia often is patient specific. Assessing the treatment a patient has received can help to determine whether the cause is tumor obstruction, stricture, or fibrosis. An upper endoscopy also can be performed if further evaluation is needed.

Management

Options for palliation of dysphagia include dilatation, stent, ablation therapies, and brachytherapy. The clinical situation, local expertise, and cost effectiveness help determine the appropriate treatment modality (Javle et al., 2006).

Dilatation

Dilatation of the esophagus includes an endoscopic procedure and stretching the strictures with devices such as balloons or rubber tubes while the patient is under sedation. Dilatation for malignant obstruction generally is used only as a preliminary modality before endoscopic ablation therapy or tube-feeding placement because the relief is short and repeat dilatation usually is required within two weeks (Javle et al., 2006). Dilatation is used more commonly for dysphagia related to anastomotic strictures (Kight, 2008). Dilatation is not a typical palliation modality because it provides very short relief and requires frequent re-intervention, with a small risk of perforation and bleeding (Javle et al., 2006).

Ablation Therapy

Ablation therapies used for esophageal cancer include laser treatment, photodynamic therapy, argon plasma coagulation, and chemical injection (Javle et al., 2006). Laser treatment vaporizes malignant tissue to restore lumen patency. Treatments are performed every other day and usually take three to four treatments to be effective (Javle et al., 2006). Risks of ablation therapy include perforation, fistula formation, hemorrhage, and sepsis. Dysphagia relief usually last about one month (Javle et al., 2006).

Argon plasma coagulation causes tissue coagulation, desiccation, and destruction of the malignant tissue. However, only a few investigations have studied this technique for the treatment of malignant dysphagia (Javle et al., 2006). More than half of recipients in one study (N = 83) had adequate relief after one session, but most of the patients needed retreatment every three or four weeks to maintain relief (Javle et al., 2006). Perforation is a risk of argon plasma coagulation. In addition, this intervention is not widely available to date because it is a newer procedure.

Chemical injection of ethanol into the malignant tissue causes coagulation of the tissue, increasing the patency of the esophagus. This treatment can provide dysphagia relief for about one month but includes risks of chest pain, perforation, and fistulization (Javle et al., 2006). Photodynamic therapy involves injecting the patient with a photosensitizing agent that is absorbed by the malignant cells. A few days later, the patient undergoes an endoscopic procedure in which a low-powered laser initiates a photochemical reaction resulting in tumor necrosis (Javle et al., 2006). Photodynamic therapy provides symptom relief for two months but has a higher cost than other procedures (Javle et al., 2006). Associated risks include chest pain, worsening dysphagia related to esophagitis, photosensitivity, strictures, fever, and leukocytosis (Javle et al., 2006).

Table 1. Grades of Dysphagia

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>1</td>
<td>Normal swallowing</td>
</tr>
<tr>
<td>2</td>
<td>Difficulty swallowing some hard solids but can swallow semisolids</td>
</tr>
<tr>
<td>3</td>
<td>Unable to swallow any solids but can swallow liquids</td>
</tr>
<tr>
<td>4</td>
<td>Difficulty swallowing liquids</td>
</tr>
<tr>
<td>5</td>
<td>Unable to swallow saliva</td>
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Thermal and chemical ablative techniques provide equivalent palliation when compared to each other and to self-expanding metal stents. However, those modalities are not widely available and have increased requirements for re-intervention, which preclude preference for self-expanding metal stents (Sreedharan, Harris, Crellin, Forman, & Everett, 2009).

Brachytherapy

In brachytherapy, a sealed radiation source is placed close to or inside the tumor in the esophagus; treatments usually last 1.5 days. Brachytherapy does not cause immediate relief of dysphagia but has better long-term relief than self-expanding metal stents (Sreedharan et al., 2009). Dysphagia may worsen for about a week because of tissue edema. Potential side effects include bleeding, perforation, fistula formation, and post-treatment strictures (Javle et al., 2006). Studies have shown higher quality-of-life scores related to dysphagia and general health with brachytherapy recipients compared to stent recipients (Sreedharan et al., 2009).

Chemotherapy and Radiation

Phase II studies using cisplatin combinations have shown dysphagia relief in a majority of patients with esophageal cancer (Ilson et al., 1999, 2000). Effective palliation of dysphagia can be achieved with systemic chemotherapy alone, but the systemic toxicities must be considered (Javle et al., 2006). Radiation for esophageal cancer palliation has a lower total dose than radiation for definitive treatment. Fistula and postradiotherapy stricture formation may occur (Javle et al., 2006). Esophagitis is a side effect of radiation to the neck and can temporarily increase dysphagia (Edmondson & Schiech, 2008). No data support the notion that chemotherapy and radiation provide better dysphagia palliation compared to newer modalities such as self-expanding metal stent insertion and brachytherapy (Sreedharan et al., 2009).

Conclusion

Because esophageal cancer has a poor prognosis, palliation is the goal for most patients. No single intervention palliates dysphagia all of the time for every patient; therefore, healthcare providers must assess the risks and benefits of each palliative intervention for individual patients. In addition, interventions should be chosen based on which modalities are available to the patient, which treatments have the greatest benefit with the fewest risks, and the patient’s preference and goals.

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References


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