University College Hospital

UGI Service
Oesophagectomy
1 Introduction
This leaflet provides information on the investigation and management of oesophageal (gullet) cancer. It aims to answer most of your questions about this condition and its treatment at University College London Hospitals.

2 What is an Oesophagectomy?

The Oesophagus (Gullet): This is a tube that transports food and drink from the throat to the stomach. It sits in the chest.

Cancer of the Oesophagus: This is a cancer that grows in the oesophagus and will most often cause difficulty in swallowing which can lead to weight loss. It may also cause vomiting and / or anaemia (low blood count). It is amongst the ten commonest cancers in the UK. Removing the cancer by surgery may cure it.

Before Surgery: To diagnose this cancer we use endoscopy to look down the oesophagus directly. We also arrange a CT scan (imaging procedure) and usually another type of scan (PET) as well as a further endoscopy with an ultrasound machine at its tip. Finally we need to perform a laparoscopy (keyhole investigation) under general anaesthesia. After these tests are complete we can advise you on the need for an operation to remove the cancer. This operation is called an “Oesophagectomy”.

If surgery is required we shall explain to you the details of the operation and then recommend you undergo a course of
chemotherapy which often lasts about nine weeks. After the chemotherapy, we will arrange a new CT scan to ensure the cancer has not spread and then proceed to surgery within four to six weeks. A visit to a hospital clinic is required to ensure all the tests before surgery are complete and that the anaesthetist has a chance to see you early if required.

3 What are the risks of having an Oesophagectomy? An oesophagectomy is a big operation. The commonest complications are:

- Those affecting the lungs such as chest infection, fluid around the lungs and collapsed lungs. It is, therefore, vital that you breathe comfortably after the operation and that you work closely with the physiotherapist.
- Wound infections which require only simple wound care or antibiotics. Sometimes removing the skin clips early helps.
- Loss of blood needing a blood transfusion.
- A leak from the new join that we make. This happens in about 10% of patients and mostly means delaying your ability to drink or eat until the leak heels by itself. Occasionally we have to perform another operation to deal with this problem.
- Weight loss. You may need to take nutritional supplements to help meet your nutritional requirements while you adjust to the changes made to your body. We usually place a feeding
tube directly into your small bowel during the surgery. This is called a “Jejunostomy” and stays in until we are all satisfied you can maintain adequate nutrition after the surgery. It may stay during any planned chemotherapy due after the surgery.

- Chyle leak. This is a leak of creamy lymphatic fluid through the chest drain and which most often stops on its own. Occasionally we may need to reopen the chest to seal it off.

4 What alternatives are available?
The only treatment that may provide cure for most oesophageal cancers is surgery combined with chemotherapy. However, there are other treatments that can help and can improve symptoms. These include radiotherapy, chemotherapy, laser therapy and stents.

Each person’s cancer is different and therefore there is no single treatment that is suitable for everyone.

5 How should I prepare for the operation?
We need you to be in as good a condition as possible. This includes good nutrition, which we can help you with and stopping smoking at least one month before your treatment starts
Please fast from the midnight before the day of your surgery.

6 Asking for your consent
By law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the operation and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of the treatment proposed, please do not hesitate to speak with a senior member of staff again.

7 What happens during the operation?
The object of the operation is to remove the cancer with surrounding tissue to ensure that it’s all removed. The stomach is then used to replace the oesophagus and is connected to the remaining oesophagus in the chest or neck. Before the operation starts the anaesthetist will spend time placing an epidural (anaesthetic placed next to the spine) as well as starting the general anaesthesia. You will also have other tubes connected to you to drain urine, empty the stomach and at the end of the operation you will also have drains to empty the chest of any excess fluid and help re-expand the lungs. There are different ways of performing an oesophagectomy. Most patients will have a cut in the upper part of the abdomen as
well as one either in the left or right side of the chest. The cut in the abdomen may be replaced by keyhole small cuts. This will be discussed with you before surgery by your surgeon. Occasionally we also make a cut on the left side of the neck

Before oesophagectomy:
After oesophagectomy:

The stomach is made into a long tube to stretch from the back of the throat to the abdomen.
These details will be discussed with you before the operation. We also use a tube for feeding after the operation. This tube will either go directly into the small bowel through the abdominal wall or into a vein in the neck.

8 Who will perform my operation?

Your surgery will be performed by a team of surgeons lead by a consultant. This is most often the consultant you met in clinic but occasionally may be another consultant from the same team. Your doctors will advise you on this.

9 What should I expect after the operation?

After the Operation you will wake up in the Intensive Care Unit (ICU). We plan to keep you there for a short while until the medical team decide when it is safe to transfer you to the surgical ward. We aim to control the pain from your wounds as well as possible so that you are able to take deep breaths and cough comfortably. This is vital in reducing the risk of chest infections and you must tell the nurse looking after you if your pain interferes with this. The physiotherapists will help you from very early on to exercise your breathing and coughing muscles. We aim to get you out of bed as quickly as possible and keep you mobile to minimise the risk of infections and blood clots. The plastic tubes attached to you will be assessed on a daily basis and removed when appropriate. The tubes draining fluid
from around the lungs can be uncomfortable but do help in improving your ability to breath. They often remain in place for about 5 days.

You will be allowed sips of water from when you are awake. We will advise you on when to start drinking and eating properly and this often takes a week. This is a stage by stage approach which your dietician will advise on to help you gradually get back to eating normal consistency foods.

In some cases we may arrange a special swallow X-ray before advising you to start drinking or eating. The move to a surgical ward will be decided upon by the team looking after you.

The clips holding your skin wound closed will be removed after about 10 to 14 days.

10 Getting back on your feet

We encourage you to get active as soon as possible after the operation. A team of physiotherapists will help you achieve this.

11 When can you leave hospital?

On average patients stay for a period of 10 to 14 days after this operation. If there are complications then this stay may be prolonged. On the day of discharge most patients go home using their own transport and may need to wait in a discharge lounge after 11am to ensure the bed is ready for the next patient requiring admission.
12 When can you return to normal activities and work?

It is normal for you to feel exhausted for a few months after this operation. Keeping this in mind will help as many patients find the fatigue very frustrating. Returning to work may take a couple of months and you will find that your energy levels improve gradually over the few months after the operation.

13 What should you eat?

Immediately after the operation you will be allowed sips of water and will get your nutrition through a bag which is fed to a vein or your small bowel (through a tube called a jejunostomy). The nutrition you receive either via the vein or via the jejunostomy will be tailored by the dietician to meet your daily nutritional requirements. After about five to seven days we would expect you to start eating if the recovery has progressed normally. Once you start eating your dietician will advise you of the appropriate consistency of foods and fluids you should be eating and drinking during this time.

You will need to change your eating habits. It will be necessary to have much smaller meals very often (between six to eight small meals per day) and not three large meals. This is because the stomach has been changed and a large volume of food is likely to make you feel sick. Your dietician will help you by tailoring the advice about portion sizes and the number of meals you require each day to your specific needs. It helps if you sit up or have a walk after every meal as this will aid the
movement of food down into the rest of the bowels. We will measure your weight whenever you attend a clinic to look out for any weight loss. You may also need to have nutritional supplements to help prevent any further weight loss or to help maintain your nutritional status in the first few months following surgery. Again, your dietician can help and support you through this process.

14 Follow up after discharge

We will arrange to see you in clinic approximately two weeks after you leave hospital. At this point we can discuss the need for any further treatment. After that we normally see you every three months for the first year and then every 6 to 12 months for the next four years. We do not arrange any routine tests but if your symptoms require it we shall arrange the appropriate test.

If you have concerns once home, then either contact your GP or use the contact details given to you during your hospital stay.
15 Where can I get more information?

Macmillan:
Website: www.macmillan.org.uk

The Oesophageal Patient’s Association:
Website: www.opa.org.uk

Cancer Research UK:
Website: www.cancerResearchUK.org

16 Contact details

The Oesophagogastric Surgery Team:
The team is made up of nurses, doctors, dieticians, physiotherapists and other supporting staff.

Consultant Surgeons
Professor Muntzer Mughal
Mr Khaled Dawas
Mr Majid Hashemi
Mr Borzoueh Mohammadi
Ms Frances Hughes
Mr Bijen Patel
Mr Ashish Rohatgi

Clinical Nurse Specialists

Nathalie Osborn  Clinical Nurse Specialist
Direct line:  020 3447 5023 (Clinical Nurse Specialists)

Dietician: Krupa Patel  Upper GI Dietician

Ward Sisters and Matron

Lauren Molyneux  T9 South Ward
Ebenezer Philips  T9 North Ward
Sally Beyzade  Matron

Direct Telephone:  020 3447 9202 (Surgical PA)
Email:  alia.yunus@uclh.nhs.uk
Website:  www.uclh.nhs.uk

Unit and ward T9 nurses
Dietician: Krupa Patel Upper GI Dietician
17 Space for notes and questions
18 How to find us

- **Euston Square Station**
- **Warren Street Station**
- **University College Hospital**
- **Elizabeth Garrett Anderson Wing**
- **Rosenheim Building**
- **Hospital for Tropical Diseases**
- **Macmillan Cancer Centre**
- **Cotton Rooms**
- **Goodge Street Station** (0.5 km (0.3mi))

**Bus Stops**
- **N**: 10, 14, 24, 29, 73, 134, 390
- **V**: 18, 27, 30, 88, 205
- **P & Q**: 10, 18, 30, 73, 205, 390
- **Z**: 18, 30, 205
- **S T U & R**: 24, 27, 29, 88, 134

- Congestion Charge Zone
- Main entrance