

# Oesophago-gastric cancer: assessment and management in adults

NICE guideline

Published: 24 January 2018

Last updated: 4 July 2023

[www.nice.org.uk/guidance/ng83](https://www.nice.org.uk/guidance/ng83)

## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

# Contents

Overview .....	4
Who is it for? .....	4
Recommendations.....	5
1.1 Information and support.....	5
1.2 Organisation of services.....	6
1.3 Assessment after diagnosis .....	7
1.4 Radical treatment .....	8
1.5 Palliative management.....	11
1.6 Nutritional support .....	16
1.7 Follow-up.....	16
Recommendations for research .....	18
1 External beam radiotherapy in addition to stenting to prevent bleeding .....	18
2 Enteral feeding for people with luminal obstruction and dysphagia.....	18
3 Radical treatment of squamous cell carcinoma of the oesophagus.....	19
4 Radical treatment of T1bN0 adenocarcinoma of the oesophagus .....	19
5 Nutritional support after radical surgery .....	20
6 Jejunostomy support after radical surgery .....	20
7 Follow-up after treatment with curative intent .....	21
Rationale and impact.....	22
Luminal obstruction in oesophageal and gastro-oesophageal junction cancer .....	22
Finding more information and committee details.....	24
Update information .....	25

This guideline is the basis of QS176.

This guideline should be read in conjunction with NG231.

## Overview

This guideline covers assessing and managing oesophago-gastric cancer (oesophageal cancer, gastro-oesophageal junction cancer and gastric cancer) in adults, including radical and palliative treatment and nutritional support. It aims to reduce variation in practice through better organisation of care and support, and improve quality of life and survival by giving advice on the most suitable treatments depending on cancer type, stage and location.

This guideline refers to NHS England commissioning policies. In Wales and Northern Ireland, follow Welsh or Northern Irish commissioning positions if applicable.

## Who is it for?

- Healthcare professionals involved in the care of people with oesophago-gastric cancer
- Commissioners of oesophago-gastric cancer services
- People with oesophago-gastric cancer, their family members and carers, and the public

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Health professionals should follow our general guidelines for people delivering care:

- [Care of dying adults in the last days of life](#)
- [Patient experience in adult NHS services](#)
- [Shared decision making](#)

## 1.1 Information and support

- 1.1.1 Offer all people with oesophago-gastric cancer access to an oesophago-gastric clinical nurse specialist through the person's multidisciplinary team. **[2018]**
- 1.1.2 Provide psychosocial support to the person with oesophago-gastric cancer and those important to them (as appropriate). Cover:
- the potential impact on family life, changing roles and relationships
  - uncertainty about the disease course and prognosis
  - concerns over heredity of cancer, recovery and recurrence
  - where they can get further support. **[2018]**

## Radical treatment

- 1.1.3 Provide information about possible treatment options, such as surgery, radiotherapy or systemic anticancer therapy, in all discussions with people with oesophago-gastric cancer who are going to have radical treatment. Make sure the information is consistent and covers:
- treatment outcomes (prognosis and future treatments)
  - recovery, including the consequences of treatment and how to manage them
  - nutrition and lifestyle changes. **[2018]**

## Palliative management

- 1.1.4 For people with oesophago-gastric cancer who can only have palliative management, offer personalised information and support to them and the people who are important to them (as appropriate), at a pace that is suitable for them. This could include information on:
- life expectancy, if the person has said they would like to know about this, and
  - dietary changes, and how to manage these and access specialist dietetic support. **[2018]**
- 1.1.5 For people with oesophago-gastric cancer who can only have palliative management, consider providing support from:
- a specialist cancer care dietitian
  - a specialist palliative care team
  - a peer support group, if available. **[2018]**

## 1.2 Organisation of services

- 1.2.1 Review the treatment of people with confirmed oesophago-gastric cancer in a

- multidisciplinary meeting that includes an oncologist and specialist radiologist with an interest in oesophago-gastric cancer. **[2018]**
- 1.2.2 Review the treatment of people with confirmed localised, non-metastatic oesophago-gastric cancer in a specialist oesophago-gastric cancer multidisciplinary meeting. **[2018]**
- 1.2.3 Ensure curative oesophago-gastric resections are done in a specialist surgical unit by specialist oesophago-gastric surgeons. **[2018]**

## 1.3 Assessment after diagnosis

### Histologically-confirmed oesophageal or gastro-oesophageal junction cancer after endoscopy and whole-body CT scan diagnosis

- 1.3.1 Offer F-18 FDG PET-CT to people with oesophageal and gastro-oesophageal junction tumours that are suitable for radical treatment (except for T1a tumours). **[2018]**
- 1.3.2 Do not offer endoscopic ultrasound only to distinguish between T2 to T3 tumours in people with oesophageal and gastro-oesophageal junction tumours. **[2018]**
- 1.3.3 Offer endoscopic ultrasound to people with oesophageal and gastro-oesophageal junction cancer only if it will help guide ongoing management. **[2018]**
- 1.3.4 Consider staging laparoscopy for people with oesophageal or gastro-oesophageal junction cancer only if it will help guide ongoing management. **[2018]**

## Histologically-confirmed gastric cancer after endoscopy and whole-body CT scan diagnosis

- 1.3.5 Offer staging laparoscopy to all people with potentially curable gastric cancer. **[2018]**
- 1.3.6 Consider endoscopic ultrasound for people with gastric cancer only if it will help guide ongoing management. **[2018]**
- 1.3.7 Consider F-18 FDG PET-CT for people with gastric cancer only if metastatic disease is suspected and it will help guide ongoing management. **[2018]**

## HER2 testing

- 1.3.8 Offer HER2 testing to people with advanced (locally advanced unresectable, advanced or metastatic) oesophago-gastric adenocarcinoma. **[2018]**

## 1.4 Radical treatment

Other treatment options may also be available for oesophago-gastric cancer. See the [NHS England Cancer Drug Fund list](#).

## Oesophageal and gastro-oesophageal junction cancer

### T1N0 oesophageal cancer

- 1.4.1 Offer endoscopic mucosal resection for staging for people with suspected T1N0 oesophageal cancer. **[2018]**

### Squamous cell carcinoma of the oesophagus

- 1.4.2 Offer people with T1bN0 squamous cell carcinoma of the oesophagus the choice of:

- definitive chemoradiotherapy or
- surgical resection.

Only make this choice after the surgeon and oncologist have discussed each option with the person and those who are important to them (as appropriate).  
**[2018]**

1.4.3 Offer people with resectable non-metastatic squamous cell carcinoma of the oesophagus the choice of:

- radical chemoradiotherapy or
- chemoradiotherapy before surgical resection. **[2018]**

## Oesophageal and gastro-oesophageal junction adenocarcinoma

1.4.4 For recommendations on managing stage 1 oesophageal adenocarcinoma, see [NICE's guideline on Barrett's oesophagus and stage 1 oesophageal adenocarcinoma](#). **[2018]**

1.4.5 For people with localised oesophageal and gastro-oesophageal junction adenocarcinoma (excluding T1N0 tumours) who are going to have surgical resection, offer:

- chemotherapy, before or before and after surgery or
- chemoradiotherapy, before surgery.

Encourage people to join relevant clinical trials, if available. **[2018]**

## Surgical treatment for oesophageal cancer

1.4.6 Consider an open or minimally invasive (including hybrid) oesophagectomy for surgical treatment of oesophageal cancer. **[2018]**

For more information on surgical treatment options for oesophageal adenocarcinoma, see [recommendations on managing stage 1 oesophageal adenocarcinoma in NICE's guideline on Barrett's oesophagus and stage 1 oesophageal adenocarcinoma](#).

## Lymph node dissection for oesophageal cancer

- 1.4.7 Consider two-field lymph node dissection when performing a curative oesophagectomy for people with oesophageal cancer. **[2018]**

## Adjuvant treatment for residual disease after complete resection of oesophageal or gastro-oesophageal junction cancer

- 1.4.8 Nivolumab is recommended as an option for adjuvant treatment of completely resected oesophageal or gastro-oesophageal junction cancer in adults who have residual disease after previous neoadjuvant chemoradiotherapy. For full details, see [NICE's technology appraisal guidance on nivolumab \(TA746, 2021\)](#).

## Gastric cancer

- 1.4.9 Offer chemotherapy before and after surgery to people with gastric cancer who are having radical surgical resection. **[2018]**
- 1.4.10 Consider a D2 lymph node dissection when performing a curative gastrectomy for people with gastric cancer. **[2018]**
- 1.4.11 Consider chemotherapy or chemoradiotherapy after surgery for people with gastric cancer who did not have chemotherapy before surgery with curative intent. **[2018]**

## Peritoneal carcinomatosis

For people with peritoneal carcinomatosis, see [NICE's HealthTech guidance on cytoreduction surgery with hyperthermic intraoperative peritoneal chemotherapy](#), which

recommends that this procedure should only be used with special arrangements for clinical governance, consent, and audit or research.

## 1.5 Palliative management

Other treatment options may also be available for oesophago-gastric cancer. See the [NHS England Cancer Drug Fund list](#).

### Non-metastatic oesophageal cancer that is not suitable for surgery

- 1.5.1 Consider chemoradiotherapy for people with non-metastatic oesophageal cancer that can be encompassed within a radiotherapy field. **[2018]**
- 1.5.2 When the cancer cannot be encompassed within a high-dose radiotherapy field, consider 1 or more of:
- systemic anticancer therapy
  - local tumour treatment, including stenting or palliative radiotherapy
  - best supportive care. **[2018]**
- 1.5.3 After a person with oesophageal cancer has had treatment, assess the tumour's response to chemotherapy or chemoradiotherapy and reconsider whether surgery is an option. **[2018]**

### Systemic anticancer therapy for untreated advanced oesophago-gastric cancer

- 1.5.4 Offer palliative combination chemotherapy to people with untreated advanced oesophago-gastric cancer who have a performance status of 0 to 2 and no significant comorbidities. Possible treatment combinations include:
- doublet treatment: 5-fluorouracil or capecitabine in combination with cisplatin or oxaliplatin

- triplet treatment: 5-fluorouracil or capecitabine in combination with cisplatin or oxaliplatin plus epirubicin.

Capecitabine in combination with a platinum-based regimen is recommended as an option for untreated inoperable advanced gastric cancer. For full details, see [NICE's technology appraisal guidance on capecitabine \(TA191, 2010\)](#).

## Oesophageal cancer

- 1.5.5 Pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy is recommended as an option for untreated locally advanced unresectable or metastatic carcinoma of the oesophagus in adults whose tumours express PD-L1 with a combined positive score (CPS) of 10 or more. For full details, see [NICE's technology appraisal guidance on pembrolizumab \(TA737, 2024\)](#).
- 1.5.6 Nivolumab with fluoropyrimidine-based and platinum-based combination chemotherapy is recommended as an option for untreated unresectable advanced, recurrent, or metastatic oesophageal squamous cell carcinoma in adults whose tumours express PD-L1 at a level of 1% or more. It is recommended only if pembrolizumab plus chemotherapy is not suitable. For full details, see [NICE's technology appraisal guidance on nivolumab \(TA865, 2023\)](#).
- 1.5.7 Nivolumab with platinum- and fluoropyrimidine-based chemotherapy is recommended as an option for untreated HER2-negative, advanced or metastatic oesophageal adenocarcinoma in adults whose tumours express PD-L1 with a CPS of 5 or more. For full details, see [NICE's technology appraisal guidance on nivolumab \(TA857, 2023\)](#).

## Gastric and gastro-oesophageal junction cancer

- 1.5.8 Pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy is recommended as an option for untreated locally advanced unresectable or metastatic HER2-negative gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS of 1 or more.

For full details, see [NICE's technology appraisal guidance on pembrolizumab \(TA997, 2024\)](#).

1.5.9 Nivolumab with platinum- and fluoropyrimidine-based chemotherapy is recommended as an option for untreated HER2-negative, advanced or metastatic gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS of 5 or more. For full details, see [NICE's technology appraisal guidance on nivolumab \(TA857, 2023\)](#).

1.5.10 Offer trastuzumab (in combination with cisplatin and capecitabine or 5-fluorouracil) as a treatment option to people with HER2-positive metastatic adenocarcinoma of the stomach or gastro-oesophageal junction. **[2018]**

Trastuzumab in combination with cisplatin and capecitabine or 5-fluorouracil is recommended as an option for untreated HER2-positive metastatic adenocarcinoma of the stomach or gastro-oesophageal junction. For full details, see [NICE's technology appraisal guidance on trastuzumab \(TA208, 2010\)](#).

1.5.11 Zolbetuximab with fluoropyrimidine- and platinum-based chemotherapy is not recommended for untreated, locally advanced, unresectable or metastatic, claudin-18.2-positive, HER2-negative, gastric or gastro-oesophageal junction adenocarcinoma in adults. For full details, see [NICE's technology appraisal guidance on zolbetuximab \(TA1046, 2025\)](#).

1.5.12 Pembrolizumab with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy is not recommended for untreated locally advanced unresectable or metastatic HER2-positive gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS of 1 or more. For full details, see [NICE's technology appraisal guidance on pembrolizumab \(TA983, 2024\)](#).

## Systemic anticancer therapy for previously treated advanced oesophago-gastric cancer

1.5.13 Consider second-line palliative chemotherapy for people with oesophago-gastric cancer. **[2018]**

- 1.5.14 Consider a clinical trial (if a suitable one is available) for people with advanced oesophago-gastric cancer.

## Oesophageal cancer

- 1.5.15 Nivolumab is recommended as an option for treating unresectable advanced, recurrent or metastatic oesophageal squamous cell carcinoma in adults after fluoropyrimidine and platinum-based therapy. For full details, see [NICE's technology appraisal guidance on nivolumab \(TA707, 2021\)](#).

## Gastric and gastro-oesophageal junction cancer

- 1.5.16 Pembrolizumab is recommended as an option for treating unresectable or metastatic gastric cancer with high microsatellite instability (MSI) or mismatch repair (MMR) deficiency that has progressed during or after 1 therapy. It should be stopped at 2 years of uninterrupted treatment, or earlier if the cancer progresses. For full details, see [NICE's technology appraisal guidance on pembrolizumab \(TA914, 2023\)](#).
- 1.5.17 Trifluridine–tipiracil is recommended as an option for treating metastatic gastric cancer or gastro-oesophageal junction adenocarcinoma in adults who have had 2 or more treatment regimens. For full details, see [NICE's technology appraisal guidance on trifluridine–tipiracil \(TA852, 2022\)](#).
- 1.5.18 Ramucirumab alone or with paclitaxel is not recommended for advanced gastric cancer or gastro-oesophageal junction adenocarcinoma previously treated with chemotherapy. For full details, see [NICE's technology appraisal guidance on ramucirumab \(TA378, 2016\)](#).

## Neurotrophic tyrosine receptor kinase (NTRK) fusion-positive solid tumours

- 1.5.19 Larotrectinib is recommended as an option through the Cancer Drugs Fund for treating locally advanced or metastatic NTRK fusion-positive solid tumours when there are no other satisfactory treatment options. For full details, see [NICE's](#)

[technology appraisal guidance on larotrectinib \(TA630, 2020\)](#).

## Luminal obstruction in oesophageal or gastro-oesophageal junction cancer

- 1.5.20 Offer self-expanding stents to people with oesophageal or gastro-oesophageal junction cancer who need immediate relief of dysphagia. **[2018]**
- 1.5.21 Offer self-expanding stents or radiotherapy to people with oesophageal or gastro-oesophageal junction cancer, depending on the degree of dysphagia and its impact on nutrition and quality of life, performance status and prognosis. **[2018]**
- 1.5.22 Do not routinely offer external beam radiotherapy after stenting for people with oesophageal or gastro-oesophageal junction cancer. **[2023]**
- 1.5.23 Consider external beam radiotherapy after stenting of oesophageal or gastro-oesophageal junction cancer for people with prolonged post-interventional bleeding or a known bleeding disorder. **[2023]**

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on luminal obstruction in oesophageal and gastro-oesophageal junction cancer](#).

Full details of the evidence and the committee's discussion are in [evidence review A: management of luminal obstruction in adults with oesophageal cancer not amenable to treatment with curative intent](#).

## Outflow obstruction in gastric cancer

- 1.5.24 Offer uncovered self-expanding metal stents or palliative surgery to people with gastric cancer, depending on fitness to have surgery, prognosis and extent of disease. **[2018]**

## 1.6 Nutritional support

### Radical treatment

- 1.6.1 Offer nutritional assessment and tailored specialist dietetic support to people with oesophago-gastric cancer before, during and after radical treatments. **[2018]**
- 1.6.2 Offer immediate enteral or parenteral nutrition after surgery to people who are having radical surgery for oesophageal and gastro-oesophageal junction cancers. **[2018]**
- 1.6.3 For people with oesophago-gastric cancer, follow the recommendations in [NICE's guideline on nutrition support for adults](#). **[2018]**

### Palliative care

- 1.6.4 Consider support from a specialist cancer-specific dietitian for people with oesophago-gastric cancer receiving palliative care. **[2018]**

## 1.7 Follow-up

- 1.7.1 For people who have no symptoms or evidence of residual disease after treatment for oesophago-gastric cancer with curative intent:
- provide information about the symptoms of recurrent disease, and what to do if they develop these symptoms
  - offer rapid access to the oesophago-gastric multidisciplinary team for review, if symptoms develop. **[2018]**
- 1.7.2 For people who have no symptoms or evidence of residual disease after treatment for oesophago-gastric cancer with curative intent, do not offer:
- routine clinical follow up solely to detect recurrent disease

- routine radiological surveillance solely to detect recurrent disease. **[2018]**

## Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of recommendations for research are detailed in the [full guideline](#).

### 1 External beam radiotherapy in addition to stenting to prevent bleeding

What is the effectiveness and cost-effectiveness of external beam radiotherapy in addition to self-expanding stents to prevent prolonged bleeding after stent insertion in people with oesophago-gastric cancer who are undergoing palliative management of dysphagia due to luminal obstruction with no curative intent? [2023]

For a short explanation of why the committee made this recommendation for research, see the [rationale section on luminal obstruction in oesophageal and gastro-oesophageal junction cancer](#).

Full details of the evidence and the committee's discussion are in [evidence review A: management of luminal obstruction in adults with oesophageal cancer not amenable to treatment with curative intent](#).

### 2 Enteral feeding for people with luminal obstruction and dysphagia

In people experiencing partial or complete luminal obstruction resulting from incurable oesophago-gastric cancer, is enteral feeding an effective and cost-effective method of preserving quality of life and survival, when the first-line management of dysphagia (for example, self-expanding stents) has failed or is contraindicated? [2023]

For a short explanation of why the committee made this recommendation for research, see the [rationale section on luminal obstruction in oesophageal and gastro-oesophageal junction cancer](#).

Full details of the evidence and the committee's discussion are in [evidence review A: management of luminal obstruction in adults with oesophageal cancer not amenable to treatment with curative intent](#).

## 3 Radical treatment of squamous cell carcinoma of the oesophagus

Does the addition of surgery to chemoradiotherapy improve disease-free and overall survival in people with squamous cell carcinoma of the oesophagus? [2018]

### Why this is important

The aetiology of squamous cell carcinoma (SCC) of the oesophagus is changing. People with SCC are now fitter, with fewer comorbidities than in previous years. Standard radical treatment for SCC of the oesophagus is usually chemoradiotherapy, which is associated with a median survival of between 12 and 18 months. Given a fitter patient population, surgery may be a therapeutic option but its effectiveness in addition to chemoradiotherapy is unknown and a randomised controlled study to investigate whether the combination improves disease-free and overall survival would provide useful information to guide future clinical practice.

## 4 Radical treatment of T1bN0 adenocarcinoma of the oesophagus

What is the optimal treatment for T1bN0 adenocarcinoma of the oesophagus? [2018]

### Why this is important

In people with submucosal (T1b) N0 oesophageal adenocarcinoma (OAC), the associated risk of lymph node metastases is estimated to be between 4% for sub-mucosal 1 (sm1) and up to 16% for sm3 based on retrospective surgical data. Most people with a submucosal

T1bN0 OAC therefore currently have major surgical resection without detecting any cancer cells in the oesophagus or lymph nodes. Oesophagectomy is also a procedure associated with significant morbidity (up to 50%) and mortality (2% to 4%).

In comparison, endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) are techniques that can remove the submucosa with less morbidity and mortality than surgery and, providing there is no lymph node involvement, can lead to a cure. However, compared to surgery nodal involvement can only be assessed by F-18 FDG PET-CT scanning and endoscopic ultrasound (EUS), which may lead to under-treatment of some patients with T1b disease.

A study to assess who should have endoscopic therapy or surgery for T1bN0 OAC would be useful, as this would help prevent both under- and over-treatment of this group of people. This could be a randomised controlled trial comparing surgery and endoscopic treatment.

## 5 Nutritional support after radical surgery

What is the optimal method of delivering nutritional support to adults after surgery with curative intent for oesophago-gastric cancer? **[2018]**

### Why this is important

People who have surgery for oesophago-gastric cancer have a prolonged period without adequate oral intake after surgery. Oral, enteral and parenteral nutrition support strategies are used to support people during this time. Evidence suggests that providing some form of nutrition support improves surgical outcomes. However, which of these methods is the safest and most effective has not been determined and because of this, practice in this field varies nationally. A study to identify the best method of delivering safe and effective nutritional support interventions which aim to reduce post-operative complications in this population would help guide future clinical practice.

## 6 Jejunostomy support after radical surgery

What is the effectiveness of long-term jejunostomy support compared to intensive dietary counselling and support along with symptom management for people having radical surgery for oesophago-gastric cancer? **[2018]**

## Why this is important

People who have had surgery for oesophago-gastric cancer have nutritional difficulties as a result of problems eating, ongoing symptoms, and side effects related to the surgery. It is well recognised that they have a poor quality of life. Most people have adjuvant treatment, however their nutritional status may negatively impact on their ability to tolerate this, meaning treatment can be stopped early or not received. Jejunostomy feeding tubes are often used to provide nutrition support after discharge from hospital after surgery. Some small studies have shown a benefit in terms of weight preservation, but none have shown that this leads to better recovery, tolerance of treatment or quality of life. Practice in this area varies greatly, with some centres placing jejunostomy tubes and continuing enteral feeding after discharge, some placing the jejunostomy tubes and not using them routinely and others not placing jejunostomy tubes at all. Studies should aim to identify if jejunostomy placement leads to clinical benefit in adults who have had surgery for oesophago-gastric cancer.

## 7 Follow-up after treatment with curative intent

Is the routine use of CT and tumour markers effective in detecting recurrent disease suitable for radical treatment in asymptomatic people who have had treatment for oesophago-gastric cancer with curative intent? [2018]

## Why this is important

There is no clearly defined follow-up protocol for people with oesophago-gastric cancer treated radically. Detection of early recurrence potentially suitable for radical treatment offers the possibility of increased survival. However, the best methods of detecting recurrence are unclear and there is no evidence to show whether early detection leads to improved overall survival. The alternative is to wait until symptoms reoccur and then re-evaluate the further treatment options available. Studies examining the role of screening in this scenario would show whether routine follow-up in asymptomatic people was effective at detecting recurrence and improving overall survival.

## Rationale and impact

This section briefly explains why the committee made the recommendations and how they might affect practice.

### Luminal obstruction in oesophageal and gastro-oesophageal junction cancer

#### Why the committee made the recommendations

##### Recommendations 1.5.20 to 1.5.23

The committee did not find any new evidence that would affect recommendations 1.5.20 and 1.5.21 and therefore did not update the recommendations made by the previous committee on the basis of the evidence they considered (see the [previous full guideline from 2018](#)).

Most of the evidence considered by the committee did not show a difference between the effectiveness of different interventions for relieving dysphagia caused by luminal obstruction of the oesophagus in people with oesophageal and gastro-oesophageal junction cancer whose condition was not being treated with curative intent. A high quality, UK-based health technology assessment provided new evidence on external beam radiotherapy (EBRT) after stenting for people with dysphagia whose condition needed palliation.

This study compared self-expanding metal stents (SEMS) alone to SEMS and adjuvant EBRT and concluded that the data could not differentiate between them for all outcomes considered in the evidence review. The committee agreed that they did not support the routine use of EBRT for people after stenting. However, the committee noted that there was some evidence of better outcomes for gastrointestinal-related bleeding. Although this was of low certainty, they agreed that from their experience EBRT helps to prevent bleeding. Therefore, they made a recommendation to consider EBRT for people with prolonged bleeding after stent insertion or a known bleeding disorder. Stopping bleeding is important to people who have incurable oesophageal and gastro-oesophageal junction cancer because it improves their quality of life. The committee made a [recommendation](#)

for research about the use of EBRT to prevent bleeding because there was not enough evidence to make a strong recommendation about it.

The committee agreed that only offering EBRT after stent insertion to people with oesophageal and gastro-oesophageal junction cancer if they had prolonged bleeding or a known bleeding disorder would lead to more effective targeting of comparatively scarce EBRT services. Furthermore, it will reduce the treatment burden for people with oesophageal and gastro-oesophageal junction cancer who are not bleeding from the cancer site, or do not have a known bleeding disorder, and their carers and relatives. This is because they will not have the inconvenience of travelling for unnecessary EBRT treatment and the side effects associated with it.

The committee made a recommendation for research on the effectiveness of enteral feeding for people who have dysphagia caused by luminal obstruction as no evidence was found.

## **How the recommendations might affect practice**

The committee agreed that the new recommendations are likely to be cost saving because they will reduce the number of people receiving EBRT after stenting, and the number of different treatments that most people receive since most people will not receive EBRT.

Resources for EBRT after stent insertion can be more effectively directed to people with incurable oesophageal and gastro-oesophageal junction cancer who have prolonged bleeding or a known bleeding disorder.

[Return to recommendations](#)

## Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic pages on oesophageal cancer](#) and [stomach cancer](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence review](#) and [full guideline](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

## Update information

**July 2023:** We have reviewed the evidence and made new recommendations on palliative management of luminal obstruction with no curative intent for adults with oesophageal or gastro-oesophageal junction cancer. These recommendations are marked **[2023]**.

### Minor changes since publication

**May 2026:** We added links to relevant NICE technology appraisal guidance in the [sections on radical treatment](#) and [palliative management](#). We also simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines.

**January 2025:** We added a link to NICE's interventional procedures guidance on cytoreduction surgery with hyperthermic intraoperative peritoneal chemotherapy for peritoneal carcinomatosis (IPG688) to the section on radical treatment.

**February 2023:** We have updated the recommendations on T1N0 oesophageal cancer in line with the new guideline on Barrett's oesophagus and stage 1 oesophageal adenocarcinoma.

ISBN: 978-1-4731-5280-9