Model Summery

65 year old farmer presented with oesophageal type progressive dysphagia for 3 months duration. It progressed rapidly during last 2 months duration and now it is grade 3 dysphagia, all features are more towards oesophagial malignancy.patient has experienced several episodes of oesophagel pseudo vomiting without aspiration.except for beetle chewing he denies a history of corrosive ingestion or longstanding GORD.He does not have features of local or distent spread of the disease.

Except patient is diagnosed with COPD with regular medical followup rest of the past medical history,surgical history and family history is not significant.

on Examination patients BMI is 22.5 without evidance of malnutrition.patient is nat pale and no other locoregional lymphnode enlargement. No organomegaly or freefluid in the abdomen.DRE is normal.

Patient has underwent UGIE + biopsy with CECT neck,chest abdomen and pelvis. He was diagnosed to have lower oesophageal malignancy (Adeno carcinoma).patient has a good insight regarding his diagnosis and course of his treatments.

* For Explanatory audio on history and examination follow the below link.

**Investigation and Management plan.**

**Problem list**

* Dysphagia due to lower oesophageal adenocarcinoma
* Risk of Nutritional deficiency / malnutrition
* Smoking induced COPD
* Poor Oral hygiene
* Risk of cardiac disease

**Investigation plan**

1. Blood workup
	1. FBC –to detect anemia
	2. Liver functions- to detect any evidence of hepatic impairment due to metastatic disease
	3. Renal functions – to detect background renal functions before contrast CT and to prepare patient for surgery (anesthesia fitness)
	4. Albumin-To check patient protein status of the body.
2. Endoscopy
	1. Upper GI endoscopy to assess location of the tumor and take representative biopsies.
	2. To assess the involvement of future gastric conduit.
3. Imagine
	1. CECT (neck, chest, abdomen) to stage the disease. (TNM)
4. Cardiac assessment
	1. 2D Echo- to assess cardiac fitness for surgery and fitness for neo-adjuvant chemo radiotherapy.
5. Chest assessment
	1. CXR, Lung function test.
6. Nutritional assessment
	1. Anthropometric measures
	2. Biochemical assessment-albumin, pre-albumin, ferritin.
	3. Dynamometric measurements. -hand grip

**Management overview**

1. Multidisciplinary meeting to discuss about neo-adjuvant chemotherapy, Staging of the disease and operative plan.
2. Family meeting to discuss about patient’s future treatment plan outcome.
3. Nutritional optimization with enteral or parenteral route after discussing with nutritionist.
4. Cessation of smoking and pulmonary rehabilitation.
5. Oral care and dental hygiene. (because dental caries can cause severe lung infection after intubation and ventilation)
6. Plan for surgery.
	1. Minimal invasive oesophagectomy, open oesophagectomy.
	2. Endoscopic resection for very early lesions.
7. Post-operative ICU care
8. Adjuvant chemotherapy.
9. Follow-up
	1. To see for early recurrences
	2. To see for distant metastasis
	3. To detect late operative complications (anastomotic stricture)

Palliative procedures

* Oesophageal stenting and re- establishment of oral feeding.
* Definitive chemo-radiotherapy.
* Percutaneous endoscopic gastrostomy and enteral feeding.
* Feeding jejunostomy if stomach involved with the tumor.
* Pain management at a pain clinic.
* Regular follow-up to detect metastatic complications early.

**Over-view of oesophagectomy**.

