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Impact of Otolaryngology in the diagnosis of early oesophageal malignancy

A. Tsikoudas[*], *A. Vijendren*, *N. Haloob*, *G. Mochloulis*

Lister Hospital, Department of ORL, Stevenage, UK

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ABSTRACT

Introduction: A large number of patients present in Otolaryngology clinics with vague upper gastro intestinal symptoms, some potentially originating from the oesophagus. In the United Kingdom there is no consensus for investigation protocols. The concern is that diagnosis of early oesophageal malignancy can be delayed with detrimental effects to the prognosis of the patient. The aim of this paper is to attempt to establish the impact of Ear Nose and Throat (ENT) work up in the diagnostic pathway of these patients.
Methods: Retrospective analysis of case notes of newly diagnosed oesophageal carcinoma over a 15 month period.
Results: Sixty five patients with a new diagnosis of oesophageal carcinoma were identified from the upper GI cancer network. A cohort of 7 patients was initially referred to ENT with related symptoms. Delays occurred at different stages during the course of their diagnostic pathways. Only 2 patients were diagnosed from ENT prior to referral to upper GI.
Conclusion: We support the creation of one stop clinics incorporating the use of transnasal oesophagoscopy. The current literature is discussed.

Introduction

Globus is a common condition and a significant amount of patients with this problem present daily to ENT departments.

The concern is that a small number of patients with mainly oesophageal and to a lesser extend hypopharyngeal malignancies, will present to the ENT surgeon with vague globus type symptoms.[1–3] It is well known that the incident of oesophageal adenocarcinoma is on the increase and any delay in the diagnosis can have grave impact in the prognostic outlook of the patient. In the year 2000, the United Kingdom (UK) had the highest reported incidence worldwide for reasons yet unknown.[4]

The pool of globus patients is a heterogeneous one. Several options exist for the investigation of these patients (barium swallow, endoscopy, "standard" flexible oesophagoscopy etc). In the UK, there is no consensus for investigation protocols.[5,6] Gold standard is endoscopy. Until now, the oesophagus could represent a "grey" area between ENT and Gastroenterology. This can result in a number of patients not having, or receiving a complete examination of the oesophagus with significant delay.

This study aims to answer the following questions: How common is it for a patient harbouring oesophageal

* *Corresponding author*. Department of ORL, Gartnavel G Hospital, Glasgow, UK. Tel.: +44 141 2113000; fax: +44 141 2111671.
E-mail address: atsikoudas@nhs.net (A. Tsikoudas).
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malignancy to present to an ENT specialist and how efficient are the current diagnostic methods in detecting early cancer in the upper oesophagus? Can this be improved? A recent review of the literature revealed a paucity on the subject.

Methodology

A retrospective analysis of cases with a confirmed diagnosis of oesophageal cancer were obtained via the Mount Vernon cancer Network over a 15 months period. Cases with ENT involvement prior to diagnosis were extracted and their diagnostic pathways examined.

Ethical considerations

The project was registered in the hospital audit registry in order to gain access to the information held in the case notes.

Inclusion criteria

Patients with confirmed histological diagnosis of oesophageal cancer who were initially referred to ENT.

Outcome measures

Epidemiological data and time interval from referral to clinic appointment investigation and diagnosis were measured. Secondary measures included grade of ENT clinician, investigations requested, staging and overall outcome.

Results

Sixty five patients were identified with a confirmed diagnosis of oesophageal cancer during this period. In fifteen of these cases there was ENT involvement.

Of these 15 cases, 8 were excluded (one was seen post diagnosis for vocal cord paralysis and 7 were referred for unrelated problems ie tinnitus, hearing aid replacement etc) leaving a total of 7 cases.

There were 5 males and 2 females. Three patients were below the age of 50, whilst three were above 80. The mean age amongst the males was 53 and amongst the females was 81.5 whilst the mean age amongst all patients was 61.

The mean waiting time between GP referral and first ENT appointment was 56 days (range 17–128) and the mean waiting time between first ENT appointment and referral to gastroenterology was 24 days (range 5–82).

All seven patients had at least one "red flag" symptom mentioned in the referral letter. Four cases, were referred as "cancer wait" (CW), two as "soon" and one presented in the accident and emergency department (A&E) pending a semi-urgent referral from the GP.

Two patients underwent successful panendoscopy. The rest of them were essentially investigated with barium swallows. Four patients presented to A&E with deterioration of their symptoms during the course of their ENT investigations. As a result, referral to gastroenterology was expedited.

Two patients presented at T4 stage, four at a T3 stage and one at T2. The level of the malignancy in the oesophagus in all the cases was: One patient in the upper oesophagus, one described in the junction between the upper and middle oesophagus and one in the middle. Two cases were identified in the distal oesophagus, whilst in the remaining two it was not entirely clear in the notes and it is assumed to be in the distal oesophagus.

The ENT service diagnosed 2 out of the 7 patients with oesophageal carcinoma prior to referral to Gastroenterology. The level of the malignancy in these two cases was in the upper and middle oesophagus.

One patient had a pharyngeal pouch treated a few years prior to diagnosis.

The details of each patient can be seen on Table 1.

Discussion

A striking finding was that only two patients were diagnosed by ENT. The reason for this is firstly because some of the pathology was originating in the lower oesophagus which can be missed, as some surgeons performing rigid endoscopy limit their endoscopy at 26–28 cm. Secondly, because of the late presentation causing the majority of these patients to present in A&E with acute dysphagia (pending their ENT investigations), and were subsequently referred to gastroenterology for upper GI endoscopy.

This study highlighted significant delays occurring at different stages of the diagnostic pathway. More specifically in the 3 cases with the longest delays, the first case was due to a cancelled OPD appointment, the second case the urgent referral to the radiology department was rejected (prompting an incident form). The delay was picked up early from the ENT department and managed appropriately. Finally in the third,

Table 1 – Details of the seven cases.

Patient	Referred as	ENT dr	ENT plan	GP to gastro	ENT to gastro	Reason for delay	Staging/outcome
41M	Soon	Middle grade	Bar swl A&E	49	11		T3N2M1 palliative
81M	CW	Middle grade	CT-Bar. swallow- endoscopy	28	16		T3N1M1 palliative
42M	Soon	Consultant	Endoscopy Bar swall A&E	128	29	Cancelled opd apt	T4N2M0 surgery
80F	CW	Middle grade	B swallow Ref to GP	99	82	Ref back to GP for gastro app	T4N0Mx RIP
42M	CW	Middle grade	B swallow (cancelled) A&E	17	5	Cancelled Radiology appt	T3N1M0 RIP
57M	A&E	Middle grade	B swallow	14	14		T2N1M0 CT-RT
83F	CW	Middle grade	B swallow A&E	17	12		T3N0M0 palliative