Oesophagectomy

Information for patients

Working with you to make Highland the healthy place to be
This leaflet provides information about oesophagectomy (removal of the gullet). It has been produced to help you understand what the operation involves.

Cancer of the oesophagus (gullet)

The gullet is a long tube which connects your throat to the stomach. The most common symptom is difficulty swallowing due to a malignant growth. Cancer of the oesophagus can be treated using surgery, chemotherapy or radiotherapy. The choice of treatment will depend on the stage of the cancer, its position and size, as well as your age and general health. The treatments can be used in combination or alone.

Oesophagectomy is presently considered the best treatment for potentially curable oesophageal cancer. It gives good symptom relief and offers the best chance of a long term cure.

Oesophagectomy

An oesophagectomy is the surgical removal of the gullet. Your test results have shown that the cancer can be removed by an oesophagectomy. It is a major operation and is done under general anaesthetic. You will be asleep for the entire operation. It is difficult to say how long your operation will take but you can be in the operating theatre for a number of hours.

Most patients will have a cut across the upper part of the abdomen under their ribs and one in the right side of their chest. Some patients will not have the chest cut but instead will have a cut in the left side of their neck.

The consultant will discuss the exact details of the operation with you.

If you have any further queries regarding this operation please contact:

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If you require further information you can access the Cancer Backup website @ www.cancerbackup.org.uk
Are there any complications from the operation?

Oesophagectomy is a major operation and recovery from surgery can take some months. As with all major surgery there are risks attached to it, but it is done to try and remove your cancer, so you may feel that some risks are worth taking. Make sure you discuss possible complications with your surgeon and ask all questions you need to.

- The main risk from this operation is a leak. This is a disruption of the join between the remaining oesophagus and stomach.
- Risk of chest problems due to the type of surgery
- Risk of bleeding, although it is usually minimal
- Infection can occur at the wound site
- DVT (deep vein thrombosis)
  In a small number of people the tumour will be found to be inoperable at the time of surgery, despite pre-operative scanning.
- After discharge from hospital you may experience symptoms that are related to your surgery. Theses include reflux, diarrhoea, weight loss and difficulty swallowing; due to narrowing of the join at the lower end of the oesophagus.

Complications can be serious and would delay your recovery, lengthening your hospital stay. They are becoming less common as more of these operations are done in specialist centres, but even so, as many as 5-10% of people who have this surgery die directly as a result of complications after their surgery. Your surgeon will discuss this in more detail.

Oesophagectomy is presently considered the best treatment for potentially curable oesophageal cancer. A specialist multidisciplinary (including your consultant) has also discussed your case and they believe surgery is the most appropriate treatment.

Before surgery

You will have had a number of tests and scans before your surgery including endoscopy and CT scans.

The day before your surgery you will be admitted to ward 4C.

The surgeon and anaesthetist will see you before your operation. The surgeon will once again explain how the operation will be done and you will have to sign a consent form. If you have any questions or are worried about anything it is important to ask at this stage. The anaesthetist will explain the anaesthetic to you and discuss pain control options with you.

The evening before your operation you may eat and drink as normal. Usually you will have no food 6 hours before your planned operation. You may have a drip in your arm. If you are diabetic you may be given an infusion of glucose and insulin to control your blood sugars.

You will be given a pair of stockings to wear and given an injection of Clexane (medicine that thins the blood). This helps reduce the risk of deep vein thrombosis (blood clotting in the vein). You will change into a theatre gown and remove any jewellery.

You will be taken down to theatre to a waiting area and then taken to the anaesthetic room. In the anaesthetic room you will be given an epidural if this has been discussed and agreed with the anaesthetist. It is a fine plastic needle inserted into your back near the spinal cord, to allow continuous painkillers to be given through this. The anaesthetist will then give an injection through a drip in your hand, which will send you to sleep.
The Operation

There are different ways of doing the operation. Your surgeon can approach the gullet via the neck, chest or stomach. The way in which the operation is done depends on where the cancer is situated in the gullet. You may hear words like trans-thoracic oesophagectomy or trans-hiatal oesophagectomy; this describes the way in which the surgeon does the surgery. The operation involves:

- Removing the affected part of the gullet
- Reshaping the stomach and allowing it to be pulled up into the chest or neck
- Removing the surrounding lymph nodes that may have cancer in them
- Joining the stomach to the remaining oesophagus in the chest
- Inserting a temporary feeding tube into the small bowel (jejunum), known as a feeding jejunostomy.

During this operation, because the top part of the stomach is usually removed, the position of the stomach will be higher than before. This process will help you to swallow.

After your operation

When you wake up you will be in the Intensive Care Unit. This is normal and does not mean anything has gone wrong. As mentioned before, as this is a major operation you will need to be monitored closely. You will soon be transferred to a surgical ward, usually 4C.

When you wake there will be several tubes attached to you. Try not to be alarmed. They may include:

- A drip (intravenous infusion) will be used to maintain the body’s fluids until you are able to eat and drink.

You will also have a plastic drain at one or both sides of your chest (chest drains). They will be removed after 3-5 days after your operation.

You may also have some tubes in your abdomen, chest and down your nose. The doctor will discuss and explain the purpose of them.

There will be some discomfort and pain in the area of the operation. We aim to control your pain by using the epidural. Pain relieving drugs are given through the epidural. The drugs numb the pain. This is important as it will allow you to cough and move around as much as possible.

After the operation you will be encouraged to start moving about as soon as possible. This is to help prevent chest infections and an essential part of your recovery. If you have to stay in bed the nurses will encourage you to do regular leg movements and deep breathing exercises. There will be a physiotherapist working with you to help you do the exercises.

Approximately 5 days after your surgery you will be given a special drink and have an x-ray. This special x-ray is to check that the join inside has sealed and that there is no leak. You will not be able to drink until you have had this test. This will be gradually increased and after a few days you will be allowed to start drinking again normally and commence a light diet.

You will usually be ready to go home 2 weeks after the operation. However, you will need to rest at home and it usually takes some months to return to normal activity.

Before you leave hospital you will be given an appointment for a check up at the outpatient clinic. The feeding tube you have will remain in place until this appointment, where it will be removed.