Many cases of upper gastrointestinal cancer in Cheshire East are preventable and are associated with a low survival and high mortality. 

Key messages

• Many cases of upper gastrointestinal (Upper GI) cancer are preventable (up to 89% of oesophageal cancers but only 37% of pancreatic cancers). Smoking, obesity and poor diet are significant risk factors for upper GI cancer.

• While rates of new Upper GI cancers in Cheshire East decreased since 2001-2003, rates of new cases of oesophageal and pancreatic cancers increased and so there may be great value in further preventative efforts aimed at these cancers.

• Mortality rates have fallen since 2001-2003. However, Upper GI cancer is the cause of 7% of new cancer cases in Cheshire East and 14% of all cancer deaths reflecting the poor survival associated with this group of cancers at both one year and at five years. This is particularly true for pancreatic cancers, where the number of deaths increased by 40%, with very large increases in NHS South Cheshire CCG.

• A large decrease in mortality rates in NHS Eastern Cheshire CCG resulted in significantly lower mortality rates than the England average. Mortality rates are higher in South Cheshire CCG.

• 7 out of 10 upper GI cancers are diagnosed at late stage in Cheshire. This is important as late diagnosis is associated with worse survival. Emergency presentations appear to be a greater issue in NHS South Cheshire CCG than in NHS Eastern Cheshire CCG.

• 59% of diagnoses and 55% of deaths occur in men indicating that men are disproportionately affected.

• Despite the overall decrease in Upper GI cancer incidence rates, the numbers of new cases increased by 18% locally, which most likely reflects our increasing and ageing population.

• Consideration should be given as to whether local endoscopy services are being used effectively.
Burden of upper gastrointestinal cancer

New diagnoses of upper GI cancer in Cheshire East (2012-2014)
Source: CancerStats, 2016

- Pancreas: 181 (36%)
- Oesophagus: 199 (39%)
- Stomach: 130 (25%)

Deaths from upper GI cancer in Cheshire East (2012-2014)
Source: CancerStats, 2016

- Pancreas: 175 (41%)
- Oesophagus: 162 (38%)
- Stomach: 88, (21%)

Summary of upper gastrointestinal cancer burden in Cheshire East

There were 510 new diagnoses of upper gastrointestinal cancer in 2012-2014 in Cheshire East. These were 7% of all new cancer diagnoses in Cheshire East. There were 425 deaths due to upper gastrointestinal cancer in 2012-2014 in Cheshire East. These were 14% of all Cheshire East cancer deaths. Consequently, upper GI cancers are a significant driver of mortality and premature mortality in Cheshire East.

It is of note that stomach cancer is the cause of 25% of upper GI cancer diagnoses but only 21% of upper GI cancer deaths. In contrast, pancreatic cancer is the cause of 36% of upper GI cancer diagnoses but 41% of upper GI cancer deaths. This reflects the much poorer survival associated with pancreatic cancer which has not seen a significant improvement over the last 40 years. Reducing local deaths from upper GI cancer will depend on achieving earlier diagnosis as well as preventing cancers from developing to start with in the long term.

Whilst upper GI cancer is only the 6th most common cancer in Cheshire East, it is the second top cause of both cancer deaths and early (i.e. before the age of 75) cancer deaths.

This reflects the fact that survival from upper GI cancer nationally is poor with one- and five-year survival being around 41.9% and 15.1% for oesophageal cancer, 41.8% and 18.9% for stomach cancer and 20.8% and 3.3% for pancreatic cancer.

Source: Cancer Research UK
Prevention of oesophageal cancer

The oesophagus is the tube that carries consumed food from the mouth to the stomach. Up to 89% of oesophageal cancers are thought to be preventable.

Risk factors for oesophageal cancer include tobacco use and alcohol misuse (21%) which play a significant part in the development of a type of oesophageal cancer called squamous cell cancer (SCC). This particularly affects the upper 2/3 of the oesophagus. In addition, a digestive disorder called gastro-oesophageal reflux disease (GORD) and one of its consequences, Barrett’s metaplasia (which refers to cell abnormalities in the lower oesophagus) are associated with obesity and place people at increased risk of oesophageal adenocarcinoma. This type of cancer has taken over from squamous cell carcinoma in recent years as the most common type of oesophageal cancer in the UK.

Key to preventing the development of oesophageal cancer is likely to be reducing levels of smoking, alcohol and obesity and improving diet in the local population.

Prevention of stomach cancer

Most cancers of the stomach are adenocarcinomas. Up to 75% of stomach cancers are preventable. Risk factors for stomach cancer include smoking (which doubles risk); linked to 22% and Helicobacter Pylori (a type of long-term stomach bug which can cause stomach ulcers but often doesn’t cause any symptoms) infection. In addition, a diet low in fruit and vegetables and rich in salted/pickled products can place people at additional risk.

Key to preventing the development of stomach cancer is likely to be reducing levels of poor diet in the local population and ensuring adequate eradication of Helicobacter Pylori when detected as well as reducing smoking.
Prevention of upper GI cancer

In contrast to gastro-oesophageal cancers which are mostly preventable, only 37% of pancreatic cancers are thought to be preventable.

Most pancreatic tumours occur in the head of the pancreas and are related to the part of the pancreas that produces digestive juices rather than the part which produces hormones. Tobacco smoking is known to increase risk of pancreatic cancer. Other risk factors include diabetes, chronic inflammation of the pancreas, overweight/obesity and poor diet and certain hereditary conditions.

Key to preventing the development of pancreatic cancer is reducing levels of smoking and overweight/obesity in the population.

Source: Cancer Research UK, 2016
Upper GI cancer incidence rates in men and women

Upper GI cancer incidence in females, directly standardised rates, C15+16+25, 2012-2014
Source: CancerStats, 2016

208 cases (41% of total) of upper gastrointestinal cancer were diagnosed amongst females in Cheshire East in 2012-2014

Incidence rates of upper gastrointestinal cancer amongst females in Cheshire East (31.5 per 100,000; 95% CI: 27.3–37.2) are in keeping with England average (31.1 per 100,000; 95% CI: 30.7 – 31.5)

Upper GI cancer incidence in males, directly standardised rates, C15+C16+C25, 2012-2014
Source: CancerStats, 2016

302 cases (59% of total) of upper gastrointestinal cancer were diagnosed amongst males in Cheshire East in 2012-2014.

Incidence rates of upper gastrointestinal cancer amongst males in Cheshire East (57.1 per 100,000; 95% CI: 51-64 per 100,000) are in keeping with England average (58.2; 95% CI: 57.6 – 58.8 per 100,000)
Incidence of upper GI cancer (ICD 10 C15, C16 & C25), all ages, directly standardised rate per 100,000 (with 95% CIs), 2009-14

<table>
<thead>
<tr>
<th>Location</th>
<th>Males, 2009-14</th>
<th>Females, 2009-14</th>
<th>Persons, 2009-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alderley Edge, Chelford, Handforth, Wilmslow</td>
<td>50.3 (46.5-54.2)</td>
<td>35.0 (31.4-38.7)</td>
<td>42.2 (38.5-46.0)</td>
</tr>
<tr>
<td>Macclesfield</td>
<td>70.2 (65.9-74.7)</td>
<td>40.1 (36.3-43.9)</td>
<td>51.8 (47.8-55.8)</td>
</tr>
<tr>
<td>Bollington, Poynton, Disley</td>
<td>65.9 (61.5-70.5)</td>
<td>35.0 (31.3-38.7)</td>
<td>46.3 (42.5-49.9)</td>
</tr>
<tr>
<td>Knutsford</td>
<td>72.1 (67.6-76.3)</td>
<td>40.0 (36.3-43.7)</td>
<td>51.6 (47.7-55.6)</td>
</tr>
<tr>
<td>Congleton, Holmes Chapel</td>
<td>90.2 (85.5-94.6)</td>
<td>45.0 (41.3-48.7)</td>
<td>57.4 (53.5-61.3)</td>
</tr>
<tr>
<td>Nantwich and Rural</td>
<td>65.8 (61.3-70.4)</td>
<td>35.0 (31.3-38.7)</td>
<td>46.2 (42.3-49.8)</td>
</tr>
<tr>
<td>Crewe</td>
<td>70.1 (65.7-74.6)</td>
<td>35.0 (31.3-38.7)</td>
<td>46.0 (42.1-49.7)</td>
</tr>
<tr>
<td>SMASH</td>
<td>75.0 (70.3-80.2)</td>
<td>35.0 (31.3-38.7)</td>
<td>46.6 (42.6-50.6)</td>
</tr>
</tbody>
</table>

Source: Cheshire East Public Health Intelligence Team; Data for this study is based on information collected and quality assured by the PHE National Cancer Registration and Analysis Service. Access to the data was facilitated by the PHE Office for Data Release.

There was very marked variation in upper gastrointestinal cancer incidence rates between localities in Cheshire East for 2009-2014, particularly amongst men. Upper GI cancer male incidence rates in Congleton and Holmes Chapel were 2.4 times higher than incidence rates in Alderley Edge, Chelford, Handforth and Wilmslow which had rates that were significantly lower than Cheshire East average.

The wide variation in incidence rates amongst men in Cheshire East indicates significant opportunities to prevent upper gastrointestinal cancer within the borough.

For females, there was a far less variation in local upper GI cancer incidence rates. Rates were highest in Nantwich and Rural where rates were 28% higher than in Alderley Edge, Chelford, Handforth and Wilmslow.
The number of new cases of upper gastrointestinal cancer increased by 17.5% between 2001-2003 and 2012-2014. Yet, in South Cheshire CCG area, the number of new cases has only risen by 2.6%. In contrast, in Eastern Cheshire CCG area the number of new cases has increased by 34.0% over the same time period with these increases being seen for oesophageal (57.3%) and pancreatic cancer (54.0%). Whilst these increases have affected both men and women, much larger increases have been observed amongst men.

Overall, stomach cancer numbers in Cheshire East in 2012-2014 have fallen by 29.0% since 2001-2003 reflecting a changing prevalence of risk factors.

Between 2001-2003 and 2012-2014, upper GI cancer incidence rates decreased by 8.2% for England (+14.6% pancreas; +1.5%; -34.4% stomach).

Similarly in Cheshire East a 5.5% decrease has been observed reflecting an increase in oesophageal and pancreatic cancer rates (from 14.17 to 17.27 and from 12.4 to 15.5 per 100,000 respectively) alongside significant decreases in stomach cancer rates (from 20.3 to 11.5 per 100,000). This highlights that there may be great value in further preventative efforts at oesophageal and pancreatic cancer.
Upper gastrointestinal cancer caused 190 deaths amongst females in Cheshire East in 2012-2014 (45% of total upper GI cancer deaths).

Upper gastrointestinal cancer mortality rates amongst females in Cheshire East are **28.2 per 100000 per year** (95% CI: 24.2-32.6) are in keeping with England average.

Upper gastrointestinal cancer caused 235 deaths amongst males in Cheshire East in 2012-2014 (55% of total upper GI cancer deaths).

Upper gastrointestinal cancer mortality rates amongst males in Cheshire East (**44.9 per 100000 per year; 95% CI: 39.2 – 51.3**) are in keeping with England average.

Upper GI cancer mortality is significantly lower than England average (by 17.4%) in NHS Eastern Cheshire CCG.
Emergency presentation is the most common means of diagnosis. 35% of upper GI cancer presentations occur as an emergency in Cheshire East.

Emergency presentations appear to be a greater issue in NHS South Cheshire CCG than in NHS Eastern Cheshire CCG. This is important since cancers diagnosed via the emergency route are associated with higher mortality and worse survival.

In Crewe, 48% of cancers were diagnosed as an emergency. The figures for Nantwich and Rural, SMASH and Macclesfield were 50%, 41% and 24% respectively. It is important to point out that numbers of upper GI cancers are small at this level of geography so it is difficult to place any significance in the variation observed.

Out of all of the emergency presentations of upper GI cancer in 2013 in Cheshire East, 33% occurred in those over the age of 85 and 31% occurred in those aged 75-85. Thus older age is a significant risk factor for being diagnosed with upper GI cancer as an emergency.
Late stage i.e. stage 3 or 4 diagnoses generally refer to more advanced cancers i.e. larger cancers that have spread into surrounding tissues and lymph nodes and may have spread further.

Unfortunately, late stage diagnoses of upper GI cancer are very common. When those cancers for which staging data are unavailable (approximately 28%) are excluded, it can be seen that nearly 7 in 10 upper GI cancers are diagnosed at a late stage in Cheshire East.

Again, there are very small numbers involved (<=20) which stops us from drawing definitive conclusions. In Bollington, Disley and Poynton, nearly 9 in 10 upper GI cancers were diagnosed late whereas only 5 in 10 upper GI cancers were diagnosed late in Congleton and Holmes Chapel. On the whole, it appears that late stage diagnosis was more common in NHS South Cheshire CCG but there is a higher proportion of cancers for which staging data is unavailable in NHS South Cheshire CCG.

34% of those diagnosed at a late stage were aged 65-74.
Barrett’s oesophagus

Certain high-risk groups may benefit from monitoring. These groups include those with Barrett’s oesophagus, pernicious anaemia, intestinal metaplasia of the stomach or previous gastric surgery. Current research is examining the role of two-yearly endoscopic surveillance in Barrett’s oesophagus. Risk of oesophageal cancer is up to 0.5% per year in these patients but is higher in those with high-grade dysplasia. These patients should be referred to an Upper GI multi-disciplinary team (MDT) for further investigation. Endoscopic therapy may be used to remove this dysplasia and early cancer. These should occur in high volume tertiary referral centres with access to an oesophageal and gastric cancer surgeon and should be performed by appropriately trained staff.

The 2016 Oesophago-Gastric Cancer Audit reported that nationally 66% of these patients are diagnosed via GP referral, 13.7% following emergency admission (and the proportion was higher for stomach cancers than oesophageal cancers). Curative treatment is less likely if a diagnosis is received following emergency admission. Ensuring timely referral and investigation of those suspected to have upper GI cancer is essential. Locally, 100% of patients referred for suspected cancer should be seen within 2 weeks.

Be Clear on Cancer Campaign

Public Health England launched a national campaign to raise awareness of oesophago-gastric cancers which ran for 4 weeks in January and February 2015.

The marketing campaign promoted the following messages aimed at promoting early diagnosis:
- Having heartburn, most days, for 3 weeks or more could be a sign of cancer – tell your doctor.’
- ‘Food sticking when you swallow could be a sign of cancer – tell your doctor.

A previous regional pilot that had run in 2014 demonstrated the following findings:
- A significant increases in spontaneous awareness of symptoms
- 52% increase in 2WW referrals for suspected upper GI cancers, compared with a 17% increase in the rest of England
- Increase in the number of Barrett’s oesophagus cases diagnosed
- A significant increase of 29 percentage points in the proportion of upper GI cancers diagnosed via a 2WW referral, among those aged 60–69 only (though no increase in total numbers of cancers diagnosed)

Source: Cancer Research UK (2016).

Screening: There are currently no national screening programmes for upper GI cancer as evidence does not support this. However, EUROPAC is running a screening programme for those aged 40 and over who have hereditary pancreatitis or a strong family history of pancreatic cancer.
Oesophageal cancer

- Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for oesophageal cancer in people: with dysphagia or aged 55 and over with weight loss and any of the following: upper abdominal pain; reflux; dyspepsia.
- Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people with haematemesis.
- Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people aged 55 or over with: treatment-resistant dyspepsia or upper abdominal pain with low haemoglobin levels or raised platelet count with any of the following: nausea; vomiting; weight loss; reflux; dyspepsia; upper abdominal pain, or nausea or vomiting with any of the following: weight loss; reflux; dyspepsia; upper abdominal pain.

Pancreatic cancer

- Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice.
- Consider an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following: diarrhoea; back pain; abdominal pain; nausea; vomiting; constipation; new-onset diabetes.

Stomach cancer

- Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer.
- Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for stomach cancer in people: with dysphagia or aged 55 and over with weight loss and any of the following: upper abdominal pain; reflux; dyspepsia.
- Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people with haematemesis.
- Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people aged 55 or over with: treatment-resistant dyspepsia or upper abdominal pain with low haemoglobin levels or raised platelet count with any of the following: nausea; vomiting; weight loss; reflux; dyspepsia; upper abdominal pain or nausea or vomiting with any of the following: weight loss; reflux; dyspepsia; upper abdominal pain.
Initial investigation for oesophageal and gastric cancer includes upper gastrointestinal endoscopy though suspicion of upper gastrointestinal cancer is not the only reason why someone would have this test. In Cheshire East, this investigation can be carried out in our local hospitals. The 2010 NICE document ‘Upper GI Endoscopy Service. Commissioning Guide’ stated that:

• Dyspepsia affects 40% of the population, very few of which will have significant morbidity (5% will consult their GP and 0.5% will have alarm symptoms)
• 1 in 200 people having an endoscopy will experience an adverse event and 1 in 2000 will die although ambulatory patients are at lower risk.
• Areas with a relatively elderly population (as Cheshire East has) or other risk factors might be expected to have a slightly higher rate.

Eastern Cheshire and South Cheshire upper GI endoscopy rates in 2015/16 were 27% and 41% higher than England average. Reasons for higher than expected endoscopy rates include disease/symptom prevalence and other clinical reasons, increased service capacity and differences in referral criteria. Locally it may be that there is more service capacity than elsewhere. However, worse access to endoscopy is associated with poorer outcomes in oesophageal and stomach cancer. Nevertheless, the reasons why local upper gastrointestinal endoscopy rates are so high requires exploration, particularly with respect South Cheshire. Reducing inappropriate referrals may be useful in achieving efficiency savings and minimising adverse events from endoscopy.
**Staging:**

Staging should be carried out to determine TNM classification to guide the most appropriate mode of treatment. This should be coordinated by the upper GI MDT following an agreed pathway. Locally, MDTs are coordinated via the specialist centres e.g., making use of weekly video links. For oesophageal and gastric tumours:

- An initial CT scan of the thorax, abdomen and pelvis to detect spread of the tumour
- Endoscopic Ultrasound which is useful for determining local spread in oesophageal and gastro-oesophageal junction tumours
- PET with CT scans - This should be carried out in a centre that carries out at least 100 staging examinations annually. These are provided at specialist centres within the region.

For suspected pancreatic cancer, urgent abdominal ultrasound is recommended as an initial investigation. Where pancreatic cancer is suspected – CT scans, endoscopic retrograde cholangiopancreatography (ERCP) and magnetic resonance investigations and in some cases endosonography and laparoscopy with laparoscopic ultrasonography may be useful.

**Treatment:**

**For oesophageal and gastric cancer** - Surgery should be carried out by surgeons who work in a specialist MDT in a specialist cancer centre and who perform at least 20 oesophageal and gastric resections per year.

Chemoradiotherapy is the treatment of choice for localised squamous cell carcinoma of the oesophagus and for tumours of the lower and middle third of the oesophagus may also be used with surgery. Preoperative chemoradiotherapy and chemotherapy (but not radiotherapy alone) is beneficial in oesophageal adenocarcinoma. Perioperative chemotherapy is also beneficial for gastric adenocarcinoma and certain types of oesophago-gastric junctional adenocarcinoma.

Chemotherapy is carried out either locally or at University Hospital North Midlands Trust or The Christie NHS Foundation Trust. Radiotherapy is carried out at The Christie NHS Foundation Trust or University Hospital North Midlands.

**Pancreatic cancer:** Obstructive jaundice may be treated with stent insertion (or surgical bypass if expected survival >6 months). Resectional surgery (e.g., pancreaticoduodenectomy) is carried out in specialist centres.

**Palliative care:** Palliative treatment should be planned by the MDT with early direct involvement of the palliative care team and the clinical nurse specialist (CNS).
Similar to incidence rates, there is quite marked variation in mortality rates for upper gastrointestinal cancer in Cheshire East. For males, mortality rates are highest in Congleton and Holmes Chapel (similar to incidence rates) and are 2.19 times higher than those observed in Alderley Edge, Chelford, Handforth and Wilmslow.

For females, mortality rates from upper gastrointestinal cancer in Nantwich and Rural appear to be 56.7% higher in Nantwich and Rural than those observed in Alderley Edge, Chelford, Handforth and Wilmslow.
The number of deaths from upper GI cancer decreased by a modest 3% between 2001-2003 and 2012-2014 despite the overall increase in new diagnoses. This suggests overall improved outcomes for those diagnosed with upper gastrointestinal cancer.

It is of note that deaths from stomach cancer have decreased by 42% within this time period. In contrast, deaths from pancreatic cancer have increased by 40% in this same time period with very large increases being observed in NHS South Cheshire CCG.

Between 2001-2003 and 2012–2014, upper GI cancer mortality rates decreased by 12.2% for England. In Cheshire East mortality has fallen by 23.1%. Very large decreases (29.1%) in mortality have been observed in NHS Eastern Cheshire CCG and recent rates here are significantly better than England average. A more modest decrease of 16.1% has been observed in NHS South Cheshire CCG.

Small decreases in oesophageal mortality observed nationally appears to have been replicated locally. A more substantial and significant 38.1% decrease in stomach cancer mortality nationally has been observed which has been even more dramatic locally in NHS Eastern Cheshire CCG (58.5%) and NHS South Cheshire CCG (53.3%).
Assets:

- **Upper GI Project:** In the summer of 2015, a project aimed at further developing the upper GI cancer pathway in South Cheshire to improve services. Work has focussed on improving diagnosis and treatment pathways, raising awareness, using intelligence and monitoring performance and in progressing the survivorship agenda. As part of this project, the Mid-Cheshire NH Foundation Trust’s webpages have been developed and contain a wealth of information: [http://www.mcht.nhs.uk/information-for-patients/departmentsandservices/upper-gi/](http://www.mcht.nhs.uk/information-for-patients/departmentsandservices/upper-gi/)

- **The Action on Cancer** in South Cheshire outlined in the Cancer Overview JSNA has a specific role to play in ensuring earlier diagnosis.

- Access to **Clinical Nurse Specialists (CNSs)** can be effective for the purposes of clinical education, provision of advice, and psychological support, coordination of patient care, research and development of care pathways. Regular patient review following treatment is beneficial for the purposes of symptom control (including those arising secondary to treatment), support and ongoing surveillance. However, in the UK upper GI cancer patients have less access to specialist nurses than patients with other types of tumours. There are upper GI CNSs at both Leighton and Macclesfield.

- The CNS coordinates a **monthly upper GI cancer patient group** at Leighton as well as a pancreatic cancer support group. Whilst East Cheshire NHS Trust has a number of local cancer patient groups, there is no specific upper GI cancer group.

- At both local trusts, a **Macmillan Cancer Information and Support Manager** is in post. This specific role concerns provision of information and support to cancer patients (including regarding financial/benefits and employment) and an open-door policy is followed on the unit. Also, one day per week is spent increasing cancer awareness in the community. Specific activities have included outreach work in local supermarkets, talks with support groups, cancer awareness including signposting and brief advice in the community etc. Advice and support for patients encountering difficulties is also provided e.g. financial, transport.

- **Guidelines:**
Opportunities for improvement

- Prevention (as suggested by observations on time trends) is the most effective way to reduce mortality from upper GI cancer in the long term. Preventing pancreatic cancer through smoking cessation and maintaining healthy weight should be a particular area of focus given increasing rates locally and nationally and the poor survival associated with this cancer type:
  - Reduce smoking, alcohol, poor diet and obesity levels, particularly where they are more prevalent (such as Crewe and Macclesfield) and in areas of high upper GI cancer incidence (such as Congleton and Holmes Chapel).
- Improve targeted early presentation of patients with upper GI cancer symptoms in line with NICE guidelines, particularly in the older age groups, as most cancers are currently diagnosed at a late stage.
- Maximise opportunities for appropriate patients to receive prompt investigation including endoscopy. Key to achieving this may be minimising any inappropriate referrals which may otherwise affect service availability.
- Introduce interventions such as Making Every Contact Count i.e. offering brief advice around tobacco and alcohol use particularly for high-risk patients with Gastro-oesophageal reflux disease (GORD), Barrett’s oesophagus and patients undergoing an upper GI endoscopy.
- Review the experience of those diagnosed with upper GI cancer locally and whether there is scope to implement the opportunities for improvement identified nationally (e.g. improving waiting times and experience of care by providing written information, communicating the diagnosis sensitively and not talking in front of patients as though they were not there).

What we don’t know but would like to know...

- One year and five year survival rates from upper GI cancer in Cheshire East and for our 2 local CCGs (currently unavailable)
- Prevalence and incidence of Barrett’s oesophagus in Cheshire East
- Incidence of oesophageal adenocarcinoma and squamous cell carcinoma in Cheshire East
Further information:

- JSNA sections at [www.cheshireeast.gov.uk/jsna](http://www.cheshireeast.gov.uk/jsna) including:
  - Tobacco
  - Drugs and alcohol
- Cancer Research UK: [www.cancerresearchuk.org](http://www.cancerresearchuk.org)
- British Society of Gastroenterologists: [www.bsg.org.uk](http://www.bsg.org.uk)
- NHS Choices: [www.nhs.uk](http://www.nhs.uk)

Version control

<table>
<thead>
<tr>
<th>Publication date</th>
<th>Changes made</th>
<th>Content sponsor</th>
<th>Sign-off</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>New JSNA section created</td>
<td>Charlotte Simpson (Public Health)</td>
<td>Tracey Wright (Service Delivery Manager, CCGs)</td>
</tr>
</tbody>
</table>

JSNA section contributors: Ceriann Tunnah, Rhonwen Ashcroft, Anna Whitehead (Public Health)