V1.4

Cancer Support Helpline: 0121 704 9860

Oesophagogastric Cancer: The Patient's Pathway

Oesophageal and Gastric Cancer Support

OPA

Caring for the cancer patient & their family

Registered Charity No. 1194327

Contents

Introduction	3 – 5
Curative pathway	5 – 7
Surgery	7 – 11

OESOPHAGOGASTRIC CANCER
THE PATIENT'S PATHWAY

Edited by Cara Baker, James Gossage and Andrew Davies
{Based on The St Thomas' Hospital Pathway}
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Cara Baker, Consultant Upper GI Surgeon GSTT
Robert Mason, Chairman OPA

INTRODUCTION

This document is a guide to your pathway following diagnosis. It is based on the pathway at St Thomas' Hospital in London, but as the treatment is standardised across the UK it should largely reflect that in the centre where you are treated.

The incidence and distribution of cancer of the oesophagus and stomach have changed in the last 40 years. The incidence of oesophageal cancer has increased significantly, especially adenocarcinoma of the lower end. This results from an increase in acid reflux, which may cause the development of Barrett's oesophagus. This condition is associated with an increased risk of malignancy. In contrast the incidence of gastric cancer has reduced, particularly at the outlet of the stomach. This is likely due to a reduced incidence in infection with H Pylori, which has a strong association with these tumours as well as peptic ulcers.

The management of these cancers has also evolved with advances in diagnosis, imaging, surgery, and the impact of combining chemotherapy and in some cases radiotherapy with surgery. This has delivered significant improvements in outcome, with 5-year survival increasing from 25-50% for patients undergoing active treatment and mortality following surgery falling to well under 5%

Diagnosis

The journey begins with diagnosis, which is the result of endoscopy and a positive biopsy. At this point you will be told the diagnosis and referred to a specialist multidisciplinary team.

The advent of such teams guarantees consistency in management.
The team consists of: -
Upper Gastrointestinal Surgeons
Oncologists – Medical: drug treatment and Clinical: radiotherapy
Gastroenterologists – treatment of early disease & endoscopic surveillance
Radiologists – imaging
Histopathologists – examining any specimens
Dieticians
Physiotherapist
Psychologist
Patient Support Group

And most important – Clinical Nurse Specialists who manage your pathway.

When you come to hospital there are important initial decisions to be made concerning the stage of the cancer (more later) and the fitness of the individual. Treatment is strenuous, and both chemotherapy and surgery require that the patient should have a strong constitution. In addition, such cancers mostly affect elderly patients with other significant medical conditions, and treatment options may then be more limited. At all times, however, you will be fully involved in decisions regarding your treatment.

Staging
It is crucial early in the pathway to determine the stage of the cancer. This means how deeply the cancer has invaded and whether there is any evidence of its having spread away from the oesophagus or stomach. If there is extensive spread (other than to local lymph nodes), then the cancer is unfortunately incurable and a major operation is not indicated. Treatment has to focus on the whole person if they are fit, using chemotherapy.

Method of Staging
CT or MRI scan – this will be the initial test which can demonstrate the size of the tumour, possible lymph node enlargement and spread of disease.

PET CT scan – if the CT scan does not demonstrate any evidence of spread of the cancer then this scan is used as it demonstrates the function as well as structure of the tumour.

Endoscopic Ultrasound – in very early tumours, which may be treated by endoscopy without the need for surgery, this can give very detailed images of the organ wall, demonstrating penetration and local lymph nodes.

Laparoscopy – this involves a general anaesthetic and passing a telescope into the abdominal cavity to look for tumour spread to the other organs in the abdomen. This is important in gastric cancer and cancers of the lower oesophagus.

With all this information, together with your fitness assessment and background medical condition, your case is discussed at a meeting of all the members of the team. Your cancer will be staged based on the penetration of the wall of the oesophagus or stomach (T stage), the presence of involved lymph nodes (N stage), and presence or absence of distant spread to liver, lungs, bone, etc. (M stage).

A recommendation of treatment options will be made then, for discussion with you and your carers in the clinic afterwards.

Treatment Options
These fall into two main categories:

1. **Curative –** you are fit enough to undergo treatment. The cancer is localized to the oesophagus or stomach and any involved lymph nodes on imaging will be in the operative field (and can probably be removed) or fall within a radiotherapy field.
2. **Palliative –** either you are not fit, with an unacceptably high risk for surgery, and/or the disease has spread beyond the stomach or oesophagus invading other structures or you have spread of disease to distant organs.

Such decisions are reviewed during the pathway as your cancer is reassessed. Depending on your response to treatment, decisions can be changed, although it is relatively rare to move from a palliative to curative intent.

CURATIVE PATHWAY

Very Early Disease
In patients with disease limited to the innermost lining of the oesophagus or stomach or if there are pre-cancerous cells, low grade or high grade dysplasia, the lesion can be removed by an Endoscopic Mucosal resection or Endoscopic Dissection. The surrounding area may then be treated with endoscopic radiofrequency ablation which burns the remaining abnormal tissue. The results appear to be as good as surgery, with minimal risk.

Oesophageal Cancer
In the majority of cases the disease will have penetrated further into or through the wall of the oesophagus and possibly into adjacent lymph nodes. In such cases the use of chemotherapy and possibly radiotherapy followed by surgical resection is now standard practice. This follows the results of large clinical trials, which have demonstrated significant improvements in overall survival, over surgery alone. Such preoperative (neoadjuvant) therapy (usually 3 or 4 cycles followed by a 6-8 week recovery period) is believed to work by shrinking the tumour and treating the small groups of cells that have spread from the primary tumour but are too small to see on scanning. This is the treatment pathway for adenocarcinoma, which constitutes 75% of oesophageal cancer. Depending on the findings when the specimen is removed you may have further chemo(radio)therapy.

In some cases of squamous cancer, which is relatively radiosensitive, chemoradiotherapy alone may be used.

Gastric Cancer
The principles are similar to oesophageal cancer, in that preoperative chemotherapy is now routinely given before surgical resection. In more elderly or frail patients with cancer in the lower half of the stomach, surgery alone can sometimes be the correct treatment if the risks are thought to be acceptable.

Palliative Treatment
If the investigations demonstrate that your cancer is advanced and has spread to other organs, curative treatment is not possible. This does not mean that you can't be helped. If you have a good fitness level, chemotherapy and sometimes radiotherapy can improve the quality of life and longevity. If complications such as blockage of the stomach or oesophagus occur, a self expanding metal stent can be placed to relieve this. In elderly and frail patients whose fitness precludes aggressive treatment, help can still be given with tailored chemoradiotherapy.

In such cases early involvement with palliative care specialists will be commenced to help with symptom management.

Starting The Pathway
The combination of chemotherapy (or chemoradiotherapy) followed by major surgery is a significant undertaking and your level of fitness is important. Diet and nutrition are central to getting through it, and dieticians will have a major input in/during your journey. It is not just a question of getting in calories, but other supplements such as iron and calcium (see our booklet on diet and eating) too, . With preoperative chemotherapy it is not unusual for swallowing to improve with treatment and for you to regain some weight. Close monitoring is however required and supplements are given when needed. Dietary Advice is given on an individual level; some patients may need their weight increased, whereas others (particularly if they were overweight at presentation) need a fine balance. Large shifts in weight (up or down) are rarely desirable.

It is increasingly recognised that regular exercise – prehabilitation – improves outcomes.

If we were to use the analogy that having major surgery is like running a marathon, nobody would consider turning up at the marathon start line without having done (at least) a few months of training. This does not mean that everybody needs to start marathon training, but a focus on improving activity levels and fitness certainly helps. Lifestyle modification (especially stopping smoking) is crucial. The physiotherapist helps in the case.

Monitoring Treatment
The Clinical Nurse Specialist is central to managing your progress, dealing with issues that arise, and arranging for follow up scans and blood tests to monitor progress and response. As we are continually trying to improve treatments, patients are asked to take part in clinical trials in which new treatments are compared with the gold standard to either improve outcomes or reduce side-effects. In such cases you may be asked to complete quality of life questionnaires, which help us assess response. Involvement in any trial is always voluntary.

Pre Surgery
Assuming your preoperative treatment has gone well and there is no evidence of disease progression on repeat imaging, you will proceed to surgery. As this is major surgery, usually involving entering both the abdomen and chest to enable removal of the oesophagus, you will have a thorough review with the anaesthetic team to optimise you for surgery. The gap of 6-8 weeks between finishing chemotherapy and surgery allows your body to recover from the effects of chemotherapy. Patients often express concern that the tumour can regrow in this time. This is very unusual.

SURGERY

Oesophageal Resection
This surgery involves entering the abdomen and chest to remove the cancer, leaving clear margins above and below. This involves removing the top of the stomach plus the associated lymph nodes. The resected oesophagus is replaced by forming a tube of stomach and bringing this up into either the chest or even the neck. The tube is then joined to the proximal oesophagus with sutures or staples.

There are several alternative approaches to this, which are outlined below. In addition, parts of the operation are now done using keyhole surgery and even robotic surgery. There is however no proven advantage to any individual approach (including open or keyhole surgery) regarding long-term survival. Early recovery may be helped by keyhole surgery. With specialist teams, the in-hospital mortality is well under 3% and long-term survival for those undergoing surgery approximately 50%. Of course these are average figures and your team will be trying to choose the best options for you as an individual.
The experience of the surgeon and wider team is more important than the approach!

Ivor Lewis resection – Abdomen and right chest for lower and middle third tumours, Three stage resection – Abdomen, right chest and neck for middle and upper third tumour.

Left thoracoabdominal Resection – Abdomen and left chest for lower third and junctional tumours involving upper stomach.

Transhiatal resection – Abdomen and neck for lower third tumours, avoiding opening the chest.

Fig 1 Operative incisions shown from left to right for a Transhiatal resection, Left Thoracoabdominal resection and Keyhole assisted Ivor Lewis resection.

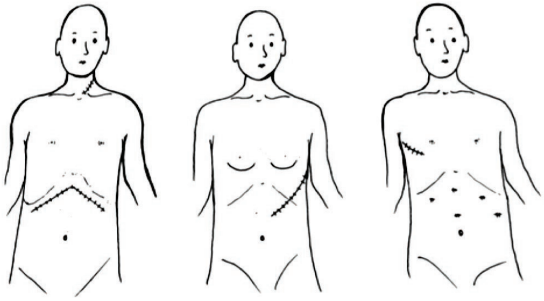
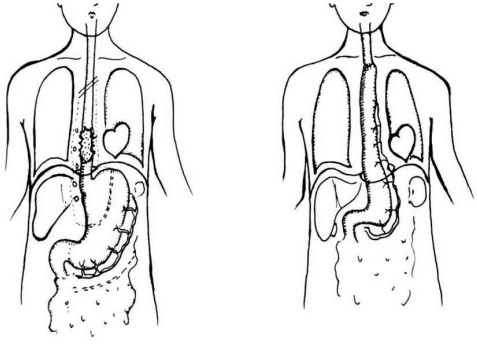


Fig 2 Shows the principles of an oesophageal resection with replacement of the oesophagus with a stomach tube.



Gastric Resection

This is performed through the abdomen and can be undertaken either as a fully open or a keyhole procedure. Again there is no proven benefit for either approach, although keyhole surgery may have some early post-operative advantages. This should not compromise the intention to perform the best possible cancer operation. For cancers in the lower half of the stomach where there is a clear proximal margin of at least 5 cm between the tumour and where

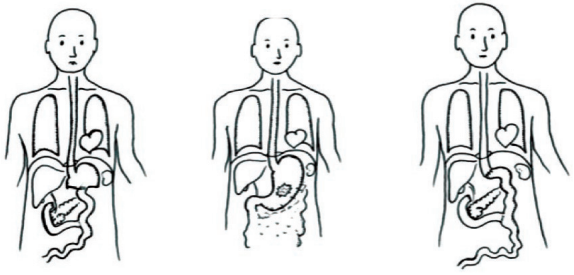
the oesophagus enters the stomach, resection of the distal stomach leaving the top 1/3 of the stomach is acceptable. Keeping some stomach (where possible) has some nutritional advantages in the post-operative period. The duodenum is closed and the small intestine is joined to the stomach to restore continuity either as a loop or a Roux-en-Y reconstruction to prevent bile reflux.

If the cancer is in the more proximal half of the stomach (or of the linitis plastica type which gives a shrunken rigid stomach), a total gastrectomy is undertaken. The resection involves removal of the stomach with its associated draining lymph nodes. Resection of the spleen and pancreas is not usually required. Intestinal continuity is restored by joining the oesophagus to the small bowel.

Fig 3 Shows the principles of resection of a gastric cancer with reconstruction following a partial resection (left) and total resection (right).

Immediate Post Operative Care

Following such surgery you will go from theatre to intensive care for the next 24 hours. Depending on fitness and the difficulty of surgery, some patients may require a prolonged period of ventilation to stabilise their condition. If there are no issues then you may be woken up in theatre prior to transfer or in intensive care shortly after. Pain relief is achieved by epidurals, nerve blocks or intravenous opiates (morphine or similar). There are always drains placed in the chest at surgery to allow the lung to expand fully and any blood or fluid to drain out. When stable you will be transferred to high dependency and then the ward, dependent on progress. Good physiotherapy is crucial. Early mobilisation to the chair and standing will progress to walking on the spot quicker than you may think (day 1 after surgery). This is proven to prevent chest infections, one of the most important complications of surgery. Chest drains are removed as soon as possible and oral intake commences usually on day 3 – 4. If there is any delay in starting oral intake of nutrition the short period of intravenous feeding following surgery may be extended. If it is anticipated that post-operative nutrition is going to be a problem, a feeding tube may be inserted at surgery or in the post-operative period, either directly into the small intestine (jejunostomy tube) or via the nose.



Nutritional issues are especially common following total gastrectomy. Unlike all the other operations there is no stomach pouch, and therefore taking sufficient volume of nutrition can be an issue. On occasion, such patients may require a long-term feeding tube which may necessitate a separate later operation to insert. Patients who undergo gastrectomy require appropriate antibiotic cover and vaccinations to prevent, in particular, chest infections

If a total gastrectomy has been performed, the patient will require vitamin B12 injections for life.

The usual inpatient stay is 8-10 days.

The resected tumour is sent for thorough analysis by a specialist histopathologist to determine the exact stage and response to treatment. The results are usually discussed with you and your family on your first postoperative visit.

In rare cases at surgery, the disease has progressed and is more advanced than the imaging would suggest. In such cases the operation is abandoned at an early stage as all the evidence demonstrates that putting an individual through major surgery only to leave cancer behind reduces survival and quality of life. However, such a scenario is much less likely today, given advances in imaging

Early Post Operative Follow-up
You will be visited frequently after discharge to ensure you are making a good recovery, which can take up to 3 months until you feel normal, and that your nutrition is adequate. This is largely the duty of the dietician and Clinical Nurse Specialist, along with the surgeons. At this time you will meet the oncologist to discuss whether any further therapy in the form of chemotherapy and or radiotherapy is recommended This will depend on many factors including your recovery and analysis of the resected specimen.

Long Term Follow-up
There are different views regarding the frequency and duration of follow up. It should occur as often as is required. A telephone link and rapid review if there are any issues is considered the best practice. In follow-up, emphasis is centered on nutrition and quality of life as well as addressing physical limitation issues. Blood tests are done routinely, as certain deficiencies

especially iron and vitamin B12 will not be obvious in the early stages. A CT scan may be performed on completion of treatment to provide a baseline for the future. Regular annual scans are not routinely, used as they can give a false sense of security.

Post Surgical Morbidity
Such complex surgery and treatment can have long term consequences. These include:-

Weight loss due to inability to intake sufficient volume resulting from loss of the stomach. This is particularly so following total gastrectomy, and requires close dietetic follow-up with supplements and possibly adjuvant tube feeding.

Specific deficiencies – iron and vitamin B12

Dysphagia (difficulty swallowing) due to narrowing of the joint between oesophagus and either stomach or small bowel. This usually responds to dilatation (balloon stretches performed at endoscopy).

Acid or bile reflux which is a consequence of loss of the valve at the outlet of the stomach and division of the vagus nerves. This usually improves with time, but may require sleeping more upright with a foam wedge, and medications such as gaviscon.

Dumping and Diarrhoea arise largely as a result of division of the vagus nerves during the resection. These nerves act as coordinators of the gut. Changes to eating patterns and fluids plus taking sugar can help, together with pancreatic enzyme supplements. Improvement of the nerves can take up to 18 months after the operation. Dietitian input is crucial here as there can be a number of causes for similar sounding symptoms.

DO NOT IGNORE ANY OF THESE SYMPTOMS!
Tell the nurse, dietician or doctor, as there are treatable causes for these distressing symptoms.

GIST Tumours

These are different from cancer of the stomach and oesophagus, as they arise not from the inner lining of the bowel but from stromal tissue, muscle or nerves in the wall. They behave differently, with a spectrum of malignancy dependent on size and the activity of the dividing cells. They can present as an incidental mass (often during scans for other problems) or following a gastrointestinal bleed.

Treatment, if they are small, is by local excision without the need to remove large areas of bowel or lymph nodes. This can usually be achieved by keyhole techniques.

If they are large or have spread, they are treated with imatinib (or similar drugs) which are specifically targeted at the tumour.

Reviewed by Mr Andrew Davies, Consultant Surgeon based at St Thomas' Hospital, London

ABOUT US

The Oesophageal Patients Association (OPA) is an independent registered charity formed in 1985 when a few former oesophageal cancer patients met and found tremendous reassurance in sharing experiences. Since then, we have helped thousands of patients, carers and their families. The friends and users of the OPA are primarily patients who have experienced oesophageal or gastric difficulties, not forgetting the hard work of their carers, of course, and the support of their families, friends and our excellent health care professionals. We produce many thousands of our booklets and leaflets, as a valuable reference for many organisations, patients, carers and their families.

The Charity is represented on various committees involved with the management of upper GI cancers and research into new treatments. Patient involvement is increasingly recognised as a valuable input to the thinking and documentation on such matters.

WHAT WE OFFER

Our objectives are to help patients, carers and their families to cope with any difficulties arising as a result of treatment and giving support, encouraging them to achieve a good quality of life. This is done by providing information booklets and leaflets on matters of concern, a telephone support line, and arranging patient support meetings around the UK.

We make no charge to patients or their families for any support and advice provided. The OPA can only maintain its vital service through trust donations and other fundraising activities generated by the community it serves.

It costs the OPA substantial funds to keep vital services running, providing advice, support and practical help.

We produce many thousands of our booklets and leaflets as a valuable reference for patients, carers and their families, as well as many organisations, and all of this is supplied free of charge and paid for by the OPA. We would be grateful for any donations you could make so we can continue to help those who need it – https://opa.org.uk/donations/

Support Nationwide
The OPA has led the fight against oesophageal and gastric cancers for over 30 years. Our purpose is to support patients, their families and carers and raise awareness of these cancers and their prevention. Whatever stage you're at, the OPA is here to help you.

Group Support
By sharing experiences and discussing our issues and problems, we are often able to help each other overcome areas of common concern.

Support meetings: These are held online and in person around the UK throughout the year and inevitably, most patients attending these meetings have had, or will be having surgery. The OPA's aim is to help new patients, families and carers to cope with difficulties arising as a result of treatment, giving support and encouraging patients to achieve a good quality of life.

Our patient support meetings provide the opportunity for patients to meet former patients and carers, some of whom are leading relatively normal lives.

One to One Support
From personal experience, we know that the first few weeks and months before and after the treatment can be challenging.

Most patients find it helpful and encouraging to talk to someone who has experienced similar symptoms and has undergone the same course(s) of treatment. Our volunteers (all of whom are current or former patients themselves) are on hand and willing to offer you support, encouragement and reassurance.

Whilst the OPA does not offer counselling or medical advice, based on our own experiences, we offer general guidance and suggestions, from questions to ask your GP to tips on what to eat, and a lot more.'

We will be happy to put you in touch with someone local to talk to via a Zoom appointment or over the telephone. Please contact our Cancer Support Helpline via phone: – 0121 704 9860 or by email: enquiries@opa.org.uk

Newsletters
Sign up for our twice yearly newsletter with articles of interest and latest news of treatments. https://opa.org.uk/register/

MEDICAL SUPPORT

The OPA is an independent registered charity that works with specialist hospitals and medical teams around the UK where oesophageal and gastric problems are regularly treated. The teams involving upper gastrointestinal surgeons, thoracic surgeons, gastroenterologists, oncologists, dieticians and physiotherapists have extensive experience of treatments and provide continual support and advice to the OPA.

HOW YOU CAN HELP

We receive no government funding, and we do not make any charge to patients, carers' or their families for any support and advice provided. The OPA can only maintain its vital service through donations and other fundraising activities among the community it serves.

If you can support the work of the OPA at this time, we would be indebted to you.

Cheques should be made payable to The OPA and sent to:
Fundraising Dept. The OPA, 6 & 7 Umberslade Business Centre, Pound House Lane, Hockley Heath, Solihull B94 5DF.

YOUR LEGACY COULD MAKE A DIFFERENCE

A message from our patron Fiona Wade:

"Your legacy will help to save the lives of future generations. Please consider making a gift in your Will to The OPA and help us to continue our fight against oesophageal and gastric cancers.

I lost my father to oesophageal cancer. He was such an amazing person, the best father I could ever wish for, and it was so sad and shocking when he was diagnosed. I had never heard of his type of cancer before and I always feel to this day that if we had been more aware of oesophageal cancer or reflux disease then, for sure, earlier diagnosis would have made a huge difference and maybe saved his life.

Early diagnosis by spreading awareness is absolutely key in saving lives from this cancer. So please help us carry on doing all we can to make people more aware and help us to save lives and to support every single patient who needs our help.
Thank you."

You can support The OPA by making a gift in your Will; one of the most effective ways to help ensure that our fight against oesophageal and gastric cancers continues and saves the lives of future generations. Scan the QR code below to view the legacy leaflet.

HOW YOUR GIFT WILL HELP

Your gift will help the Oesophageal Patients Association (OPA) to encourage seeking early diagnosis and will assist patients who are facing or recovering from an operation for one of the most unpleasant, life-changing and rapidly increasing cancers.

Early symptoms may only show as heartburn or indigestion, often resulting in late referral and diagnosis. Treatment by surgery is extremely complex with long operations that often involve restructuring the digestive organs in the chest, which is a traumatic procedure.

We can continue to give medically informed support to patients, carers and families through:

- Our cancer support helpline
- Online information and support
- Medically approved high quality information booklets & leaflets
- UK wide network of patient support groups & OPA buddies
- Zoom Meetings

Your gift will also help us to continue to work with the NHS to improve cancer treatment and outcomes and to continue our support across the UK.

Making your Gift

The OPA is an independent registered charity. We receive no government support and depend entirely on public support.

The Chairman and Trustees of The OPA will ensure that your legacies' are used to the greatest advantage and your gift will not be used for administration costs.

Name.....

Postal Address .....

Email Address .....

Phone Number.....

If you would like further information, please complete your details below and return to this address: The OPA, 6 & 7 Umberslade Business Centre, Pound House Lane, Hockley Heath, Solihull B94 5DF.

☐ I am considering leaving a legacy to The Oesophageal Patients Association – please send me more information about your work

☐ I have made a gift in my Will to The Oesophageal Patients Association – please keep me informed about news and events

I would love to make a donation

I am pleased to send a donation of £ _____ Please tick here ☐ if this is to be treated as a Gift Aid donation.
Title: (Mr/Mrs/Dr etc.)_____ Name:_____
Address: _____

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Tel: _____ Email: _____

Signature: _____ Date: ____ /____ / ____
For online donations – Account number: 51354981 Sort Code: 40-42-12

For Standing Order Donations

By bank transfer
Recipient bank: HSBC Bank
Sort Code: 40 – 42 – 12
Account Number: 02301636

To make an online donation visit:
https://www.opa.org.uk/donations.html

By regular Standing Order payment – **Sort Code: 40-42-12** **Account Number: 51354981**
I wish to make regular donations to the Oesophageal Patients Association of *(tick appropriate box)*
☐£2 ☐£5 ☐£10 ☐£25 ☐£100, or other amount: _____
Please state amount in words:
every *(tick appropriate box)* ☐Week ☐Month ☐Year starting on ___ /___ /___ until further notice.

Your bank details
To: (insert name and address of your bank) _____
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Sort Code: ____-____-____ Account Number: _____

Boost your donation by 25p of Gift Aid for every £1 you donate

Gift Aid is reclaimed by the charity from the tax you pay for the current tax year. Your address is needed to identify you as a current UK taxpayer.

In order to Gift Aid your donation you must tick the box below:
☐ I want to Gift Aid my donation of £_____ and any donations I make in the future or have made in the past 4 years to the OPA.

I am a UK taxpayer and understand that if I pay less income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year it is my responsibility to pay.

Your Details
Title: (Mr/Mrs/Dr etc.)_____ Name: _____
Address: _____
_____
Tel: _____ Email: _____
Signature: _____ Date: ____ /____ / ____

Please send this form to: Fundraising Dept. The OPA, 6 & 7 Umberslade Business Centre, Pound House Lane, Hockley Heath, Solihull B94 5DF, or email to; enquiries@opa.org.uk Charity Number: 1194327
For further information, please contact The OPA on 0121 704 9860 or send an email to charity@opa.org.uk.

Ways You Can **Donate**

Online Donations

Online donations make things really simple, there is no need for you to collect money in person or worry about banking cheques, etc. Online donations are becoming more popular; many donation portals also allow you to log in and check how your fundraising is going and check your progress.

The OPA accepts payments via Paypal, bank transfer, Just Giving, debit or credit card or donations via mobile.

Text Donations

One-off Text Giving

Text **HELPOPA 3** to 70450 to donate £3.
Simply change the amount, e.g. **5, 10 or 20 to donate more.**

Regular Text Giving

Text **DONATEOPA 3** to 70450 to donate £3 a month.
Simply change the amount, e.g. **5, 10 or 20 to donate more.**

Postal Donations

You can now make a single donation by cheque or set up a regular payment via standing order. Please make cheques payable to the **"Oesophageal Patients Association" (or "OPA")** or download our Standing Order form (PDF). **https://opa.org.uk/wp-content/uploads/2022/05/Standing-Order-Form-2022.pdf**

Please address your donation to:
6 & 7, Umberslade Business Centre, Pound House Lane,
Hockley Heath, Solihull B94 5DF
Gift Aid form: **https://opa.org.uk/wp-content/uploads/2021/02/Gift-Aid-Declaration-for-a-single-donation.pdf**

PayPal

You can make a donation to the OPA via our PayPal page – see **https://www.paypal.com/donate/?cmd=_s-xclick&hosted_button_id=X2FRXGH7FTGCG**

Bank Transfer

Account Payee: OPA Bank: HSBC Bank.
Sort Code: 40-42-12. Account Number: 02301636

Just Giving

Visit the OPA's Just Giving page at
https://www.justgiving.com/oesophagealpatientsassociation

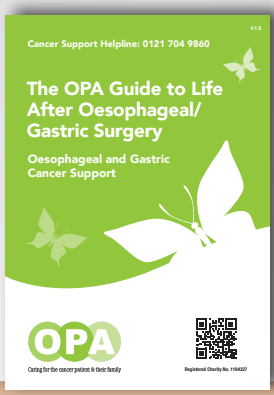
Legacy

OPA Legacy Leaflet –
https://www.opa.org.uk/edit/files/20200901_legacy_leaflet_dl_6pp_-_final.pdf

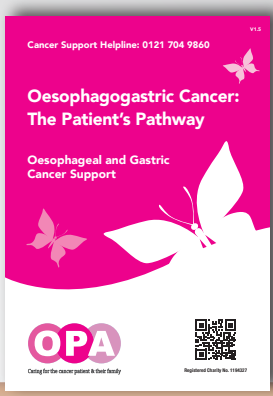
We accept all major credit and debit cards.

Publications from the OPA.

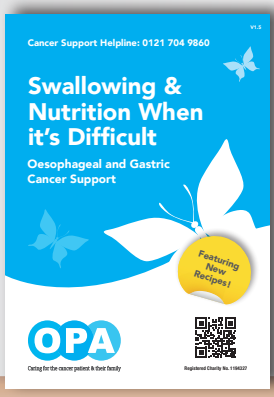
We are here to help those with or affected by Oesophageal and Gastric Cancer. Here are some of our helpful booklets; they are free and can be posted or downloaded from our website.



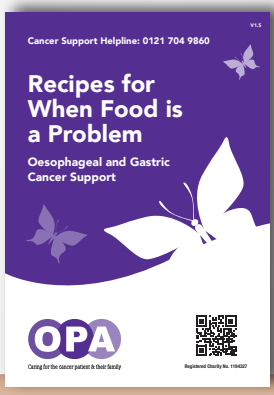
A Guide to Life After Oesophageal/Gastric Surgery – Oesophagectomy & Gastrectomy
(Informative guide for Oesophageal & Gastric patients following surgery)



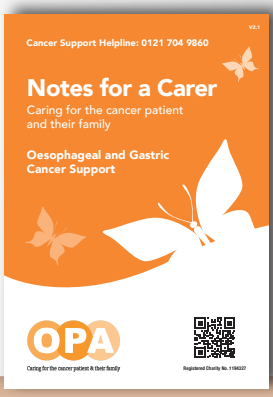
Oesophagogastric Cancer: The Patient's Pathway
(Patient's guide following diagnosis based on the St. Thomas' Hospital Pathway)



Swallowing & Nutrition – when it's difficult
(For those not having an operation but perhaps having a stent inserted or other treatments)



Recipes for When Food is a Problem
(Recipe book for patients post surgery/ treatment)



Notes for a Carer
(Informative guide for carers of Oesophageal & Gastric patients following diagnosis)

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Reviewed by Philip Wright 2021, Ewen Griffiths, MD FRCS Consultant Upper GI Surgeon and Laura Nicholson, Upper GI Dietitian at University Hospitals Birmingham NHS & Professor Janusz Jankowski, MBChB MSc MD PhD PGCE PGCM AGAF FACG FRCP SFHEA 2019.

Cancer Support Helpline
Tel: 0121 704 9860

9.00am – 5.00pm Monday to Friday.
(Answerphone for out of hours callers)

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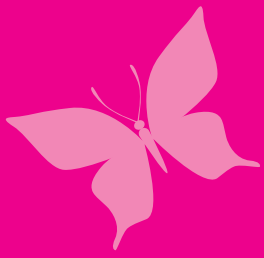

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Caring for the cancer patient & their family