Cancer Council

CANCER TYPE
fact sheet

Understanding
Oesophageal Cancer

A guide for people affected by cancer

This fact sheet has been prepared to help you understand more about oesophageal cancer. It is common to feel shocked and upset when told you have cancer. We hope this information will help you, your family and friends understand how oesophageal cancer is diagnosed and treated.

About the oesophagus

The oesophagus (the food pipe) is a muscular tube that connects the throat to the stomach. In adults, it is about 25 cm long and lies behind the windpipe, which is used for breathing.

The oesophagus is part of the upper gastrointestinal (GI) tract, which is a section of the digestive system. It takes food and liquids (including saliva) from the mouth to the stomach. A valve (sphincter) at the lower end of the oesophagus stops acid and food moving from the stomach back into the oesophagus.

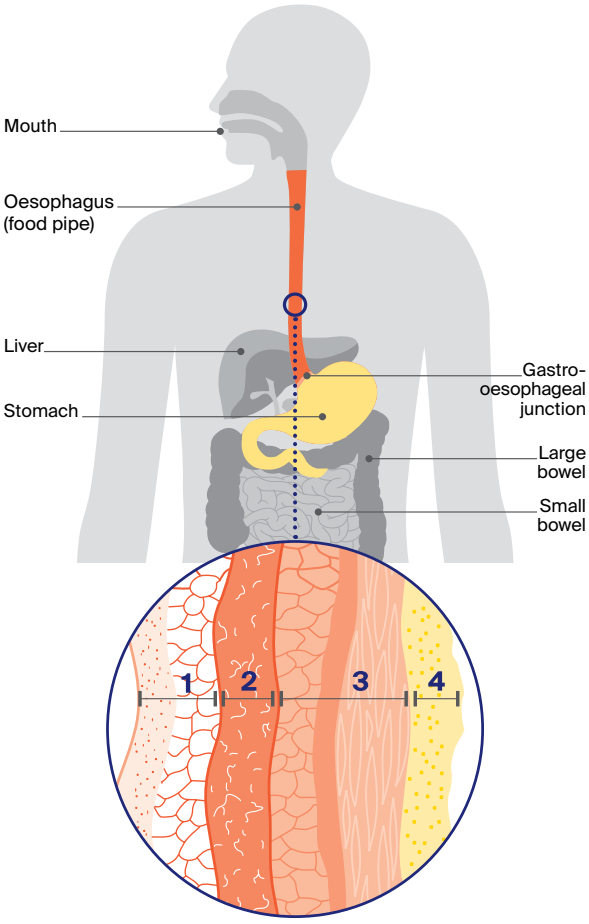
What is oesophageal cancer?

Oesophageal cancer begins when abnormal cells develop in the innermost layer of the oesophagus, called the mucosa. A tumour can start anywhere along the oesophagus. There are 2 main types:

Oesophageal adenocarcinoma – This type often starts near the gastro-oesophageal junction and is linked with Barretts oesophagus (see next page). Adenocarcinomas are the most common form of oesophageal cancer in Australia.

Oesophageal squamous cell carcinoma – This type starts in the thin, flat cells of the mucosa, which are called squamous cells. It often begins in the middle and upper part of the oesophagus.

Parts of the oesophagus



Layers of tissue in the oesophageal wall

1. **mucosa (inner layer)**
   made up of squamous cells (thin, flat cells)
2. **submucosa**
   contains glands that make fluid (mucus), this fluid helps to move food through the oesophagus
3. **muscularis propria (muscle layer)**
   produces contractions to help push food down the oesophagus and into the stomach
4. **adventitia (outer layer)**
   connective tissue that supports the oesophagus

Another type is gastro-oesophageal junction cancer. This starts where the oesophagus meets the stomach. It is usually treated like oesophageal cancer, but sometimes like stomach cancer.

If not found and treated early, oesophageal cancer can spread to nearby lymph nodes or to other parts of the body (e.g. liver and lungs). It can also grow through the oesophageal wall and into nearby organs.

How common is oesophageal cancer?

In Australia, about 1785 people are diagnosed with oesophageal cancer each year. Men are almost 3 times more likely than women to be diagnosed with this cancer. It is more common in people over 60, but it can occur at any age.[1]

What are the symptoms?

Oesophageal cancer may not cause any symptoms in the early stages. If there are symptoms, these can include:

- difficulty swallowing
- heartburn or reflux that is new
- reflux that doesn't go away
- food or fluids "catching" in the throat, or episodes of bringing food back up (regurgitation)
- pain when swallowing
- unexplained weight loss or loss of appetite
- feeling uncomfortable in the upper abdomen, especially when eating
- unexplained tiredness that won't go away
- vomit that has blood in it
- black or bloody stools (poo).

Not everyone with these symptoms has oesophageal cancer. If you have symptoms that do not improve, see your general practitioner (GP).

What are the risk factors?

The exact causes of oesophageal cancer are not known. However, certain factors can increase the risk. Many people with these risk factors do not develop oesophageal cancer. The risk factors are different for oesophageal adenocarcinoma and oesophageal squamous cell carcinoma.

GORD and Barretts oesophagus

Reflux occurs when stomach acid flows up into the oesophagus. When reflux happens over a long time, it can lead to gastro-oesophageal reflux disease (GORD).

Over time, acid and bile can damage the oesophagus lining, causing inflammation or ulcers (oesophagitis). This can lead to Barretts oesophagus, which affects about 1 in 10 people with GORD.

Rarely, Barretts oesophagus can develop into oesophageal adenocarcinoma (see previous page). If you have Barretts oesophagus, your doctor may recommend regular endoscopies.

For oesophageal adenocarcinoma:

- being overweight or obese
- medical conditions, including gastro-oesophageal reflux disease (GORD) and Barretts oesophagus
- smoking tobacco
- being over 60.

For oesophageal squamous cell carcinoma:

- drinking alcohol
- smoking tobacco
- being over 60
- damage to the oesophagus from swallowing very hot liquids or corrosive substances (e.g. acid).

Diagnosis

If your GP suspects oesophageal cancer, they will examine you, arrange initial tests and refer you to a specialist, such as a gastroenterologist. These are some of the tests you may have:

Endoscopy and biopsy

The main tests are endoscopy and biopsy, which are often done at the same time.

An endoscopy (also called a gastroscopy or upper endoscopy) lets your doctor look inside your oesophagus and stomach. It is usually done as day surgery. Before the test, you will probably need to fast (not eat or drink) for about 6 hours.

You could be offered a light sedation to make the procedure more comfortable.

Further tests

If a biopsy shows you have oesophageal cancer, you may have more tests to see if the cancer has spread. Some tests may be repeated during or after treatment to check your health and how well treatment is working.

Test	What it is	Why it's done	What to expect
blood tests	A sample of your blood is checked.	Checks your general health, blood cell count and how your liver and kidneys are working.	Quick test, usually a needle in your arm.
imaging scans	Pictures of the inside of your body using CT, MRI or PET–CT scans.	Checks if the cancer has spread to other parts of your body.	You lie still on a table. For some scans, a liquid dye (contrast) is injected into a vein.
laparoscopy	Keyhole surgery using a thin tube with a camera.	Sometimes used to check if cancer has spread to the stomach's outer layer or the lining of the abdomen.	Done under general anaesthetic. The tube is inserted through small cuts in your belly. Afterwards, you may feel bloated or have shoulder pain.
genomic testing	Special tests on tissue removed during surgery.	Finds gene changes (mutations) in cancer cells to help decide which treatments may work best.	No extra procedure is needed. Uses tissue already taken during surgery or biopsy.

A general anaesthetic is only needed in a small number of cases. Once the sedative takes effect, a long, flexible tube with a light and small camera on the end (endoscope) is passed into your mouth, down your throat and oesophagus, and into your stomach and small bowel.

If the doctor sees anything unusual during the endoscopy, they may take a small sample of tissue (biopsy). A specialist, called a pathologist, will check the tissue sample under a microscope to look for cancer.

The endoscopy takes about 10 minutes. You may feel sleepy afterwards, so someone will need to take you home. You may also have a sore throat or feel bloated for a short time.

Endoscopic ultrasound (EUS)

An EUS is often done at the same time as a standard endoscopy. Sometimes it is done shortly after if more information is needed or to help with staging (see opposite). The doctor uses an endoscope with an ultrasound probe on the tip or with a built-in ultrasound device. The probe releases soundwaves that echo when they bounce off anything solid, such as an organ or tumour.

If you have cancer, this test can help to show whether the cancer has spread into the oesophageal or stomach wall, nearby tissues or lymph nodes. During the EUS, your doctor may use the ultrasound to guide a needle into the area they want to look at and take tissue samples.

Staging

Working out how far the cancer has spread is called staging. It helps your doctors recommend the best treatment for you.

The TNM staging system is the method most often used to stage oesophageal cancers. TNM stands for "tumour, node, metastasis". The specialist gives numbers to the size of the tumour (T1–4), whether or not lymph nodes are affected (N0–N3), and whether the cancer has spread or metastasised (M0 or M1). Lower numbers mean the cancer is less advanced.

The TNM scores are combined to work out the overall stage of the cancer, from stage 1 to stage 4 (see table next page). Ask your doctor to explain what the stage of the cancer means for you. You can also call Cancer Council 13 11 20.

Stages of oesophageal cancer		
stage 1	early or limited cancer	tumour is found only in the oesophageal wall lining
stages 2–3	locally advanced cancer	tumour has spread deeper into the layers of the oesophageal wall and to nearby lymph nodes
stage 4	metastatic or advanced cancer	tumour has spread beyond the oesophageal wall to nearby lymph nodes or parts of the body, or to distant lymph nodes and parts of the body

Treatment

The most important factors in planning treatment for oesophageal cancer are the type of cancer and the stage of the disease. Treatment will also depend on your age, medical history and general health.

Your multidisciplinary treatment (MDT) team may include a gastroenterologist, surgeon, radiation and medical oncologists, specialist nurses, and allied health professionals, such as a dietitian, exercise physiologist or social worker.

Treatment options for oesophageal cancer include:

- surgery alone
- chemotherapy before and after surgery
- combined chemotherapy and radiation therapy before surgery
- combined chemotherapy and radiation therapy without surgery
- radiation therapy alone
- clinical trial (ask your doctor for more information).

When chemotherapy and radiation therapy are combined, this is called chemoradiation. You will usually have both treatments on the same day.

Surgery

Surgery is often recommended if oesophageal cancer has not spread to other parts of the body. The aim is to remove all of the cancer while keeping as much healthy tissue as possible. The surgeon will also remove some healthy tissue around the cancer (a margin) to reduce the risk of the cancer coming back in the future.

Depending on where the tumour is growing and how advanced the cancer is, you may have an endoscopic resection (see next page) or an oesophagectomy (see below).

The surgery can be done in 3 ways:

- **open surgery** – the surgeon makes a large cut in the chest and the abdomen, and, sometimes, a small cut in the neck
- **keyhole surgery** – the surgeon makes some small cuts in the abdomen and/or between the ribs, then inserts a thin instrument with a light and camera (laparoscope) into one of the cuts to see inside the body. Sometimes, a small cut is made at the base of the neck on the left side
- **robotic surgery** – a type of keyhole surgery where the surgeon uses robotic tools to remove cancer from the oesophagus through small cuts in the abdomen and/or chest

Your surgeon will talk to you about the best type of surgery for you.

Oesophagectomy (surgical resection)

Surgery to remove part or all of the oesophagus is called an oesophagectomy. Nearby affected lymph nodes are also removed. Many people have chemotherapy before and after surgery, as this approach has been shown to have better long-term results (see *Chemotherapy* page 6). Your treatment team will recommend the best option for you.

Depending on where in the oesophagus the cancer is, the surgeon may also remove part of the upper stomach. This is the preferred option for cancer that has spread deeper into the wall of the oesophagus or to nearby lymph nodes.

Oesophageal cancer surgery is complex. Surgeons who regularly perform this type of surgery have better outcomes. If you live far from a specialist centre, you would have to travel to have surgery. You may be eligible for help with travel costs. For more information, call Cancer Council 13 11 20.

Once the parts with cancer have been removed, the stomach is pulled up and rejoined to the healthy part of the oesophagus. This could be in the upper chest area or in the neck. The surgery will allow you to swallow and, in time, eat relatively normally.

Risks and side effects – As with any major surgery, oesophageal surgery has risks and side effects. These may include infection, bleeding, blood clots, damage to nearby organs, leaking from the joins between the oesophagus and stomach or small bowel, pneumonia and voice changes. Some people may have an irregular heartbeat, but this usually settles within a few days.

Surgery can sometimes cause scars that narrow the oesophagus. This is called oesophageal stricture and may make it difficult to swallow. If the oesophagus becomes too narrow, your doctor may need to gently stretch it (called dilatation).

Endoscopic resection

Endoscopic resection is a way for doctors to remove tissue from the oesophagus without needing more major surgery. A thin tube is passed through the mouth and into the oesophagus. An endoscopic resection helps with diagnosis and staging (see pages 3–4). For some people with early-stage oesophageal cancer, it may also treat the cancer by removing the whole tumour.

An endoscopic resection is often done as a day procedure but in some cases, you may need to stay in hospital overnight for observation.

What to expect after oesophageal surgery

Recovery time

You will most likely be in hospital for 7–10 days, but you may stay longer if you have any complications. It is likely to take 6–12 months to feel completely recovered after an oesophagectomy.

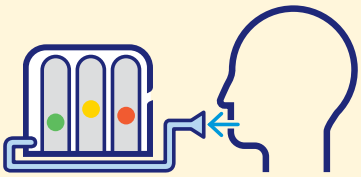
Drips and drains

You will have drains in the chest after surgery and maybe other drains in the abdomen or neck. These will be removed before you go home. You may also have a feeding tube (see right) to get the nutrition you need, and another tube (nasogastric or NG tube) to drain fluids from the stomach. The NG tube will be removed before you leave hospital, but a feeding tube may stay in place when you leave the hospital.

Eating and drinking

You will not be able to eat or drink straight after surgery. A feeding tube is often inserted during surgery (see right). Your first foods will usually be fluids such as soup. You will then move on to pureed foods, then soft foods, and eventually solid foods. It is best to eat 5–6 small meals throughout the day, as you may feel full quickly.

Breathing problems



Controlling pain will help avoid problems with breathing that can lead to pneumonia. A physiotherapist can teach you exercises to help keep your lungs clear. You may also be shown how to use an incentive spirometer, a device to help your lungs expand and prevent a chest infection.

Having a feed tube

Some people with oesophageal cancer may need a feeding tube before, during or after treatment. This helps keep your weight steady and gives your body strength. A feeding tube can go into your stomach or small bowel. It may be placed through your nose (nasogastric or nasojejunal tube) or through your belly with a small operation (gastrostomy or jejunostomy tube). You might need the tube after surgery until you can eat and drink normally again.

A special liquid food (called formula) goes through the tube to give you the nutrients you need. If you go home with the feeding tube, a dietitian will tell you how much formula to take and how often. Your health care team will show you how to keep the tube clean and working well. The doctor will remove the tube when you no longer need it.

Chemotherapy

Chemotherapy uses drugs to kill or slow the growth of cancer cells. The aim is to destroy cancer cells, while causing the least possible damage to healthy cells.

Chemotherapy for oesophageal cancer may be given alone, or it may be combined with radiation therapy (chemoradiation). It may be used:

- **before surgery (neoadjuvant chemotherapy)** – to shrink a large tumour and destroy any cancer cells that may have spread
- **after surgery (adjuvant chemotherapy)** – to reduce the chance of the cancer coming back
- **combined with radiation therapy** – this is called chemoradiation
- **on its own (palliative treatment)** – for people who cannot have surgery or when cancer has spread to other parts of the body. Also to help control the cancer and improve quality of life.

For people having surgery, chemotherapy is now commonly recommended before and after surgery.

Chemotherapy drugs are usually given through a drip inserted into a vein (intravenous infusion). They may also be given through a central venous access device (CVAD) or as tablets you swallow. You will usually have treatment as an outpatient. Most people have a combination of chemotherapy drugs over several sessions. There may be a rest period of a few weeks between each session.

Side effects – Chemotherapy can cause nausea and/or vomiting, appetite changes, difficulty swallowing, mouth ulcers, skin and nail changes, numbness or tingling in the hands or feet, ringing in the ears or hearing loss, changed bowel habits (e.g. constipation, diarrhoea), and hair loss/thinning.

Chemotherapy affects your immune system, so you may also be more likely to catch infections. If you feel unwell or have a temperature of 38°C or higher, seek urgent medical attention.

▸ See our *Understanding Chemotherapy* booklet.

Radiation therapy

Also known as radiotherapy, this is the main treatment for oesophageal cancer that cannot be removed by surgery and has not spread to other parts of the body. Radiation in low doses is also often used to shrink cancer that has spread to other parts of the body.

Radiation therapy uses a controlled dose of radiation, such as focused x-ray beams, to kill or damage cancer cells. The radiation is targeted at the cancer, and treatment is carefully planned to do as little harm as possible to healthy body tissue near the cancer.

Radiation therapy may be given alone or combined with chemotherapy (chemoradiation). Chemoradiation is sometimes the only treatment needed or it may be used before surgery.

Side effects – The lining of the oesophagus can become sore and inflamed (oesophagitis). This can make swallowing and eating difficult. In rare cases, you may need a temporary feeding tube (see previous page) to help you get enough nutrition. Other side effects can include fatigue, skin redness, loss of appetite and weight loss. Most side effects improve within about 4 weeks of treatment finishing.

Very rarely, radiation therapy can cause long-term side effects. Scar tissue can develop in the oesophagus, making it narrower (oesophageal stricture). Stretching the walls of the oesophagus (dilatation) – done during an endoscopy – can make it easier to swallow food and drink. Radiation therapy can also cause irritation and swelling (inflammation) in the lungs, which can make you short of breath.

▸ See our *Understanding Radiation Therapy* booklet.

Having a stent

People with advanced oesophageal cancer who have trouble swallowing and do not have any other treatment options may have a flexible tube (called a stent) inserted into the oesophagus during an endoscopy.

The stent expands the oesophagus so that fluid and soft food can pass into the stomach more easily. It also can prevent food and saliva going into the lungs and causing infection. The stent does not treat the cancer but will allow you to eat and drink more normally, although there may be some foods you are no longer able to eat.

Immunotherapy

Immunotherapy uses the body's own immune system to fight cancer. It is sometimes used after surgery or to treat people with advanced oesophageal cancer. This type of cancer treatment is changing rapidly. Talk to your doctor about whether immunotherapy is an option for you.

Side effects – The side effects of immunotherapy can vary from person to person. Immunotherapy can cause redness, swelling or pain (inflammation) in any of the organs of the body. This may cause side effects such as fatigue, skin rash, diarrhoea and cough. In some people, the inflammation can lead to more serious side effects, but this will be monitored, and any issues will be managed quickly.

Let your treatment team know immediately if you develop any side effects or have concerns.

▸ See our *Understanding Immunotherapy* fact sheet.

Managing side effects

Oesophageal cancer and its treatment can cause side effects. Some may be permanent and may change what you can eat, and how your body digests foods and absorbs essential nutrients.

Eating during and after treatment

It is important to eat and drink enough to get the nutrition to stay hydrated and maintain your weight. This will help you avoid malnutrition. If you are unable to eat and drink enough to meet your nutritional needs, you may need a feeding tube (see page 5) during or after treatment.

To help prevent weight loss during treatment:

- try eating small meals or snacks every 2–3 hours
- keep a variety of snacks handy and eat when you feel hungry or crave a particular food
- drink high-energy fluids like milkshakes or nutritional supplement drinks
- talk to a dietitian about how to get more energy and increase your protein.

After treatment, you may also find that some foods cause digestive problems. You will need to try different foods and change your eating habits, such as eating smaller meals more often throughout the day. Ask your doctor for a referral to a dietitian with experience in cancer care.

▸ See our *Nutrition for People Living with Cancer* booklet.

Reflux and choking

Stomach acid rising into the oesophagus (reflux) is common after surgery for oesophageal cancer. This can cause heartburn, chest discomfort, or your stomach contents to flow up your oesophagus, particularly when lying flat or bending over. Medicines to reduce stomach acid may help.

After surgery or radiation therapy for oesophageal cancer, scar tissue may cause choking or swallowing problems while eating or drinking. See your doctor if this continues. After an oesophagectomy, the stomach can take longer to empty. You may feel full more quickly or be more likely to vomit or bring up food after eating.

To reduce reflux and choking, avoid spicy or fatty foods, fizzy drinks, and alcohol. Sit upright while eating and for at least 30 minutes afterwards. Take small sips of water to help with coughing. You can also try raising the head end of your bed so your head is higher than your stomach.

Swallowing difficulties

You may have difficulty swallowing (dysphagia) before, during or after treatment. This may be caused by the cancer itself or by swelling in the oesophagus after surgery. Signs include taking longer to chew and swallow; food getting caught in your mouth or throat; or bringing up food or vomiting.

Some people find that food and fluid go into the windpipe instead of the food pipe. This is called aspiration, and it can lead to chest infections like pneumonia. Talk to your doctor about these symptoms.

How to eat when it is hard to swallow

- Make food softer by chopping, mashing, slow-cooking, mincing or pureeing food.
- Between meals, snack on soft foods that are higher in energy (e.g. avocado, ice-cream and diced tinned fruit) and protein (e.g. yoghurt and milkshakes).
- Chew carefully and slowly, sitting upright and still. Try to avoid talking while eating.
- Wash food down with small sips of fluid.
- Ask your doctor for a referral to a speech pathologist for help managing symptoms.

Palliative treatment

Palliative treatment helps improve people's quality of life by managing the symptoms of cancer without trying to cure the disease. It is best thought of as supportive care. Many people think palliative care is only for people at the end of life, but it can help at any stage of advanced oesophageal cancer.

Treatments will be tailored to your individual needs. For example, radiation therapy can relieve pain and make swallowing easier by helping to shrink a tumour that is blocking the oesophagus. Palliative treatments can also slow the spread of the cancer.

- See our *Understanding Palliative Care* and *Living with Advanced Cancer* booklets.

Follow-up appointments

You will have regular appointments to monitor your health, manage any long-term side effects and check whether the cancer has come back or spread.

During check-ups, you may have blood tests, imaging scans or an endoscopy if necessary. You will also be able to discuss how you are feeling and any concerns you have. How often you see your doctor will depend on the level of monitoring needed for the type and stage of the cancer you had. You may also see a dietitian for advice about nutrition.

For some people, oesophageal cancer does come back. If this happens, you may have further treatment, including chemotherapy, radiation therapy or surgery.

Where to get help and information

Call Cancer Council 13 11 20 for more information about oesophageal cancer. Our experienced health professionals can provide support, put you in touch with services and send you our free information. You can also visit your local Cancer Council website.

ACT	actcancer.org
NSW	cancercouncil.com.au
NT	cancer.org.au/nt
QLD	cancerqld.org.au
SA	cancersa.org.au
TAS	cancer.org.au/tas
VIC	cancervic.org.au
WA	cancerwa.asn.au
Australia	cancer.org.au

Other useful websites

Not all websites are reliable. The websites below are good sources of information and support.

Australian and Aotearoa New Zealand Gastric and Oesophageal Surgery Association	aanzgosa.org
Dietitians Australia	dietitiansaustralia.org.au
Gastroenterological Society of Australia	gesa.org.au
GI Cancer Trials	gicancer.org.au
Pancare Foundation	pancare.org.au

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Note to reader
Always consult your doctor about matters that affect your health. This fact sheet is intended as a general introduction and is not a substitute for professional medical, legal or financial advice. Information about cancer is constantly being updated and revised by the medical and research communities. While all care is taken to ensure accuracy at the time of publication, Cancer Council Australia and its members exclude all liability for any injury, loss or damage incurred by use of or reliance on the information provided in this fact sheet.

References

1. Australian Institute of Health and Welfare (AIHW), *Cancer Data in Australia 2025,* viewed 20 November 2025, available from aihw.gov.au/reports/cancer/cancer-data-in-Australia.

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Cancer Council acknowledges Traditional Custodians of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Islander cultures and to Elders past and present.

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