

Episode 18 – Surgery for Oesophageal or Stomach Cancer

(Intro) Rosie: Do you have upcoming surgery? Are you feeling a little overwhelmed? Then this is the podcast for you. Welcome to Operation Preparation. You are listening to the Pre Anaesthetic Assessment Clinic podcast, or PAAC for short, from St. James's Hospital, Dublin. Here we put together a series of short episodes to help you, your family and your loved ones learn more about your upcoming perioperative experience.

Rosie: Welcome back to Operation Preparation, the final episode in Season 3. My name is Roseann Murray, clinical nurse specialist, and here also is Consultant Anaesthesiologist, doctor Aislinn Sherwin. We're delighted to have here today with us Consultant Surgeon in Upper Gastrointestinal Surgery, Ms Claire Donohoe, and clinical nurse specialist, Jenny Moore, to talk to us today about upper gastrointestinal surgery, like oesophagectomy and gastrectomies. The upper GI or gastrointestinal team are very specialised and here in St James' Hospital we are a national referral centre. So, what does this mean to you Jenny, upper gastrointestinal surgery?

Jenny: Well Roseann, it means any surgery or intervention for tumours of the oesophagus or the food pipe and stomach.

Rosie: So Jenny, how did you come to be a part of the Upper GI team?

Jenny: Well, Roseann, I started my nurse training back in 1986 in hospital 7, unit 3, which was the oesophageal cancer ward at the time. That ward isn't even there anymore, the children's hospital is now upon it. But I was very well taught by the ward manager at the time, Sister Pam O'Callaghan, who is the queen of oesophageal cancer and always will be in my eyes. Pam taught me three nuggets about caring for patients with this disease that I've carried throughout my career. One, that it's a fundamental right to be able to swallow your saliva, fluid and food. Two, any intervention to the GI tract will change a person's life forever. And number three, which was very important, the oesophagus is one of the most stubborn parts of our anatomy, which refuses to be removed easily. Hence, the surgery is very complex. So the recovery also is very complex for patients.

Aislinn: Thanks, Jenny, that's a great answer. And thank you for giving us a bit of a history lesson. I also remember hospital 7 and I'm sad it's not there anymore. But we'll move on to Claire, can you tell us a little bit about what exactly is an oesophagectomy?

Claire: Yeah, sure, so an esophagectomy is an operation that we do in order to remove the Oesophagus. We also do operations on the stomach called gastrectomies where we're removing the stomach depending on where the problem is. So, it's probably worth refreshing a little bit about what the upper digestive tract is like, just so that you know what I'm talking about. So, when we swallow food, it goes into our mouth and then from our throat level, it goes into the oesophagus, which is a long muscular tube about two centimetres wide that joins the upper part of the stomach just underneath the breastbone. When we do an oesophagectomy we remove about two thirds of the oesophagus and the upper part of the stomach and then we make the stomach into a really long thin tube that during the second part of the operation where we're operating on the chest is brought into

the chest and it's joined up to the remaining part of the oesophagus. When we're doing a gastrectomy, however, we're leaving the oesophagus behind and we're removing either all of the stomach or almost all of the stomach and to reconstruct the digestive tract we then bring a piece of the small bowel up and join that up to the oesophagus.

Aislinn: And Claire, why would patients need this surgery?

Claire: So, the specific reason why you might need the surgery will be discussed in detail with you by the surgical team. But in general, we do most of these operations for cancers of the oesophagus or of the stomach.

Rosie: Okay, that's really, really interesting and really clear, but what kind of tests would a patient need then before the surgery?

Claire: So there's a couple of different types of tests, some of the tests are tests so that we can figure out what stage their cancer might be at. And for that, we usually do some specialised scans. A CT scan, for example, of the thorax, abdomen and pelvis would often be done, which is where we're looking in detail at the chest and at the belly and the pelvis. We sometimes do a specialised scan called a PET-CT scan where you get an extra tracer that's taken up by cells that are active in the body so generally we see activity then in the tumour and it helps us identify if the tumour has moved elsewhere in the body. So once we know what the stage of the cancer is then we will know whether surgery will form a part of the treatment.

We also do a number of other tests if we decide that patients need surgery in order to assess their fitness. We often test their breathing with what are called pulmonary function tests where you breathe into a machine and it gives us a readout of how good your lungs are. We will often do an echo test of the heart where we're looking at the heart's function to make sure that there's no unexpected structural problems with the heart. We'll often do an ECG where we trace and measure the electrical activity of the heart. And we do a panel of blood tests to make sure that there's no obvious problems with the other organ systems.

We also like to get a general assessment of how fit a person is because in order to be able to undergo major surgery like this, you need to be very fit. So, we want people to be able to walk up and down stairs with ease and often for them to be doing some good physical activity in order to demonstrate that their heart and lungs are good enough to be able to get through an operation like this.

Aislinn: Thanks, Claire, it is indeed a very major surgery, and is there anything that patients can do to prepare physically for the surgery?

Claire: So, we want people going into the surgery being as fit as they possibly can be. So, we want people to stay active, even if they're having treatments like chemotherapy or radiation therapy before their surgery. And we have a special team called the prehabilitation team in the hospital where they'll meet with the specialist physiotherapist who'll give them an exercise prescription. So, give them an idea of how to build on their existing physical activity

and try to enhance it before their surgery. They also do lots of online classes and in-person classes for people to attend to if they can.

One of the other important things physically that we remind people is that if they are a smoker, that we really, really, really want them to stop smoking. Even if they've been a smoker all of their lives, we can measure the benefit even of a short period of time stopping smoking before surgery. So we don't ever want to turn people down for not stopping smoking before an operation, but we really, really strongly emphasize that it's important to stop it and I understand that you've done an episode all around smoking cessation on the podcast, so they should listen to that if they have questions about how to stop smoking.

Other things like cutting down alcohol, if you are a regular drinker, can be a good preparation for surgery too.

Rosie: It's great, you know, we have covered these things on previous episodes, covered them on our website, Steps for a Stronger Start. But it's great to see, you know, how things are coming full circle and how we can put these into a context, you know, for a particular surgery. But following on from that, will a patient need to make changes to their diet ahead of this kind of surgery?

Claire: So in general there's no specific healthy diet that we want people to be on but often when people have problems in their oesophagus or their stomach, they've often lost an awful lot of weight before they have even been diagnosed and they might lose weight while they're going through their treatment. They might also have specific difficulties with feeling full quickly or not being able to swallow properly. So, we have a specialist dietetics team here who meet with patients who are having difficulties with their food and fluid intake to make sure that they're maintaining as healthy a diet as they can. We tend to focus a lot on high energy foods, so calorie dense foods and foods that have lots of protein in them. And giving people supplementary protein drinks can be also a helpful supplement to their diet. But in general, if you're having difficulty with your eating and drinking or maintaining your weight, we want to know about it early so that we can try to optimize you before your surgery.

Aislinn: Thanks, Claire, and I know we've maybe covered a little bit of this question before in episode 8, but is there any particular medications that you want patients to stop before surgery?

Claire: So it's useful for the surgical team to know what medications you're on. So anytime you're coming to an appointment with us, do bring a list of your medications. If you're on blood thinners, it's really important for us to know about that and you'll often be asked specifically about that because you might need to stop that a number of days before you have any tests or procedures done in the hospital. But in general, your pre-op assessment clinic appointment will be an opportunity where we'll go through all of your medications and tell you which ones to stop and when to stop them before your surgery. I think there's also another episode of the podcast that goes into that in more detail too, so that might be a good resource to check out.

Rosie: So this is such a huge event for anyone, so what about mental and emotional preparation?

Claire: Yeah, so as Jenny said at the very start, any surgery on the GI tract can really change somebody's life and it's a huge stress for people to be diagnosed with the problems that we deal with. So it's really normal to feel anxious or stressed. If you're not anxious or stressed, you do wonder if the person actually understands the significance of what they're about to undertake. So it's really important to acknowledge that that's a normal part of treatment practice. If you talk to people about it, that often helps lessen anxieties and worries and sometimes engaging in relaxation techniques or if you're really struggling with your mental health, letting us know so that we can get you linked in with our psychology service. That can be really helpful to make sure that you're feeling well prepared or as well prepared as you can be when you're facing major treatment.

Rosie: So what kind of things should patients arrange maybe before their planned surgery or their admissions?

Claire: Yeah, I was thinking about this before the podcast and made a little list of things that might be good to think about. If you have a good partner, they might do all of these things for you already but particularly if you live alone these might be important things to think about. So, you need to arrange transport to the hospital and thinking about how you're going to get home from the hospital. When you're coming into the hospital you need a small bag with some loose clothing. Initially you'll be using a hospital gown but once you're starting to recover it's good to get into your own clothing but making it loose and comfortable is important. We really need people to have well-fitting slippers or shoes so that we can get them up and walking and we'll tell you lots about walking probably later on in this episode. Make sure you have your phone and a charger for your phone and that it's fully charged coming into the hospital, that you have any toiletries that you use. You don't need to bring your medications because we'll give those to you when you're here. If you find it useful to have an eye mask or earplugs for sleeping in busy environments, that can be really helpful in hospital because it's very busy at nighttime, unfortunately. And things to distract yourself like books or magazines or a tablet with some shows downloaded can be really helpful. If you have a list of your medications, bring that with you. And if you do live alone, think about being ready to come home when you're ready to leave hospital, that you've stocked up on any food items that you need or that you have somebody who's going to help you with that, that your house is nice and clean and that you've got an empty bin and all your recycling has been put out, that you've changed your bedsheets and all your laundry is ready so that when you come home, you're kind of ready for recovery.

Aislinn: That's great, and they're really important things, Claire, to mention because I'm sure lots of people don't think about the after they're so focused on the actual surgery itself so it's great to have that reminder. How long do your patients usually stay in hospital?

Claire: So this varies from person to person, so we give people kind of a general guidance and it depends on what part of their body they're having removed but in most of the upper GI surgeries that we do the absolute quickest time we can get people in and home is about eight days and that's unusual. The average time that people are in hospital after surgery is

about 10 to 14 days because for the first part of their stay, we'll be resting their digestive system and not getting them back eating and drinking. And usually as they recover, then we slowly reintroduce food and fluids to them, so that process takes time.

If you have any complication, however, you will be in hospital for longer than that. So it's important to be aware that people can have complications after major surgery and that some people are in hospital for a longer period of time.

Rosie: And so what kind of pain management then will patients receive after their surgery?

Claire: So this will be discussed with you in detail with the pre-op assessment clinic team and the anaesthetic doctor who will be doing your surgery on the day. So they guide us in determining what the best form of pain management is. We use lots of different ways of helping control people's pain because even though we expect people to have some pain after surgery, we really, really want them to be in control of their pain and able to take a nice deep breath and be able to cough comfortably. If they can't take a deep breath or cough comfortably, then we haven't done a good job of their pain relief and we need to work on it. And then what pain medications you need will depend on your past experience of surgery or what medications you've taken before and will be, I suppose, tailored for you and your specific factors.

If you've had an open operation, we'll often use an epidural, which is a little catheter that goes into the back and that we give continuous pain relief for the first four or five days after surgery. We always give our patients a patient controlled analgesia device after the surgery too so that's a little button that you can hold in your hand and you can press it to give yourself a small dose of strong painkillers so that you're in control of when you need the medication so they're the two most common ways that we have of giving extra painkillers but we also give pain medications to drips in people's arms and we also sometimes give them through people's back passage there's one painkiller that's can be very helpful for muscular pain that we give that way too. So we will discuss that with you before, during and after your surgery so that we try to get your pain under as good a control as we can.

Aislinn: And it's really important, Claire, that we usually tell our patients not to suffer in silence, that we do want to know if they're sore because it does have a big impact upon their recovery. The other thing that patients might worry about are tubes and drains and they might wonder what they are and why they're there.

Claire: Yeah, it's a good idea, I think, to know about what lines and drips and tubes you'll have, and usually your surgeon will mention these to you. But when you wake up after the surgery, you'll have lots of attachments, and it's good to know in advance, or at least to have a picture of what they might be. So probably the most uncomfortable one that people have is a tube in their nose that goes into their digestive system, and that helps us take extra fluid out and helps with the healing process on the inside. You'll also have a line in your neck that's used for giving, sometimes, intravenous medications or fluids or food. You'll have a number of lines in your arms for monitoring your blood pressure and for giving medications and fluids. You'll have a tube in your bladder and then you'll often have drains coming out of the chest or the belly and or a small feeding tube and all of those drains will be discussed

with you before your surgery but when you do wake up you have an awful lot of attachments and it can be hard sometimes just getting moving with those lines and drips and tubes which is part of why we always get a team of people helping you get up and out of bed after the surgery.

Rosie: Thanks for that, Claire, and it's probably useful for any of our listeners to know that episode 10 goes into all of those lines and tubes in great detail, and there's also a video attached in the show notes as well. So, if anyone's interested in what those look like, they can have a look at them there.

So probably maybe this is a big burning question for patients. How soon will they be able to eat and drink after their surgery?

Claire: So that depends on the recovery. We're monitoring very closely to make sure everything is healing as we want it to. But typically, we don't give people any food or fluids through their mouth until at least four or five days after surgery. Sometimes we do tests or investigations to check on what the healing is like before we get people back eating and drinking. And then when we do get people back eating and drinking, it's not an all or nothing. So we are very slow to reintroduce food and fluids just to make sure that people are tolerating it well and they don't have any nausea issues. So typically when we start people back they just get very small amounts of clear water on the first day that they're drinking and then they might move on to free fluids which are whatever fluids they want but in kind of limited quantities we don't want people chugging down lots and lots of fluid and making themselves feel sick and that's then followed by progressing on to some soup or some jelly and ice cream or something light to test how their digestion is working and then we move on to a modified texture diet which is a texture diet where it's usually easy to chew and easy to digest and the options are discussed with them and explained to them by both the dietitian team and the catering team in the hospital.

Aislinn: Thanks Claire and you did mention a bit about getting out of bed and we have a previous episode on physiotherapy, prehab and rehab, in episode 15 but can you tell us specific to your types of surgery what a patient should do about getting out of bed and moving around?

Claire: Yeah, I think patients probably think we're totally obsessed with getting them out of bed, but the reason we are is because it's a really good marker of how they're recovering. So if they're able to get up and get moving, they can minimize any chest-related complications and it also tells us that their organ systems are working well and able to support them getting moving.

Obviously, we do a number of checks before we get people moving to make sure that it's safe to get them moving. So we'll never force you out of bed if you're not able to. But if you are able to, we will strongly encourage you to get up and get moving as soon as possible. If we are lying in bed, even for a short number of days, we start losing muscle. So we're very keen to minimise that as much as possible so people can stay healthy and well in the long term.

Rosie: So most patients after their Oesophagectomies will go directly to ICU after their surgery. So, can families visit them there?

Claire: So in general, yes, we usually advise that it's a good idea maybe to ring ahead of any planned visit just to check with the nurse who's looking after your loved one, whether it's a good time for visiting or not. Some areas of the ICU can be very busy and if other patients are unwell, they might have to postpone your visit to a later time.

And in general, if patients are back on the ward, we do encourage visitors, but we try to limit it to visiting hours and we ask that, we try to limit visitors in numbers so we don't overwhelm people and the spaces that's in the hospital so try to limit it to one or two people at a time coming on the ward.

Rosie: And what's the best way to stay in touch with family members when I'm in hospital? And what's the best way the family members can get an update from the hospital staff?

Claire: Yeah, we always try to call the family member after we finish the surgery. Usually, it's a couple of hours actually after we finish the surgery and we're happy that everything's going well and the patient's recovering well and is steady in the recovery area. So we'll give you an update then. If there's any deterioration or unexpected change with your loved one, we will call the person who's nominated as their next of kin on the hospital system to let them know as soon as we can. So sometimes no news is good news is something that people need to bear in mind.

If at any point you want to get an update from the hospital staff about your loved one, the best thing to do is to speak to the nurse who's looking after them and ask for a member of the team to talk to you and we'll do our best to give you an update. Also, if you have contact numbers for our nurse specialists and they're on duty, they can also help sometimes with giving you an update on the patients. But also you can get an update from your family member themselves, they'll often have their phone and they'll usually be well able to switch it on and get in contact with you themselves so that can often be the best way of getting an update.

Aislinn: So Claire, recovery then at home and the road ahead, what sort of dietary changes will patients need to make long term?

Claire: So these are really big surgeries to the digestive tract and they cause a number of changes to your ability to eat that don't necessarily go away with time. So a very small proportion of people will adapt relatively quickly and, you know, have only minimal changes to their diet. But the vast majority of people need to learn a new way of eating.

Our dietitian staff go through all of this in great detail with the patient and with their supporters when they're in hospital. And again, do long term follow up with them when they're in the clinic after they've recovered from surgery. But the important things to think about are because your digestive system has been changed and your stomach has either been removed or has been made into a small thin tube. This results in you feeling fuller quicker so you will have to reduce your portion size in order not to eat too much that you

feel uncomfortable after eating. When you reduce your portion size it means that you have to eat more frequently during the day in order to get all the energy that you need and some foods and fluids are less well tolerated after this type of surgery so we usually advise people to separate eating and drinking activities so to try to eat little and often but to spread your fluid intake between meals rather than at the same time as meals and that's partly so that you don't fill up too quickly and also partly so that you don't push the fluid into your intestine too quickly and give yourself an unpleasant cramping sensation called dumping.

There are also some food choices that will be less well tolerated after this type of surgery, particularly in the early stages after the surgery. So typically, people will find if they eat very sugary foods that have lots of simple sugars in them that they might feel more uncomfortable afterwards because it causes more shifts on their gut hormones and their insulin levels on the inside so they might feel more uncomfortable and be more prone to diarrhoea if they eat very simple sugars. So we're focusing on high energy, high protein, high fat content meals that are easy to digest and in small portions eaten throughout the day.

Rosie: So how long should it take to fully recover and for someone to feel back to their normal selves?

Claire: So we've done lots of studies on this and typically most patients will say it truly takes them about three to six months before they feel like they're at a new normal for them and at their new baseline and that they've kind of adapted their eating strategies and they're starting to feel more physically robust afterwards. So it's a really long arduous process and the first part of recovering from the surgery is in hospital but most of it actually happens when you're out at home. And then we talked a little bit about how long people are in hospital. So in or around two weeks or so. But the first few weeks when they come home can be a gradual process of learning what works for them from a nutrition point of view. They'll often have days where they feel like they're making good strides forward and days where they feel like they've maybe taken a step backwards. But that's quite normal for people, so really trying to stay positive and focused on the long term prospect of being recovered in a few months is important for people.

Rosie: And if you could talk us through some of the potential complications that a patient should be aware of.

Claire: Yeah, it's really important to know what can go right with the surgery, but also what can go wrong with the surgery. When we're talking about oesophageal and gastric cancer surgeries, they're such big surgeries and they put so much stress on the body. It's very common for us to see people having complications after the surgery. So for oesophagectomies, about two in five people will have some sort of complication or deviation in their recovery. And for gastrectomy patients is about one in five. Not all complications are major problems. They can be as simple as a change in the heart rhythm or rate that might need medication to change it. They can be common complications like a chest infection or pneumonia that needs medications or antibiotics to treat it as well as physiotherapy to help clear secretions.

And then there could be more major complications. And in some people, they can even be life-threatening so it's important people are aware that that is a potential thing that can happen to somebody when they have major surgery like this. So, the risk of having a major complication is somewhere between 5% and 10% of patients. And the major complications are ones where whatever the complication is, it puts a major stress on the body and its other organ systems and they can end up either staying in ICU for a long period or having to return to the intensive care unit or go to the intensive care unit for extra organ support. And while that's not a very common complication, sadly, it's not entirely infrequent because we do lots and lots of these types of surgeries, we are very experienced in recognising complications and in the management of the complications that we have a really excellent intensive care unit team that look after our patients in the intensive care unit and help support us to identify patients who would benefit from being in the intensive care unit in order to help us get people back and recovered after major complications.

Rosie: Thanks for that, Claire, and what would you say to someone about returning to their normal activities?

Claire: So that depends a little bit on what kind of activities people are thinking about doing. So when people leave hospital, we expect them to be able to wash and dress themselves, to be able to get around the house, get up and down the stairs, be able to do those kind of normal activities of their daily lives without too much extra support unless they already needed support before they came into hospital or if they had a major complication where they took a long period to recover, they might need some help or extra help as they recover at home.

In terms of getting back to activities where you're doing, you know, work based activities or physical activities like going out golfing or playing tennis again, obviously that takes a number of weeks to fully recover. We always recommend after abdominal surgery, giving yourself about six weeks before you're putting any strain on the abdominal wall to let it heal up and that's usually the period of time when people would start feeling like they might be able to do kind of maybe more strenuous activities. But there are many people who it takes them longer to catch up to what they would have been able to do from a stamina and energy perspective, just because of the adaptations to their diet and the major surgery that they've just come through.

Aislinn: Thanks, Claire. So, Jenny, can you tell us, are there any extra supports out there for patients who are undergoing this journey?

Jenny: Yes, Aislinn, we always inform patients that they can contact the Irish Cancer Society for support, but in particular to oesophageal cancer, there is the Oesophageal Cancer Fund support group and they meet twice yearly in the Talbot Hotel and it's a fantastic forum for patients and their families to connect and discuss their new normal as they see it and survivorship.

Aislinn: And what kind of follow up care then do your patients receive?

Claire: So all of our patients come back and see us really regularly in the clinic. So we see them initially two weeks after they go home and we'll see them as frequently as they need to be seen to support the recovery journey. But usually the dietitians will see them at the four-week post discharge time period and we see them again somewhere between six and eight weeks after discharge. And then gradually, as long as they're doing well, we increase the interval between when we see people. So we typically see people every three months for the first year and then every six months for two years after that. And then usually an annual checkup until about five years. So you'll be seeing lots of us in the future.

Aislinn: That's great, thanks a million, Claire. So, Jenny, maybe could you give us a few take home points at the end of our episode?

Jenny: Well, I can't reassure patients enough that they're in the best of hands and that's the first thing I say to them. There are at least 50 different professional specialties that will get them not only from diagnosis to treatment, but also through the surgical pathway and back home, so they're definitely in the best of hands, surgeon-wise, anaesthetic-wise. I reassure them that all the drugs in the last few years have changed. They're much more sophisticated. Pain relief and pain control is very sophisticated. And because so much work goes into preparing them psychologically and physically for this massive operation. Usually it can get a little overwhelming, so I give them the few top tips that they have to do everything that they're told to do because they're not going to be expected to know what to do. And also to keep reporting any soreness or pain, which will enable them to do the work that's expected of them, the deep breathing, coughing and getting out of bed the following day, doing their walking. And also to keep their head relaxed and focused because that's what's going to carry them through possibly two weeks in hospital and the next three to four months of recovery at home because it's such a big operation.

I also reassure their loved ones that their surgeon will ring after surgery and that keeps them focused because it's a very hard day for them to fill in and that they'll be allowed to visit or phone the intensive care nurse afterwards. So, with all the highly advanced technology we have now and the specialties, theatre nurses, intensive care nurses and ward nurses, we aim to make it the most least stressful experience that they have to undergo.

Rosie: That's fantastic, so from myself, Rosie and Aislinn here for the last episode in season 3, we'd just like to say thank you both very, very much for such concise and clear and fantastic information for anyone going ahead for oesophagectomy or gastrectomy surgery, so thank you both. We've had here today, Consultant Surgeon in Upper Gastrointestinal surgery, Ms Claire Donohoe, and our clinic nurse specialist, Jenny Moore, here today. Thank you both again. Stay tuned for season 4 coming your way in early 2026.

(Outro) Aislinn: You have been listening to Operation Preparation, the Pre Anaesthetic Assessment Clinic podcast from St. James's Hospital, Dublin. Don't forget to subscribe and check out our website, links and abbreviation in our show notes to learn more about the topics we've covered today. If you have a question that you would like us to cover here, email us at operationpreparation@stjames.ie. Thank you for listening. Until next time.