

Cancers of the GI System

NUR 143

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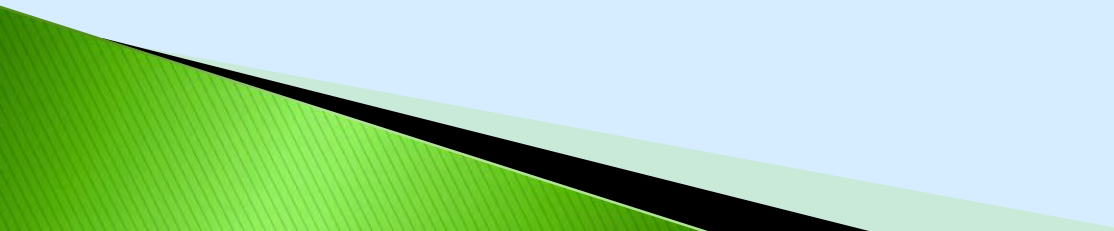
Oral Cancer

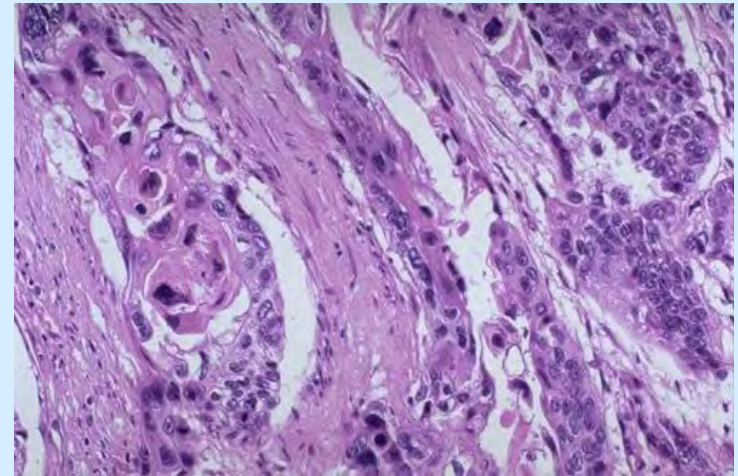
- ▶ Rare, but high morbidity & mortality
- ▶ Higher rated in men, and those over the age of 40
- ▶ Risks- smoking, chewing, ETOH, THC, HPV, other toxins
- ▶ Usually squamous cell carcinoma
- ▶ Lower lip, floor of mouth, tongue, other sites
- ▶ Clinical Manifestations
 - inflammatory areas,
 - shallow painless ulcerations
 - difficulty with speaking-eating-swallowing
 - biopsy suspicious non-healing lesions
- ▶ Surgery- may involve radical neck dissection, radiation and chemotherapy

Esophageal Tumors

- ▶ Benign or Malignant
 - ▶ 3rd most common GI cancer
 - ▶ Mortality is high
 - ▶ Arise from epithelium
 - ▶ 50% located in lower esophagus
 - ▶ Lymph node involvement
 - ▶ Accounts for 1% of all cancers
 - ▶ 5 year survival rate
- ▶ Risk Factors
 - Tobacco use
 - Alcohol ingestion
 - GERD
 - High levels of nitrates
 - Diets low in fresh fruit and vegetables
 - Certain genetic factors

Clinical Manifestations

- ▶ Dysphagia
 - ▶ Weight loss
 - ▶ Food sticking in throat
 - ▶ Odynophagia
 - ▶ Steady, dull, substernal pain
 - ▶ Regurgitation
 - ▶ Chronic cough
 - ▶ Hoarseness
- 



Interventions

Nutritional Support

- dietitian determines caloric needs
- Weighs daily, careful positioning HOB elevated – prevent reflux
- semi soft foods, thickened liquids

Radiation: palliative therapy – reduce tumor size so you have relief of the symptoms(50-76%) and lengthen life

- but can cause stenosis or strictures of esophagus – then need dilation

Esophageal dilation

- temporary relief of dysphagia caused by tumor, radiation, scarring

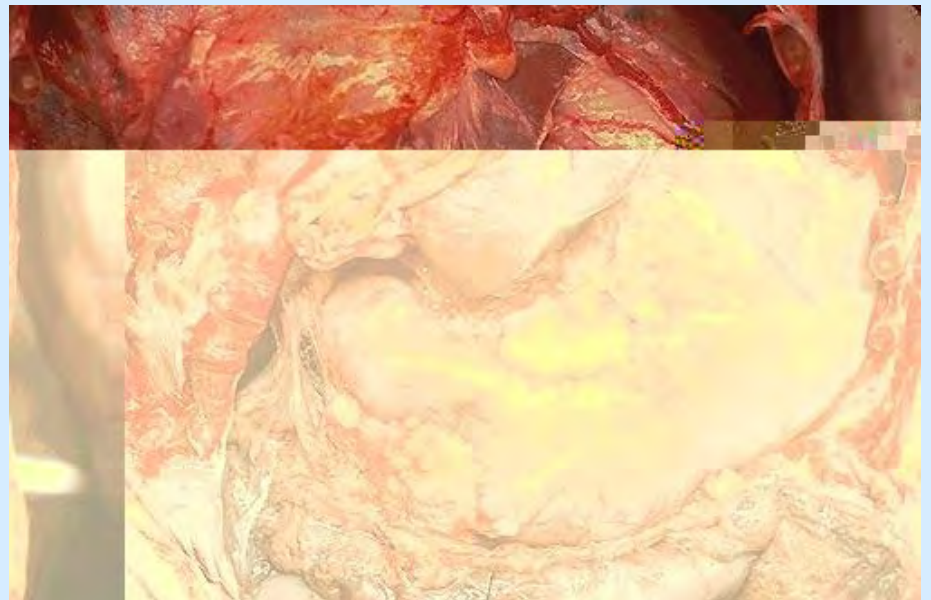
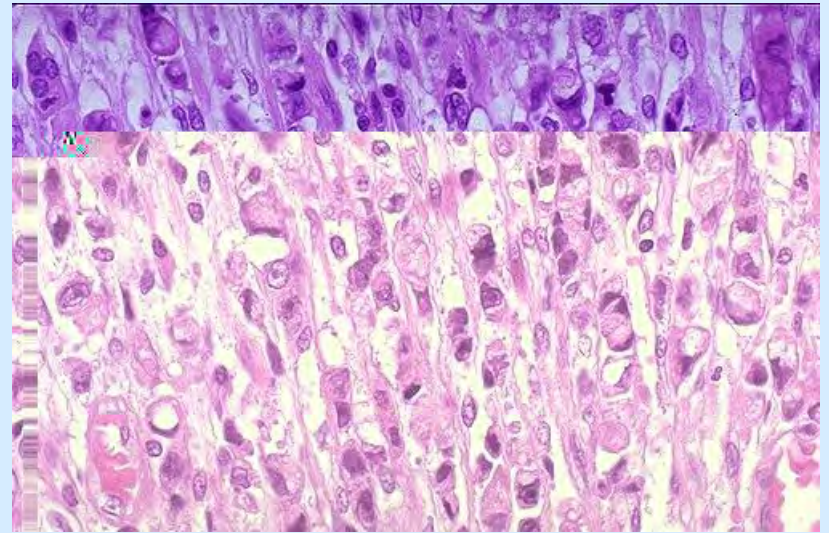
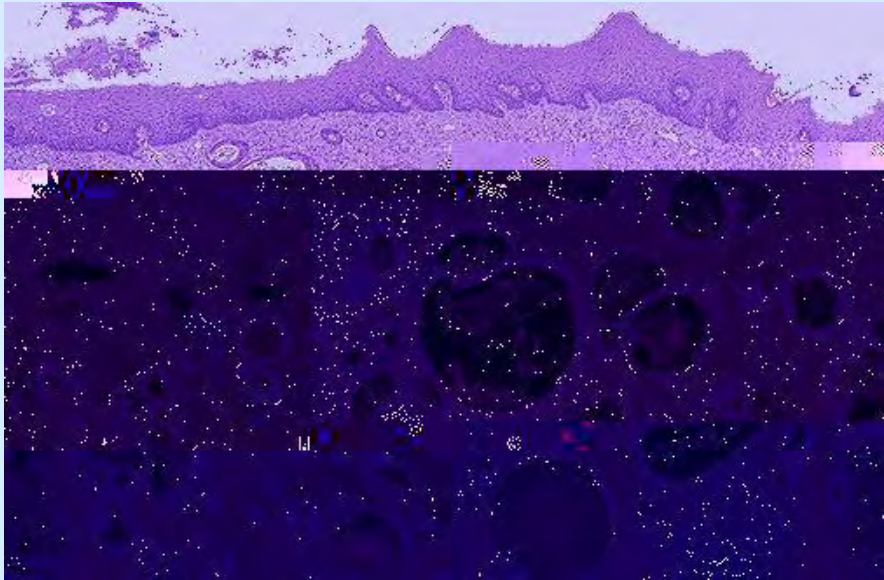
Prosthesis Insertion

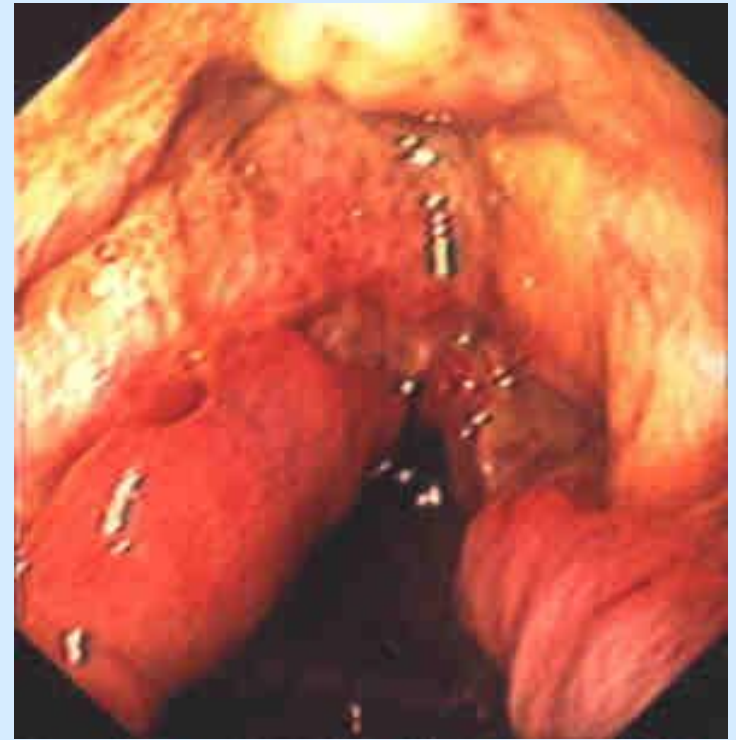
- ▶ semi rigid prosthesis to keep esophagus open (advanced disease or fistulas)
- ▶ can become dislodged or migrate
- ▶ interrupts function of LES, watch closed, SM feedings, don't lie flat

Chemotherapy

Gastric Cancer

- ▶ An abnormal malignant growth in the stomach
- ▶ Risk factors include:
 - diet high in foods containing nitrates
 - diet low in fresh, green leafy vegetables, fresh fruit
 - smoking and alcohol
 - history of gastric ulcers
- ▶ The goal of treatment is to remove the tumor and provide a nutritional program
- ▶ Complications include
 - hemorrhage, obstruction, metastasis, and dumping syndrome





Gastric Cancer

<http://www.gastrolab.net/welcomee.htm>

Gastric Cancer as Seen through an Endoscope.



Gastric Cancer

► Clinical Manifestations

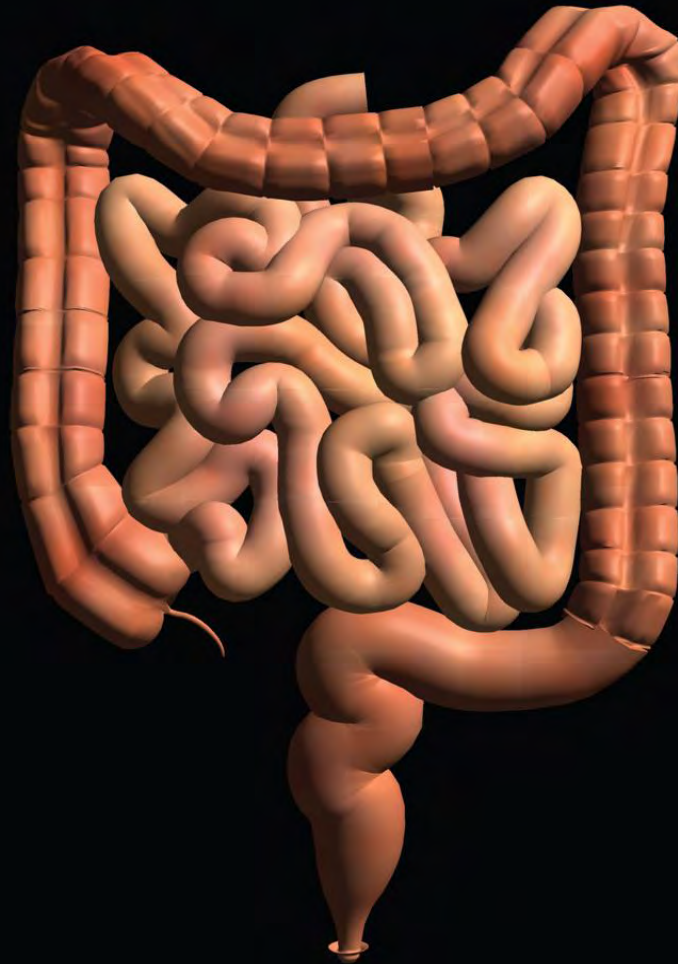
- Anorexia
- Nausea and vomiting
- Indigestion and epigastric discomfort
- A sensation of pressure
- Dysphagia
- Weight loss
- Palpable mass
- Fatigue
- Anemia
- Ascites
- Treatment: Surgery

► Post-op Interventions

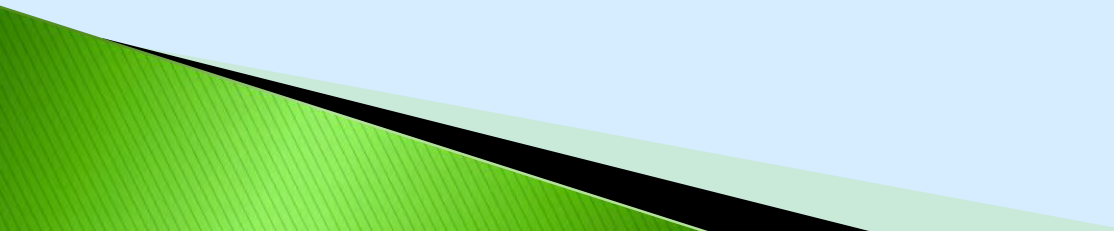
- Monitor vital signs
- Position in Fowler's for comfort and to promote drainage
- Monitor I&O
- Monitor fluids and electrolyte replacements IV
- Monitor bowel sounds
- Monitor nasogastric suction
- Do not irrigate or remove the NG tube
- Maintain NPO status for 1 to 3 days until peristalsis returns

Colorectal Cancer

- ▶ 3rd most common cancer overall
- ▶ 3rd highest cause of death
- ▶ Equal among men & women, increases over age 50
- ▶ Caught early - high 5 yr survival rate
- ▶ Risk factors- age, polyps, family history and/or history of inflammatory bowel conditions, radiation exposure, high animal fat diet



A Word About Polyps

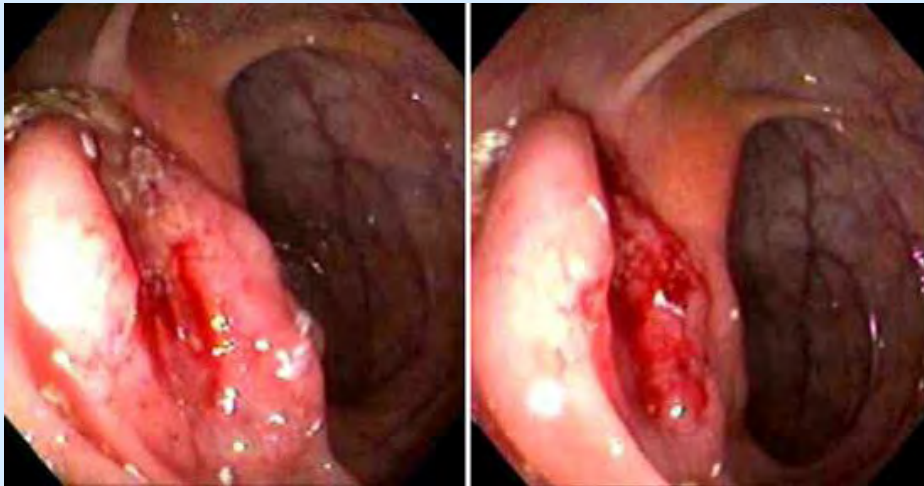
- ▶ A mass of tissue arising from wall of colon and protruding into lumen
 - ▶ 30% of people over 50 have polyps
 - ▶ Single or multiple, more in sigmoid colon & rectum, From proliferation of epithelial cells with or w/o dysplasia
 - ▶ 1 to 5 cm in size
 - ▶ Precancerous, may develop into adenocarcinomas
 - ▶ Found and removed during colonoscopy (monitor for bleeding/perforation)
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Colorectal Cancer

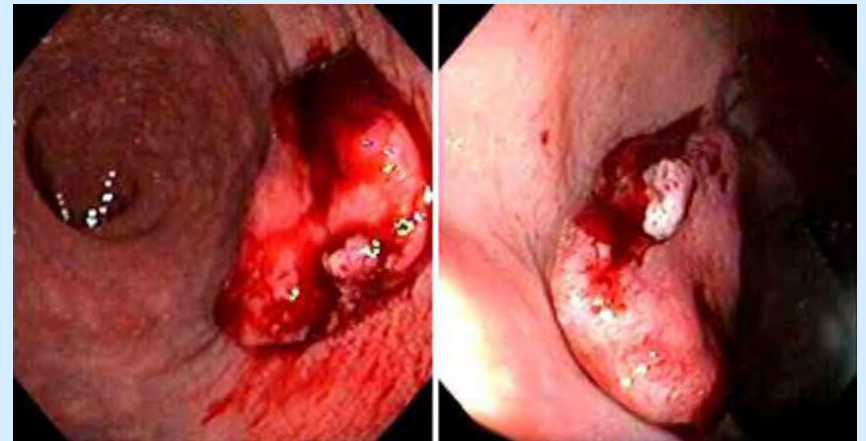
- ▶ Most develop from polyps and grow slowly
 - over 5-15 yrs
- ▶ Most develop in sigmoid colon and rectum
- ▶ Spread by direct extension into adjacent tissue
- ▶ May also metastasize via blood/lymph
- ▶ Early manifestations- anorexia, change in bowel habits, change in stool caliber, bleeding (frank or occult), pain, palpable rectal mass
- ▶ Complications- bowel obstruction, bowel perforation (peritonitis), invasion of adjacent organs

Colorectal Cancer - Screening

- ▶ Fecal Occult Blood Testing (FOBT)
- ▶ Sigmoidoscopy every five years
- ▶ Colonoscopy (gold standard) every ten years
- ▶ Polypectomy/biopsy
- ▶ Screen over age 50, and over 35-40 with family history
- ▶ Re-screen every 10years if no polyps, or every 3-5 yrs if polyps
- ▶ Diagnosis-
 - CEA tumor antigen
 - CT or MRI to look for metastasis
- ▶ Staging done through TNM system



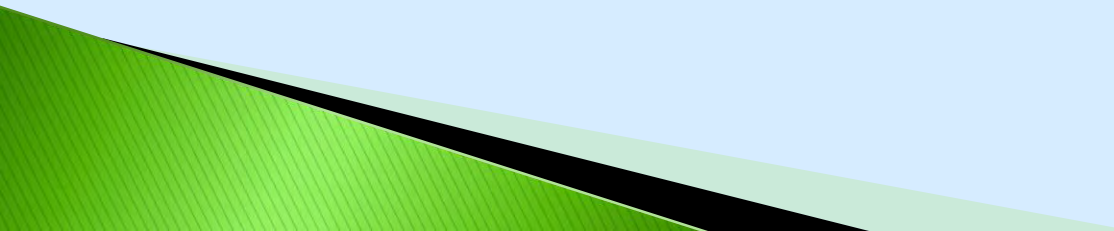
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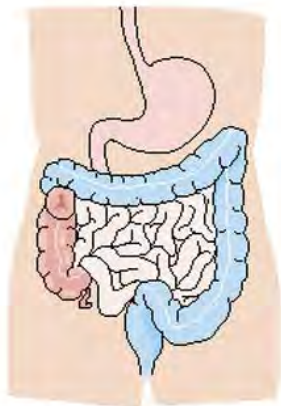


Colorectal Cancer - Treatment

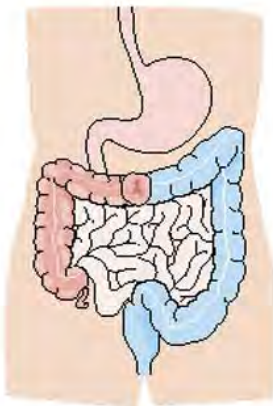
- ▶ Surgery – remove or debulk tumor
- ▶ Surgery yields a temporary or permanent colostomy
- ▶ Radiation/Chemo as follow-up to surgery

Preop Colostomy/Ileostomy

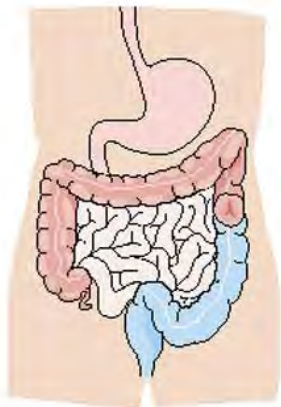
- ▶ Consult with an enterostomal therapist to assist in identifying optimal placement of the ostomy
 - ▶ Instruct the client to eat a low-residue diet for a day or two prior to surgery
 - ▶ Administer intestinal antiseptics and antibiotics to decrease bacterial content of the colon and to soften and decrease the bulk of the contents of the colon
 - ▶ Administer laxatives and enemas
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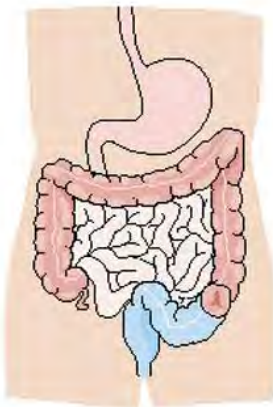
Ascending colostomy



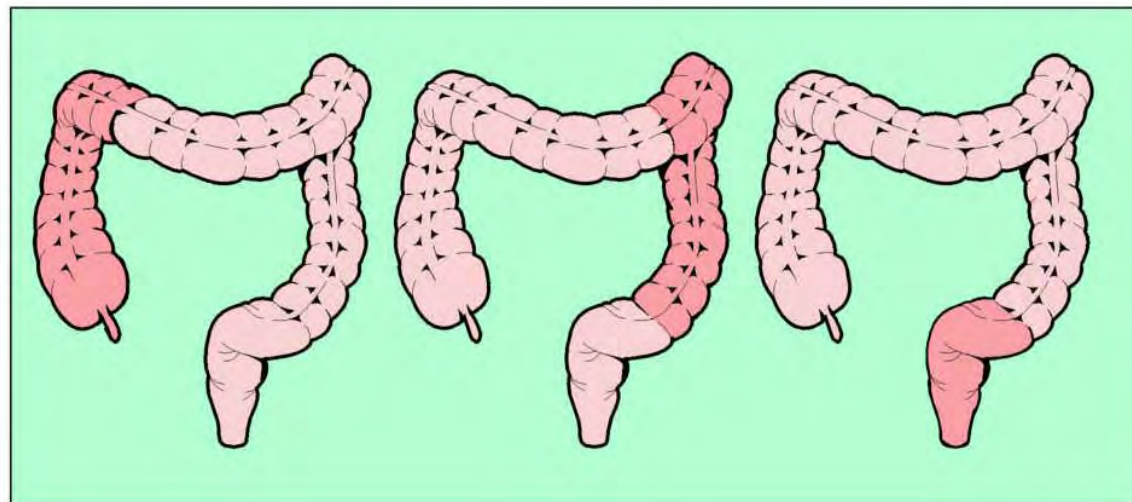
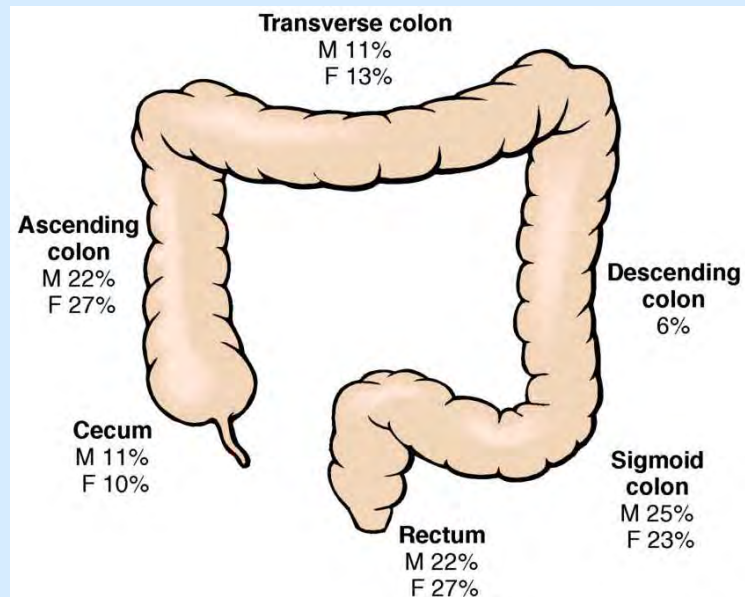
Transverse colostomy



Descending colostomy



Sigmoid colostomy



Postop Colostomy

- ▶ Assess the functioning of the colostomy
- ▶ Expect that stool is liquid immediate postoperative but becomes more solid depending on the area of the colostomy
 - ascending colon—liquid stool
 - transverse colon—loose to semiformed
 - descending colon—close to normal
- ▶ Monitor the pouch system for proper fit and signs of leakage
- ▶ Empty pouch when one-third full
- ▶ Fecal matter should not be allowed to remain on the skin



Treatment

► *Goals*

- *Pain management*
 - Rest the bowel: NGT to low intermittent suction
 - Control inflammation & prevent infection
 - Prevent respiratory complications
 - Monitor surgical site and drains
 - Fluid & electrolyte replacement
 - Nutritional management
 - Nutritional therapy: a goal of adequate nutrition
 - Increase activity
- ## ► Colostomy/ileostomy care

Liver Cancer

- ▶ Primary liver CA rare in U.S.
- ▶ But more common in Africa/Asia where hepatitis is more common
 - Most hepatocellular carcinoma
- ▶ Risk- presence of Hep B or Hep C Infection, alcoholic cirrhosis, carcinogenic agents, androgenic hormones
- ▶ Clinical Manifestations
 - anorexia, weight loss, fever, malaise, jaundice, bloating/fullness, palpable RUQ mass, pain, altered Liver Function Tests (LFTs)
- ▶ Treatment: possible resection
 - radiation/chemotherapy
 - transplant possible
- ▶ Most die within 6 months
- ▶ Secondary liver cancer
 - metastasis from primary site in lungs, breast, other GI

Gallbladder Cancer

- ▶ Rare, women & over age 65
 - 95% die within 1 yr
- ▶ Clinical Manifestations:
 - weight loss, jaundice, pain, mass to RUQ

Pancreatic Cancer

- ▶ Rare but deadly
- ▶ More women, more African-Americans, more over age 50
- ▶ Risk factors- pancreatitis, diabetes, high fat diet, smoking, obesity, exposure to chemicals/toxins
- ▶ Over 30 thousand deaths/year
- ▶ Usually: adenocarcinoma
- ▶ Clinical Manifestations
 - anorexia, weight loss, nausea, flatulence, dull pain, may obstruct bile flow
- ▶ Treatment
 - surgery, chemo, radiation
- ▶ 98% die in 1-3 years of diagnosis