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## Upper gastrointestinal cancer misses: could we do better?

### Introduction

In the UK approximately 8,500 cases of upper gastrointestinal (GI) cancers are diagnosed annually. Many studies have indicated that survival is related closely to time and stage of diagnosis. This has prompted a move by the UK Department of Health towards encouraging innovations that promote early diagnosis such as the Be Clear on Cancer campaign.[1–3] Endoscopy remains the gold-standard investigation for the diagnosis of gastro–oesophageal cancer. Unlike colonoscopy, where there are standardised key performance indicators and audits of all colonoscopists' practice, no parallel standards are currently in use in upper GI endoscopy.

The incidence of oesophageal malignancy is increasing and survival is poor. Upper GI cancer miss rates are reported to be approximately 5–13%.[1,4] It is accepted that a cancer detected within three years following an endoscopy is considered to be a 'potential miss' and if detected within one year after an endoscopy is likely to be a 'definite miss'.[4,5] In view of public health campaigns to detect cancer at an earlier stage we sought to review missed cancers in our trust over a four-year period.

### Method

We conducted a retrospective, case study of patients diagnosed with oesophageal and gastric cancers between January 2011 and January 2015. Data were extracted from the cancer registry at Barnet and Chase Farm Hospital, a two-site district hospital that serves a population of approximately 500,000 patients. Information regarding any gastroscopies done within 3–36 months of cancer diagnosis was obtained for each patient using our electronic endoscopy reporting tool.

### Results

In total there were 305 new cases (male, 207 (68%); mean age, 73.8 years; range, 26–100 years) of upper GI cancer, of whom 23 (7.5%) had undergone a gastroscopy within 3–36 months of the diagnosis. Only 2 patients had undergone an endoscopy procedure in the 3–12 months prior to diagnosis. Alarm symptoms were present in 11 patients (48%; information available in 20 patients) at the time of the index 'miss' endoscopy.

Oesophago–gastric cancers appear to have been missed at endoscopy in 7.5% of patients in our unit. This value parallels outcomes reported elsewhere.[4,5]

### Discussion

Given the poor prognosis associated with upper GI malignancy, this study reminds us to be vigilant when examining the mucosa, particularly at the cardia, which is most vulnerable with regard to missing a cancer. The endoscopist and referring clinician should also have a low threshold for suspicion in patients presenting with alarm symptoms. Although there are many established performance indicators for colonoscopy, endoscopists are less familiar with gastroscopy measures of quality, which are currently being addressed by the British Society of Gastroenterologists. We believe that addressing gastroscopy technique will have an impact on early detection of upper GI cancers and improve outcomes for these patients. An audit such as this also serves as a reminder to referring clinicians that alarm symptoms may warrant further evaluation even if the endoscopy is reported as normal. ■


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## Venous thromboembolism: a role for weight-stratified thromboprophylaxis?

Venous thromboembolism (VTE) encompasses a range of presentations from asymptomatic deep vein thrombosis to fatal pulmonary emboli. These common clinical problems are associated with significant morbidity, mortality and resource expenditure.[1] Routine use of thromboprophylaxis, when administered to appropriately assessed patients, reduces adverse patient outcomes and decreases overall healthcare costs, with