Stomach and oesophageal cancer

First published June 1995
This edition June 2011
This booklet is available online – visit www.cancervic.org.au

Acknowledgments
Cancer Council Victoria thanks everyone who contributed to the development and revision of this booklet including our clinical reviewers:

Mr Marty Smith, Upper Gastrointestinal and Hepatobiliary Surgeon, Victorian HPB Surgery Group (Cabrini Hospital)

Kellie Wright, Accredited Practising Dietitian, Austin Health

Illustration on page 7 by Con Stamatis.

Interpreting service: Deaf or hearing or speech impaired
If you use text-based communication, call the Cancer Council Helpline (13 11 20) through the National Relay Service (NRS) 13 3677. If you can hear and still use your voice, but have a speech impairment, call the Cancer Council Helpline through NRS 1300 555 727.

Generous Victorians who fundraise to fight cancer make many Cancer Council services, including the publication of this booklet, possible. For information on how you can help, visit www.cancervic.org.au or call 1300 65 65 85.
Introduction

This booklet is about stomach cancer (also known as gastric cancer) and oesophageal cancer (cancer of the oesophagus, also known as the gullet).

Many people feel shocked and upset when they are told that they have or may have cancer of the stomach or oesophagus. This booklet aims to help you understand how these cancers are diagnosed and treated. We also tell you about support services you may like to use.

We cannot tell you what is the best treatment for you. You need to discuss this with your doctors. However, we hope this information will answer some of your questions and help you think about the questions you want to ask your doctors.

You may like to pass this booklet on to your family and friends.

This booklet does not need to be read from cover to cover, but can be read in sections according to your needs or interest. The words in bold are explained in the glossary at the back of this booklet.

Are you reading this for someone who does not understand English? Tell them about the Multilingual Cancer Information Line. See the back cover for details.
# Contents

What is cancer? 4

## The oesophagus and stomach 6
- Stomach cancer 6
- Oesophageal cancer 8
- Causes of stomach and oesophageal cancer 8
- How common is stomach and oesophageal cancer? 9

## Diagnosis 10
- Doctors and other health professionals you may see 11
- How stomach and oesophageal cancer is diagnosed 12
- ‘Staging’ the disease 16

## Treatment 18
- Surgery 19
- Radiotherapy 21
- Chemotherapy 22
- Complementary and alternative medicines 23
- When cancer can’t be cured 24
- Prognosis 25

## Making decisions about treatment 27
- Talking with doctors 27
- Talking with others 28
- Getting a second opinion 28
- Taking part in a clinical trial 29
- Research into stomach and oesophageal cancer 30
### Seeking support

- Practical and financial help 31
- Wigs 32
- Diet 32
- Exercise 33
- Relaxing 33
- Sexuality and cancer 34
- Cancer Council Helpline 34
- Multilingual Cancer Information Line 35
- Talk to someone who has been there 35
- Living with Cancer Education Program 36

### Caring for someone with cancer

37

### Questions to ask your doctors

39

### Glossary: what does that word mean?

41

### Index

45
What is cancer?

Cancer is a disease of the body’s cells. Our bodies are always making new cells: so we can grow, to replace worn-out cells, or to heal damaged cells after an injury. This process is controlled by certain genes. All cancers are caused by changes to these genes. Changes usually happen during our lifetime, although a small number of people inherit such a change from a parent.

Normally, cells grow and multiply in an orderly way. However, changed genes can cause cells to behave abnormally. They may grow into a lump. These lumps can be benign (not cancerous) or malignant (cancerous).

Benign lumps do not spread to other parts of the body.

A malignant lump (more commonly called a malignant tumour) is made up of cancer cells. When it first develops, this malignant tumour may be confined to its original site. If these cells are not treated they may spread into surrounding tissue and to other parts of the body.

The beginnings of cancer
For people with stomach and oesophageal cancer, their families and friends

When these cells reach a new site they may continue to grow and form another tumour at that site. This is called a secondary cancer or metastasis.

For a cancer to grow bigger than the head of a pin, it must grow its own blood vessels. This is called angiogenesis.
The oesophagus and stomach are parts of the digestive system.

The oesophagus is a hollow tube that takes food and fluids from the mouth to the stomach. When you swallow, the muscular walls of the oesophagus push food down to the stomach.

The stomach is a hollow, muscular organ between the end of the oesophagus and the beginning of the small bowel. It sits in the upper left part of the abdomen. The stomach’s role is to store food that has been swallowed, begin breaking down food, and pass the food into the small bowel.

Muscles in the stomach mash food. Gastric juices are released from glands in the mucosa, the innermost layer of the stomach. These juices turn the food into a thick fluid. The thick fluid passes into the bowel, where digestion continues. Nutrients begin to be absorbed from the broken-down food, through the walls of the small bowel, into the bloodstream.

**Stomach cancer**

Most stomach cancers develop in cells that line the mucosa. These are called adenocarcinoma of the stomach.

Other types of stomach cancer are:

- lymphoma: cancer of lymphatic tissue
- gastric stromal tumours: cancer of muscle or connective tissue
- carcinoid tumours: cancer of hormone-producing cells.

These less common cancers are not discussed in this booklet.
The digestive system

Note: Organs are spaced wider apart in this diagram than they actually are.

- Mouth
- Throat (pharynx)
- Oesophagus
- Diaphragm
- Liver
- Gall bladder
- Stomach
- Spleen
- Pancreas
- Colon
- Rectum
- Small bowel
- Anus
Stomach cancer can grow through the wall of the stomach and into nearby organs, such as the liver, pancreas or colon. It can also spread via the lymphatic system into local lymph nodes. If the cancer cells get into the bloodstream, the cancer can spread to other parts of the body, such as the liver, lungs and bones. Cells can also leak into the space around the bowel and other organs in the abdomen. This may cause swelling in the abdomen.

Stomach cancer grows slowly. It may grow for many years before any symptoms are felt.

**Oesophageal cancer**

There are two main types of oesophageal cancer: squamous cell carcinoma, which begins in squamous cells that line the middle and upper part of the oesophagus, and adenocarcinoma, which begins in glandular tissue in the lower part of the oesophagus.

Oesophageal cancer can spread to nearby lymph nodes and then to other parts of the body if it is not found and treated early.

**Causes of stomach and oesophageal cancer**

It is not known what causes stomach and oesophageal cancer.

Some risk factors make it more likely that a person will develop stomach or oesophageal cancer. These risk factors include:

- smoking
- age over 50
- being male: both cancers are more common in men than in women.

Additional risk factors for stomach cancer include:

- infection with *Helicobacter pylori*
- a diet high in smoked, pickled and salted foods and low in fresh fruit and vegetables
For people with stomach and oesophageal cancer, their families and friends

- a family history of stomach cancer
- partial gastrectomy for ulcer disease (after about 20 years)
- inheriting a genetic change that causes the bowel disorders **FAP** or **HNPCC**.

Additional risk factors for oesophageal cancer include:
- alcohol
- obesity (**adenocarcinoma** of the oesophagus is related to being overweight or obese)
- long-term gastro–oesophageal reflux disease (GORD)
- frequent drinking of very hot liquids
- a diet low in fresh fruit and vegetables
- occupational exposure to solvents used for dry-cleaning, and some other chemical fumes
- coeliac disease (intolerance to gluten in food)
- a history of Barrett oesophagus. This is a condition where some of the lining of the oesophagus changes, usually due to long-term **reflux** of stomach contents into the oesophagus with accompanying heartburn.

Having one or more of these risk factors does not mean that you will develop stomach or oesophageal cancer. However, these factors are often seen in people who have these cancers.

**How common is stomach and oesophageal cancer?**

About 550 Victorians develop stomach cancer each year and 350 people develop oesophageal cancer. These cancers are more common in people over the age of 50, but can sometimes occur in younger people.
Diagnosis

In their early stages, these cancers often do not cause any symptoms. This means that they are usually not diagnosed until the cancer is more advanced.

Symptoms of stomach cancer are like those of many other conditions. Signs of early stomach cancer include a painful or burning sensation in the abdomen, heartburn or indigestion. If someone who is aged over 45 develops these symptoms, and they do not go away, they may need to be examined for stomach cancer.

Other symptoms can occur later, including:
- a sense of fullness, even after a small meal
- nausea and/or vomiting
- loss of appetite and/or weight loss
- swelling of the abdomen
- unexplained tiredness or weakness
- blood in vomit
- black-coloured faeces.

Symptoms of oesophageal cancer include:
- difficult or painful swallowing
- weight loss
- vomiting/coughing up blood
- regurgitation of saliva or food.

If you have not been diagnosed with cancer and are just looking through this booklet, please be aware that many of these symptoms occur without any serious disease being present. However, if you have any of the symptoms for more than two weeks, see your doctor for a check-up.
Doctors and other health professionals you may see

Your doctor will examine you and refer you for tests to see if you have cancer. This can be a worrying and tiring time, especially if you need to have several tests. If the tests show you have or may have cancer, your doctor will refer you to a specialist, who will examine you and may ask you to have some more tests. If you have cancer, one or more specialists will advise you about treatment options.

You should expect to be cared for by a team of health professionals from the relevant major fields listed below. Ideally, your tests and treatments should be available at your hospital; however, this may not be possible. Specialists and other health professionals who care for people with stomach and oesophageal cancer include:

<table>
<thead>
<tr>
<th>Gastroenterologists and gastrointestinal surgeons</th>
<th>diagnose and treat people with diseases of the digestive system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical oncologists</td>
<td>specialise in chemotherapy</td>
</tr>
<tr>
<td>Radiation oncologists</td>
<td>specialise in radiotherapy (also known as radiation therapy)</td>
</tr>
<tr>
<td>Nurses and general practitioners</td>
<td>will help you through all stages of your cancer</td>
</tr>
<tr>
<td>Dietitians</td>
<td>will recommend the best diets to follow during and after treatment</td>
</tr>
<tr>
<td>Social workers, psychologists, counsellors, physiotherapists and occupational therapists</td>
<td>will advise you on support services and help you to get back to normal activities</td>
</tr>
<tr>
<td>Palliative care physicians</td>
<td>will help with the relief of symptoms</td>
</tr>
</tbody>
</table>
How stomach and oesophageal cancer is diagnosed

The common tests for these cancers are described in this section. You may not have all of the tests. When the tests are done, your doctor or doctors will tell you what they have learned and suggest the best treatment for you.

Before referring you for tests, your doctor will take a full medical history and examine you. You may also have a blood test and chest x-ray to check your general health.

Endoscopy/gastroscopy

In this test, a thin, flexible ‘telescope’ (called an endoscope) will be passed down your throat so that the doctor can examine your oesophagus, stomach and the upper part of your bowel.

If anything unusual is seen, the doctor can put instruments down the endoscope and remove tissue to examine under a microscope – this is called a biopsy.

You will have a sedative and a local anaesthetic to make you as comfortable as possible during the test. (Some people need to have a general anaesthetic.) You may even fall asleep. You will be asked not to eat or drink anything for a period of time before the test. Following the test, because of the sedative, you should not drive a car or operate machinery until the next day.

This test has some risks, including bleeding and a very small risk of perforation (where a hole is accidentally made in the stomach or oesophagus). A small number of people are affected (less than 0.1%). Your doctor should explain all the risks before you consent to having the procedure.
Barium swallow/upper gastrointestinal x-ray

This test is less commonly done now that endoscopy is available.

If you have this test you will drink a thick, chalky liquid called barium. This will coat the lining of your oesophagus, stomach and the first part of your bowel. You will lie down on a table and a radiologist will take x-ray pictures of your chest and abdomen. X-rays can’t pass through the coating of barium, so anything unusual will be seen.

To look for stomach cancer, you may be asked to swallow a thin tube, through which air can be pumped into your stomach. This makes the barium coating very thin, so even small abnormalities will show up. (The tube will be taken out of your throat afterwards.)

You may be slightly uncomfortable as the table is tipped in different ways to help the barium flow through your whole stomach. The test takes about an hour. You will be asked not to eat or drink for several hours beforehand.

Endoscopic ultrasound

This is similar to having an endoscopy. It may be used for people who may have oesophageal cancer and sometimes for people who may have stomach cancer. For this test, the endoscope has a small ultrasound probe on the end. The probe releases high-frequency sound waves and then detects the sound wave echoes that bounce off tissue of the oesophageal or stomach wall. A computer translates the pattern of echoes into a picture.

This test may show whether cancer has spread into the wall of the stomach or oesophagus, nearby tissue and to nearby lymph nodes.
Further tests

If you are diagnosed with stomach or oesophageal cancer, you may have some more tests to find out if the cancer has spread. These tests will help your doctor or doctors advise the best treatment for your cancer.

Computerised tomography (CT) scan

A CT scan is a type of x-ray that takes pictures of your organs and other structures, including tumours. These are put together to build up a three-dimensional picture of your body. A CT scan is used to see if cancer has spread into the lymph nodes, liver, abdomen cavity or other parts of the body.

CT scans are usually done at a hospital or a radiology clinic. It usually takes 30 to 40 minutes to complete this painless test.

You may be asked not to eat or drink before the scan. You will have a liquid dye (contrast) before the scan, in a drink and in an injection. This dye makes your organs appear white on the scans, so anything unusual will show more clearly. You will be asked to lie on a table that slowly moves through the CT scanner, which is large and round like a doughnut. Most people can go home as soon as their scan is over.

There is a small chance of the injected dye causing an allergic reaction. You should tell your doctor if you are allergic to iodine or to contrast dyes, or if you are diabetic or have abnormal kidney function.

Ultrasound scan

In this test, sound waves are used to create a picture of your internal organs, including your liver, to see if cancer has spread.

You will uncover your abdomen and lie on a table. Once you are comfortable, a gel will be spread on the skin over the area being scanned.
A small device called a ‘transducer’ will be moved across your abdomen. It makes sound waves and receives echoes. A computer makes a picture of the echoes produced when the sound waves meet something dense, like an organ or a tumour.

An ultrasound scan is mainly used to see if cancer has spread to the liver. This test is painless and takes 15 to 20 minutes.

**Positron emission tomography (PET) scan**
This is a test that helps find out how far a tumour has advanced and whether it has spread to other parts of the body. It is often combined with a CT scan.

You will be asked not to eat or drink anything before the PET scan.

A small amount of radioactive material will be injected into a vein in your arm one hour before the scan. You will then be asked to lie or sit in a darkened room until the scan. For the scan, you will lie on a table and be moved through a large, ring-shaped scanner. The tube may make some people feel claustrophobic. If you think you are likely to feel this way, please tell the treatment centre before your scan.

Only a few centres in Victoria offer this test, so you may have to travel to have this done.

**Laparoscopy**
This test is for people diagnosed with stomach cancer, and sometimes for people with oesophageal cancer.

You will be admitted to hospital and will have a general anaesthetic. Through small cuts in your abdomen, the doctor will use a tube to put gas into your abdomen, then put in a thin ‘telescope’ called a laparoscope. Through this, the doctor can look for small amounts of cancer that may have spread into the liver or the lining of the abdomen.
A biopsy can be taken of any unusual tissue. This may be done as a separate procedure, or as a first step before major surgery.

**Bronchoscopy**

This test is similar to endoscopy. A thin, lighted tube called a bronchoscope will be put into your mouth or nose and passed down your windpipe to look into the breathing passages.

You may have this test if there is concern that the oesophageal cancer has spread close to or involved the windpipe.

**Bone scan**

If the doctor suspects that your cancer has spread, they may order a bone scan. This can show whether cancer has spread to the bones.

A small amount of a radioactive substance will be injected into a vein. This travels through the body and collects in bone, especially if there is unusual growth. A scanner will then measure the radioactivity in these areas.

**‘Staging’ the disease**

The tests described on previous pages show whether you have cancer and some can also show whether it has spread. The cancer may have spread into blood vessels or lymph nodes near the stomach or oesophagus or into organs further away, like the liver. This is called metastasis. Knowing if and how far the cancer has spread is called ‘staging’ the disease. Staging helps your doctors to work out the best treatment for you.

‘Staging’ is a way of describing whether a cancer has spread, and if so, how far. Stage 1 means it has not spread; Stage 4 means it has spread to distant organs such as the liver or lungs.
The staging system used for stomach and oesophageal cancer is known as the ‘TNM system’ (T = tumour, N = lymph nodes, M = metastases).

<table>
<thead>
<tr>
<th>TNM system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>T</strong></td>
</tr>
<tr>
<td>T followed by a number between 1 and 4 shows how far the tumour has spread through the wall of the stomach or oesophagus. T1 shows the tumour is only in the mucosa on the inside of the stomach or oesophagus. A higher number after the T (for example, T3 or T4) means it has spread further, for example, to the outer layers of the stomach or deeper into the lining of the oesophagus, or to nearby organs.</td>
</tr>
<tr>
<td><strong>N</strong></td>
</tr>
<tr>
<td>N followed by 0 means that there is no spread to lymph nodes near the tumour. N followed by 1 means there is spread to nearby lymph nodes. The small letters after 1 (e.g. 1a, 1b, 1c) refer to how many of the lymph nodes are involved.</td>
</tr>
<tr>
<td><strong>M</strong></td>
</tr>
<tr>
<td>M followed by 0 means there is no distant metastasis; M1 means there is distant metastasis. Distant metastasis means that there is evidence the cancer has spread away from the area in and around the stomach or oesophagus, for example, to the liver or other organs.</td>
</tr>
</tbody>
</table>

Doctors combine this information to determine the stage of the cancer, from Stage 1 to Stage 4. For example, a stomach cancer staged as T3, N1, M0 (tumour spread through the stomach wall, some lymph nodes affected, no metastasis) is a Stage 3 stomach cancer.

Ask your doctor to explain the stage of your cancer in a way you can understand. This will help you to choose the best treatment for your situation.
Many years of treating cancer patients and testing different treatments in clinical trials has helped doctors know what is likely to work for a particular type and stage of cancer. Your doctor will advise you on the best treatment for your cancer. This will depend on the type of cancer you have, where it is and how far it has spread, your general health, and what you want.

The main treatment for stomach and oesophageal cancer is surgery; however chemotherapy and radiotherapy may also be used. You may have just one of these treatments, or a combination.

If the tests showed no evidence of the cancer having spread, and you are fit for major surgery, your doctor will discuss the benefit of surgery with you. You may also be offered chemotherapy, radiotherapy or the combination of chemotherapy and radiotherapy before or after the surgery.

If the cancer has spread and surgery to remove all the cancer is not possible, your doctor will arrange treatment for symptoms (palliative treatment) and discuss options such as surgery, chemotherapy and/or radiotherapy.

Before any treatment begins, make sure that you have discussed it with your doctor so that you know what to expect. You may find it useful to have your partner or a friend with you when you talk with the doctor. You may also find it helpful to make a list of questions before your visit: nurses on the Cancer Council Helpline (13 11 20) can help you prepare questions to take to your doctor or you could also use the questions listed at the back of this booklet.
People having treatment for oesophageal cancer may be advised to visit a dentist for an examination before treatment, because cancer treatment can increase the risk of mouth infection.

**Surgery**

If the extra tests have shown no evidence of cancer spread, and you are well enough, your doctor will discuss surgery with you.

**Stomach cancer**

The operation for stomach cancer is called gastrectomy. In a partial gastrectomy, the doctor removes part of the **stomach**. In a total gastrectomy, the doctor removes all of the stomach. **Lymph nodes** near the stomach and other **tissue** are also likely to be removed.

If you have a partial gastrectomy, the doctor will connect the part of your stomach that remains to your **small bowel**. If you have a total gastrectomy, your **oesophagus** will be connected to your small bowel.

The operation is generally done through a cut (incision) from the bottom of the breastbone to the belly button (navel). Sometimes a cut on the side of the chest is also used.

Sometimes before surgery for stomach cancer, chemotherapy – or chemotherapy and radiotherapy – is used to try to shrink the cancer.

Gastrectomy for stomach cancer is major surgery. If you are able to have surgery, it is possible that gastrectomy could cure your cancer. You also need to be aware of its risks. Ask your surgeon to explain the risks before you have the operation.

**Oesophageal cancer**

This operation (oesophagectomy) removes the cancer and nearby **lymph nodes** and **tissue**. The remaining, healthy part of the **oesophagus** is
connected to the stomach so that you are able to continue swallowing and eating relatively normally.

Depending on where the cancer is, cuts will be made to your abdomen and chest, to your abdomen and neck, or to your abdomen, chest and neck, to take out the affected part of the oesophagus. In this operation, your stomach will probably be raised into your chest. Your oesophagus may be joined to the bowel if it cannot be joined to the stomach.

It sometimes happens that the surgeon finds, during the operation, that the cancer cannot safely be removed. Various procedures can be tried, including stretching the oesophagus and shrinking the tumour, to help your swallowing return to normal.

Surgery for oesophageal cancer is sometimes done after radiotherapy or chemotherapy have been used to shrink the cancer.

This is major surgery and it will take time to recover.

People with smaller cancers that have not spread outside the oesophagus, and who have good general health, have a greater chance of cure.

**After the operation**

You will have some pain and discomfort for several days after the operation. You will have pain-relieving drugs to deal with this.

An intravenous drip will be used to replace your body’s fluids until you are able to drink and eat again a few days after the operation. You may have a feeding tube put through your abdomen and into your upper bowel during the surgery, so you can have adequate nutrition. When you start eating, you will have liquids, then soft foods, then solid foods. You will probably be ready to go home seven to 12 days after the operation.

When they first start eating, people who have had a partial or total gastrectomy find they feel full with a small amount of food. This improves
with time as the ‘new’ stomach gradually enlarges. You will need to eat frequent small meals after leaving hospital. A dietitian can help you with changes to your diet, if needed.

In some people, the operation can cause bile from the small bowel to reflux back up into the remaining part of your stomach or oesophagus. This causes the feeling of having an upset stomach. There are drugs that can help.

People who have a total gastrectomy cannot absorb vitamin B12. You will need to have regular injections of vitamin B12, and may need to take iron supplements as well.

People who are treated for oesophageal cancer will be taught breathing and coughing methods to help keep their airway clear. A dietitian will also discuss changes to your diet, such as needing to eat smaller meals.

**Radiotherapy**

Radiotherapy treats cancer by using radiation to destroy cancer cells. Radiation can be targeted to cancer sites in your body. Treatment is carefully planned to do as little harm as possible to your normal body tissues.

For treatment aimed at curing the stomach or oesophageal cancer, radiotherapy is often combined with chemotherapy. It can be given before surgery to make the cancer smaller and to increase the chances of cure. Alternatively, it can be given after surgery to reduce the chances of the cancer coming back. The radiotherapy is given daily for about five weeks, and this only takes a few minutes a day.

For palliative treatment, radiotherapy can help to relieve symptoms, particularly pain. Radiotherapy can help to relieve pain and make swallowing easier if an oesophageal cancer cannot be removed.

This treatment usually only takes one to two weeks for a few minutes a day.
Side effects of radiotherapy

Side effects of radiotherapy may include tiredness, reddening of the skin, feeling sick (nausea), vomiting, diarrhoea, and sometimes painful swallowing. Talk with your doctor or the radiotherapy staff about any possible side effects and how to manage them.

You will not be radioactive after your treatment.

For a copy of the Cancer Council’s booklet Coping with radiotherapy, visit www.cancervic.org.au or phone 13 11 20.

Chemotherapy

This is the treatment of cancer by anti-cancer drugs. The aim is to destroy cancer cells while doing the least possible damage to normal cells. The drugs work by stopping cancer cells from growing and reproducing.

If your cancer is found at an early stage, you may have chemotherapy, radiotherapy, or both as additional treatments to surgery. This is called adjuvant therapy. It can be used before an operation, to try to shrink the tumour and to destroy any cancer cells that may have spread away from where the cancer began. Adjuvant chemotherapy after an operation aims to destroy cancer cells that might remain in the body but cannot be detected. This treatment can reduce the chance of the cancer coming back (recurring).

You will probably have the chemotherapy by injection into a vein in your arm. This is called intravenous treatment. You will probably have a combination of drugs over a few days, followed by a rest period of two to three weeks. Or you may have continuous treatment, where you have the chemotherapy through a pump.
You can usually have chemotherapy as an outpatient. You should discuss with your doctor which drugs you are having and how long your treatment will last.

**Side effects of chemotherapy**

Some drugs used in chemotherapy can cause side effects. They may include feeling sick (nausea), vomiting, feeling unwell and tired, and some thinning or loss of hair from your body and head. Generally, these side effects are short term, and steps can be taken to prevent or reduce them.

The doctor who prescribes the chemotherapy (medical oncologist) will discuss these and other side effects and risks with you.

For a copy of the Cancer Council’s booklet *Coping with chemotherapy*, visit www.cancervic.org.au or phone 13 11 20.

**Complementary and alternative medicines**

It’s common for people with cancer to seek out complementary and alternative treatments. Many people feel that it gives them a greater sense of control over their illness, that it’s ‘natural’ and low-risk, or that they just want to try everything that seems promising.

*Complementary therapies* include massage, meditation and other relaxation methods, which are used *along with* medical treatments. *Alternative therapies* are unproven remedies, including some herbal and dietary remedies, that are used *instead of* medical treatment. Some of these have been tested scientifically and found to be not effective or even harmful.

Some complementary therapies are useful in helping people to cope with the challenges of having cancer and cancer treatment. However, some alternative therapies are harmful, especially if:

- you use them instead of medical treatment
• you use herbs or other remedies that make your medical treatment less effective
• you spend a lot of time and money on alternative remedies that simply don’t work.

Be aware that a lot of unproven remedies are advertised on the Internet and elsewhere without any control or regulation. Before choosing an alternative remedy, discuss it with your doctor or a cancer nurse at the Cancer Council Helpline.

For more information we recommend you read the following:

• Complementary and alternative cancer therapies: for people with cancer, their family and friends (booklet)
• Complementary and alternative medicine: making informed decisions (fact sheet for people with cancer and their families).

You can find out about what scientific research has been done into specific herbs, supplements and other products on the Memorial Sloan-Kettering website (http://www.mskcc.org/). The US National Center for Complementary and Alternative Medicines (NCCAM) (http://nccam.nih.gov/) and Quackwatch (www.quackwatch.com) are also a reliable websites.

**When cancer can’t be cured**

If your cancer has spread and it is not possible to cure it by surgery, your doctor may still recommend treatment. In this case, treatment may help relieve any symptoms, can make you feel better and may allow you to live longer.

Whether or not you choose to have anti-cancer treatment, symptoms can still be controlled. For example, if you have pain, there are effective treatments for this.
If your cancer is blocking the flow of food through your **stomach**, you may be advised to have palliative surgery to remove or bypass the cancer. A common procedure is to join the **small bowel** from below the cancer to the stomach above the cancer. Sometimes a blockage can be cleared by putting a tube across the tight area to hold the path open (this is often called ‘**stenting**’ the blockage). This can be done using a gastroscope.

Stomach cancer is quite often **advanced** when it is discovered. In these cases, chemotherapy may be used to shrink the cancer and reduce the symptoms. Following this type of treatment, the doctor may recommend further treatment, possibly surgery or radiotherapy.

Radiotherapy can also be used to relieve pain caused by a stomach cancer, if the cancer cannot be removed by surgery.

**Palliative treatment** for oesophageal cancer also includes stenting.

General practitioners, specialists and palliative care teams in hospital all play important roles in palliative treatment for people with cancer. For further information, contact the Cancer Council Helpline on 13 11 20 or Palliative Care Victoria on 9662 9644.

For a copy of the Cancer Council’s booklet on advanced cancer for people with cancer and a booklet for carers of people with advanced cancer, visit www.cancervic.org.au or phone 13 11 20.

**Prognosis**

Treatment for stomach or oesophageal cancer is most effective if the cancer is found in its early stages; it can be cured if the cancer is removed before it spreads. However, because there are few symptoms in the early stages, and symptoms are similar to those of many other disorders, these cancers are often not discovered until they are more advanced.
If the cancer has advanced and it cannot be removed, **palliative treatment** is possible. This might include chemotherapy or radiotherapy, and can provide relief from symptoms and help people to live a normal life for as long as possible.

The question, ‘How long am I likely to live?’ is often raised by people who have stomach or oesophageal cancer. It is not possible for your doctor to give a precise length of time for you as an individual. However, they may be able to give an estimate based on the average length of time lived by people with a similar cancer to yours. It is important to remember that this is an average, and will not necessarily apply to you: some people survive for less than the average time and some survive much longer.

If you would like information about your own **prognosis**, you need to speak to a doctor who knows your full medical history.
Making decisions about treatment

Sometimes it is hard to decide which is the right treatment for you. You may feel that everything is happening so fast that you do not have time to think things through. Waiting for test results and for treatment to begin can be very difficult.

While some people feel they have too much information, others may feel that they do not have enough. You need to make sure that you know enough about your illness, the possible treatment and side effects to make your own decisions.

If you are offered a choice of treatments, you will need to weigh up the good and bad points about each treatment. If only one type of treatment is recommended, ask your doctor to explain why other treatment choices have not been advised.

Some people with advanced cancer will always choose treatment, even if it only offers a small chance of cure. Others want to make sure that the benefits of treatment outweigh any side effects. Still others will choose the treatment they think offers them the best quality of life. Some may choose not to have treatment except to have any symptoms managed to maintain the best possible quality of life.

Talking with doctors

You may want to see your doctor a few times before making a final decision on treatment. It is often hard to take everything in, and you may need to ask the same questions more than once. You always have the right to find out what a suggested treatment means for you, and the right to accept or refuse it.
Before you see the doctor, it may help to write down your questions. A cancer nurse from the Cancer Council Helpline (13 11 20) can assist you to prepare questions to take to your doctor. There is also a list at the end of this booklet which may help you. Taking notes during the session can be helpful. Many people like to have a family member or friend go with them, to take part in the discussion, take notes, or simply listen. Some people find it is helpful to tape record the discussion. Check with your doctor first.

Talking with others

Once you have talked about treatment options with your doctor, you may want to talk them over with family or friends, with nursing staff, the hospital social worker or chaplain, or your own religious or spiritual adviser. Talking it over can help to sort out which course of action is right for you. You may find it useful to call the Cancer Council Helpline (13 11 20) to help clarify things in your own mind.

You may be interested in looking for information about stomach or oesophageal cancer on the Internet. While there are some very good websites, you need to be aware that some websites provide wrong or biased information. We recommend that you begin with Cancer Council Victoria’s site (www.cancervic.org.au) and use our links to find other good cancer websites. For more, contact the Cancer Council Helpline on 13 11 20.

Getting a second opinion

Seeing another specialist and asking for their view on your cancer and its treatment options is know as getting a second opinion. Some people feel uncomfortable about asking for a second opinion but this is common practice. Most cancer doctors understand why patients may want to do this. People say gaining the opinion of another specialist helps them feel more in control of their cancer and its treatment.
Your specialist or local doctor can refer you to another specialist. You can ask for a copy of your results to be sent to the second-opinion doctor. You can still ask for a second opinion even if you have started treatment or still want to be treated by your first doctor.

“I think you need to trust your specialist. If you don’t, then get another one. But if you trust them, and work with them, you’ll come out as best as you possibly can. You don’t have to be friends: they may be quite abrupt, and may not want to sit at the end of your bed and have a chat. But it’s the trust that’s important.”

**Taking part in a clinical trial**

Cancer Council Victoria supports participation in clinical trials. They are the most accurate way to determine the effectiveness of promising new treatments or new ways of combining cancer treatments. Always discuss treatment options with your doctor.

If your doctor suggests taking part in a clinical trial, make sure that you fully understand the reasons for the trial and what it means for you. Before deciding whether or not to join the trial, you may wish to ask your doctor:

- What is the standard (best available) treatment for my cancer if I don’t go in the trial?
- Which treatments are being tested and why?
- Which tests are involved?
- What are the possible risks or side effects?
- How long will the trial last?
- Will I need to go into hospital for treatment?
- What will I do if any problems occur while I am in the trial?

If you decide to join a randomised clinical trial, you will be given either the best existing treatment or a promising new treatment. You will be allocated
at random to receive one treatment or the other. In clinical trials, people’s health and progress are carefully monitored.

If you do join a clinical trial, you have the right to withdraw at any time. Doing so will not affect your treatment for cancer.

It is always your decision to take part in a clinical trial. If you do not want to take part, your doctor will discuss the best current treatment choices with you.

The Victorian Cooperative Oncology Group and Clinical Trials Office have developed a clinical trials database to make it easier for people affected by cancer and health professionals to find suitable clinical trials. This database was funded by the Victorian Cancer Agency.


Research into stomach and oesophageal cancer

Research into all aspects of stomach and oesophageal cancer is occurring in Australia and around the world. The information from research studies is made available to doctors through medical journals and meetings of medical societies. New treatments become available when it is clear they are more effective than existing treatments. Ask your doctor about any new research results that might be relevant to your illness.
When you are first told you have cancer, you may feel a range of emotions, such as fear, sadness, depression, anger or frustration. It may be helpful to talk about your feelings with your partner, family members or friends, or with a hospital counsellor, social worker, psychologist or your religious or spiritual adviser.

You can phone the Cancer Council Helpline on 13 11 20, Monday to Friday, 8.30 am to 6 pm.

Sometimes you may find that your friends and family do not know what to say to you. They may have trouble dealing with their feelings too. Some people may feel so uncomfortable that they avoid you. This can make you feel very lonely. You may feel able to approach your friends directly and tell them what you need. You may prefer to ask a close family member or a friend to talk with other people for you.

Practical and financial help

A serious illness may cause practical and financial problems. You do not need to face these alone. Apart from offering emotional support, a social worker may be able to suggest useful tips to help. Ask at your hospital or community health centre, or ring the Cancer Council Helpline.

Many services are available, including:

- financial assistance, which may be available for transport costs to medical appointments, prescription medicines, or through benefits or pensions – contact the social worker at your hospital
• home nursing care, which is available through district nursing, or through the local palliative care service – your doctor or hospital can arrange this
• meals on wheels, home care services, and aids and appliances, which can make life easier – contact the hospital social worker, occupational therapist or physiotherapist, or your local council.

Wigs
If you lose your hair during chemotherapy, you may want to wear a wig, scarf or hat while it’s growing back. You can borrow a wig; some hospitals and cancer care units have wig libraries where wigs are available for a small fee. You can buy a wig, though they can be expensive. Ask your treating hospital or call the Cancer Council Helpline on 13 11 20 to find out more. Some private health funds cover part of the cost of purchasing wigs – check with your health fund.

Diet
It can be difficult to eat well after being treated for stomach or oesophageal cancer. Your doctor or the hospital dietitian will advise you about the sort of diet that you need to follow.

Stomach cancer treatment can cause loss of appetite and a sense of fullness after eating only a small amount. You may find that, after eating, you have cramps, nausea, diarrhoea and dizziness. This is called ‘dumping syndrome’, and can happen when the food enters the small bowel too quickly. People who have had a gastrectomy are usually advised to eat several small meals throughout the day, avoid sugary foods (soft drinks, fruit juice, jelly and lollies) and eat meals high in protein (meat, fish, eggs, dairy foods, soy foods and nuts). For help with these and other problems, speak with your doctor or dietitian.

People who have been treated for oesophageal cancer can have difficulty swallowing and may have some of the symptoms described above. After an operation you may have nutrients intravenously for a while, or have a
feeding tube that goes directly from your mouth or nose to your **stomach**. Some people have a tube that goes directly through the **abdomen** into the upper bowel. Both of these tubes allow nutrition to be provided while you build up your eating and help to reduce weight loss.

These approaches will help until you can eat normally again. When you are able to eat normally, you will probably be advised to have several small meals and snacks through the day, rather than usual larger meals. To begin with, soft, moist and semi-liquid foods like soups and ice-cream will be easier to eat.

It is very important that you try to eat as well as you can, to maintain your weight and strength. This is also true if you have chemotherapy or radiotherapy, although food may seem very unappealing at times.

In the longer term, plan to stick to a healthy diet and include regular exercise in your week. There is growing evidence that a good diet, staying a healthy weight and exercising regularly may reduce the chance of cancer coming back.

**Exercise**

You may find it helpful to stay active and exercise regularly if you can. Exercise can help with fatigue. The amount and type of exercise you do will depend upon what you are used to and how well you feel. Talk with your doctor about what will be best for you.


**Relaxing**

Some people find relaxing or meditating helps them to feel better. The hospital social worker or nurse will know whether the hospital runs any
programs, or may be able to advise you on programs in your area. Your local community health centre may also be able to help.

For Cancer Council tips on relaxing and coping with anxiety, visit www.cancervic.org.au or phone 13 11 20.

Sexuality and cancer

Cancer treatment and the emotional effects of cancer may affect people with cancer and their partners in different ways.

Some people may withdraw through feelings of being unable to cope with the effects of treatment on themselves or their partner. Others may feel an increased need for sexual and intimate contact for reassurance.

It is important to talk about your feelings with your partner. If you have trouble continuing with your usual sexual activities, discuss this with your doctor or a trained counsellor.

Some people can feel sad about going through a cancer diagnosis and treatment without a partner. Sharing these feelings with a counsellor or a trusted friend or family member can make a big difference to how you feel.

For Cancer Council information on sexuality and cancer, visit www.cancervic.org.au or phone 13 11 20.

Cancer Council Helpline

The Cancer Council Helpline is a confidential service where you can talk about your concerns and needs with cancer nurses. They can send you information and can put you in touch with support services in your area. Phone 13 11 20 or visit www.cancervic.org.au to ask a cancer nurse a question online.
I think that one of the most important things is that although you feel that you’re on your own, you don’t have to do it on your own. You need to ask questions and not try to be too stoic. There is a lot of help available. We have to find out where it is and what sort of help suits us.”

**Multilingual Cancer Information Line**

The Multilingual Cancer Information Line is a confidential Cancer Council service. You can call and speak to a specially trained nurse with the help of an interpreter for the cost of a local call. It is for people with cancer, and people who are close to them. People who speak any language can use the service. See the back cover for details.

**Talk to someone who has been there**

Getting in touch with other people who have been through a similar experience can be very helpful. There are many ways to contact others for mutual support and to share information.

In these support settings, most people feel they can speak openly, share tips with others, and just be themselves. You will probably find that you feel comfortable talking about your diagnosis and treatment, your relationships with friends and family, and your hopes and fears about the future.

Support services available for patients, carers and family members include:

- Cancer Connect, a telephone peer support program that matches you with a volunteer who has been through a similar cancer experience, and who understands how you’re feeling
- face-to-face support groups, which are often held in community centres or hospitals
- telephone support groups for certain situations or types of cancer, which trained counsellors facilitate
• online discussion forums, where people can connect with each other any time – see www.cancerconnections.com.au

Ask your nurse or social worker to tell you about support groups in your area. Visit www.cancervic.org.au or call the Cancer Council Helpline on 13 11 20 to access the Cancer Services Directory and find out how you can connect with others.

Joining a consumer advocacy group can also be rewarding for people who would like to use their experience to make a difference for others. Visit www.cancervoicesvic.org.au for more information.

**Living with Cancer Education Program**

Cancer Council Victoria’s Living with Cancer Education Program provides information on cancer and ways of coping with it. The program runs over one day or a few hours across several weeks. Groups are small, with plenty of time for talking.

Courses are held at hospitals and community organisations throughout Victoria. Contact your hospital social worker or the Cancer Council Helpline. The program is also conducted in languages other than English in some areas.

“It’s good to talk to other people if you’re afraid, and try to look at ways to overcome the things you’re frightened about.”
Caring for someone with cancer

A carer is anyone, whether family or friend, who is helping to look after someone with cancer. Caring for someone with cancer can be very stressful, particularly when it is someone you care about very much. The person with cancer may be distressed about their cancer diagnosis, side effects from treatment and mood changes from the effects of drugs.

Look after yourself during this time. Give yourself some time out, enjoy a cup of coffee with a friend, and share your worries and concerns with someone not involved. Make a list of 10 things you like to do and make sure that you do one each day.

You may have to make many decisions. You will probably have to attend many appointments with doctors, support services and hospitals. It helps to write down questions before you go, and to take notes during the appointment.

Cancer Support Groups are usually open to patients and carers. A support group can offer the chance to share experiences and ways of coping. There is a range of support services such as home help, meals on wheels and visiting nurses that can help you cope with treatment at home. These are provided by local councils, the Royal District Nursing Service and the palliative care services.

Call the Cancer Council Helpline on 13 11 20 to:

- be linked with another carer by telephone
- speak with a cancer nurse for further support and information
- be sent a carer’s kit so that you can find out about financial assistance and other resources.
For Cancer Council information about caring for someone with cancer, visit www.cancervic.org.au or phone 13 11 20.
Questions to ask your doctors

You may find the following list helpful when thinking about the questions you want to ask your doctor about illness and treatment.

1. Has my stomach/oesophageal cancer spread? If so, how far?
2. What are my chances of cure?
3. What treatment do you advise for my cancer and why?
4. Will my treatment be performed by a doctor who specialises in stomach/oesophageal cancer?
5. Are there other treatment choices for me? If not, why not?
6. Are there any clinical trials of new treatments that I should know about?
7. What are the risks and possible side effects of each treatment?
8. What if I don't have any treatment?
9. Will I have to stay in hospital, or will I be treated as an outpatient?
10. How long will the treatment take? How much will it affect what I can do? How much will it cost?
11. Will I have a lot of pain with the treatment? What will be done about this?
12. If I need further treatment, what will it be like and when will it begin?
13. Will the treatment affect me sexually or physically? Will I be able to do normal things?
14. How often will my check-ups be and what will they involve?
15. Are there any problems I should watch out for?
16. I would like to have a second opinion. Can you refer me to someone else?
17. Is my cancer hereditary?
How can I contact you?
Can I delay a decision?
How will I know whether the treatment is working?

If there are answers you do not understand, feel comfortable to say, ‘Can you explain that again?’ or ‘I am not sure what you mean by ...’
Glossary: what does that word mean?

Most of the words listed here are used in this booklet, others are words you are likely to hear used by doctors and other health professionals who will be working with you.

**abdomen** The lower part of the torso, which contains major organs involved with digestion and excretion, including the stomach, liver, small and large bowel, kidneys and bladder.

**adenocarcinoma** A cancer that involves the cells lining the walls of many different organs of the body. It starts in glandular tissue or has a gland-like appearance.

**adjuvant therapy** Treatment that aims to prevent a recurrence of cancer, following surgical treatment of a tumour.

**advanced cancer** Cancer that has spread and/or is unlikely to be cured.

**anaesthetic** A drug that is taken to stop a person feeling pain during a medical procedure. A local anaesthetic numbs only a part of the body; a general anaesthetic, which is used in many major surgeries, causes a person to lose consciousness for a period of time.

**barium** An edible substance that does not let light through. It is used in x-rays of the digestive system.

**benign** Not cancerous. Benign lumps do not spread like cancer.

**bile** A fluid made in the liver and stored in the gall bladder. It helps the digestion of fats.

**biopsy** The removal of a sample of tissue from the body for examination under a microscope to help diagnose a disease.

**cells** The ‘building blocks’ of the body. A human is made of billions of cells, which are adapted for different functions.
**colon** The main part of the large bowel. It removes water and other substances from undigested food passed from the small bowel, and moves the faeces towards the rectum.

**diagnosis** The process of identifying a person’s illness.

**digestive system** The organs that are responsible for getting food into and out of the body and for making use of food to keep the body healthy. These include the mouth, oesophagus, stomach, liver, gall bladder, pancreas, small bowel, colon and rectum.

**endoscope** An instrument for examining the inside of the body. It is a long hollow tube with a light and camera attached. It can project magnified pictures of internal organs, and instruments can be inserted through the tube, if needed.

**FAP** Familial adenomatous polyposis. A hereditary condition that causes hundreds of small growths (polyps) in the bowel of the person affected.

**genes** The tiny factors that control the way the body’s cells grow and behave. Each person has a set of many thousands of genes inherited from both parents. These genes are found in every cell of the body.

**Helicobacter pylori** A bacteria that causes inflammation and ulcers in the stomach and is a risk factor for stomach cancer as well as lymphoma affecting the stomach.

**HNPCC** Hereditary non-polyposis colorectal cancer. A condition in some families where the tendency to develop bowel (and some other) cancers is inherited.

**intravenous** Into a vein. An intravenous drip gives fluids or drugs directly into a vein.

**liver** The organ that sits in the top right part of the abdomen, under the ribs. It has many important functions, including making bile, regulating the amount of blood sugar, storing fat and making various hormones.

**lymph nodes** Also called lymph glands. Small, bean-shaped structures that form part of the lymphatic system. Lymph is the fluid that flows through this system and carries cells that help to fight disease and infection. The lymph nodes filter the lymph to remove bacteria and other harmful agents, such as cancer cells.
malignant Cancerous. A malignant tumour is the same as a cancer. It tends to spread, and eventually causes death if it is not treated.

metastasis (plural metastases) Also known as a secondary tumour. A tumour that develops when cancer cells break away from the original (or primary) tumour and are carried by the lymph and blood systems to other parts of the body.

mucosa The innermost of the linings of the stomach and oesophagus.

oesophagus Also known as the ‘gullet’. The muscular tube, about 23 cm long, that extends from the back of the throat (pharynx) to the stomach.

palliative treatment Also known as palliative care or palliation, this treatment is aimed at providing relief from symptoms without attempting to cure the disease, though palliative treatment may increase survival and improve overall quality of life.

pancreas A gland that lies behind the stomach. It adds the hormones insulin and glucagon to the blood and supplies digestive juices to the small bowel.

prognosis An assessment of the course and likely outcome of a person’s disease.

radiation Energy in the form of waves or particles, including gamma rays, x-rays and ultraviolet rays. This energy can injure or destroy cells by damaging their genetic material. This ability is ‘harnessed for good’ when it is used in radiotherapy to destroy cancer cells.

reflux Regurgitation of acid stomach contents into the oesophagus.

risk factors Things that cause people to have a greater chance of developing an illness.

small bowel The bowel is the tube that extends from the stomach to the anus. The small bowel is the first part of the bowel, where most of the digestion and absorption of food and liquid takes place.

stent A device placed in a blood vessel or other passage in the body to keep the structure open.
**stomach** An abdominal organ, part of the digestive system. Continues the process of digestion that begins in the mouth. Glands in the lining of the stomach produce gastric juice, which, with the churning of the muscular layers of the stomach, reduces food to a semi-liquid mass.

**tissue** A collection of similar cells.

**tumour** A new or abnormal growth of tissue in or on the body.
Index

abdomen 6, 8, 10, 13-15, 20, 41
adenocarcinoma 6-9, 41
adjuvant therapy 22, 41
advanced cancer 10, 15, 25, 27, 41
anaesthetic 12, 15, 41
barium 13, 41
Barrett oesophagus 9
benign 4, 41
bile 21, 41
biopsy 12, 16, 41
blood test 12
bone scan 16
breathing 16, 21
Cancer Support Groups 35, 37
carcinoid tumours 6
carers 25, 35, 37, 38
chemotherapy 11, 18-23, 32, 33
clinical trials 18, 29, 30, 39
colon 7, 8, 42
coughing 10
dentists 19
diagnosis 10-17, 34, 35, 37, 42
diarrhoea 22, 32
diet/dietitians 8, 9, 11, 20, 21, 23, 32, 33
digestive system 6, 7, 11, 42
diabetes 31, 34
endoscopy 12, 13, 16, 42
exercise 33

family history 9
FAP 9, 42
financial assistance 31, 37
gastroscopy 9, 19-21, 32
gastric stromal tumours 6
gastroenterologists 11
genes 4, 9, 42
Helicobacter pylori 8, 42
HNPCC 9, 42
intravenous 20, 22, 32, 42
iron 21
liver 7, 8, 14-17, 42
Living with Cancer Education Program 36
lymph nodes 8, 13, 14, 16, 17, 19, 42
lymphoma 6
malignant 4, 43
mouth infection 19
mucosa 6, 17, 43
Multilingual Cancer Information Line 35, back cover
nausea 10, 22, 23, 32
oesophageal cancer defined 8
pain 10, 14, 15, 20-22, 24, 25, 39
palliative treatment 11, 18, 21, 24, 25, 32, 37, 43
pancreas 7, 8, 43
prognosis 25, 26, 43
radiation 11, 21, 43
radiotherapy 11, 18, 19, 21, 22, 25, 33
relaxing 23, 33, 34
research 30
risk factors 8, 9, 43
second opinion 28, 29, 39
sexuality 34, 39
side effects 22, 23, 27, 29, 37, 39
small bowel 6, 7, 19, 21, 25, 32, 43
squamous cell carcinoma 8
stage/staging 10, 16, 17, 18, 22, 25
stent 25, 43
stomach cancer defined 6
surgery 18-22, 24, 25
swallowing 6, 10, 20, 21, 22, 32
symptoms 8, 10, 11, 18, 21, 24, 25, 27, 32
tiredness 10, 22
treatment 18-26
tumour 4, 5, 6, 14, 15, 17, 20, 22, 44
ultrasound 13, 14, 15
vitamin B12 21
For support and information on cancer and cancer related issues, call the Cancer Council Helpline for the cost of a local call.

**Call Monday to Friday 8.30 am – 6 pm:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>English</strong></td>
<td>13 11 20</td>
</tr>
<tr>
<td><strong>Arabic</strong></td>
<td>9209 0160</td>
</tr>
<tr>
<td><strong>Arabic</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cantonese</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mandarin</strong></td>
<td>9209 0164</td>
</tr>
<tr>
<td><strong>Greek</strong></td>
<td>9209 0162</td>
</tr>
<tr>
<td><strong>Italian</strong></td>
<td>9209 0163</td>
</tr>
<tr>
<td><strong>Polish</strong></td>
<td>9209 0165</td>
</tr>
<tr>
<td><strong>Russian</strong></td>
<td>9209 0166</td>
</tr>
<tr>
<td><strong>Spanish</strong></td>
<td>9209 0167</td>
</tr>
<tr>
<td><strong>Vietnamese</strong></td>
<td>9209 0168</td>
</tr>
<tr>
<td><strong>Other languages</strong></td>
<td>9209 0169</td>
</tr>
</tbody>
</table>