

3.3 Oesophagus

Table 3-3.1
Overview of key epidemiological parameters for Germany, ICD-10 C15

	2009		2010		Prediction for 2014	
	Men	Women	Men	Women	Men	Women
Incident cases	4,880	1,370	4,890	1,420	5,400	1,500
Crude incidence rate ¹	12.1	3.3	12.2	3.4	13.6	3.7
Standardised incidence rate ^{1,2}	9.0	2.0	8.9	2.1	9.1	2.2
Median age at diagnosis	67	71	66	70		
Deaths	3,776	1,161	3,837	1,142		
Crude mortality rate ¹	9.4	2.8	9.6	2.7		
Standardised mortality rate ^{1,2}	6.8	1.6	6.9	1.5		
5-year prevalence	8,000	2,200	8,100	2,300		
Absolute 5-year survival rate (2009-2010) ³			18 (15-24)	19 (10-29)		
Relative 5-year survival rate (2009-2010) ³			21 (17-27)	22 (12-31)		

¹ per 100,000 persons ² age-standardised (European standard) ³ in percentages (lowest and highest value of the included German federal states)

Epidemiology

Men are diagnosed approximately three to four times more frequently than women with cancer of the oesophagus and contributing to this is the greater distribution of major risk factors, i.e. alcohol and tobacco consumption, among men.

Squamous-cell carcinomas account for 50 % to 60 % of all cases of cancer of the oesophagus. In recent years, the proportion of adenocarcinomas, which are mainly found in the lower section of the oesophagus, has risen to approximately one third of cases.

Following considerable improvements, the survival prospects of patients with oesophageal cancer are still just a little less favourable than with stomach cancer. Currently, the relative 5-year survival rates for both men and women are over 20 %. Only one in eight cases is diagnosed at an early stage (T₁).

The age-standardised incidence and mortality rates have remained virtually unchanged since the turn of the millennium, whilst the absolute number of cases in both sexes is increasing.

The highest incidence rates in Germany are being recorded in the northern federal states. Internationally, high incidence and mortality rates are apparent in the Netherlands and in the United Kingdom.

Risk factors

The most important risk factors for the development of the more frequent squamous-cell carcinoma in the oesophagus include alcohol and tobacco consumption. In combination, the two factors reinforce one another. Studies have also shown that those affected, often eat little fruit and vegetables.

Adenocarcinomas, which are somewhat less frequent, often originate in combination with a gastro-oesophageal reflux disease (long-term flow of gastric juices back into the oesophagus, chronic heartburn). This leads to changes to the mucous lining of the lower part of the oesophagus, causing a Barrett's oesophagus, which is regarded as a precursor to cancer. Also in the case of adenocarcinoma, a consumption below the average of fruit and vegetables increases the risk of developing the disease.

Recently, adenocarcinomas of the oesophagus have been associated with smoking, being overweight and possibly also with type 2 diabetes. Family clusters of cases are known, but these may possibly be attributable to shared lifestyle risks.

The possible influence of the human papilloma viruses is a topic of controversial debate.

Figure 3.3.1a
Age-standardised incidence and mortality rates, by sex,
ICD-10 C15, Germany 1999 – 2010
per 100,000 (European standard)

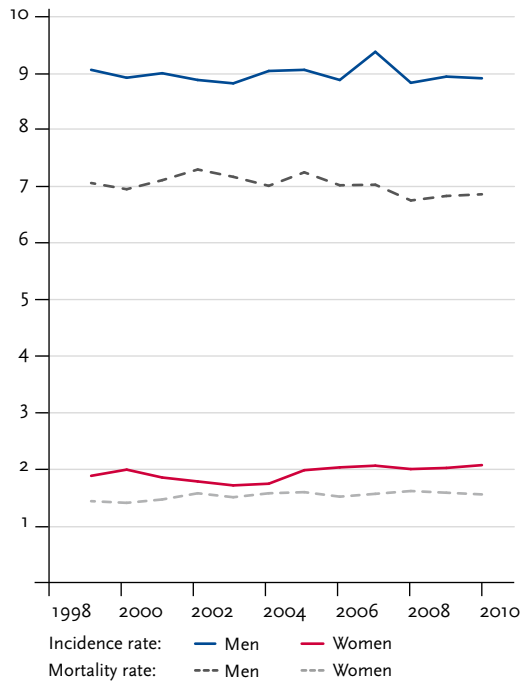


Figure 3.3.1b
Absolute numbers of incident cases and deaths, by sex,
ICD-10 C15, Germany 1999 – 2010

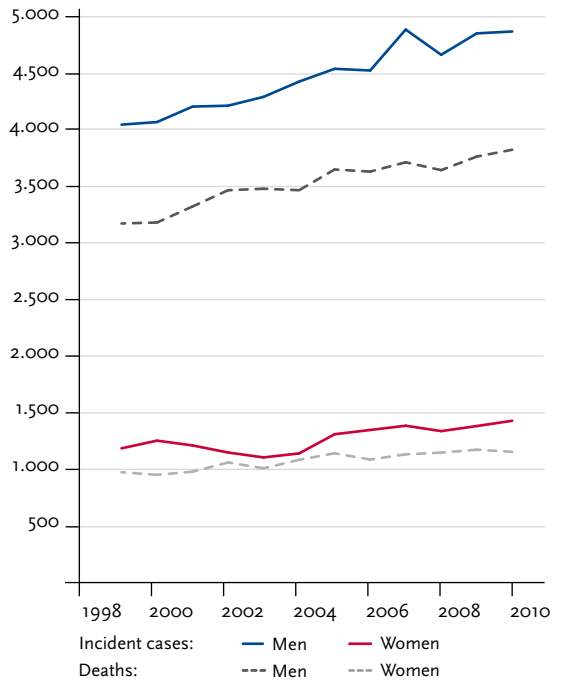


Figure 3.3.2
Age-specific incidence rates by sex, ICD-10 C15, Germany 2009 – 2010
per 100,000

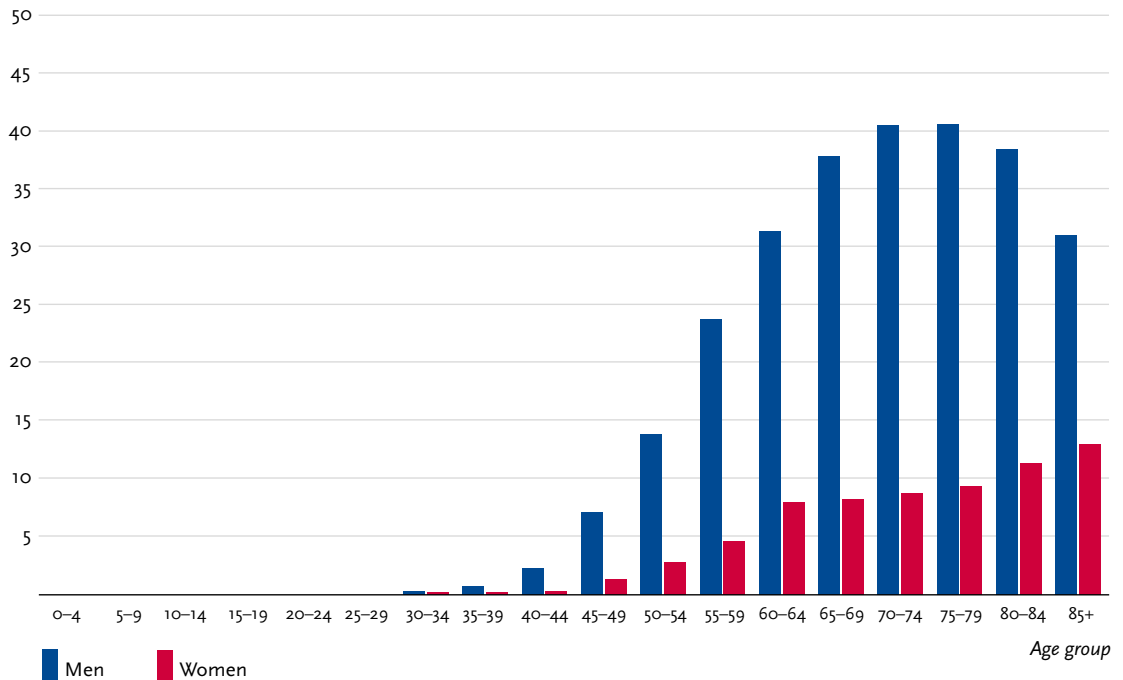


Table 3.3.2
Cancer incidence and mortality risks in Germany by age and sex, ICD-10 C15, database 2010

Men aged	Risk of developing cancer				Mortality risk			
	in the next ten years		ever		in the next ten years		ever	
35 years	<0.1%	(1 in 5,200)	0.9%	(1 in 110)	<0.1%	(1 in 10,000)	0.8%	(1 in 130)
45 years	0.1%	(1 in 930)	0.9%	(1 in 110)	0.1%	(1 in 1,400)	0.7%	(1 in 130)
55 years	0.3%	(1 in 380)	0.9%	(1 in 120)	0.2%	(1 in 520)	0.7%	(1 in 140)
65 years	0.3%	(1 in 290)	0.7%	(1 in 150)	0.3%	(1 in 370)	0.6%	(1 in 170)
75 years	0.3%	(1 in 340)	0.4%	(1 in 240)	0.3%	(1 in 370)	0.4%	(1 in 250)
Lifetime risk			0.9%	(1 in 110)			0.8%	(1 in 130)
Women aged	in the next ten years		ever		in the next ten years		ever	
35 years	<0.1%	(1 in 26,000)	0.3%	(1 in 360)	<0.1%	(1 in 65,000)	0.2%	(1 in 440)
45 years	<0.1%	(1 in 4,800)	0.3%	(1 in 360)	<0.1%	(1 in 8,300)	0.2%	(1 in 440)
55 years	0.1%	(1 in 1,700)	0.3%	(1 in 390)	<0.1%	(1 in 2,300)	0.2%	(1 in 450)
65 years	0.1%	(1 in 1,200)	0.2%	(1 in 470)	0.1%	(1 in 1,500)	0.2%	(1 in 530)
75 years	0.1%	(1 in 1,100)	0.1%	(1 in 390)	0.1%	(1 in 1,300)	0.1%	(1 in 720)
Lifetime risk			0.3%	(1 in 360)			0.2%	(1 in 440)

Figure 3.3
Distribution of T-stages at first diagnosis by sex (top: all cases; bottom: only valid reports)
ICD-10 C15, Germany 2010

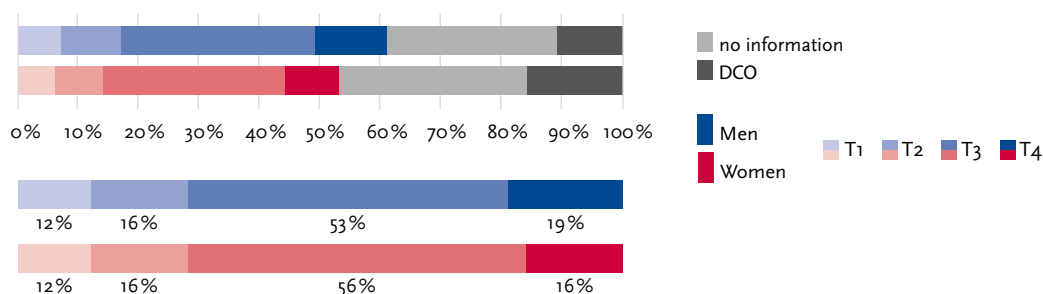


Figure 3.3.4a
Absolute survival rates up to 5 years after first diagnosis,
by sex, ICD-10 C15, Germany 2009 – 2010

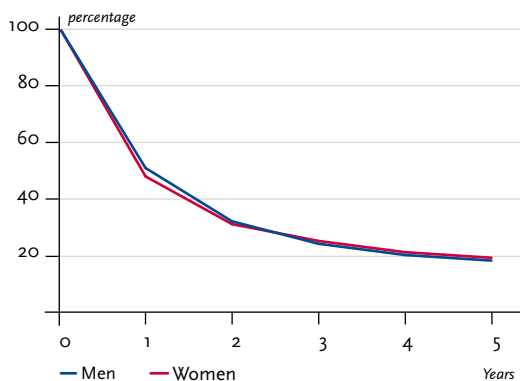


Figure 3.3.4b
Relative survival rates up to 5 years after first diagnosis,
by sex, ICD-10 C15, Germany 2009 – 2010

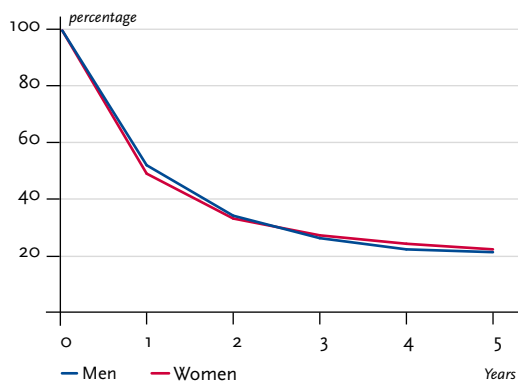


Figure 3.3.5
Registered age-standardised incidence and mortality rates in German federal states, by sex,
ICD-10 C15, 2009 – 2010
per 100,000 (European standard)

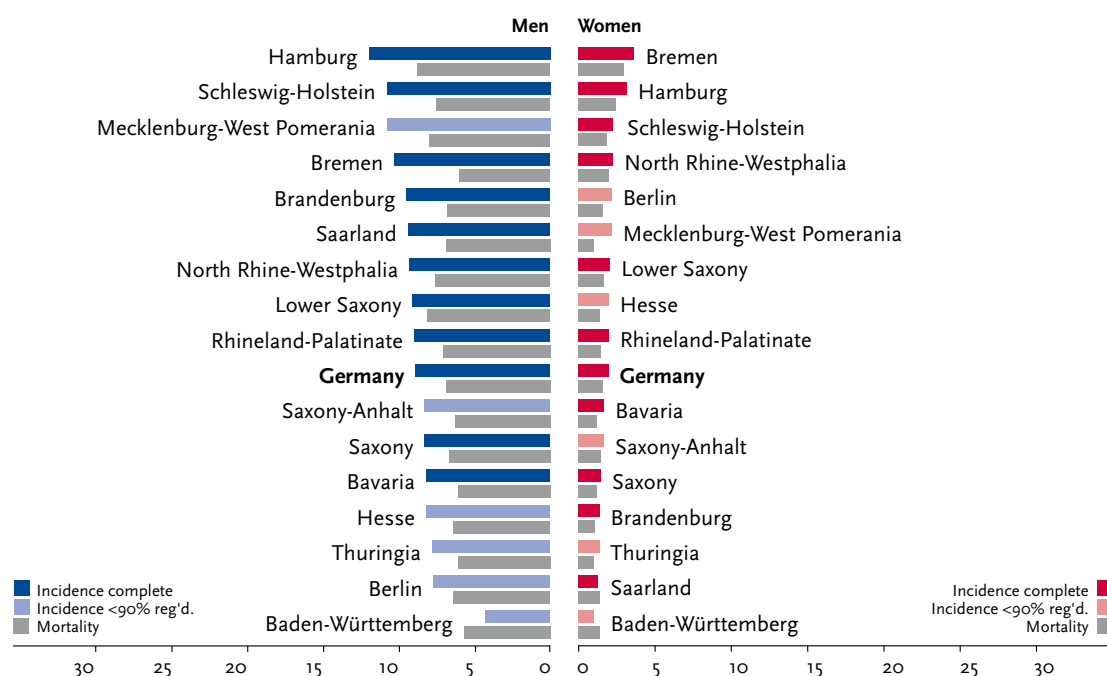


Figure 3.3.6
International comparison of age-standardised incidence and mortality rates, by sex,
ICD-10 C15, 2009 – 2010 or latest available year (details and sources, see appendix)
per 100,000 (European standard)

