NGN NCLEX 2026 · ONCOLOGY & GASTROINTESTINAL

GI Cancers & Management

A high-yield reference covering esophageal, gastric, colorectal, pancreatic, liver, and oral cancers — with pathophysiology, priority interventions, pharmacology, and NCJMM clinical judgment cues.

Oncology | GI / Digestive | Priority Assessment | Clinical Judgment | NCJMM Framework

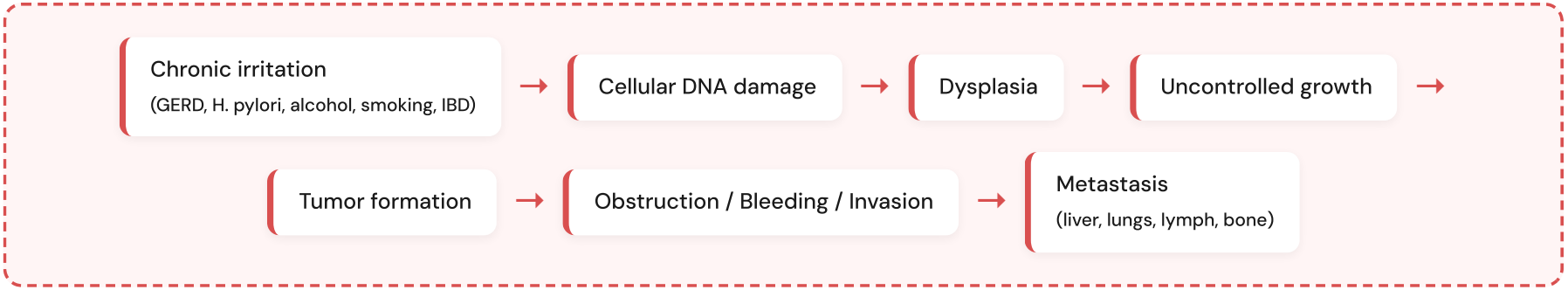
01 Definition & Overview

GI cancers are malignant tumors arising anywhere along the digestive tract — from the mouth to the rectum — as well as accessory organs (liver, pancreas, gallbladder).

Many GI cancers are **asymptomatic in early stages**, allowing disease to progress silently. This delayed presentation contributes to high mortality, especially in **pancreatic** and **esophageal** cancers.

Colorectal cancer is the 3rd leading cause of cancer-related death in the U.S. — but it is among the *most preventable* with screening.

02 Pathophysiology (Simplified)



Cancer-by-Cancer Snapshot

Esophageal

DYSPHAGIA IS THE HALLMARK

- **Risks:** GERD, Barrett's, smoking, alcohol, hot liquids
- **Key sign:** Progressive dysphagia (solids → liquids)
- **Also:** Weight loss, odynophagia, hoarseness
- **Surgery:** Esophagectomy

DYSPHAGIA progression

Gastric (Stomach)

VAGUE EARLY, SEVERE LATE

- **Risks:** H. pylori, smoked/salted foods, pernicious anemia
- **Key signs:** Early satiety, indigestion, weight loss
- **Late:** Coffee-ground emesis, epigastric mass
- **Post-gastrectomy:** B12 deficiency (lifelong injections), dumping syndrome

EARLY SATIETY

Colorectal

MOST PREVENTABLE WITH SCREENING

- **Risks:** Age 45+, family hx, IBD, polyps, low-fiber/high-fat diet
- **RIGHT-sided:** Anemia, fatigue, vague pain
- **LEFT-sided:** Pencil stools, obstruction, rectal bleeding
- **Screen:** Colonoscopy at age 45

CHANGE IN BOWEL HABITS + BLEEDING

Pancreatic

THE "SILENT KILLER"

- **Risks:** Smoking, chronic pancreatitis, DM, obesity
- **Key sign:** Painless jaundice
- **Also:** Clay stools, dark urine, weight loss, pruritus

Liver (Hepatocellular)

OFTEN FROM CIRRHOSIS

- **Risks:** Cirrhosis, Hep B/C, alcohol, aflatoxins
- **Signs:** RUQ pain, jaundice, ascites, weight loss

Oral

EARLY LESIONS ARE TREATABLE

- **Risks:** Tobacco, alcohol, HPV
- **Key signs:** Non-healing mouth sore > 2 weeks
- **Also:** Leukoplakia (white), erythroplakia (red), neck lump

- **Surgery:** Whipple procedure (pancreaticoduodenectomy)

PAINLESS JAUNDICE

- **Labs:** ↑ AFP, ↑ liver enzymes, coagulopathy
- **Watch:** Bleeding & ammonia levels

ELEVATED AFP

- **Teach:** Self-exam, dental visits

SORE THAT WON'T HEAL

03 ⚠️ Signs & Symptoms

🌱 Early / Vague

- Unintentional weight loss
- Fatigue & weakness
- Early satiety / feeling full quickly
- Chronic indigestion or heartburn
- Iron-deficiency anemia (occult bleeding)
- Vague abdominal discomfort
- Change in bowel habits

🚨 Late / RED FLAGS

- Hematemesis (coffee-ground emesis)
- Melena (black tarry stools) — upper GI bleed
- Hematochezia (bright red blood) — lower GI
- Painless jaundice = pancreatic until proven otherwise
- Palpable abdominal mass
- Pencil / ribbon-thin stools
- Progressive dysphagia (solids → liquids)
- Obstruction: no stool, no flatus, vomiting, distention
- Ascites with weight loss

04 🏥 Priority Nursing Interventions

ABCs always come first, followed by safety, nutrition, and psychosocial support.

🅰 Airway

- ✓ HOB elevated 30–45° (esophageal/oral cancers — aspiration risk)
- ✓ Suction at bedside
- ✓ Assess swallowing before PO intake
- ✓ Oral care q2–4h (oral cancer / chemo)

🅱 Breathing

- ✓ Monitor SpO_2, breath sounds
- ✓ Watch for pleural effusion / atelectasis post-op
- ✓ Incentive spirometer q1–2h while awake
- ✓ Early ambulation

🅒 Circulation

- ✓ Monitor H&H, platelets, coags
- ✓ Assess for GI bleeding signs
- ✓ Watch for hypovolemic shock (↓BP, ↑HR, pallor)
- ✓ Strict I&O

🛡 Safety

- ✓ Bleeding precautions: soft toothbrush, electric razor
- ✓ Neutropenic precautions (chemo)
- ✓ Fall precautions (weakness, anemia)
- ✓ No IM injections if thrombocytopenic

🥗 Nutrition

- ✓ Weigh daily/weekly — track trend
- ✓ Small, frequent, high-calorie/protein meals
- ✓ Supplements (Ensure, Boost)
- ✓ TPN if NPO > 7 days
- ✓ B12 injections lifelong post-gastrectomy

💊 Pain & Comfort

- ✓ Around-the-clock dosing for cancer pain (NOT PRN)
- ✓ WHO analgesic ladder
- ✓ Monitor for constipation on opioids
- ✓ Non-pharm: positioning, relaxation, heat

🧠 NCJMM Clinical Judgment Framework

RECOGNIZE · ANALYZE · PRIORITIZE · EVALUATE

RECOGNIZE CUES

Painless jaundice, pencil stools, progressive dysphagia, unexplained weight loss, early satiety, melena/hematochezia, Trousseau's sign.

ANALYZE CUES

Link risk factors (smoking, H. pylori, IBD) to presentation. Distinguish upper vs lower GI bleed. Right- vs left-sided colon patterns.

PRIORITIZE HYPOTHESES

Airway (aspiration) > Bleeding / shock > Obstruction > Pain > Nutrition > Psychosocial.

GENERATE SOLUTIONS

HOB up, NS bolus for shock, NGT for obstruction, bleeding precautions, antiemetics, enzyme replacement, pain ATC.

TAKE ACTION

Stop irritant, notify HCP for red flags, administer blood/fluids, implement neutropenic/bleeding precautions, teach dumping syndrome prevention.

EVALUATE OUTCOMES

Weight stable, pain ≤ 3/10, H&H improving, no bleeding, tolerating diet, client verbalizes self-care.

05 Pharmacology — Chemo & Supportive

DRUG / CLASS	USED FOR	KEY TOXICITY	NURSING PRIORITY
5-Fluorouracil (5-FU) Antimetabolite	Colorectal, gastric, pancreatic	Mucositis, diarrhea, myelosuppression	Oral care, monitor CBC, hydration
Oxaliplatin Platinum agent	Colorectal	Cold-induced peripheral neuropathy	**Avoid cold drinks / cold air**, warm gloves
Cisplatin Platinum agent	Esophageal, gastric	Nephrotoxicity, ototoxicity, neuropathy	Hydration, audiometry, monitor BUN/Cr
Gemcitabine Antimetabolite	Pancreatic	Flu-like symptoms, myelosuppression	Monitor CBC, acetaminophen for fever
Irinotecan Topoisomerase inhibitor	Colorectal	Severe diarrhea (early & late)	Atropine for acute; loperamide for late
Bevacizumab (Avastin) VEGF inhibitor — targeted	Colorectal	HTN, bleeding, GI perforation	Monitor BP, assess for abdominal pain
Cetuximab EGFR inhibitor — targeted	Colorectal, head & neck	Acneiform rash, infusion reaction	Pre-medicate, skin care teaching

DRUG / CLASS	USED FOR	KEY TOXICITY	NURSING PRIORITY
Ondansetron (Zofran) Antiemetic — 5-HT3 blocker	Chemo-induced N/V	Headache, constipation, QT prolongation	Give 30 min before chemo; monitor ECG
Pancrelipase Enzyme replacement	Pancreatic cancer / post-Whipple	Abdominal cramping	**Give with every meal & snack**; don't crush
Opioids (morphine, oxycodone, fentanyl)	Cancer pain	Constipation, respiratory depression	**ATC dosing**, stimulant laxative, naloxone available

06 NCLEX Test Traps

TRAP #1 — PAINLESS JAUNDICE

Students confuse painless jaundice with hepatitis. **Painless jaundice = pancreatic head cancer** until proven otherwise. Hepatitis typically has RUQ pain and flu-like symptoms.

TRAP #2 — LEFT VS RIGHT COLON

RIGHT-sided: anemia, fatigue (occult bleeding). **LEFT-sided:** obstruction, pencil stools, bright red bleeding. Students often mix these up — the left colon has smaller diameter, so it obstructs first.

TRAP #3 — DUMPING SYNDROME DIET

After gastrectomy, teach the client to **avoid fluids with meals**, eat small frequent meals, high-protein/fat, LOW simple carbs, and **lie down 30 min after meals**. Students often say "drink plenty with meals" — this is wrong.

TRAP #4 — OXALIPLATIN + COLD

The patient who just started oxaliplatin and asks for ice water — **decline and offer room-temperature liquids**. Cold triggers acute neuropathy.

TRAP #5 — B12 AFTER GASTRECTOMY

Loss of intrinsic factor means B12 cannot be absorbed orally — **lifelong B12 injections required**. Oral B12 alone is the wrong answer.

TRAP #6 — SCREENING AGE

Colonoscopy screening now begins at **age 45** (not 50) for average-risk adults. Earlier if family history or IBD.

TRAP #7 — CANCER PAIN DOSING

Cancer pain is managed **around-the-clock (ATC)**, NOT PRN. PRN dosing leaves gaps that let pain escalate. Students often pick PRN — wrong for chronic cancer pain.

TRAP #8 — MELENA VS HEMATOCHEZIA

Melena (black, tarry) = UPPER GI bleed (blood is digested). **Hematochezia** (bright red) = LOWER GI bleed. Don't confuse the two when localizing the source.

TRAP #9 — PROGRESSIVE DYSPHAGIA

Dysphagia that progresses **solids → soft foods → liquids** = esophageal cancer (mechanical obstruction). If it's solids AND liquids from the start = achalasia / motility issue.

TRAP #10 — PANCREATIC ENZYMES

Pancrelipase is given **WITH every meal and snack** — not before, not after. Students confuse with PPIs (before) or antacids (after).

07 Patient Education

Screening & Prevention

- Colonoscopy every 10 yr starting age 45
- Annual FOBT or FIT
- Quit smoking, limit alcohol
- High-fiber, low-fat diet

When to Call HCP

- Any rectal bleeding
- Change in bowel habits > 2 weeks
- Unexplained weight loss
- Mouth sore not healed in 2 weeks

Ostomy Care

- Empty pouch when 1/3 to 1/2 full
- Change appliance every 3–7 days
- Assess stoma: pink/red & moist = healthy
- Call HCP if purple/black (ischemia)

- Maintain healthy weight
- Persistent indigestion / dysphagia
- Protect peristomal skin

Dumping Syndrome

- Small frequent meals (6/day)
- High protein & fat, LOW simple carbs
- NO fluids with meals (30 min before/after)
- Lie down 20–30 min after eating
- Avoid very hot or cold foods

Chemo Safety

- Avoid crowds, sick contacts
- Report fever ≥ 100.4°F immediately
- Good hand hygiene & oral care
- Use electric razor; soft toothbrush
- Flush toilet 2× after use (48 hr post-chemo)

Nutrition Support

- Eat small, frequent meals
- High-calorie, high-protein foods
- Liquid supplements (Ensure, Boost)
- B12 injections monthly (post-gastrectomy)
- Pancrelipase with every meal/snack

08 🧠 Memory Boosters & Mnemonics

🚨 "CAUTION"

American Cancer Society warning signs:

Change in bowel/bladder habits

A sore that does not heal

Unusual bleeding or discharge

Thickening / lump

Indigestion or dysphagia

Obvious change in wart/mole

Nagging cough or hoarseness

⬅️ LEFT = LOG-jam

Left-sided colon cancer:

Lower stool caliber (pencil)

Obstruction symptoms

Gross red rectal bleeding

Smaller lumen, bulky tumors, solid stool → blockage.

➡️ RIGHT = RED cells 🩸

Right-sided colon cancer:

RBCs low (iron-deficiency anemia)

Exhaustion / fatigue

Dull, vague abdominal pain

Larger lumen, liquid stool, occult bleeding.

🟡 Pancreatic = "3 P's"

🍽️ Dysphagia Progression

❄️ "Cold is Cruel"

Painless jaundice

Palpable gallbladder (Courvoisier's sign)

Poor prognosis

Esophageal cancer dysphagia goes:

SOLIDS → SOFTS → LIQUIDS

Getting worse = getting narrower.

Oxaliplatin & cold exposure:

No ice water

No cold air on skin

Warm gloves/scarf outside

Room-temperature foods/drinks

💉 "VAD" for Gastric

Vague symptoms (indigestion)

Anorexia & early satiety

Dumping syndrome post-op

Plus lifelong B12 injections.

🩸 Bleeding Color Code

Coffee-ground emesis → upper GI (gastric)

Melena (black tarry) → upper GI

Hematochezia (bright red) → lower GI (colorectal)

Clay stools + dark urine → pancreas / bile duct