THE ROLE OF SURGERY AT THORACIC ESOPHAGEAL CANCER

Montazer Majid m.d

Thorax ward of Imam Reza hospital

Tabriz – winter 2117

HISTORY

- The first ESOPHAGEAL RESECTION WAS> 125Y ago **1877** Czerny at ***Heidelberg***
- ***Iver lewis*** – **1946**
- ***McKeown*** – **1962**(3 incisional technique)
- ***Transhiatal (orringer)***
- ***Thoracoscopic and Laparoscopic*** **Today**

5 YEAR SURVIVAL

- 2013 -------- > **19%**
- Today ------ > **35%**

WHAT IS PURPOSE ?

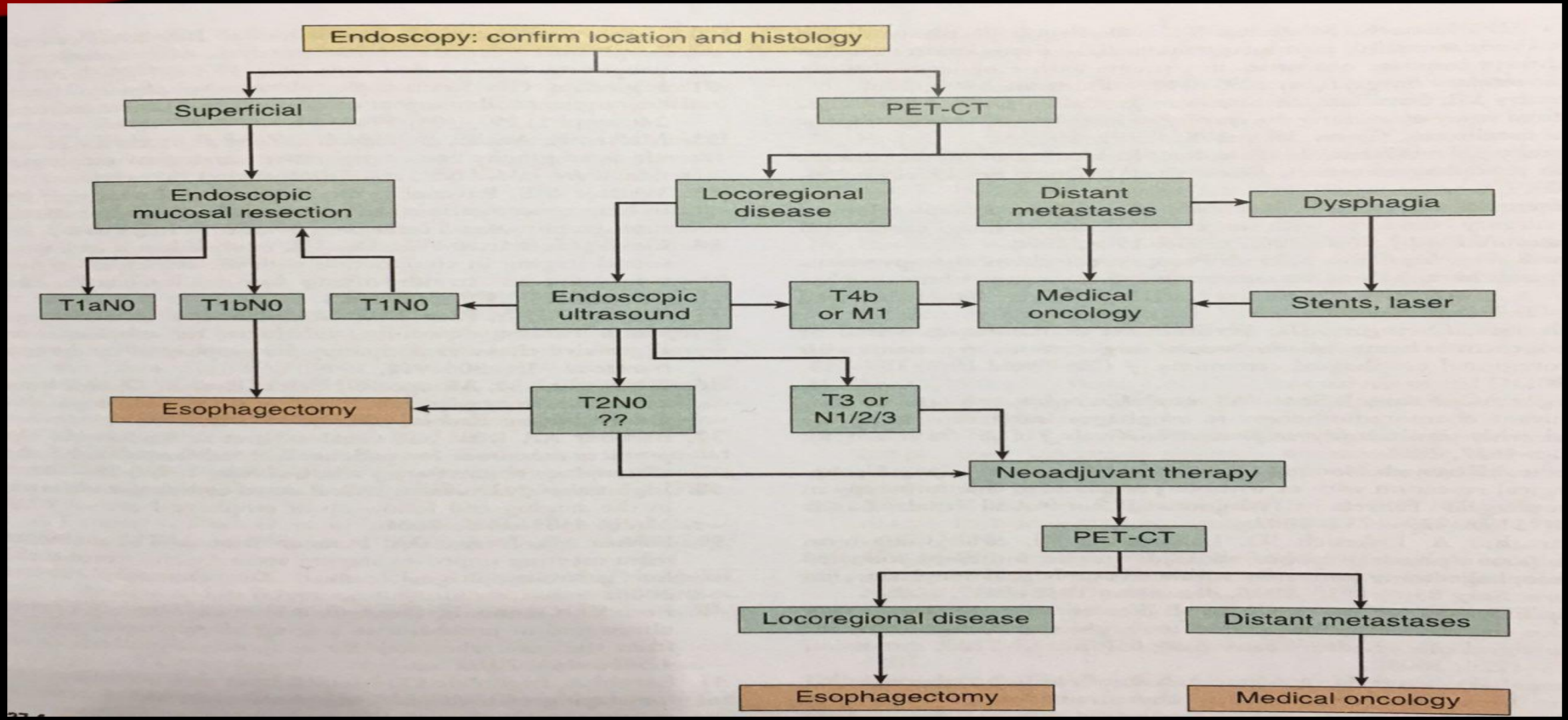
Palliation and ***increase survival*** and **disease free**

REDUCTION OF PERIOPERATIVE MORTALITY

- **40%** -------- > 50 YEARS ---------- > **3%**

- IMPROVEMENT:

1- ***PATIENT SELECTION***
2- ***OPERATIVE TECHNIQUE***
3- ***INTENSIVE CARE***
4- ***AGGRESSIVE MANAGEMENT OF PERIOPERATIVE COMPLICATION***


Endoscopy: confirm location and histology
Superficial
PET-CT
Endoscopic mucosal resection
Locoregional disease
Distant metastases
Dysphagia
T1aN0
T1bN0
T1N0
Endoscopic ultrasound
T4b or M1
Medical oncology
Stents, laser
Esophagectomy
T2N0 ??
T3 or N1/2/3
Neoadjuvant therapy
PET-CT
Locoregional disease
Distant metastases
Esophagectomy
Medical oncology

- Surgical therapy :
- ***the best chance for cure*** with a complete resection
- ***effective palliation*** *with relief of dysphagia*

- ***Esophagectomy***

- ***Substitutes****: gastric tube , jejenum , colon*

- ***Extent of surgical resection****: up 12 cm & 5cm distal grossly normal*

- ***En bloc resection***

- ***Lymph node dissection***

SURGERY OF ESOPHAGEAL CARCINOMA

Operable:

- T4A : Invading pleura – pericardium - diaphragm
- T2A : Simple esophagectomy
- **Surgical option: one of methods**

Inoperable:

- T4B: Aorta – vertebral body – trachea
- Obstruction, trachea esophageal fistula
- **Surgical option: esophageal bypass+ gastrostomy+ jejenostomy**

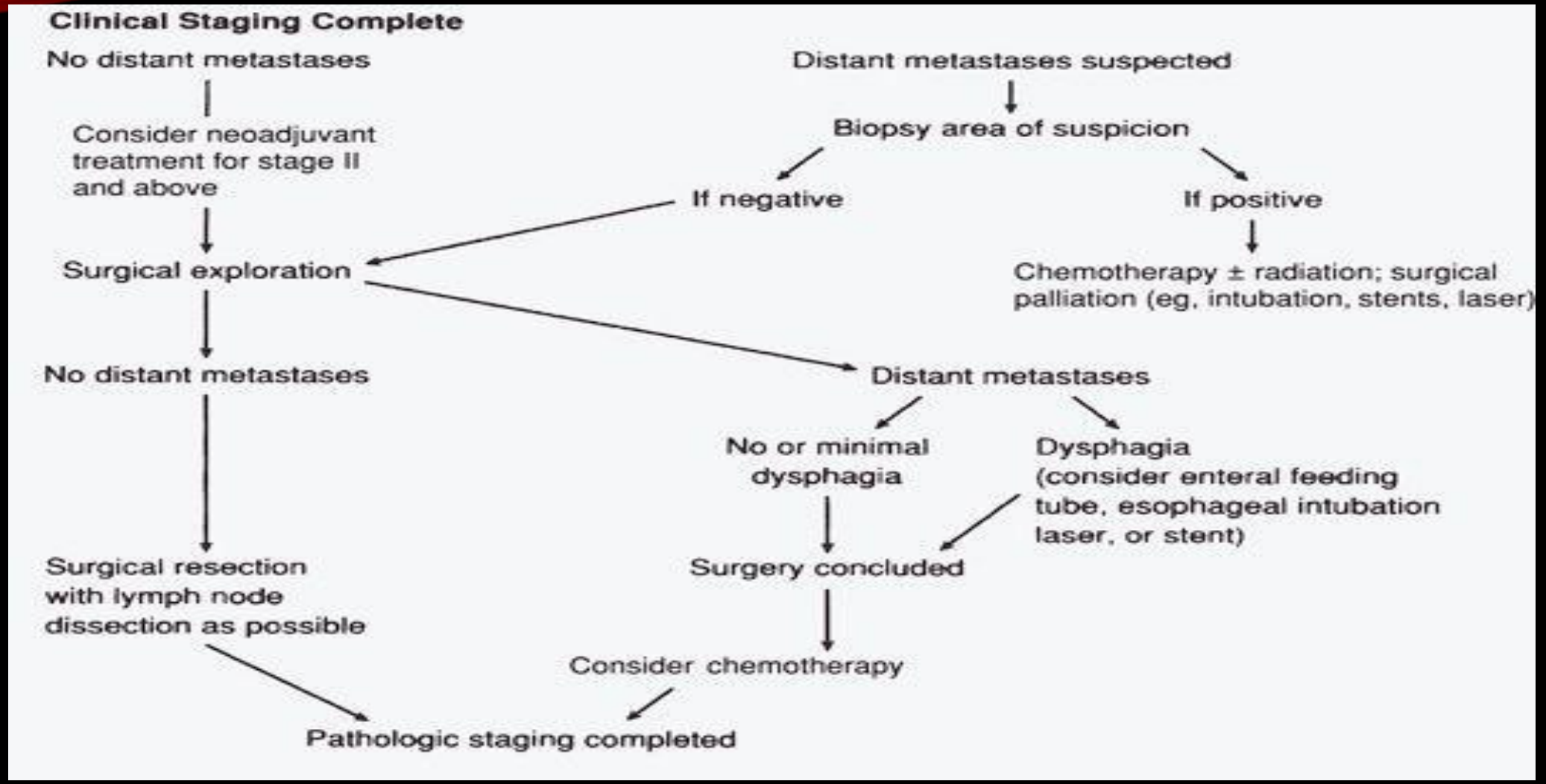

Clinical Staging Complete
No distant metastases
Consider neoadjuvant treatment for stage II and above
Surgical exploration
No distant metastases
Surgical resection with lymph node dissection as possible
Distant metastases suspected
Biopsy area of suspicion
If negative
If positive
Chemotherapy ± radiation; surgical palliation (eg, intubation, stents, laser)
Distant metastases
No or minimal dysphagia
Dysphagia (consider enteral feeding tube, esophageal intubation laser, or stent)
Surgery concluded
Consider chemotherapy
Pathologic staging completed

TABLE 38-1 **Comparison of Transthoracic and Transhiatal Approaches to Esophagectomy: Perioperative Complications**

Complication	Transthoracic	Transhiatal
Blood loss (mL)	1001	728
Operative time (hours)	5.6	4.0
Cardiac complications (%)	6.6	19.5
Pulmonary complications (%)	18.7	12.7
Anastomotic leak (%)	7.2	13.6
Vocal cord paralysis (%)	3.5	9.5
Chyle leak (%)	2.4	1.4
In-hospital mortality (%)	9.2	5.7

Adapted from Hulscher JB, Tijssen JG, Obertop H, et al: Transthoracic versus transhiatal resection for carcinoma of the esophagus: a meta-analysis. Ann Thorac Surg 72:306–313, 2001.

A TRIAL RANDOMIZEAD 100 E.C

- Preoperative chemotherapy followed by T.H.E versus T.H.E ALONE:

- SURVIVAL in neoadjuvant group **30%** at 3 y
- in T.H.E **16%**

A EUROPIAN STUDY RANDOMIZING 382 E.C S.C.C

- **Chemo+ tri field en bloc trans thoracic esophagectomy** versus **esophagectomy alone**:

- No difference 5 y survival

WLASH AND COWORKERS RANDOMIZED 113 PATIENT WITH ADENOCARCINOMA

- Surgery alone versus chemoradiation followed surgery
- 5 y survival :
- ***50%*** for neo+ surgery
- ***8%*** for surgery

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