

Esophagectomy for Superficial Esophageal Neoplasia

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KEYWORDS

- Esophageal cancer • Barrett's esophagus • Intramucosal carcinoma
- High-grade dysplasia • Esophagectomy

KEY POINTS

- Despite the recent success of endoscopic resection and ablation in the management of Barrett's esophagus with high-grade dysplasia and intramucosal adenocarcinoma, esophagectomy continues to play a role in the treatment of superficial esophageal neoplasia.
- The managing physician needs to be aware of the limitations of endoscopic therapies so that they are not misapplied.
- Until more data are available regarding the efficacy of endoscopic therapies for superficial submucosal carcinoma, esophagectomy with regional lymphadenectomy remains the standard of care in most operative candidates.
- When undertaken in specialty centers for appropriately selected patients, esophagectomy can be performed with a mortality of $\leq 1\%$, acceptable morbidity, and good long-term quality of life.
- When operating for early esophageal neoplasia, the surgeon should choose a technique that assures eradication of disease while minimizing the potential for perioperative morbidity and a negative impact on long-term quality of life.

INTRODUCTION

The standard of care for the treatment of superficial esophageal neoplasia has evolved dramatically over the past decade in the United States and Western Europe. Current guidelines published by specialty medical societies and the National Comprehensive Cancer Network (NCCN) recommend endoscopic therapies, including resection and ablation, as the preferred treatments for most cases of Barrett's esophagus (BE)

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with high-grade dysplasia (HGD) or intramucosal carcinoma (IMC).¹⁻³ The NCCN also recommends endoscopic resection (ER) with or without ablation as an option for selected cases of superficial submucosal carcinoma (SMC).³ Endoscopic treatment modalities, when expertly performed in appropriately selected patients, have been shown to achieve cure rates equivalent to surgery, but with less morbidity. Esophagectomy, the prior standard of care for all superficial neoplasia, has been relegated to the minority of cases of HGD and IMC not suitable for endoscopic approaches. Although surgical resection reliably cures early-stage disease in a single intervention, its role has been marginalized due to the perception of high rates of perioperative mortality, particularly in low-volume centers, a significant complication profile, and the potential to impair long-term quality of life (QOL).

Given such a rapid change in treatment paradigms, the managing physician must remain mindful of the limitations and potential pitfalls of endoscopic therapies as well as knowledgeable about the indications for and outcomes following esophagectomy; a “one-size-fits-all” strategy does not apply. Although the use of surgical resection has diminished in the setting of early-stage esophageal neoplasia, it remains the treatment of choice in specific circumstances. Treatment may be inappropriately underaggressive, following the course of endoscopic therapies, when a more extensive surgical resection is indicated. Performed in experienced hands and with the appropriate techniques, esophagectomy for early neoplasia can be undertaken not only with a high likelihood of cure but also with a low mortality, acceptable morbidity, and good long-term alimentary function.

LIMITATIONS OF ENDOSCOPIC THERAPIES: THE RISK OF NODAL METASTASES

Fundamental to the utilization of endoscopic modalities for the cure of esophageal cancer is the principle that they are appropriate only when the absence of nodal spread can be assured. The treating physician, therefore, must understand how the depth of tumor invasion and other risk factors determine the potential for lymph node metastases, which mandate a surgical resection with regional lymphadenectomy should they be suspected.

The deep border of the esophageal epithelium is its basement membrane (Fig. 1). Neoplasia limited to the epithelium, and not penetrating beyond the basement membrane, is termed low-grade dysplasia (LGD) or HGD in the United States, or low-grade

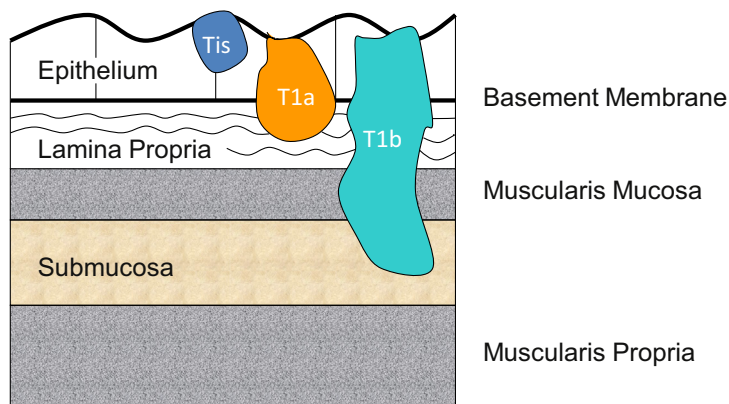


Fig. 1. Subtypes of superficial esophageal neoplasia.

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