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FIVE YEAR SURVIVORS AFTER RADICAL OPERATION FOR ESOPHAGEAL CARCINOMA: INFLUENCE OF PATHOLOGICAL FINDINGS.

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The aim of this work was: (a) to study 5-years survivors after radical resection for esophageal squamous cell carcinoma and (b) to compare pathological findings observed with those of patients dead between 1 and 4 years after operation (control group).

Patients: from 1979 to 1985, among 195 patients operated on, 30 (15.4%) were alive five years after operation. There were 28 men and 2 women (mean age: 57.5 +/- 8 years). 6 patients had preoperative medical treatment (radiotherapy or chemotherapy). Tumor was located on higher (n=4, 14%), middle (n=9, 32%) and lower thoracic region (n=15.54%). Esophagectomy with mediastinectomy and coeliac nodes dissection was performed in 28 cases; in 2 cases (7%), esophagectomy without thoracotomy was performed.

Results: Mean survival rate was 73 +/- 18 months (range 60,147 months, 23 patients (77%) were asymptomatic, 7 patients (23%) presented: reflux (n=3), dysphagia (n=1) and postprandial epigastralgias (3 cases). One patient presented lung and liver metastases (3%); 4 patients (13%) had an associated cancer during follow-up: tongue (n=1), lungs (n=2), gastropathy (n=1). In the 30 survivors, 11 (33%) presented lymph nodes metastasis (9 juxtatumoral, 1 cervical and 1 cardiac). On 195 patients: 88 presented without nodes survived and 19 survived more than 5 years (10.3%). Compared to control group, cellular reaction within tumor (i.e. lymphocytes and polynuclear) and absence of fibrotic stroma within tumor seem associated with good prognosis. These results must be confirmed; however, it could indicate adjuvant treatment in poor risk patients.

Conclusions: (a) among 5-year survivors, no patient presented visceral or coeliac nodes, metastasis, or positive node with capsular rupture; (b) on the other hand, other reported poor-risk criteria can be observed (i.e. tumor >10cm, cardiac or cervical positive nodes); (c) functional results are good with 2/3 patients asymptomatic; (d) 4 patients (13%) presented associated cancer, demonstrating the importance of long-term follow-up; (e) Systematic mediastinectomy and extensive coeliac nodes dissection systematically performed during esophagectomy could explain that 11 patients (37%) with positive nodes are alive 5 years later.

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LASER THERAPY OF ESOPHAGEAL CANCER

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Carcinomas of the esophagus and of the gastric cardia are often diagnosed at advanced stage. When dysphagia and malnutrition require a palliation, endoscopic laser photocoagulation (ELT) of malignant tissue produce an immediate effect, can be repeated, and is usually performed on an out patient basis with a low complication rate. From 6/81, 352 patients were treated in a total of 950 sessions with the Nd:YAG laser. Luminal patency was restored in 93% of patients and a subjective improvement of dysphagia was described by 75% of patients. Morbidity and mortality related to the procedure were 2% and 1%, respectively. One year survival of recanalized patients was 20%, whereas in not recanalized patients it was 7%.

In conclusion, ELT of cancers in the esophagus and gastric cardia offers satisfactory palliation for dysphagia, thereby allowing longer survival and a better quality of life in these patients.

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ESOPHAGEAL CANCER: DIAGNOSIS AND PREOPERATIVE STAGING

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Dysphagia and weight loss are the main presenting symptoms of oesophageal carcinoma. Pain is less common and may indicate ulceration or advanced disease with infiltration of the spine.

The diagnosis is usually made on barium-swallow or endoscopic examination. Advantages of the latter procedure are the possibility to obtain material for histologic examination and more accurate detection of proximal submucous metastasis and/or gastric involvement. In addition, a correlation exists between the endoscopic appearance of oesophageal lesions and depth infiltration; this feature can also be assessed with CAT scanning (which furthermore yields essential information regarding lymph node, pulmonary or hepatic metastases) or endoscopic ultrasonography (EUS). Detection of coeliac lymph node metastases remains difficult with all the aforementioned methods.

Bronchoscopy (for exclusion of tracheal involvement) and ultrasonographic examination of supraclavicular lymph nodes have been advocated as additional diagnostic procedures, especially in proximal tumors.

The availability of flexible video-endoscopes has revived the interest in preoperative laparoscopy, although a distinct advantage over the traditional method with rigid instruments still remains to be proven.

Conclusion Endoscopy is the superior method for diagnosing oesophageal cancer; for preoperative staging purposes, many additional procedures have become available, most of which are complementary.

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PROGNOSTIC FACTORS IN ESOPHAGEAL CARCINOMA

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Identification of prognostic factors which may influence survival in patients with squamous cell carcinoma of the esophagus is critical for the selection of those patients who benefit from a surgical resection and the choice of the radicality of the procedure. We evaluate the tumor characteristics which independently influenced survival in 249 consecutive patients with squamous cell carcinoma of the esophagus who had undergone en-bloc resection and 2-field lymphadenectomy. Multivariate analysis in the entire patient population identified (1) the pT category, (2) the pN category, (3) more than 7 positive mediastinal lymph nodes, and (4) the presence of residual tumor after resection, i.e. a R1- or R2-resection, as the only independent factors influencing survival time. In a second multivariate analysis of 94 patients who survived the procedure for at least 30 days, who had a R0-resection, and who did not have preoperative neoadjuvant therapy, only the pN category, the presence of more than 7 positive mediastinal lymph nodes, and the ratio between positive and removed mediastinal lymph nodes independently influenced survival. These data suggest that only a R0-resection, i.e. complete macroscopic and microscopic tumor removal, can increase survival in patients with squamous cell carcinoma of the esophagus. In patients with a limited number of positive mediastinal lymph nodes the prognosis may be improved by a 2-field lymphadenectomy, if the number of removed mediastinal lymph nodes exceeds the number of positive nodes by a factor of at least 5.

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Summary: Radiotherapy in esophageal carcinoma.

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There is a role for Radiotherapy as curative treatment, usually combined with surgery, occasionally alone. Several randomized trials have addressed preoperative radiotherapy. A Scandinavian trial in 186 patients found improved survival in groups who had preoperative treatment including radiotherapy, compared to groups without preoperative radiotherapy. No corresponding effect could be found for chemo-therapy as preoperative treatment. However, there are other trials who have failed to show any effect of preoperative radiotherapy.

One trial was started, with the intent to compare surgery and radiotherapy in operable patients, but was stopped due low recruitment of patients. (Earlam-R). Postoperative radiotherapy may be important only in a small group with residual tumor in the mediastinum - to prevent recurrence with obstruction of the tracheobronchial tree. (A randomized study. Fok, M & al 1993.)

Radiotherapy combined with chemotherapy has failed to show any effect of chemotherapy in most reports. In the Scandinavian trial a group of inoperable, but localized esophageal cancer was given either radiotherapy alone, or combined chemo-radiotherapy. There was no difference between the two subgroups.

Radiotherapy may be important in palliation. In advanced cases with metastatic disease, a short course of external radiotherapy with moderate doses can give good palliation. Over the past years endocavitary radiotherapy with afterloading equipment has become an interesting possibility.

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Palliative surgical therapy (PST) in esophageal cancer (EC).

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In most European countries and in North America EC often progresses to an advanced stage when first diagnosed and in more than 50% cases appears to be nonresectable. Despite increased rate of resectability and improved surgical techniques, most esophageal resections are in fact, palliative. The main aim of PST in EC is to relieve suffering, and to improve quality of life i.e. to relieve dysphagia, to prevent aspiration and to keep patient in reasonably good condition for a possible adjuvant therapy. For patients with advanced EC following PST procedures are available: palliative resection, bypass, intubation and prosthesis application, gastro- or jejunostomy, and dilatation in combination with laser therapy. At present, resection (in selected patients) seems to offer the best chance of long-term survival and as well as radiotherapy provides the best palliation. Despite the disadvantages (blockage of the tube, abnormal swallowing) insertion of prosthesis by pulsion is considered to be the most effective PST. The laser therapy is the alternative procedure for high surgical risk patients. Pros and cons of the above methods have been summarized. The recommended procedure depends on: condition of the patient, localization and stage of the primary tumour and technical circumstances.