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ABSTRACTS

Esophageal Cancer

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Oncologic Indications for Esophageal-Sparing Surgery in Early-Stage Adenocarcinoma

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Background: The incidence of early esophageal adenocarcinomas, defined as high-grade dysplasia and T1 tumors, is increasing at a rapid rate. Traditional management of these early cancers has been with an esophagectomy. More recently, esophageal-sparing techniques have been developed which might allow endoscopic treatment of these tumors. The two major hurdles to the acceptance of these techniques are oncologic and technical. The oncologic concerns center on under-treating patients with potential nodal disease, and the technical limitations relate to the inability to obtain complete local disease clearance. In this review, we focus primarily on the oncologic concerns of these therapies.

Methods: We performed a retrospective review of the Memorial Sloan-Kettering esophagectomy database. We included all patients with early-stage esophageal adenocarcinoma who underwent an esophagectomy. All pathology specimens were re-reviewed by a single pathologist. Data analyzed included pathologic details (depth of invasion, presence of nodal disease, grade, and lymphovascular invasion), disease status, and survival. The statistical analyses used for the database review included chi-square analysis for categorical variable, a t-test for continuous variables, and the Kaplan-Meier method for survival.

Results: From 1996 to present, 1,222 patients underwent an esophagectomy for cancer. A total of 177 were appropriate for this analysis; 42 patients had high-grade dysplasia (HGD), 44 had a mucosal tumor (<SM), 51 had tumor invading up to 50% of the depth of the submucosa (SM1), and 40 patients had tumor invading >50% of the submucosa (SM2). Overall, 10.2% of patients had nodal metastases. Of the patients with invasive cancers (<SM, SM1, SM2), 28 patients (21%) had LVI, and 35 (26%) were poorly differentiated. Univariate and multivariate predictors of nodal metastases ($P < .05$) were SM2 and LVI. “Low-risk” patients (no LVI, no SM2) had a < 1% likelihood of nodal disease, whereas “high-risk” patients had a 34% risk of nodal metastases. Overall survival ($P < .001$) and disease-free survival ($P < .001$) were significantly better in the “low-risk” group.

Esophageal Cancer

Conclusions: From an oncologic standpoint, local treatment of early-stage adenocarcinomas is feasible in patients without SM2 invasion or LVI. While technical limitations are not addressed in the analysis, concerns remain about the adequacy of any submucosal resection (SM1 and SM2), as well as the ability to assess the exact extent of submucosal invasion.