



The cutting edges of esophageal cancer management

About 40 years ago as a young resident at professor Pezzuoli and Peracchia school of surgery, when I moved my first steps across the esophageal cancer world, surgery of this organ was burdened by an extremely high complication rate. The procedures were deeply invasive, quality of life was extremely poor and patient survival was very low.

Nowadays, after many years of research and effort, many advancements have been made, even if there is still wide room for improvement in surgical techniques, patient clinical management, and research in the field of biology, immunology and in general of personalized or targeted therapies.

Surgery is no longer the only way to treat this aggressive disease. A multimodal approach with preoperative chemo and chemo-radiotherapy is the standard care in most cases and the evaluation of the response to these treatments with new techniques such as MRI, represent a new field of investigation and development. Identification and prediction of response to various treatment modalities is a very promising field of research for proper patient selection.

An important step forward has also been made with the development of endoscopic resection for early stage disease, avoiding “overtreatment”, leaving intact the esophageal function with a better long term quality of life.

The idea to reduce the impact of our surgical procedure in order to reduce complication rate and its entity, has resulted in the introduction of minimally invasive surgery which, once the technicalities have been established, has at least the same oncologic value with better clinical results. Probably, robotics will give further improvement if brought to reasonable prices and once the commercially driven policy has been abandoned.

A further evolution in the area of improving outcome and quality of life, is the development of pre-habilitation pathways. Attention to the nutritional status, physical and psychological preparation of our patients to this challenging trial can really have a deep impact on the quality of clinical results. Patients know that this could be the most important trial of their life and should be prepared as for an athletic competition.

Debates are still open on the most suitable surgical approach to treat cardia cancer. While there is a general agreement for Siewert I and III, Siewert II, for of its nature of a border disease between the esophagus and the stomach, is a hot topic between extended total gastrectomy or Ivor Lewis esophagogastric resection.

Even more debated and far away from standardization is the treatment of the most severe surgical complication, the anastomotic leak.

Esophageal surgery, due to its extremely high complexity and to the large number of professionals involved, needs a centralization policy. This is strongly suggested by many authors, but it is realized in very few countries.

Common large databases from the most experienced centres, in these days of very easy access to the web, allow easy sharing of experiences, easily-accessible international registries for surgical data collection, and might allow benchmarking and internal auditing of results having immediately online all the information available worldwide.

In this special number of AOE the most brilliant scientists in esophagology reported their experiences and I would like to sincerely thank all of them for their efforts and outstanding contribution.

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