In the Name of Allah

Esophagogastric Junction Tumors & Challenges.

Jalaluddin Khoshnevis

Associate Professor of Surgery,
Shohada Medical Center,
Department of General & vascular Surgery,
Shahid Beheshti University of Medical Sciences (SBUM)
Where is the EGJ, GEJ?

- Anatomist = HIS

- Physiologist = Manometry → Lower Sphincter.

- Pathologist = End of Gastric Fold.

- Endoscopist = End of Gastric Fold. SCJ 3-10 mm proximal. Caveats: Stenosis, Hiatal hernia, Diaphragm movement.
Migration from Antrum to Cardia

• Since 1970.

• The incidence of Gastric Cancer at Cardia have increased.

• AJCC 2017 8th edition
  1- EGJ involvement
  2- Epicenter within 2 Cm.

• Changes: Prognostic stage grouping, C, P, yP, TNM specific for SCC & Adenocarcinoma.
Siewert Classification 1987

• Type 1: Reflux. Barret. Male, Hyperacidity.

• Type 2: HP. Atrophic Gastritis. Barret.

• Type 3: HP. Atrophic Gastritis, Hypoacidity.

• One multimodality approach but different surgical approach.
Staging

- Endoscopy.
- EUS. Locoregional. TN, M in left lobe. Ascites. Stenosis..
- Contrast enhanced CT.
- PET-CT. CT by IV. 9% F+, Biopsy is mandatory for metastases.

Thoracoscopy? Bronchoscopy can R/O 9% for Surg.

- Laparoscopy: Liver. Node. Peritoneum. Lavage & Cytology if + then neoadjuvant, if converts to – then proceed to Surgery. T3,4 Siewert II,III (NCCN, ESMO). T1,2 by plan of Curative Surg. (SAGES)
What is the indicators of unresectability?

• Metastases.

• Extraregional (paraortic, retroperitoneal or mesenteric LN).

• T4b

• AJCC 2017 Celiac, Mediastinal and supraclavicular nodes are scored as regional.

• Lymph node number that involved.
Surgery: Is R0 resection Prolongs Survival?

• NO.

• Multimodality Treatment.
Trials:

• US 0116: Postop CRT in adenoca.

• Magic: Periop CT.

• POET: CT+CRT > CT.

• CROSS: CRT.
Optimal regimen?

- FU+Cisplatin…..French FNLLC/FFCD.

- Oxiplatin+ Leucovorin +FU(FOLFOX)…..GALGB 80803.

- +Docetaxel (FLOT) triplet ….FLOT4-AIO for fit patients.
Postoperative Guide: By Pathologic response

- Preop CT ➔ Postop CT amid Node +. If margin + = CRT.

- Preop CRT 41-50 cGY
  - IF Node + CT by other agents.
  - IF Node+ Observation.

- Surgery
  - CT - CRT if margin or node+
Multimodality treatment. Stage IIA, IIB, III. ASCO 2020

- Definitive CRT for SCC.
Necessity for surgery?

- Definitive CRT  ➔ Hx for SCC.
- RTOG 0436 a phase III RCT for adenoca=OS 19.7 month

- Complete responder definition. (25%)? EUS + FNA. Endoscopy + Biopsy. PET- CT?
- Persistence and recurrence is high without surgery. (all reports).
- SEER: 5 Yrs Survival with Stage I-III + Surgery = 28% - Surgery=10%

Better Locoregional control.
Neoadjuvant Therapy.

- Impact on perioperative mortality & morbidity ???

- 23 randomized studies showed No increase.
Standard Approach for Esophageal Cancer
Standard Approach for Gastric Cancer

- D2 Lymphadenectomy
- D1 Lymphadenectomy
What is the Standard Approach for EGJ?

• Phase III Dutch Trial: 220 cases with Siewert Type I & Type II. THE & RTA. Better 5 Yrs survival for Type I. (51 vs 37) favors RTA.

• JCOG 9502 Trial: THE & LTA for Type II & III. If margin + -> Thoracotomy & Lymphadenectomy. Closed prematurely due to inhospital mortality was high (4 vs 0 %). 5 Yrs survival (38 vs 52%) favors THE.
Why different surgical approach?
What is the standard approach?
Radical en bloc dissection - The East School

- Three field lymphnode dissection in treating the esophageal cancer
Radical en bloc Esophagectomy
Transthoracic Approach

Disadvantages

• Respiratory Complications 17%,

• Bile Reflux 20-30%,

• Anastomosis Leak (4%) with mortality of 64%.
Technique: TransHiatal Esophagectomy (THE)

Disadvantage: lower extent of Lymph Node Dissection.
Extent of Lymphadenectomy?

- The More the dissection, the Better the Survival.
- Prospective study: No difference.
- Stage migration phenomenon?
Gastrectomy for EGJ Adenoca Type II,III.

- D1  Lymphadenectomy. OK.

- D2  Lymphadenectomy. OK.

Without Splenectomy & distal Pancreatectomy.

- D3  Lymphadenectomy. NO.
Total Gastrectomy & Reconstruction by R-Y or Loop.
Minimally Invasive Procedures

Conventional?
Laparoscopic?
Thoracoscopic?
Robotic?
Hybrid?


Which approach fits for the patient?
It is the surgeon’s responsibility to choose the best approach.
Thank you for your attention