Velda Chow
Consultant, Department of Surgery
Queen Mary Hospital

Esophago-gastric preservation in pharyngo-esophageal cancer – less is more?

Isolated tumours in the pharyngo-laryngo-esophageal region have traditionally been managed by upfront surgery followed by adjuvant radiotherapy if necessary. With the global trend towards organ-preserving therapy, upfront therapeutic chemo-radiotherapy has gained increasing popularity over primary surgical therapies. The role of surgery is being reserved for those with locally advanced disease, and as a means of salvage for failure after chemo-radiotherapy and recurrent disease.

Management of recurrent pharyngo-laryngo-esophageal tumours poses certain challenges. In addition to surgery, many patients would have undergone prior chemo-radiotherapy, leading to extensive radiation-induced tissue fibrosis. More importantly, such tumours are frequently found in a deep-seated location behind the manubrium bone in the cervico-thoracic region, in close proximity to great vessels in the lower neck and superior mediastinum. Extensive radiation-induced tissue fibrosis further increases the complexity of surgery, leading to increased risk of morbidity and mortality. Previous surgery would further complicate the picture in terms of the extent and severity of fibrosis, and depletion of recipient vessels for potential microvascular reconstruction. As a result management in the majority has been palliative.

We hereby propose a means of cure for many such patients who were previously deemed inoperable. In removing the manubrium bone, the entire length of cervical esophagus is exposed down to the level of the aortic arch, enabling resection of pharyngo-esophageal tumours under direct vision with adequate distal resection margins. Tumours with posterior tracheal wall invasion can also be catered for. Level VI lymph node dissection can be performed in case of nodal metastasis. Resultant defects in the pharynx, cervical esophagus,

Our study have shown that pharyngo-laryngo- cervico-esophagectomy allows adequate tumor resection while preserving the esophagus and stomach below. In resecting less, operative morbidity and mortality outcomes were improved without compromising oncologic control.

周令宇
玛丽医院外科顾问

咽食管癌的食管胃保留——少即是多?

传统意义上，咽食管区域的孤立肿瘤通常采用先行手术，如有需要则进行辅助放疗的方案。伴随着器官保留疗法在全球的流行，治疗性化疗和放疗方案在初次手术治疗之上越来越受欢迎。手术方案逐渐留给那些局部晚期病例以及作为化疗放疗失败或复发后的挽救手段。

复发的咽食管肿瘤的治疗具有挑战性。除手术外，许多患者还可能接受过化疗和放疗，导致广泛的放射后组织纤维化。更重要的是，这类肿瘤常常位于颈胸部深处，靠近下颈部和上纵隔的重要血管后的位置。广泛的放射性组织纤维化进一步增加了手术的复杂性，导致更高的发病率和死亡率。前次手术也会在纤维化的范围和严重程度以及潜在微血管重建的供受体血管的耗竭方面导致进一步复杂化。因此，对大多数患者而言，治疗通常是姑息性的。

本文旨在提出一种治愈许多此类被认为无法手术的患者的新方法。通过切除胸骨柄骨，将颈段食管完全暴露至主动脉弓水平，我们可以通过直接视野下获得足够的远端切除间隙，从而切除咽食管肿瘤。该方法还适用于具有后壁气管侵犯的肿瘤。在淋巴结转移的情况下，可以进行VI区淋巴结清扫。研究结果显示在切除过程中，我们保留了食管和胃，从而在尽可能减少切除范围的同时，改善了手术的发病率和死亡率，同时没有牺牲对肿瘤的控制。