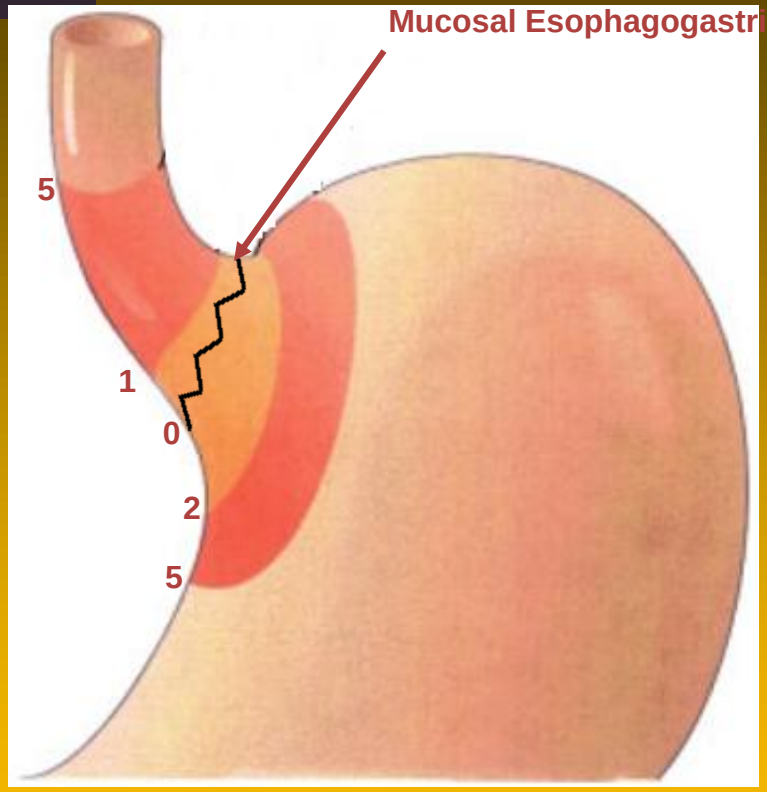
Approccio chirurgico dei tumori della giunzione esofago-gastrica

CARMINE NAPOLITANO

AOU "SAN GIOVANNI DI DIO E RUGGI D'ARAGONA"

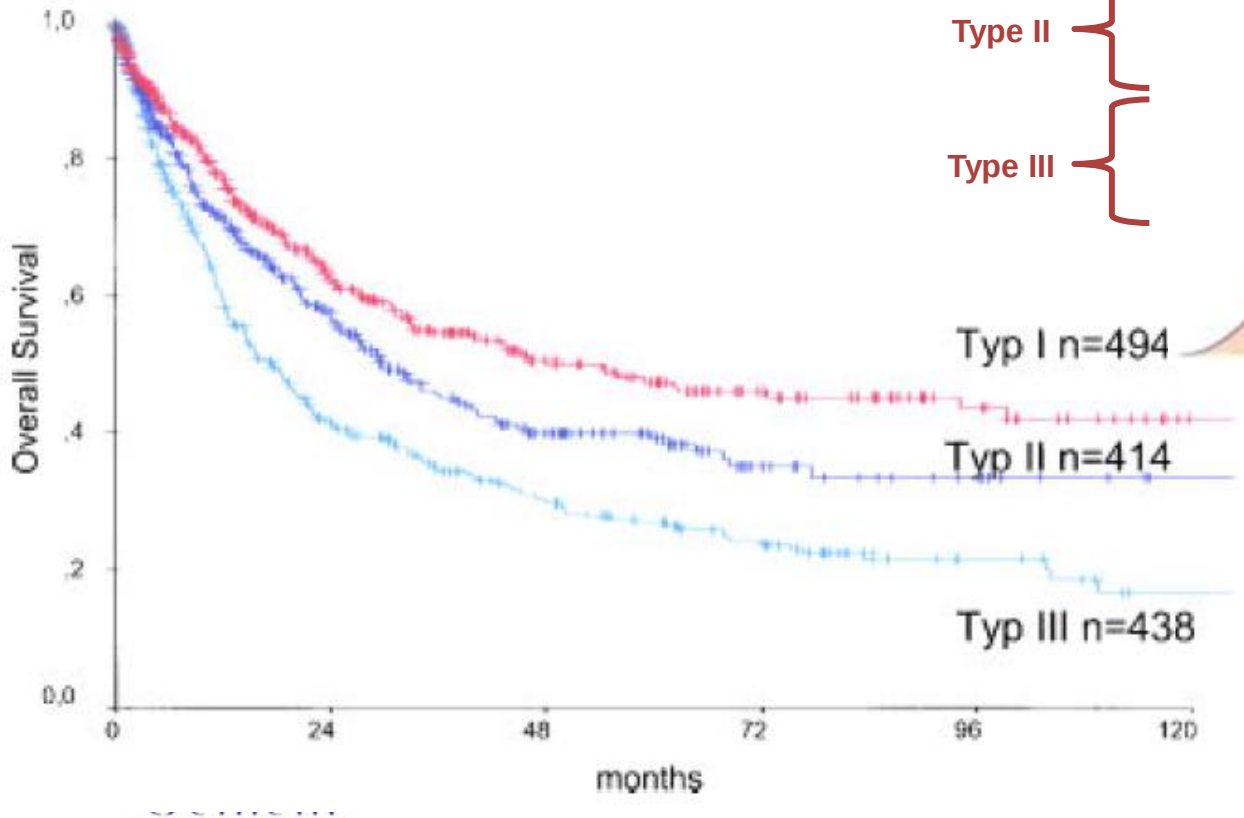
CHIRURGIA ONCOLOGICA e M.I.

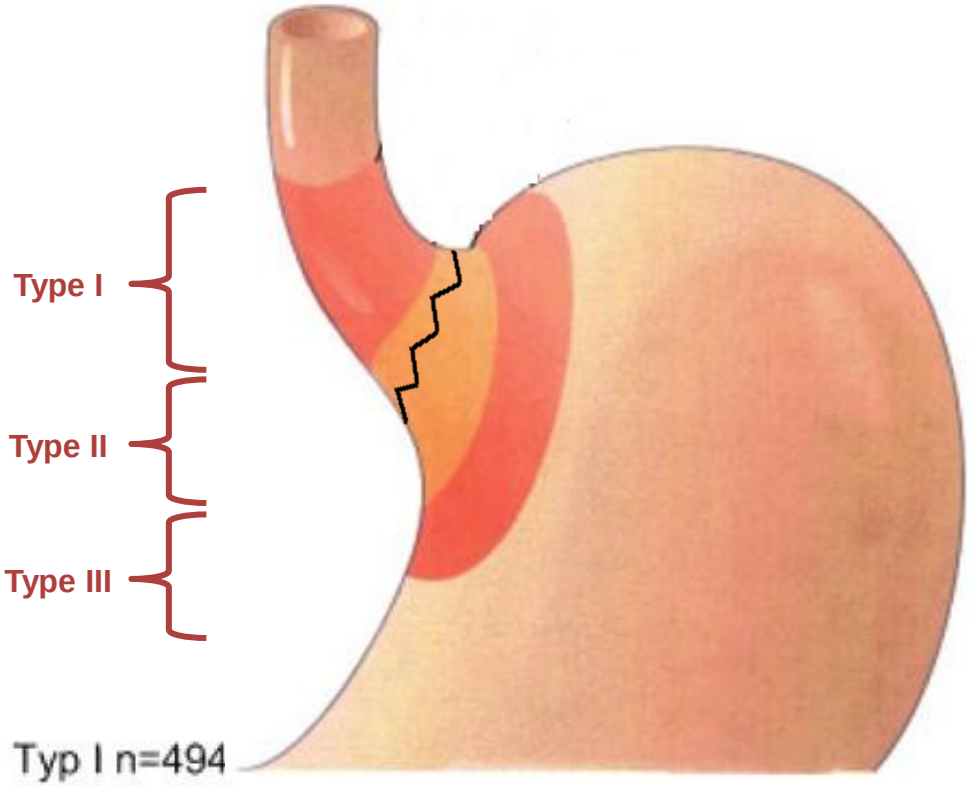
Siewert's Classification



Siewert JR, Ann Surg 2000

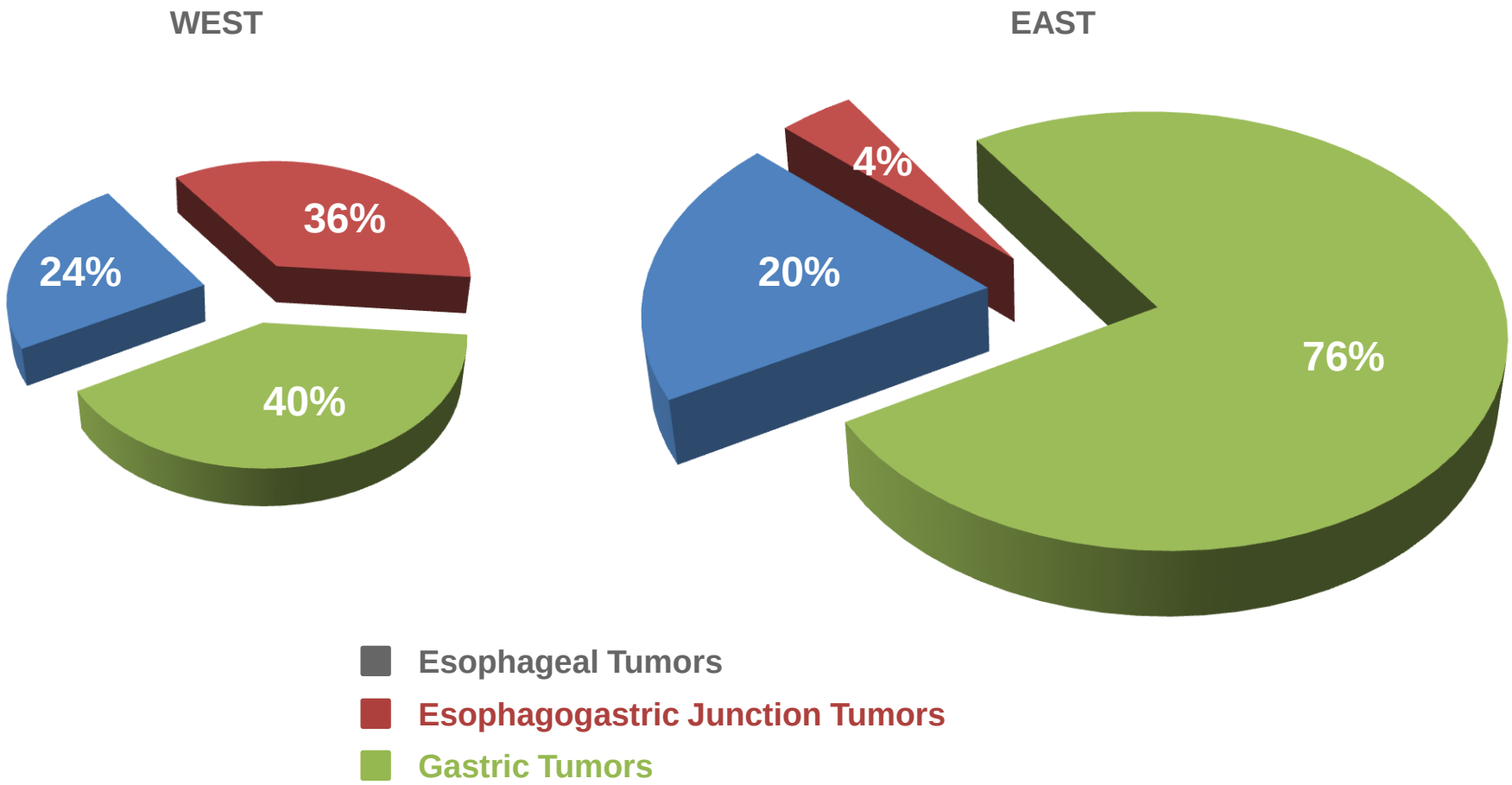
Siewert's Classification: prognosis





Siewert J, JSO 2005

Incidence (West vs. East)



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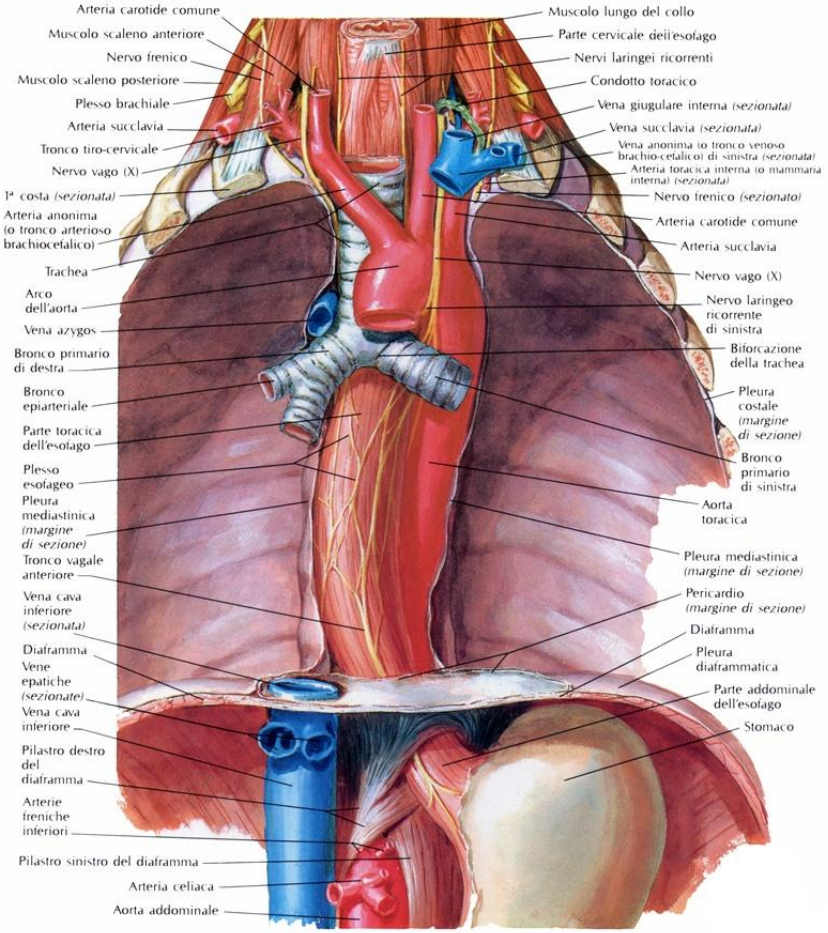
Hasegawa S, World J Surg 2009 - Siewert JR, J Surg Oncol 2005 - De Manzoni, Ann Thorac Surg 2002 - Devesa S, Cancer 1998

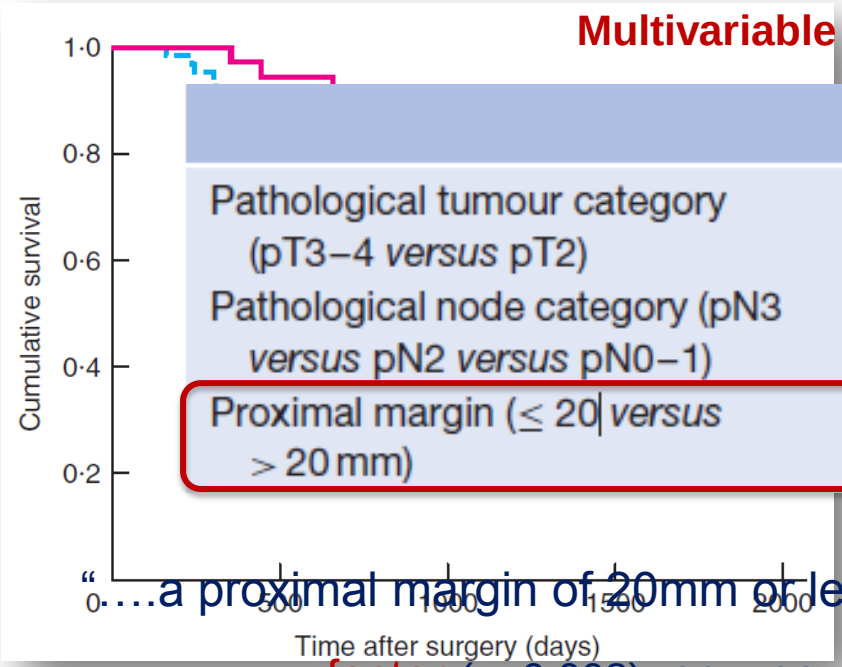

Arteria carotide comune
Muscolo scaleno anteriore
Nervo frenico
Muscolo scaleno posteriore
Plesso brachiale
Arteria succlavia
Tronco tiro-cervicale
Nervo vago (X)
1ª costa (sezionata)
Arteria anonima (o tronco arterioso brachiocefalico)
Trachea
Arco dell'aorta
Vena azygos
Bronco primario di destra
Bronco epiarteriale
Parte toracica dell'esofago
Plesso esofageo
Pleura mediastinica (margine di sezione)
Tronco vagale anteriore
Vena cava inferiore (sezionata)
Diaframma
Vene epatiche (sezionate)
Vena cava inferiore
Pilastro destro del diaframma
Arterie freniche inferiori
Pilastro sinistro del diaframma
Arteria celiaca
Aorta addominale
Muscolo lungo del collo
Parte cervicale dell'esofago
Nervi laringei ricorrenti
Condotto toracico
Vena giugulare interna (sezionata)
Vena succlavia (sezionata)
Vena anonima (o tronco venoso brachio-cefalico) di sinistra (sezionata)
Arteria toracica interna (o mammaria interna) (sezionata)
Nervo frenico (sezionato)
Arteria carotide comune
Arteria succlavia
Nervo vago (X)
Nervo laringeo ricorrente di sinistra
Biforcazione della trachea
Pleura costale (margine di sezione)
Bronco primario di sinistra
Aorta toracica
Pleura mediastinica (margine di sezione)
Pericardio (margine di sezione)
Diaframma
Pleura diaframmatica
Parte addominale dell'esofago
Stomaco

Proximal Margin length

Proximal margin length with transhiatal gastrectomy for Siewert type II and III adenocarcinomas of the oesophagogastric junction

S. Mine, T. Sano, N. Hiki, K. Yamada, T. Kosuga, S. Nunobe and T. Yamaguchi

100 pts with pT2–4N0–3M0 tumours
underwent gastrectomy via a transhiatal approach



Multivariable Analysis

	Hazard ratio	*P*
Pathological tumour category (pT3–4 *versus* pT2)	7·47 (0·98, 56·71)	0·052
Pathological node category (pN3 *versus* pN2 *versus* pN0–1)	1·76 (1·08, 2·86)	0·024
Proximal margin (≤ 20 *versus* > 20 mm)	3·56 (1·39, 9·14)	0·008

than

vival

ter

"….a proximal margin of 20mm or less was an independent prognostic factor (p=0.008), as was **pN status** (p=0.024)…."

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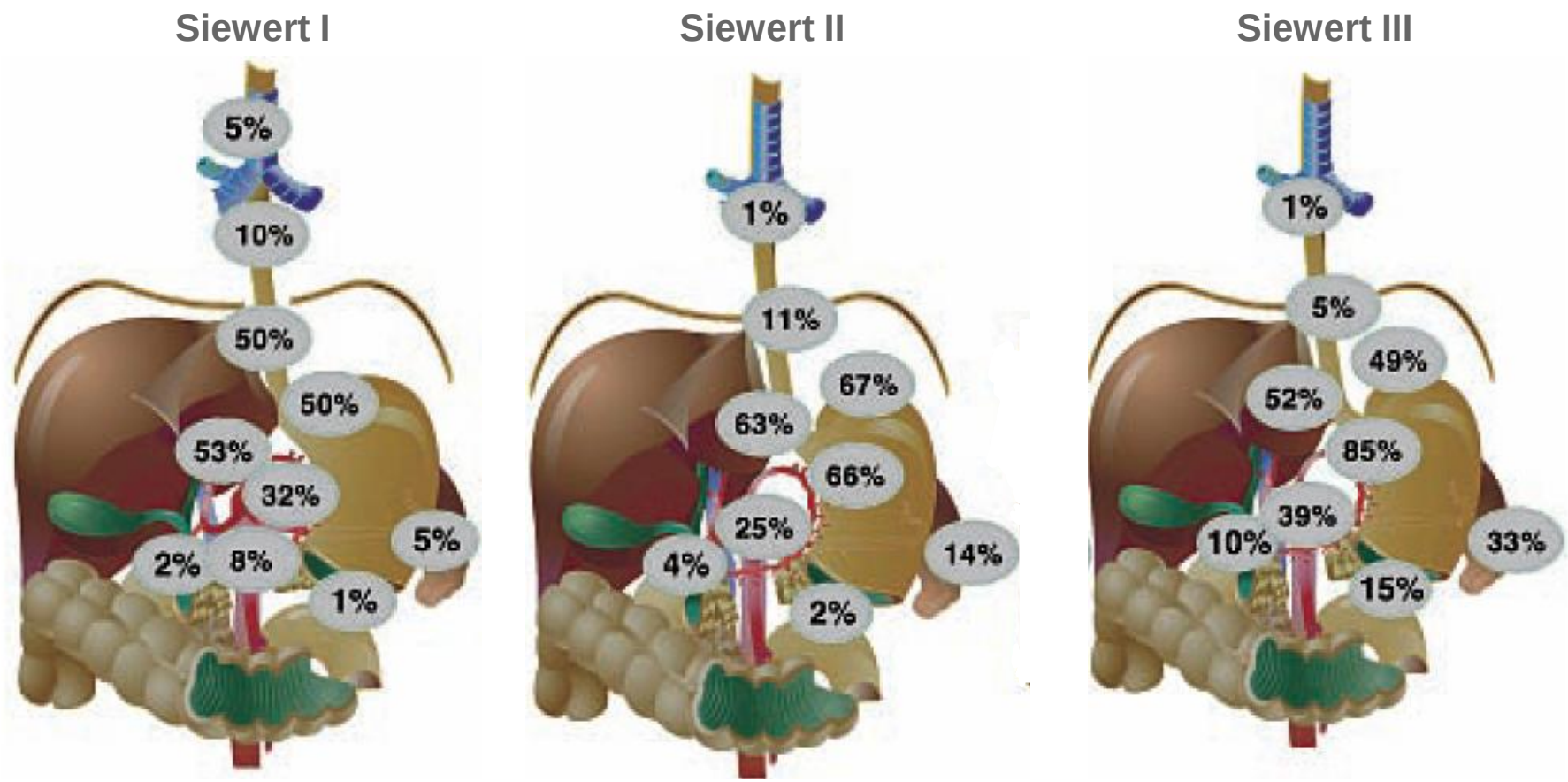
British Journal of Surgery 2013

Siewert type / N+ (EU)



"… The classification of adenocarcinomas of the esophago-gastric junction in three types, AEG type I, type II and type III shows marked differences between the tumor entities and is recommended for selection of a proper surgical approach…"

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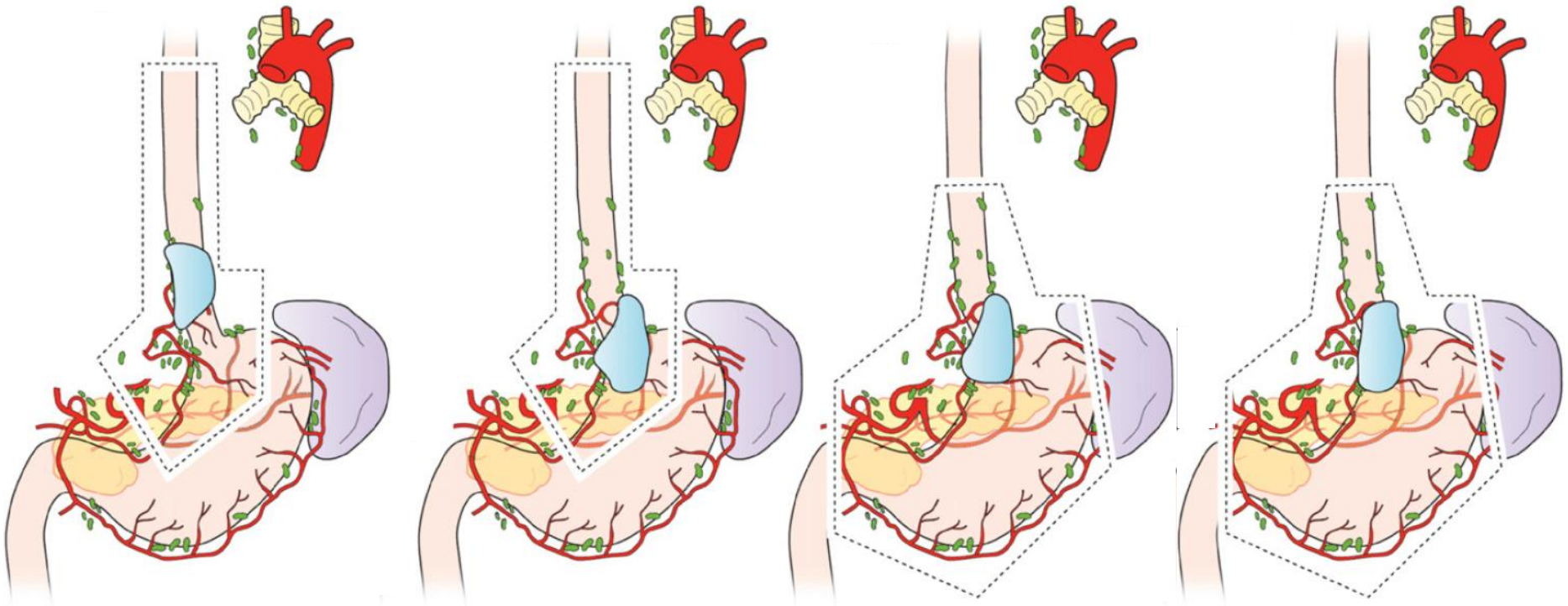
Siewert JR, Scand J Surg 2006

Siewert's Classification: surgical treatment

Siewert Type I

Siewert Type II

Siewert Type III



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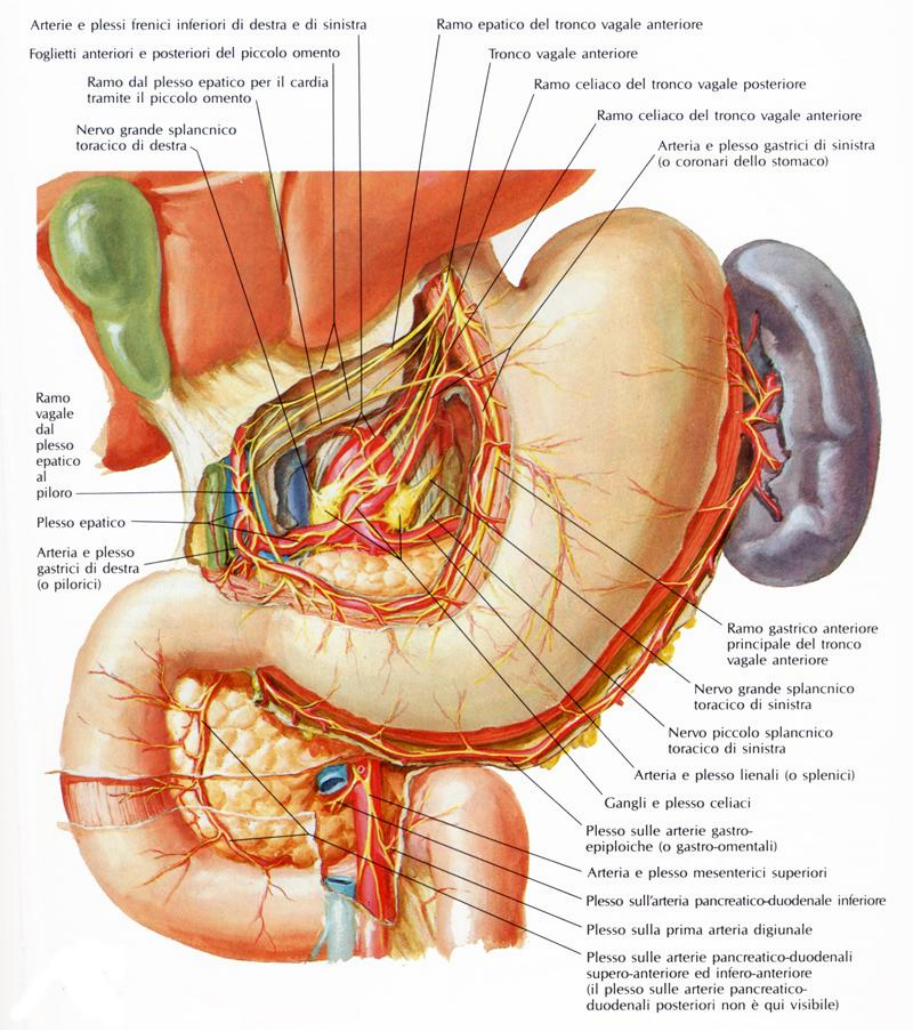
Gronnier C et al, J Visc Surg 2012

Gastrolisi per esofagectomia



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Optimal Extent of Lymph Node Dissection for Siewert Type II Esophagogastric Junction Carcinoma

Hiroharu Yamashita, MD, Hitoshi Katai, MD,* Shinji Morita, MD,* Makoto Saka, MD,* Hirokazu Taniguchi, MD,† and Takeo Fukagawa, MD**

Nodal station	Number of patients with metastatic nodes	Number of patients in whom the station was dissected	Incidence of lymph node metastasis (%)	5-year overall survival rate of patients with metastatic nodes (%)
No. 1	86	225	38.2	36.0
No. 2	52	225	23.1	30.5
No. 3	79	225	35.1	38.9
No. 4sa	9	225	4.0	25.4
No. 4sb	3	225	1.3	0.0
No. 4d	0	169	0.0	NA
No. 5	1	169	0.6	0.0
No. 6	2	169	1.2	0.0
No. 7	47	225	20.9	18.3
No. 8a	14	225	6.2	35.7
No. 9	23	225	10.2	14.7
No. 10	6	147	4.1	16.7
No. 11p	25	225	11.1	23.8
No. 11d	12	173	6.9	32.4
No. 12a	0	102	0.0	NA
No. 110	7	95	7.4	23.8
No. 111	3	95	3.2	0.0
No. 112	1	79	1.3	0.0
No. 16a2	8	73	11.0	12.5
No. 16b1	7	38	18.4	0.0

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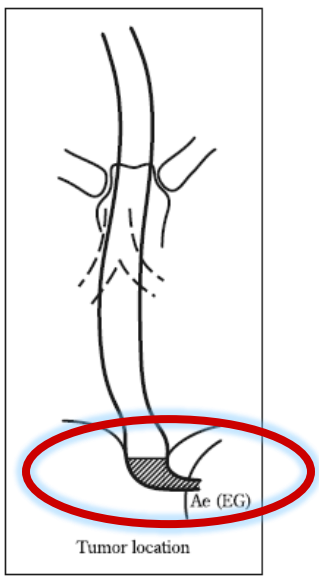
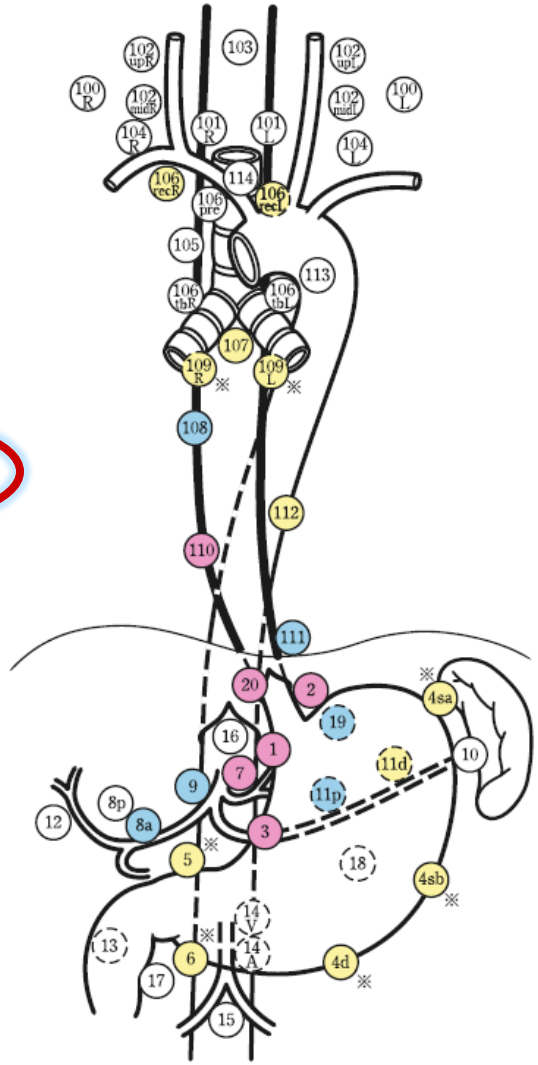
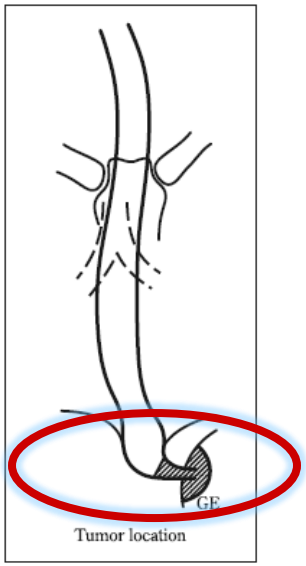
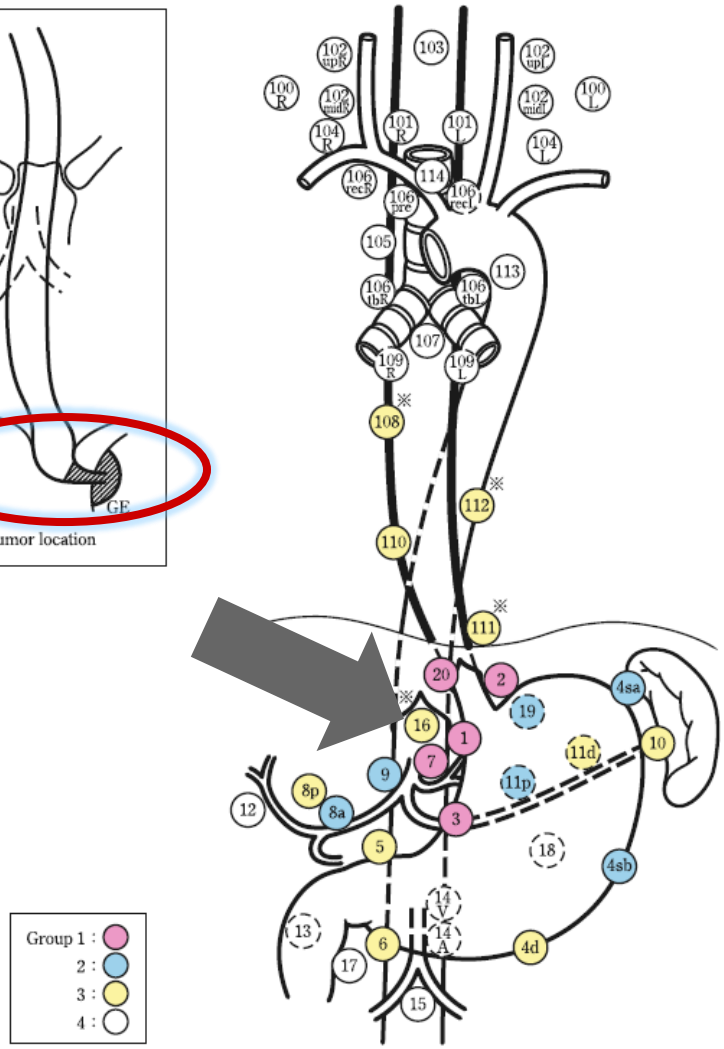
Ann Surg 2011

Siewert Type II: extended lymphadenectomy









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Japanese Classification of Esophageal Cancer, tenth edition, Esophagus 2009

Esophago-Gastric or Gastro-Esophageal Cancer ?

Siewert Type I
(~esophageal adenoca)

Marked male predominance

History of reflux symptoms

Intestinal type Lauren histology

Siewert Type III
(~distal gastric adenoca)

Less marked male predominance

No history of reflux symptoms

Intestinal/diffuse type Lauren histology

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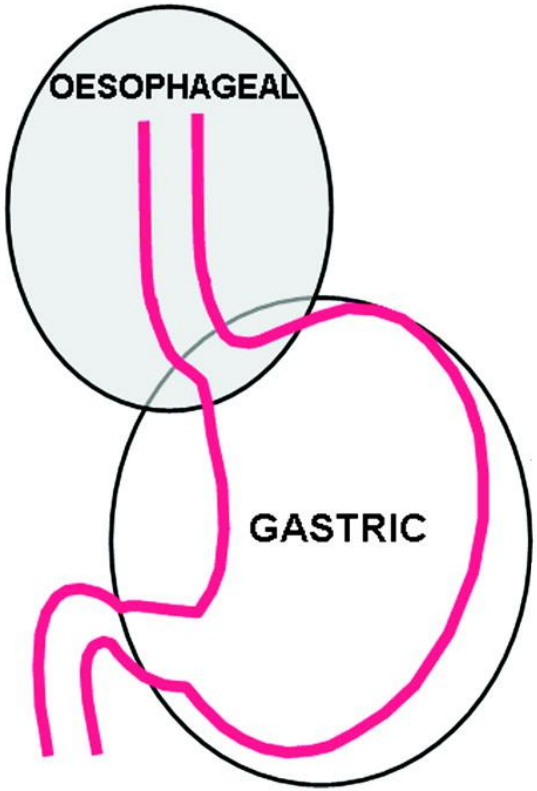
Siewert JR, Ann Surg 2000 – Siewert JR, Br J Surg 1998

Esophago-Gastric or Gastro-Esophageal Cancer ?



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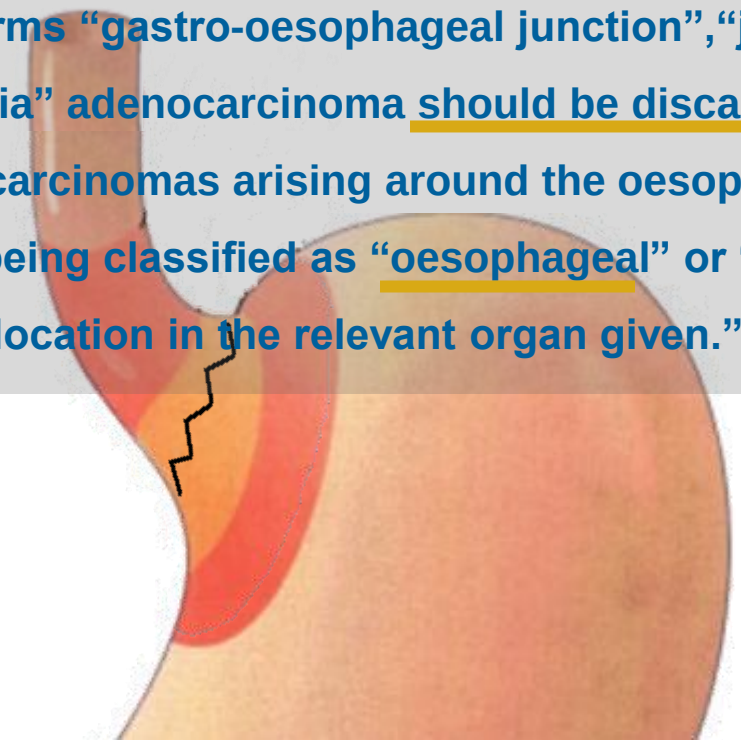
McColl K, GUT 2010

Classification proposal : Esophageal Adenoca. / Gastric Adenoca.

Esophagogastric Junction Adenocarcinoma

"…The terms "gastro-oesophageal junction","junctional" and "cardia" adenocarcinoma should be discarded, with all adenocarcinomas arising around the oesophogastric junction being classified as "oesophageal" or "gastric" and their location in the relevant organ given."



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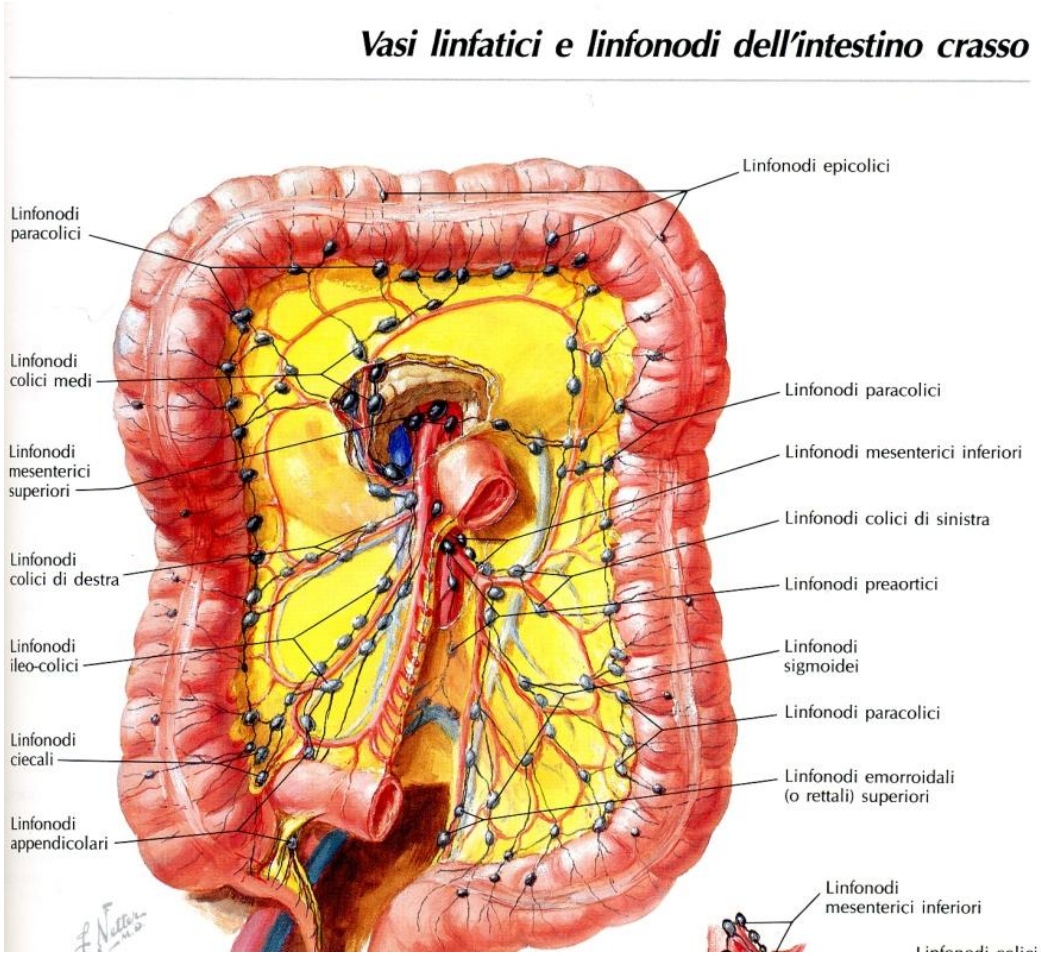
McColl K, GUT 2010

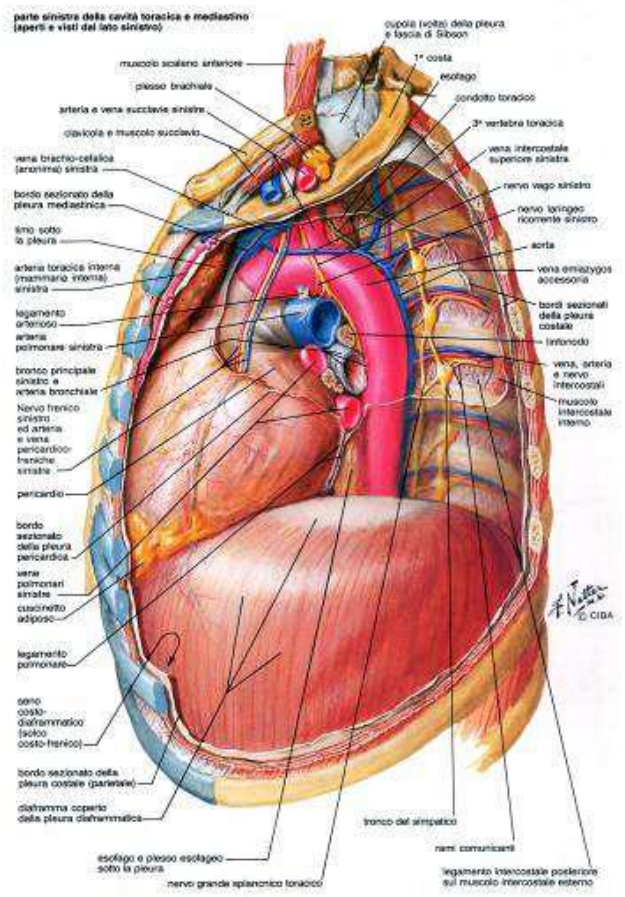
Optimal Management of Gastric Cancer: Results From an International RAND/UCLA Expert Panel

- Results: The following tenets were scored appropriate and necessary: (1) preoperative staging by computed tomography of abdomen/pelvis; (2) positron-emission tomographic scans not routinely indicated; (3) consideration for adjuvant therapy; (4) further clinical trials; (5) multidisciplinary decision making; (6) sufficient support at hospitals; (7) assessment of 16 or more lymph nodes (LNs); (8) in metastatic disease, surgery only for palliation of major symptoms; (9) surgeons experienced in GC management; (10) and surgeons experienced in both GC management and advanced laparoscopic surgery for laparoscopic resection. The following were scored appropriate, but of indeterminate necessity: (1) diagnostic laparoscopy before treatment; (2) a multidisciplinary approach to linitis plastica; (3) genetic assessment for diffuse GC and family history, or age less than 45 years; (4) endoscopic removal of select T1aN0 lesions; (5) D2 LN dissection in curative intent cases; (6) D1 LN dissection for early GC or patients with comorbidities; (7) frozen section analysis of margins; (8) nonemergent cases performed in a hospital with a volume of more than 15 resections per year; and (9) by a surgeon with more than 6 resection per year.

Esofago-colon-plastica retro-sternale



Esofago-colo-plastica retro-sternale



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