To resect or not to resect: The decision in T1 esophageal adenocarcinoma

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A little more than 100 years ago, Dr Torek¹ performed the first successful resection of the thoracic esophagus. This patient lived 13 years, but with the aid of an external feeding tube connecting the end of the esophagus to the gastric lumen. The past 100 years have given witness to improvements in the conduct of the operation, such as the 2-layer anastomosis,² gastric mobilization³ and tubularization, reductions in operative mortality, advancements in intensive care, and an increase in survival from this devastating disease.^{4,5} But these advances required the patient to undergo resection of the esophagus and reconstruction, which although functional did alter the patient's alimentary function.

In the Expert Opinion "The Dilemma of T1 Esophageal Adenocarcinoma," Drs Molena and DeMeester⁶ provide the underpinnings that allow for curative treatment of an early esophageal cancer using endoscopic techniques that not only avoid esophagectomy but also preserve the patient's native functioning esophagus. This is no small achievement, and although it is written as an Expert Opinion, it provides thoracic surgeons with the required understanding of why endoscopic therapy, and not esophagectomy, is now the standard of care for many T1a cancers and why T1b cancers should be carefully evaluated to determine appropriate treatment, which is usually esophagectomy.

Although this treatment paradigm is well known to thoracic surgeons who have a dedicated interest in esophageal disease, it is important for all thoracic surgeons to understand the data surrounding endoscopic therapy. We have an important role to play in this disease regardless of whether we perform endoscopic therapy or not. First, it is necessary to counsel patients about options because many patients who are evaluated will be excluded from endoscopic therapy and will require surgery.^{7,8} Second, knowledge is required to have a multidisciplinary discussion with the advanced endoscopist, particularly for T1b disease or end-stage esophageal function. This may result in more appropriate treatment with esophagectomy. Third, surgical treatment of the underlying disease (gastroesophageal reflux disease) remains a more effective therapy than proton pump inhibitors and for selected patients may

Cap-based endoscopic mucosal resection.

Central Message

Thoracic surgeons should understand the treatment options for T1 esophageal adenocarcinoma. In T1a disease, endoscopic therapy is preferred, but esophagectomy remains the standard of care for T1b disease.

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lead to better symptom control, may lower recurrence rates of Barrett's esophagus, and may halt progression to cancer.⁹

As therapy for esophageal cancer continues to evolve, it is imperative that thoracic surgeons maintain their expertise in this disease. Although not all thoracic surgeons will become facile with endoscopic techniques, we must, at a minimum, be able to provide input to the other members of the multidisciplinary esophageal team where and when esophagectomy should be the treatment of choice.

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