and remains an important option and the timeless gold standard.

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Commentary: Age is just a number: Let's give endoscopy a chance in the treatment of early esophageal cancer

Jesse Rappaport, MD, and Siva Raja, MD, PhD

Siva Raja, MD, PhD (left), and Jesse Rappaport, MD (right)

CENTRAL MESSAGE

Endoscopic resection for very early esophageal cancer may be the right first-line choice for all patients, especially elderly patients, who may be at greater risk for conventional surgery.

As the expertise in complex interventional endoscopic therapies increases, the need for traditional esophagectomy for cT1a esophageal cancer as the treatment of choice has been increasingly called into question. Esophagectomy as an operation is almost universally considered a life-altering operation despite significant improvements in minimally invasive surgical options and markedly decreased mortality compared with the past. The radical aspect of this operation was and is justified by the aggressive biology of the disease process. However, recent works have shown the premalignant condition of Barrett's esophagus can be eradicated with radiofrequency ablation,¹ and the biology of mucosal esophageal cancer is often relatively indolent with low rates of lymph node metastasis.² These are the rationale that have driven the field to adopt organ-preserving options such as endoscopic resections in the place of esophagectomy for these early cancers.

In their article, Raman and colleagues³ sought to evaluate the effect of age on survival in the growing use of

endoscopic resection compared with esophagectomy for clinical T1a carcinoma. In their retrospective review of the National Cancer Database, they found that survival was comparable between the 2 treatments across all age groups. Their study took on the hurdles of incomplete data in the National Cancer Database through propensity score-matched patients and a "high-risk" subset, which demonstrated similar results in overall survival for both treatment options. The trends toward greater 90-day mortality with esophagectomy could not statistically be confirmed based on their patient subset, likely limited by too few numbers, but has been noted by others.⁴

There is no doubt that the work by Raman and colleagues³ adds to the literature that suggests that endoscopic therapy for T1a cancer is both safe and effective, albeit the database lacks the granularity to determine what that "endoscopic resection" may actually be. Even within this very

From the Department of Thoracic and Cardiovascular Surgery, Heart and Vascular Institute, Cleveland Clinic, Cleveland, Ohio.

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Address for reprints: Siva Raja, MD, PhD, 9500 Euclid Ave, J4-1, Cleveland, OH 44195 (E-mail: rajas@ccf.org).

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early cancer, it is important to consider specific risk factors for potential upstaging and lymph node disease including size, differentiation, and lymphovascular invasion.^{5,6} Although a difference was not noted in the “high-risk” group in the study³ that is being discussed, nearly 50% of the patients had missing data in each of the aforementioned variables, calling into question the value of that particular subset analysis regardless of the statistical methodology.

Studies have found that endoscopic ultrasound (EUS) T1 staging sensitivity and specificity were limited to 81.6% and 92.4% respectively.⁷ Our own study⁵ showed that for pathologic T1b cancers, only about 50% of patients had a cT1b diagnosis on EUS. With the growing use of endoscopic resection and the resulting increase in accuracy for assessing pathologic stage over EUS,⁸ we may be turning to an era in which endoscopic treatment can be employed as an initial staging adjunct.

As we close in on the optimal treatment for very early esophageal cancer, we must not lose sight of the goal of oncologic success. With endoscopic resection as a first line for all age groups in clinical T1a disease, patients must be counseled on the long-term follow-up required for continued surveillance of locoregional disease, but also the potential for the confirmation of “high-risk” pathologic features, upstaging, and need for further surgical

resection after endoscopic treatment. Using our least-invasive treatment as first line improves upon patient outcomes, accuracy in staging, and does not burn any further treatment bridges.

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