

THE ROLE OF NEOADJUVANT POLYCHEMOTHERAPY IN THE TREATMENT OF CARDIOESOPHAGEAL AND ESOPHAGEAL CANCER

Makhsudov Bekhruzбек Dilshodbek ugli
1st year master of Tashkent Medical Academy

Abstract: Currently, there is no standardized surgical strategy for the treatment of gastroesophageal junction cancer. The issues of resection margin, volume of lymph node dissection, and optimal size of the gastric stump remain debatable. The article discusses the impact of these parameters on relapse-free survival and postoperative quality of life of patients according to literature data.

Keywords: stomach cancer, esophageal cancer, quality of life, gastric resection, gastrectomy, reconstruction.

INTRODUCTION

The choice of the optimal resection margin is an important decision for the postoperative prognosis. The minimum resection margin margin in esophagogastric junction (EGJ) cancer has been studied by many modern researchers, and its impact on patient survival has also been assessed. M. Bissolati et al. [2] wrote about the relationship between a positive or negative resection margin in their study. The authors show a significant difference in patient survival after surgery depending on the state of the resection margins — 89.5 and 28.9 months with negative and positive margins, respectively. In addition, the authors claim that in T1 EGJ cancer, a margin of less than 2 cm is a risk factor for the presence of a positive resection margin, and in stage T2–T4 cancer, such a risk factor is a margin of less than 3 cm.

MATERIALS AND METHODS

A. Barbour et al. [2] described an 18-year follow-up of 505 patients who underwent resection of the esophagus or stomach without neoadjuvant chemotherapy. The researchers found that for stage T1 and T2 tumors, a proximal resection margin of 3.8 cm was sufficient; for tumors of a higher stage, a margin of more than 3.8 cm is proposed. S. Tsujitani et al. histologically analyzed 175 samples of the proximal margins of resected pancreatic gastrointestinal tract tumors. The authors claim that a margin of more than 4 cm guarantees a safe state of the proximal margin, except in cases of tumor metastasis to the lymph nodes. S. Mine et al. [3] studied the results of operations on 140 patients, 120 of whom underwent total gastrectomy. Two patients had a positive resection margin, and two more developed a recurrence at the anastomotic site. Among patients with T2-4N0-3M0 who underwent gastrectomy via the transhiatal approach, higher survival rates were observed in the case of a proximal resection margin size of more than 2 cm. A margin of less than 2 cm was a risk factor for recurrence, based on which the authors recommend a margin of more than 2 cm for type II and III EGJ adenocarcinomas. In the study by A. Casson et al. [4], a distal margin of 3 cm was performed, and in 12% of cases (12 out of 100 patients) a positive resection margin was found in primary esophageal adenocarcinoma and in 28% (11 out of 39 patients) in gastric cardia adenocarcinoma. The authors propose to consider 5 cm as the optimal margin of the distal resection edge.

RESULTS AND DISCUSSION

D. Avella et al. [1] in their study consider the survival results of patients with severe stages of pancreatic cancer who underwent total esophagectomy or total gastrectomy depending on the location of the tumor. The authors claim that this surgical approach is satisfactory, but the study

group consists of only 6 patients. J. Butte et al. [2] also studied the long-term results of total gastrectomy and esophagectomy with colon interposition in 9 patients. The researchers are confident that patients who did not undergo radical resection have a worse prognosis, but more aggressive surgical tactics are associated with increased mortality. In addition to the volume of surgery and the margin of resection, lymph node dissection plays an important role in the consequences of the operation. The depth of invasion, as shown in the above study, plays an important role in assessing the damage to the lymph nodes. In the study by H. Yamashita et al. [3], the clinical records of 2807 patients with pancreatic cancer without preoperative therapy were analyzed and the condition of the lymph nodes was assessed. Most often in this situation, the right and left cardiac lymph nodes, nodes of the lesser curvature were affected, while metastases of the lymph nodes of the distal region of the stomach were much less common. Therefore, lymph node dissection of the latter, according to the authors, is not of great significance. Removal of the lymph nodes of the lower mediastinum can provide higher survival rates for patients with operated pancreatic cancer. A. Shiozaki et al. analyzed the results of treatment of 52 patients with distal esophageal and cardiac gastric cancer who underwent esophagectomy with lymph node dissection in three areas. Among these patients, 16 had positive and 36 had negative resection margins, as well as metastases to the lymph nodes of the middle, upper mediastinum and neck. The analysis showed that the margin of resection toward the esophagus was longer in the group of patients with metastatic lesions of the lymph nodes. Thus, the authors noted the primary role of the margin of the proximal resection margin over the distance from the esophagogastric junction to the deepest part of the tumor.

Y. Ueda et al. [4] compared the spread of the tumor toward the esophagus or stomach and the localization of the affected lymph nodes. The authors concluded that the predictor of the presence of metastatic foci in the lymph nodes of the neck, upper and middle mediastinum is the proximal edge of the tumor, and the predictor of the presence of metastatic lesions of the abdominal lymph nodes is the distal edge of the tumor: the longer the edges in one direction or another, the greater the likelihood of damage to the lymph nodes of the corresponding zones.

CONCLUSION

Despite the increasing incidence of pancreatic cancer, there is no consensus on the standard operation for its treatment depending on the tumor location. There are also no specific figures on the proximal and distal resection margins, lymph node dissection localization, and the optimal length of the gastric stump. In a study by Yasuyuki Seto, the authors argue that the minimum resection margin does not entail an increased risk of recurrence after surgery (proximal margin 13 mm, distal margin 65 mm), with a tumor invasion length into the esophagus of more than 30 mm, it is necessary to remove the upper and middle mediastinal lymph nodes, and with an invasion site into the stomach of less than 40 mm, proximal gastrectomy can be used and its distal part preserved. In addition, if the size of the gastric stump is more than 12 cm along the lesser curvature and 25 cm along the greater curvature, proximal gastrectomy is used.

REFERENCES

1. Niclauss N, Jung MK, Chevallay M, Mönig SP. Minimal length of proximal resection margin in adenocarcinoma of the esophagogastric junction: a systematic review of the literature. *Updates Surg.* 2019;71(3):401–409. doi:10.1007/s13304-019-00665-w.
2. Bissolati M, Desio M, Rosa F, et al. Risk factor analysis for involvement of resection margins in gastric and esophagogastric junction cancer: an Italian multicenter study. *Gastric Cancer.* 2017;20(1):70–82. doi:10.1007/s10120-015-0589-6.
3. Qureshi YA, Sarker SJ, Walker RC, Hughes SF. Proximal re-section margin in ivor-lewis oesophagectomy for cancer. *Ann Surg Oncol.* 2017;24(2):569–577. doi: 10.1245/s10434-016-5510-y.
4. Mariette C, Castel B, Balon JM, et al. Extent of oesophageal resection for adenocarcinoma of the oesophagogastric junction. *Eur J Surg Oncol.* 2003;29(7):588–593. doi: 10.1016/s0748-7983(03)00109-4.