CARCINOMA OF THE OESOPHAGUS

Pages with reference to book, From 77 To 79

M.H.A.Beg (K.V.S.S. Hospital, Karachi.)

Carcinoma of the Oesophagus is a dreadful disease which is mortal not only due to presence of malignancy but also due to starvation patient suffers by gradual and increasing inability to swallow. Not enough knowledge is available about this local problem and more efforts are needed to lessen the suffering from this pathology.

Cancer of Oesophagus is known for centuries. Galen described fleshy growths which obstructed oesophagus in 2nd century[1]. In 10th century Ibn-e-Seena described various conditions causing dysphagia and noted tumours to be frequent cause for it. Ibn-e-Zuhr in eleventh century suggested insertion of Silver tubes for a patient who developed dysphagia[2]. The landmarks in oesophageal surgery are provided by Kussmaul who passed first oesophagoscope in 1863, Torek who performed first successful resection in 1913 and Janeway who developed a safe oesophagoscope in 1918. Resectional surgery of oesophagus started in second decade of this century and gradually became popular.

The geographic distribution of the pathology has become more clear recently due to availability of better diagnostic methods. In Iran, copstal area around Caspian sea are a store house for Carcinoma Oesophagus[3]. Transkei Province of South Africa, Linksien Province of China, Turkmania in Russia, Hong Kong and Japan are the countries where this tumour is common. Nearer to us in Bombay, Paymaster and his colleagues have found cancer Oesophagus to be the commonest when compared to stomach, colon and rectum[4]. In Karachi 850 cases of Carcinoma oesophagus were seen during 1960 1971 in a department of radiotherapy[5] The oesophagus has taken the third place after oral cavity and pharynx. The pattern has also been confirmed by a report from a Department of Otolaryngology where oesophagus maintains third position after pharynx and oral cavity[6]. The problem of carcinoma oesophagus in Karachi does not appear as magnanimous as in Bombay but it is definitely substantial.

Various causative factors suggested for Carcinoma Oesophagus are alcohol, hot food, smoking, anaemia, oral sepsis, chilies and other dietary habits, probably the most important factors contributing locally are chewing habits mainly of Tobacco with betal and betal nuts. [7,8]

Oesophagus in an average adult is only 10 inches long. It starts in neck at circopharynx, passes through chest into abdomen. Anatomical division of oesophagus into cervical, thoracic and abdominal portions is good enough for localisation of the growth in oesophagus. Following the anatomical relationships it is advisable to approach oesophagus from left side in the neck, right side in the chest and midline per abdomen. Commonest form of cancer oesophagus is Squamous Cell Carcinoma of varying grades of differenciation and it is cervical and upper thoracic oesophagus which is the common site for this mallgnancy. Lower thoracic and abdominal portions are less frequently involved. The spread of disease is local to start with, spreading to the wall of viscus in annular fashion. There is no serosal layer in oesophagus thus growth extends from wall of oesophagus to adjacent structures. Spread to lymph nodes is well known to be followed by trachea and bronchi. McKeown[9] has laid much stress on submucosal spread. The tendency to burrow under mucosal layer is characteristic and growth may extend far beyond the apparent upper limit of growth. This necessitates resection to be well above the upper margin of growth.

Oesophagoscopy and biopsy are the recoganised procedures accepted all over the world to confirm the diagnosis of malignancy and treatment of a lesion without prior biopsy is most undesirable. Fibreoptic instruments have a very small biopsy forceps and a raised margin which appears to be malignant may have the growth much deeper and would not come in the bite of the jaws of small biopsy forceps.

Slough also forms in advanced lesions, thus preventing the correct histological diagnosis. It is almost impossible to persuade a patient for a repeat biopsy thus unnecessary delay in diagnosis and management necessitates the use or rigid oesophagoscope for an adequate biopsy. Limited radiotherapy and thoracic surgery services necessitates involvement of General Surgeons and Otolaryngologists in the management of these lesions. Reports from abroad have claimed 18% one year survival and 6% five year survival by radiotherapists[10]. Linear accelerator is supposed to have excellent results[11] This also excludes operative mortality as well. Surgery seems to be first choice when and wherever possible in this country as other facilities are not readily available.

There is no uniformity on the surgical approach to oesophagus. Multiple surgical methods have been reported by various authors. [12-18] Operations on both sides of neck, both sides of thorax and abdomen separately or combined have been advocated in single and staged procedures. Carcinoma of abdominal and lower thoracic oesophagus which can be approached per abdomen is probably the easiest surgical procedure. The incision may be limited to abdomen or it may be extended into chest or diaphragm. Thoracic oesophagus need to be approached through thoracotomy on right 5th intercostal space and resection is done including any glands which are visible. This may be combined with abdominal approach if need be.

Resection of growth in cervical oesophagus using a incision in the neck and its repair by skin flaps has become obsolete as the procedure is tedius, multistage and disappointing. Visceral repair is more frequently used. McKeown[12] advocates three phase technique of combining abdomen, right chest and right side neck. A technique of resecting oesophagus without opening chest has recently been gaining popularity. T wo teams working together per abdomen and neck can joint to completely remove oesophagus and bringing stomach to the pharynx or oesophagus. This technique was introduced by Denk in 1913[13] and subsequently practicised by Grey Turner[14]. Abel[15] described this technique as a standard procedure for excision of cancer of oesophagus. Lam et al[16] have found this a useful technique •as the resection of oesophagus can be carried out under vision as high as bifurcation of trachea. He excises the oesophageal hiatus producing an opening of almost 8 cm in diameter. By inserting two beaver retractors the dissection can be done under direct vision. Beyond this level blunt dissection is under taken from neck. Wong[17] also have found this method safe and expeditious, as significant advance has taken place in middle of 1960s in transhiatal mobiisation. of thoracic oesophagus. He employs it in pharyngo-laryngo oesophagectomy, transsternal oesophagectomy, two phase abdomino-cervical oesophagectomy. McKeown in this recent report also accepts that operations for growths in mid and upper thoracic oesophagus are palliative in nature[18] Block dissection of glands in these growths is not possible and frozen sections are not available locally. 80% of the lesions in carcinoma of oesophagus are in the upper and middle thirds of thoracic oesophagus[19]. Resectabiity rate for oesophageal carcinoma, particularly midoesophageal lesion is low. Ong[20] found 45% of mid oesophageal lesions unresectable. In a large series of 5412 cases of carcinoma oesophagus from 13 clinics in China 40.5% of the oesophageal cancers were unresectable[21]

Two methods have been advocated for unresectable growths. While Ong[20] and Orel et a1[22] advised bye pass operations whenever possible, others[23,24,25] advised intubation. Twenty varieties of tubes have so far been reported[25]. Baulieux et al[26] advocates palliative resection. They have found postoperative mortality and morbidity not significantly different after palliative resection. Long term results are encouraging and superior to those obtained with other medical and surgical palliative therapies. In their series of 223 cases 70% were palliative resections.

In carcinoma oesophagus the goal remains early detection of malignancies[27] but as this seems far away the role of all medical practitioners becomes more important and they can definitely help the cause by early referral to obtain expert opinion, endoscopy and biopsy.

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