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Abstract / Oral Communication

Title :

“Oesophagus Cancer : wich Treatment ? Personal experience using a Multidisciplinary Therapeutic Approach “

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Declaration : It is not present clashing interests

BachGround :Actually the oesophageal and cardias carcinoma is a high morbility and mortality disease too.The main reason is a underestimated disphagic disease with a delayed clinical evaluation. The result is a very low quality of life and severe mortality.
The purpose of this study was to reduce the high grade of the disphagia and improve the quality of life in patients

affected by oesophagus cancer stenosis using a MultiDisciplinary Therapeutic Approach.

Materials & Methods :In our last Universitary Endoscopic Ambulatory,during 10 years, we observed 135 patients affected by oesophageus disease .The grave or severe disphagia was the more frequent symptom.Sometime,there were other symptoms linked to disphagia (tab.1). The 89% cases arrived to our evaluation without an adeguate clinical-endoscopic-radiological documentation.All had previously been treated with anti H2 and pro-kinetic drugs for several months.We observed 1)Primitive Neoplasm (78/120 p.=65%) 2)Secondary Neoplasm(12/120 p.= 10%) 3)Neoplastic Recurrences (17/120 p.=14.5%) 4)Flogistic Disease (5/120p.=4.16%) 5)Achalasia (5/120p.=4.16) 6)Barrett's Disease (3/120p.=2.5%) (tab.2-3).Male/female ratio was 2.5/1.Various risk factors were classified (smoke=60%,Alchohol intake over 1000cc/die=60%,Obesity=25%,Barrett =2.5%)(tab.4)

All the patients were valued with accurate clinical evaluation using a Multianalises Score System (tab.5-6-7-8-)

In evaluating operability,we considered several parameters concerning the General Clinical Status and the Neoplasm Stage (TNM) (tab.9-10-11)

Surgical treatment was established for only a few patients (15/135) which might gain advantages one-step open-surgical oesophagectomy,alone or combined to chemo-radio therapy,in according to international leterature.

The others 120 patients with disphagia (III°rd level=80 p.,

IV°th level = 40 p.) were valued no-responders to classic open-VLS Surgery (tab.12-13).They were treated with ELS (Endoscopic Laser Surgery) alone or combined to others treatments (EGDS Savary Dilatation,Endoprosthesis, X-Rays Therapy).

Flexible fibre CO2 Laser and single-use pinches were employed to perform this kind of treatment.The Endoscopic Laser Energy was administered with a continuous power flow (20-40 Watts) and mixed Technique.We used a specific treatment to single patient and disease.The single dose ranged 800-2000 Joules.The procedure was cyclically repeated every 15-60 days.The Total Dose ranged 2000-6000 Joules.In general ,we prefered the EGDS Savary Dilatation before the LES and positionating self expanding covered or non-covered stents (102)after ELS according Radiologist collegues.

If necessary ,RadioTherapy (mean dose 39 Gy) was associated too.

Results : we obtained a total recanalisation in flogistic disphagia disease.We obtained an important recanalisation in the first 12 months in the 85% of the neoplastic stenosis and an enough recanalisation in the 60% of the cases between 12-24 months from the first treatment.After 24 months ,we obtained an useful canalisation only in the 30% of the cases(tab.14).We registered some complications link to the treatment.(tab.15).The only one intra-operative death was in a 78 y.old patient affected by cardiomegaly.Probably ,the cause was an arrest hearth because of the fatality laser energy propagation.So,the mortality for this laser-surgery treatment was lower than 1% and also the morbidity was

reduced when compared to the other centers ‘dates.We registered oesophagus Iatrogenous perforations (3) too.These healed spontaneously after specific therapy (2) using thoracic drainage,antibiotic drugs,total parenteral nutrition).It has been necessary to place only one covered endoprosthesis. Our protocol provided a 3-years follow-up with long term survival ranging 30-900 days.

Conclusions :ELS could be considered the main treatment to inoperable oesophageal cancer.According our dates we think that the Treatment don’t influence the survival ,reduces absolutely the disphagic symptoms and improve the quality of life. The Cost/Benefit is profitable too.(tab.16)

Tab.1

Symptom	%
Dysphagia	78
Epigastric pain	6
Heatburn	3
Weight loss only	3
Odinophagia	2
Vomiting/Regurgitation	2
Fatigue	2
GastroIntestinal bleeding	1

Nausea	1
Indigestion	1
Sore throat	1

Tab.2 Patology

Diagnosis	n.patients	%
Primitive Cancer	78	65
Secondary Cancer	12	10
K. Recurrences	17	14.5
Flogistic disease	5	4.16
Achalasia	5	4.16
Barrett'esophagus	3	2.5

Tab.3 Primitive Cancer

	n.patients	%
Cervical esoph.	10/78	12.8
Thoracic	17/78	21.7
Cardias	51/78	66.5

Tab.3 Secondary Cancer

	n.patients	%
Cervical esoph. (from laringeal K.)	7/12	58.2
Cardias (from lung-mediastinic K.)	5/12	39.7

Tab.4 Risk Factors

Smoke	70 %
Alcohol	60 %
Obesity	30 %
Barrett's esophagus	2.5 %

Tab.5 Clinical Evaluation

General Status
Pulmonary Function
Cardio-Vascular Function
Hepatic Function
Renal Function
Neurological Function
Diabetes
Tumor Stage

Tab.6 Clinical Evaluation - General Status

Sex
Age
Karnofsky Index
Alcohol Abuse
Tobacco Abuse
Weight loss
Dispepsia
Mental Cooperation
Blood examination

Tab.7 Clinical Evaluation - Pulmonary/Renal Function

Vital Capacity	V.C
Focal Expiratory Volume	FEV 1
Peak Flow	
PaO2	mm/Hg
PaCO2	mm/Hg

Creatinine Clearance mg/ml

Tab.8 Clinical Evaluation - Cardiac/Hepatic Function

ECG
X-rays Chest
Cardiologist Visit
Serum Albumin
Bilirubin
P.T- P.T.T
Aminopyrine Breath Test
Cirrhosis

Tab.9 Clinical Evaluation - Mental cooperation / Risk

Karnofsky Index > 80 & good cooperation / Normal
Karnofsky Index < 80 & good cooperation/ Compromised
Karnofsky Index < 80 & bad cooperation/Severely impaired

Tab.10 Clinical Evaluation - Cardiac Function / Risk

Normal	Normal
Compromised	Increased
Severely impaired	Highest

Tab.10 Clinical Evaluation -Pulmonary Function / Risk

VC > 90%	PaO2 >70 mm/Hg	Normal
VC < 90%	PaO2< 70 mm/Hg	Compromised

Tab.11 Clinical Evaluation –Hepatic Function / Risk

ABT > 0.4	Normal
ABT < 0.4 no Cirrhosis	Compromised
Cirrhosis	Severely Impaired

Tab.12 Conditions for inoperable patients

III th Stage Neoplasm	T3 N2 M0-1
Age over 75	
Cardio-Vascular disease	
Coagulopaties	
Weight loss	
Immuno Compromised	

Tab.13 Pre-Operative Disphagia

Patients	III grade	IV grade
120	80	40

Tab.14 Post-Operative Disphagia

grade	%	n.patients	Follow-up/months
I	85	102/120	<12
I	60	72/120	>12 <24
II	30	36/120	>24

Tab.15 Intra-Peri Operative Complications

	n.patient	%
Exitus	1/120	0.83
Iatrogenous perforation	3/120	2.5
Re – Stricture (after RadioTherapy)	2/120	1.66

Tab.16 Cost effectiveness in the management of oesophageal K.

	Surgery	RadioTherapy	Laser	Stents	No Treatm.
Median Cost $	8070	4720	3520	2450	1390
Range	2540-39780	3364-6687	2530-6340	1647-5550	1132-2348
Cost /month					
Survival	457	364	342	/	/

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