

Comment

Comment: Delayed Cervical Esophagogastrostomy: A Surgical Alternative for Patients With Ischemia of the Gastric Conduit at Time of Esophagectomy[☆]



Comentario a: Esofagogastronomía cervical diferida: una opción técnica cuando se evidencia isquemia del tubo gástrico en el momento de la esofagectomía

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I would like to congratulate the authors for their treatment of a patient with several comorbidities who required esophagectomy. The risk factors that are known to be associated with poor healing of an esophagogastrostomy are diabetes, hypertension, cardiac arrhythmias, chronic obstructive pulmonary disease and neoadjuvant treatment. The author's patient had 3 of the risk factors from this list: diabetes, hypertension and chronic obstructive pulmonary disease.

Comorbidities such as these should alert surgeons to the fact that the perfusion of the digestive tube used for reconstruction could show signs of marginal ischemia, and an alternative back-up treatment plan should be available. In reality, ischemia of the digestive tube is the "Achilles' heel" of esophageal resection and reconstruction. If it is not treated properly, it can lead to a cascade of processes, including anastomotic leak, sepsis, multi-system failure and death of the patient.

For these patients, we have designed a delayed reconstruction strategy. The ischemic digestive tube is mobilized, it is secured in the neck, and a cervical esophagostomy is constructed. 90 days after the initial operation, esophagogastrostomy is performed in a second procedure at the cervical level.

We have used this delayed reconstruction strategy in 37 patients over the years. All of them recovered from the

esophagectomy with no signs of ischemic necrosis or fistulas of the gastric conduit. In 35 out of the 37 patients, a delayed esophagogastrostomy was performed. At the time of reconstruction, all of the cases presented well-perfused digestive tubes and the anastomoses had healed with no leaks, wound infections or sepsis. Three patients developed stenosis, which was successfully treated with dilatation. The delayed esophagogastrostomy was not done in 2 patients due to recurrence of the malignant disease.

This experience has led us to believe that delayed esophagogastrostomy is an acceptable strategy for the treatment of patients with comorbidities and an ischemic digestive tube at the time of esophagectomy. Its use allows for safe recovery from the initial operation and provides time for the ischemic conditioning of the stomach. The main difference between our strategy and the ischemic conditioning strategies described by other authors is that we apply the concept of ischemic conditioning selectively in patients with signs of ischemia of the digestive tube at the time of esophagectomy.

Our team is glad to see that our strategy has been of use to the Dr. Pera workgroup and that their experience coincides with ours. After all, this is the objective of publishing clinical reports in a scientific manner.

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