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Editorial

Surgical Treatment for Esophageal Cancer: Are the Questions Finished or Are the Surgeons Finished by the Questions?☆



La cirugía en el tratamiento del cáncer de esófago: ¿cuestiones agotadas o cirujanos agotados en las cuestiones?

For decades, surgery has been fundamental in the therapeutic approach to fighting esophageal cancer. Quoting the forefathers of esophageal surgery alone, such as Theodor Billroth, Ivor Lewis¹ and Franz Torek, does not do justice to all the people whose knowledge and courage have led us to the current development of esophageal resection techniques. However, since having overcome the innumerable medical, logistical and life-support barriers that existed in the last century, research has now been aimed at, among other things, determining prognostic factors (including those related with our actions on the tumor),² defining the extension of lymphadenectomy in association with visceral resection, and settling the eternal question about the best possible approach: transthoracic or transhiatal.

However, even though the techniques have been standardized and the centralization of these processes emphasized, the current cancer mortality rate of these patients 5 years after diagnosis continues to be high. No one questions the need of surgery for allies to win the battle against the disease in most cases.³ For years, multimodal treatment has gained popularity, associating surgery, chemotherapy and radiotherapy in different regimens. But are we surgeons still at the forefront, or are we being left behind?

A recent bibliometric analysis of trends in esophageal cancer research in the last decade⁴ confirms this suspicion, focusing on genomic alterations linked to these tumors and perioperative treatments.^{5,6} As in many other areas related to cancer, the search for specific therapeutic targets is of special interest, such as selective inhibitors of tyrosine kinase in the treatment of gastrointestinal stromal tumors. No less important and hopeful is the study of micro-RNA associated with carcinogenesis in the esophagus and cardia.⁷ The loss of

prominence of surgeons is corroborated by observing that a high percentage of the scientific journals and prominent authors in the research on esophageal cancer are specialists in Oncology and/or Gastroenterology.⁴

So, what can we as surgeons do to reverse this situation? As Professor Ramón y Cajal said, are we exhausted by questions? Or rather, have the questions in our field been exhausted? The first aspect to consider is the way in which we can participate and promote early diagnosis, while speeding up the presentation of patients before a multidisciplinary committee to determine adequate treatment for immediate application. Unfortunately, it is relatively frequent to observe how the interval between the onset of symptoms and diagnosis/extension studies is excessively long. Furthermore, minimally invasive surgery, one of the most outstanding surgical advances of our specialty, has provided some advantages over the traditional approach when applied to the treatment of esophageal cancer. This is an incredible field of research for improving the quality of treatment while reducing the aggressiveness, morbidity and mortality of surgical interventions.

Even so, for the moment, laparoscopy and thoracoscopy applied to esophageal cancer have not been able to increase patient survival or disease-free period.⁸ Correct patient selection, as well as their physical and nutritional appropriateness prior to surgery, are 2 very important factors to consider in order to improve our results. The technological innovations related with the optimization of substitution plasties and the resolution of surgical complications are another factor to take into account in daily practice. In addition, the application of clinical practice consensus guidelines helps reduce costs without negatively affecting quality parameters. In summary,

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and considering how demanding esophageal resection surgery is, any research and treatment developments aimed at increasing our oncological radicality, while minimizing aggression and complications at the lowest possible cost, will not be in vain.

Nonetheless, we are repeatedly faced with the reality of the situation, which requires us to maintain constant and daily interaction with other clinical specialists and basic researchers if we surgeons want to continue taking part in the active fight against this disease. Heading multicenter studies and participating in translational research seems to be the only path to follow to maintain surgery in the position at the forefront that it deserves.

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David Ruiz de Angulo*, Pascual Parrilla
 Unidad de Cirugía Esofagogástrica, Servicio de Cirugía General,
 Hospital Universitario Virgen de la Arrixaca, Murcia, Spain

*Corresponding author.

E-mail address: druizdeangulo@hotmail.com
 (D. Ruiz de Angulo).

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