



GASTRIC TUBE ANATOMIC CONFIGURATION AFTER ESOPHAGECTOMY: AN UNDERESTIMATED PROBLEM



To the Editor:

I read with great interest the article by Wong and colleagues.¹ The treatment of esophageal cancer has changed over years, and the prognosis has improved (for example, neoadjuvant treatment, minimally invasive surgery, and immunotherapy). At this point, postoperative quality of life has emerged as a very relevant topic for discussion. This retrospective case study series brought several points contributing to delayed gastric emptying (leading to dysphagia, aspiration, and nutritional status), such as redundant or dilated conduit, endoscopic findings regarding pylorus status, and postoperative anatomical issues.²

However, the following points should be highlighted: (1) The assessment of gastric tube emptying is not clear in the literature, even for a dynamic x-ray swallowing contrast or technetium-99m scintigraphy; there are no parameters to determine it.² (2) The definition of pylorus functional obstruction and its assessment is uncertain. Most studies use endoscopic findings to suggest pylorus contraction or spasm, representing a subjective tool to state it.² (3) Issues with gastric tube construction, such as wide conformation, twisted gastric pull-up, immediate postoperative gastric tube distension with axial direction deviation (simulating a sigmoid end-stage achalasia), and leakage anastomosis with stenosis.³ (4) The time to adapt the new dietary habits to the new anatomical conformation (smaller amounts of food, more periods) is considerable. It can take 2 years to reach it and involves bariatric surgery with full psychological adaptation for patients with obesity. (5) Differences in anastomotic locations, since cervical anastomosis might have more up-down tension in the gastric tube and less axial deviation. (6) Finally, the baseline of quality of life's assessment after esophagectomy is considered relative and undefined. It is a subjective parameter, difficult to judge and propose a technical solution. All those factors must be considered and analyzed since they could interfere with the results.

This case report series by Wong and colleagues¹ discussed the possible management of late complications after

esophagectomy. However, the surgical approach (thoracotomy, adhesions lysis, pulmonary wedge resections, and hiatal fixation) represents a high risk of postoperative complications, mainly pulmonary ones, which brings an issue related to the percentage of total cases, which was indicated in this procedure, and the mean follow-up time of those cases. We all know that pleural adhesion, thorax negative pressure, and pilar hiatus frailty could lead to recurrent anatomical issues (similar to the recurrence of the hiatal hernia and reflux disease), and this procedure could represent a temporary anatomical condition.⁴ Nevertheless, this procedure also requires a highly skilled surgical team and high-volume institution, which must be congratulated.

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