

The author reported no conflicts of interest.

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**REPLY FROM
AUTHORS:
LEAKAGE OF
CERVICAL
ANASTOMOSIS AFTER
ESOPHAGECTOMY:
INSIGHTS OF LOCAL
TISSUE PERFUSION**



Reply to the Editor:

We appreciated the comments from Zhang and colleagues,¹ who pointed out the interference of cervical esophagus mobilization related to anastomotic leakage after cervical anastomosis. In our view, some issues might interfere with that conclusion: (1) The distribution of direct vessels to the esophagus according to topography is heterogeneous, and are much more intense in the upper part of the esophagus²; (2) we systematically obtain 5 to 6 cm of esophageal remnant stump due to oncologic proximal margin, anatomically favorable to the lateral–lateral stapled anastomosis, and a favorable route to cervical incision could be made³ if there is any leakage; and (3) the final topography of the anastomosis is up to the manubrium sternal. Therefore, we do not maintain fibrous tissue around the remnant esophagus in our institution.³

Our previous study discussed the improvement of tissue perfusion after the supercharged cervical anastomosis for esophagectomy (SAFE) procedure and focused mainly on the area close to the lateral–lateral esophagogastric anastomosis. Since the extension of the esophageal stump was practically identical, we did not find any differences in perfusion of the esophageal stump mobilization even after reviewing the angiography with the SPY device (SPY Elite System; LifeCell Corp) before and after supercharging.

Technically, their hypothesis of the relationship between local differences of perfusion in residual esophagus and the occurrence of cervical anastomotic leakage is challenging to prove, mainly because of the following: (1) apparently, there is no considerable difference of perfusion captured by the SPY device. (2) The number of cases to obtain a substantial difference is huge with an equal technique in a high-volume center with a good quality and controlled methodology.⁴ (3) The quantitative assessment of perfusion is still unclear. Most of the available devices have been improved, but they are subject to many biases, such as intra-operative interference, medications, clinical conditions, and comorbidities.^{4,5} (4) The interference of perioperative treatment, such as chemotherapy and radiotherapy, in tissue healing is under debate, which could be a factor that interferes even more in the results.⁴ To conclude, we really appreciate all comments regarding our previous study, and hopefully we will move on to a randomized controlled trial very soon.

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