Traitement du cancer de l'oesophage: revue systematique sur les techniques chirurgicales
[Treatment of esophageal cancer: systematic review on surgical techniques]
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Record Status
This is a bibliographic record of a published health technology assessment from a member of INAHTA. No evaluation of the quality of this assessment has been made for the HTA database.

Citation

Authors' objectives
This document was produced at the request of the Direction de la lutte contre le cancer, on the recommendation of the Comite de l'evolution des pratiques en oncologie (CEPO), and is a systematic review of studies comparing the efficacy of different surgical techniques, including invasive procedures, minimally invasive techniques, and lymph node dissection, for the curative treatment of esophageal cancer.

Authors' conclusions
In light of the analysis of the selected studies on the surgical treatment of esophageal cancer, and given that the studies were limited in number, had low statistical power owing to small samples and were of poor methodological quality, AETMIS has reached the following conclusions: No difference was shown between the transthoracic and transhiatal techniques in terms of: postoperative mortality, regardless of histological tumour type; cardiac or infectious complications. Transthoracic en-bloc esophagectomy (according to the results of one RCT): increases the risk of pulmonary complications and chylothorax in patients with adenocarcinoma of the esophagus or of the gastro-esophageal junction; permits dissection of a greater number of lymph nodes; improves long-term overall survival (five-year) and disease-free survival when the number of involved lymph nodes (N1) is less than eight in the case of adenocarcinoma of the distal esophagus or of the gastro-esophageal junction; and when tumour resection is complete, there is no lymph node involvement (N0) and the resection specimen has more than 16 involved lymph nodes in the case of squamous cell carcinoma of the esophagus. Transhiatal esophagectomy: increases the risk of recurrent laryngeal nerve lesions. Cervical anastomosis: is associated with anastomotic leaks; these leaks are frequent but have less severe consequences than thoracic or mediastinal leaks. Note that the transhiatal technique is always associated with a cervical anastomosis. Minimally invasive esophagectomy: The weakness of the available evidence on the efficacy of the different invasive and non-invasive techniques, on the one hand, and on that of the multiple combinations of these techniques, on the other hand, does not make it possible to conclude on the superiority of MIE in terms of short-term and oncological outcomes. Minimally invasive esophagectomy remains under development. Three-field lymph node dissection: Available data are insufficient to conclude on the clinical benefit of extending lymph node dissection to the cervical region.

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