The prevalence of esophageal cancer in the developed world has been estimated to be five per 100,000. Adenocarcinoma of the esophagus has been diagnosed with an increased frequency in the Western world but squamous cell carcinoma remains to be the most frequent esophageal cancer in the world [1].

Several prognosticators have been proposed by different authors but the most widely reported factors include the T and N stage of the tumor. Computed tomography and endoscopic ultrasound (EUS) have been shown to be accurate modalities for staging in esophageal cancer and play a complimentary role.

EUS has been shown to give accurate information in regards to the T and N status on patients with esophageal cancer [2]. The cost-effectiveness of EUS has also been shown in several studies [3,4]. The accuracy of EUS for staging of locally advanced tumor has been reported to be around 80% especially for those tumors that allow the advancement of the endoscope. The localization of celiac axis nodes has also shown to be better than any other available modality especially when fine needle aspiration (FNA) is added [5]. Once a celiac node is detected it impacts the management planning of patients though not all agree in this approach.

An increasing number of patients with locoregionally advanced cancer are being managed by neoadjuvant chemotherapy or chemoradiotherapy. Better accuracy in staging and also careful triaging of patients to the appropriate treatment modality will reduce unneeded morbidity in those patients that are less likely to benefit from neoadjuvant treatment [6].

It is widely agreed that the prognosis of patients with esophageal cancer as with many cancers is directly related to the stage of the diseases. Of the many studies regarding the stages of esophageal cancer and prognosis, detection of lymphnode status stands out mainly due to the fact that celiac and cervical nodal involvement are considered separately from nodal disease and are considered metastatic disease. In addition, the number of lymphnodes has been shown to be correlated with prognosis [7,8] though not found in this study.

Rice et al. reported that patients with two or less malignant regional lymph node had better prognosis when compared to patients with more than two lymphnodes [9]. Focusing on celiac lymphnodes, Eloubeidi et al. have reported that the presence of any number of celiac lymph nodes reduced the five-year survival rate from 30% in those with no celiac nodes to 13% in those with a celiac node [10]. In addition, the number of metastatic lymphnodes has been shown to be an important prognostic factor reducing the five-year survival from 50% in those without nodes to 11% in those with three or more positive lymphnodes [11].

The study by Burtin et al. [13] presented in the current issue of Gastroenterologie clinique et biologique found three factors on multivariate analysis which were associated with worse prognosis. Of these the presence of three or more nodes resulted in a five-year survival rate of 10% as compared to 52% in those with absent celiac nodes. This has implications in patients with more than three celiac lymphadenopathies, since the likelihood of lymphnode metastasis is high making FNA less critical. This finding needs to be stressed since the interobserver agreement for the detection and characterization of celiac axis nodes is sig-
significantly better than EUS assessment of lymphadenopathy in other regions [12]. Endoscopists should pay close attention to the number and other characteristics of celiac and other sub diaphragmatic nodes for better patient selection in the management of esophageal carcinoma.

References


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