Adenocarcinoma of the esophagogastric junction; going up or down?

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Received: 12 November 2019 / Accepted: 10 April 2020 / Published online: 22 April 2020
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Dear Editor,

We have read with great interest the paper by Blank et al. [1] entitled “Surgical strategies in true adenocarcinoma of the esophagogastric junction (AEG II): thoracoabdominal or abdominal approach?” recently published in *Gastric Cancer*. The article is a retrospective evaluation comparing two classical surgical approaches for Siewert II AEG and their respective oncological outcomes.

We totally agree with the authors on the lack of evidence in the treatment of true AEG. As well described, no RCT exists about this topic. Consequently, whether to perform an extended gastrectomy with distal esophagectomy by an abdominal approach or an Ivor-Lewis procedure is debated.

As already considered by the same group, adenocarcinoma with signet ring cells (SRC) of the esophagus and of the stomach are found in an increasing number. Furthermore, different results were shown about the chemo-sensitivity of these tumors in a neoadjuvant setting [2]. These aspects deserve in our opinion some considerations.

Advanced gastric SRC represents an aggressive disease with microscopic spread into the gastric wall, generally not well described in the preoperative staging (endoscopy or CT scan). Nevertheless, the histologic sub-type should be always known preoperatively to plan the appropriate surgical treatment (total versus subtotal gastrectomy). Translating this biological behavior to the esophago-gastric junction, the

neoplastic submucosal invasion, either towards the abdomen (into the gastric tube) or towards the thorax (into the esophageal wall), could justify a more extensive resection of the esophagus or of the stomach than preoperatively planned. Siewert classification is useful and indispensable for the best surgical treatment; however, it should be associated with these considerations.

Large tumors of the esophagogastric junction (especially if SRC are present) sometimes cannot be treated neither with a standard Ivor-Lewis procedure nor with an extensive gastrectomy with distal esophagectomy, but with a total esophago-gastrectomy with a right intrathoracic esophago-jejunal anastomosis and 2-field lymphadenectomy. The real topic is how to identify these patients, considering the high risk of preoperative underestimation and the false negative rate of the frozen section in the submucosal invasion.

The role of the neoadjuvant treatment for SRC of the upper-GI cancers is debated; little is known about the real clinical implication of this different profile but, especially for advanced tumors, a more aggressive disease with a poorer clinical outcome has been detected. In this scenario, the role of a R0 surgery remains the primary objective.

As already mentioned by the authors, the percentage of SRC in the context of poorly cohesive cells tumors could be an important factor. For this reason a new classification of the poorly cohesive gastric carcinoma has been published [3]. Perhaps this classification could be applied also to esophagogastric junction lesions but at the moment we don't know if these considerations will be able to change the surgical management of esophagogastric junction cancers.

Finally, we congratulate the colleagues for their paper which led us to write our perspectives focusing this topic.

This comment refers to the article available online at <https://doi.org/10.1007/s10120-017-0746-1>.

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Funding This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval This article does not contain any studies involving human participants performed by any of the authors. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. For this type of study formal consent is not required.

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