

I

Oesophageal Carcinoma

I. GROSS DESCRIPTION

Specimen

- oesophageal cancer usually presents with progressive dysphagia initially for solids and ultimately liquids. Investigation is by endoscopy and biopsy, and chest X-ray to detect any enlargement of the heart, mediastinal lymph nodes or lung lesion that may be causing extrinsic compression. For biopsy-proven cancer, staging for local and distant disease includes endoluminal ultrasound (tumour depth and nodal spread), computed tomographic (CT) scan chest and abdomen and positron emission tomographic (PET) scan. Treatment may be palliative (radiotherapy, stent) in bulky high-stage disease, or curative in intent with earlier lesions. The latter may involve neoadjuvant radio-/chemotherapy to downstage the tumour and then surgery, or surgery alone. Choice of operative procedure depends on the general health of the patient, the tumour site and extent, the choice of planned oesophageal substitute (stomach, jejunum, colon) and preference of the surgeon. Ideally, longitudinal clearance margins of 5–10 cm should be achieved. Transthoracic or transdiaphragmatic hiatal approaches are available, with the latter particularly suitable for localized distal oesophageal lesions and resulting in less operative morbidity than thoracotomy.
- biopsy/partial oesophagectomy/total thoracic oesophagectomy (TTO)/oesophagectomy with limited gastrectomy/oesophagogastric resection.
- procedure: transthoracic or transhiatal.
- number of fragments/length of oesophagus and proximal stomach (cm). Measurements are better assessed on the fresh specimen as formalin fixation causes up to 30% contraction. The external surface is also inspected for the presence of adventitial fat, lateral mediastinal pleura and distally abdominal peritoneum.

Tumour

Site

- mid/lower oesophagus/oesophagogastric junction/cardia. Tumour is considered oesophageal if >50% of its mucosal bulk or epicentre is

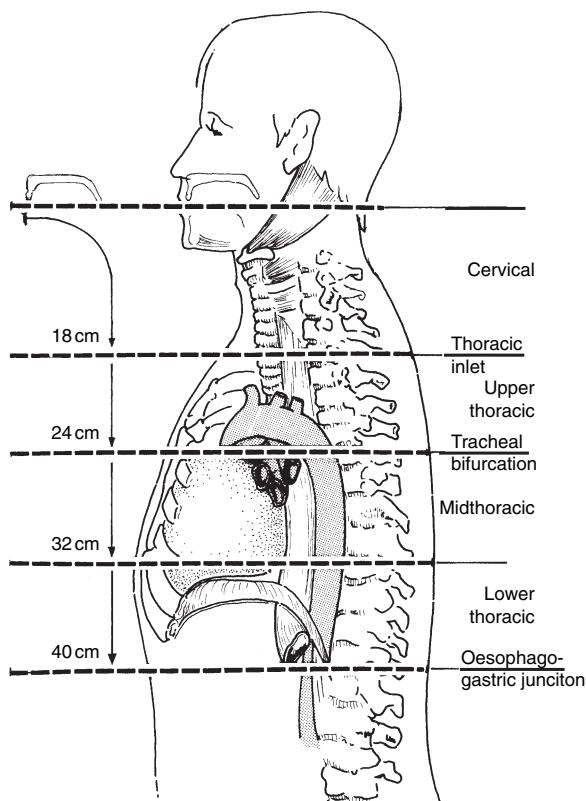


FIGURE 1-1. Oesophagus. 

above the oesophagogastric junction as defined by internal or external landmarks, i.e. where the tubular oesophagus ends and the saccular stomach begins. Equally, adjacent oesophageal Barrett's metaplasia or mucosal dysplasia indicates an oesophageal lesion, and gastric mucosal dysplasia a gastric tumour.

- distances (cm) to the proximal and distal resection limits and the oesophagogastric junction. The junction can vary in location or be obscured by tumour and anatomically distal oesophagus has an external layer of adventitia or abdominal peritoneum whereas proximal stomach is oriented to serosa. Distinction is important as the TNM staging and mode of spread differ. Tumours involving the junction are classified as either Siewert I (distal oesophagus growing down), II (truly junctional) or III (gastric cardia growing up). Siewert