Indication

- Mid thoracic esophageal carcinoma
- Esophageal squamous-cell carcinoma in the lower third of the esophagus
- Long peptic stricture, if transhiatal resection is not possible.

Contraindication

- Severe cardio-pulmonary insufficiency.

Risks and patient’s informed consent

- Refer to chapter 13 blunt dissection. Additionally, the patient should be informed about bilateral pareses of the recurrent laryngeal nerve, pareses of the phrenic nerve, and chylothorax.

Special preoperative preparations

Anesthesia: Orotracheal intubation with a double-lumen tube for single lung ventilation.

Patient’s position

- Position of the patient on his left side for the thoracal part of surgery
- Supine position, comparable to blunt transhiatal dissection
- Alternatively 45° positioning is possible, in this case intraoperative changes of the position are not necessary.

Surgical approach

- Anterolateral thoracotomy through 5th ICR
- Transverse laparotomy with cranial median enlargement (inversed T-incision).

Operative procedure

1. Right-sided anterolateral thoracotomy through 5th ICR
2. Incision of the mediastinal pleura along the hilum of the right lung and the superior caval vein
3. Dissection and ligation of the azygos vein
4. Preparation of the vena cava by resection of the accompanying adipose and lymphatic tissue
5. Dissection of the vagus nerve distal to the recurrent laryngeal nerve
6. Dissection of intercostal veins, sparing the arteries
7. Dissection between esophagus, aorta, and trachea and resection of paratracheal, parabronchial, paracarinal, and infracarinal lymph nodes
8. Thoracic drainage and closure of the thoracotomy
9. Abdominal and cervical part (see chapter 13).
Fig. 15.2. After thoracotomy in 5th ICR, two retractors are placed to spread the incision and to retract the ribs. Single left lung ventilation. Incision of the mediastinal pleura along the marked line for the en bloc esophagectomy. It starts from the pulmonary ligament, runs along the dorsal part of the right hilum of the lung to the lateral margin of the superior caval vein up to the upper thoracic aperture. Incision direction is changed to the right lateral margin of the spine, down to the diaphragm along the azygos vein. The most important part of this step is the recognition of the right recurrent laryngeal nerve and the right phrenic nerve.