CARDIO-OESOPHAGECTOMY

- for oesophageal and junctional cancers
- radical excision with three field nodal clearance and >5cm proximal resection margin and > 2cm distal resection margin where possible
- cuff of diaphragm and resection of mediastinal pleura to maximize circumferential resection margin (CRM) clearance
- pyloroplasty is our preference to prevent gastric stasis and improve gastric emptying
- feeding jejunostomy placement is undertaken selectively when nutritional state is sub-optimal or recovery is likely to be prolonged
- Thoracic epidural, single lung ventilation and level 2 observation in the early post-operative period are part of the standard protocol of care

Surgical approach:

1. Open 2-stage cardio-oesophagectomy (Ivor Lewis):
    - Rooftop incision for abdominal mobilization of the stomach, hiatal dissection and pyloroplasty
    - Right thoracotomy through 5th intercostal space for mediastinal and sub-carinal dissection with division of the azygous vein and ligation of the thoracic duct

2. Hybrid laparoscopic / open cardio-oesophagectomy
    - Laparoscopic abdominal phase
    - Open thoracic phase
    - Recruitment to ROMIO trial where possible

3. Robotic-assisted three stage cardio-oesophagectomy
    - Open abdominal phase
    - Synchronous Robotic-assisted thoracic phase (Da-Vinci Xi – Intuitive Surgical Inc.)
    - Open left neck exploration and oesophago-gastric anastomosis
    - The favoured approach following neoadjuvant chemoradiotherapy to maximize clearance of the radiotherapy field

GASTRECTOMY

- for gastric cancers not involving the gastro-oesophageal junction
- radical excision with D2 nodal dissection: perigastric D1 nodes plus left gastric, common hepatic, splenic and coeliac nodes when appropriate
- full omentectomy
- excision of pre-pancreatic peritoneum for posterior tumours with serosal involvement
- division of duodenum at least 2cm distal to pylorus
- oesophagojejunostomy with retrocolic Roux-en-Y reconstruction
- "extended" gastrectomy including several centimetres of oesophagus may be appropriate for gastric cancers approaching the GOJ in order to maximize proximal clearance

SUB-TOTAL GASTRECTOMY

- for distal gastric cancer
- redical excision with D2 nodal dissection as for total gastrectomy
- inclusion of left gastric pedicle but preservation of short gastric vessels
- Roux loop anastomosed to gastric pouch of cardia and fundus

Surgical approach:

1. Open resection via rooftop incision
    - Omnitract lifting of the costal margin
    - Mobilization left lobe liver
    - Pack behind the spleen to facilitate dissection of splenic hilum
    - Stapled anastomoses with monofilament suture support
    - Placement of feeding jejunostomy when deemed necessary

2. Laparoscopic assisted gastrectomy
    - This approach may be considered for early stage cancers and in patients with impaired respiratory function
    - The surgical procedure is identical to the open procedure and small laparotomy is commonly performed for retrieval of the specimen and construction of anastomoses

3. Robotic assisted gastrectomy
    - This approach is being evaluated with pan-European comparative audit
    - Along with lap assisted surgery, has the potential to accelerate recovery and return to full physical activity
    - Training in robotic surgery and access to the single robot are restricting factors at the present time

https://mmcts.org/tutorial/978

https://publishing.rcseng.ac.uk/doi/pdf/10.1308/003588407X209518