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Enucleation for gastrointestinal stromal tumors at the esophagogastric junction: Is this an adequate solution?

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Abstract

The authors discussed the proposal by Coccolini and colleagues to treat gastrointestinal stromal tumors (GISTs) at the esophagogastric junction with enucleation and, if indicated, adjuvant therapy, reducing the risks related to esophageal and gastroesophageal resection. They concluded that, because the prognostic impact of a T1 high-mitotic rate on esophageal GIST is worse than that of a T1 high-mitotic rate on gastric GIST, enucleation may not be an adequate surgery for esophagogastric GISTs with a high mitotic rate in which the guarantee of negative resection margins and adjuvant therapies can be the only chance of survival.

Key words: Gastrointestinal stromal tumor; Esophagogastric junction; Surgery; Resection; Enucleation

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TO THE EDITOR

We read with great interest the article by Coccolini and colleagues on the treatment of gastrointestinal stromal tumors (GISTs) at the esophagogastric junction[1]. They stated the problems related to the choice of extended esophageal and gastroesophageal resection (i.e. a better guarantee of R0 resection but a higher prevalence of morbidity and mortality) or enucleation (i.e. a higher risk of microscopically positive margins but a better postoperative outcome).

The impact of microscopically negative margins on long-term survival remains controversial and there is no evidence that extensive resections are related to a better survival rate. The authors suggested that, for GISTs at the esophagastric junction, enucleation and adjuvant therapies can be useful alternatives to avoid the high prevalence of morbidity and mortality associated with esophageal and esophagogastric resections. However, the 2009 edition of the TNM Classification of Malignant Tumors states that, in the absence of nodal metastasis, esophageal GISTs $\leqslant$ 2 cm (T1, i.e. tumors that may be treated with enucleation more frequently) are classified as stage Ⅰ in the case of a low mitotic rate but as stage ⅢA in the case of a high mitotic rate. This case is different from T1 gastric GISTs that are classified as stage Ⅰ or stage Ⅱ in the presence of a low or high mitotic rate, respectively[2]. In the case of a high mitotic rate, the prognostic impact of a T1 esophageal GIST is worse than that of a gastric GIST with an identical size. Prospective, multicenter evaluation of the different treatment strategies for esophagogastric GISTs is sorely needed. However, enucleation may not be an adequate surgery for esophagogastric GISTs with a high-mitotic rate in which the guarantee of negative resection margins and adjuvant therapies can be the only chance of survival.

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