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Titel des Beitrags: Chirurgische Therapie bei Karzinomen des proximalen Magendrittels und des ösophagogastralen Übergangs

Abstract: Despite the continuing incidence and prevalence of adenocarcinoma of the proximal gastric third and esophago-gastric junction, the classification and optimal therapy of these tumors remains controversial. From the anatomic, pathologic and therapeutic point of view a discrimination of these tumors into those of the gastric fundus, subcardial gastric carcinoma (or adenocarcinoma of the esophago-gastric junction type III according to Siewert, AEG type III), true carcinoma of the gastric cardia (AEG type II) and adenocarcinoma of the distal esophagus (AEG type I) appears logical. A special aspect of tumors of the proximal gastric third is their lymphatic drainage towards the splenic hilum and the left para-aortic lymph nodes. In addition, the proximal gastric third is characterized by a rather large proportion without serosal covering in the area of the major and lesser gastric curvature. Consequently, transmural tumors at this location are frequently assigned the T2 category according to the current UICC criteria, although the true depth of wall penetration and prognosis correspond to that of a more advanced T category. The surgical therapy of choice for tumors of the gastric fundus as well as for subcardial gastric cancers (AEG type III) and true carcinomas of the gastric cardia (AEG type II) is an extended total gastrectomy with resection of the distal esophagus. The optimal extent
of lymphadenectomy in these patients includes, at least theoretically, the lymph nodes along the splenic artery, the splenic hilum and the para-aortic lymph nodes at the left renal hilum in addition to the so-called compartments I and II. Since a left pancreatic resection is associated with significant morbidity, a pancreas-preserving splenectomy (PPS) should be performed to complete the lymphadenectomy in the retroperitoneum. The markedly worse prognosis of proximal-third gastric cancer, as compared to more distally located gastric tumors, is due to the current UICC classification which does not take into account the special location and lymphatic drainage of these tumors. A modification of the UICC classification for these tumors appears reasonable. Copyright © 1999 S. Karger GmbH, Freiburg