Because of effective surveillance programs in patients with known Barrett's esophagus, adenocarcinoma of the distal esophagus is increasingly diagnosed at early stages. With the introduction of limited surgical and endoscopic treatment modalities, the need for radical esophagectomy and extensive lymphadenectomy in such patients has been questioned. When selecting the approach to early Barrett's cancer, the precancerous nature of the underlying Barrett's esophagus, the frequent multicentricity of neoplastic alterations within the Barrett mucosa, the inaccuracy of current staging modalities, and the presence of lymph node metastases should be taken into account. Invasiveness and morbidity of the procedures, as well as quality of life aspects, should also be considered. From an oncologic point of view the minimum extent of a resection for early Barrett's cancer should include a full-thickness removal of the entire segment of the distal esophagus covered by intestinal metaplasia together with a regional lymphadenectomy. In appropriately selected patients this can be achieved by a limited surgical procedure involving transhiatal resection of the distal esophagus, but not by endoscopic mucosal ablation or endoscopic mucosa resection. Our experience with 49 limited surgical resections with regional lymphadenectomy indicates that this procedure is oncologically adequate and safe. Reconstruction with an interposed jejunal loop prevents postoperative gastroesophageal reflux.
and is associated with good quality of life. In contrast, endoscopic interventions are plagued by a high tumor recurrence rate, probably from persistence of Barrett's mucosa and gastroesophageal reflux.