Commentary

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Good healing of the cervical esophagogastric anastomosis after esophagectomy or cardiae is an essentials part of transhiatal, endoscopic and transpleural surgery. It prevents from exchanging oncologic dysphagia into surgical dysphagia. Strictures occur in 1-42% operations.

Predisposition factors of stricture anastomosis occurrence are:

- the technique of anastomosis,
- the experience of the surgeon,
- blood supply of the place of the anastomosis,
- blood loss during the surgery,
- leakiness of the anastomosis after the operation and later reflux of the gastric content into esophagus.

In the research on improving the technology of cervical esophagogastric anastomosis, a few significant periods can be distinguished:

Hand-sewn anastomoses

At the beginning they were done by hand (mono- and two-layered).

A. there were transverse anastomoses – done in short and narrow conduit. Those anastomoses did not have anti-reflux mechanism.

B. transverse anastomoses with anti-reflux mechanism that was done while the fundus was pulled-up and around the esophagus and in long and wide conduit.

Mechanical anastomoses

Mechanical anastomoses made the surgery technically easier, shortened the operation and resulted in the standardisation of the anastomoses.

A. The anastomosis carried out by a circular stapler was possible with wide conduit and esophagus. The wideness of the anastomosis in this case was largely dependent on the diameter of the stapler. Mostly there were used the circular staplers with diameter 21 mm, 25 mm and less frequently 27 mm. Those anastomoses were possible to perform with anti-reflux mechanism providing the length and width of the conduit were sufficient.

B. Mechanical or half-mechanical side to side anastomoses proved to be the most successful. Such anastomosis could be done regardless the width of the esophagus and conduit. However, on condition that the conduit is long enough. Those anastomoses keep anti-reflux mechanism. The frequency of complications after that type of anastomoses performed by the experienced surgeon is as low as 0-1%.

The most frequently, the width of the anastomosis is estimated by endoscopy, radiologically and rarely with the help of radioisotopes. In judging the efficiency of the anastomosis, two following methods can be used: the scale of dysphagia according to Des and Earlman and the estimation of the heaviness of gastric content aspiration according to Huning and Wuttge-Hannig.

The publication of Farahnake M. and co is a valuable contribution in discussion of choosing the cervical esophagogastric anastomosis after esophagectomy or cardiae. It confirms world's and our experience that the anastomosis is better when it is less transverse and with anti-reflux mechanism.

There is controversy about making a free passage in the stomach (pyloroplasty or pyloromyotomy) in each of the cases of surgical interventions whereas it is only necessary in the obvious case of pylorostenosis.

The work is worth publishing because in the specialised literature there is a lack of randomised reports concerning comparison of the hand-sewn cervical transverse and oblique anastomosis after esophagectomy.

References

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