

【3-4 クリニカルクエスションの設定】 CQ-18

スコープで取り上げた重要臨床課題 (Key Clinical Issue)

CQの構成要素

P (Patients, Problem, Population)

性別	指定なし
年齢	指定なし
疾患・病態	内視鏡治療後pT1a-MM
地理的要件	なし
その他	なし

I (Interventions) / C (Comparisons, Controls) のリスト

経過観察/手術を中心とした治療／根治的化学放射線療法

O (Outcomes) のリスト

	Outcomeの内容	益か害か	重要度	採用可否
O1	リンパ節転移割合	益	10 点	○
O2	5年疾患特異生存割合	益	9 点	○
O3	有害事象	害	9 点	○
O4			点	
O5			点	
O6			点	
O7			点	
O8			点	
O9			点	
O10			点	

作成したCQ

食道表在癌に対して内視鏡治療を行いpT1a-MMであった場合、追加治療を行うことを推奨するか？

【4-6 評価シート 観察研究】

診療ガイドライン	食道癌診療ガイドライン
対象	T1aMM食道癌
介入	EMR+追加治療
対照	

*バイアスリスク、非直接性
各ドメインの評価は“高(-2)”、“中/疑い(-1)”、“低(0)”の3段階
まとはは“高(-2)”、“中(-1)”、“低(0)”の3段階でエビデンス総体に反映させる

** 上昇要因
各項目の評価は“高(+2)”、“中(+1)”、“低(0)”の3段階
まとはは“高(+2)”、“中(+1)”、“低(0)”の3段階でエビデンス総体に反映させる
各アウトカムごとに別紙にまとめる

アウトカム																												
個別研究		バイアスリスク*																										
		選択 バイアス	実行 バイアス	検出 バイアス	症例 現象 バイアス	その他		上昇要因**				非直接性*				リスク人数(アウトカム率)												
研究コード	研究デザイン	背景 因子の差	ケア の差	不適切な アウトカム 測定	不完全な フォロー アップ	不十分な 交絡の調整	その他の バイアス	まとめ	量反 応関係	効果減弱 交絡	効果の 大きさ	まとめ	対象	介入	対照	アウト カム	まとめ	対照 群母	対照 群分子	(%)	介入 群母	介入 群分子	(%)	効果 指標 (種類)	効果 指標 (値)	信頼区間		
2007 Katada	症例集積	-1		0	0	0		-1	0	0	0		0	0		0	0	NA	NA	NA	104		1.90%	リンパ 節転移		EMR		
2000 Endo M	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	36		8%	リンパ 節転移		手術		
2002 Araki	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	22		0%	リンパ 節転移		リンパ節再発 18.2%		
2000 Noguchi	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	17		11%	リンパ 節転移		再発なし		
2006 Eguchi	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	50		18%	リンパ 節転移		生存成績なし		
2013 Yamashita	症例集積	-1		0	0	0		-1	0	0	0		0	0		0	0	NA	NA	NA	70		4.20%	リンパ 節または 遠隔転移		EMR		
2010 Herrero	症例集積	-1		0	0	0		-1	0	0	0		0	0		0	0	NA	NA	NA	57		0%	リンパ 節転移		adeno		
2011 Choi	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	24		25%	リンパ 節転移				
2011 Leers	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	57		1.30%	リンパ 節		adeno		
2007 Kim	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	19		21%	リンパ 節		生存成績なし		
2008 Ancona	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	12		0%	リンパ 節転移		adeno/scc		
2010 Barbour	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	15		0%	リンパ 節転移		adeno/scc		
2009 Kato	その他	-2		-1	0	0		-1	0	0	0		-2	-1		-1	-1	NA	NA	NA	72		19%	リンパ 節転移		EMR適応のないT1 に対するCRT前向き		
2006 Yamada	その他	-2		-1	0	0		-1	0	0	0		-2	-1		-1	-1	NA	NA	NA	63		11%	リンパ 節または 遠隔転移		T1bに対するCRT		
2014 Merkow	症例集積	-2		-1	0	0		-1	0	0	0		-1	-1		0	-1	NA	NA	NA	1810		5%	リンパ 節または 遠隔転移		adeno90%		
2014 Tanaka	症例集積	-2		-1	0	0		-1	0	0	0		-2	-1		0	-1	NA	NA	NA	35		9%	リンパ 節転移		術後リンパ節再発2 例 (5.7%)		
2013 Akutsu	症例集積	-1		0	0	0		-1	0	0	0		0	0		0	0	NA	NA	NA	42		0%	リンパ 節転移		手術標本内リンパ 節転移27%		
2004 Shimizu	症例集積	-1		0	0	0		-1	0	0	0		0	0		0	0	NA	NA	NA	16		0%	リンパ 節転移		MM/SM1EMR+CRT		

コメント(該当するセルに記入)

	症例集積	多施設 のEMR 症例	単群	EMR		単群						T1aM M	EMR	単群	リンパ 節転移														
2007 Katada	症例集積		単群	EMR		単群						T1aM M	EMR	単群	リンバ 節転移														多施設
2000 Endo	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														5年生存割合86%
2002 Araki	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														リンバ節再発18.2%
2000 Noguchi	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														再発なし
2006 Eguchi	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														リンバ節転移率 LY(-) 4/38(10.3%) vs LY(+) 5/12 (41.7%)
2013 Yamashita	症例集積	単施設 EMR	単群	EMR		単群						T1aM M	EMR	単群	リンバ 節転移														粘膜内癌 LY(+)vs LY(-) 累積転移発生 割合46.7% vs 0.7%(p<0.0001)
2010 Herrero	症例集積	単施設 EMR	単群	EMR		単群						T1aM M	EMR	単群	リンバ 節転移														adeno、リンバ管侵襲5.2%
2011 Choi	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														リンバ管浸襲陽性 割合不明
2011 Leers	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														adeno
2007 Kim	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														T1全例で、リンバ節 転移のリスク、リン バ管侵襲のオッズ 比3.63,p=0.007
2008 Ancona	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														T1全例で、リンバ節 転移のリスク、リン バ管侵襲のハザー ド比0.134(95%CI 0.024- 0.747),p=0.04、術後 合併症による60日 以内 死亡2例(2%)
2010 Barbour	症例集積	手術 単群	単群	手術		単群						T1aM M	手術	単群	リンバ 節転移														T1全例で、リンバ管 浸襲陽性vs 陰性の 5年DSS 47% vs 89%, p<0.001
2009 Kato	その他、単 群前向き試験	CRT 単群	単群	CRT		単群						T1	CRT	単群	リンバ 節転移														EMR適応のない病 変のみが対象。4年 全生存割合80.5%。 無再発(majorのみ) 生存割合68%。有害 事象grade3はない がGrade3の心虚血 1%呼吸不全2.8%
2006 Yamada	その他、単 群前向き試験	CRT 単群	単群	CRT		単群						cT1b	CRT	単群	リンバ 節転移														5年全生存割合 66.4%、疾患特異生 存割合76.8%.T1aでは疾患特異生存割 合85.2%.重篤な晩 期毒性は食道瘻2 例、食道狭窄(液体 のみ)2例
2014 Merlow	症例集積	手術、 EMR	単群	手術、 EMR		単群						T1	手術、 EMR	単群	リンバ 節転移														T1a 54% T1b 46%。 手術後30日以内に死 亡139/3963 (3.5%)
2014 Tanaka	症例集積	手術	単群	手術、 EMR		単群						T1a	手術	単群	リンバ 節転移														T1aの手術標本内 リンバ節転移3例 (8.6%)術後リンバ節 再発2例 (5.7%)T1a 5年疾患特異生存 割合 100% 術後 合併症による死亡2 例(3.6%)

2013 Akutsu	症例集積	手術	単群	手術、 EMR		単群									T1a	手術、 EMR	単群	リンパ 節転 移																			MMのリンパ管侵襲 手術例6/15 EMR例 0/42 脈管陰性での リンパ節転移3/47 (6%) 陽性では 2/6 (33%) オッズ比 7.333 MM疾患特異 5年生存 全生存と もに 100%
2004 Shimizu	症例集積	EMR+ CRT	単群	EMR+ CRT		単群									T1aM M, T1bS M1	EMR+ CRT	単群	リンパ 節転 移																			5年全生存割合 100%、疾患特異生 存割合100% 重篤な 有害事象や治療関 連死亡は報告無し

【4-7 評価シート エビデンス総体】

診療ガイドライン	食道癌診療ガイドライン
対象	T1aMM食道癌
介入	EMR+追加治療
対照	

エビデンスの強さはRCTは“強(A)”からスタート、観察研究は弱(C)からスタート

* 各ドメインは“高(-2)”、“中/疑い(-1)”、“低(0)”の3段階

**** エビデンスの強さは“強(A)”、“中(B)”、“弱(C)”、“非常に弱(D)”の4段階**

*** 重要性はアウトカムの重要性(1~9)

[illegible]

コメント(該当するセルに記入)

[illegible]

【4-10 SR レポートのまとめ】

CQ 18 食道表在癌に対して内視鏡治療を行い pT1a-MM であった場合、追加治療を行うことを推奨するかという CQ に対して文献検索を行ったところ、PubMed : 122 件、Cochrane : 44 件、医中誌 : 143 件が 1 次スクリーニングされた。2 次スクリーニングを終えて、16 件の症例集積と 2 件の単群介入研究に対して定性的システマティックレビューを行った。

16 件の症例集積は、いずれも後ろ向き研究で、EMR 治療例のみの報告が 3 報、手術治療例のみが 8 件、EMR と手術いずれも含む報告が 4 件であり、EMR に追加化学放射線療法の症例集積報告を認め、症例対照研究は認めなかった。本邦からの報告は 9 件で主に扁平上皮癌の症例が扱われていた。海外からの報告で主に腺癌の症例で検討されていたのは 5 件認めた。2 件の単群介入研究は、いずれも本邦で行われた cT1N0M0 食道癌を対象とした化学放射線療法の前向き研究で、うち 1 件は、多施設研究 (JCOG9708) であった。

手術治療例の症例集積では、リンパ節郭清が行われており、リンパ節転移頻度やリンパ節転移のリスク因子が主な解析項目であった。pT1a-MM 扁平上皮癌症例の手術標本での郭清リンパ節転移頻度は 0~27% と報告されており腺癌では、MM での転移頻度はほとんど報告がないが、pT1a では 0~5% と報告されていた。リンパ節転移のリスク因子としては、リンパ管侵襲陽性例が陰性例と比較してリンパ節転移頻度が有意に多いと報告されている (陰性例 : 4/38 (10.3%)、陽性例 : 5/12 (41.7%)。一方で、内視鏡治療切除標本で pT1a-MM と評価された症例の異時性リンパ節転移の頻度は、扁平上皮癌で 0~4.2%、腺癌で 0% と報告されている。

追加治療の候補になり得る手術や化学放射線療法の毒性に関しては、T1 症例に対する手術合併症による死亡割合は、0.2~3.6% と報告されている。化学放射線療法の重篤な晚期合併症として、食道瘻 3.2%、食道狭窄 3.2%、Grade3 の心虚血 1%、呼吸不全 2.8% が報告されているが、治療関連死亡例の報告はない。

【5-1 推奨文章案】

1. CQ

CQ 18 食道表在癌に対して内視鏡治療を行いpT1a-MMであった場合、追加治療を行うことを推奨するか？

2. 推奨草案

pT1a-MMかつ脈管侵襲陽性例である場合、追加治療を行うことを強く推奨する。

3. 作成グループにおける、推奨に関連する価値観や好み(検討した各アウトカム別に、一連の価値観を想定する)

本CQの推奨にあたっては、治療後の転移リスクを重要視した。

4. CQに対するエビデンスの総括(重大なアウトカム全般に関する全体的なエビデンスの強さ)

☒ A(強) ☐ B(中) ☐ C(弱) ☐ D(非常に弱い)

5. 推奨の強さを決定するための評価項目(下記の項目について総合して判定する)

推奨の強さの決定に影響する要因	判定	説明
アウトカム全般に関する全体的なエビデンスが強い ・全体的なエビデンスが強いほど推奨度は「強い」とされる可能性が高くなる。 ・逆に全体的なエビデンスが弱いほど、推奨度は「弱い」とされる可能性が高くなる。	<input checked="" type="checkbox"/> はい <input type="checkbox"/> いいえ	
益と害のバランスが確実(コストは含まず) ・望ましい効果と望ましくない効果の差が大きければ大きいほど、推奨度が強くなる可能性が高い。 ・正味の益が小さければ小さいほど、有害事象が大きいくほど、益の確実性が減じられ、推奨度が「弱い」とされる可能性が高くなる。	<input checked="" type="checkbox"/> はい <input type="checkbox"/> いいえ	

推奨の強さに考慮すべき要因

患者の価値観や好み、負担の確実さ(あるいは相違)

正味の利益がコストや資源に十分に見合ったものかどうかなど

内視鏡治療後の病理結果でpT1a-MM+脈管侵襲があった場合はリンパ節転移のリスクがあるため、実施しなかった場合のデメリット(転移による根治性の低下)を考慮すれば、患者は追加治療(化学放射線療法)を希望すると考えられる。ただし、転移しない症例のほうが多い(約80%近く)と想定されるため、患者の希望や状態(臓器機能)等によっては、実施しない場合も想定される。また、化学放射線療法を行った場合には、有害事象(悪心・嘔吐、腎障害、肺臓炎、白質脳症など)の発生があり、手術を行った場合も縫合不全や術後狭窄などの有害事象の発生を考慮しなければならない。

明らかに判定当てはまる場合「はい」とし、それ以外は、どちらとも言えないを含め「いいえ」とする

1次スクリーニング	ID	Language	Authors	Title	Journal	Year	Volume	Pages	Pub. Type	Abstract	Memo
除外	CN-01074716		Ebi M, Shimura T, Yamada T, Mizushima T, Itoh K, Tsukamoto H, Tsuchida K, Hirata Y, Murakami K, Kanie H, Nomura S, Iwasaki H, Kitagawa M, Takahashi S, Joh T	Multicenter, prospective trial of white-light imaging alone versus white-light imaging followed by magnifying endoscopy with narrow-band imaging for the real-time imaging and diagnosis of invasion depth in superficial esophageal squamous cell carcinoma.	Gastrointestinal endoscopy	2015	81(6)	1355-1361.e2	Journal: Article	Background Magnifying endoscopy with narrow-band imaging (ME-NBI) has been used to estimate the invasion depth of superficial esophageal squamous cell carcinoma (SESCC), but the real diagnostic power of ME-NBI remains unclear because of few prospective studies. Objectives To evaluate whether ME-NBI adds additional information to white-light imaging (WLI) for the diagnosis of invasion depth of SESCO. Design Multicenter, prospective trial using real-time imaging and diagnosis. Setting Seven Japanese institutions. Patients Fifty-five patients with SESCO were enrolled from June 2011 to October 2013, and the results for 49 lesions were analyzed. Interventions Patients underwent primary WLI followed by ME-NBI, and reports of primary WLI (WLI alone) were completed before secondary ME-NBI (WLI followed by ME-NBI). To standardize diagnosis among examiners, this trial was started after achievement of a mean kappa value >.6 among 11 participating endoscopists. Main Outcome Measurements Diagnosis of invasion depth by each tool was divided into cancer limited to the epithelium and the lamina propria mucosa and cancer invading beyond the muscularis mucosae (>T1a-MM) and then collated with the final pathologic diagnosis by an independent pathologist blinded to the clinical data. Results The accuracy of invasion depth in WLI alone and WLI followed by ME-NBI was 71.4% and 65.3% (P =.375), respectively. Sensitivity for >T1a-MM was 61.1% for both groups (P = 1.000), and specificity for >T1a-MM was 77.4% for WLI alone and 67.7% for WLI followed by ME-NBI (P =.375). Limitation Open-label trial. Conclusions ME-NBI showed no additional benefit to WLI for diagnosis of invasion depth of SESCO. (University Hospital Network Clinical Trials Registry number: UMIN000005632.)	
除外	CN-00156542		Keller SM, Ryan LM, Coia LR, Dang P, Vaught DJ, Diggs C, Weiner LM, Benson AB	High dose chemoradiotherapy followed by esophagectomy for adenocarcinoma of the esophagus and gastroesophageal junction: results of a phase II study of the Eastern Cooperative Oncology Group.	Cancer	1998	83(9)	1908-16	Clinical Trial; Clinical Trial, Phase II; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, U.S. Gov't, P.H.S.	BACKGROUND: To assess the toxicity, local response, and survival associated with multimodality therapy in a cooperative group setting, patients with biopsy-proven clinical Stage I or II adenocarcinoma of the esophagus (staged according to 1983 American Joint Committee on Cancer criteria) or gastroesophageal junction were treated with concomitant radiation and chemotherapy followed by esophagectomy. METHODS: Radiotherapy was administered in daily 2-gray (Gy) fractions 5 days a week until a total of 60 Gy was reached. 5-fluorouracil (5-FU) was infused continuously at a dose of 1000 mg/m2/day for 96 hours on Days 2-5 and 28-31. On Day 2, a 10 mg/m2 bolus of mitomycin was injected intravenously. Esophagectomy was performed 4-8 weeks following completion of the radiotherapy. RESULTS: During the 18-month study period (August 1991 through January 1993), 46 eligible patients were accrued from 21 institutions. Eight patients were Stage I and 38 Stage II. Eighty-seven percent of patients (40 of 46) received 6000 centigray (cGy), and all received >5000 cGy. Seventy-eight percent of patients (36 of 46) received >90% of the planned 5-FU dose. Follow-up ranged from 11 to 36 months (median, 22 months). There were eight treatment-related deaths; two were preoperative (from adult respiratory distress syndrome) and six were postoperative. Complete or partial response prior to esophagectomy was observed in 63% of cases, stable disease in 15%, and progression in 20%. Thirty-three patients underwent esophagectomy (transhiatal, n=14; Ivor Lewis, n=16; other, n=3). No tumor was found in the specimens resected from 8 of these 33 patients; this represented a pathologic complete response rate of 17% overall and 24% for those who underwent esophagectomy. Overall median survival was 16.6 months, 1-year survival 57%, and 2-year survival 27%. Survival was significantly worse for patients with circumferential cancers (median, 18.1 months vs. 8.3 months; P <0.05). CONCLUSION: High dose radiation therapy with concurrent 5-FU and mitomycin may be administered to patients with esophageal adenocarcinoma with acceptable morbidity. However, in a cooperative group setting, esophagogastrectomy following intensive chemoradiotherapy is associated with excessive morbidity and mortality. Circumferential tumor growth is a significant adverse prognostic factor.	
除外	CN-00685524		Hejli M, Lanschot JJ, Koppert LB, Berge Henegouwen MI, Muller K, Steyerberg EW, Dekken H, Wijnhoven BP, Tlanius HW, Richel DJ, Busch OR, Bartelsman JF, Koning CC, Offerhaus GJ, Gaast A	Neoadjuvant chemoradiation followed by surgery versus surgery alone for patients with adenocarcinoma or squamous cell carcinoma of the esophagus (CROSS).	BMC surgery	2008	8	21	Clinical Trial, Phase III; Journal Article; Multicenter Study; Randomized Controlled Trial	BACKGROUND: A surgical resection is currently the preferred treatment for esophageal cancer if the tumor is considered to be resectable without evidence of distant metastases (cT1-3 N0-1 M0). A high percentage of irradical resections is reported in studies using neoadjuvant chemotherapy followed by surgery versus surgery alone and in trials in which patients are treated with surgery alone. Improvement of locoregional control by using neoadjuvant chemoradiotherapy might therefore improve the prognosis in these patients. We previously reported that after neoadjuvant chemoradiotherapy with weekly administrations of Carboplatin and Paclitaxel combined with concurrent radiotherapy nearly always a complete R0-resection could be performed. The concept that this neoadjuvant chemoradiotherapy regimen improves overall survival has, however, to be proven in a randomized phase III trial. METHODS/DESIGN: The CROSS trial is a multicenter, randomized phase III, clinical trial. The study compares neoadjuvant chemoradiotherapy followed by surgery with surgery alone in patients with potentially curable esophageal cancer, with inclusion of 175 patients per arm. The objectives of the CROSS trial are to compare median survival rates and quality of life (before, during and after treatment), pathological responses, progression free survival, the number of R0 resections, treatment toxicity and costs between patients treated with neoadjuvant chemoradiotherapy followed by surgery with surgery alone for surgically resectable esophageal adenocarcinoma or squamous cell carcinoma. Over a 5 week period concurrent chemoradiotherapy will be applied on an outpatient basis. Paclitaxel (50 mg/m2) and Carboplatin (Area-Under-Curve = 2) are administered by i.v. infusion on days 1, 8, 15, 22, and 29. External beam radiation with a total dose of 41.4 Gy is given in 23 fractions of 1.8 Gy, 5 fractions a week. After completion of the protocol, patients will be followed up every 3 months for the first year, every 6 months for the second year, and then at the end of each year until 5 years after treatment. Quality of life questionnaires will be filled out during the first year of follow-up. DISCUSSION: This study will contribute to the evidence on any benefits of neoadjuvant treatment in esophageal cancer patients using a promising chemoradiotherapy regimen. TRIAL REGISTRATION: ISRCTN80832026.	
除外	CN-00530627		Chiu PW, Chan AC, Leung SF, Leong HT, Kwong KH, Li MK, Au-Yeung AC, Chung SC, Ng EK	Multicenter prospective randomized trial comparing standard esophagectomy with chemoradiotherapy for treatment of squamous esophageal cancer: early results from the Chinese University Research Group for Esophageal Cancer (CURE).	Journal of gastrointestinal surgery	2005	9(6)	794-802	Comparative Study; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	We conducted a prospective randomized trial to compare the efficacy and survival outcome by chemoradiation with that by esophagectomy as a curative treatment. From July 2000 to December 2004, 80 patients with potentially resectable squamous cell carcinoma of the mid or lower thoracic esophagus were randomized to esophagectomy or chemoradiotherapy. A two- or three-stage esophagectomy with two-field dissection was performed. Patients treated with chemoradiotherapy received continuous 5-fluorouracil infusion (200 mg/m2/day) from day 1 to 42 and cisplatin (60 mg/m2) on days 1 and 22. The tumor and regional lymphatics were concomitantly irradiated to a total of 50-60 Gy. Tumor response was assessed by endoscopy, endoscopic ultrasonography, and computed tomography scan. Salvage esophagectomy was performed for incomplete response or recurrence. Forty-four patients received standard esophagectomy, whereas 36 were treated with chemoradiotherapy. Median follow-up was 16.9 months. The operative mortality was 6.8%. The incidence of postoperative complications was 38.6%. No difference in the early cumulative survival was found between the two groups (RR = 0.89; 95% confidence interval, 0.37-2.17; log-rank test P = 0.45). There was no difference in the disease-free survival. Patients treated with surgery had a slightly higher proportion of recurrence in the mediastinum, whereas those treated with chemoradiation sustained a higher proportion of recurrence in the cervical or abdominal regions. Standard esophagectomy or chemoradiotherapy offered similar early clinical outcome and survival for patients with squamous cell carcinoma of the esophagus. The challenge lies in the detection of residue disease after chemoradiotherapy.	

除外	CN-01008844		Ito Y, Kato K, Hashimoto J, Akimoto T, Katano S, Saito Y, Igaki H	Phase 2 study of neoadjuvant chemoradiation therapy with cisplatin plus 5-fluorouracil and elective nodal irradiation for stage II/III esophageal squamous cell carcinoma.	International Journal of Radiation Oncology Biology Physics	2014	90(1 SUPPL. 1)	S338	Journal: Conference Abstract	Purpose/Objective(s): Based on the JCOG 9907 trial results, neoadjuvant chemotherapy with cisplatin (CDDP) plus 5-fluorouracil (5-FU) is considered a standard treatment for stage II/III esophageal squamous cell carcinoma (ESCC) in Japan. However, patient survival remains unsatisfactory and neoadjuvant chemoradiation therapy (NeoCRT) may improve the outcome of stage II/III ESCC patients. We conducted a feasibility study of NeoCRT with CDDP plus 5-FU and elective nodal irradiation (ENI) for stage II/III ESCC. Materials/Methods: Eligibility criteria included clinical stage II/III (UICC 6th, non-T4)ESCC, PS 0-1, and age 20-75 years. Chemotherapy consisted of 2 courses of 5-FU infusion (1000mg/m2, days 1-4) and a 2-hCDDP infusion (75 mg/m2, day 1), with a 4-week interval. Radiation therapy was concurrently administered to a total 41.4 Gy in 23 fractions for primary tumor, metastatic lymph nodes and regional lymph nodes. The regional lymph nodes for ENI included bilateral supraclavicular fossae and superior mediastinal lymph nodes for carcinoma of the upper thoracic esophagus, and mediastinal and perigastric lymph nodes for carcinoma of the middle or lower thoracic esophagus. The three or four field technique was used for middle or lower thoracic esophagus tumor. After completion of CRT, transthoracic esophagectomy with extensive lymphadenectomy (D2) was performed. The primary endpoint was the completion rate of NeoCRT and R0 resection. Results: From July 2010 to June 2011, 33 patients were enrolled, including 2 ineligibles. In 31 eligible patients, the median age was 63 years (range, 40-73); male/female: 28/3; PS0/1: 19/12; cStage IIA/IIB/III: 2/10/19. During CRT, the most common grade 3 or 4 toxicities were leukopenia (65%), neutropenia (65%), anemia (19%), thrombocytopenia (13%), febrile neutropenia (13%), anorexia (16%), esophagitis (16%), stomatitis (6%) and hyponatremia (19%). In total, 31 patients (100%) underwent CRT and 30 (97%) underwent surgery; 1 patient (3%) did not undergo surgery due to disease progression. Twenty-nine patients (93.5%) underwent NeoCRT with R0 resection. Among patients who underwent surgery, there was 1 treatment-related death, and the incidence of operative morbidity was similar to that in previous studies. According to RECIST, the overall response rate was 78% (14/18) after CRT. Pathological complete response was achieved in 13 patients (42%) who underwent esophagectomy. With a median follow-up duration of 30 months, 2-year progression-free survival rate and 2-year overall survival rates were 71.0% and 77.4%, respectively. Conclusions: NeoCRT with ENI was well tolerated and appears to be highly promising. The randomized controlled trial (JCOG1109) compared with neoadjuvant chemotherapy is now ongoing.	
除外	CN-01055914		Fu J, Liu M, Fang W, Wang J, Chen Y, Chen Z, Zhu C, Xiang J, Yang H, Yu Z, Pang Q, Mao W, Zheng X, Han Y	A phase III clinical trial of neoadjuvant chemoradiotherapy followed by surgery versus surgery alone for locally advanced squamous cell carcinoma of the esophagus.	Journal of clinical oncology	2014	32(15 SUPPL. 1)		Journal: Conference Abstract	Background: Surgery is the main treatment of esophageal squamous cell carcinoma (ESCC), but the prognosis of patients with locally advanced ESCC is rather poor. Preoperative chemoradiotherapy followed by surgery seems to hopefully improve the survival of ESCC. Nevertheless, the results of different studies were inconsistent. We are to carry out a phase III clinical trial to investigate the effect of this multidisciplinary therapy for the overall survival of patients with locally advanced ESCC. Methods: This study is a multi-centered randomized controlled phase III clinical trial. According to Sixth Edition AJCC Cancer Staging, patients with IIB-III staged squamous cell carcinoma of the thoracic esophagus are randomly allocated to either preoperative chemoradiotherapy followed by surgery (arm A), or surgery alone (arm B). The intended number of randomized patients will be 430, 215 per arm. In the arm A, Chemotherapy and radiotherapy are performed concurrently. Patients received two cycles of vinorelbine and cisplatin. Vinorelbine at 25 mg/m2 per day is administered in bolus infusion on d1, d8, d22 and d29. Cisplatin at 75 mg/m2 is administered by intravenously infusion on d1 and d22 (or 25 mg/m2 days 1 to 4 and 22 to 25). A total radiotherapy dose of 40 Gy is delivered in 20 daily fractions of 2.0 Gy each (given 5 d/wk for 4 weeks). McKeown esophagectomy or Ivor Lewis esophagectomy will be performed 4-6 weeks after chemoradiotherapy. Two-field lymphadenectomy with total mediastinal lymph node dissection is performed during surgery. Primary outcomes are 3 and 5 years overall survival. From 2007 July to 2013 December, over 300 eligible patients were randomly assigned in eight cooperative cancer centers.	
除外	CN-00328508		Urba SG, Orringer MB, Turrisi A, Jannettoni M, Forastiere A, Strawderman M	Randomized trial of preoperative chemoradiation versus surgery alone in patients with locoregional esophageal carcinoma.	Journal of clinical oncology	2001	19(2)	305-13	Clinical Trial; Journal Article; Randomized Controlled Trial; Research Support, U.S. Gov't, P.H.S.	PURPOSE: A pilot study of 43 patients with potentially resectable esophageal carcinoma treated with an intensive regimen of preoperative chemoradiation with cisplatin, fluorouracil, and vinblastine before surgery showed a median survival of 29 months in comparison with the 12-month median survival of 100 historical controls treated with surgery alone at the same institution. We designed a randomized trial to compare survival for patients treated with this preoperative chemoradiation regimen versus surgery alone. MATERIALS AND METHODS: One hundred patients with esophageal carcinoma were randomized to receive either surgery alone (arm I) or preoperative chemoradiation (arm II) with cisplatin 20 mg/m2/d on days 1 through 5 and 17 through 21, fluorouracil 300 mg/m2/d on days 1 through 21, and vinblastine 1 mg/m2/d on days 1 through 4 and 17 through 20. Radiotherapy consisted of 1.5-Gy fractions twice daily, Monday through Friday over 21 days, to a total dose of 45 Gy. Transhiatal esophagectomy with a cervical esophagogastric anastomosis was performed on approximately day 42. RESULTS: At median follow-up of 8.2 years, there is no significant difference in survival between the treatment arms. Median survival is 17.6 months in arm I and 16.9 months in arm II. Survival at 3 years was 16% in arm I and 30% in arm II (P = .15). This study was statistically powered to detect a relatively large increase in median survival from 1 year to 2.2 years, with at least 80% power. CONCLUSION: This randomized trial of preoperative chemoradiation versus surgery alone for patients with potentially resectable esophageal carcinoma did not demonstrate a statistically significant survival difference.	
除外	CN-00754968		Jin M-G, Jiang S-C, Chen Z-W, Wang Z-Q	[Clinical trial of preoperative concurrent chemoradiation followed by surgery versus surgery alone for advanced esophageal carcinoma]	Chinese Journal of Cancer Prevention and Treatment	2008	15(23)	1815-7	Journal: Article	Objective: To evaluate the curative effect and safety of combined concurrent chemotherapy (paclitaxel + cisplatin) and radiotherapy (neoadjuvant chemoradiation) followed by surgery on treating advanced esophageal carcinoma. Methods: Sixty patients with advanced esophageal cancer were divided into two groups, 30 patients every group. In Group 1 (treatment group), 30 patients received neoadjuvant chemoradiation followed by operation. In Group 2 (control group), 30 patients received surgery alone. In Group 1, the radiotherapy was used conventional fraction regimen, clinical target volume dose was 38-44 Gy, and the chemotherapy was used paclitaxel and cisplatin (TAX 135 mg/m2, d1, d22; DDP 20-30 mg/m2, d1-d5, d22-d26; the surgery followed chemotherapy after 2-4 weeks). The rate of complete resection, the frequency of complication, and the rates of overall survival (3 years) were compared between the two groups. Results: The radical excision rates were 93.3% (28/30) in the treatment group, and 70.0% (21/30) in the control group. It showed significant difference between the two groups (chi2 = 5.455, P = 0.020). The rates of complication after the operation were 36.7% (11/30) in Group 1, and 20.0% (6/30) in Group 2, there were no death during the therapy, and there was no significant difference between the two groups (chi2 = 2.052, P = 0.152). The 1-year overall survival rates were 83.3% in Group 1 and 56.7% in group 2, 3 year overall survival rates were 53.3% in group 1 and 26.7% in group 2. It showed significant difference between the two groups (chi2 = 5.613, P = 0.018). The 3-year overall survival rate in Group 1 was much higher than that in Group 2. Conclusions: Concurrent chemotherapy combined with paclitaxel and cisplatin and radiotherapy before surgery for advanced esophageal carcinoma improves the radical excision rate and 3-year survival rate. Moreover, the complication rate is not increased. Copyright © 2011 Elsevier B. V., Amsterdam. All Rights Reserved.	

除外	CN-00522300		Thota PN, Zuccaro G, Vargo JJ, Conwell DL, Dumot JA, Xu M	A randomized prospective trial comparing unsedated esophagoscopy via transnasal and transoral routes using a 4-mm video endoscope with conventional endoscopy with sedation.	Endoscopy	2005	37(6)	559-65	Clinical Trial; Comparative Study; Journal Article; Randomized Controlled Trial	BACKGROUND AND STUDY AIMS: Unsedated upper endoscopy is an attractive alternative to conventional sedated endoscopy because it can reduce the cost, complications, and recovery time of the procedure. However, it has not gained widespread acceptance in the United States. A prototype 4-mm-diameter video esophagoscope is available. Our aims were to compare unsedated esophagoscopy using this 4-mm esophagoscope with conventional sedated endoscopy with regard to diagnostic accuracy and patient tolerance, to determine the optimal intubation route (transnasal vs. transoral), and to identify the predictors of tolerance of unsedated endoscopy. PATIENTS AND METHODS: Outpatients presenting for conventional endoscopy were randomized to undergo unsedated esophagoscopy by either the transnasal or the transoral route, followed by conventional endoscopy. The diagnostic findings, optical quality, and patient tolerance scores were assessed. RESULTS: A total of 137 patients were approached and 90 (65.6 %) were randomized to undergo esophagoscopy by the transnasal route (n = 44) or by the transoral route (n = 46) before undergoing conventional esophagoscopy. Patient tolerance of unsedated esophagoscopy was comparable to that of conventional endoscopy. The transnasal route was better tolerated than the transoral route, except with respect to pain, and 93.2 % in transnasal group and 91.3 % in transoral group were willing to have the procedure again. The diagnostic accuracy of endoscopy using the 4-mm video endoscope was similar to that of standard endoscopy. Patients who tolerated the procedure well had lower preprocedure anxiety scores (29 vs. 42.5, P = 0.021) and a higher body mass index (31.5 kg/m ² vs. 28 kg/m ² , P = 0.029) than the other patients. CONCLUSIONS: Unsedated esophagoscopy with a 4-mm esophagoscope was well tolerated and has a level of diagnostic accuracy comparable to that of conventional endoscopy. Factors associated with good tolerance of unsedated esophagoscopy were low anxiety levels, high body mass index, and use of the transnasal route. Unsedated endoscopy may be offered to a selected group of patients based on these criteria.	
除外	CN-00913914		Wang WP, Gao Q, Wang KN, Shi H, Chen LQ	A prospective randomized controlled trial of semi-mechanical versus hand-sewn or circular stapled esophagogastrostomy for prevention of anastomotic stricture.	World journal of surgery	2013	37(5)	1043-50	Journal: Article	BACKGROUND: Successful anastomosis is essential in esophagogastrectomy, and the application of the circular stapler effectively reduces the anastomotic leakage, although stricture formation has become more frequent. The present study, a randomized controlled trial, compared the recently developed semi-mechanical anastomosis with a hand-sewn or circular stapled esophagogastrostomy in prevention of anastomotic stricture. METHODS: Between November 2007 and September 2008, 160 consecutive patients with esophageal carcinoma underwent surgical treatment our department. Five patients were excluded from this study, and the remaining 155 patients were completely randomized to receive either an everted plus side extension esophagogastrostomy (semi-mechanical [SM] group) or a conventional hand-sewn esophagogastric anastomosis ([HS] group) or a circular stapled ([CS] group) esophagogastric anastomosis, after dissection of the esophageal tumor and construction of a tubular stomach. The primary outcome was the incidence of an anastomotic stricture at 3 months after the operation (defined as the diameter of the anastomotic orifice \geq 0.8 cm on esophagogram). Secondary outcomes were the dysphagia score and reflux score, as well as the anastomotic diameter. RESULTS: The anastomotic stricture rate was 0 % (0/45) in the SM group, 9.6 % (5/52) in the HS group, and 19.1 % (9/47) in the CS group (p < 0.001). The mean diameter of the anastomotic orifice was 18.2 \pm 4.7 mm in the SM group, 11.5 \pm 2.4 mm in the HS group, and 9.5 \pm 3.0 mm in the CS group (p < 0.001). The reflux/regurgitation score among the three groups was similar. CONCLUSIONS: Semi-mechanical esophagogastric anastomosis could prevent stricture formation more effectively than hand-sewn or circular stapler esophagogastrostomy, without increasing gastroesophageal reflux.	
除外	CN-00123479		Pouliquen X, Levard H, Hay JM, McGee K, Fingerhut A, Langlois-Zantin O	5-Fluorouracil and cisplatin therapy after palliative surgical resection of squamous cell carcinoma of the esophagus. A multicenter randomized trial. French Associations for Surgical Research.	Annals of surgery	1996	223(2)	127-33	Case Reports; Clinical Trial; Journal Article; Multicenter Study; Randomized Controlled Trial	BACKGROUND: The curative rate of surgical resection of squamous cell carcinoma of the esophagus is low. Reports on the efficacy of preoperative and postoperative chemotherapy are conflicting or have included limited disease or radical surgery alone. OBJECTIVE: The authors' objective was to study the results of chemotherapy on the duration and quality of survival in patients who have undergone palliative surgical resection for esophageal squamous cell carcinoma. PATIENTS AND METHODS: Of 124 patients with histologically proven esophageal squamous cell carcinoma situated more than 5 cm from the upper end of the esophagus, 4 patients were withdrawn for failure to comply with the protocol. The remaining 120 patients, 116 males and 4 females (mean age, 57 \pm 9 years), were randomly assigned to either a control group who were to receive no chemotherapy (68 patients) or to a group who were to be treated with chemotherapy (52 patients). Patients were subdivided into two strata as follows: (1) stratum I, complete resection of the tumor with lymph node involvement (62 patients) and (2) stratum ii, incomplete resection leaving macroscopic tumor tissue in situ or with metastases. Noninclusion criteria were histologically proven tracheobronchial involvement, esophageal fistula, major alteration of general health status (Karnofsky score <50), cerebral or extensive (>30% of parenchyma) hepatic metastasis, peritoneal carcinomatosis, associated or previously treated upper airway cancer, or, conversely, complete resection of tumor without lymph node involvement. Chemotherapy was given in 5-day courses, every 28 days, with a maximum of 8 courses. Cisplatin was administered either as a single dose of 100 mg/m ² at the beginning of the course or as 20 mg/m ² /day for 5 days given over 3 hours. 5- Fluorouracil (5-FU) (100 mg/m ² /day) was infused over 24 hours for 5 days. The duration of treatment ranged from 6 to 8 months. The main aim was to establish median survival and actuarial survival curves. The subsidiary aim was to evaluate quality of survival as judged by complications due to treatment and the duration of autonomous oral feeding, that is, without palliative endoscopic treatment. No difference in survival was noted between the two groups, overall (median, 14 months), or between the strata. Conversely, significantly more patients in the treated group had hematologic, neurologic, and renal complications compared with the control group. Four patients died of complications of chemotherapy. The duration of autonomous oral alimentation was exactly the same in both groups (median, 12 + months). CONCLUSION: The results of this study suggest that 5-FU and cisplatin are not useful for patients with squamous cell carcinoma of the esophagus who have not undergone curative resection.	
除外	CN-01063239		Nozaki I, Kato K, Igaki H, Ito Y, Daiko H, Yano M, Udagawa H, Nakagawa S, Takagi M, Okabe H, Abe T, Nakamura T, Hihara J, Toh Y, Akutsu Y, Shibuya Y, Mizusawa J, Nakamura K, Fukuda H, Kitagawa Y	Safety profile of thoracoscopic esophagectomy for esophageal cancer compared with traditional thoracotomy from the results of JCOG0502: A randomized trial of esophagectomy versus chemoradiotherapy.	Journal of clinical oncology	2014	32(3 SUPPL. 1)		Journal: Conference Abstract	Background: Esophagectomy for esophageal cancer via the thoracoscopic approach (TA) is expected to reduce the extent of trauma compared with traditional thoracotomy (TT) However, there have been few prospective studies comparing perioperative complications between TA and TT after esophagectomy. Therefore, this study aimed to clarify whether TA is a safe procedure with regard to morbidity and mortality using the data of patients (pts) who underwent esophagectomy in the JCOG0502 trial. Methods: The JCOG0502 trial is a currently on-going randomized trial including a patient preference arm of esophagectomy versus chemoradiotherapy for treatment of clinical stage I esophageal cancer. The primary analysis of overall survival is planned in 2018. In this trial, thoracic squamous cell carcinoma, adenocarcinoma, and basaloid carcinoma of stage T1b/N0/M0 were eligible. When pts were randomized to surgery or selected surgery, esophagectomy with D2-3 lymphadenectomy was performed. TA or TT was selected at the surgeon's discretion. Perioperative complications were defined as adverse events of grade 2 or greater as per CTCAE v3.0. Results: A total of 379 pts (11 randomized and 368 in the patient preference arm) were enrolled between December 2006 and February 2013 from 37 institutions, and 211 pts underwent surgery. Of these 211 pts, TA was performed in 101 pts while TT was performed in 110 pts. Blood loss was less in the TA group than in the TT group (median, 293 vs. 410 mL, respectively), and the surgical duration was longer in the TA group than in the TT group (median, 510 vs. 398 min). The proportion of intraoperative complications was similarly low in both groups. However, postoperative anastomotic leakage, pneumonia, and atelectasis were less common in the TA group than in the TT group (7%, 8%, and 11% vs. 14%, 17%, and 22%). Moreover, the proportion of recurrent nerve palsy was similar among both groups (15% vs. 16%). Each group had one in-hospital death. Conclusions: This study indicated that TA did not increase morbidity or mortality after esophagectomy and can be safely performed with risks comparable to those with TT.	

除外	CN-00157651		Levard H, Pouliquen X, Hay JM, Fingerhut A, Langlois-Zantain O, Huguier M, Lozach P, Testart J	5-Fluorouracil and cisplatin as palliative treatment of advanced oesophageal squamous cell carcinoma. A multicentre randomised controlled trial. The French Associations for Surgical Research.	European journal of surgery = Acta chirurgica	1998	164(11)	849-57	Clinical Trial; Journal Article; Multicenter Study; Randomized Controlled Trial	OBJECTIVE: To compare chemotherapy with no chemotherapy as palliative treatment for oesophageal squamous cell carcinoma. DESIGN: Randomised study. SETTING: Multicentre trial in France. SUBJECTS: Of 161 patients with histologically confirmed oesophageal squamous cell carcinoma located more than 5 cm from the mouth of the oesophagus, five were withdrawn because of protocol violation. The remaining 156 patients, 149 men and 7 women, mean (SD) age 58 (9) years range 36 to 77, were randomly allocated to either a control group without chemotherapy (n = 84) or a group treated by chemotherapy (n = 72). Patients were divided into four strata: I = complete resection of the tumour but with lymph node involvement (n = 62); II = incomplete resection of tumour leaving gross tumour behind (n = 58); III = no resection because of local or regional invasion (n = 22); and IV = no resection because of distant metastasis (n = 14). Exclusion criteria were histologically confirmed tracheobronchial involvement, oesophagotracheal fistula, Karnofsky score < 50, cerebral metastases, or hepatic metastases occupying more than 30% of the liver, peritoneal carcinomatosis, associated or previously treated ear-nose-throat carcinoma, or complete resection of tumour without lymph node involvement. INTERVENTIONS: 5 fluorouracil (5FU) and cisplatin (CDDP) were given in 5-day courses, once every 28 days, for a maximum of eight cycles. 5 FU, 1 g/m2, was infused for 24 hours after a water overload, during five days. Cisplatin was given either in one dose of 100 mg/m2 at the beginning of the cycle or 20 mg/m2/day over three hours for five days. Duration of treatment ranged from 6-8 months. OUTCOME MEASURES: Median and actuarial survival. The subsidiary endpoint was quality of survival judged by complications of treatment, swallowing disorders, and the duration of ability to feed normally. RESULTS: There was no difference in survival, either overall (median = 12 months) or in any of the strata. There were however significantly more patients with neurological (p < 0.003), haematological (p < 0.0001), and renal (p < 0.0002) complications in the treated group compared with the control group. Four patients (6%) died of complications of chemotherapy. The course of swallowing disorders did not differ between the two groups. The duration of autonomous oral feeding was exactly the same in both groups (median = 10.5 months). CONCLUSION: The results suggest that 5FU and CDDP do not help in patients with squamous cell carcinoma of the oesophagus whether or not the tumour has been resected.	
除外	CN-00708643		Peng L, Xie T-P, Han Y-T, Lang J-Y, Li T, Fu B-Y, Chen L-H, Fang Q	[Randomized controlled study on preoperative concurrent chemoradiotherapy versus surgery alone for esophageal squamous cell carcinoma]	Tumor	2008	28(7)	620-2	Journal: Article	Objective: This study was performed to assess the efficacy and safety of preoperative concurrent chemotherapy and radiotherapy for esophageal cancer and its value in improving survival rate. Methods: Eighty patients at II B and III clinical stages and without contraindications for surgery and radiochemotherapy were selected in the study. They were randomly assigned into two groups with 40 patients in each group. Patients in combined therapy group were given two cycles of neoadjuvant chemotherapy (5-fluorouracil 500 mg/m2 + cisplatin 75 mg/m2) and the concurrent radiotherapy. Linear accelerator machine produced radiation at the dosage of 40 Gy. The tumor was resected at 3-5 weeks after concurrent chemotherapy and radiotherapy. Patients in the control group received surgery alone. SPSS software was used to perform chi2 test and make survival rate analysis. Results: The radical resection rates were 97.5% and 90% in the combined therapy group and control group, respectively. TNM staging was significantly decreased in the combined therapy group than that in the control group; there was no significant difference in the incidence of postoperative complications between the two groups. The postoperative survival rate of the combined therapy group was significantly higher than that of the control group. Conclusion: Preoperative adjuvant chemoradiotherapy markedly increased the radical resection rate and survival rate, decreased the TNM staging and regional lymph node metastasis, and suppressed local recurrence and distal metastasis. Copyright © 2011 Elsevier B. V., Amsterdam. All Rights Reserved.	
除外	CN-01063215		Suntharalingam M, Winter K, Ilson DH, Dicker A, Kachnic LA, Konski AA, Chakkravarthy B, Gaffney DK, Thakrar HV, Horiba MN, Deutsch M, Kavadi V, Raben A, Roof KS, Videtic GMM, Pollock J, Safran H, Crane CH	The initial report of RTOG 0436: A phase III trial evaluating the addition of cetuximab to paclitaxel, cisplatin, and radiation for patients with esophageal cancer treated without surgery.	Journal of clinical oncology	2014	32(3 SUPPL. 1)		Journal: Conference Abstract	Background: RTOG 0436 is a randomized Ph III trial designed to evaluate the benefit of cetuximab added to the concurrent chemoradiation for patients undergoing non-operative management of esophageal carcinoma. Methods: Pts with biopsy-proven squamous cell or adenocarcinoma of the esophagus (T1N1M0; T2-4 AnyN M0; Any T/N M1a) were randomized to weekly concurrent cisplatin (50 mg/m2), paclitaxel (25 mg/m2), and daily radiation 50.4 Gy/1.8 Gy fractions +/- weekly cetuximab (400 mg/m2 day 1 then weekly 250 mg/m2). Patients were stratified by histology, tumor size (< 5 cm vs > 5cm), and the status of celiac lymph nodal involvement. Overall survival (OS) was the primary endpoint, with a planned accrual of 420 pts to detect an increase in 2-year OS from 41% to 53%; 80% power and 1-sided 0.025 alpha. An interim analysis of cCR was planned for the first 150 of each histology. Results: The study accrued 344 pts from 2008-2013 and 328 were eligible. Based on interim analyses, the study stopped accruing adeno pts in 5/2012 and SCC pts in 1/2013. Pts were well matched for pretreatment characteristics: 80% with T3/4 disease, 66% N1, and 19% with celiac nodal involvement. Incidence of grade 3/4/5 treatment (tx) related AEs was 45%, 22%, 4% in Arm 1 (cetuximab) and 49%, 17%, 1% in Arm 2 (no cetuximab). A cCR rate of 56% was observed in Arm 1 vs 59% in Arm 2 (p=0.72). No differences were seen in cCR between tx arms for either histology. The 12 and 24 mo OS rates for cCR pts were 79% and 58% vs 53% and 30% for those with residual disease (p<0.0001). Median follow-up for all pts is 15.4 mos. The 12 and 24 mo OS (95% CI) for Arm 1 is 64% (56%, 71%) and 44% (36%, 52%) vs 65% (57%, 72%) and 42% (34%, 50%) for Arm 2 (p=0.70). Adeno pts (n=203) had a 12 and 24 mo OS of 65% and 43% for Arm 1 vs 64% and 41% for Arm 2 (p=0.37). The 12 and 24 mo OS for the 125 SCC pts was 62% and 46% for Arm 1 vs 67% and 43% for Arm 2 (p=0.97). Conclusions: The addition of cetuximab to concurrent chemoradiation did not improve OS. There were no differences in cCR rates by tx arm. These Ph III results point to little benefit for current EGFR targeted agents in the tx of esophageal cancer.	
除外	CN-00123122		Malhaire JP, Labat JP, Lozac'h P, Simon H, Lucas B, Topart P, Volant A	Preoperative concomitant radiochemotherapy in squamous cell carcinoma of the esophagus: results of a study of 56 patients.	International journal of radiation oncology, biology, physics	1996	34(2)	429-37	Clinical Trial; Clinical Trial, Phase I; Clinical Trial, Phase II; Journal Article; Randomized Controlled Trial; Review	PURPOSE: Today the prognosis for patients with esophageal carcinoma still remains quite poor. In the last few years interesting results have been obtained by associating radio- and chemotherapy with or without surgery with this type of cancer. In this work we report the results of concomitant radio- and chemotherapy in a split-course schedule preceding surgery for the treatment of squamous cell carcinomas of the esophagus. METHODS AND MATERIALS: Fifty-six patients with squamous cell carcinomas of the esophagus were treated between April 1989 and September 1993 in the Centre Hospitalier Universitaire in Brest, France with two courses of preoperative concomitant radiochemotherapy, separated by a 2-week interval, and followed by surgery (each course 18.5 Gy in five fractions, days 1-5 with continuous infusion 5-fluorouracil (5-FU) 800 mg/m2 days 1-5 and cisplatin 70 mg/m2 day 2). Patients who had responded well to preoperative treatment (response > 50%) received four more courses of chemotherapy alone. The two patients who were not operated and those with palliative surgery received a third course of radiochemotherapy (radiotherapy 12 Gy in five fractions, days 1-5). RESULTS: Fifty-four patients were operated on. Twenty-one showed histological complete response at surgery (37.5% of the whole group). Actuarial survival for the 56 patients was 55% at 3 years and 30% at 4 years, with a median survival of 37.4 months (40.4 months for complete responders to preoperative treatment). Toxicity of preoperative concomitant radio-chemotherapy was low (5-FU had to be stopped in one patient because of cardiac rhythm disturbances and in another patient because of aplasia Grade 4 associated with infection after the first course). Postoperative mortality was 11% (six patients). CONCLUSION: This combination of preoperative radiochemotherapy followed by surgery seems to improve both response rates and survival in patients with esophageal cancer when compared with previous patients treated with surgery alone in our hospital or with results found in literature and it warrants further studies.	

除外	CN-00327497		Nakano S, Baba M, Natsugoe S, Kusano C, Shimada M, Fukumoto T, Aikou T	The role of neoadjuvant radiochemotherapy using low-dose fraction cisplatin and 5-fluorouracil in patients with carcinoma of the esophagus.	The Japanese journal of thoracic and cardiovascular surgery : official publication of the Japanese Association for Thoracic Surgery = Nihon Ky?bu Geka Gakkai zasshi	2001	49(1)	11-6	Clinical Trial; Comparative Study; Journal Article; Randomized Controlled Trial	OBJECTIVE: We clarified the role of neoadjuvant radiochemotherapy in patients with carcinoma of the esophagus and compared it to neoadjuvant chemotherapy. METHODS: We retrospectively examined 40 patients diagnosed with advanced thoracic esophageal carcinoma who underwent neoadjuvant therapy followed by esophagectomy between 1993 and 1999. We divided them into 2 groups: radiochemotherapy (17) and chemotherapy (23). Radiochemotherapy patients underwent 40 Gy radiation and low-dose fraction cisplatin (7 mg/body/day, 5 days a week x 4 weeks) and 5-fluorouracil (350 mg/body/day x 28 days). Chemotherapy patients received high-dose fraction cisplatin/5-fluorouracil involving 2 courses of cisplatin (70 mg/m ² /day on day 1) and 5-fluorouracil (700 mg/m ² /day on days 1-5). RESULTS: Complete pathological response was 17.6% in the radiochemotherapy group and 0% in the chemotherapy group respectively. No hospital mortality occurred in the radiochemotherapy group, and 1 of the 23 chemotherapy patients died in the hospital due to postoperative complications. The incidence of residual tumors was significantly higher in the chemotherapy group (34.8%) than in the radiochemotherapy group (0%). Actuarial survival in the radiochemotherapy group at 1 year was 80.2% and at 3 years 53.5%. Actuarial survival in the chemotherapy group at 1 year was 56.5% and at 3 years 30.4%. CONCLUSIONS: Histological effectiveness was greater in patients treated with preoperative radiochemotherapy than those treated with preoperative chemotherapy. The combination of radiation and low-dose fraction CDDP/5-FU thus is first choice in neoadjuvant radiochemotherapy for the advanced esophageal carcinoma.	
除外	CN-00514570		Pozzo C, Barone C, Szanto J, Padi E, Peschel C, B-ki J, Gorbunova V, Valvere V, Zaluski J, Biakhov M, Zuber E, Jacques C, Bugat R	Irinotecan in combination with 5-fluorouracil and folinic acid or with cisplatin in patients with advanced gastric or esophageal-gastric junction adenocarcinoma: results of a randomized phase II study.	Annals of oncology	2004	15(12)	1773-81	Clinical Trial; Clinical Trial, Phase II; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	BACKGROUND: To identify the most effective of two combinations, irinotecan/5-fluorouracil (5-FU)/folinic acid (FA) and irinotecan/cisplatin, in the treatment of advanced gastric cancer, for investigation in a phase III trial. PATIENTS AND METHODS: Patients were randomized to receive irinotecan [80 mg/m ² intravenously (i.v.)], FA (500 mg/m ² i.v.) and a 22-h infusion of 5-FU (2000 mg/m ² i.v.), weekly for 6 weeks with a 1-week rest, or irinotecan (200 mg/m ² i.v.) and cisplatin (60 mg/m ² i.v.), on day 1 for 3 weeks. RESULTS: A total of 115 patients were eligible for analysis in the per-protocol population. The overall response rate in the irinotecan/5-FU/FA arm (n=59) was 42.4%, with a complete response rate of 5.1%. Corresponding figures for the irinotecan/cisplatin arm (n=56) were 32.1% and 1.8%, respectively. The median time to progression was 6.5 months (irinotecan/5-FU/FA) and 4.2 months (irinotecan/cisplatin) (P < 0.0001), with median survival times of 10.7 and 6.9 months, respectively (P=0.0018). The major toxicity was grade 3/4 neutropenia, which was more pronounced with irinotecan/cisplatin than with irinotecan/5-FU/FA (65.7% versus 27%). Diarrhea was the main grade 3/4 non-hematological toxicity with both irinotecan/5-FU/FA (27.0%) and irinotecan/cisplatin (18.1%). CONCLUSIONS: Both combinations were active, with acceptable safety profiles. Irinotecan/5-FU/FA was selected as the most effective combination for investigation in a phase III trial in advanced gastric cancer.	
除外	CN-01055909		Ilson DH, Moughan J, Suntharalingam M, Dicker A, Kachnic LA, Konski AA, Chakravarthy B, Anker C, Thakrar HV, Horiba N, Kavadi V, Deutsch M, Raben A, Roof KS, Suh JH, Pollock J, Safran H, Crane CH	RTOG 0436: A phase III trial evaluating the addition of cetuximab to paclitaxel, cisplatin, and radiation for patients with esophageal cancer treated without surgery.	Journal of clinical oncology	2014	32(15 SUPPL. 1)		Journal: Conference Abstract	Background: RTOG 0436 is a randomized Ph III trial evaluating cetuximab added to concurrent chemoradiation for patients (pts) undergoing non-operative management of esophageal carcinoma (EC). Methods: Pts with biopsy proven squamous cell or adenocarcinoma of the esophagus (T1N1M0; T2-4 AnyN M0; Any T/N M1a) were randomized to weekly concurrent cisplatin (50 mg/m ²), paclitaxel (25 mg/m ²) for 6 weeks and daily radiation 50.4 Gy/1.8 Gy fractions +/- weekly cetuximab (400 mg/m ² day 1 then weekly 250 mg/m ²) for 6 weeks. Pts were stratified by histology, tumor size (< 5 cm vs > 5cm) and the status of celiac lymph nodal involvement. Overall survival (OS) was the primary endpoint, with a planned accrual of 420 pts to detect an increase in 2-year OS from 41% to 53%; 80% power and 1-sided 0.025 alpha. An interim analysis of cCR was planned for the first 150 of each histology. Results: The study accrued 344 pts from 2008-2013 and 328 were eligible. Based on interim analyses, the study stopped accruing adeno pts in 5/2012 and SCC pts in 1/2013. Pts were well matched for pretreatment characteristics: 80% T3/4 disease, 66% N1, and 19% celiac nodes. Grade 3/4/5 treatment (tx) related AEs were 45%, 22%, 4% in Arm 1 (cetuximab) and 49%, 17%, 1% in Arm 2 (no cetuximab). A cCR rate of 56% was observed in Arm 1 vs 59% in Arm 2 [p=0.72]. No differences were seen in cCR between tx arms for either histology. The 12 and 24 mo OS rates for cCR pts were 79% and 58% vs 53% and 30% for those with residual disease [p<0.0001]. Median follow-up for all pts is 15.4 mos. The 12 and 24 mo OS (95% CI) for Arm 1 is 64% (56%, 71%) and 44% (36%, 52%) vs 65% (57%, 72%) and 42% (34%, 50%) for Arm 2 [p=0.70]. Adeno pts (n=203) had a 12 and 24 mo OS of 65% and 43% for Arm 1 vs 64% and 41% for Arm 2 [p=0.37]. The 12 and 24 mo OS for the 125 SCC pts was 62% and 46% for Arm 1 vs 67% and 43% for Arm 2 [p=0.97]. Conclusions: Cetuximab added to chemoradiation did not improve OS. There were no differences in cCR rates by tx arm. These results add to the growing body of literature indicating no benefit for current EGFR targeted agents in the tx of unselected patients with EC.	
除外	CN-00982346		Haase O, Raue W, Neuss H, Koplin G, Mielitz U, Schwenk W	Influence of postoperative fluid management on pulmonary function after esophagectomy.	Acta chirurgica Belgica	2013	113(6)	415-22	Journal Article; Randomized Controlled Trial	PURPOSE: The aim of this study was to investigate the effects of a restrictive vs. a liberal postoperative fluid therapy guided by intrathoracic blood volume index (ITBVI) on hemodynamic and pulmonary function in patients undergoing elective esophagectomy. Perioperative fluid therapy may influence postoperative physiology and morbidity after esophageal surgery. Definitions of adequate infusion amounts and evident rules for a fluid therapy are missing. METHODS: After esophagectomy, 22 patients were randomized either to a restrictive group (RG) with low range of ITBVI (600-800 ml/m ²) or a liberal group (LG) with normal ITBVI (800-1000 ml/m ²). Infusion regimen was modified twice a day according to transpulmonary thermodilution measurements until the 5th postoperative day. Primary endpoint was paO ₂ /FIO ₂ -ratio. Secondary endpoints were pulmonary function, fluid balance and hemodynamic as well as morbidity. RESULTS: Demographic and surgical details did not differ between both groups. The calculated sample size was not reached. There were no postoperative differences in paO ₂ /FIO ₂ -ratio, ITBVI, hemodynamic parameters, or morbidity either. Cumulative fluid uptake was 4.1 liter less in the RG on the 5th postoperative day (p = 0.01), and pulmonary function was better in these patients (area under curve day 2-7 for forced vital capacity (FVC), forced expiratory volume in one second (FEV1), peak expiratory flow (PEF) each <0.05). CONCLUSION: ITBVI guided restrictive infusion therapy yields a lower fluid uptake, but may not result in a difference of clinical relevant parameters. A fluid restriction after esophagectomy should always be combined with hemodynamic monitoring because additional infusions may be required.	
除外	CN-01028140		Wilke H, Cunningham D, Ohtsu A, Nuber U, Bruns R, Beate S-B	A randomized, multicenter, double-blind, placebo (PBO)-controlled phase III study of paclitaxel (PTX) with or without ramucirumab (IMC-1121B; RAM) in patients (pts) with metastatic gastric adenocarcinoma, refractory to or progressive after first-line therapy with platinum (PLT) and fluoropyrimidine (FP).	Journal of clinical oncology	2012	30(15 SUPPL. 1)		Journal: Conference Abstract	Background: Vascular endothelial growth factor (VEGF) expression in gastric cancer (GC) is associated with more aggressive clinical disease. VEGF expression in resected GC is associated with tumor recurrence and shorter survival. Data from Phase 2 and 3 studies suggest that agents targeting the VEGF pathway improve the efficacy of some chemotherapy regimens in 1st- and 2nd-line treatment of patients with gastric or gastroesophageal carcinomas. RAM, a fully human monoclonal antibody, binds to the VEGF receptor-2 (VEGFR-2), potentially blocks the binding of VEGF to VEGFR-2, inhibits VEGF-stimulated activation of VEGFR-2, and neutralizes VEGF-induced mitogenesis of human endothelial cells. Methods: Pts are randomized 1:1 to receive PTX + RAM or PTX + PBO until disease progression or intolerable toxicity (28-day cycle; RAM/PBO 8 mg/kg Days 1, 15; PTX 80 mg/m ² Days 1, 8, 15). Eligibility includes metastatic or locally advanced, unresectable gastric or gastroesophageal junction adenocarcinoma; prior first-line therapy with any PLT/FP doublet with or without anthracycline; progressive disease during or following first-line therapy; ECOG PS 0-1; bilirubin < 1.5 x upper limit of normal (ULN), transaminases < 3 x ULN for ALAT/ASAT if no liver metastases, < 5 x ULN if liver metastases; creatinine < 1.5 x ULN; absolute neutrophil count > 1.5 x 10 ⁹ /L, hemoglobin > 9 g/dL; platelets > 100 x 10 ⁹ /L. The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival, time to progression, best overall response, objective response rate, safety, patient-reported outcome measures, pharmacodynamics, immunogenicity, and pharmacokinetics. This study, powered at 90% to show an increase in OS (mdn: 7 m PTX + PBO, 9.33 m PTX + RAM) at a 1-sided 2.5% significance level, will randomize 663 pts. As of 18 January 2012, approximately 58% of planned pts were randomized. The IDMC reviewed this study 23 June and 01 December 2011 and recommended the study continue unmodified.	

除外	CN-00165183		Baba M, Natsugoe S, Shimada M, Nakano S, Shirao K, Kusano C, Fukumoto T, Aikou T	Does preoperative chemotherapy cause adverse effects on the perioperative course of patients undergoing esophagectomy for carcinoma?	The Japanese journal of thoracic and cardiovascular surgery : official publication of the Japanese Association for Thoracic Surgery = Nihon Ky?bu Geka Gakkai zasshi	1999	47(5)	199-203	Clinical Trial; Journal Article; Randomized Controlled Trial	The aim of this study was to clarify whether preoperative chemotherapy caused adverse effects on the perioperative course of patients undergoing esophagectomy. A total of 42 esophageal cancer patients were entered into a randomized trial and were analyzed. Twenty-one patients were assigned to immediate surgery (Surgery Group). The other 21 received two 5-day courses of chemotherapy comprising cisplatin (70 mg/m ²) on day 1, and fluorouracil (700 mg/m ²) and leucovorin (20 mg/m ²) on each of days 1 to 5 (chemotherapy group). Hospital mortality comprised of one patient (2.3%) who had undergone an operation in the beginning of this series at 21 days after chemotherapy. Thereafter, the interval between the chemotherapy and operation was prolonged, with the average being 35 +/- 7 days. Preoperatively, both the lymphocyte counts and serum albumin levels were not increased in the chemotherapy group of patients even though their body weights increased. In the chemotherapy group, the operation time and the blood loss were increased and, on the 1st postoperative day, the development of systemic inflammatory response syndrome was high but the level of C-reactive protein was low. The incidence of positive microbial cultures of sputum and/or wound discharge within 8 postoperative days was higher in the chemotherapy group (42.9%) than in the surgery group (4.8%). The host defense damage caused by chemotherapy may be prolonged and may show adverse effects in patients undergoing esophagectomy in the early postoperative period. Minimally, a 4-week interval between the completion of chemotherapy and operation is recommended for preventing surgical mortality related to the preoperative chemotherapy.	
除外	CN-01002560		Tholoor S, Bhattacharyya R, Tsagkournis O, Longcroft-Wheaton G, Bhandari P	Acetic acid chromoendoscopy in Barrett's esophagus surveillance is superior to the standardized random biopsy protocol: Results from a large cohort study (with video).	Gastrointestinal endoscopy	2014	80(3)	417-24	Journal: Article	Background Currently, various advanced endoscopic techniques are available with varying success rates. These technologies are manufacturer dependent, which has financial implications in the current era of austerity. Acetic acid is a commonly available dye that has been used in the detection of neoplasia within Barrett's esophagus. It has been shown to be effective in detecting neoplasia in high-risk subgroups, but its efficacy in a low-prevalence surveillance population remains unproven. Objective This study aimed to investigate the effectiveness of acetic acid chromoendoscopy in a Barrett's esophagus surveillance population. We aimed to compare the neoplasia yield of acetic acid chromoendoscopy (AAC) with the neoplasia yield from standardized random biopsy (SBP) protocol-guided biopsies in the routine surveillance of patients with Barrett's esophagus. Design Retrospective cohort study. Setting Tertiary referral hospital in the United Kingdom. Patients Patients 18 years of age and older with a diagnosis of Barrett's esophagus undergoing surveillance gastroscopy. Interventions AAC versus standardized random biopsy protocol (SBP) for Barrett's esophagus surveillance. Main Outcome Measurements Neoplasia detection in 2 groups. Results The overall neoplasia detection rates for all grades of neoplasia were 13 of 655 (2%) in the SBP-guided biopsy cohort and 41 of 327 (12.5%) in the AAC cohort (P =.0001). On per-patient analysis, a 6.5-fold gain in neoplasia detection was seen in the AAC cohort compared with the SBP cohort (0.13 vs 0.02, P =.000). In the SBP cohort, a total of 13 of 655 (2%) neoplasias were detected, of which 3 of 655 patients (0.5%) had low-grade dysplasia, 7 of 655 (1%) had high-grade dysplasia, and 3 of 655 (0.5%) were found to have superficial cancer (T1a/T1b). In the AAC cohort, a total of 41 of 327 neoplasias (12.5%) were found, of which 9 of 327 patients (2.7%) had low-grade dysplasia, 18 of 327 (5.5%) had high-grade dysplasia, and 14 of 327 (4.2%) were found to have superficial cancer. The number of biopsies required to detect 1 neoplasia was 15 times lower in the AAC cohort (40 biopsies) than in the SBP cohort (604 biopsies). On per-biopsy analysis, a 14.7-fold increase in neoplasia detection was seen in the AAC cohort per biopsy compared with the SBP cohort (0.025 vs 0.0017; P =.000). Limitations Not a randomized, controlled study. Conclusions Our study demonstrates that acetic acid detects more neoplasias than conventional protocol-guided mapping biopsies and requires 15 times fewer biopsies per neoplasia detected. 2014 by the American Society for Gastrointestinal Endoscopy.	
除外	CN-00162858		Cooper JS, Guo MD, Herskovic A, Macdonald JS, Martenson JA, Al-Sarraf M, Byhardt R, Russell AH, Beitler JJ, Spencer S, Asbell SO, Graham MV, Leichman LL	Chemoradiotherapy of locally advanced esophageal cancer: long-term follow-up of a prospective randomized trial (RTOG 85-01). Radiation Therapy Oncology Group.	JAMA	1999	281(17)	1623-7	Clinical Trial; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, U.S. Gov't, P.H.S.	CONTEXT: Carcinoma of the esophagus traditionally has been treated by surgery or radiation therapy (RT), but 5-year overall survival rates have been only 5% to 10%. We previously reported results of a study conducted from January 1986 to April 1990 of combined chemotherapy and RT vs RT alone when an interim analysis revealed significant benefit for combined therapy. OBJECTIVE: To report the long-term outcomes of a previously reported trial designed to determine if adding chemotherapy during RT improves the survival rate of patients with esophageal carcinoma. DESIGN: Randomized controlled trial conducted 1985 to 1990 with follow-up of at least 5 years, followed by a prospective cohort study conducted between May 1990 and April 1991. SETTING: Multi-institution participation, ranging from tertiary academic referral centers to general community practices. PATIENTS: Patients had squamous cell or adenocarcinoma of the esophagus, T1-3 N0-1 M0, adequate renal and bone marrow reserve, and a Karnofsky score of at least 50. Interventions Combined modality therapy (n = 134): 50 Gy in 25 fractions over 5 weeks, plus cisplatin intravenously on the first day of weeks 1, 5, 8, and 11, and fluorouracil, 1 g/m ² per day by continuous infusion on the first 4 days of weeks 1, 5, 8, and 11. In the randomized study, combined therapy was compared with RT only (n = 62): 64 Gy in 32 fractions over 6.4 weeks. MAIN OUTCOME MEASURES: Overall survival, patterns of failure, and toxic effects. RESULTS: Combined therapy significantly increased overall survival compared with RT alone. In the randomized part of the trial, at 5 years of follow-up the overall survival for combined therapy was 26% (95% confidence interval [CI], 15%-37%) compared with 0% following RT. In the succeeding nonrandomized part, combined therapy produced a 5-year overall survival of 14% (95% CI, 6%-23%). Persistence of disease (despite therapy) was the most common mode of treatment failure; however, it was less common in the groups receiving combined therapy (34/130 [26%]) than in the group treated with RT only (23/62 [37%]). Severe acute toxic effects also were greater in the combined therapy groups. There were no significant differences in severe late toxic effects between the groups. However, chemotherapy could be administered as planned in only 89 (68%) of 130 patients (10% had life-threatening toxic effects with combined therapy vs 2% in the RT only group). CONCLUSION: Combined therapy increases the survival of patients who have squamous cell or adenocarcinoma of the esophagus, T1-3 N0-1 M0, compared with RT alone.	
除外	CN-01026425		Chaudhari PB, Chander S, Mohanti BK, Sharma A, Kaur J, Pathy S, Deo SVS	Phase II randomized study comparing concurrent chemoradiation versus neoadjuvant chemotherapy followed by chemoradiation in locally advanced unresectable squamous cell carcinoma of esophagus.	Journal of clinical oncology	2013	31(15 SUPPL. 1)		Journal: Conference Abstract	Background: A significant number of patients diagnosed with esophageal cancer (EC) presents with locally advanced disease. Nonsurgical curative therapy for unresectable EC has limited outcome. Methods: Phase II randomized control trial to assess early locoregional response (LRR) to neoadjuvant chemotherapy (NACT) followed by concurrent chemoradiation (CRT) versus definitive CRT in surgically unresectable squamous cell carcinoma of esophagus (ESCC). A total of 30 patients were randomly assigned to two arms. Arm 1: 2 cycles NACT regimen of 5-fluorouracil (750mg/m ² D1-4) and cisplatin (80mg D1-2) followed by CRT, radiation of 56Gy/ 28 Fr concurrent with weekly paclitaxel 50mg/m ² and carboplatin AUC2. Arm2: CRT; consisting of radiation 56Gy/28Fr and weekly paclitaxel 50mg/m ² and carboplatin AUC2. All the patients were followed till 6 months post treatment. LRR assessment was done at 1, 3 and 6 months post treatment. Wilcoxon multivariate analysis was carried out and difference of the factors were assessed by chi square test (x2 p<0.05). Results: Mean age in two arms were 52 and 54 years respectively. The study had median follow up of 6.6 months. Conclusions: In unresectable EC, CRT showed higher LRR, treatment completion and lesser toxicity compared to NACT combined with CRT. In this pilot cohort of locally advanced unresectable EC paclitaxel and carboplatin combined with radiotherapy has good tolerance and compliance. (Table presented).	

除外	CN-00832376		Nava HR, Allamaneni SS, Dougherty TJ, Cooper MT, Tan W, Wilding G, Henderson BW	Photodynamic therapy (PDT) using HPPH for the treatment of precancerous lesions associated with Barrett's esophagus.	Lasers in surgery and medicine	2011	43(7)	705-12	Journal Article; Randomized Controlled Trial; Research Support, N.I.H., Extramural; Research Support, Non-U.S. Gov't	BACKGROUND AND OBJECTIVES: Photodynamic therapy (PDT) with porfimer sodium, FDA approved to treat premalignant lesions in Barrett's esophagus, causes photosensitivity for 6-8 weeks. HPPH (2-[1-hexyloxyethyl]-2-devinyl pyropheophorbide-a) shows minimal photosensitization of short duration and promising efficacy in preclinical studies. Here we explore toxicity and optimal drug and light dose with endoscopic HPPH-PDT. We also want to know the efficacy of one time treatment with HPPH-PDT. STUDY DESIGN/MATERIALS AND METHODS: Two nonrandomized dose escalation studies were performed (18 patients each) with biopsy-proven high grade dysplasia or early intramucosal adenocarcinoma of esophagus. HPPH doses ranged from 3 to 6?mg/m ² . At 24 or 48?hours after HPPH administration the lesions received one endoscopic exposure to 150, 175, or 200?J/cm of 665?nm light. RESULTS: Most patients experienced mild to moderate chest pain requiring symptomatic treatment only. Six patients experienced grade 3 and 4 adverse events (16.6%). Three esophageal strictures were treated with dilatation. No clear pattern of dose dependence of toxicities emerged. In the drug dose ranging study (light dose of 150?J/cm at 48?hours), 3 and 4?mg/m ² of HPPH emerged as most effective. In the light dose ranging study (3 or 4?mg/m ² HPPH, light at 24?hours), complete response rates (disappearance of high grade dysplasia and early carcinoma) of 72% were achieved at 1 year, with all patients treated with 3?mg/m ² HPPH plus 175?J/cm and 4?mg/m ² HPPH plus 150?J/cm showing complete responses at 1 year. CONCLUSIONS: HPPH-PDT for precancerous lesions in Barrett's esophagus appears to be safe and showing promising efficacy. Further clinical studies are required to establish the use of HPPH-PDT.	
除外	CN-01008599		Ando N	Adjuvant therapy for SCC.	Diseases of the esophagus	2012	25	18A	Journal: Conference Abstract	The epidemiologic shift in esophageal carcinoma from squamous cell carcinoma to adenocarcinoma in Western countries since 1990s has never been seen in Japan, and the majority of treatment subjects in esophageal carcinoma is squamous cell carcinoma in Japan. Surgery is a major modality in the treatment of esophageal cancer, and in order to improve the results of this approach a number of studies have been carried out on adjuvant therapy. The Japan Esophageal Oncology Group (JEOG), a subgroup of the Japan Clinical Oncology Group (JCOG), has conducted consecutive randomized controlled trials aimed at determining the potential of new treatment modalities to improve care. Japanese surgeons believe that the relatively acceptable local tumor control by transthoracic radical esophagectomy avoids the need for preoperative radiotherapy and prefer to chemotherapy than radiotherapy. JEOG initiated a randomized controlled trial (JCOG9204, 1992-97) to determine whether postoperative adjuvant chemotherapy had an additive effect on survival in patients undergoing radical surgery for pathologic stage II, III or IV (M1lym) squamous cell carcinoma. This study compared surgery alone with surgery plus postoperative chemotherapy (cisplatin 80 mg/m ² plus 5-fluorouracil 800 mg/m ² , on days 1-5 x 2 courses). The 5-year disease-free survival rate (primary endpoint) was 45% in the surgery alone group (122 patients) and 55% in the postoperative chemotherapy group (120 patients) (p = 0.04). Risk reduction by postoperative chemotherapy was remarkable in the subgroup with lymph node metastasis. On the basis of these data, postoperative adjuvant chemotherapy using cisplatin and 5-fluorouracil came to be considered the standard treatment for patients with ESCC in the early 2000s. Thereafter, we should evaluate the peri-operative optimal timing, before or after surgery, for giving chemotherapy. JEOG initiated JCOG9907 (2000- 06) comparing postoperative (adjuvant) chemotherapy with preoperative (neoadjuvant) chemotherapy in patients with resectable clinical stage II, III squamous cell carcinoma. Two courses of chemotherapy with same regimen as the JCOG9204 were given following surgery or before surgery. 330 patients (Post /Pre; 166/164) from 24 institutions were randomized. Updated analyses showed the 5-year overall survival to be 42.7% in the Post group and 55.0% in the Pre group (hazard ratio 0.73, 95% confidence interval 0.54-0.99; p = 0.04). On the basis of these data, preoperative chemotherapy with cisplatin plus 5-fluorouracil came to be regarded as the standard treatment for patients with stage II, III squamous cell carcinoma. Thus, the optimal perioperative timing of surgical adjuvant therapy returned from after to before surgery. The results of subgroup analysis of JCOG9907 with survival benefit in cStage III being insufficient suggest that more aggressive adjuvant therapy is needed, such as preoperative chemoradiotherapy for local tumor control or aggressive adjuvant chemotherapy for systemic disease control. Therefore, the clinical question of which is better, preoperative aggressive chemotherapy or preoperative chemoradiotherapy, remains to be answered. Now, JCOG is preparing to conduct a 3-arm randomized controlled trial comparing preoperative chemoradiotherapy and preoperative chemotherapy with docetaxel in addition to cisplatin and 5-fluorouracil (DOF) to standard preoperative treatment with cisplatin plus 5-fluorouracil.	
除外	CN-00278998		Bozzetti F, Cozzaglio L, Gavazzi C, Bidoli P, Bonfanti G, Montalto F, Soto Parra H, Valente M, Zucali R	Nutritional support in patients with cancer of the esophagus: impact on nutritional status, patient compliance to therapy, and survival.	Tumori	1998	84(6)	681-6	Clinical Trial; Comparative Study; Controlled Clinical Trial; Journal Article	AIMS AND BACKGROUND: The multimodal approach to patients with esophageal squamous cell carcinoma often includes polychemotherapy combined with radiation therapy. Cancer dysphagia and drug-related anorexia, mucositis and vomiting can all lead to malnutrition. The aim of this study was to analyze the impact of the administration of enteral nutrition (EN) on the patient's nutritional status, tolerance of chemotherapy and radiotherapy, and final oncological outcome. METHODS: Fifty esophageal cancer patients who were to be submitted to chemotherapy (days 1-4 5-fluorouracil (FU) 1 g/m ² /day and cisplatin (CDDP) 100 mg/m ² /day 1) for two cycles plus radiotherapy (31 Gy) were referred to the Nutrition Support Unit prior to any therapy due to their malnourished status. Twenty-nine dysphagic patients received nutrition via tube (37 kcal/kg/day + 2.0 g proteins/kg/day for 34 days), while 21 others who were not dysphagic were given a standard oral diet (SD). The patients who received EN had a more severe weight loss than the SD patients (16.8% vs 12.8%, P <0.02). RESULTS: The dose of administered EN represented 86% of the planned support, and 70% of the nutritional therapy was administered in the home setting. Administration of EN support resulted in stable body weight and unchanged levels of visceral proteins, while SD patients had a decrease in body weight, total proteins and serum albumin (P <0.01). There was no difference between the two groups in terms of tolerance and response to cancer therapy, suitability for radical resection and median survival (9.5 months). CONCLUSIONS: EN in patients with cancer of the esophagus undergoing chemotherapy and radiotherapy is well tolerated, feasible even in the home setting, prevents further nutritional deterioration and achieves the same oncological results in dysphagic patients as those achieved in non-dysphagic patients.	
除外	CN-01029185		Mariette C, Dahan L, Maillard E, Mornex F, Meunier B, Boige V	Surgery alone versus chemoradiotherapy followed by surgery for stage I and II oesophageal cancer: Final analysis of a randomised controlled phase iii trial-FFCD 9901.	Diseases of the esophagus	2012	25	53A	Journal: Conference Abstract	Background: Resection remains the best treatment for local control of oesophageal carcinoma (OC), but local recurrence, distant metastasis and poor survival remain an issue after surgery. Often investigated in locally advanced OC, the impact of neoadjuvant chemoradiotherapy (NCRT) is unknown in patients with stage I or II OC. The aim of this multicentre randomised controlled phase III trial was to assess whether NCRT improves outcomes for patients with stage I or II OC. Methods: 195 patients were randomly assigned to surgery alone (S group, n = 98) or to NCRT group (NCRT group, n = 97; 45 Gy 25 fractions/5 weeks/2 courses of concomitant chemotherapy by 5Fluorouracil 800 mg/m ² d1-4 and cisplatin 75 mg/m ² d1).The primary endpoint was overall survival. Secondary endpoints were progression free survival, postoperative morbidity and 30 day-mortality, R0 resection rate and prognostic factor identification. Analysis was done by intention to treat. Results: Patient and tumour characteristics were well-balanced between the two groups. Patients were preoperatively staged I in 18%, IIA in 49.7%, IIB in 31.8%, unknown in 0.5%. Postoperative morbidity and 30 day-mortality rates were 49.5% vs. 43.9% (p = 0.17) and 1.1% vs. 7.3% (p = 0.054) in the S group and NCRT group, respectively. After a median follow-up of 5.7 years, 106 deaths were observed. Median survivals were 43.8 vs. 31.8 months, respectively (HR 0.92, 95% CI 0.63-1.34, p = 0.66). The trial was stopped due to futility. Discussion: Compared with surgery alone, NCRT with cisplatin and 5-Fluorouracil does not improve overall survival but enhances postoperative mortality for patients with stage I or II OC.	

除外	CN-00348461		Ancona E, Ruol A, Santi S, Merigliano S, Sileni VC, Koussis H, Zaninotto G, Bonavina L, Peracchia A	Only pathologic complete response to neoadjuvant chemotherapy improves significantly the long term survival of patients with resectable esophageal squamous cell carcinoma: final report of a randomized, controlled trial of preoperative chemotherapy versus surgery alone.	Cancer	2001	91(11)	2165-74	Clinical Trial; Journal Article; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	BACKGROUND: Surgery is the standard treatment for patients with resectable esophageal carcinoma, but the long term prognosis of these patients is unsatisfactory. Some randomized trials of preoperative chemotherapy suggest that the prognosis of patients who respond may be improved. METHODS: This randomized, controlled trial compared patients with clinically resectable esophageal epidermoid carcinoma who underwent surgery alone (Arm A) with those who received preoperative chemotherapy (Arm B). Overall survival and the prognostic impact of major response to chemotherapy were analyzed. Forty-eight patients were enrolled in each arm. Chemotherapy consisted of two or three cycles of cisplatin (100 mg/m ² on Day 1) and 5- fluorouracil (1000 mg/m ² per day continuous infusion on Days 1-5). In both study arms, transthoracic esophagectomy plus two-field lymphadenectomy was performed. The two groups were comparable in terms of patient characteristics. RESULTS: Forty-seven patients were evaluable in each arm. The curative resection rate was 74.4% (35 of 47 patients) in Arm A and 78.7% (37 of 47 patients) in Arm B. Treatment-related mortality was 4.2% in both arms. The response rate to preoperative chemotherapy was 40% (19 of 47 patients), including 6 patients (12.8%) who achieved a pathologic complete responses. Overall survival was not improved significantly. The 19 patients in Arm B who responded to chemotherapy and underwent curative resection had significantly better 3-year and 5-year survival rates (74% and 60%, respectively) compared with both nonresponders (24% and 12%, respectively; P = 0.0002) and patients in Arm A who underwent complete resection (46% and 26%, respectively; P = 0.01); Patients who achieved a pathologic complete response (P = 0.01), but not those who achieved a partial response (P = 0.2), had significantly improved survival. CONCLUSIONS: Patients with resectable esophageal carcinoma who underwent preoperative chemotherapy and obtained a pathologic complete response had a significantly improved long term survival. Major efforts should be undertaken to identify patients before neoadjuvant treatments who are likely to respond.	
除外	CN-00459570		Ando N, Iizuka T, Ide H, Ishida K, Shinoda M, Nishimaki T, Takiyama W, Watanabe H, Isono K, Aoyama N, Makuuchi H, Tanaka O, Yamana H, Ikeuchi S, Kabuto T, Nagai K, Shimada Y, Kinjo Y, Fukuda H	Surgery plus chemotherapy compared with surgery alone for localized squamous cell carcinoma of the thoracic esophagus: a Japan Clinical Oncology Group Study--JCOG9204.	Journal of clinical oncology	2003	21(24)	4592-6	Clinical Trial; Comparative Study; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	PURPOSE: We performed a multicenter randomized controlled trial to determine whether postoperative adjuvant chemotherapy improves outcome in patients with esophageal squamous cell carcinoma undergoing radical surgery. PATIENTS AND METHODS: Patients undergoing transthoracic esophagectomy with lymphadenectomy between July 1992 and January 1997 at 17 institutions were randomly assigned to receive surgery alone or surgery plus chemotherapy including two courses of cisplatin (80 mg/m ² of body-surface area x 1 day) and fluorouracil (800 mg/m ² x 5 days) within 2 months after surgery. Adaptive stratification factors were institution and lymph node status (pN0 versus pN1). The primary end point was disease-free survival. RESULTS: Of the 242 patients, 122 were assigned to surgery alone, and 120 to surgery plus chemotherapy. In the surgery plus chemotherapy group, 91 patients (75%) received both full courses of chemotherapy; grade 3 or 4 hematologic or nonhematologic toxicities were limited. The 5-year disease-free survival rate was 45% with surgery alone, and 55% with surgery plus chemotherapy (one-sided log-rank, P =.037). The 5-year overall survival rate was 52% and 61%, respectively (P =.13). Risk reduction by postoperative chemotherapy was remarkable in the subgroup with lymph node metastasis. CONCLUSION: Postoperative adjuvant chemotherapy with cisplatin and fluorouracil is better able to prevent relapse in patients with esophageal cancer than surgery alone.	
除外	CN-00561167		Lee J, Lee KE, Im YH, Kang WK, Park K, Kim K, Shim YM	Adjuvant chemotherapy with 5-fluorouracil and cisplatin in lymph node-positive thoracic esophageal squamous cell carcinoma.	Annals of thoracic surgery	2005	80(4)	1170-5	Controlled Clinical Trial; Journal Article	BACKGROUND: In this study we explored the effectiveness of adjuvant chemotherapy in node-positive, resected thoracic esophageal squamous cell carcinoma patients. METHODS: A prospective study of postoperative chemotherapy in N1 esophageal cancer patients who received curative resection was conducted and compared with the historical control group in regard to recurrence rate, patterns of failure, disease-free survival rate, and overall survival rate. The postoperative chemotherapy consisted of cisplatin (60 mg/m ² intravenously) and 5-fluorouracil (1,000 mg/m ² per day) in a continuous infusion for 4 days. Three cycles were administered at 3-week intervals. RESULTS: Forty patients were accrued from January 1998 to January 2003 at Samsung Medical Center for adjuvant chemotherapy. The historical control group consisted of 52 patients who received curative resection but not adjuvant chemotherapy during the same period of time. The 3-year disease-free survival rate was 47.6% in the adjuvant group and 35.6% in the control group (p = 0.049). The estimated 5-year overall survival rates were 50.7% in the adjuvant group and 43.7% in the control group (p = 0.228). The significant predictive factors for tumor recurrence were the number of positive lymph nodes (p = 0.008) and the adjuvant chemotherapy (p = 0.030). CONCLUSIONS: This study suggests that the postoperative chemotherapy may prolong disease-free survival in lymph node-positive, curatively resected esophageal cancer patients. The postoperative treatment modality for esophageal cancer patients should be determined according to the lymph node status and a randomized phase III clinical trial is warranted using adjuvant chemotherapy if the esophageal cancer is lymph node-positive.	
除外	CN-00142916		Ando N, Iizuka T, Kakegawa T, Isono K, Watanabe H, Ide H, Tanaka O, Shinoda M, Takiyama W, Arimori M, Ishida K, Tsugane S	A randomized trial of surgery with and without chemotherapy for localized squamous carcinoma of the thoracic esophagus: the Japan Clinical Oncology Group Study.	Journal of thoracic and cardiovascular surgery	1997	114(2)	205-9	Clinical Trial; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	OBJECTIVE: To determine whether postoperative adjuvant chemotherapy confers a survival benefit on patients with esophageal squamous cell carcinoma undergoing radical surgery, we undertook a cooperative, prospective randomized controlled trial. METHODS: A total of 205 patients underwent transthoracic esophagectomy with lymphadenectomy at eleven institutions between December 1988 and July 1991. These patients were prospectively randomized into two groups (100 patients underwent surgery alone and 105 patients had additional two courses of combination chemotherapy with cisplatin (70 mg/m ²) and vindesine (3 mg/m ²). The two groups did not differ with respect to sex, age, location of tumor, and distributions of pT, pN, pM, or p stage. RESULTS: The 5-year survival was 44.9% in the surgery alone group and 48.1% in the surgery plus chemotherapy group. The relative risk was estimated to be 0.89 (95% confidence interval, 0.61 to 1.31) in the surgery plus chemotherapy group compared with the surgery alone group. No significant differences in survival were detected between the two groups, even with lymph node stratification. CONCLUSION: Postoperative adjuvant chemotherapy with cisplatin and vindesine has no additive effect on survival in patients with esophageal cancer compared with surgery alone.	
除外	CN-00163876		Lokich JJ, Sonneborn H, Anderson NR, Bern MM, Coco FV, Dow E, Olinynk P	Combined paclitaxel, cisplatin, and etoposide for patients with previously untreated esophageal and gastroesophageal carcinomas.	Cancer	1999	85(11)	2347-51	Clinical Trial; Controlled Clinical Trial; Journal Article	BACKGROUND: Paclitaxel (T), etoposide (E), and cisplatin (P) are each active in gastric carcinoma, either as single agents or as part of a multidrug regimen. To the authors' knowledge, the combination of these three agents in the treatment of patients with esophageal or gastroesophageal carcinoma has not been previously studied. METHODS: Previously untreated patients with locally advanced carcinoma of the stomach, esophagus, or gastroesophageal (GE) junction received at least 2 cycles of TPE administered twice weekly for 3 weeks, with the cycle repeated every 28 days. Drug doses, administered over 3 hours on either Monday and Thursday or Tuesday and Friday, consisted of T 50 mg/m ² /dose, P 15 mg/m ² /dose, and E 40 mg/m ² /dose. For patients with local disease only, subsequent therapy consisted of radiation with or without surgical resection. RESULTS: Twenty-five patients with gastric (10) or gastroesophageal or GE junction (15) carcinoma were treated. Eighteen had locally advanced disease and 7 had liver metastases at presentation. Hematologic toxicity, namely, Grade 3 anemia and neutropenia, was experienced by all patients. The median number of treatment cycles was 4 (range, 2-6). Three patients were not evaluable for response. All 22 evaluable patients responded; 3 were complete responders and 19 were partial responders. Eleven patients received radiation therapy with (6) or without (5) concomitant 5-fluorouracil, and 8 patients subsequently underwent surgical resection. Three of 8 patients had no tumor at surgery, 4 had minimal microscopic tumor at the primary site, and 3 had microscopic lymph node involvement. Twenty-three patients are alive, of whom 14 are without evidence of disease. Two patients with metastatic disease at presentation died at 9 and 29 months, respectively. The median survival was 12.5 months (range, 6 to 30+ months). CONCLUSIONS: Multifractionated TPE chemotherapy is a highly active regimen in gastric and gastroesophageal carcinoma. It could be evaluated in Phase III trials against other active regimens for the treatment of patients with this disease. The introduction of 5-fluorouracil could also be an interesting direction to explore because of its primary role in the treatment of patients with gastric and esophageal carcinoma.	

除外	CN-01024683		Sun W, Sheng X, Cao Y, Liu H, Lan C, Chen D	Comparison of endoscopic ultrasonography and CT scan for patients with esophageal carcinoma.	Journal of gastroenterology and hepatology	2013	28	721-2	Journal: Conference Abstract	Objective: To evaluate the guidance value of EUS and CT scan in preoperative clinical staging for diagnosis and treatment of esophageal cancer. Methods: 68 patients with esophageal cancer were randomized in a 1 : 1 ratio using a random numbers table. Patients in EUS group were examined by EUS and staged according to the TNM staging system (2003). Patients in the other group were examined by CT scan. The EUS findings were compared with surgical pathologic findings. Results: The accuracy rates of T staging by EUS were 0.0% (0/2) for Tis, 75.0% (3/4) for T1, 75.0% (6/8) for T2, 86.7% (13/15) for T3, 80.0% (4/5) for T4, and 76.5% (26/34) for T; those of N staging were 71.4% (5/7) for N0, 75% (9/12) for N1, 0.0% (0/11) for N2, 0.0% (0/4) for N3, and 41.2% (14/34) for N. The accuracy rates of T staging by CT scan were 0% (0/1) for Tis, 33.3% (2/6) for T1, 28.6% (2/7) for T2, 78.6% (11/14) for T3, 83.3% (5/6) for T4 and 58.8% (20/34) for T (p = 0.005); those of N staging were 77.8% (7/9) for N0, 76.9% (10/13) for N1, 66.7% (4/6) for N2, 50% (3/6) for N3 and 70.6% (24/34) for N (p = 0.005). Conclusion: The accuracy rates of EUS are higher for diagnosis in esophageal cancer and preoperative T staging. The accuracy rates of CT scan are higher for the preoperative N staging. EUS combined with CT scan has great significance for choosing ideal therapy plan for esophageal cancer, and for estimating prognosis of esophageal cancer. (Figure Presented) .	
除外	CN-01055922		Chen Q, Xu Y, Zheng Y, Yu X, Lin Q, Jiang Y, Zhou X, Mao W	Neoadjuvant versus adjuvant treatment: Which one is better for resectable locally advanced esophageal squamous cell carcinoma?.	Journal of clinical oncology	2014	32(15 SUPPL. 1)		Journal: Conference Abstract	Background: In China, the main treatment of esophageal squamous cell carcinoma (ESCC) is surgery combined with postoperative adjuvant chemoradiotherapy. The role of preoperative neoadjuvant chemoradiotherapy is not well established. We compared neoadjuvant chemoradiotherapy followed by surgery with surgery followed by adjuvant chemoradiotherapy in a Chinese ESCC population. Methods: We randomly assigned patients with resectable locally advanced tumors (T3-4N0-1M0, T1-2N1M0) to receive surgery and weekly administration of carboplatin (AUC=2) and paclitaxel (50 mg/m ²) for 6 weeks and concurrent radiotherapy (50.4 Gy/28f, 5 days per week) at preoperative (the neoadjuvant group) or postoperative (the adjuvant group). Results: From April 2011 through December 2013, we enrolled 42 patients: 23 were randomly assigned to chemoradiotherapy followed by surgery, and 19 to surgery followed by adjuvant chemoradiotherapy. Among these 42 patients, the most common major hematologic toxic effects were leukopenia (9.5%), neutropenia (11.9%), thrombocytopenia (14.3%), and anaemia (16.6%); the most common major nonhematologic toxic effects were anorexia (14.3%), fatigue (11.9%), and cervical anastomotic fistula (19.1%). Complete resection with no tumor of the resection margins (R0) was achieved in 100% of patients in the neoadjuvant group versus 90.4% in the adjuvant group. A pathological complete response was achieved in 8 of 23 patients (34.8%) who underwent resection after chemoradiotherapy. Postoperative complications and treatment-related mortality were similar in the two groups. The disease free survival rate at 18 months was 78.7% in the neoadjuvant group as compared with 63.6% in the adjuvant group, which exceeded the goal of this study design. Conclusions: Our preliminary result suggests that, in patients with resectable locally advanced ESCC, there is a benefit tendency for the preoperative neoadjuvant chemoradiotherapy compared with postoperative adjuvant chemoradiotherapy. The regimen was associated with acceptable adverse-event rates. These trends warrant further study.	
除外	CN-01025994		Robb WB, Mariette C, Dahan L, Maillard E, Mornex F, Meunier B, Boige V, Genet C, Pezet D, Thomas PA, Triboulet JP	Surgery alone vs chemoradiotherapy followed by surgery for stage I and II oesophageal cancer: Final analysis of a randomised controlled phase III trial-FFCD 9901.	Gut	2012	61	A37-A38	Journal: Conference Abstract	Introduction: Resection remains the best treatment for local control of oesophageal carcinoma (OC), but local recurrence, distant metastasis and poor survival remain an issue after surgery. Often investigated in locally advanced OC, the impact of neoadjuvant chemoradiotherapy (NCRT) is unknown in patients with stage I or II OC. The aim of this multicentre randomised controlled phase III trial was to assess whether NCRT improves outcomes for patients with stage I or II OC. Methods: 195 patients were randomly assigned to surgery alone (S group, n=98) or to NCRT group (NCRT group, n=97; 45Gy given in 25 fractions over 5 weeks with two courses of concomitant chemotherapy by 5-Fluorouracil 800 mg/m ² on days 1-4 and cisplatin 75 mg/m ² on day 1 or 2). The primary endpoint was overall survival. Secondary endpoints were progression free survival, postoperative morbidity and 30-day mortality, R0 resection rate and prognostic factor identification. Analysis was done by intention to treat. Results: Patient and tumour characteristics were well-balanced between the two groups. Patients were preoperatively staged I in 18%, IIA in 49.7%, IIB in 31.8%, unknown in 0.5%. Postoperative morbidity and 30-day mortality rates were 49.5% vs 43.9% (p=0.17) and 1.1% vs 7.3% (p=0.054) in the S group and NCRT group, respectively. After a median follow-up of 5.7 years, 106 deaths were observed. Median survivals were 43.8 vs 31.8 months, respectively (HR 0.92, 95% CI 0.63 to 1.34, p=0.66). The trial was stopped due to futility. Conclusion: Compared with surgery alone, NCRT with cisplatin and 5-Fluorouracil does not improve overall survival but enhances postoperative mortality for patients with stage I or II OC (Clinical Trial.gov identifier NCT 00047112).	
除外	CN-00708101		Li S-Y, Wan L-X, Ling Y, Yuan B-L, Gu M, Zhang F-L, Li X-Y, Tong J-D, Wu Z-D, Liu L, Xu J-Z, Wang Z	[Diminished dose nedaplatin combined with low-dose cisplatin as first-line therapy for advanced esophageal carcinoma: a randomized clinical trial]	Tumor	2008	28(5)	446-9	Journal: Article	Objective: To investigate the safety and efficacy of the combination of diminished dose of nedaplatin (NDP) and low dose of cisplatin (PDD) for advanced esophageal carcinoma. Methods: The patients who had no indications for surgery or radiotherapy were recruited in our study. They were divided into the three groups randomly. Group A were given NDP (25 mg/m ² , iv) and PDD (15 mg/m ² , iv) on day 1 and day 8 and continuously infused with 5-FU (300 mg/m ²) for 24 h on days 1-5 and days 8-12. Group B were given NDP (40 mg/m ² , iv) on days 1-2 and continuously infused with 5-FU (500 mg/m ² , iv) on days 1-5. Group C were administered PDD (40 mg/m ² , iv) on days 1-2 and infused with 5-FU (500 mg/m ² , iv) on days 1-5. All the patients were given folic acid tablet 60 mg/d following infusion of 5-FU. The therapeutic regimens were repeated every 22 days (one cycle). The effect was evaluated after two cycles. Results: The total response ratio (complete response and partial response) and median remission time were 60.00% and 5.5 months for group A, respectively; 54.54% and 5.0 months for group B, respectively; 41.18% and 3.0 months for group C, respectively. The difference was not significant between group A and group B (P>0.05). The clinical efficacy in groups A and B was significantly different compared with group C (P<0.05). The main toxicities included leucopenia and thrombocytopenia. The incidence rate of III to IV grade leucopenia was 14.29%, 27.27%, and 8.82% in groups A, B, and C, respectively; and that of thrombocytopenia was 11.43%, 39.39%, and 5.88%, respectively. The difference was significant (P<0.05). Conclusion: Diminished dose of NDP combined with low dose of cisplatin has definite effects on advanced esophageal carcinoma with less hematological toxicity. Copyright © 2011 Elsevier B. V., Amsterdam. All Rights Reserved.	

除外	CN-00876735		Lordick F, Kang YK, Chung HC, Salman P, Oh SC, Bodoky G, Kurteva G, Volovat C, Moiseyenko VM, Gorbunova V, Park JO, Sawaki A, Celik I, Gille H, Melezinkov H, Moehler M	Capecitabine and cisplatin with or without cetuximab for patients with previously untreated advanced gastric cancer (EXPAND): a randomised, open-label phase 3 trial.	The Lancet. Oncology	2013	14(6)	490-9	Clinical Trial, Phase III; Journal Article; Multicenter Study; Randomized Controlled Trial; Research Support, Non-U.S. Gov't	BACKGROUND: Patients with advanced gastric cancer have a poor prognosis and few efficacious treatment options. We aimed to assess the addition of cetuximab to capecitabine-cisplatin chemotherapy in patients with advanced gastric or gastro-oesophageal junction cancer. METHODS: In our open-label, randomised phase 3 trial (EXPAND), we enrolled adults aged 18 years or older with histologically confirmed locally advanced unresectable (M0) or metastatic (M1) adenocarcinoma of the stomach or gastro-oesophageal junction. We enrolled patients at 164 sites (teaching hospitals and clinics) in 25 countries, and randomly assigned eligible participants (1:1) to receive first-line chemotherapy with or without cetuximab. Randomisation was done with a permuted block randomisation procedure (variable block size), stratified by disease stage (M0 vs M1), previous oesophagectomy or gastrectomy (yes vs no), and previous (neo)adjuvant (radio)chemotherapy (yes vs no). Treatment consisted of 3-week cycles of twice-daily capecitabine 1000 mg/m ² (on days 1-14) and intravenous cisplatin 80 mg/m ² (on day 1), with or without weekly cetuximab (400 mg/m ²) initial infusion on day 1 followed by 250 mg/m ² per week thereafter). The primary endpoint was progression-free survival (PFS), assessed by a masked independent review committee in the intention-to-treat population. We assessed safety in all patients who received at least one dose of study drug. This study is registered at EudraCT, number 2007-004219-75. FINDINGS: Between June 30, 2008, and Dec 15, 2010, we enrolled 904 patients. Median PFS for 455 patients allocated capecitabine-cisplatin plus cetuximab was 4.4 months (95% CI 4.2-5.5) compared with 5.6 months (5.1-5.7) for 449 patients who were allocated to receive capecitabine-cisplatin alone (hazard ratio 1.09, 95% CI 0.92-1.29; p=0.32). 369 (83%) of 446 patients in the chemotherapy plus cetuximab group and 337 (77%) of 436 patients in the chemotherapy group had grade 3-4 adverse events, including grade 3-4 diarrhoea, hypokalaemia, hypomagnesaemia, rash, and hand-foot syndrome. Grade 3-4 neutropenia was more common in controls than in patients who received cetuximab. Incidence of grade 3-4 skin reactions and acne-like rash was substantially higher in the cetuximab-containing regimen than in the control regimen. 239 (54%) of 446 in the cetuximab group and 194 (44%) of 436 in the control group had any grade of serious adverse event. INTERPRETATION: Addition of cetuximab to capecitabine-cisplatin provided no additional benefit to chemotherapy alone in the first-line treatment of advanced gastric cancer in our trial. FUNDING: Merck KGaA.	
除外	CN-01055918		Castro G, Skare NG, Andrade CJC, Segalla JGM, Azevedo SJ, Silva IDCG, Filho FM, Grossi Neusquen LP, Oliveira Berto CR	Chemoradiation with or without nimotuzumab in locally advanced esophageal cancer (LAEC): A randomized phase II study (NICE trial).	Journal of clinical oncology	2014	32(15 SUPPL. 1)		Journal: Conference Abstract	Background: Chemoradiation is the standard therapy for patients (pts) with inoperable LAEC. We sought to assess the safety and activity of chemoradiation combined with nimotuzumab, a humanized antibody against the epidermal growth factor receptor, in LAEC. Methods: We randomized pts with inoperable LAEC, previously untreated, and with no distant metastases 1:1 to chemoradiation (cisplatin 75 mg/m ² D1, and 5-FU 1 g/m ² /d CI D1-4, both for four 28-day cycles, combined with external-beam radiation 50.4 Gy) or the same chemoradiation plus nimotuzumab 200 mg IV, once weekly for 26 wks. The primary endpoint was endoscopic complete response (eCR, defined as absence of elevated, vegetative or exophytic lesions), whereas combined eCR/pathologic CR (pCR), overall survival (OS), quality of life and safety were secondary endpoints. Results: We enrolled 107 pts, 82% male, mean age 59 y, 100 pts (93%) had squamous cell carcinoma (SCC); performance status (ECOG-PS) was 0/1 in 34%/60% of cases. The relative dose intensity of chemotherapy and radiotherapy was nearly identical in both arms, and the median number of nimotuzumab doses was 24. We performed post-treatment endoscopy in 67 pts, in 60 of whom with biopsy. In the ITT population, eCR rates with vs. without nimotuzumab were 47.2% vs. 33.3% (p=0.17), whereas combined eCR/pCR rates were 62.3% vs. 37.0% (p=0.02). In a median follow-up of 14.7 mo., the hazard ratio (HR) for OS was 0.68 (95%CI 0.44-1.07; p=0.09), with a median OS of 15.9 vs. 11.5 months, respectively. In an unplanned subgroup analyses, the HR for OS in pts with ECOG-PS 0 was 0.32 (95%CI 0.12-0.85; p=0.02). We found no significant differences in quality of life between arms. Toxicity was manageable in both arms, with no significant differences in adverse events or serious adverse events. Conclusions: Combined chemoradiation and nimotuzumab is safe in pts with LAEC, and appears to increase the combined eCR/pCR rate and to impact favorably on OS. This is a promising regimen in pts with locally advanced esophageal SCC, and a phase III trial is under consideration.	
除外	CN-00708554		Zhao J-S, Liao K-L, Yang K, Zhang W, Xiong G, Li J, Tan W-F	[Effect of glutamine dipeptides on the postoperative nutrition and immunofunction of patients with esophagus carcinom]	Chinese Journal of Clinical Nutrition	2007	15(6)	347-50	Journal: Article	Objective: To evaluate the effect of glutamine dipeptides-enhanced parenteral nutrition on the postoperative nutrition and immunofunction of patients with esophagus carcinoma. Methods: One hundred patients with esophagus carcinoma were randomly divided into Gln group and control group. All patients were administered with parenteral nutrition for seven days, and patients in Gln group were simultaneously added with alanyl glutamine solution (0.4 g/kg per day). The serum album (ALB) level, T lymphocyte subgroups, IgA, IgG, IgM, and body mass index (BMI) were measured. Results: The ALB level, IgA, IgG, and BMI were (42.8 +/- 3.4) g/L, (2.7 +/- 2.2) g/L, (10.8 +/- 2.2) g/L, and (19.1 +/- 1.6) kg/m ² in Gln group on the sixth postoperative day, which were significantly higher than those in control group (All P < 0.05). Conclusion: Alanyl glutamine solution-enhanced TPN therapy can improve the postoperative nutrition and immunofunction in patients with esophagus carcinomas. Copyright © 2011 Elsevier B. V., Amsterdam. All Rights Reserved.	
除外	CN-01026801		Crosby T, Hurt C, Falk S, Gollins S, Mukherjee S, Staffurth J, Ray R, Bridgewater JA, Geh I, Cunningham D, Maughan T, Griffiths G	SCOPE 1: A phase II/III trial of chemoradiotherapy in esophageal cancer plus or minus cetuximab.	Journal of clinical oncology	2013	31(4 SUPPL. 1)		Journal: Conference Abstract	Background: SCOPE 1 is the largest multicentre trial of definitive chemo-radiotherapy (dCRT) in localised oesophageal cancer (LOC) in the UK and investigated adding cetuximab to standard cisplatin and fluoropyrimidine treatment. Methods: Patients in this phase II/III trial had LOC and been selected to receive dCRT and were randomised to receive cisplatin 60mg/m ² D1 and capecitabine 625mg/m ² daily D1-21 for 4 cycles, cycles 3 and 4 given concurrently with 50Gy in 25 fractions of RT with or without cetuximab 400mg/m ² D1 followed by 250mg/m ² weekly. Recruitment continued from 02/2008 until analysis of the phase II endpoint (24 week failure free survival in the cetuximab arm, overall sample size 180: p1=0.60 and p2=0.75, alpha=0.05, beta=0.9) in 01/2012. The phase II endpoint was not met and the IDMC recommended trial closure on the basis of futility. Results: 258 patients were recruited. Median age 67; morphology(%) SCC:ACA 73.27; tumour location(%) upper:middle:lower 11:45:44; stage(%) I:II:III 3:37:60; reason not for surgery(%) disease extent:patient choice:comorbidity 47:38:16. Patients who received cetuximab had: higher non-haematologic toxicity (78 vs 62.8%, p=0.004; primarily dermatological (22 vs 4%) and metabolic (24% vs 11%)); a lower rate of completion of standard therapy (capecitabine 69 vs 85%, p=0.002; cisplatin 77 vs 90%, p=0.005 and radiotherapy (75 vs 86%, p=0.027); reduced failure free survival at 24 weeks (66 vs 77%), median survival (22 vs 25 months, log rank p=0.043) and 2-yr survival (41 vs 56%). Conclusions: In SCOPE 1, disease control and survival in the standard dCRT arm is superior to any previous published multi-centre studies. The use of cetuximab was associated with greater toxicity, lower doses of dCRT and worse survival. Cetuximab cannot be recommended in combination with standard dCRT for unselected patients with oesophageal cancer. Strategies to build on these results should incorporate biomarker driven treatment and latest radiotherapy technologies to safely intensify treatment.	

除外	CN-00747854		Zhang P, Xie CY, Wu SX	[Concurrent chemoradiation with paclitaxel and platinum for locally advanced esophageal cancer]. [Chinese]	Chung-Hua Chung Liu Tsa Chih [Chinese Journal of Oncology]	2007	29(10)	773-7		<p>OBJECTIVE To assess the efficacy of concurrent chemoradiation with paclitaxel and platinum and external irradiation, and to compare the effect of extensive regional field irradiation with conventional local field irradiation for locally advanced esophageal cancer. METHODS: From Oct. 2000 to Jan. 2006, 89 patients with locally advanced esophageal cancer were registered in this study. All patients were inoperable or refused to undergo operation. Patients were divided into two groups: extensive regional field group (51 patients) and conventional field group (38 patients). Patients received radiotherapy at a total dose of 60 Gy in 30 fractions within 7 weeks, and concurrent paclitaxel 125 mg/m² on D1, cisplatin 20 mg/m² on D1-D3, or oxaliplatin 130 mg/m² on D2 in the first and fourth week of external radiation. RESULTS: Of these patients, 87.6% completed the treatment regimen with a response rate of 75.5% and 66.7% in the extensive regional field group and conventional field group, respectively. Grade 3 or severe toxicities of leucopenia (33.3% vs. 23.7%), thrombocytopenia (76.0% vs. 2.6%), and esophagitis (17.7% vs. 26.3%) were observed in extensive regional field group and conventional field group, respectively. Major late toxic effect was lung fibrosis. There were no statistically significant differences in the incidence of the toxicity profile between two groups. The overall 3-year survival rates were 32.8%, and the overall 3-year recurrence and metastasis-free survival rates were 34.5%. The overall 3-year locoregional control rate was 44.0%. No significant difference was found between two groups in the 3-year survival (38.2% vs. 28.1%, P = 0.59). For the patients with stage II and stage III cancers who completed the planned treatment, large regional field radiotherapy significantly improved the 3-year survival (57.3% vs. 22.2%, P = 0.03) or 3-year recurrent and metastasis-free survival (55.5% vs. 23.0%, P = 0.03) or 3-year locoregional control (65.9% vs. 30.2%, P = 0.02) than conventional field radiotherapy. CONCLUSION: historical results, the combination of paclitaxel/platinum and radiation in this study can improve the survival for locally advanced esophageal, and the side effect is well tolerated. Compared with the conventional field group, concurrent chemoradiotherapy with the large regional field can significantly improve 3-year survival and locoregional control for stage II or stage III esophageal cancer</p>	
除外	CN-00675569		Adenis A, Mariette C, Mirabel X, Sarrazin T, Lartigau E, Triboulet JP	Acute respiratory disease syndrome with preoperative chronomodulated chemoradiotherapy in patients with esophageal cancer. Early termination of a phase I trial	European journal of surgical oncology	2008	34(1)	30-5		<p>A phase I trial was initiated to establish the dose-limiting toxicities (DLTs) and the maximum tolerated dose (MTD) of chronomodulated 5-fluorouracil and cisplatin given concurrently with preoperative radiotherapy in patients with esophageal cancer. Patients with stage I or II esophageal cancer received preoperative radiation therapy (28-30 daily 1.8-Gy fractions for a total of 50.4 or 54 Gy) and concurrent three fortnightly cycles of chronomodulated 5-fluorouracil (700-835 mg/m² per day, d1-d4, with peak delivery at 4.00 am) and cisplatin (50 mg/m², d1, with peak delivery at 4.00 pm) administered by a time-programmable pump. Ten patients were treated on this study. Two of six patients treated at the starting dose-level experienced acute DLTs (esophagitis, asthenia) which required de-escalation of 5-fluorouracil. Five patients out of ten experienced seven DLTs (severe esophagitis, asthenia, vomiting: 5/1/1) at any dose-level. The MTD was not assessed because the study was halted due to slow accrual. Finally, two patients deceased from an Acute Respiratory Distress Syndrome due to inadequate radiation therapy planning. Without definitively ruling out any possible impact of chronomodulation in that setting, our data reinforce the need of a better selection of patients aimed to be treated by CRT plus surgery</p>	

CQ番号	CQ名	検索式	文献数	検索DB	検索担当者	検索実行日	保存ファイル名	メモ
CQ18	食道表在癌に対して内視鏡治療を行いpT1a-MMであった場合、追加治療を行うことを推奨するか？	#1 *esophag* near/3 (cancer* or tumor* or tumour* or neopla* or *carcinoma*) :ti,ab,kw #2 T1a-EP or (T1a and EP) or M1 or Tis or T1a-LPM or (T1a and LPM) or M2 or T1a or T1a-MM or (T1a and MM) or M3 or T1b or pT1a-MM or T1b or SM or SM1 or SM2 or SM3 or T1b-SM :ti,ab,kw #3 esophagoscop* or endoscop* or thoracoscop* or laparoscop* or catheterization or (muco* and surgery) or EMR or ESD or surg* or dissect* or resect* or *esophagect* or operation or Endoscopic Mucosal Resection or Endoscopic Submucosal Dissection:ti,ab,kw #4 #1 and #2 and #3 Publication Year from 1995 to 2015 in Trials	44	Cochrane	園原	2015/08/06		件数が非常に少なかったため、内視鏡に限らず、外科手術にまで検索を広げております。

一次スクリーニング	除外理由	取り寄せ	2次スクリーニング	除外理由	ID	Language	Authors	Title	Journal	Year	Volume	Pages	Pub. Type	Abstract	Memo
除外	非含数				2015048872	英語	Swangsi Jirawat, Nakajima Yasuaki, Kawada Kenro, Tokairin Yutaka, Suzuki Tomoyoshi, Miyawaki Yutaka, Hoshino Akhiro, Okada Takuya, Ota Shunsuke, Ryotokuji Tairo, Fujiwara Naoto, Nishikage Tetsuro, Nagai Kagami, Kawachi Hiroshi, Kawano Tatsuyuki	Changes in the microvascular structure of mucosal squamous cell carcinoma of the esophagus and their significance in tumor progression(食道の粘膜性扁平上皮癌の微細血管構造の変化と腫瘍進行におけるそれらの意義)	Journal of Medical and Dental Sciences	2013	60(4)	83-91	原著論文	2010年4月～2012年4月に得られた15症例の食道切除試料について、拡大内視鏡像で捉えた56ポイント(うち197の乳頭内ループも細血管(PL)像を分析し、表面性食道扁平上皮癌(ESCC)の病変内の微細血管構造を調べた。微細血管構造は、螺旋状ループ(Spl), 幅広ループ(ShL), 球状(S), 網状(R)の4つにパターン分類された。Splパターンはさらに単純ループ(SL)と複合ループ(CL)に分類され、Rパターンは単一網状(SR)と複合網状(CR)に分類された。CL, SL, WL, G, SR, CRの検出率は各々16%, 42.9%, 17.8%, 8.9%, 8.9%, 5.4%であった。腫瘍浸潤度によって微細血管の特徴や大きさは異なっていた。M1やM2病変では均一性との関連は認められなかったが、大部分のM3病変において不均一性が認められた。内視鏡所見によるM2とM3鑑別に対する本手法の有用性が示唆された。	
除外	総説				2015002946	日本語	小山 恒男, 高橋 亜紀子	【消化管内視鏡治療の最前線】食道内視鏡治療の最前線 食道ESDの現状と将来展望	医学のあゆみ	2014	250(10)	899-903	解説/特集	食道癌診断治療ガイドライン2016では食道扁平上皮癌に対する内視鏡的切除の適応基準が改訂され、周在の制限が無くなった。これはESDの技術が進歩し、大きな病変に対しても安全に施行すること、および術後の狭窄予防が進歩したことに基づく。この結果、食道扁平上皮癌では、大きな、悪化性にもかかわらず深達度T1a-EP-LPMまでが内視鏡治療の適応となった。技術的には糸付きクリップを用いた牽引法の普及がESDの安全性向上に貢献した。食道ESDの長期予後は外科治療成績と比較しても遜色がなく、表在型食道扁平上皮癌治療の第一選択手法としての地位を確立した。一方、Barrett食道癌のリンパ節転移危険因子はいまだに明確ではない。胃癌のように組織型、大きさ、深達度、潰瘍の有無という、詳細な危険因子解析に基づき危険因子の説明が急務である。(著者抄録)	
除外	非含数				2014355642	日本語	川田 智樹, 河野 辰幸, 中島 慶史, 松井 俊大, 奥田 将史, 小嶋 泰一, 藤原 尚志, 齋藤 賢博, 藤原 直人, 了徳寺 大志, 太田 俊介, 岡田 卓也, 富田 隆, 東海林 祐, 熊谷 洋一, 永井 龍	食道早期癌に対するアルゴンプラズマ焼灼法の長期成績	日本気管食道科学会会報	2014	65(4)	314-321	原著論文	【目的】食道早期癌に対するアルゴンプラズマ焼灼、上下下焼灼法(APC-SEA)の治療成績を検討した。【方法】2001年10月より2010年4月まで食道早期癌747例でAPC-SEA治療を行った70例(9.4%)の病変(43例男性、27例女性、平均年齢71歳、観察期間中央値102ヵ月)を対象とした。【結果】264回中165回(62.5%)は外来治療で行った。穿孔、出血はなく、周在性の広い病変でEMRと併用した12例に狭窄を認めた。Overallの5年生存率は81.6%で、原病死はなく、他病死12例、他病死8例であった。また後発の異時性食道表在癌の内視鏡切除は14例に行った。最終的に、7例は局所制御不良または転移再発し、3例は根治手術、3例はCRT、1例はリンパ節切除+断骨手術治療を行ったが、1例がCRT時に死亡を遂げた。APC治療で制御しえる条件は大きく2cm以下、深達度がT1a-EP/LPMの病変であった。【結論】食道早期癌へのAPC-SEA治療は簡便かつ安全に施行でき、長期予後も良好であった。内視鏡切除が簡単に選択できない、ハイリスク症例への治療選択肢として有用である。(著者抄録)	
全文取り寄せ		可	否	MM症例数不明	2014335738	日本語	成宮 孝祐, 太田 正徳, 工藤 健司, 佐藤 拓哉, 白井 雄史, 井手 博子, 大杉 治司, 山本 雅一	【バレット食道癌の診断と治療】 Barrett食道癌の転移形式と術式選択の検討	消化器内科	2014	59(1)	28-33	原著論文/特集	Barrett食道癌と診断治療された33例(男性30例、女性3例、平均65.4歳)を対象に、転移形式により至適リンパ節郭清と治療法について検討した。肉眼型では隆起型が多く、表在癌19例、進行癌14例、平均腫瘍径は4.2mm、平均Barrett径は3.9mmであった。病理学的所見はリンパ管浸潤が顕在で、分化型癌が多く、広範囲なリンパ節転移を認めた。癌の占拠部位は腹部食道16例、下部食道14例、中部食道3例、西分類のBarrett癌腫が16例で、Barrett上皮上縁の癌が24例であった。食道切除術施行例29例のリンパ節転移部位は腹部41.4%、縦隔31.0%、腹部3.4%であり、深達度別ではT1b以上で腹部、T2以上で腹部+頭部であり、T3では腹部80%、下縦隔40%であった。治療法は内視鏡的粘膜剥離術4例、開胸開腹手術20例、開腹下食道切除7例、非開胸食道切除2例であった。予後は再発生存17例、転癌生存1例、原病生存12例、他病死3例であった。	
除外	総説				2014262564	日本語	門田 智裕, 矢野 友規, 小島 隆嗣, 小野澤 正樹, 宮本 美樹, 堀真 森本 浩二, 大瀬良省三, 小田裕 智之, 小野 康寛, 池松 弘朗, 金子 和弘	【表面型表層拡大型食道癌の診断と治療戦略】 表面型表層拡大型食道癌の治療成績 CRTの立場から	胃と腸	2014	49(8)	1206-1216	解説/特集	表面型表層拡大型食道癌に対する治療は、内視鏡治療、外科手術、化学放射線療法(CRT)があり、その治療選択に迷うことも多い。JCOG9708試験では、cStage I食道癌に対する根治的CRTが外科手術と同等の有効性を持ち、それに伴う有害事象が軽微であることが報告され、内視鏡治療困難例で外科手術拒否例や不順例に対してはCRTが行われている。また、内視鏡治療技術の進歩により、癌対癌の病変のみならずT1a～MM以上の病変にも内視鏡治療を施行することが増えてきている。追加治療としてのCRTについてもその有効性が報告され、現在多施設前向き臨床試験で評価中である。一方、CRT後再発は局所再発例が多く、その早期診断が重要である。早期診断により内視鏡的サルベージ治療が可能となり、その有効性も報告されている。(著者抄録)	
全文取り寄せ		可	否	small sample size	2014262563	日本語	島田 英雄, 山本 壮一郎, 千野 修, 西 隆之, 奥栗 智子, 名久井 美樹, 飯野 城人, 新田 美穂, 中田 周司, 熊本 伸枝, 佐藤 慎吉, 小澤 壮治, 幕内 博康	【表面型表層拡大型食道癌の診断と治療戦略】 表面型表層拡大型食道癌の治療成績 外科治療の立場から	胃と腸	2014	49(8)	1191-1205	原著論文/特集	表面型表層拡大型食道癌66例に対する外科切除術43例と内視鏡的切除(endoscopic resection)ER例23例について臨床病理学検討を行った。内視鏡検査、食道X線造影所見による壁深達度診断の正診率は37.0%であり、表在型でのT1a0と比較し極めて低率であった。リンパ節転移に関しては、T1a-MM/T1b-SM1の18例中5例(27.7%)に認め、表在型より多い傾向が認められ、危険因子は尿管侵襲性例であった。表面型拡大型食道癌の診断に関しては、術前診断精度が低いたため、T1a-EP/LPMと診断される症例は、まずERの適応と詳細な病理組織診断を行う。5cmよりはるかに長い全周性病変でSM浸潤の可能性が高い病変では手術も考慮する。リンパ節転移が疑われる症例は外科的根治術の適応と考える。(著者抄録)	
全文取り寄せ		可	否	Subjects are included in another paper	2014262562	日本語	小山 恒男, 高橋 亜紀子, 竹内 学, 石原 立山, 山階武, 小野 裕之, 田中 雅樹, 小田 一郎, 阿部 清一郎	【表面型表層拡大型食道癌の診断と治療戦略】 ESDによる表層拡大型食道癌の治療成績 多施設共同研究	胃と腸	2014	49(8)	1182-1189	原著論文/特集	2000年1月～2010年12月までの間に対象施設で内視鏡的粘膜下層剥離術(ESD)が施行された腫瘍長径が50mm以上の表在型食道扁平上皮癌138例を対象とした。内訳は男性118名、女性20名と男性に多く、中央値は69(42～88)歳であった。腫瘍長径が50～95mmと大きな病変であるにもかかわらず、138例中137例で一括切除が施行され、分割切除はわずかに1例のみであった。また、一括完全切除率は88%(122/138)と全食道ESDを対象とした既報と比し遜色のない結果であった。ESDの適応病変である深達度T1a-EP/LPMは、それぞれ30例、51例であり、全体の59%とどまっていた。一方、相対適応であるT1a-MMとSM1-T1b-SM1は5例と28%を占め、残りの18例(13%)はT1b-SM2まで適応外病変であった。138例中、局所再発は1例のみで、51ヵ月後に2型進行癌として再発を来した。138名中16名に追加治療が施行され、その治療法はRT 1例、CRT 15例で外科切除例はなかった。追加治療が施行された16名は、観察期間中央値58(13～110)ヵ月で、全例が無再発生存中であり、ESD+RT or CRTの予後は、深達度にかかわらず極めて良好であった。一方、経過観察された122名中11名は予後観察がでず、4例が原病死、18例が他病死であった。追加治療なしで経過観察され、予後が判明している121名のcause specific all overの5年生存率はT1a-MM:90.7/1%, T1b-SM1:67.6/7%, T1b-SM2:90.6/7%であった。ESDは表面型拡大型食道扁平上皮癌に対する有効で、安全な治療であった。一方、深達度T1a-MM以上の癌の比率が約40%と高く、術前の深達度診断が残された課題である。(著者抄録)	
除外	非含数				2014262558	日本語	小田 文二, 入口 陽介, 水谷 勝, 高柳 聡, 富野 泰弘, 山根 哲郎, 岸 大輔, 藤田 直哉, 大村 孝俊, 飯橋 浩一, 中河原 亜希子, 神谷 綾子, 竹中 由紀夫, 山村 彰彦, 堀井 重三, 河野 辰幸	【表面型表層拡大型食道癌の診断と治療戦略】 表面型表層拡大型食道癌の深達度診断 X線の立場から	胃と腸	2014	49(8)	1141-1156	原著論文/特集	表面型表層拡大型食道癌25例を対象に、X線造影検査による深達度診断について検討を行った。これまでに報告した側面変形による深達度診断に当てはめるとA群13例はB1～B2型変形であり、側面変形に浸潤する部位を正確に診断できなかった。B群は12例存存し、T1b-SM2以上の7例中3例は側面変形から診断可能であったが、それ以外B2型までの変形でありA群と同様にピンポイントで浸潤する症例は診断困難であった。0-1型を伴う混合型病変7例は従来とどりの側面変形による診断で十分に対応可能であった。(著者抄録)	
除外	非含数				2014229248	日本語	島田 英雄, 西 隆之, 新田 美穂, 千野 修, 小澤 壮治, 幕内 博康	【Barrett食道の診断と治療up-to-date】 Barrett食道の治療方針 Barrett癌に対する外科治療	臨床消化器内科	2014	29(6)	731-738	解説/特集	Barrett癌の治療は壁深達度、占拠部位、Barrett食道変異、転移リンパ節の状況により決定される。本邦においては、基本的には食道扁平上皮癌や食道胃接合部癌に準じた治療が行われている場合も多い。Barrett癌の手術術式やリンパ節郭清範囲に関する標準術式を提示するものはない。SM2以上では腫瘍の占拠部位とBarrett食道変異から下咽頭門切除術や中間胸腹癌を選択している。また、進行症例ではBarrett癌でも頭部リンパ節転移を認め、胸部扁平上皮癌と同様の胸部食道全摘3領域リンパ節郭清術が必要な症例もある。リンパ節郭清範囲や切除再建に関する標準術式の決定には、さらなる症例の蓄積が求められる。(著者抄録)	
除外	非含数				2014213984	日本語	田久保 海登, 相田 順子, 松田 陽介, 吉村 誠, 熊谷 洋一, 岩切 勝彦, 星原 芳雄, 新井 篤生	【表在型Barrett食道癌の診断と治療戦略】 表在型Barrett癌の病理組織像と病理診断	消化管内視鏡	2014	26(4)	500-507	解説/特集	表在型Barrett癌の病理組織像と胃癌との鑑別診断について記載した。表在型Barrett癌は新生した表層の粘膜組織でなり、ほぼすべてが分化型癌である。また、深達度が胃癌の粘膜深達度(リンパ節転移)と異なる。以上から、Barrett癌の内視鏡治療の適応は粘膜内癌である。また、低分化、リンパ管侵襲、神経侵襲、20mm以上の大きさ、潰瘍のいずれも伴わないsm1癌まで適応を拡大できる可能性がある。深達度とリンパ節転移に関して、さらに詳細な研究が必要である。一方、癌組織や癌細胞自体の差異により、Barrett癌と胃癌を鑑別できるとする報告はない。しかし、胃とは異なり、Barrett食道には癌組織特異的な微細扁平上皮癌、固有血管腫瘍とその増殖、組織学的増殖抑制、一重化(腸管化)が観察され、粘膜の周囲粘膜にBarrett食道にみられる組織学的4徴の存在を知り、Barrett癌と胃癌を鑑別する。食道胃接合部にまたがる癌の発生母地の決定方法には議論がある。(著者抄録)	

除外	非合数			2014195785	日本語	幕内 博康	【消化器内視鏡治療の最前線】食道疾患内視鏡治療の最前線 食道疾患内視鏡治療 オープンビュー	Modern Physician	2014	34(5)	455-457	解説/特集	1 食道表在癌の深達度診断にNBIを用いた拡大内視鏡が広まり、食道学会分類がまとめられた。2 ESDが普及し、適応拡大が進んでいるがT1a-MM、T1b-SM1で特にy(+)/y(+)のもの、表層拡大型のものでリンパ節転移に注意する。3 ESD後の追加治療は化学療法を行えばいいというとはない。外科的根治術も考慮する。4 バレット腺癌の診断もNBI拡大内視鏡が有用である。粘膜接合部の癌にESDを行う際は重複扁平上皮下の食道噴門腺癌の癌化に注意する。5 食道アカラシアでは取扱い規約第4版が出版され、POEMがトピックスとなっている。6 食道静脈瘤ではEVLが主流となり、静脈瘤再発防止には定期経過観察と追加治療が望まれる。症例ごとの至適門脈圧についての検討が期待される。(著者抄録)
除外	非合数			2014178216	日本語	山階 武, 石原 立一, 上室 文也, 長井 健悟, 松井 美英, 河田 奈都子, 太田 高志, 神崎 淳光, 花岡 正雄, 山本 幸子, 鼻岡 昇, 竹内 洋司, 東野 晃治, 飯石 浩康	50mm以上の表在型食道癌に対するESDの安全性と治療効果	Gastroenterologic al Endoscopic	2014	56(3)	515-521	原著論文	【背景・目的】50mm以上の表在食道癌に対するESDの報告は少なく、今回われわれは50mm以上の表在食道癌に対するESDの安全性と治療効果を検証することとした。【方法】大阪府立成人病センターで2004年1月から2011年4月までT1ESDにて治療された50mm以上の表在食道癌39例を後ろ向きに検討した。【結果】全症例がESDにて一括切除されており、1例で穿孔のない無痛麻酔を認めた。また、1例で術後狭窄を認め、複数回のバルーン拡張を要した(中央値5回)。術前にCEP/LPM癌と診断された33例は28例寛がEP/LPM癌、7例寛がMM癌、3例寛が尿管侵襲性であった。一括切除率は100%、完全一括切除率は92%であった。ESDの治療切除率は70%、病変率は2.5%に起こっていた。【結論】ESDでの一括完全切除率は92%で治療切除率は70%と許容されるものであった。しかし50mm以上のESDを検討する際には術後狭窄を考慮する必要がある。(著者抄録)
全文取り寄せ	可	否	MM症例数不明	2014145594	英語	Motoyama Satoru, Jin Mario, Matsushashi Tamotsu, Nanjo Hiroshi, Ishiyama Koichi, Sato Yusuke, Yoshino Kei, Sasaki Tomohiko, Wakita Akiyuki, Saito Hajime, Minamiya Yoshihiro, Ohnishi Hirohide, Ogawa Jun-ichi	Outcomes of patients receiving additional esophagectomy after endoscopic resection for clinically mucosal, but pathologically submucosal, squamous cell carcinoma of the esophagus(臨床的にには粘膜内、病理学的には粘膜層上皮癌にに対し、内視鏡下切除後に追加治療として食道切除術を受けた患者の転帰)	Surgery Today	2013	43(6)	638-642	原著論文	臨床的には粘膜内、病理学的には粘膜下の食道癌に対する内視鏡的粘膜下層剥離術(ESD)を受けた後に食道切除術・リンパ節郭清を受けた患者におけるリンパ節転移の実態の発現または範囲、または生存転帰を検討した。2006-2010年に、臨床的には粘膜内、病理学的には粘膜下の食道癌に対するESDを受けた後に、追加治療として食道切除および2領域または3領域リンパ節郭清を受けた患者17名を分析の対象とした。リンパ節転移の発現または範囲、および患者転帰を評価した。腫瘍の深達度は、切除標本の分析に基づき9名でSM1、9名でSM2と診断されていた。リンパ管侵襲は13名で明らかであり、静脈侵襲は5名に検出されていた。5名はリンパ節転移が病理学的に検出されていた。切除リンパ節80癌の1例に浸透が認められた。患者3名は縦隔または腹部に1個の転移リンパ節、2名は腹部に2個の転移リンパ節を有していた。中央値23か月の追跡を受け、全員が最終フォローアップ時に再発を示さず生存していた。ESD後に臨床的に粘膜内、病理学的に粘膜下の胸部食道扁平上皮癌と診断された患者の29%が、縦隔下部および腹部に1-2個の転移リンパ節を有した。これらの患者には必要かつ有効な追加治療として食道切除術・リンパ節郭清を考慮すべきであると思われる。
除外	非合数			2014115263	日本語	高田 理, 清崎 浩一, 吉田 行雄, 丸山 敏樹	【知っておきたい消化器疾患の知識-専門医の診方・治し方】食道癌の内視鏡治療の適応と実態	耳鼻咽喉科・頭頸部外科	2013	85(10)	802-808	解説/特集	<POINT>通常(白色光)観察による診断は、色調、隆起の高さ、陥凹の深さ、大きさなどを参考に深達度の診断を行う。拡大内視鏡観察による診断は、食道癌の深達度の診断を向上させた例にT1a-EP(M1)/T1a-LPM(M2)の拾い上げ。頸部食道や梨状状の病変は観察しづらいため、十分気をつけて観察する必要がある。粘膜下層剥離術は大きなには制限なく病変を一括で大きく切除することが可能で、外科的切除に比べ侵襲度の低い治療である。(著者抄録)
全文取り寄せ	可	否	review	2014113536	日本語	門馬 久美子	消化管 食道癌内視鏡治療の適応とその長期予後	Annual Review 消化器	2014	2014	14-19	解説	食道扁平上皮癌に対する内視鏡的切除術(endoscopic resection:ER)は、2007年4月版の食道癌診断・治療ガイドラインにて、リンパ節転移が極めて稀な深達度EP/LPMの病変で粘膜切除後に癌転移が発生しない、現在性2/3期以下の病変が絶対的適応と決められた。しかし、2012年4月版の食道癌診断・治療ガイドラインでは、内視鏡治療の適応基準は癌の深達度のみに変更され、粘膜切除後に癌転移が予測される粘膜切除が3/4期以上に及ぶ症例への治療や、所々で深達浸潤をすることがある表層拡大型癌の診断に関しては注意にとどめられた。また、リンパ節転移の可能性があるMM、SM1癌は、相対的適応とされた。リンパ節転移が極めて稀で局所切除にて根治可能なEP/LPM癌の長期予後を左右する因子は、基礎疾患や合併する他臓器癌あるいは異時性他臓器癌である。異時性食道癌は3-10%程度、異時性他臓器癌は13-15%に見られ、他臓器癌では頭頸部癌と胃癌が半数以上を占めていた。死因は他臓器癌と他病死であり、cause specificの生存率は100%であった。一方、相対的適応とされるMM、SM1癌は、術前のリンパ節の診断能が未だ不十分でありかつリンパ節転移が判明した段階で治療を行っても救済しえないことから追加治療の適応と判断された症例には、積極的な追加治療が望まれている。(著者抄録)
除外				2013315794	日本語	林 真也, 青木 秀俊, 矢野 光俊, 田村 満, 河野 真喜, 中村 文香, 岸 久美子, 浦田 真里, 北添 健一, 鈴木 康博, 中本 次郎, 柴田 啓志, 佐竹 宣法, 広瀬 隆則	当院でESDを行ったBarrett腺癌の検討	徳島県立中央病院医学雑誌	2013	34	53-58	原著論文	2007年以降の5年間に内視鏡的粘膜下切離術(ESD)を行ったBarrett腺癌6例(男性5例、女性1例、60~85歳)について検討した。平均病変長は17.5mm(7~25mm)で、全例で合併症はなく、一括切除が可能であった。一括切除率は時間短縮のため最終にスナインにて切除を行った。1例のみ断端陽性であった。深達度は例でSM1000μm、SM200μmまでのSM浸透が認められたが、その他の症例では深達度Mであった。尿管侵襲は1例でリンパ管侵襲が認められた。扁平上皮で進展は1例でT0-IIa型で最大3mmまで認めた。2例で追加手術が施行されたいがいずれも遠隔病変はなく、完全切除と判断された4例は全例再発なく生存中である。ESDで全病変が切除でき、詳細な病理学的検討を可能にした。H.pylori非感染世代の高齢化でBarrett腺癌が増加する可能性が示唆された。
全文取り寄せ	可	否	review	2013275389	日本語	澤田 亮一, 本間 義崇, 司 広和, 高島 洋生, 岩佐 信, 中田 南都子, 加藤 健, 濱口 哲弥, 山田 康秀, 伊藤 芳紀, 島田 安博	【食道表在癌治療の最先端】食道SM癌に対する治療成績 CRTの立場から	胃と腸	2013	48(9)	1285-1289	解説/特集	本邦における切除可能食道へん上皮癌に対する標準治療は、食道切除術である一方で、化学放射線療法でも食道切除術と同等ないし優れた治療成績が得られるようになってきた。JCOG708の結果から、Stage I食道癌に対する根治的・化学放射線療法の高い有効性が示唆され、標準治療である食道切除術と根治的・化学放射線療法を比較する臨床試験が現在進行中である。近年内視鏡治療の開発も進み、内視鏡治療の結果非治癒切除と診断される事例も増え、こうした対象への追加治療としての化学放射線療法の有用性についても検討がなされている。治療後のQOLを保つ侵襲の少ない治療法としての化学放射線療法の確立。そして、JCOG0502/0508の結果に期待が寄せられている。(著者抄録)
除外	非合数			2013275388	日本語	三浦 昭雄, 門馬 久美子, 加藤 順, 河村 英彦, 久米 雄一郎, 十倉三千代, 了徳寺 太郎, 出江 洋介, 藤原 純子, 比島 恒和, 吉田 操	【食道表在癌治療の最先端】食道SM癌に対する治療成績 内視鏡切除の立場から	胃と腸	2013	48(9)	1277-1284	原著論文/特集	食道SM2以降の癌の内視鏡治療(ER)を中心とした温存治療の可能性を探るため、1990~2010年までに当院で深達度Ia以降食道癌と診断した手術症19例、ER症例65例の合計184例を検討対象とした。手術症例では、尿管侵襲を3例例、リンパ節転移を5例に認め、尿管侵襲性21例は、全例のリンパ節転移を認めず、無再発であった。ER症例は、追加治療不能行方22例、うち耐術能を有する7例は全例、無再発生存で、尿管侵襲性SM2浸透部の距離や面積が小さい特徴を認めた。化学放射線療法(CRT)は27例で、耐術能を有する症例は11例であった。そのうち1例が照射範囲外のリンパ節再発で原病死となった。手術療法が16例で、うち2例にリンパ節転移を認めたが、全例が無再発生存であった。ER症例65例中49例(75%)に温存治療を施行した。他病死を除いた5年生存率はER単独が89%、ER+CRTが82%と良好で、特に尿管侵襲性11例は全例無再発生存であった。この結果から、SM2以降Stage I食道癌においてstep upとしてのERは有効であり、特に尿管侵襲性例では温存治療の可能性があると示された。(著者抄録)
全文取り寄せ	可	否	Subjects are included in another paper	2013275386	日本語	石原 立一, 山階 武, 長井 健悟, 松浦 慎一, 伊藤 貴史, 松井 美英, 藤井 正嗣, 鼻岡 昇, 山本 幸子, 竹内 洋司, 東野 晃治, 上室 文也, 飯石 浩康, 竜田 正晴, 富田 裕彦, 石黒 信吾	【食道表在癌治療の最先端】食道表在癌に対するESDの治療成績	胃と腸	2013	48(9)	1263-1269	原著論文/特集	当センターにおいてESDを行った食道癌208例を対象に予後を検討した。ESDは208例中205例寛(98.6%)が一括切除であった。そのうち25例に異時性多発癌、7例に転移再発を認め、分割切除となった1例に遠隔再発を認めた。転移再発を来したのは、SM2癌が4例、T1a-MM、y1、0癌が2例、T1a-LPM、y1、0癌が1例であった。SM2癌とT1a-MM、y1、0癌には再発を予防するため、CRTが行われていたにもかかわらず、転移再発を来した。208例中4例(食道癌3例、下咽頭癌1例)例寛(1例)が死亡していた。y1、0癌、EP/LPM癌、T1a-MM/SM1癌、SM2癌の3年全生存率はそれぞれ98.8%,95.8%,88.9%であった。(著者抄録)
全文取り寄せ	可	否	MM症例数不明	2013275385	日本語	田中 雅樹, 小野 裕之, 滝沢 耕平, 角嶋 直美, 今井 健一郎, 堀田 成一, 松林 宏行	【食道表在癌治療の最先端】食道表在癌に対するESDの治療成績	胃と腸	2013	48(9)	1253-1261	原著論文/特集	初回治療としてESDを施行した早期食道癌249症例を対象とし、組織深達度別にT1a-EP、LPM、T1a-MM、T1b-SM1/T1b-SM2の3群に分類して治療成績(一括切除率、R0切除率、病変症、局所再発、リンパ節・遠隔再発、予後)を検討した。各群の治療成績は、一括切除率が98.4%/100%/82.3%、穿孔率が0.6%/3.3%/3.8%、治療後食道狭窄率が25%/37%/48%であった。中央値38か月の観察期間において、3群の疾患特異的生存率は100%/97.4%/100%と良好であったが、リンパ節・遠隔再発を0%/10.7%/7.7%に認めたMM-尿管侵襲なしの症例や追加治療施行例にもリンパ節再発例を認め、追加治療の慎重な経過観察が重要と考えられた。(著者抄録)
除外	非合数			2013259096	日本語	吉澤 奈津子, 藤崎 順子, 大前 博史, 湯島 智樹, 堀内 裕介, 石川 寛高, 松尾 康正, 菅沼 孝紀, 檀 清寿, 石山 晃世治, 平澤 俊明, 山本 福正, 土田 知宏, 五十嵐 正広, 井下 尚子, 山本 智理子	表在型Barrett食道癌の深達度診断について CV(caliber variation)の所見はSM癌の診断に有用か	Therapeutic Research	2013	34(5)	596-600	原著論文	2005~2012年に内視鏡治療または手術が施行された表在型Barrett食道癌症例のうちNBI拡大内視鏡でCVの所見を観察し、えた22例を対象に、CVと深達度との関連について検討した。また、組織学的・免疫学的検査で粘膜表層にみられるsmooth muscle actin(SMA)陽性血管とCVとの関連について検討した。結果、NBI拡大内視鏡によってCVを認めたのは14例(44%)で、この割合を深達度別で比較するとM癌が20%(4/20例)、SM癌が93%(10/12例)であり、SM癌のほうが有意に高かった。CVを認めた群(CV陽性群)とCVを認めなかった群とでSMA陽性血管の出現率(SMA陽性率)を比較すると、それぞれ71%、33%であり、CV陽性群のほうが有意に高かった。SMA陽性群と陰性群でCV陽性率を比較すると、それぞれ71%、29%であり、SMA陽性群のほうが有意に高かった。

除外	非含数				2013171308	日本語	井野 裕治, 三浦 義正, 北村 尚, 大澤 博之, 藤 貴一, 山本 博徳, 菅野 健太郎	高齢者における早期食道癌ESDの治療成績と問題点 非治癒切除(深部浸潤)後の追加治療と予後について	日本高齢消化器病学会誌	2013	15(2)	53-59	原著論文	早期食道癌のESD治療成績、深部浸潤の際の追加治療の有無と予後を検討した。対象は2006年4月より2011年9月のあいだにESDを施行した食道癌85症例(80例: 65歳未満(A群)、16例: 65歳以上75歳未満(B群)、75歳以上89歳以上に分け、ESD治療成績と非治癒切除術における追加治療の有無、予後をretrospectiveに検討した。3群間において偶発症に発生率に差は認めなかった。MMは深は全体で19例あり、平均観察期間23.3か月で他病死1例、原病死0例、リンパ節再発2例を認め、3例が他院で経過観察され、残りの13例は現在生存中である。高齢者であっても重篤な合併症は認めず、MM、SM1病変でも尿管侵襲がなければ再発の可能性は低く、ESDが第一選択になり得ると考えられた。(著者抄録)
全文取り寄せ	可	否			2013163353	日本語	松井 啓, 山田 晃弘, 土門 隆, 山下 聡, 吉畑 司, 菊池 大輔, 中村 仁紀, 三谷 年史, 小川 修, 飯塚 敏郎, 布袋屋 修, 貝瀬 満, 藤井 文士	消化管の慢性炎症と発癌 表在型バレット腺癌の内視鏡的治療の検討	消化器医学	2012	10	50-54	原著論文	内視鏡的治療を行った表在型バレット腺癌26例(27病変)(男性23例、女性3例;平均年齢63.8歳を対象に、内視鏡的治療の適応について検討した。4例に内視鏡的経路切除術(SMR)、23例に内視鏡的経路で全層剥離術(ESD)を行った。病型は隆起性癌0例、0-Ia型が16例(59.3%で、組織型は1例以外は分化型腺癌であった。術後偶発症は4例(14.8%)に穿孔を認めた。治療切除基準を満たしたのは14例(51.9%で、全例が再発はなく生存中である。口側扁平上皮下進展は23例(85.2%)に認め、その平均距離は深達度T1aの病変と比較してT1bで有意に長く、深達度が深いIと進展距離が長いことが示された。
除外	非含数				2013118826	日本語	門馬 久美子	食道癌 食道扁平上皮癌の内視鏡診断	BIO Clinica	2013	28(2)	116-121	解説	自覚症状のない早期食道癌を効率よく拾い上げるには、食道癌の高危群を中心に内視鏡検査を行う。検査時はNB観察やヨード染色の併用が有用である。病型と深達度は密接に関連しており、粘膜炎の大半は0-II度、粘膜下層癌の多くは、0-I型、0-II型、0-III型(主)に混合型に占まれる。深達度診断の目標は、(1)リンパ節転移がないT1a-EP、LPM癌、(2)リンパ節転移が低率なT1a-MM、SM1癌、(3)リンパ節転移が高頻度のSM2-3癌に分けることである。(著者抄録)
除外	非含数				2013106674	英語	Kawai Hiroki, Niwa Yasumasa, Tajika Masahiro, Kondo Shinya, Matsuo Katsuro, Yamao Kenji, Joh Takashi	Is endoscopic mucosal resection acceptable for Stages 0 or IA esophageal squamous cell carcinoma?(内視鏡下粘膜切除は病期0またはIAの食道扁平上皮癌に適合するか)	Nagoya Medical Journal	2012	52(3)	185-197	原著論文	0またはIA期の表在性食道扁平上皮癌(ESCC)に対する内視鏡下粘膜切除(EMR)の有効性をトロスコピーに評価した。1994年5月〜2008年4月にEMRを受けた179名(EMR群)、手術を受けた50名(OP群)、化学療法または放射線療法を受けた91名(CRT群)を対象に検討した。EMR群は、OPおよびCRT群と比較して高い生存率を示した。再発は、深達度がMM/SM1よりもEP/LPMの病変を有する患者で少なかった。局所再発と全死生存率には差がなかったが、食道再発はMM/SM1患者で多かった。遠転移EP/LPM患者は観察下で死亡はなかった。EMRは術前に深達度がEP/LPMと診断され、最長病変が10mm未満の0またはIAの表在性ESCCに対して実施すべきである。
除外	非含数				2012337585	日本語	藤野 節, 加藤 洋	【食道表在癌-症例から学ぶ診断と治療戦略】食道表在癌(扁平上皮癌)の病理組織診断の基礎、特徴および今日の問題点	消化器内視鏡	2012	24(8)	1247-1257	解説/特集	食道表在癌(扁平上皮癌)の基礎的・特徴的な組織所見を提示し、表在癌組織診断における今日の問題点を概説した。組織学的なレベルでの食道表在癌の基本的な増殖様式には、①直接性増殖型(replacing type)、②下方向増殖型(down-growth type)、③基底増殖型(basal type)、④乳頭増殖型(reticular type)、⑤乳頭状増殖型(papillary type)の5型がある。食道表在癌の組織診断では、しばしば上皮内癌か浸潤癌かの鑑別が問題となるが、筆者らは癌の先進部が、本来の基底膜の線より下方に及んでいれば浸潤癌と判断している。癌の食道腺管および食道腺への上皮内進展は、非浸潤性癌変であり、しばしば周囲にリンパ球浸潤を伴う。浸潤性では、尿管侵襲とともに、潰状浸潤(droplet infiltration)があり、リンパ節転移の危険因子として意義のある所見である。約1/80以上の例に転移のない転移率が20%にすぎないMM/SM1癌において潰状浸潤がない場合は、内視鏡的切除術(EMR/ESD)のみで根治できている可能性があり、喫禁の検討課題となっている。(著者抄録)
除外	非含数				2012271905	日本語	竹内 学, 橋本 智, 小川 正明, 渡辺 玄, 水野 研一, 佐藤 祐一, 成澤 林太郎, 味岡 洋一, 青柳 豊	【食道癌の発育進展-初期浸潤の病態と診断】病変の形態からみた発育進展 初期病変から粘膜癌までを中心に 表層拡大型癌の発育進展	胃と腸	2012	47(9)	1410-1417	原著論文/特集	ESDにて切除した表層拡大型食道癌(以下:表層群)45例において臨床病理学的因子をヨード不染色(Lugol-voiding lesions:LVL)の頻度,同時性・異時性多発癌の割合,さらに同時性多発癌において全癌最近例に併存する数値,腫瘍内ヨード染色癌の有病と分布,深達度T1a-MMに深達度の病理学的所見について,同時期にESDを施行した腫瘍径10〜30mm食道表在癌(以下:非表層群)と比較検討した。表層群におけるmultiple LVLsの頻度は非表層群と同率に高く,多数の腫瘍内ヨード染色癌が網目状に分布することが特徴的であった。同時性多発癌や主癌最近例の併存病変,異時性多発癌は非表層群で有意に高く,深達度T1a-MMは深達度部での病理組織的見解もなかった。以上より,表層癌の多くはさらに浸潤を伴ったmultifocallyに癌化がはじまり,次第に癌化したものと考えられた。非表層群ではmultiple LVLsが約半数に認められ,併存病変かつ異時性多発癌を表層群より多く認めたことは,側方に進展・癌化し,表層拡大型食道癌へ発育する過程をとらえている可能性がある(著者抄録)
除外	非含数				2012271904	日本語	門馬 久美子, 藤原 純子, 加藤 剛, 佐藤 大郎, 三浦 明暎, 出江 洋介, 木村 麻衣子, 剛崎 有加, 比島 恒和, 吉田 保	【食道癌の発育進展-初期浸潤の病態と診断】微小癌あるいは小癌からの発育進展	胃と腸	2012	47(9)	1393-1408	原著論文/特集	食道癌の初期癌および発育形態をみるため,2007年4月から2012年5月の5年間に,病巣発見から経過観察,内視鏡治療を行った異時性食道癌33例を対象に検討を行った。病変は,非拡大の白色光とNB観察で拾い上げた33例の内訳は,T1a-EP癌20例,T1a-LPM癌7例,T1a-MM癌3例,SM2以深3例であった。発見病変の大きさが5mm以下で6ヵ月以上経過観察した23例の病型は,0-Ia 1例(4%),0-IIb 8例(35%),0-IIc 14例(61%)であり,0-IIbを食道癌の初期癌と規定すると0-IIcや0-IIaへの分化は非常に早く,微小病変の時期から始まっていた。病変は,発見後約1〜2年で拡大を始め,2〜3年で増進するようになり,増大して大きさが10mm以下で増進した場合,80%以上は粘膜癌であり,粘膜癌の時期は少なくとも3.0年以上と推測された。病型の変化が確認できた7例は,0-IIbから0-IIcへ変化したT1a-EP癌3例,0-IIbから0-I-IIcへ変化したT1a-MM癌1例,0-IIbから0-IIc,0-IIcに変化したSM2癌2例と0-IIc-LPMから0-IIc-SM2へ変化したSM2癌1例であり,病型は0-IIbから0-IIc,T1a-EPになりT1a-LPMを経過,0-IIcの病型のままT1a-MM/SM1あるいはSM2へ進展した。検討例の内視鏡検出から,(1)乳頭状・数珠状に広がる病変,(2)表面に白色網の付着物を有する病変,(3)粘膜下に広がる病変は,増大が早く,早期に浸潤する傾向があり,注意が必要な病変であった。(著者抄録)
除外	非含数				2012271902	日本語	千野 修, 喜内 博康, 島田 英雄, 西 隆之, 木勢 佳史, 葉梨 智子, 山本 壮一郎, 原 正三, 朝 博仁, 名久井 美伊, 栗城 敏野 晴人, 小澤 壮治, 梶原 博, 今井 裕	【食道癌の発育進展-初期浸潤の病態と診断】内視鏡的肉眼形態と病理組織学的所見からみた0-IIa型食道表在癌の発育進展に関する臨床病理学的検討	胃と腸	2012	47(9)	1369-1382	原著論文/特集	0-IIa型食道表在癌の内視鏡所見と病理所見を対比し,肉眼形態と癌細胞の浸潤について相互の関連性を検討した。また,0-IIa型食道癌の臨床病理学的特徴からその病態と発育進展形式について考察した。0-IIb-0-IIc型を随伴する0-IIa混合型が高頻度であった。基底層型上皮内癌から粘膜上皮全層置換型の0-IIb型または0-IIc型を介し,癌細胞の一部がup-ward growthを示し分化勾配と角化傾向を伴って肥厚性上方発育をとり,0-IIa混合型に発育進展して粘膜固有層に深に浸潤する形式が考えられた。また,0-IIa単独型は少なく,de novo癌型と考えられる白色網状転移癌および白色扁平転移癌は深達度T1-LPMを示しており,白色網0-IIa病変は粘膜癌の代表的病型と考えられる。一方,基部にくびれを有する赤色小結節状癌の深達度はT1a-LPMからSM1程度で,基部が癌を引く赤色小結節状0-IIa癌起は粘膜下層癌を示した(著者抄録)
除外	総説				2012174694	英語	Miura Akinori, Momma Kumiko, Yoshida Misao	Endoscopic resection for T1a-MM and T1b-SM1 squamous cell carcinoma of the esophagus(食道のT1a-MMおよびT1b-SM1扁平上皮癌に対する内視鏡的切除術)	Clinical Journal of Gastroenterology	2009	2(4)	252-256	総説	
除外	非含数				2012168931	日本語	有馬 美和子, 多田 正弘	【消化管EUS診断の現状と新たな展開】食道表在癌の高周波数超音波超音波プローブによる深達度診断	胃と腸	2012	47(4)	467-480	原著論文/特集	高周波数超音波超音波プローブ(細径プローブ)の診断成績を,食道表在癌129例(CRT後の再発例5例を含む)を対象として,拡大内視鏡と比較しながら検討した。細径プローブによる正診率はEP/LPM癌97.6%,MM/SM1癌75.0%,SM2/SM3癌95.8%,全体で89.9%であった。NB/FICE併用拡大内視鏡でEP/LPM癌97.6%,MM/SM1癌71.0%,SM2/SM3癌81.3%,全体で84.6%であった。MM/SM1癌において,拡大内視鏡の正診率は細径プローブより良好であった。細径プローブの誤診の主な原因は,粘膜剥離への微小浸潤を誤影でなかったことによる誤読み,リンパ道閉塞形成や食道癌を癌と誤認したことによる誤読みであった。拡大観察では深部浸潤を示唆する血管像がとらえられないこともあるため,SM2/SM3癌の正診率が意外に低いことが弱点となっている。細径プローブはSM2/SM3癌の正診率が低く,誤診が少ないことが期待された。病変の形態と拡大内視鏡による正診率とを比較し,粘膜下層癌様の病変,拡大観察でTypeRを示す病変では細径プローブが有用である。CRT後の再発例でも腫瘍の厚みや固有層との距離なども,食道壁の状態も把握もできるため,ESDを安全に行ううえで有用な情報を得ることができる(著者抄録)
除外	非含数				2012151045	日本語	有馬 美和子, 多田 正弘, 田中 洋一	【咽頭・頭部食道癌の鑑別診断】頭部食道表在癌の特徴と鑑別診断 FICE内視鏡を中心に NBIとの対比を含めて	胃と腸	2012	47(3)	373-386	解説/特集	頭部食道を第1生理学的狭窄部(食道入口部)から約4cmの範囲と定義し,内視鏡的に切除した頭部食道癌21例を対象として,臨床・病理学的特徴を検討した。自施設発見15例中,挿入時に発見したものが1例(73%)。抜去時に発見したものが4例(27%)であった。内視鏡型は0-IIb型が少なく,少し厚みをもつ0-IIc型と0-I型がやや多かった。鑑別すべき病変は,乳頭腫,異所性胃粘膜と粘膜筋板由来の平滑筋腫であった。深達度はEP/LPM癌が12例(57%),MM/SM1癌が7例(33%),SM2癌が2例(10%)で,術前表在性食道癌に比べてやや進行した状態で見えれていた。深達度診断にはNB/FICE併用拡大内視鏡による縦断血管診断が有用で,深達度正診率は85%であった。導管伸張由来の浸潤など,表面構造を保ちながら深部浸潤する症例で誤診がみられた。リンパ節再発はMM/SM1癌の7例中1例(14%),SM2癌の2例中1例(50%)にみられたが,頭部と縦断リンパ節部清で根治し,原病死はなかった。頭部食道癌では内視鏡治療を適応拡大にて選択することが多いが,多角的な診断方法で癌変に経過観察する必要がある(著者抄録)

除外	非合数			2012151044	日本語	藤原 純子, 門馬 久美子, 立石 陽子, 木村 麻衣子, 渡海 貴雄, 剛崎 有加, 鈴木 友宣, 三浦 昭順, 加藤 剛, 出江 洋介, 比島 恒和, 吉田 操	【咽頭・頭部食道癌の鑑別診断】頭部食道表在癌の特徴と鑑別診断 NBI内視鏡を含めて	胃と腸	2012	47(3)	360-372	解説/特集	2007～2010年に経験した頭部食道表在癌16例(男性15例,女性1例)を対象に検討を行った。内視鏡検査は、スコープ挿入時は白色光を主体に、抜去時はNBI観察で行った。他院発見例を含め、通常観察発見：12例(75%)、NBI発見：4例(25%)であった。同時性多発食道癌：5例(31%)、異時性食道癌5例(31%)であり他臓癌と腫瘍の既往を11例(69.0%)に認めた。2例に化学放射線療法,14例にEMR/ESDを行いEMR/ESD施行14例で詳細な検討を行った。病型は0-IIa型：5病変(36%),0-IIb型：1病変(7%),0-IIc型：7病変(50%),0-型：1病変(7%)であった。深達度はT1a-EP:6病変(43%),T1a-LPM:3病変(22%),T1a-MM:2病変(14%),SM2:3病変(21%)でありSM2/22病変は断層侵襲性であった。頭部食道表在癌を効率よく検出するには、食道癌のハイリスク群を中心に鎮静剤使用やNBI併用,透明フード観察などの工夫を行い注意深く観察することが必要である。また、狭い頭部食道では、壁伸展による病変の形態変化の評価が困難なため、拡大観察やEUSを用いた深達度の評価が有効である。(著者抄録)
除外	総説			2011301926	日本語	菊池 大輔, 飯塚 敏郎, 布保屋 修, 矢作 直久, 貝瀬 満	【食道癌の治療戦略】表在食道癌の治療戦略 T1a-MM～SM2の表在食道癌に対する治療戦略	臨床消化器内科	2011	26(10)	1359-1365	解説/特集	内視鏡治療の進歩により表在食道癌を一括切除することが可能となった。そのメリットは、局所を完全にコントロールできると正確な病理組織学的診断が可能になることである。われわれはT1a-MM～SM2の表在食道癌に対し、内視鏡治療により病変を一括切除し、うすて正確な病理組織学的診断のもとで追加治療を決定しており、その成績と治療戦略について概説する。ESDは機能温存やQOLの点から非常に優れた治療法であるが、T1a-MM以降の表在食道癌には潜在的なリンパ節転移のリスクが存在しており、個々の病変を慎重に判断する必要がある。治療後の経過観察も非常に重要である。再発は治療後2年以内に発生することが多く、その間はいより厳重な経過観察が必要と考えられる。(著者抄録)
除外	総説			2011301925	日本語	竹内 学, 橋本 哲, 小林 正明, 佐藤 祐一, 成澤 林太郎, 青柳 豊	【食道癌の治療戦略】表在食道癌の治療戦略 表在食道癌内視鏡的相対適応病変に対するESDの有用性と問題点	臨床消化器内科	2011	26(10)	1351-1358	解説/特集	食道癌の内視鏡的相対適応病変は、深達度T1a-EP/LPMかつ間在性2/3以上あるいは臨床的に転移がない深達度T1a-MM,SM1の病変とされている。技術的には間病変とも内視鏡的粘膜下層剥離術(ESD)にて安全な一括完全切除が可能であるが、前者では術後狭窄、後者ではリンパ節転移を10～15%に認めることが問題である。術後狭窄に対しは、ステロイド局注療法の実入により安全な一括切除の約70%で内視鏡的ルーメン拡張術(EBD)が不満足であり、全周切除除ではEBD施行回数をEBD単独群に比べ減らすことが可能であった。また、ESD切除標本の詳細な病理組織学的検討を行いリンパ節転移危険因子(断層侵襲陽性、低分化型癌,INFb,c)の有無により追加治療の要否を判定することで、T1a-MM,SM1に対する内視鏡治療の成績は良好であった。以上より、現段階では相対適応病変に対するESDは妥当であると思われる。(著者抄録)
除外	非合数			2011287937	英語	Oda Ichiro, Abe Seichiro, Kusano Chika, Suzuki Haruhisa, Nonaka Satoru, Yoshinaga Shigetaka, Taniguchi Hirokazu, Shimoda Tadakazu, Gotoda Takuji	Correlation between endoscopic macroscopic type and invasion depth for early esophagogastric junction adenocarcinomas/早期食道胃移行部腺癌における内視鏡的肉眼型と浸潤深度との関係)	Gastric Cancer	2011	14(1)	22-27	原著論文	食道胃移行部(EGJ)に位置する粘膜(M)と粘膜下(SM)腺癌における内視鏡的肉眼型と腫瘍深達度との関係について検討した。2000年1月～2008年12月に内視鏡的および/または外科的治療を受けた73名(男性62名、女性11名、63.9歳)の連続患者における73の早期EGJ腺癌(M-SM/33・40、分化型/未分化型=70・3)を後向きに検討した。ポリープ状型病変0-Iは14例、混合型病変の無い非ポリープ状型(0-IIa、0-IIb、または0-IIc)が3例、混合型(0-IIa-IIcまたは0-IIc-IIa)が2例であった。混合型病変の無い非ポリープ状型病変(3%, 12/39)は、ポリープ状型病変(79%, 11/14)および混合型病変(85%, 17/20)に比べ、SM浸潤のリスクが有意に低かった。ポリープ状型病変では、無差性のサブタイプ(0-Ib)病変に比べ有差性のサブタイプ(0-Ia)においてSM浸潤リスクが有意に低かった。M病変は、SM病変より有意に小型であった。内視鏡的肉眼型の判定は、早期EGJ腺癌の正確な浸潤深達診断に有用と考えられた。
除外	非合数			2011216967	日本語	井上 靖洋, 石堀 智之, 三澤 可史, 池田 晴夫, 加賀 まこと, 雨 ひとみ, 佐藤 高嘉, 工藤 進英	【「うすればできる」画像強調内視鏡による腫瘍診断】食道 扁平上皮癌の精査 NBI拡大観察による病変の性状診断および深達度診断	消化器内視鏡	2011	23(4)	703-712	解説/特集	近年、高解像度の「NBI拡大」内視鏡の登場により、特に扁平上皮領域では深達度診断のみならず、微小な腫瘍性病変の診断に専ら用いられてきた。NBIの検査は、上段へべルに存在する毛細血管と上皮乳頭内血管、ループIPCLを褐色に強調できるところにある。NBI通常観察(非拡大)でbrown spot(あるいはbrownish area)を同定して、同部のNBI拡大観察を行うことで、病変の性状診断が可能である。NBI拡大内視鏡でIPCLの変化は、本文中のIPCLパターン分類(図3)の非枠に示した平坦病変の内視鏡的異型度診断から、青枠で示した深達度診断まで広く適用される。IPCLの変化は、組織の構造類型を反映していると考えられる。特に深達度診断においては、IPCL type V<0.042(深部浸潤)とM3SM1に示しており、治療方針の分岐点ともなることから、その亜分類が重要となる。V-3-Aを異常血管が水平面上に走行する場合でM2深部(50%)とM3SM1(50%)に相当する。一方、V-3-Bは深部方向への延長が顕著な場合であり、73%がM3SM1、23%がSM2以降である。ヨード染色とNBIの位置づけとして、NBIの普及した現在において、狭い視野診断、性状診断において、NBI拡大診断は詳細かつ正確なものとなった。ヨード染色は、1)炎症の強い炎症例(例えばばたら食道)などの評価において高いコントラストの画像を提供する。また、2)ESDを行う場合に病変の範囲を明確に指示示すものである。(著者抄録)
除外	非合数			2011175004	日本語	藤原 純子, 門馬 久美子, 藤原 康, 江原 秀人, 江川 直人, 丁徳孝, 大剛, 出江 洋介, 立石 陽子, 比島 恒和, 吉田 操	【食道表在癌2011】小癌・微小小癌 小癌・微小小癌	胃と腸	2011	46(5)	739-748	原著論文/特集	2005年1月から2009年12月までに内視鏡治療を行った10mm以下の食道表在癌は126病変であり、超微小癌11病変、微小小癌41病変、小癌74病変であった。[症例1]超微小小癌2×1.5mm,0-IIc,T1a-LPM,化学療法後の異時性多発癌。[症例2]微小小癌4×4mm,0-IIb,T1a-MM,y0,v0。[症例3]微小小癌5×4mm,0-IIc,SM1,y0,v0。[症例4]小癌10×8mm,0-IIc,T1a-MM,y1,v1。[症例5]小癌6×3mm,0-IIc,SM2,y0,v0。NBI発見の頭部食道癌症例6)小癌8×5mm,0-IIc,SM2,y1,v0。126病変の病型は0-IIa 11病変(9%),0-IIb 41病変(33%),0-IIc 72病変(57%),0-I 2病変(1%)であり、深達度はT1a-EP 105病変(83%),T1a-LPM 5病変(4%),T1a-MM 11病変(9%),SM1 1病変(1%),SM2 4病変(3%)であった。T1a-MM以降癌16病変の内訳は、微小小癌のT1a-MM 1病変,SM1 1病変、小癌のT1a-MM 10病変,SM2 4病変で、その病型は14病変が0-IIc,2病変が0-Iであった。5mmを超える0-IIc病変の約20%は、T1a-MM以降に浸潤しており、深達度診断時は、癌周囲の盛り上がりや陥凹内の凹凸、発赤の強さに注目し評価することが必要である。(著者抄録)
除外	総説			2011175001	日本語	三梨 桂子	【食道表在癌2011】食道表在癌の治療 放射線・化学療法	胃と腸	2011	46(5)	716-722	解説/特集	食道表在癌は局所治療である内視鏡切除が適応だが、粘膜筋板(MM)から粘膜下層(SM)へ浸潤すると所属リンパ節への転移頻度が10～40%以上と上昇するため、リンパ節清浄を伴う外科切除術が標準的治療である。根治的放射線療法(RT)は多施設での第Ⅲ試験で有効性が評価され、現在外科的切開とのララング化比較試験が進行中である。また、主病巣をまず内視鏡切除し、切除標本の病理結果から転移のハイリスク群を抽出し追加治療を考慮する臨床試験も行われている。これら非外科的治療の有効性を検証する臨床試験によりリンパ節転移を有さない食道表在癌に対して臓器温存を含めた治療が可能になってくることが期待される。(著者抄録)
除外	非合数			2011174994	日本語	門馬 久美子, 吉田 操, 藤原 純子, 江原 秀人, 江川 直人, 丁徳孝, 大剛, 出江 洋介, 立石 陽子	【食道表在癌2011】食道表在癌の深達度診断 通常観察と色素内視鏡	胃と腸	2011	46(5)	650-663	解説/特集	深達度診断の目標は、(1)リンパ節転移がなく局所治療で根治可能なT1a-EP-LPM癌、(2)リンパ節の転移頻度が低率で、局所治療の相対的適応であるT1a-MM-SM1癌、(3)リンパ節転移を高頻度と認め、リンパ節清浄を含めた外科治療が必要なSM2-3癌の3群に分類することである。深達度診断を行う場合の観察ポイントとは、(1)隆起性病変では隆起の大きさ、高さ、隆起の基部の形態、隆起の色調や表面性状、(2)陥凹性病変では陥凹の深さ、陥凹底の凹凸や色調、陥凹辺縁の盛り上がり、また、TB染色所見や量目指標の有無、さらにMM以降への浸潤が疑われる場合はNBI併用拡大観察にて血管変化を観察する。2007年1月～2009年12月にEMR/ESD治療を行った食道表在癌247例(29%病変)は、0-IIb:70.0-IIc:191.0-IIc:18.0-IIc:10.2型例172例を対象とした。病型分布としては、0-IIcが食道表在癌の65%を占めていた。深達度診断の診断精度は、全体で89%,T1a-EP-LPM癌は94%と良好であったが、T1a-MM-SM1癌は86%,SM2以降癌は61%と低率であった。T1a-MM以降癌で、深達度を誤った病変の84%は0-IIcであった。0-IIcにおいて、深達度を過減みしたT1a-MM-SM1癌の71%,SM2以降癌の50%は微小浸潤であった。浸潤幅1.8mm程度の微小浸潤は、現状での通常観察の診断限界と考えられる。(著者抄録)
全文取り寄せ	可	否	MM症例数不明	2011113360	日本語	西 隆之, 葺内 博康, 小澤 杜治, 島田 英雄, 千野 修, 大野 佳史, 郷持 孝弘, 田島 隆行, 山本 壮一郎, 原 正三, 朝 博仁, 武智 眞彦, 名久井 実, 伊東 英樹, 黒川 竜彦, 市原 明子, 数野 映人, 葉梨 智子, 生越 尚二	【バレット食道癌の早期発見】バレット食道癌の早期発見のための臨床病理	消化器内科	2010	51(6)	586-592	原著論文/特集	1975年から2010年3月までに、自腹鏡52例を含め、医学中央雑誌で検索したBarrett食道癌の深達度T1aおよびT1bの表在癌524例について臨床病理学的に検討した。T1aは269例、T1bは255例、年齢は平均64.2歳で90歳代・70歳代が最も多く、性別は男47・女68例と男性が女性の約6倍であった。発見動機は無症状で、検診の際に発見されたものが最も多く、次いで胸やけであった。背景粘膜であるBarrett上皮の長さとは、T1aではshort segment Barrett esophagusが57%と過半数を占めたが、T1bではlong segment Barrett esophagusが53%と多かった。食道裂孔ヘルニアは83%に合併し、逆流性食道炎も77%に合併していた。腫瘍の局在は咽頭・後壁で最も多く、右壁は左壁の3倍以上多く発生していた。腫瘍の肉眼視は、0-IIaと0-IIcがほぼ同等で最も多かった。深達度と組織型の関係を検討すると、T1aでは全例が分化型であったが、T1bでは低分化、未分化を13%に認めた。また、T1aではリンパ節転移率が1%であったが、T1bでは28%であり、リンパ管侵襲と脈管侵襲はT1aでは各々7%、3%と低率であったが、T1bでは58%、31%であった。

除外	非合数				2011109517	日本語	大高 雅彦、小馬瀬 一樹、山口 達也、花輪 充彦、嵯峨 哲哉、大塚 博之、佐藤 公、榎本 信幸、中村 俊也	食道癌内視鏡的切除術の成績	山梨医学	2010	38	112-116	原著論文	著者らは1995年～2010年に食道癌の内視鏡的切除術を69症例に施行したので、長期成績を報告した。1) 局所再発はEndoscopic mucosal resection(EMR)を施行した49例中8例に、Endoscopic submucosal dissection(ESD)を施行した18例中1例に認められた。2)pT1a+EP+T1a+LPM例の局所再発には内視鏡的切除術やArgon plasma coagulation焼灼が行われた。pT1a-MM以降では手術が施行された。また、リンパ節再発はEMR群で2例にみられ、食道切除術が施行された。3) EMR群の無再発生存率はpT1a+EP+oT1a+LPM例で3年が88.9%、5年が81.1%でみられたが、pT1a-MM+oSM1例では3年が35.0%と両者間で有意差が認められた。一方、ESD群では差は認められず、最長15年の長期経過で、両群に原病変はなかった。4) 異時性多発癌を両群合わせて18.8%に認められ、10.8%は頭頸部癌を合併していた。5) 早期食道癌に対する内視鏡治療例の長期予後は良好であったが、異時性多発癌や他臓器重複癌を含めた管理が必要であると示唆された。
除外	非合数				2011034205	日本語	梅原 誠司、藤原 斉、窪田 健、市川 大輔、岡本 和真、大辻 英吾	食道癌に合併した食道穿孔7例の検討	外科	2010	72(11)	1208-1211	原著論文	著者らは2001～2008年の8年間に食道癌を合併した食道穿孔と診断された7症例(全男性、年齢49～74歳、中央値55歳)における治療成績を、文献的考察を加えて検討した。その結果、1) 初診時の病期は内視鏡的粘膜切除(EMR)時穿孔例のStage 0が1例、Stage IIが1例、Stage IIIが1例、Stage IVaが4例であった。2) 占拠部位はM4が4例と最も多く、また深達度はT4が4例(いずれも気管・気管支に浸潤)、T3が2例で、EMR時穿孔例はT1aであった。3) 治療は保存的治療が6例、手術治療が2例で、保存的治療の2例および手術治療の1例に食道ステントが留置された。4) 食道ステント留置の3例は穿孔部の閉鎖が得られ、進行食道癌の穿孔例では総じて予後不良(2ヵ月～12ヵ月後に死亡)であったが、EMR時穿孔例では術後4年4ヵ月の現在、無再発生存中である。
除外	非合数				2010248160	日本語	竹内 学、小林 正明、橋本 智、成澤 林太郎、青柳 聖	【拡大内視鏡はどこまで必要か?】食道内視鏡 専門病院の立場から	臨床消化器内科	2010	25(6)	1105-1112	解説/特集	専門病院には、前面にて発見された食道病変に対する精査と治療を目的に患者が紹介されることが多い。よって前哨精査は、その後の治療に影響を及ぼさないよう患者と病変にダメージを与えないように行うことが重要であり、そのために拡大内視鏡検査は欠かさない拡大観察は紹介病変の再確認や同時多発癌発見に対し生検を行わずとも質的診断を可能とするさらに深達度診断においても有用であり、内視鏡治療の絶対適応病変のEP・LPM癌の診断や、表層拡大病変に含まれる凹凸の少ない狭い領域でのMM・SM1浸潤部の同定もできるようになった。またリンパ節転移と相関のある癌の分化度や浸潤様式も推測できる確かな治療方針決定に寄与する。一方Barrett腺癌においても許容併用およびNBI拡大観察では、通常・色素内視鏡では同定できなかった平坦な側方進展範囲も正確に診断でき、その意義は大きい。(著者抄録)
除外	総説				2010051661	日本語	島田 英雄、堀内 博康、小澤 壮治、千野 修、西 隆之、栗梨 智子、山本 壮一郎、名久井 実、数野 曉人	【今日の食道癌診療】食道表在癌に対する治療	外科治療	2009	101(5)	558-569	解説/特集	食道表在癌に対して多岐に渡る治療法が選択され行われている。内視鏡的切除で根治できるT1a+EP、LPM症例、リンパ節転移を確実に認めるSM2,3症例に対する胸部食道全摘、3領域リンパ節部清術、また両者の中間的位置にあるT1a+MM、SM1症例に対する食道温存を考慮しての内視鏡的切除の適応拡大である。とくにT1a+MM、SM1症例では内視鏡的切除後を行い、病理組織評価による追加治療選択も行われている。今後のさらなる壁深達度、リンパ節転移診断の進歩により、根治性を維持した低侵襲治療を提供できる領域と思われる。(著者抄録)
全文取り寄せ		可	否		2009321950	日本語	西 隆之、堀内 博康、小澤 壮治、島田 英雄、千野 修、木勢 佳史、藤持 孝弘、田島 隆行、山本 壮一郎、原 正三、朝 博仁、武智 晶彦、名久井 実、伊東 英輔、河島 俊文、石井 明子、数野 曉人、栗梨 智子、生越 尚二	【NERD+RE+Barrett食道と内視鏡】Barrett腺癌の臨床病理学的検討 当科45例と本邦報告656例の検討	消化器内視鏡	2009	21(8)	1199-1206	解説/特集	本邦のBarrett食道癌は症例が少ないため、臨床的にも病理学的にも不明な点が多く、治療方針も確立されていない。当科で扱ったBarrett食道癌45例を含む、本邦報告701症例を臨床病理学的に検討した。深達度のリンパ節転移状況から、粘膜癌ではリンパ節転移はほとんどなく、内視鏡治療で対応可能であるが、SM1以降ではリンパ節転移を認めることが多く、手術を第一選択とすべきである。また、Barrett食道・Barrett食道癌の頻度についても、内外の報告を概説した。(著者抄録)
除外	総説				2009229719	日本語	島田 英雄、堀内 博康、千野 修、西 隆之、木勢 佳史、栗梨 智子、山本 壮一郎、原 正三、名久井 実、数野 曉人、生越 尚二	【ここまでの食道疾患の内視鏡下治療・外科手術】内視鏡下治療 食道表在癌に対するEMRの位置付けと適応拡大の現状	外科治療	2009	100(6)	754-765	解説/特集	内視鏡的粘膜切除術(EMR)は低侵襲性であり、切除標本の病理組織学検査が可能ことから、早期食道癌に対する治療法として広く普及した。適応症例もT1a+LPM(M2)までを絶対適応としていた時代からリンパ節転移陽性と推測されるT1a+MM(M3)、SM1にまで適応が拡大され、切除標本の病理組織学的検査から追加治療の選択が行われているが、エビデンスに基づく明確な基準はない。食道癌診療において食道温存のメリットは大きく、現状でのEMRを考慮した食道表在癌の治療体系について述べた。(著者抄録)
全文取り寄せ		可	否		2009192829	日本語	小山 恒男、北村 陽子、友利 彰寿、堀田 欣一、高橋 亜紀子、宮田 佳典	【食道扁平上皮癌に対するESDの適応と実際】食道扁平上皮癌に対するESDの成績 T1a+MM,SM1を中心に	胃と腸	2009	44(3)	405-416	原著論文/特集	2000年1月から2008年12月までにESDが施行された食道扁平上皮癌158例(180病変)のうち、深達度T1a+MM28例とT1b(SM1)12例を症例を対象とした。一括完全切除率はT1a+MM癌96.4%、T1b(SM1)癌83.3%であった。T1a+MM癌28例中5例(17.9%)にリンパ管侵襲を認め2例にCRTが追加施行され、他の3例は経過観察された。CRTが施行された2例は無再発経過観察3例中1例はリンパ節転移が生じたが他病変、他の2例には再発を認めなかった。一方、陰性のT1a+MM癌23例にリンパ節再発例はなかった。SM1癌12例中4例(33.3%)にリンパ管侵襲を認め2例にはCRTが追加施行され2例は経過観察された。CRTの2例は無再発経過観察2例中1例は2年5ヵ月後に現病変、他の1例は無再発のまま他病変死亡した。陰性SM1癌8例中4例にCRTを施行し4例は経過観察されたがこの群にリンパ節再発はなかった。T1a+MMやT1b(SM1)の食道SCCに対して安全にESDを施行することは可能であり臨床的に転移がない場合はESDによる一括完全切除を施行し追加治療の要否を判定すべきと思われる。(著者抄録)
全文取り寄せ		可	否		2009192820	日本語	藤田 昌宏、佐藤 利宏、藤田 裕美、吉井 新二、高橋 宏明、細川 正夫	【食道扁平上皮癌に対するESDの適応と実際】食道ESD切除症例の病理学的検索成績	胃と腸	2009	44(3)	345-358	原著論文/特集	食道扁平上皮癌のESD切除171病変を臨床病理学的に検討し、切除断端陽性例と局所再発ないリンパ節転移再発例についての特徴を調べた。171病変はすべて一括切除が行われたが、腫瘍病変の大きさは長径3mm大から90mm大であった。切除断端陽性ないし疑陽性例は11病変で認められた。深部断端陽性例は2例でSM癌が認められ、うち局所再発は1例にみられた。側方断端陽性と考えられた9例中、局所再発は2例であり、T1a+LPM、T1a+EPの深達度であったが側方断端に上皮浸染像が認められ判定困難されていた。病理組織学的に切除断端判定に至らなかった症例では、切除時の熱凝固による変性や堆積(平均1,000μm)伸展固定時の組織崩壊と低異型度の腫瘍病変の良悪判断、非腫瘍性上皮異型などが存在するリンパ節転移再発例は2例みられたがESD試料においては陽子陽性例は少なかった。詳細な再検索でリンパ管侵襲が見い出された例もあった。再発例やリンパ節転移例のEMR組織において、進展食道癌のINF+を示す傾向がみられた。また、EMR症例300病変と比較検討した結果、局所再発率は3.5%であったが分割切除が33例あり、この分割切除例では局所再発が11例(33%)にみられた。一括切除が可能なESDはEMRに比べ再発率は低く(1.7%)、ESDによる切除は良好な成績であった。ESD実施時の正確な診断と範囲や、切除時ないし固定時の変性、堆積などを考慮して切除断端を考え、病理診断において組織像、リンパ管侵襲、断端における低異型度の病変を見落としがないことが大切である。(著者抄録)
除外	総説				2009137681	日本語	結城 敏志、小松 嘉人、浅香 正博	【食道がんの治療をどう行うか】食道がんの病期分類と治療方針	臨床腫瘍プラクティス	2009	5(1)	19-23	解説/特集	食道がん診療にあたっては治療選択前の病期診断が非常に重要である。食道がんはその進行度に応じて、内視鏡治療、外科的治療、化学放射線療法、化学療法など多様な治療の中から最適な治療方針を選択しなければならない。深達度T1症例の中でもm1+m2症例に関しては、内視鏡的切除の適応となる。m1+m2を除くStageⅡ～Ⅲの症例に関しては、外科的切除が標準治療とされているが、近年、化学放射線療法で良好な成績が報告されており、ひとつの治療オプションとして位置づけられている。T4もしくはM1+Lymを有する症例に対しては根治的外科切除が困難であり、化学放射線療法が選択される。(著者抄録)
除外	非合数				2009058317	日本語	吉井 貴子、本橋 修、西村 貴、中山 典典、高木 一、佐野 秀弥、柳田 直哉、亀田 陽一	化学・放射線治療後遠・再発食道癌に対するsalvage EMRの経験	Progress of Digestive Endoscopy	2008	73(2)	30-35.1	原著論文	【目的】内視鏡的粘膜切除(以下、EMR)は、化学・放射線療法後の食道癌遠・再発病変に対する有用なsalvageの手段として期待されるが十分な報告は無い。salvage EMRの経験を報告する。【対象】過去5年間に当院で化学・放射線療法にsalvage EMRを施行した食道癌5例。【結果】年齢中央値71歳(64～78歳)、全例男性。病理組織:sc/scc+smcc(4/1例)、病変占拠部位:Ut/Mt/Lt(1/3/1例)、肉眼型(=EMR前)type12例(=0-I/0-IIc各1例)、0-IIa+IIc(=0-IIc)1例、0-I+IIc(=0-IIc)1例、表層拡大型0-IIc(=0-IIc)1例、一括/分割切除(3/2例)、EMR深達度:LPM/am2/m3(1/3/1例)、局所再発1例(AP追加)、LNM再発1例、EMR後MST 290日(167～1230日)、局所無再発生存期間中央値290日(41～690日)、他病変1例、原病変なし、重畳合併症なし。【総括】salvage EMRの安全性、局所制御は良好だった。(著者抄録)

除外	非合数				2009056115	日本語	船川 慶太, 小山 恒男, 友利 彰寿, 高橋 重紀子, 北村 陽子, 堀田 欣一, 宮田 佳典	【超高齢者の内視鏡】超高齢者の早期食道癌に対するESDの適応と問題点	消化器内視鏡	2008	20(11)	1659-1665	原著論文/特集	食道表在癌に対するESDは、高度な技術が必要で、施行時間も長時間に及び、高齢者では脳虚性肺炎や血栓症、出血などの合併症が懸念される。今回の筆者らの検討では、超高齢者群、高齢者群、非高齢者群の3群間で偶発症の発生率に有意差を認めなかった。十分な準備と注意深い経過観察を行うことにより、高齢者、超高齢者にも安全にESDを施行し得た。また、翌期までの脱落投与率は、非高齢者群に比べて超高齢者・高齢者群で高率であり、これらの群では麻酔による覚醒遅延があると考えられ、ESD後も引き続き全身状態のチェックと適切な対応が必要であると考えられた。非高齢者群に比べて、超高齢者・高齢者群で深達度がsm2以下の場合が高率であった。食道癌は手術侵襲が大きいため、高齢者ではより低侵襲な内視鏡治療が選択されることが多く、今後とも高齢者に対する食道ESDは増加することが予測される。(著者抄録)
除外	非合数				2008373423	日本語	有馬 美和子, 有馬 秀明, 多田 正弘	【早期食道癌の診断 最近の進歩】早期食道癌深達度診断の進歩 FICE併用拡大内視鏡を中心に	胃と腸	2008	43(10)	1489-1498	解説/特集	拡大内視鏡を用いた微細血管像による、食道表在癌の深達度診断の成績と問題点について検討した。使用機種は主にFITS社製EG-5902Wを用い血管拡張モードのFICEを併用した。微細血管パターンはtype 3とtype 4は癌に特徴的な血管像でストレッチされたtype 4血管で囲まれたAVA/SSIVは、その大きさは4.45、4.4の3つのカテゴリーに重分類される。type 3とtype 4Sをm1・m2癌、type 4Mをm3・sm1癌、type 4Lをsm2・sm3癌の診断基準とする。m1・m2癌の診断率は98.6%、m3・sm1癌は68.8%、sm2・sm3癌は85.3%。全体の正確率は77.7%。癌集中351例(93.1%)であったAVAを形成しないVeticularな血管から成るtype 4RIは、低分化型や特殊な組織型の癌、INFαの浸潤様式を示す病変でみられた。深達度診断で前進した点は、m1・m2癌の診断レベルが向上したこと、細かな浸潤部を投影できるようになったこと、癌の進展形態や浸潤様式が鑑別できるようになったことである。誤診の原因は微小浸潤、角化の強い病変や表層が浅い癌で覆われたが、深部で細かい癌結果がハッキリと浸潤していたことによる誤診であった。病変の深さと血管像の間に相違がある場合には、高周波数超音波フローを併用した深達度評価が必要である。(著者抄録)
除外	非合数				2008247903	英語	Kawada Kenro, Kawano Tatsuyuki, Nagai Nagami, Nishikage Tetsuro, Nakajima Yasuaki, Ogiya Kazuo, Haruki Shingo, Suzuki Tomoyoshi, Kawachi Hiroshi	Argon plasma coagulation for local recurrence of squamous cell carcinoma of the esophagus after endoscopic mucosal resection: technique and outcome(内視鏡的粘膜切除術後の食道の扁平上皮癌局所再発に対するアルゴンプラズマ凝固 技術と転帰)	Esophagus	2008	5(1)	27-32	原著論文	内視鏡的粘膜切除術(EMR)によって治療できない初期の食道癌再発の治療に対してアルゴンプラズマ凝固(APC)が有効かつ安全な手法か否かを評価した。1989年12月から2005年3月の276例(142例・198例・96例)を有する患者249名における粘膜食道癌の治療に対するEMR施行の経緯について考察した。EMR後の疾患の局所再発は24名で認められた。17名の患者がAPC治療を受けた。経過60℃/2分/10mmのアルゴンガスフローを使用した。17名の追跡期間は13~87ヵ月(中央値68ヵ月)であった。内視鏡で評価した腫瘍浸潤深さは全患者で粘膜層であった。73セッション(平均4.3セッション/人、1~12セッション)実施した。全病変が容易に照射された。出血、穿孔または狭窄といった重篤な合併症は認められなかった。17名中16名の患者で完全な局所コントロールが達成されたが、残りの患者では再発を必要とする手術が必要であった。3名が死亡した。2名は他の疾患が原因であり、1名は他の癌が原因で、食道癌による死亡はなかった。結論として、APCはEMR後の食道の扁平上皮癌の局所的再発治療に対して安全かつ有効な方法であると考えられた。
除外	非合数				2008165446	日本語	小林 慎二, 太田 正徳, 倉持 美和, 天満 信夫, 松浦 裕史, 金子由香, 若島 隆, 山本雅一, 大橋 正樹	食道表在癌の拾い上げ診断についての検討 当院で発見し、EMRを施行した食道表在癌11症例の検討	消化器科	2008	46(2)	253-256	原著論文	1995~2005年に施行した上部消化管内視鏡検査2683例において、食道表在癌は11例(14例男/10例女、1例平均62歳)に発見し、内視鏡的粘膜切除術(EMR)を施行した。初期の8年間には発見がなかったが、内視鏡機種と検査方法変更後は毎年2例(発見率0.0068%)、4例(0.135%)、5例(0.159%)発見され、最終年には前年までのEMR施行例の異時性多発病変を3例で発見した。11例中喫煙または喫煙歴のあるのは9例で、胸焼け、心窩部痛などの有訴者は4例のみであった。肉眼形態は0-Iaが2例、0-IIaが7例、0-IIcが5例、病理組織学的深達度はm1が10例、m2が1例、m3が3例で、全例0、v0であった。異時性多発病変があった3例を含め、全例無再発生存中である。
全文取り寄せ	可	否	Subjects are included in another paper	2008101034	日本語	門馬 久美子, 吉田 操, 藤原 純子, 江頭 秀人, 来間 佐和子, 江川 直人, 三浦 昭雄, 加藤 剛, 出江 洋介, 根本 善生, 船田 信嗣, 栗梨 智子	【食道表在癌内視鏡切除後の長期成績】食道T1a-MM・SM1癌内視鏡切除後の経過	胃と腸	2007	42(9)	1341-1354	原著論文/特集	食道T1a-MM・SM1癌内視鏡治療後の経過【目的】臨床的N0症例を対象にEMRを行い、組織学的に深達度T1a-MMまたはSM1と判定された症例に対して組織学的所見に基づいて一定の判断基準を設け追加治療を行った。その治療成績を検討し、治療方針の妥当性を検討した【対象と方法】87例(組織学的深達度T1a-MM:65例とSM1:22例)を検討対象とした。追加治療の適否基準は癌内の浸潤を伴った。病理組織所見で、病型が0-I・0-II・0-III・0-IIIc・0-IIIcのものと、病理組織所見で尿管侵襲(+)・浸潤様式(+)・潰瘍浸潤(+)・分化度(低分化)型などの場合は追加治療必要症例とし、それ以外の場合は経過追跡の適応とした。治療法の選択は患者との相談で決定し、CRT・RTまたは根治手術のいずれかを選択した。追加治療の適応であるにもかかわらずEMR後の治療を望まなかった症例は治療拒否例とし、経過追跡を行った【結果】経過追跡群は47例(T1a-MM:44例、SM1:3)で追加治療はCRT・RT群15例(T1a-MM:11例、SM1:4)、手術群7例(T1a-MM:1例、SM1:6)、治療拒否群は18例(T1a-MM:13例、SM1:5)であった。経過追跡群には局所再発6例(12.7%)リンパ節再発1例(2.1%)を認めた。追加治療症例における再発はなかった。すなわちCRT・RT群では再発はなく手術群の2例(28.5%)で組織学的にリンパ節転移を確認したが術後再発はなかったこの症例は組織学的にリンパ管侵襲2度でありこのような症例には手術をすべきである。治療拒否群においては2例(11%)に転移再発(尿管転移1例とリンパ節転移1例)を認めた。経過追跡群における局所再発は部分切除症例で、再EMR術後CRT群で行い追加したEMR後の転移再発は経過追跡群2.1%、追加治療0%、治療拒否群11%であった【結論】組織学的深達度T1a-MMまたはSM1症例に対するEMR後の追加治療を病理組織所見(尿管侵襲、浸潤様式、潰瘍浸潤、分化度)を参考に、追加治療の適応を決定することは妥当であると考えられるなかでも尿管侵襲中等症例には根治手術を適用すべきである。(著者抄録)	
除外	非合数				2008101032	日本語	北村 陽子, 小山 恒男, 宮田 佳典, 友利 彰寿, 堀田 欣一, 高橋 重紀子, 古立 真一	【食道表在癌内視鏡切除後の長期成績】食道m1・m2癌ESD後の経過	胃と腸	2007	42(9)	1323-1329	原著論文/特集	2000年1月から2005年12月の期間にESDを行い、組織学的深達度がm1・m2であった食道扁平上皮癌79例を対象とした。結果(1)一括完全切除率93.7%(2)偶発症:穿孔0.8%、穿孔0.8%、穿孔0.8%、穿孔0.8%(4)遠隔転移0.8%(5)異時多発食道癌24.1%(6)3年生存率95.1%考察:食道ESDの偶発症と長期予後はEMRと同等であった。食道ESDはEMRより一括完全切除率が高く(詳細な病理学的検討が可能となり)局所再発率が低かったESDは食道表在癌の治療に有用であると考えられる。(著者抄録)
除外	総説				2008042371	日本語	竹内 裕也, 才川 義嗣, 須田 康一, 北川 雄光	【癌診療に役立つ最新データ2007-2008】V.食道癌 食道癌の治療に関する最新のデータ	臨床外科	2007	62(11)	153-161	解説/特集	早期食道癌発見率の上昇によって内視鏡的粘膜切除術の適応症例は増加しているリンパ管転移のないT1aでは深達度2mmまでが適応となるが、耐手術性不良例でも中心に3~5mmまで適応を拡大する試みはなされている。従来、cT1bN0例では根治手術が選択されてきたが、化学放射線療法による高いOR率が明らかとなり、今後、手術療法との比較試験の結果が注目される。T4aないしL1 M1 Lym症例を対象に始められた化学放射線療法は、従来は外科治療が中心であったT2-T3食道癌にも適応が拡大しており、その是非に関して臨床試験による検証が必要となろう。また、今後、化学放射線療法後の腫瘍進展、再発例に対するsalvage治療の適応決定とその臨床的意義の評価、根治性と安全性を重視したsalvage手術手技の確立などが求められる。無作為化比較試験の結果、術前化学療群の術後生存率は術後化学療群よりも有意に良好であることが明らかとなった。この結果から、今後わが国では手術療法に際し、術前化学療法が標準治療として組み込まれることが予想される。(著者抄録)
除外	非合数				2008028375	日本語	為我井 芳郎, 斉藤 幸夫, 正木 尚彦, 大嶋 隆夫, 長沖 祐子, 矢野 美恵子, 三宅 大, 清水利夫	【大腸ESDの現状と将来展望】大腸ESDの技術習得とそための必要条件	胃と腸	2007	42(7)	1115-1126	解説/特集	ESDは、全周性腫瘍を除き内視鏡的に一括切除の可能な大きさの限界を払拭しつつある。大腸ESDは食道・胃ESDに比べ解剖学的・組織学的特性から難度が高い。その技術習得は断然と並行して胃のESDトレーニングシステムのうえに位置付けられる。また、偶発症の頻度は高く、高度な手技やリスクマネジメントのみならず倫理的要素も問われる。大腸ESDの適応は、(1)大きさは20mm以上、(2)低ILM、N0、V0のpit patternを示す推定深達度mないしLsm微小浸潤癌、(3)VN型pit patternを認めず、明らかにnon lifting sign陰性の病変と位置付けられる。以上の基準で大腸腫瘍127例(男76例、女51例、平均65.9歳)130病変に対しHook knifeによるESDを行った。一括切除は126病変(96.9%)で腫瘍の進展・再発例はない1病変(0.77%)で小穿孔を認めたがクランプにより閉鎖し完治した。大腸ESDの安全性と根治性は徐々に確立されてきた。今後その標準化に向け、機器の開発や技術習得を目的とした教育システムの構築が急務である。(著者抄録)
除外	非合数				2007307123	日本語	青木 利佳, 安田 貢, 北村 晋志, 林 亨, 山ノ井 昭, 堀馬 隆寛, 佐竹 直夫	食道胃接合部癌の臨床病理学的検討 香川県下集計	香川県内科医会誌	2007	43	39-48	原著論文	目的:香川県下各施設における食道胃接合部癌を集計し、その臨床病理学的特徴を検討した。対象・方法:平成13年から17年までの5年間に、香川県下13施設で経腹した食道胃接合部癌88例を対象とした。その臨床病理学的特徴は、当センターで同時期に経腹した非接合部胃癌145例と比較した。成績:(1)全胃癌2,609例中、食道胃接合部癌は88例(3.4%)で、そのうちBarrett癌は18例(3.4%)であった。(2)年齢は65.4歳。性別は、非接合部胃癌と比較して年齢が高く、進行癌が有意に多かった。(3)早期期では、非接合部癌に比較して腫瘍径の割にSM癌がやや多く、尿管侵襲率は有意に高率であった。肉眼型は隆起型が多かった。接合部から1cm以内に存在する病変ではSM癌、分化型、尿管侵襲がさらに多い傾向を認めた。(4)進行癌では非接合部癌に比較して比較的にMP~SS癌が多かった。また、腫瘍径は小さく、分化型が有意に多かった。尿管侵襲率は高率に認められたが、リンパ節転移率は逆に低かった。結論:食道胃接合部癌は、腫瘍径が小さくても深部浸潤しやすい、尿管侵襲が高率であった。Barrett癌に関しては、今後の症例の蓄積が重要と考えられた。(著者抄録)

除外	非合数			2007006135	日本語	大嶋 隆夫、為我井 芳徳、永田 尚哉、樺井俊之、矢嶋 祐三、林裕子、酒匂 赤人、森島康彦、保坂 浩子、小飯塚 仁彦、秋山 純一、今村 康俊、正田 良介、正木 尚彦、上村 直実、斉藤 澄	食道表在癌の質的診断,深達度診断における拡大内視鏡の有用性について	Progress of Digestive Endoscopy	2006	68(2)	27-30	原著論文	当センターで2004年1月～2005年4月に内視鏡の粘膜下層切開術を行った食道表在癌12例を対象に、術前拡大内視鏡所見と組織標本所見との相関性を調べ、拡大内視鏡による術前検査の有用性について検討した。拡大内視鏡所見からm1-m3と診断した9例、m3以上と診断した2例の組織診断は、いずれも拡大内視鏡診断と一致した。拡大内視鏡所見から「dysplasia」と診断した1例の組織診断は「severe dysplasia」であったこれらの結果から拡大内視鏡による術前検査の有用性が示された
除外	非合数			2006135980	日本語	有馬 美和子、有馬 秀明、多田 正弘	【拡大内視鏡の現況と問題点】 食道粘膜の拡大観察の基本	臨床消化器内科	2006	21(4)	391-398	解説/特集	表在食道癌の拡大内視鏡観察で得られる基本的な微細血管像と病理組織像との関係について検討した。拡大観察で描出される微細血管パターンは大きく四つに分類される。type 1は細く直線的な乳頭内血管が観察されるものでほとんどは健康粘膜であり、type 2は血管の伸長や血管径の拡張はあるが乳頭内血管構造が保たれるもので、炎症性変化が大半を占めた。type 3は乳頭内血管構造の破壊と口径不同を伴う螺旋状や潰れた赤丸状血管がみられ、配列が不揃いなもので、m1・m2癌がほとんどであった。type 4は乳頭構造から逸脱した多重状・不整樹枝状・網状の血管で、m2深部以深浸潤癌にみられる。浸潤部で形成される腫瘍塊は、avascular area(AVA)として認識され、AVAを取り囲むストレッチされたtype 4血管が観察され、AVAの大きさから深達度が鑑別できる(著者抄録)。
除外	非合数			2006117581	日本語	奥島 憲彦、阿嘉 裕之、藤谷 健二、久志 一朗、宮平 工、友利 健彦、西原 実、城岡 文二、津鎌 理知子、折田 均、比嘉 良夫、宮里 稔、喜友名 正也	内視鏡的一括切除術を行った食道癌症例の検討	冲縄医学雑誌	2005	44(2)	1-3	原著論文	内視鏡的粘膜切除術(EMR)を施行した食道癌患者11例(48～78歳)を対象に、フックナイフを用い切開、剥離法による内視鏡的一括切除術(ESD)を行ったが、成績について検討した。腫瘍長径の長い初期の2例でESDが完遂できず、先端キャップ法へ分割切除となったが9例は病変を一括切除できた。全例扁平上皮癌で、深達度はm1が7例、m2-2m3が各2例であった。ESD後2ヶ月～3年2ヶ月の経過後再発は1例、健在である。ESDは病変が一括切除でき、病理組織学的検討には優れていた。治療成績は良好で、術後全例術前と同様な摂食量で良好なQOLであった。合併症はあるものの機能障害を残し、手術を要するものとはなかった。手技の盲然には時間を要し、熟達者のライブの見学と同時に、最初は小さい病変や良性病変を行うことが大切と思われた。
全文取り寄せ	可	否	MM症例数不明	2006061372	日本語	村上 祐司、赤木 由紀夫、田中 清浩、木村智樹、梅文 明彦、渡安祐子、和田崎 晃一、広川 裕、伊藤 勝雄	【期食道癌】に対する放射線治療	日本放射線腫瘍学会誌	2005	17(3)	149-154	原著論文	【目的】期食道癌に対する放射線治療成績を検討し報告した。【対象と方法】化学療法を併用せず放射線治療を施行した期食道癌81例(m1-2:28例,m3+m1:30例,m2-3:30例,不明:3例)を対象とした。照射野EMR施行率は65%で、m1+m2症例では約6割を占めた。放射線治療は、m1-2症例は腔内照射単独、m3以上では外照射・腔内照射にて加療した。経過観察期間中は生存例で中央値58ヶ月であった。【結果】5年全生存率、原病生存率は61%,83%であった。深達度別では、m1-2,m3+m1,m2-3症例の5年全生存率は81%,67%,35%,5年原病生存率は100%,81%,63%であった。81例中29例(32%)に再発を認め、深達度別再発率は、m1-2:29%,m3+m1:23%,m2-3:47%であった。初再発部位は食道22例、領域リンパ節4例、食道+領域リンパ節同時発症2例、部位不明1例で、食道再発はm1-2では異時性多発癌が63%を、m3以上では局所再発が69%を占めた。救済可能であった症例は、表在癌の状態で見出し得た食道再発症例が主体であった。再発は5年程度まで比較的長期にわたり認めた。G3以上の有害事象は食道潰瘍を5%に認めた。【結論】m1-2では、異時性多発癌を考慮した照射野設定が必要であり、m3以上では治療成績向上のため化学放射線治療を考慮すべきである。再発の早期発見・救済のため治療後5年間は厳密な経過観察が必要である(著者抄録)。
除外	非合数			2006059410	日本語	有馬 美和子、有馬 秀明、多田 正弘	【消化管癌の微小血管診断学とは】 表在食道癌の微細血管像による深達度診断	消化器内視鏡	2005	17(12)	2076-2083	原著論文/特集	拡大内視鏡観察で得られる微細血管像からみた、食道表在癌の深達度診断について検討した。拡大観察で描出される微細血管パターンは、大きく4つに分類された。type 1は細く直線的な乳頭内血管が観察されるもので、ほとんどは健康粘膜であった。type 2は血管の伸長や血管径の拡張はあるが、乳頭内血管構造が保たれるもので、炎症性変化が大半を占めた。type 3は乳頭内血管構造の破壊と口径不同を伴う螺旋状血管や潰れた赤丸状血管がみられ、配列が不揃いなもので、m1・m2癌がほとんどであった。type 4は乳頭構造から逸脱した不整な多重状・樹枝状・網状の血管を示すもので、m2深部以深に浸潤した癌にみられた。浸潤部で形成される腫瘍塊は、avascular area(AVA)として認識されるようになり、AVAを取り囲むストレッチされたtype 4血管が観察された。AVAの大きさは癌深達度と密接な関係があり、m2深部浸潤癌で10.0-5mm以下(type 4S),m3+m1癌では3mm以下(type 4M),m2+m3癌では3mmを超える(type 4L)と、大きく深達度が鑑別できる。拡大内視鏡による微細血管像を捉えることで、内視鏡的組織診断が可能であり、浸潤部の範囲と深達度の診断ができる(著者抄録)。
除外	非合数			2006059409	日本語	井上 晴洋、加賀 まこと、菅谷 聡、佐藤 嘉高、小倉 紀子、星崎 均、工藤 達美	【消化管癌の微小血管診断学とは】 血管パターン分類からみた食道粘膜の性状診断	消化器内視鏡	2005	17(12)	2069-2075	解説/特集	食道においては、拡大内視鏡観察による微小血管(IPCL)/パターンの変化が、癌・非癌の質的診断および癌の深達度診断にきわめて有用であることを報告してきた。正常粘膜では、上皮乳頭内毛細血管ループ(IPCL)が小さい赤点(red dots)として同定される。IPCLパターン分類では、上皮内癌ではヨド不安定ななかIPCLの変容として、1)拡張、2)走行、3)口径不同、4)形状不揃い、の4つの変容が確認し認められること、IPCL type V-I)が多い。この分類では、type Iの正常粘膜からtype-V-Iのm1の癌まで1)分類される。Type IIは非腫瘍で、炎症に相当し、type IIIは食道炎やlow grade dysplasia,IVはlow gradeの一部あるいはhigh gradeのdysplasia)に対応する。type V-Iの多くは、high grade dysplasiaあるいはm1に相当する。m2,m3になるにつれ、IPCLの破壊は徐々に進行し、さらにIPCLの変化は深部に向かって延長される。IPCLが破壊され消失すると、新生の腫瘍血管(new tumor vessels)VNを観察する。VNは浸潤に特徴的である。微小癌の描出し上げには、拡大内視鏡は不可欠で、1)発赤した局面をみつねること(領域の形成)、2)樹枝状血管網(正常血管網)の遠見の消失、3)凹凸不整の局面をみつねること(白色調の辺縁隆起)、4)その局面のなか存在するIPCLの変化(IPCL type IV)を観察することである。この4つが微小癌の拾い上げのポイントである(著者抄録)。
除外	非合数			2006016590	日本語	島田 英雄、千野 修、西 隆之、山本 壮一郎、原 正、幕内 博康	【消化管腫瘍の内視鏡的診断と治療】最新の動向を探る】 内視鏡治療の適応病変と治療戦略 食道癌 深達度からみた治療方針	内科	2005	96(4)	638-641	解説/特集	食道表在癌は多岐にわたる治療法を選択できる領域である。標準治療として、m1,m2ではリンパ節転移の可能性もなく、内視鏡治療のよい適応である。m2,3リンパ節転移も高頻度に認められ、外科切除が施行されている。m3,m4はこれらの境界的領域にあり、リンパ節転移のない症例では、内視鏡治療の適応拡大ができると思われている。深達度診断や転移リンパ節診断の精度に限界がある状況では、内視鏡治療後の病理組織検査から追加の外科手術や化学放射線療法なども施行されている。(著者抄録)
全文取り寄せ	可	否	MM症例数不明	2005275492	日本語	松本 康男、杉田 公、秋山 修宏、船越 和博、本山 展隆、加藤 俊幸、新井 太、斎藤 真理	【期食道癌】に対する放射線治療成績の検討	臨床放射線	2005	50(7)	864-869	原著論文	放射線治療を行った期食道癌58例(男56例・女2例、平均66歳)の成績を報告した。深達度は粘膜癌(m)が12例、粘膜下層癌(sm)が41例、不明が5例で、放射線単独が26例(A群)、化学療法併用は32例(B群)であった。経過観察中中央値35.1ヶ月で、全体の5年生存率は57%、原病生存率は62%、局所再発生存率は42%であった。深達度別生存率は、m癌70%,sm癌57%であったが有意差はな。A群とB群との間にも有意差はなかった。A群を外照射単独13例(A1群)と腔内照射併用13例(A2群)に分けると、A1群とB群で生存率に有意差傾向がみられた。治療法別にみると、局所再発率はA1群がやや高く、深達度別にみるとm癌では治療法別の局所再発率に差はなかったが、sm癌は外照射単独で局所再発が多い傾向がみられた。リンパ節単独再発は3例のみで、いずれも腹部リンパ節転移であった。照射野内リンパ節の単独再発はなかった。
除外	非合数			2005270953	日本語	有馬 美和子、多田 正弘	【EUSによる診断と治療】 現状と将来展望】 食道癌のEUS診断	臨床消化器内科	2005	20(11)	1499-1505	解説/特集	内視鏡的粘膜切除術(EMR)の適応決定、表在食道癌へのEMRや治療、進行癌に対する手術や化学放射線療法(CRT)の選択など、治療方針の決定には正確な深達度とリンパ節転移診断が不可欠である。表在癌の深達度診断には細径超音波プローブを用いるが、sm以下深達には超音波内視鏡(EUS)専用機が適している。誤診例は少なく、他臓器浸潤診断もCTより精度が高い。系統的な頸動脈弓領域リンパ節の検査は、両側動脈や血管との位置関係から判断するため、EUS専用機を用いる必要がある。微小転移の診断には限界があるが、CTや超音波検査の2-3倍の転移リンパ節を診断できる。治療方針の決定に直結する場合にはEUS下穿刺生検(EUS-FNAB)を行うが、定期的かつ長期的な経過観察が重要である(著者抄録)。
除外	非合数			2005108265	日本語	石原 立、飯石 浩彦、森野 晃治、杉本 直俊、上堂 文也、楢原 啓之、竜田 正晴	【Quality of Lifeを考慮した高齢者消化器癌の治療選択】 高齢者食道癌に対する内視鏡的粘膜切除術	老年消化器病	2004	16(3)	149-155	解説/特集	食道癌に対する内視鏡的粘膜切除術は正しい適応のもとに行えば、根治性および術後のQOLが高く非常に優れた治療法である。一般的には転移の可能性がない深達度m1,m2の食道癌がEMRの適応とされている。一方、リンパ節などへ転移している可能性がある症例では外科手術が標準的治療とされている。外科手術は根治性に優れた治療ではあるが、術後合併症の危険性やQOLの低下があり、高齢者においてはそれらがその後の生活に重大な影響を与える可能性がある。従って、高齢者ではたとえEMRの適応から外れる症例でも、EMRを行った場合に再発する危険性と外科手術や化学放射線療法を行った場合の各種危険性をとを勘案した上で最も良い治療を柔軟に選択すべきである(著者抄録)。

除外	非合数			2005075231	英語	Kumagai Youichi, Inoue Haruhito, Kawano Tatsuyuki	MAGNIFYING ENDOSCOPIC OBSERVATION OF SUPERFICIAL ESOPHAGEAL CARCINOMA(表在性食道癌の拡大内視鏡的観察)	Digestive Endoscopy	2004	16(3)	277-281	原著論文	食道癌の腫瘍浸潤の深さを超高度拡大内視鏡にて観察した。その結果、乳頭内部のlooped毛細血管(intrapapillary capillary loop:IPCL)の観察に成功した。m1癌内部のIPCLはcaliberにおいて拡張、網状化、様々な形状のような異常な変化を示した。表在性食道癌は深浸潤型によって特徴的な変化を示すことが確認された。超高度拡大内視鏡を用いた表在性食道癌の正確な診断率は、はっきした面像が得られた症例において83.1%であった。超高度拡大内視鏡を用いた表在性食道癌の微小血管構造の観察は、特に粘膜防壁(m3)に達する表在性食道癌、及びわずかに存在する粘膜下組織(sm1)表在性食道癌の腫瘍浸潤を診断するに有用であると考えられた。	
全文取り寄せ		可	否	2005039364	日本語	江頭 秀人、柳澤 昭夫、加藤 洋	m3食道癌におけるリンパ節転移予測因子 滴状浸潤(droplet infiltration)の有用性	Gastroenterologic Endoscopy	2004	46(9)	2086-2094	原著論文	外科切除m3食道癌27例を対象にリンパ節転移と関連する具体的な滴状浸潤(d)の組織像を求め、リンパ節転移予測因子としての有用性について検討した。その結果、m3食道癌のリンパ節転移予測因子としての組織像は、長径 $\leq 20\mu m$ と構成細胞数 ≤ 4 であり、その感度、陽性結果の精度比は脈管侵襲と同等以上であった。	
全文取り寄せ	可	否	small sample size	2004180286	日本語	門馬 久美子、吉田 操、小澤 広、川田 研郎	【食道癌の診断と治療】 胸部食道癌の治療 内視鏡的粘膜切除	消化器外科	2004	27(1)	83-89	解説/特集	早期食道癌の内視鏡的粘膜切除において粘膜切除の適応は、1)癌の壁浸潤度 2)病変の大きさ 3)病変数 4)病変の組織学的特徴の4つの因子で決定され、リンパ節転移が不要なm1,m2癌が粘膜切除の絶対的適応である。局所再発率は8.3%、全例分割切除例であり、粘膜切除後1年以内に6%が発見された。局所再発病変の大半は粘膜切除にて治療を行い、全て粘膜癌であった。異時性食道癌は10%にみられ、粘膜切除にて治療し、全て粘膜癌であった。食道粘膜癌での食道癌死は2例であり、治療拒否の多発食道粘膜癌症例と肺結核と腫瘍にて治療の既往のある手術拒否のm3癌症例であった。	
全文取り寄せ	可	否	MM症例数不明	2004134029	英語	Shimizu Yuichi, Tsukagoshi Hroyuki, Fujita Masahiro, Hosokawa Masao, Kato Mototsugu, Asaka Masahiro	RECURRENT AFTER ENDOSCOPIC MUCOSAL RESECTION OF ESOPHAGEAL SQUAMOUS CELL CARCINOMA INVADING THE MUSCULARIS MUCOSAE OR UPPER SUBMUCOSA(粘膜筋板(m3)または上粘膜膜下(sm1))に侵襲している食道扁平上皮癌の内視鏡的粘膜切除(EMR)後の再発	Digestive Endoscopy	2003	15(4)	266-269	原著論文	1992~2001年にEMRを行ったm3或いはsm1の34例について検討し、5例で術後経過観察中に遠隔転移或いはリンパ節転移を見出した。患者1は3ヵ月後に再転移で死亡した。患者2は扁平上皮癌(SCC)病変が異常高頻度の化学療法を行った。患者3は6ヵ月後に上咽頭リンパ節転移で死亡した。患者4は1ヵ月後に胃転移のため胃全摘を行いEMR後81ヵ月以上経過後リンパ節転移のため放射線化学療法を実施した。患者5は42ヵ月後に超音波内視鏡で噴門部リンパ節転移を認め、根治的郭清を行った。以上より、拡大EMRを行った患者は注意して長期的経過観察を行い、早期リンパ節転移を発見して治療すべきと考えられた。	
除外	非合数			2004097955	日本語	荒井 渉、端谷 好則、齋藤 心、平嶋 勇希、横山 卓、横藤 正信、安田 達和、永井 秀雄、西野 宏	頭頸部癌に重複した食道表在癌治療経験・内視鏡によるスクリーニング及びフォローアップの重要性	栃木県医学会々誌	2003	33	178-181	原著論文	頭頸部癌に重複した食道表在癌治療経験を報告した。対象は、1992年~2003年5月までに治療した8例(全例男性、平均59歳)であった。頭頸部癌は下咽頭癌4例、喉頭癌2例、甲状腺癌、舌癌各1例で、甲状腺乳頭癌を除き全てが扁平上皮癌であった。治療は放射線照射を主体とした集学的治療を施行した。表在癌発見の契機は、頭頸部癌治療前のスクリーニング時4例、頭頸部癌治療後の定期検査による内視鏡検査が2例、表在癌治療後の下咽頭癌発見が1例であった。重複部位はm1が4例、m2が2例、m3とsm1とが各1例で、深浸潤はm2が2例、m2以下が4例であった。治療は内視鏡的粘膜切除術が4例、根治術が2例、放射線治療が2例であった。転移は2例に下咽頭癌死を認めたが、表在癌による死亡はなかった。なお、頭頸部癌(喉頭癌)に重複した進行食道癌7例では、頭頸部癌治療後3年以上経過してからの発見(6例)、原病死5例と極めて予後不良であった。	
除外	総説			2004069107	日本語	吉田 操	【食道癌治療 最近の話題】 食道癌治療ガイドラインにみる標準的治療と問題点	臨床消化器内科	2003	18(11)	1545-1551	解説/特集	食道癌治療のガイドライン作成の目的は、食道癌の治療が多様化した。現在、標準的治療法を示し、患者にとって適切な治療法の選択が行われることである。リンパ節転移頻度が低い粘膜癌には内視鏡的粘膜切除術(EMR)が第一選択であるが、大ききや深浸潤に限りがある。T1b,T2,T3癌に対しては進行癌としての治療が行われる。リンパ節転移は高頻度で、占居部位にしたがってその分布に特徴がある。頭部食道癌ではリンパ節郭清のほか、喉頭の遠位、食道の切除範囲等を検討する必要がある。胸部食道癌の場合は、右側胸膈膜下に三領域郭清と食道再建術を伴う根治手術が標準的治療である。	
除外	総説			2004069101	日本語	西尾 正造、明神 美弥子、西山 典明、田口 大志	【食道癌治療 最近の話題】 食道表在癌の放射線治療	臨床消化器内科	2003	18(11)	1499-1506	解説/特集	食道表在癌のevidenceは、レトロスペクティブな非実験的研究の報告が多く、手術治療とEMRと放射線治療の厳密な比較は困難である。しかし、リンパ節転移の明らかなない症例は、放射線治療のよい適応となる。原病生存率で比較すると、最近の報告ではリンパ節転移のない症例ではsm癌の遠隔成績は手術療法と放射線治療はほぼ同等である。今後の非切除治療では、治療しにくい切除が必要な症例の選別が必要であり、そのためには正確な深浸潤診断、リンパ節転移や脈管侵襲の情報をもちいた治療法の検討が必要である。又、総合的な視点では重複癌への対応も重要な課題である。	
全文取り寄せ	可	否	review	2003311833	日本語	門馬 久美子、吉田 操	【食道癌治療の進歩】 食道癌に対する内視鏡的粘膜切除	癌と化学療法	2003	30(7)	914-919	原著論文/特集	食道癌に対する内視鏡的粘膜切除の適応は、深浸潤ではm3,m1癌へ拡大されつつあり、局所再発では一括切除で治療可能な病変が狭窄では3/4以内の粘膜欠損にて治療できる病変が最適である。粘膜切除後19例の予後は、死亡例3例(14%)、うち食道癌死は4例(13%)、残り2例中、他病死は19例(61%)、他癌死は8例(26%)であった。臨床的に完全切除と判定し、治療を終了した食道粘膜癌の3%に局所再発のみならず、局所再発例は全例分割切除例であり、分割切除例数が多い再発率が高かった。局所再発の67%は1年以内に発見され、再粘膜切除にて治療した。病変はすべて粘膜癌であった。異時性食道癌の発生は23例(11%)で、63%は粘膜切除後1~3年で発見されていた。粘膜切除施行例で、同時に他臓器癌を合併する症例は33例(15%)、異時性に合併する症例は37例(17%)であった。他臓器癌としては、胃癌と頭頸部癌の頻度が高かったが、全身のいずれの臓器にも発生する可能性があり、最低年1回は検索を行う必要があると考えられた。	
全文取り寄せ	可	否	small sample size	2003274641	日本語	上野 正紀、宇田川 晴司、堤 謙二、木ノ下 義宏、小柳 泰久	m3・sm1食道癌の浸潤形態とリンパ節転移に関する検討	日本外科学系連合学会誌	2003	28(2)	181-186	原著論文	術前治療なく根治切除されたm3癌32例、sm1癌33例を対象とし、局所治療の妥当性と追加治療の要否の判定の可能性を検討した。治療前所見では、腫瘍の大きさは転移に関係なく、肉眼型で隆起型を含むものに転移が多い傾向があった。組織所見では、m3癌ではly(-)のN-1型、sm1癌ではSm浸潤距離 $\leq 300\mu m$ のN-1型はリンパ節転移なく、局所治療のみで根治できる可能性が高い。浸潤形態とSm浸潤距離の観察はm3/sm1食道癌のリンパ節転移を考える上で有用であった。	
全文取り寄せ	可	否	Subjects are included in another paper	2003229864	日本語	門馬 久美子、吉田 操、山田 真也、小澤 広、加藤 久人、加澤 玉恵、雨宮 こそえ、荒川 文夫、熊谷 洋一、出江 洋介、大橋 健一、船田 信爾	【食道癌と他臓器重複癌 EMR時代を迎えて】 食道癌EMR症例における他臓器重複癌	胃と腸	2003	38(3)	299-306	原著論文/特集	食道早期癌粘膜切除220例を対象に、他臓器重複癌に関する検討を行った。その結果、他臓器癌の合併は81例(37%)に認め、初回治療病変は単発例61例、多発例20例で、食道癌深浸潤度はm1~2が61例、m3~sm1が18例、m2以下2例であった。他臓器癌の合併時期は、他臓器癌先行72例、同時性他臓器癌合併34例、異時性他臓器癌合併37例で、合併時期を問わず、食道癌を含め2臓器癌は61例、3臓器癌は18例、4臓器癌は2例であった。他臓器重複癌の発生部位は、胃癌が35例と最も多く、次いで頭頸部癌31例、大腸癌11例、肺癌9例、中咽頭癌、肝臓癌各6例の順であった。異時性他臓器癌を発見時期で分けた場合、粘膜切除後3年以上以内が20例、3~5年が13例、5年以上以降が10例であった。他臓器重複癌合併例における死亡例は22例で、他病死11例、癌死11例であった。	
除外	非合数			2003229863	日本語	佐藤 浩、高木 隆、逢坂 由昭、里野 澄人、篠原 玄夫、尾形 高士、立花 慎吾、青木 達哉、小柳 泰久	【食道癌と他臓器重複癌 EMR時代を迎えて】 頭頸部癌に重複した食道表在癌の臨床像とその病理像 食道系研究会アンケート調査の報告	胃と腸	2003	38(3)	291-298	原著論文/特集	頭頸部癌に重複した食道表在癌に関するアンケート調査を行い、その成績を報告した。その結果、50施設より回答が得られた。1999~2001年の3年間で頭頸部癌患者3000例、色澤内視鏡が行われ、うち261例(8.7%)に食道癌が発見された。重複癌317例の内訳は、同時性59.6%、異時性頭頸部癌先行28.1%、異時性食道癌先行10.1%で、同時性の82.4%、異時性の73.0%が頭頸部癌先行であった。頭頸部癌の発生部位は下咽頭が41.9%と最も多く、次いで喉頭21.7%であった。喫煙率77.6%、Brimkam index 1053.0、飲酒率63.0%、Sale index 104.1といずれも高値を示した。食道癌の内視鏡型は0-IIc 47.3%、0-IIb 20.5%で、長径は11~20mmが90.7%と最も多く、深浸潤はm1,m2が49.1%を占めた。食道不楽帯の数はまだら食道が29.3%と最も多く、食道多発発癌は32.8%に認められた。治療方法は、m1,m2の58.7%にEMRを、m3,sm1の54.8%とsm2,sm3の76.6%に手術が施行され、全体の12.0%に放射線・化学療法が行われた。	
除外	非合数			2003209063	日本語	有馬 美和子、多田 正弘	【食道表在癌の治療戦略】 食道m3・sm1癌に対するEMR後の局所・リンパ節再発の早期診断	消化器内視鏡	2003	15(3)	389-396	原著論文/特集	食道表在癌145例を対象にEMRを施行し、その後の局所・リンパ節再発について検討した。その結果、局所再発は10例(6.9%)にみられ、うちm3・sm1癌の局所再発は24例中1例であった。局所再発は背脊粘膜が顕なコード不楽を示す例と、分割数が多かった例にみられ、このような症例は要注意病変として、経過観察の間隔を短く設定する必要があると思われた。局所再発病変の形態は、わずかな発赤や陥凹の0-IIa型や0-IIc型を示し、1年後に線状皺襞がコード不楽を示し、再EMRとなり、深浸潤m2であった。EUSによる食道表在癌のリンパ節転移診断成績は、sensitivity 80%,overall accuracy rate 83%で、CTの値リンパ節転移を診断できなかった。以上の結果から、EMR拡大適応症例ではEUSとともに、EUSの弱点をカバーする検査として、頭部超音波でNo.104領域、CTでNo.16と他臓器転移を検索し、これらをセットにして6ヵ月ごとにfollow-upを行うことが効果的と思われる。	

除外	非含数				2003209059	日本語	小山 恒男, 菊池 勇一, 宮田 佳典, 友利 彰寿, 島谷 茂樹, 福田 欣一	【食道表在癌の治療戦略】 フックナイフを用いた切開剥離法による食道m1・m2癌の治療成績	消化器内視鏡	2003	15(3)	357-363	原著論文/特集	食道表在癌のEMR手法として、新たにフックナイフを用いた切開剥離法(フックナイフ法)を開発したフックナイフ法は、病変周囲の粘膜を全周性に切開した後、フックナイフを用いて粘膜下層の線維や血管を剥離し、病変を切除する方法で、100mm程度の一括切除を安全に施行できるフックナイフ法によるEMRを深達度m1・m2の食道表在癌59例に施行した結果、一括切除率は95%、穿孔率0%、局所再発率0%であった。また、本法による一括切除標本は吸引の影響や把持鉗子による挫滅もなく、外科切除除と同等の十分な病理学的検索を施行しえた。出血をきたした場合には、出血部位を確認して止血鉗子で血管を把持し、凝固通電にて止血する凝固止血法が有効であった。以上よりフックナイフ法は有用なEMR手法と思われる。
除外	総説				2003180816	日本語	門馬 久美子	【消化器疾患の内視鏡的治療 最近の進歩】 消化管早期癌の内視鏡的治療 食道癌 適応拡大への動向	日本内科学会雑誌	2003	92(1)	10-20	解説/特集	外科切除と粘膜切除治療例を対象に、m3とsm1癌の解析と適応拡大について検討し述べた。リンパ節郭清を含めた外科切除を行えば、ほぼ根治可能で、m3・sm1癌に対し、手術侵襲の大きさと術後のQOLの点から、食道を温存する治療が望まれている。今後リンパ節癌の診断精度が向上し、粘膜切除後の合併症群と追加未治療群の長期予後が判明すれば、m3・sm1癌に対する治療は、1)粘膜切除治療単独群、2)粘膜切除+合併症法群、3)リンパ節郭清を含めた外科切除群の大きく3つに分かれると思われる。しかし、現時点で言えることは、術前診断にて深達度を浅読みするようなm3癌には、粘膜切除の適応が拡大できると言うことである。
除外	総説				2003180815	日本語	井手 博子, 太田 正徳	【消化器疾患の内視鏡的治療 最近の進歩】 消化管早期癌の内視鏡的治療 食道癌 適応、方法、成績 食道表在癌に対する内視鏡的粘膜切除術	日本内科学会雑誌	2003	92(1)	4-9	解説/特集	内視鏡的粘膜切除術(EMR)は食道表在癌に対する低侵襲な治療法として広く普及し数多くの施設で行われているようになった。又近年では適応の拡大と長期予後をめぐる検討がなされている。深達度ではリンパ節転移の可能性が低。m2までで一括切除による病変の完全な切除を期待できると、2/3層以下、長さ2～3cm以下の病変が対象となる。多発病変は各々の病変がEMRの適応範囲内であれば適応と考えようと思われる。代表的なEMRの手法、成績、合併症の予防と対策、EMR後の経過観察について概説した。
除外	総説				2003178614	日本語	根本 建二	食道表在癌の治療展望 放射線治療を中心に	日本医学放射線学会雑誌	2002	62(14)	801-807	総説	食道表在癌は、その深達度が食道の粘膜下層までにとどまる食道癌である。これまでX線や通常の内視鏡検査では発見が困難な場合が多かったが、化学療法普及と内視鏡技術の進歩に伴い、近年では発見の割合が増加傾向にある。現在、その治療はm2まではEMR、それ以外は手術が標準治療である。放射線治療はsm癌で標準治療となる可能性をもっているが、今後の化学療法併用での長期治療成績の見極めが必要である。又、放射線治療法の標準化はなされておらず緊急に解決しなければならない問題である。
全文取り寄せ	可	否		MM症例数不明	2003164186	日本語	田村 茂行, 西岡 清訓, 安田 卓史, 藤原 義之, 滝口 修司, 矢野 雅彦, 門田 守人	【食道癌EMR後の長期予後】 EMRの長期経過と問題点	消化器科	2002	35(6)	622-629	原著論文/特集	内視鏡的粘膜切除術(EMR)を行った食道扁平上皮癌83例を対象に、その長期成績について検討した。その結果、局所遠発再発はEMR後2～24ヵ月で9例(6%)みられ、m1が9例、m2が3が各1例でいずれもEMR導入初期例であり4例は発赤を伴う浅い陥凹で発見され、再EMRにて治療し得た。異時性多発癌は6例(13%)認め、特に頭頸部癌症例ではその頻度が高く28.6%に及んだ。頭頸部癌症例ではEMR後6～12ヵ月以内に発見されたが、頭頸部以外の症例では14～45ヵ月の発見であった。他臓器重複癌は20例(32%)みられ、臓器別では頭頸部癌と胃癌で90%を占めた。m3とsm1癌のリンパ節転移率は、それぞれ6.7%、30.0%で、特にM領域の癌では頭部からp1,2,3,7の追加治療を行う必要があると思われる。以上よりEMR後のサーベイランスでは、局所再発に加え異時性多発と他臓器重複癌の発生に注意し、長期に亘る観察が必要と思われる。
全文取り寄せ	可	否		MM症例数不明	2003164185	日本語	島谷 茂樹, 小山 恒男, 宮田 佳典, 友利 彰寿, 堀田 欣一	【食道癌EMR後の長期予後】 食道癌EMR症例の長期予後	消化器科	2002	35(6)	618-621	原著論文/特集	内視鏡的食道粘膜切除術(EMR)を行った食道表在癌103例の深達度により、m1・m2群81例とm3・sm1群22例に分けて長期予後を検討した。その結果、追加治療は、m3・sm1群の7例に行い、放射線化学療法5例、放射線照射、手術各1例であった。局所再発は、m1・m2群の2例で認め、それぞれ3ヵ月後、7ヵ月後に再発して追加EMRまたは放射線治療で治療し得た。異時性多発は、m1・m2群の15例で認め、内14例は表在癌の状態で発見されEMRで治療し得たが、1例は2型進行癌として発見され、放射線化学療法でCRが得られた。予後は、m1・m2群では生存73例、他病死8例であった。m3・sm1群では追加治療なしの15例と放射線化学療法追加5例の計20例が生存中で、放射線療法追加例と手術追加例の計2例は、それぞれ放射線心外膜炎、肺癌で死亡した。他病死を含む5年生存率は、m1・m2群93%、m3・sm1群88%であった。
全文取り寄せ	可	否		MM症例数不明	2003164184	日本語	橋原 啓之, 石原 立上, 堂 文也, 飯石 浩康, 竜田 正晴, 土岐 祐一, 佐 真能 正幸	【食道癌EMR後の長期予後】 食道表在癌m3・sm1へのEMR後の経過	消化器科	2002	35(6)	612-617	解説/特集	
全文取り寄せ	可	否		MM症例数不明	2003164183	日本語	高木 晴貴, 若下 明徳, 原岡 誠司, 松井 敏幸, 菊池 隆介, 八尾 恒良	【食道癌のEMR後の長期予後】 食道表在癌のEMRに関する臨床病理	消化器科	2002	35(6)	606-611	解説/特集	近年、早期食道癌に対する内視鏡的粘膜切除術(EMR)は多くの施設で行われ、その適応としてリンパ節転移のない粘膜固有層までの癌、即ちm1,m2癌でコンセンサスが得られている。最近では、3領域リンパ節郭清を含む外科的切除が行われてきた。m3・sm1癌でも、そのリンパ節転移率が6%から26.5%であることから術後の残存及びpT4aの重注に伴ってEMRの適応が拡大の傾向にある。これに伴い、m3・sm1癌のリンパ節転移陽性率における臨床病理学的所見とEMR後の根治性、及び追加治療の判断において極めて重要と考えられている。著者等が行ったEMR症例の成績と共に臨床医が留意すべき病理学的事項について総説的に概説した。
除外	非含数				2003164181	日本語	清水 勇一, 加藤 元朗, 塚越 洋元, 細川 正夫, 藤田 昌宏, 浅香 正博	【食道癌EMR後の長期予後】 食道癌EMR後の異時性多発癌	消化器科	2002	35(6)	596-599	原著論文/特集	過去5年間に内視鏡的粘膜切除術(EMR)を行った食道扁平上皮癌82例を対象にヨード染色内視鏡を用いて異時性多発癌の発生頻度について検討した。その結果、異時性多発癌は12例(14.6%)にみられ、発生までの期間は14～58ヵ月であった。いずれも単発癌として指摘されたが、内2例はその後第3癌が認められた。病変部の深達度は、m1が10例、m2が2例、最大径は全て5mm～10mmであり、全例再EMRにて治療し得た。異時性多発癌発生例の割合は、group Uで66例中6例(9.1%),group Sでは16例中6例(37.5%)とgroup Sで発生率が有意に高かった。
除外	総説				2003163795	日本語	西崎 朗, 川口 勝徳, 奥谷 晃一, 廣畑 成也, 安武 俊夫, 前田 哲男, 仁木 敬樹, 長野 秀徳, 谷岡 洋明, 花房 正雄	【実地診療とバレット食道】 Barrett食道癌の治療方針 自験例及び本邦報告内視鏡的粘膜切除施行早期Barrett食道癌例の検討を含めて	消化器の臨床	2002	5(6)	699-704	解説/特集	Barrett食道癌の治療は外科的治療・内視鏡的治療にわけられるが、粘膜内には内視鏡的治療が粘膜下層に深達するには外科的治療がその適応と考えられている。治療方針は患者の全身状態、病変の部位や深達度、病期・Barrett上皮の長さ等の要因により決定される。しかし、Barrett食道癌には、症例数が扁平上皮癌に比し、少ない・m3癌新発症頻度陽性例の存在・進歩Barrett上皮からの癌の異時性多発・治療後長期経過観察例が少ないなどいくつかの問題が残されており、内視鏡治療の妥当性の証明・外科的術式の標準化には更なる症例の積み重ねが必要である。
除外	総説				2003161490	日本語	門馬 久美子, 吉田 操	【EMRの高度な技術】 早期食道癌に対するEMRの標準的適応	消化器内視鏡	2002	14(11)	1714-1718	解説/特集	内視鏡的粘膜切除の適応は、癌の壁深達度、病変の大きさ、と腫在性、病巣数、腫瘍固有の条件の4つで決定されている。各要素における粘膜切除の標準的適応とは、以下のとおりである。1)癌の壁深達度ではリンパ節郭清が不要な、m1・m2癌、2)病変の大きさでは、局所再発と病理組織学的診断の問題から、一括切除が可能な、2.5～3cm前後の病変、腫在性としては、食道狭窄を起こさない、3)4層以上の粘膜欠損にて治療できる病変、3)病巣数では、個々の病巣が粘膜切除の適応に含ばない病巣数に制限はないが、食道内に無数の不染のあるままに食道は標準的適応とはならない、4)病変固有の条件として、基礎腫型と上皮内癌は切除範囲の決定が困難なため、標準的適応とはならない。
除外	非含数				2003096568	日本語	加藤 久人, 加澤 玉恵, 山田 義也, 門馬 久美子, 葉栗 智子, 出江 洋介, 熊谷 洋一, 吉田 操, 堀 健一	【食道sm癌の再評価 食道温存治療の可能性を求めて】 食道sm癌に対する食道温存治療の可能性 X線の立場からの検討、肉眼形態分類からみたリンパ節転移の推定	胃と腸	2002	37(10)	1285-1293	原著論文/特集	sm浸透食道癌65例を対象に病理組織学的に深達度亜分類、尿管侵襲sm浸透の面積とリンパ節転移の関係、肉眼形態別に検討し、リンパ節転移の少ないsm癌の形態的特徴を割り出し、X線像の形態について検討した。その結果、O-1とO-11型ではリンパ節転移の予測は困難であったが、O-11型病変ではsm浸透面積とリンパ節転移の有無は密接に関連し、臨床的にリンパ節転移の予測が可能と考えられた。リンパ節転移陽性のsm癌は、sm浸透の面積が100mm ² 以下のO-11型病変であり、X線所見は「側面像の壁変形所見の長さ」が15mm以下のO-11型病変であった。
除外	非含数				2003096567	日本語	島田 英雄, 幕内 博康, 千野 修, 西 隆之, 田中 曜, 鶴持 幸弘, 木勢 佳史, 堀野 健治, 山本 壮一朗, 原正, 生越 尚二	【食道sm癌の再評価 食道温存治療の可能性を求めて】 食道sm癌に対する食道温存治療の可能性 内視鏡の立場からの検討	胃と腸	2002	37(10)	1273-1284	原著論文/特集	食道狭き術や他臓器重複癌を除く3領域リンパ節郭清を伴う胸部食道癌切除例の133例とsm癌に対する相対的EMR例の29例を対象として、深達度とリンパ節転移の状況について再評価を行った。腫瘍長径と深達度に関連性はなかったが、腫瘍長径が50mm以上の症例でリンパ節転移の頻度が高かった。又、肉眼病型については、O-loopやO-11c・11dを含む進行癌様の病型は症例数が少ないながら、リンパ節転移の危険群と推察された。予後に関してはリンパ節転移陰性例とリンパ節転移陽性例との間で、有意差がなかった。
除外	非含数				2003096566	日本語	藤田 昌宏, 安部 達也, 細川 正夫, 久須美 貴哉, 草野 真稀, 塚越 洋元, 中野 友彦, 関根 一郎, 矢和田 敦, 菅原 伸明, 清水 勇一, 山本 博幸	【食道sm癌の再評価 食道温存治療の可能性を求めて】 食道粘膜下層癌の病態 病理学の立場から	胃と腸	2002	37(10)	1263-1272	原著論文/特集	食道癌のうち粘膜下層癌(sm癌)切除例217例を対象に、sm1,sm2,sm3と細分類して、食道sm癌のリンパ節転移の危険性、予後判断に対する危険因子について検討した。sm1群とsm2,sm3群との間に尿管侵襲陽性率やリンパ節転移率に有意な上昇の差が認められた。リンパ節転移の危険性を示唆する上で、病理組織像から尿管侵襲、sm浸透部の長さ、更にsm癌発生部位における免疫細胞の浸出に加え、C-met陽性smの発現が有意差をもって相関を示し、腫瘍先進部の高度細胞異型と重要な所見となる傾向がみられた。

除外	非合数				2003096565	日本語	真能 正幸、小堂 文也、石黒 信吾、春日 井 勝、小原 由美子、土岐 祐一郎	【食道sm臨の再評価 食道温存治療の可能性を求めて】 食道sm臨に対する食道温存治療の可能性 病理の立場からの検討	胃と腸	2002	37(10)	1257-1262	原著論文/特集	食道表在癌手術症例のうち粘膜筋板下端より最深部迄の垂直浸潤長が201μm以上(sm2-3癌)であった49例を対象に検討した。横径以外の諸計測値にリンパ節転移陽性群と陰性群間に差は認められなかった。臨床病型では両群な陽転群例ではリンパ節転移陽性であったが0-Ⅱ型では3例全例(リンパ節転移を認め、臨床病型と転移との関連が示唆された)しかし他にリンパ節転移の有力な指標を認めなかったsm2-3癌ではリンパ節転移と関連した因子が少ない為、内視鏡的粘膜切除術を主体とした食道温存治療の適応は低く、別の治療戦略が必要である	
除外	総説				2003089442	日本語	吉田 操、門馬 久美子、山田 貴也、小澤 宏、出江 洋介、熊谷 洋一、大橋 健一、船田 信顕	【食道癌治療とQOL】 食道癌に対する内視鏡的粘膜切除術(EMR)の適応拡大	外科治療	2002	87(4)	334-337	解説/特集	内視鏡的粘膜切除法(EMR)の限界を形成する条件は、1)深達度m3・sm1,2)粘膜欠損3/4周以上,3)異時性多発癌などがある。限界の克服が適応拡大である。深達度m3・sm1食道癌のリンパ節転移頻度は約10%。転移陽性例に共通する所見は、病型は0-Ⅰ-0Ⅱ、組織学的には腸管型(+)低分化、γタイプⅡの浸潤などがみられる。これらの要素を避けると外科切除とEMRの成績は同等になる。粘膜欠損が3/4周以上の切除には高率に狭窄を生じるので、狭窄に対する拡張治療をも治療計画に含める。治療後は6ヵ月毎の経過観察が必要である。これの不可能な場合はEMR以外の治療法を選択することも考慮する	
除外	非合数				2002271521	日本語	小澤 広、出江 洋介、山田 貴也、葉梨 智子、加藤 久人、門馬 久美子、柳 信廣、吉田 操	【上部消化管癌の病期診断】 細径ブロープ超音波内視鏡による食道癌の病期診断	消化器内視鏡	2002	14(5)	583-588	解説/特集	食道癌に對して内視鏡治療又は手術の適応を決める場合には、深達度とリンパ節転移を参考にする。細径ブロープ超音波内視鏡は基本的な検査の一つとなりつつある。通常用いる20MHz細径ブロープ超音波内視鏡では食道壁は7層か9層に分離され、粘膜筋板は第4層の低エコー層として描出される。食道癌は低エコーとして描出され、その最深部の層により深達度を診断した。当院での食道癌の深達度の正診率はm臨-sm臨の鑑別では91%であったが、内視鏡治療後の潰瘍傷痕例や腫瘍下にリンパ腫瘍がある症例では深達度診断が困難な場合があった。又リンパ節転移は5mm以上の類球形として描出され、その正診率は96%であった。	
除外	非合数				2002271520	日本語	有馬 美和子、多田 正弘、大倉 康男	【上部消化管癌の病期診断】 食道癌の病期診断におけるEUSの精度	消化器内視鏡	2002	14(5)	573-581	解説/特集	m3以深達食道にはリンパ節転移の危険性があるEMRの適応を拡大するには頸胸腹3領域のリンパ節を検索しておく必要がある。又、進行癌では標準術式である開胸縦断リンパ節郭清をもってしても予後の向上が得られない症例の選択がなされ、積極的に化学・放射線療法を加えるようになっているため、適応決定には正確な深達度とリンパ節転移診断が大切である。系統的なリンパ節の検索は断面臓器や血管との位置関係から判断するため、超音波とエームのペストレーションが良しEUS専用鏡を用いる必要がある。最近では判断に迷うリンパ節が描出され、治療方針の決定に直結する場合にEUS-FNAαを行っている	
除外	非合数				2002271518	日本語	田中 曜、幕内 博康、島田 英雄、千野 修、西 隆之、木勢 佳史、脇侍 幸弘、姫野 信治、田島 隆行、山本 壮一郎、原 正、伊東 英樹、武智 晶彦、星川 龍彦	【上部消化管癌の病期診断】 色素内視鏡を含めた通常内視鏡観察による食道癌の病期診断	消化器内視鏡	2002	14(5)	559-564	解説/特集	食道癌の内視鏡による深達度診断で重要なことは、観察している最中に診断を行うことである。病変の形態では高さや深さ、表面の性状、上ち上がりや辺縁粘膜の性状を見る。色調は赤色のものは1段階深く、白色調のものは1段階浅く(淡む)。0-Ⅱbは殆どm1である。0-Ⅱcは陥凹性の性状で深達度が変わる。隆起では1mm以下の0-Ⅱaはm2以深で1mmを超えるとsm浸潤を認めるものがある。0-Ⅰ型と0-Ⅲ型はsm2以深である。内視鏡による深達度診断の正診率は53例中深達度区分別では416例(78.0%)であったが、治療方針の違つ3群に分けると400例(90.1%)であり臨床的には満足できる結果であった。	
除外	非合数				2002247486	日本語	千野 修、幕内 博康	【内視鏡下手術の全て】 食道の手術 早期食道癌の内視鏡的粘膜切除術 EEMR-tube4段法の適応と手技	外科治療	2002	86(増刊)	671-676	解説/特集	早期食道癌に対する内視鏡的粘膜切除術は、根治性が維持できると同時にその低侵襲性から外科的切除術に代わり治療法の第一選択として急速に普及している。患者等が関心したEEMR-tube4段法は有効な手技と考えられ、必ずしもEMRが先行するEMRの絶対的適応はリンパ節転移のない深達度m1-m2である。しかし、現在ではその適応を拡大しつつあり、深達度m3・sm1症例ではEMR可能病変に対してはまずEMRを施行して病理組織所見を確認している。その結果、1)低分化型,2)inf,γ,3)γ(+),の症例は基本的には外科的根治手術を追加施行している	
除外	総説				2002247445	日本語	吉田 操、門馬 久美子	【食道癌診療の現状と展望】 食道癌の治療 内視鏡所見から見たEMR	日本外科学会雑誌	2002	103(4)	337-342	解説/特集	m3・sm1癌の場合はm1やm2の病巣の中に類粒状或いは小結節状の隆起がある。病変辺縁にm3浸潤がある場合は病変に接する粘膜の軽度隆起を認めるⅡaの部分にやや深い陥凹を示す場合もある。深部浸潤が隆起を示すものが70%、陥凹を示すものが22%である。形態や色調変化を示す診断の困難なものが8%ある。診断困難症例はm3浸潤頻度が高くEMRを適応してもその後良好である。最近では拡大内視鏡による乳頭内血管の観察が深達度診断の向上に役立っている。m1,m2癌の正診率は96%,m3,sm1は75%である。リンパ節転移陽性m3,sm1癌はsm2以上の浸潤を疑わせる内視鏡所見を呈するものが大部分である。EMRを関連して適応する可能性は低い	
全文取り寄せ	可	否	small sample size		2002199093	日本語	中野 静雄、松本 正隆、崎田 浩徳、中島 三郎、奥島 文雄、大脇 智朗、渡越 祥次、馬場 政道、愛甲 孝	【食道m3・sm1癌の診断と遠隔成績】 食道m3・sm1癌の病態 分子生物学的特徴	胃と腸	2002	37(1)	64-70	原著論文/特集	m3・sm1癌のリンパ節転移の危険因子について、m3・sm1と診断された51例を検討した。m3・sm1癌のリンパ節転移の危険因子はDesmoglein 1の発現が陰性。または凝膠産成分γ陽性。術前深達度診断の深読みであった。	
全文取り寄せ	可	否	small sample size		2002199090	日本語	門馬 久美子、吉田 操、山田 貴也、荒川 丈夫、南宮 こそえ、鈴木 剛佳、小澤 広、加藤 久人、柳 信廣、出江 洋介、葉梨 智子、大橋 健一、船田 信顕	【食道m3・sm1癌の診断と遠隔成績】 食道m3・sm1癌の質的・量的内視鏡診断	胃と腸	2002	37(1)	33-46	原著論文/特集	m3癌50例とsm1癌22例を対象に、術前の内視鏡診断と病理組織診断との関係、および、m3・sm1の治療成績について検討した。術前の内視鏡診断では深達度に対する誤診もあったが、治療法の選択という観点からは概ね良好であった。リンパ節転移の診断精度の向上より、m3・sm1癌に対する治療は、粘膜切除治療単独群、粘膜切除+合併療法群、リンパ節郭清を含めた外科切除群の三つに分かれるようになると思われる。	
全文取り寄せ	可	否	small sample size		2002199088	日本語	真能 正幸、上堂 文也、石黒 信吾、春日 井 勝、土岐 祐一郎	【食道m3・sm1癌の診断と遠隔成績】 食道m3・sm1癌の臨床病理	胃と腸	2002	37(1)	11-17	原著論文/特集	深達度m2～sm2の食道表在癌手術症例36例を検討した。深達度に応じた脈管侵襲(pv)率およびリンパ節転移(LN)率の有無な上昇を認め、LN(+)と細胞異型度(pv(+))臓出との間に有意な相関を認めた。内視鏡的粘膜切除術(EMR)の適応となり得るLN(-)症例は内視鏡的に目立つた隆起や陥凹がなく組織学的に(pv(+))を認めず、低異形度で臓出のないものであった。高度異型癌かつ臓出陽性の所見はLN(+)に対して感度100%、特異度76.7%であり、EMR症例の追加治療の判断基準として有用であった。	
除外	非合数				2002129490	日本語	大杉 治則、竹村 雅至、木下 博明	【食道癌治療におけるcontroversy】 胸部食癌に対する胸腔鏡下食道切除術の利点と問題点	臨床外科	2002	57(2)	173-176	原著論文/特集	胸腔鏡下食道切除術の適応を「術前面像検査で強度の胸膜癒着を認めない」「左右肺分離後で麻酔維持が可能」「術前診断で深達度がT1b～T3」の症例としており、低肺機能の症例は適応していない手術では5cmの小開胸を併用し、この前部から独自に作製した気管鞘を導入して気管を徹底的に圧排することにより、気管左側を展開し、左反回神経周囲のリンパ節郭清を行っている。本術式の利点として術後の呼吸機能の回復が早いことや疼痛が少ないこと、胸部創傷が小さく美容上有利であること等が挙げられ、根治性と手術侵襲の面からみると従来の右胸腔下手術と同程度である。本術式が標準手術の一つとして広く認められるためには、リンパ節郭清清くに気管左側を含む頭頸境界部の郭清が従来の手術と同様に行えることが必要条件と考えられる。	
全文取り寄せ	可	否	MM症例数不明		2002081994	日本語	細川 正夫、久須美 貴哉、草野 真鶴、田邊 康、安部 達也、藤田 昌宏	【早期消化管癌に対するEMR 適応拡大をめぐる問題】 食道表在癌に対するEMR 外科の立場からみたm3,sm1食道癌の取り扱い	臨床消化器内科	2001	16(12)	1625-1630	原著論文/特集	術前未治療食道癌のうち表在癌447例を対象に、粘膜筋板癌(m3)、粘膜下層浸潤の癌(sm)へのリンパ節郭清を伴う食道切除術の適応について検討した。その結果、現時点での治療方針として、M3疑う場合は診断的EMRを行ひm3でEUS,CTなどで転移を認めなければ、内視鏡的粘膜切除治療で良い。脈管侵襲陽性、凹凸の目立つものや長径5cm以上の大きなものは手術を選択する。SM1の場合は手術が第一選択である。なお検討内容は以下である。1)m3,sm1の頻度 2)m3,sm1の切除例よりみた脈管侵襲とリンパ節転移 3)EUSの深達度診断の正診率 4)リンパ節転移の正診率 5)内視鏡とリンパ節転移 6)多量血 7)死亡率 8)生存率	
除外	非合数				2002059248	日本語	井上 晴洋、吉田 達也、日高 英二、薄井 達也、日高 秀徳、田邊 和朗、坂下 正典、原 亮志、工藤 達美	【細径超音波ブロープで何が見えるか】 細径超音波ブロープは食道病変の治療法選択にどのように関与するか	消化器内視鏡	2001	13(7)	1011-1017	解説/特集	食道癌のうち、平滑筋腫等の良性腫瘍においては、粘膜から内輪筋に由来するものまでは経口内視鏡による治療(ポリペクミー、EMR、筋腫の核出術など)を行い、外縦筋由来のものは鏡視下手術により病変を摘出する。これらの治療法の選択には、細径超音波ブロープを用いて病変の由来を確認することが不可欠である。又、食道癌においては、深達度m2まではEMRの絶対的適応、m3,sm1はEMRの相対的適応、特-cm2以上は鏡視下手術或いは開胸開腹術の適応となる。細径超音波ブロープを用いることで、上記の3種類の癌の深達度を断層像として捉えることができ、その画像は、術前診断において内視鏡像と並んで重要な情報源となる。	

除外	非合数				2001247471	日本語	吉田 操, 門馬 久美子, 山根 智子, 出江 洋介, 梶 博康, 加藤 久人, 山田 義也, 小澤 広, 荒川 文夫, 大橋 健一, 田村 信顕	【消化管癌の深達度診断】食道癌の深達度診断 内視鏡像からみた深達度診断	胃と腸	2001	36(3)	295-306	解説/特集	食道扁平上皮癌のリンパ節転移頻度は癌の壁深達度と相関し,癌浸潤が粘膜固有層(m2)にとどまる限りリンパ節転移は極めてまれで,治療計画にリンパ節転移を考慮しないという浸潤が粘膜筋板(m3)を越え粘膜下層(sm1)に浸潤するとリンパ節転移を生じ,治療計画にこれを考慮しなくてはならないm2型の症例には内視鏡的粘膜切除術が,またm3以上の症例には原則的に根治手術が適応になる,深達度診断は病型の判断が基礎になる,0-I型の92%,0-II型病変の96%は粘膜下層に中程度以上浸潤している,0-IIb型の場合は圧倒的に上皮内(m1)癌が多く,一部にm2がある,0-IIa型と0-IIc型病変の場合は深達度診断を行う必要がある
除外	非合数				2001247455	日本語	井上 晴洋, 船谷 洋一, 藤澤 昭夫, 永井 彰, 河野 辰幸, 岩井 武尚	【新世代の拡大内視鏡】食道疾患の拡大内視鏡診断	消化器内視鏡	2001	13(3)	301-308	解説/特集	食道における拡大観察の特徴は,細血管網の透見である.既に拡大観察で上皮乳頭内毛細血管ループ(PCL)の観察が可能であることを報告した.その変化により食道扁平上皮の性状診断が可能であり,typo1~VIに分類した(上皮の性状診断基準),更にPCLの変化から深達度診断が可能であり,拡大観察による深達度診断基準(m1,m2,m3,sm)を提唱してきた.特に異常血管の出現はsm浸潤に特徴的な所見であった.その正診率は76%であった.80倍の観察が可能なスクリーニングスコープQ240Zの登場によって,拡大内視鏡観察はルーチン検査に位置づけられると考える
除外	総説				2001035140	日本語	幕内 博康, 島田 英雄	【プライマリケアのための消化器疾患の診かた】消化管疾患 早期,表在癌,食道癌に対する治療方針	治療	2000	82(9)	2287-2291	解説/特集	早期・表在食道癌の治療方針の決定には,病巣診断(深達度,リンパ節・遠隔臓器転移),全身状態,他臓器重量を検査する.その上で1)粘膜固有層癌(m1・m2)型に内視鏡的粘膜切除術(EMR)を行う2)m2・sm1には可能であればまずEMRを行い,病理所見を検討して追加治療を考える,3)sm2～では開胸開腹で頸胸腹部三領域リンパ節郭清を伴う外科的根治治療の方針で治療を行う
除外	非合数				2000269125	日本語	今井 賢孝, 大飼 政美, 岡岡 宣夫, 齋田 康彦, 谷田 謙史	当院における食道癌の現状	磐田市立総合病院 誌	1999	1(1)	8-11	原著論文	食道癌患者18例を癌の深達度がsm迄の表在癌と筋層以下に浸潤した進行癌に分類し比較検討した.表在癌は7例で,深達度mの2例にEMRを,深達度smの4例に手術を施行したが,現在まで再発,死亡例はない.他の1例は進達度smで肝硬変を合併し,他院で放射線治療を行った.進行癌は11例で,手術4例,化学放射線療法併用4例,化学療法単独2例,放射線療法単独1例であつて,手術例のうち,3例は進行度がⅢ度までで,術後の経過良好であつたが,4例は進行Ⅳ度で化学療法を併用したが死亡した.手術をせず化学放射線療法を施行した例は全て進達Ⅳ度であり,7例中4例が2年以内に死亡した.進行癌,特に進行Ⅳ度の症例は予後不良であつた.アルコール歴や喫煙歴のある成人男性を対象に,内視鏡で食道粘膜を丁寧に観察して早期発見に努めることが肝要と考えられた.
除外	非合数				2000221743	日本語	西 宏之, 仲原 正明, 城戸 哲夫, 中尾 量保, 辻本 正彦	同時性食道胃重複癌の検討	日本外科学会連合会誌	2000	25(2)	143-147	原著論文	過去7年間の同時性食道胃重複癌は8例で,食道癌8例中9.1%であつた.主な占拠部位は,食道,Ⅱ例,M4例,L3例,胃,Ⅱ例,M3例,L3例で,深達度は,食道,m1例,sm2例,m3例,a2例,a3例,胃,m5例,m1例,ss1例,se1例であつた.手術は食道癌に対し,6例に食道亜全摘,肺動脈併存の1例に食道抜き,m癌の1例にEMRを施行した.胃癌に対しては,ⅡM領域の3例に噴門部切除後胃癌にて再建し,4例に全摘,1例に幽門部切除術を施行した.胃全摘例では空腸にて再建し,1例はmicrosurgeryによる血行再建を併用した.根治度は,食道A4例,B1例,C3例,胃A7例,B1例であつた.予後は生存3例(30~69ヵ月),死亡5例(9~31ヵ月)で,死亡は全例食道癌再発であつた.
除外	非合数				2000058331	日本語	星原 芳雄, 山本 敬, 橋本 光代, 山本 信彦, 田中道徳, 菅原 和彦, 遠水 陽子, 石川 茂正, 松本 寿永, 布施隆 修, 吉田 勝義, 宇田川 晴司, 松下 央, 鶴丸 昌彦	【EMR時代の食道sm癌】EMRを行った食道sm癌	消化器内視鏡	1999	11(10)	1401-1406	原著論文/特集	sm1癌10例とsm2癌2例にEMRを行ったが,sm3癌の症例は1例もEMRを行っていない,sm1癌と鑑別上重要なm3癌も12例のみでEMRが施行されている,EMRが施行したm3癌5例とsm2癌のうち10例にEMR後手術を行ったが,放射線療法などを行っていない17例であつた.リンパ節転移のいずれも適性であつた.手術を行っていない12例中10例は外来にて経過観察を行い,再発等の所見を認めなかった.
除外	非合数				2000058327	日本語	幕内 博康, 島田 英雄, 千野 修, 西隆之, 田仲 颯, 大芝 玄, 木勢佳史, 堀野 信治, 剣持孝弘, 田島 隆行	【EMR時代の食道sm癌】食道sm癌の治療方針を踏まえた診断戦略	消化器内視鏡	1999	11(10)	1369-1376	解説/特集	
除外	非合数				2000058326	日本語	大倉 俊男, 田中 洋一, 八巻 信昭	【EMR時代の食道sm癌】食道sm1癌の病理組織学的検討	消化器内視鏡	1999	11(10)	1363-1368	原著論文/特集	食道sm1癌の発見頻度は検診施設では食道癌全体の2%,表在癌の2.4%と少ない.手術症例13例のsm1癌の検討では,肉眼形態は0-IIc型が多く,腫瘍径が大きなるにつれて凹凸が目立つ傾向にあった.組織学的には中分化型扁平上皮癌7例,低分化型扁平上皮癌6例であり,主組織型とsm浸潤部の組織型に差はなかった.sm浸潤様式で肉眼所見に違いがあり癌が粘膜筋板の間をすり抜ける4症例は癌累の厚みが少なく,粘膜筋板の変化が少ないために所見に乏しく,深達度診断が難しかった.リンパ節転移がみられた症例は1例のみであつた.
除外	非合数				2000058325	日本語	富松 久信, 加藤 洋, 柳澤 昭夫, 二宮 康郎, 植田 守, 松原 敏樹	【EMR時代の食道sm癌】n(+)食道sm癌・n(-)食道sm癌の病理学的比較	消化器内視鏡	1999	11(10)	1355-1361	原著論文/特集	外科的切除を受けた113例の食道sm癌をリンパ節転移のある食道癌[n(+)]癌,ない食道癌[n(-)]癌に分け,性別,年齢,年齢,部位,大きさ,肉眼型,癌の分化度,INF,リンパ管侵襲の項目に関して,n(+),n(-),n(-)に影響する因子の有無を検討した.この結果,sm1+sm2+sm3癌群,sm2癌単独群,sm2+sm3癌群でリンパ管侵襲陽性[y(+)]の割合が有意にn(+),n(-)に影響した.これらの群のy(+)]群にも高率(各々19.2%,18.8%,22.5%)のリンパ節転移がありかつリンパ管転移性を積極的に示唆する病理学的条件がないことから,sm1癌にもリンパ管転移性を積極的に示唆する条件がないことから,sm癌に対するEMR適応の拡大は現時点では望めないと考えた.しかし,m3とsm1の各々81.0%,76.2%はリンパ節転移がなく,5年生存率は共に80.0%と良好であることから,次にこれらの癌にはどこかにEMR適応の拡大を可能にすると考え,m3癌(21例)とsm1癌(21例)に関しては更に詳細に検討した.その結果,"満腔浸潤"陰性でリンパ管侵襲陰性[y(-)]の病変にはリンパ節転移が極めて低率(0%)であつた.
除外	非合数				2000058324	日本語	小池 盛雄, 海澤 豊一郎, 船田 信親, 比島恒和, 迫間 隆昭, 清水辰一郎, 山田 哲夫, 吉田 操, 重松 智子, 門馬 久美子	【EMR時代の食道sm癌】食道sm癌細分類の臨床的意義	消化器内視鏡	1999	11(10)	1349-1354	原著論文/特集	食道表在癌外科切除例124例を日本食道疾患研究会臨床症例分類検討委員会の分類に従い,m1,m2,m3,sm1,sm2,sm3に亜分類し,尿管侵襲,リンパ節転移頻度について検討した.m1・m2癌はリンパ節転移を示さず,m3・sm1癌はいずれも1例,各々7%,13%と低率であつた.sm2・sm3癌はリンパ節転移の頻度が著しく高く,各々28%,52%に認められた.リンパ節転移の頻度から食道表在癌はリンパ節転移のないEMR絶対適応とな,m1~m2癌,転移の可能性はあるが頻度の低いm3・sm1癌,転移頻度が高,EMRの適応とな,m1・sm2~sm3癌の3グループに分類される,EMR標準上のsm1は粘膜筋板から200μが妥当である.特に0-IIc型から発育進展すると考えられた,EMR標準上のsm1は粘膜筋板から200μが妥当である.
除外	非合数				2000058295	日本語	小山 恒男, 岡庭 信司, 友利 彰寿, 堀田 欣一, 山田 策, 甲斐 昭彦	【食道癌をめぐるトピックス】食道癌治療におけるEMRの位置づけ	消化器科	1999	29(3)	289-294	原著論文/特集	食道EMR3つの特徴を理解し,使い分けすることで深達度m1~m2の絶対適応症例にEMRを安全に治療得る.自験相対適応14症例(深達度m3・sm3)に遠隔転移,原病はなく,化学療法,放射線療法を併用することでEMRの適応を拡大できる可能性が示唆された.局所再発の予防には最後のヨード散布から1月以上後にEMRを施行することが大切である.
除外	非合数				2000058274	日本語	有馬 美和子, 小出 義雄, 岡住 慎一, 島田 英昭, 松原 久裕, 宮澤 幸正, 舟波 裕, 清合 武徳	胸部食道癌に対する3領域リンパ節郭清の適応とその限界についての検討	日本消化器外科学会雑誌	1999	32(10)	2484-2488	原著論文	対象はEMRを含む446例で,Ut61,Mt268,Lt117である.深達度,pEPLPMはリンパ節転移,再発ともなEMR又はBluntの適応と考えられた.pMM~SM0のU癌,LT癌の1頭部リンパ節転移+再発は極めて稀であり郭清を省略できる.As,根治度C,3領域リンパ節転移,転移頻度は個体以上の症例を予後不良群(F群),それ以外をA群としたところ,F群は90%以上の再発率で3年無再発生存例は3・Fieldで2・Fieldにはなかつた.A群では3・Field2・Fieldとも再発率は約30%,3年無再発生存率は40~50%,3・Field単独ではF群に3年無再発生存例はなかつたが,後療法追加例で予後の延長がみられ,一群には放射線化学療法を積極的に加える必要がある.
全文取り寄せ	可	否	small sample size		2000010852	日本語	遠藤 光夫, 河野 辰幸, 永井 龍, 井上 晴洋	食道表在癌におけるリンパ節転移の状況と治療方針	外科治療	1999	80(5)	590-594	原著論文	1985年~1997年3月迄に外科的に切除した術前未治療の胸部食道表在癌236例でリンパ節転移は粘膜癌(m癌)3%,粘膜下層癌(sm癌)41%で,5年生存率は,m癌84%,sm癌64%と有意差を見た,m1・m2癌を1~3に分類すると,m1癌,m2癌ではリンパ節転移は見られず,m3癌8%,sm1癌11%,sm2癌30%,sm3癌61%であつた.以上より,m1・m2グループはEMR内視鏡的粘膜切除術の適応とし,一部非開胸食道切除症例も含め,sm2・sm3グループは今後も系統的郭清を行う開胸標準手術又は胸腔鏡下手術の適応である,m3・sm1グループではまずEMRを行い,切除標本により経過観察が追加から2段階治療とする.

全文取り寄せ		可	否	small sample size	1999010614	日本語	藤田 博正, 末吉 晋, 山名 秀明, 白水 和雄, 原田 寛, 坪茂樹, 豊永 純, 田淵 絵美, 城 誠也, 早淵 尚文	外科の立場からみたm3・sm1食道癌	胃と腸	1998	33(7)	1003-1010	原著論文	m3・sm1食道癌の臨床像を検討し、外科的立場から治療方針を提案した。m3・sm1食道癌はEMRと放射線治療によって局所再発を認めなかった。m3食道癌はリンパ節転移・尿管侵襲はまれであるが(8%, 8%), sm1食道癌はそれらの頻度が高率であった(38%, 50%)。現状ではリンパ節転移の画像診断が必ずしも完全でないため、食道表在癌に対し診断と治療を兼ねてEMRを行い、尿管侵襲を伴わないm3食道癌にはEMRと必要に応じて放射線治療の追加を、尿管侵襲を伴うm3食道癌やsm1食道癌にはリンパ節郭清(3領域郭清)を伴う食道切除術が第1選択として推奨される。	
除外	非含数				1998053939	日本語	幕田 博康, 島田 英雄, 千野 修, 他	【早期食道癌 病型分類と深さ度から】早期食道癌の予後 病型分類と深さ度からみた早期食道癌の予後	臨床消化器内科	1997	12(12)	1749-1756	原著論文/特集	病型分類と深さ度から食道表在癌の予後を検討した。食道表在癌で外科的切除術を行った133例の5年生存率は85.8%であり、早期癌79例では93.4%であった。深さ度別に食道表在癌の5年生存率をみると粘膜上段(m1)から粘膜下層表層(sm1)では100%であり、sm2, sm3では72-73%であった。病型分類別にみると深さ度を反映し、0-IIa, 0-IIb型は100%、粘膜下層癌を混する0-IIc型は94.4%、殆ど粘膜下層癌である0-I型と0-III型はそれぞれ77.5%, 72.2%であった。EMRの5年生存率は100%であった。	
除外	非含数				1998053935	日本語	村田 洋子, 鈴木 茂	【早期食道癌 病型分類と深さ度から】早期食道癌の診断 内視鏡診断 EUS	臨床消化器内科	1997	12(12)	1719-1725	原著論文/特集	EUSの役割は、深さ度診断では、粘膜板を突出することにより、粘膜板内側の癌がこれを破壊するM3より深い癌かの鑑別に有用である。M2までとM3以上との鑑別には94%可能であった。リンパ節では5mm以上のリンパ節の存在診断、リンパ節のエコー像、部球形、境界明瞭、内部低エコーの所見より転移の予測が70%~80%可能であった。EUSは、明らかなep, dysplasiaを除く食道表在癌の深さ度診断、リンパ節転移診断に有用である。	
全文取り寄せ		可	否	small sample size	1998053895	日本語	福元 俊孝, 島田 麻里緒, 夏越 祥次, 他	早期食道癌に対する内視鏡的粘膜切除術の治療成績	日本消化器外科学会雑誌	1997	30(10)	1978-1984	原著論文	教室では原則として深さ度m2迄の早期食道癌は内視鏡的粘膜切除(EMR)の対象としている。EMRによって切除された30例(38例)について、その適応の妥当性、治療成績を検討した。1) 大きさは30例中20mm以下であった。2) 予測深さ度と組織学的深さ度の一致率はdysplasiaであった4例を除いて70.6%(24/34例)であった。3) 再発が3例、異時性食道癌が1例にみられ、いずれも再EMRを施行した。4) 他病死1例、深さ度sm3で手術を施行した1例が癌死した。他は最長4年5ヵ月を含め、全例生存中である。深さ度m2迄の全周性でない癌はEMRの適応であり、治療成績も満足できるものであった。	
除外	非含数				1997093157	日本語	小山 恒男, 宮田 佳典, 岡庭 信司, 他	内視鏡的食道粘膜切除後の局所再発	胃と腸	1996	31(10)	1217-1222	原著論文/特集	自検例を再検討し、36例65病変中、局所再発は2病変で、局所再発率は3.1%であった。いずれも深さ度m2の0-IIc・IIb型癌で、ヨード不染境界は一部不明瞭であった。局所再発の早期発見の為、3ヵ月後のみならず、6ヵ月後のヨード内視鏡再検が重要と思われた。ヨード染色後約1ヵ月間は癌の一部が基底層型になり、ヨードに染色される為、ヨード不染帯を完全に切除しても基底層型発育部を取り残す可能性が考えられた。したがって、最後のヨード染色から1ヵ月以上の期間を置いてから粘膜切除を施行することが局所再発予防に重要と思われる。	
除外	非含数				1997093114	日本語	青木 理恵, 田中 信治, 春間 貢, 他	食道表在癌85例の臨床病理学的検討 その悪性度からみた治療法の選択、特に内視鏡治療の適応について	広島医学	1996	49(5)	728-734	原著論文	1) 肉眼型0-IIbの深さ度はm2までであった。2) 深さ度m2までで尿管侵襲、リンパ節転移を認めた症例はなかった。3) 浸潤様式はINF-γでリンパ節転移陽性率が高かった。4) 外科的手術例の他病死を除く5年生存率は深さ度m1~m2で100%、深さ度m3~sm1で100%、深さ度sm2~sm3で77.5%であった。5) 深さ度m2までで尿管侵襲のない病変はEMR単独で根治可能であると考えられた。6) 深さ度m3以上でも、EMRに放射線療法を併用することによって根治できる可能性がある。	
除外	非含数				1996240791	日本語	石後岡 正弘, 平尾 雅紀, 山崎 在喜, 他	胸部食道表在癌外科切除例の検討	北海道外科雑誌	1996	41(1)	39-42	原著論文	当科で外科切除された胸部食道表在癌34例を深さ度別・重分類に分け、臨床病理学的所見及び治療成績からその治療方針について検討した。0-I型は全てsm, 0-IIbはm1であった。大きさによる特徴はなかった。m2までは尿管侵襲もリンパ節転移も認めず、m3になると出現し、sm2以上では高率であった。sm1までは再発例はなく、m癌の5年生存率は85%であったが、sm2以上では3例の再発死が認められ、sm癌の5年生存率は50%であった。以上から、1) m1, m2はEMRの適応である。しかし、広範囲、多発例は非開胸食道切除術も考慮する。2) m3, sm1は診断と治療を兼ねてのEMRの適応もあるが、尿管侵襲を認める症例はリンパ節転移の可能性もあり外科切除郭清が必要である。3) sm2は進行癌と同様の術式及び集学的治療が必要である。	
除外	非含数				1996175897	日本語	井上 晴洋, 永井 鑑, 河野 康幸, 他	早期食道癌に対する内視鏡的治療	Therapeutic Research	1996	17(2)	519-521	原著論文	早期食道癌に対する治療の一つとして、内視鏡的粘膜切除術を60症例64病変に施行した。深さ度m2まで、長径約2cm以下の粘膜癌を適応とした。治療に伴う死亡はなく、全例で根治的切除が可能であった。最高5年9ヵ月(平均2年9ヵ月)の観察期間中に局所再発を確認した症例はなかった。合併症は穿孔1例、出血3例、狭窄2例であった。狭窄の1例では食道切除術を施行したが、その他は保存的に経過した。5年生存率は93%、異時性多発癌及び他病死の4例を除くと100%であった。又、本法は治療後のQOLが極めて良好であった。	
除外	非含数				1996154065	日本語	木場 崇剛, 山口 肇, 白尾 国昭, 他	食道粘膜癌に対する内視鏡的粘膜切除の検討	Progress of Digestive Endoscopy(消化器内視鏡の進歩)	1995	47	52-55	原著論文	食道内視鏡的粘膜切除(EMR)を施行した40症例46病変を検討した。部位はImが32病変と多く、次はEの9病変であった。組織型は全例扁平上皮癌であり、主肉眼型であった。深さ度は0-IIcが最も多く(34病変)、0-IIaが6病変、0-IIbが6病変で、切除方式は分割切除が31病変で残りは一括切除であった。深さ度はep, mm1が20例、mm2が13例、mm3が5例、smが2例であった。EMRは食道粘膜癌に対する根治療法として有用と考えられ、合併症としての狭窄はブジを使用することにより解消可能である為、全周性切除となる病変に対しても積極的に行うべきである。完全切除と組織学的に判定された例でも再発することがある。	

CQ番号	CQ名	検索式	文献数	検索DB	検索担当者	検索実行日	保存ファイル名	メモ
CQ18	食道表在癌に対して内視鏡治療を行いpT1a-MMであった場合、追加治療を行うことを推奨するか？	<p>#6 食道腫瘍/TH or (食道/TA and がん/TA) 63,951</p> <p>#7 T1a-EP/TA or (T1a/TA and EP/TA) or M1/TA or Tis/TA or T1a-LPM/TA or (T1a/TA and LPM/TA) or M2/TA or T1a/TA or T1a-MM/TA or (T1a/TA and MM/TA) or M3/TA or T1b/TA or pT1a-MM/TA or T1b/TA or SM/TA or SM1/TA or SM2/TA or SM3/TA or T1b-SM/TA or MMがん/TA or MM癌/TA 203,899</p> <p>#8 食道鏡法/TH or 内視鏡法/TH or カテーテル法/TH or 内視鏡的粘膜切除術/TH or 内視鏡的粘膜下層剥離術/TH or 胸腔鏡法/TH or 腹腔鏡法/TH or EMR/TA or ESD/TA or (粘膜/TH and (外科手術/TH or 手術/AL)) or 胃腸内視鏡法/TH 386,829</p> <p>#9 (無病生存/TH or 生存率/TH or 生存分析/TH or 死亡率/TH or (生存/TH or 生存/AL) or (予後/TH or 予後/AL) or (治療成績/TH or 治療成績/AL) or (生存期間/TH or 生存期間/AL)) or (腫瘍再発/TH or 発癌/TH or 微小転移/TH or 腫瘍-第二原発/TH or (再発/TH or 再発/AL) or Asynchrony/TH or 腫瘍転移/TH or 微小転移/TH or 二次癌/TA or 異時性/TA or 転移再発/AL) 909,550</p> <p>#10 壁進達度/TA or 深達度/TA or 腫瘍侵人性/TH 50,302</p> <p>#11 #6 and #7 and #8 and #9 and #10 252</p> <p>#12 (#11) and (DT=1995:2015 (PT=症例報告除く) AND (PT=原著論文,解説,総説)) 143</p> <p>#13 (#12) and (PT=会議録除く) 143</p>	143	医中誌	園原	2015/6/25	食道癌CQ18IC	

1次スクリーニング	除外理由	取り寄せ	2次スクリーニング	除外理由	ID	Language	Authors	Title	Journal	Year	Volume	Pages	Pub. Type	Abstract	Memo
除外	非合致				25731401	jpn	Nako Y, Shiozaki A, Fujiwara H, Konishi H, Kosuga T, Morimura R, Murayama Y, Komatsu S, Ikoma H, Kuriu Y, Nakanishi M, Ichikawa D, Okamoto K, Sakakura C, Otsuji	[Esophagectomy after endoscopic submucosal dissection (ESD)].	Gan To Kagaku Ryoho	2014	41(12)	1997-9	English Abstract: Journal Article	Herein, we report 9 patients who underwent esophagectomy after endoscopic submucosal dissection (ESD) between April 2003 and December 2013. All patients were men, with a mean age of 65 years. En bloc ESD was performed, and no complications arose in any patient. The mean surgical time of esophagectomy was 323 minutes, and mean blood loss was 295 mL. Postoperative complications were present in 5 patients (anastomotic leakage in 3, pulmonary complications in 2, and recurrent laryngeal nerve palsy in 1). In a patient diagnosed with pT1b-SM1 disease after ESD, a residual tumor (pT1a-MM, N0) was detected after esophagectomy. In another patient diagnosed with pT1b-SM2 disease, lymph node metastasis was detected after esophagectomy. In all patients, curative resection was performed, and no recurrences have been observed to date. This highlights the importance of additional esophagectomy after ESD for patients with pT1b disease. Esophagectomy after ESD can be considered a valid treatment because it provides high curative rates with acceptable safety.	
全文取り寄せ		可	採		25031273	eng	Merkow RP, Bilimoria KY, Keswani RN, Chung J, Sherman KL, Knab LM, Posner MG, Bentrem	Treatment trends, risk of lymph node metastasis, and outcomes for localized esophageal cancer.	J Natl Cancer Inst	2014	106(7)		Journal Article; Research Support, Non-U.S. Gov't	BACKGROUND: Endoscopic resection is increasingly used to treat localized, early-stage esophageal cancer. We sought to assess its adoption, characterize the risks of nodal metastases, and define differences in procedural mortality and 5-year survival between endoscopic and surgical resection in the United States. METHODS: From the National Cancer Data Base, patients with T1a and T1b lesions were identified. Treatment patterns were characterized, and hierarchical regression methods were used to define predictors and evaluate outcomes. All statistical tests were two-sided. RESULTS: Five thousand three hundred ninety patients were identified and underwent endoscopic (26.5%) or surgical resection (73.5%). Endoscopic resection increased from 19.0% to 53.0% for T1a lesions (P < .001) and from 6.6% to 20.9% for T1b cancers (P < .001). The strongest predictors of endoscopic resection were depth of invasion (T1a vs T1b: odds ratio [OR] = 4.45; 95% confidence interval [CI] = 3.76 to 5.27) and patient age of 75 years or older (vs age less than 55 years: OR = 4.86; 95% CI = 3.60 to 6.57). Among patients undergoing surgery, lymph node metastasis was 5.0% for T1a and 16.6% for T1b lesions. Predictors of nodal metastases included tumor size greater than 2 cm (vs <2 cm) and intermediate-/high-grade lesions (vs low grade). For example, 0.5% of patients with low-grade T1a lesions less than 2 cm had lymph node involvement. The risk of 30-day mortality was less after endoscopic resection (hazard ratio [HR] = 0.33; 95% CI = 0.19 to 0.58) but greater for conditional 5-year survival (HR = 1.63; 95% CI = 1.07 to 2.47). CONCLUSIONS: Endoscopic resection has become the most common treatment of T1a esophageal cancer and has increased for T1b cancers. It remains important to balance the risk of nodal metastases and procedural risk when counseling patients regarding their treatment options.	
除外	非合致				24830402	eng	Shi Q, Ju H, Yao LQ, Zhou PH, Xu MD, Chen T, Zhou JM, Chen TY, Zhong	Risk factors for postoperative stricture after endoscopic submucosal dissection for superficial esophageal carcinoma.	Endoscopy	2014	46(8)	640-4	Journal Article; Research Support, Non-U.S. Gov't	BACKGROUND AND STUDY AIMS: Endoscopic submucosal dissection (ESD) is accepted as an established treatment modality for superficial esophageal carcinoma (SEC). The aim of this study was to identify risk factors for postoperative stricture after ESD for SEC. PATIENTS AND METHODS: This was a retrospective study at a single institution. A total of 362 patients with SEC treated by ESD at Zhongshan Hospital, Shanghai, were enrolled between January 2007 and February 2012. Demographic and clinical parameters, including patient-, lesion-, and procedure-related factors, were analyzed for postoperative stricture risk factors. RESULTS: The postoperative stricture rate was 11.6 % (42/362). The mean and median time from ESD to stricture was 58.5 +/- 12.3 days (range 21 - 90 days) and 28 days, respectively. Mild, median, and severe stricture were observed in 16.7 % (7/42), 38.1 % (16 /42), and 45.2 % (19/42) of patients, respectively. Multivariate analysis revealed that circumferential extension of > 3/4 (odds ratio [OR] 44.2, 95 % confidence interval [CI] 4.4 - 443.6) and the depth of invasion above m2 (OR 14.2, 95 %CI 2.7 - 74.2) were independent risk factors for stricture. The degree of stricture was also related to lesion circumferential extension (relational coefficient phi = 0.47; P < 0.05) and histological depth (relational coefficient phi = 0.647; P < 0.05). CONCLUSIONS: Circumferential extension and histological depth were reliable risk factors for postoperative stricture.	
全文取り寄せ		可	否	Survival data 不明	24726263	eng	Trivedi A, Cartun RW, Ligato	Role of lymphovascular invasion and immunohistochemical expression of IMP3 in the risk stratification of superficially invasive pT1 esophageal adenocarcinoma.	Pathol Res Pract	2014	210(7)	402-6	Journal Article	BACKGROUND: A problem in the management of patients with Barrett's esophagus-related pT1 esophageal adenocarcinoma is to distinguish those who should be treated conservatively (endoscopic mucosal resection and/or radiofrequency ablation) from those who require esophago-gastrectomy. Recently, lymphovascular invasion (LVI) has emerged as one of the best predictors of regional lymph node metastasis (LNM) and recurrence-free survival (RFS) in pT1 EAC. However, LVI may be underestimated, both because of interobserver variability and incomplete sampling. The aim of our study was to correlate the presence of LVI, with the immunohistochemical expression of IMP3 in pT1 EAC and assess their role in further stratifying these lesions into high and low risk groups based on the potential for lymph node metastasis and poor outcome. DESIGN: Depth of invasion, assessed in five sublevels (m2, m3, sm1, sm2, and sm3), LVI, and expression of IMP3 were studied in 30 patients who underwent esophagogastrectomy for pT1 EAC (2001-2010) at Hartford Hospital, and correlated with LNM and RFS. IMP3 was considered positive when expressed in >50% of the malignant cells with an intensity of stain of 2-3+. RESULTS: Ten of the 12 (55.5%) cases with IMP3 expression demonstrated LVI and 2/10 (20%) showed LNM and died of disease. In contrast, none of the 12 IMP3 negative cases showed LVI (p<0.004; 2-tailed Fisher exact test) or had LNM/DOD. CONCLUSIONS: In pT1 EAC, (1) based on IMP3 expression, pT1 EAC may be divided into high risk (LVI+/IMP3+) and low risk (LVI-/IMP3-) categories, (2) Absence of IMP3 expression is associated with a significantly reduced risk of LVI (Negative Predictive Value: 100%), (3) Since identifying lymphovascular invasion and other morphological parameters is prone to significant inter-observer variation, IMP3 may be useful as an ancillary marker especially in these pT1 lesions in predicting their clinical behavior, the risk stratification and potentially on the type of treatment.	
全文取り寄せ		可	否	small sample size	24565073	eng	Kagemoto K, Oka S, Tanaka S, Miwata T, Urabe Y, Sanomura Y, Yoshida S, Hiyama T, Arihiro K, Chayama	Clinical outcomes of endoscopic submucosal dissection for superficial Barrett's adenocarcinoma.	Gastrointest Endosc	2014	80(2)	239-45	Journal Article	BACKGROUND: Advances in diagnostic techniques have allowed early stage detection of superficial Barrett's adenocarcinoma (SBA) as well as resection by endoscopic submucosal dissection (ESD). Few reports exist, however, on the safety and efficacy of ESD for SBA. OBJECTIVE: To analyze outcomes of ESD for SBA in relation to clinicopathological features of the lesions. DESIGN: Retrospective study. SETTING: University hospital. PATIENTS: Twenty-three patients (21 men, 2 women; mean age, 63 years) with 26 SBAs. INTERVENTION ESD MAIN OUTCOME MEASUREMENTS: We examined outcomes of ESD in relation to the clinicopathological features of SBAs. The main outcomes assessed were en bloc resection rate, operation time, adverse event rates, additional resection rate, and time between ESD and any recurrence. RESULTS: Twenty lesions (87%) derived from short-segment Barrett's esophagus, and 3 lesions (13%) derived from long-segment Barrett's esophagus. The majority of SBAs (54%) were located in the 0 to 3 o'clock circumferential quadrant. Median tumor size was 15 mm (range 5-60 mm). Macroscopic types were flat elevated (n = 13, 50%), depressed (n = 12, 46%), and protruded (n = 1, 4%). The SBAs appeared red (n = 23, 88%) or normally pale (n = 3, 12%). Under magnifying narrow-band imaging, all SBAs showed an irregular mucosal pattern and an irregular vascular pattern. The endoscopic en bloc resection rate was 100% (26/26), and the pathological en bloc resection rate was 85% (22/26). The median procedure time was 95 minutes (range, 30-210 minutes). Delayed bleeding occurred in 1 case, but there was no perforation. The SBAs were of the differentiated type (n = 25, 96%) or poorly differentiated type (n = 1, 4%). The tumor had invaded the superficial muscularis mucosa (n = 3, 12%), lamina propria mucosa (n = 5, 19%), deep muscularis mucosa (n = 9, 34%), SM1 (n = 3, 12%), and SM2 (n = 6, 23%). Additional surgical resection after ESD was performed in 9 cases, and there were no residual tumors, but 1 lymph node metastasis was found. There were no recurrent tumors; however, 1 metachronous adenocarcinoma was diagnosed 42 months after ESD. LIMITATIONS: Single-center, retrospective study. CONCLUSIONS: ESD appears to be a safe and effective treatment strategy for early stage SBA.	

除外	非合致				24464635	eng	Swangsri J, Nakajima Y, Kawada K, Tokairin Y, Suzuki T, Miyawaki Y, Hoshino A, Okada T, Ota S, Ryotokuji T, Fujiwara N, Nishikage T, Nagai K, Kawachi H, Kawano	Changes in the microvascular structure of mucosal squamous cell carcinoma of the esophagus and their significance in tumor progression.	J Med Dent Sci	2014	60(4)	83-91	Comparative Study; Journal Article	BACKGROUND: To identify the clinical T stage by endoscopy is a major diagnostic goal for superficial esophageal squamous cell carcinoma (ESCC). The completion of a microvascular morphological study of mucosal lesions is necessary to optimize therapy. MATERIALS AND METHODS: Images of 197 intra-papillary capillary loops (IPCLs) captured by magnified endoscopy from 15 esophagectomy specimens were studied for their morphological features and IPCL dimensions. RESULTS: The microvascular morphology was classified into four basic major patterns: 1. spiral loop, 2. wide loop (WL), 3. globular (G) and 4. reticular pattern. The microvascular features and dimensions differed according to the depth of tumor invasion. Especially the mean bundle outline (IPCL diameter) showed significant changes as 20.02, 22.32, and 27.08 μm, respectively, for M1, M2 and M3, respectively (M1:M2 P < 0.05, M2:M3 P < 0.01). CONCLUSIONS: During tumor stage progression, a high-volume blood demand and cancer cell overgrowth to occupy the lamina propria mucosa (LPM) cause obvious elongation, thickening, branching, irregularity and deformity of the IPCL, which were characteristics of M3 lesions. The results of the present study support and can be applied with the current Japanese classification for improving the diagnostic accuracy, especially to differentiate between M2 and M3 lesions based on the endoscopic findings.	
除外	非合致				24456340	eng	Chung GS, Liao LJ, Lo WC, Chou YH, Chang YC, Lin YC, Hsu WF, Shuang PW, Lee	Risk factors for second primary neoplasia of esophagus in newly diagnosed head and neck cancer patients: a case-control study.	BMC Gastroenterol	2013	13	154	Journal Article	BACKGROUND: The prevalence of esophageal neoplasia in head and neck (H&N) cancer patients is not low; however, routine esophageal surveillance is not included in staging of newly-diagnosed H&N cancers. We aimed to investigate the risk factors for synchronous esophageal neoplasia and the impact of endoscopy on management of H&N cancer patients. METHODS: A total of 129 newly diagnosed H&N cancer patients who underwent endoscopy with white-light imaging, narrow-band imaging (NBI) with magnifying endoscopy (ME), and chromoendoscopy with 1.5% Lugol's solution, before definite treatment were enrolled prospectively. RESULTS: 60 esophageal lesions were biopsied from 53 (41.1%) patients, including 11 low-grade, 14 high-grade intraepithelial neoplasia and 12 invasive carcinoma in 30 (23.3%) patients. Alcohol consumption [odds ratio (OR) 5.90, 95% confidence interval (CI) 1.23-26.44], advanced stage (stage III and IV) of index H&N cancers (OR 2.98, 95% CI 1.11-7.99), and lower body mass index (BMI) (every 1-kg/m ² increment with OR 0.87, 95% CI 0.76-0.99) were independent risk factors for synchronous esophageal neoplasia. NBI with ME was the ideal screening tool (sensitivity, specificity, and accuracy of 97.3%, 94.1%, and 96.3%, respectively, for detection of dysplastic and cancerous esophageal lesions). The treatment strategy was modified after endoscopy in 20 (15.5%) patients. The number needed to screen was 6.45 (95% CI 4.60-10.90). CONCLUSIONS: NBI-ME surveillance of esophagus should be done in newly-diagnosed H&N cancer patients, especially those with alcohol drinking, lower BMI, and advanced stage of primary tumor.	
除外	非合致				24314788	eng	Bergeron EJ, Lin J, Chang AC, Orringer MB, Reddy	Endoscopic ultrasound is inadequate to determine which T1/T2 esophageal tumors are candidates for endoluminal therapies.	J Thorac Cardiovasc Surg	2014	147(2)	765-71; Discussion	Journal Article	OBJECTIVES: Esophageal endoscopic ultrasound is now regarded as essential in the staging of esophageal carcinoma. There is an increasing trend toward endoluminal therapies (ie, endoscopic mucosal resection and radiofrequency ablation) for pre-cancer or early-stage cancers because of concerns of high morbidity associated with esophagectomy. This study reviews our institutional experience with preoperative endoscopic ultrasound staging of early esophageal cancers in patients who underwent an esophagectomy to evaluate the accuracy of staging by endoscopic ultrasound and how this affects treatment recommendations. METHODS: A prospective esophagectomy database of all patients undergoing an esophagectomy for esophageal cancer at a single high-volume institution was retrospectively reviewed for patients with early-stage esophageal cancer. This study analyzed patients with clinical Tis to T1 disease, as predicted by preoperative endoscopic ultrasound, and correlated this with the pathologic stages after esophagectomy. The surgical outcomes were evaluated to assess the safety of esophagectomy as a treatment modality. RESULTS: From 2005 to 2011, 107 patients (93 male, 14 female) with a mean age of 66 years (range, 39-91 years) were staged by preoperative endoscopic ultrasound to have esophageal high-grade dysplasia, carcinoma in situ, or T1 cancer and underwent an esophagectomy. Tumor depth was correctly staged by endoscopic ultrasound in only 39% (23/59) of pT1a tumors (invading into the lamina propria or muscularis mucosa) and 51% (18/35) of pT1b tumors (submucosal). Of the endoscopic ultrasound-staged cT1a-tpN0 lesions, there were positive lymph nodes in 15% of pathologic specimens (2/13). Patients with pT1a-mm lesions had a 9% rate of pathologic lymph node involvement (1/11), and those with pT1b tumors had a 17% rate of lymph node spread (6/35). Esophagectomy was performed in all 107 patients with a 30-day mortality rate of less than 1% (1/107). CONCLUSIONS: The sensitivity and specificity of endoscopic ultrasound for determining true pathologic staging are poor for early-stage esophageal cancers. Lesions thought to be cT1a-tpN0 by endoscopic ultrasound have at least pN1 disease in 15% of cases. Endoluminal therapy of these lesions based on endoscopic ultrasound undertreats a significant number of patients. Esophagectomy is still the standard therapy for early-stage esophageal cancers in the majority of patients.	
除外	非合致				24281193	eng	Saito M, Yamashita K, Tanuma T, Kaneto H, Murakami K, Onodera K, Shimizu H, Sakamoto H, Hosokawa-Motoya M, Arimura Y, Shinomura	Pharyngeal cancer surveillance using narrow band imaging during conventional upper gastrointestinal endoscopy.	Digestion	2013	88(4)	229-34	Journal Article	BACKGROUND: Recent studies have suggested that narrow band imaging (NBI) is useful for detecting superficial pharyngeal cancer. Nevertheless, pharyngeal observation is not a routine practice during upper gastrointestinal (GI) endoscopy. Two aims of this study were to evaluate the feasibility of pharyngeal observation during upper GI endoscopy and to determine the prevalence of pharyngeal cancer in asymptomatic high-risk patients. METHODS: Fifty-year-old or older asymptomatic males with smoking and drinking habits were prospectively recruited as a pharyngeal cancer high-risk group. A total of 224 high-risk patients underwent pharyngeal observation using NBI before conventional upper GI endoscopy. The feasibility of pharyngeal examination without sedation was assessed by a questionnaire for the first 60 participants. RESULTS: The median time for pharyngeal observation was 1.7 min. The questionnaire demonstrated 88% of participants thought the pharyngeal examination acceptable. The NBI examination identified 5 superficial pharyngeal cancers (2 Tis and 3 T1) in 224 high-risk patients; the prevalence of pharyngeal cancer in this group was 2.2%. Three of the 5 patients had a concurrent or past history of esophageal squamous cell carcinoma (ESCC). CONCLUSIONS: Pharyngeal observation using NBI during upper GI endoscopy is well tolerated and recommended for all high-risk patients, particularly those with a history of ESCC. Basel.	
全文取り寄せ		可	否	MM症例数不明	24232046	eng	Nurkin SJ, Nava HR, Yendamuri S, LeVea CM, Newgo CE, Groman A, Wilding G, Bain AJ, Hochwald SN, Khushalani	Outcomes of endoscopic resection for high-grade dysplasia and esophageal cancer.	Surg Endosc	2014	28(4)	1090-5	Journal Article	BACKGROUND: Endoscopic resection (ER) is an important advance in the management of esophageal tumors. It has been used successfully for superficial esophageal cancer and high-grade dysplasia (HGD) arising out of Barrett epithelium. METHODS: From a single institution within the Department of Surgery, patients who underwent ER for esophageal tumors between December 2001 and January 2012 were evaluated. Demographic, clinical, and pathologic variables were collected and reviewed. RESULTS: We identified 81 patients who underwent ER for esophageal lesions. Median patient age was 69 years, and the median follow-up was 3.25 years. In patients with HGD, at the time of last endoscopy, the complete eradication rate of HGD was 84 % and cancer-specific survival was 100 %. During surveillance, one patient developed an invasive carcinoma that required endoscopic therapy. Patients with T1a and negative deep margins on ER had a recurrence-free and cancer-specific survival of 100 %. There were seven patients with T1b and negative margins on ER. Three patients underwent esophagectomy; final pathology revealed no residual malignancy or lymph node metastasis. Two patients had definitive chemoradiation, and two patients were observed. To date, there has been no cancer recurrence. In all patients who underwent ER, there was one episode of bleeding that required endoscopic treatment and admission for observation. CONCLUSIONS: ER can be performed safely and can adequately stage and often treat patients with HGD and superficial cancers. Patients with HGD and T1a disease with negative margins are cured with ER alone. Observation and surveillance may be an option for select patients with low-risk, early submucosal disease (T1b) and negative margins.	
除外	review				24199697	eng	Hoppo T, Jobe	Personalizing therapy for esophageal cancer patients.	Thorac Surg Clin	2013	23(4)	471-8	Journal Article; Review	Management of esophageal cancer starts with accurate tissue diagnosis and clinical staging. Advances in screening and surveillance programs and endoscopic techniques have resulted in patients with early-stage esophageal cancer diagnosed more frequently. Endoscopic mucosal resection for staging is essential to diagnose T1a cancer and crucial to exclude risk factors for progression to cancer or presence of concomitant cancer. Esophagectomy is an essential component of treatment of locally advanced, resectable esophageal cancer. Despite intensive multidisciplinary approaches, the prognosis of esophageal cancer is unacceptable. This article focuses on the process of decision making used to select optimal therapy for esophageal cancer.	

全文取り寄せ		可	否	MM症例数不明	24060519	eng	Wani S, Drahos J, Cook MB, Rastogi A, Bansal A, Yan R, Sharma P, Das	Comparison of endoscopic therapies and surgical resection in patients with early esophageal cancer: a population-based study.	Gastrointest Endosc	2014	79(2)	224-232.e	Comparative Study; Journal Article; Multicenter Study; Research Support, Non-U.S. Gov't	BACKGROUND: Outcome data comparing endoscopic eradication therapy (EET) and esophagectomy are limited in patients with early esophageal cancer (EO). OBJECTIVE: To compare overall survival and EO-related mortality in patients with early EO treated with EET and esophagectomy. DESIGN AND SETTING: Population-based study. PATIENTS: Patients with early EO (stages T0 and T1) were identified from the Surveillance, Epidemiology, and End Results database (1998-2009). Demographics, tumor specific data, and survival were compared. Cox proportional hazards regression models were used to evaluate the association between treatment and EO-specific mortality. INTERVENTION: EET and esophagectomy. MAIN OUTCOME MEASUREMENTS: Mid- (2 years) and long- (5 years) term overall survival and EO-specific mortality, outcomes based on histology and stage, treatment patterns, and predictors of cancer-specific mortality. RESULTS: A total of 430 (21%) and 1586 (79%) patients underwent EET and esophagectomy, respectively. There was no difference in the 2-year (EET: 10.5% vs esophagectomy: 12.7%, $P = .27$) and 5-year (EET: 38.7% vs esophagectomy: 42.8%, $P = .16$) EO-related mortality rates between the 2 groups. EET patients had higher mortality rates attributed to non-EO causes (5 years: 46.6% vs 20.6%, $P < .001$). Similar results were noted when comparisons were limited to patients with stage T0 and T1a disease and esophageal adenocarcinoma. There was no difference in EO-specific mortality in the EET compared with the surgery group (hazard ratio 1.4; 95% confidence interval, 0.9-2.03). Variables associated with mortality were older age, year of diagnosis, radiation therapy, higher stage, and esophageal squamous cell carcinoma. LIMITATIONS: Comorbidities and recurrence rates were not available. CONCLUSIONS: This population-based study demonstrates comparable mid- and long-term EO-related mortality in patients with early EO undergoing EET and surgical resection.
全文取り寄せ		可	否	absence of pathological finding	23988285	eng	Li B, Chen H, Xiang J, Zhang Y, Kong Y, Garfield DH, Li	Prevalence of lymph node metastases in superficial esophageal squamous cell carcinoma.	J Thorac Cardiovasc Surg	2013	146(5)	1198-203	Journal Article	OBJECTIVE: Endoscopic treatment of superficial esophageal carcinoma has been increasingly conducted around the world. Because no lymph nodes are removed in such a procedure, the risk of lymph node metastases (LNMs) should be clearly understood. The aim of the present study was to accurately clarify the pattern of lymphatic spread in patients with superficial esophageal squamous cell carcinoma and analyze the factors potentially related to LNMs. METHODS: The pattern of lymphatic spread was studied in 189 patients who had undergone radical lymphadenectomy from 2006 to 2011. The risk factors associated with LNMs were determined by multivariate logistic regression analysis. According to the depth of tumor invasion, mucosal tumors were classified as M1, M2, and M3 and submucosal tumors as SM1, SM2, and SM3. RESULTS: A total of 4252 lymph nodes were resected (average, 23 +/- 8; range, 12-68). LNMs occurred in 49 patients (25.9%). The frequency of LNMs was 4.3% in those with mucosal and 33.1% in those with submucosal cancer. LNMs were found in 0%, 0%, 11.8%, 24.0%, 20.5%, and 43.8% of the M1, M2, M3, SM1, SM2, and SM3 cancer, respectively. For submucosal cancer, SM3 cancer ($P = .006$) and lymphovascular invasion ($P = .001$) were significant independent risk factors for LNMs. Paratracheal nodes were the most frequently involved. "Skip" metastases occurred in 20 of 49 patients (40.8%). CONCLUSIONS: Endoscopic treatment can be attempted when the tumor is limited to the lamina propria mucosa. However, 2-field radical lymphadenectomy with careful upper mediastinal lymph node resection should be conducted for submucosal squamous cell carcinoma.
除外	非合致				23903626	eng	Chaves DM, Moura EG, Milhomem D, Arantes VN, Yamazaki K, Maluf F, Albuquerque W, Conrado AC, Araujo JC, Uejo PH, Sakai	Initial experience of endoscopic submucosal dissection in Brazil to treat early gastric and esophageal cancer: a multi-institutional analysis.	Arq Gastroenterol	2013	50(2)	148-52	Clinical Trial; Journal Article; Multicenter Study	OBJECTIVE: This study aimed to evaluate the feasibility and clinicopathological characteristics of early gastric and esophageal cancers treated with endoscopic submucosal dissection (ESD) at five centers in Brazil. METHODS: Five centers in Brazil reported their initial experience with ESD. The cases reported had already been collected by each center before pooled analysis. RESULTS: Were resected 62 gastric lesions; 52(83.8%) of the gastric lesions were well-differentiated adenocarcinoma, 31(50%) from the antrum, 24 (38.7%) type IIa, 51 (82.2%) lesions had en-block resection with three showing lateral margin compromise. Concerning invasion, 25 (40.3%) tumors were M1. Mean tumor diameter was 18.9 mm (range, 0.6-5.0 cm) and mean procedure duration was 119.45 minutes. Gastric perforation occurred in three (4.8%) patients. Mean follow-up duration was 11.3 months, with two local recurrences and one death from pneumonia Seven months after treatment. Of the 16 esophageal lesions resected, 14 (87.4%) were squamous cell carcinoma, 10 (62.5%) were located proximally and 8 (50.0%) type IIa. Mean tumor diameter was 23.8 mm (range, 6-60 mm). Thirteen (81.2%) lesions had en-block resection with five cases of lateral margin compromise. Eight (50.0%) lesions were M1. Mean procedure duration was 78 minutes (range, 20-150 min). Complications included pneumomediastinum in two (12.5%) patients and stenosis in one (6.2%). Mean duration of follow-up was 8.6 months, with no local recurrence despite the presence of lateral margin compromise. CONCLUSION: Different centers in Brazil feasibly perform ESD with a high success rate.
除外	非合致				23807801	eng	Li JJ, Shan HB, Gu MF, He L, He LJ, Chen LM, Luo GY, Xu	Endoscopic ultrasound combined with submucosal saline injection for differentiation of T1a and T1b esophageal squamous cell carcinoma: a novel technique.	Endoscopy	2013	45(6)	667-70	Journal Article; Research Support, Non-U.S. Gov't	Endoscopic ultrasound (EUS) is the optimum method for investigation of early esophageal squamous cell carcinoma (ESCC). However, it is difficult to substage early ESCC as T1a or T1b. The aim of this study was to improve the staging accuracy of early ESCC by using EUS combined with submucosal saline injection (SSI). The study enrolled 15 patients with suspected early ESCC who were examined by EUS and subsequently by SSI combined with EUS. The patients then underwent endoscopic or surgical resection within 10 days. The accuracy of EUS staging (alone or following SSI) was evaluated and compared with the pathological results postoperatively. No severe complications of the SSI arose. EUS plus SSI easily distinguished the mucosa from the lesion and the submucosa because of the low-echoic saline-filled cushion in the submucosa. The accuracy of SSI combined with EUS for staging T1a or T1b was 86.7 %, which was better than that using EUS alone (60.0 %).
全文取り寄せ		可	否	MM症例数不明	23795720	eng	Hunt BM, Louie BE, Dunst CM, Liphman JC, Farivar AS, Sharata A, Aye	Esophagectomy for failed endoscopic therapy in patients with high-grade dysplasia or intramucosal carcinoma.	Dis Esophagus	2014	27(4)	362-7	Journal Article; Research Support, Non-U.S. Gov't	Endoscopic therapy (ablation +/- endoscopic resection) for high-grade dysplasia and/or intramucosal carcinoma (IMC) of the esophagus has demonstrated promising results. However, there is a concern that a curable, local disease may progress to systemic disease with repeated endotherapy. We performed a retrospective review of patients who underwent esophagectomy after endotherapy at three tertiary care esophageal centers from 2006 to 2012. Our objective was to document the clinical and pathologic outcomes of patients who undergo esophagectomy after failed endotherapy. Fifteen patients underwent esophagectomy after a mean of 13 months and 4.1 sessions of endotherapy for progression of disease (53%), failure to clear disease (33%), or recurrence (13%). Initially, all had Barrett's, 73% had >=3-cm segments, 93% had a nodule or ulcer, and 91% had multifocal disease upon presentation. High-grade dysplasia was present at index endoscopy in 80% and IMC in 33%, and some patients had both. Final pathology at esophagectomy was T0 (13%), T1a (60%), T1b (20%), and T2 (7%). Positive lymph nodes were found in 20%; one patient was T2N1 and two were T1bN1. Patients with T1b, T2, or N1 disease had more IMC on index endoscopy (75% vs. 18%) and more endotherapy sessions (median 6.5 vs. 3). There have been no recurrences a mean of 20 months after esophagectomy. Clinical outcomes were comparable to other series, but submucosal invasion (27%) and node-positive disease (20%) were encountered in some patients who initially presented with a locally curable disease and eventually required esophagectomy after failed endotherapy. An initial pathology of IMC or failure to clear disease after three treatments should raise concern for loco-regional progression and prompt earlier consideration of esophagectomy.
全文取り寄せ		可	否	review	23736794	eng	Max Almond L, Barr	Management controversies in Barrett's oesophagus.	J Gastroenterol	2014	49(2)	195-205	Journal Article; Research Support, Non-U.S. Gov't; Review	The management of Barrett's oesophagus and associated neoplasia has evolved considerably in recent years. Modern endoscopic strategies including endoscopic resection and mucosal ablation can eradicate dysplastic Barrett's and prevent progression to invasive oesophageal cancer. However, several aspects of Barrett's management remain controversial including the stage in the disease process at which to intervene, and the choice of endoscopic or surgical therapy. A review of articles pertaining to the management of Barrett's oesophagus with or without associated neoplasia, was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Medline, Embase and Cochrane databases were searched to identify literature relevant to eight pre-defined areas of clinical controversy. The following search terms were used: Barrett's oesophagus; dysplasia; intramucosal carcinoma; endotherapy; endoscopic resection; ablation; oesophagectomy. A significant body of evidence exists to support early endoscopic therapy for high-grade dysplasia (HGD). Although not supported by randomised controlled trial evidence, endoscopic therapy is now favoured ahead of oesophagectomy for most patients with HGD. Focal intramucosal (T1a) carcinomas can be managed effectively using endoscopic and surgical therapy, however surgery should be considered the first line therapy where there is submucosal invasion (T1b). Treatment of low grade dysplasia is not supported at present due to widespread over-reporting of the disease. The role of surveillance endoscopy in non-dysplastic Barrett's remains controversial.

全文取り寄せ		可	否	MM症例数不明	23735443	eng	Ngamruengphong S, Wolfson HC, Wallace	Survival of patients with superficial esophageal adenocarcinoma after endoscopic treatment vs surgery.	Clin Gastroenterol Hepatol	2013	11(11)	1424-1429	Comparative Study; Journal Article; Research Support, N.I.H., Extramural	BACKGROUND & AIMS: Endoscopic therapy can improve long-term outcomes of patients with superficial esophageal adenocarcinoma (EAC), producing fewer complications than esophagectomy. However, there have been few population-based studies to compare long-term outcomes of patients who received these treatments. We used a large national cancer database to evaluate the outcomes of patients with superficial EAC who underwent endoscopic therapy or surgery. METHODS: We used the Surveillance Epidemiology and End Results database to identify 1618 patients with Tis or T1 N0M0 EAC from 1998-2009. Patients were grouped on the basis of whether they received endoscopic therapy (n = 306) or surgery (n = 1312). Multivariate logistic regression was performed to identify factors associated with endoscopic therapy. We collected survival data through the end of 2009; overall survival and esophageal cancer-specific survival were compared after controlling for relevant covariates. RESULTS: The use of endoscopic therapy increased progressively from 3% in 1998 to 29% in 2009. Factors associated with use of endoscopic therapy included age older than 65 years, diagnosis in 2006-2009 vs 1998-2001, and the absence of submucosal invasion. Overall survival after 5 years was higher in the surgery group than in the endoscopic therapy group (70% vs 58%, respectively). After adjusting for patient and tumor factors, patients treated by endoscopy had similar overall survival times (hazard ratio, 1.21; 95% confidence interval, 0.92-1.58) and esophageal cancer-specific survival times (hazard ratio, 0.74; 95% confidence interval, 0.49-1.11). CONCLUSION: In a population-based analysis, the use of endoscopic therapy for superficial EAC tended to increase from 1998-2009. Long-term survival of patients with EAC did not appear to differ between those who received endoscopic therapy and those treated with surgery.	
全文取り寄せ		可	否	MM症例数不明	23659947	eng	Lee L, Ronellenfitsch U, Hofstetter WL, Darling G, Gaiser T, Lippert C, Gilbert S, Seely AJ, Mulder DS, Ferri	Predicting lymph node metastases in early esophageal adenocarcinoma using a simple scoring system.	J Am Coll Surg	2013	217(2)	191-9	Evaluation Studies; Journal Article; Multicenter Study; Research Support, Non-U.S. Gov't	BACKGROUND: Endoscopic resection is an organ-sparing option for early esophageal adenocarcinoma, but should be used only in patients with a negligible risk of lymph node metastases (LNM). The objective was to develop a simple scoring system to predict LNM in T1 esophageal adenocarcinoma. STUDY DESIGN: All primary esophagectomies performed for T1 esophageal adenocarcinoma without neoadjuvant therapy at 5 university institutions from 2000 to 2011 were analyzed. Patient and pathologic characteristics were compared between patients with LNM at the time of surgical resection and those without. Univariate and multivariate analyses were performed to establish a simple scoring system that estimated the risk of LNM, using variables from the final surgical pathology. RESULTS: A total of 258 patients were included for analysis (mean age 65.2 years [SD 10.3 years], 88% male). The incidence of LNM was 7% (9 of 122) for T1a and 26% (35 of 136) for T1b. Tumor size (odds ratio [OR] 1.35 per cm, 95% CI 1.07 to 1.71) and lymphovascular invasion (OR 7.50, 95% CI 3.30 to 17.07) were the strongest independent predictors of LNM. A weighted scoring system was devised from the final multivariate model and included size (≥ 1 point per cm), depth of invasion (≥ 2 for T1b), differentiation (≥ 3 for each step of dedifferentiation), and lymphovascular invasion (≥ 6 if present). Total number of points estimated the probability of LNM (low risk [0 to 1 point], ≤ 2 ; moderate risk [2 to 4 points], 3% to 6%; and high risk [≥ 5 points], ≥ 7 %). CONCLUSIONS: We devised a simple scoring system that accurately estimates the risk of LNM to aid in decision-making in patients with T1 esophageal adenocarcinoma undergoing endoscopic resection.	
除外	case report				23617675	eng	Takahashi A, Oyama	Barrett's esophageal adenocarcinoma diagnosed by narrow-band imaging magnifying endoscopy.	Dig Endosc	2013	25 Suppl 2	184-9	Case Reports; Journal Article	A 40-year-old man was referred to our hospital for detailed examination of a protuberant lesion in long-segment Barrett's esophagus (LSBE). Under white light endoscopy (WLE) the lesion appeared as a protuberant lesion with a rough surface and was diagnosed as 0-IIa-type tumor suspected to be a well-differentiated adenocarcinoma. A regular villous pattern was shown in the background mucosa of the LSBE by narrow-band imaging (NBI) magnifying endoscopy (NBI-ME). However, a slightly irregular villous pattern was observed on the lateral side of the main lesion. Therefore, a 0-IIa-type tumor was estimated to have a flatly lateral extension component (i.e. 0-IIb spreading). The 0-IIb spreading was unclear when using WLE, but could be diagnosed by NBI-ME based on the surface pattern differences. Markings were placed outside the edge of the flatly lateral extension, and endoscopic submucosal dissection was carried out. The pathological diagnosis of the protuberant lesion with flatly lateral spreading was well-differentiated adenocarcinoma. The macroscopic type was 0-IIa+IIb, 45 x 43 mm in size. The invasion depth was T1a (deep muscularis mucosae). Lymphatic and venous invasions were negative; horizontal and vertical margins were negative. In conclusion, NBI-ME was useful for the diagnosis of the flatly lateral extension of this 0-IIa+IIb esophageal adenocarcinoma in Barrett's esophagus. Further investigations with many cases are necessary.	
全文取り寄せ		可	否	MM症例数不明	23539431	eng	Sgourakis G, Gockel I, Lang	Endoscopic and surgical resection of T1a/T1b esophageal neoplasms: a systematic review.	World J Gastroenterol	2013	19(9)	1424-37	Journal Article; Meta-Analysis; Review	AIM: To investigate potential therapeutic recommendations for endoscopic and surgical resection of T1a/T1b esophageal neoplasms. METHODS: A thorough search of electronic databases MEDLINE, Embase, Pubmed and Cochrane Library, from 1997 up to January 2011 was performed. An analysis was carried out, pooling the effects of outcomes of 4241 patients enrolled in 80 retrospective studies. For comparisons across studies, each reporting on only one endoscopic method, we used a random effects meta-regression of the log-odds of the outcome of treatment in each study. "Neural networks" as a data mining technique was employed in order to establish a prediction model of lymph node status in superficial submucosal esophageal carcinoma. Another data mining technique, the "feature selection and root cause analysis", was used to identify the most important predictors of local recurrence and metachronous cancer development in endoscopically resected patients, and lymph node positivity in squamous carcinoma (SCC) and adenocarcinoma (ADC) separately in surgically resected patients. RESULTS: Endoscopically resected patients: Low grade dysplasia was observed in 4% of patients, high grade dysplasia in 14.6%, carcinoma in situ in 19%, mucosal cancer in 54%, and submucosal cancer in 16% of patients. There were no significant differences between endoscopic mucosal resection and endoscopic submucosal dissection (ESD) for the following parameters: complications, patients submitted to surgery, positive margins, lymph node positivity, local recurrence and metachronous cancer. With regard to piecemeal resection, ESD performed better since the number of cases was significantly less [coefficient: -7.709438, 95%CI: (-11.03803, -4.380844), P < 0.001]; hence local recurrence rates were significantly lower [coefficient: -4.033528, 95%CI: (-6.151498, -1.915559), P < 0.01]. A higher rate of esophageal stenosis was observed following ESD [coefficient: 7.322266, 95%CI: (3.810146, 10.83439), P < 0.001]. A significantly greater number of SCC patients were submitted to surgery (log-odds, ADC: -2.1206 +/- 0.6249 vs SCC: 4.1356 +/- 0.4038, P < 0.05). The odds for re-classification of tumor stage after endoscopic resection were 53% and 39% for ADC and SCC, respectively. Local tumor recurrence was best predicted by grade 3 differentiation and piecemeal resection, metachronous cancer development by the carcinoma in situ component, and lymph node positivity by lymphovascular invasion. With regard to surgically resected patients: Significant differences in patients with positive lymph nodes were observed between ADC and SCC [coefficient: 1.889569, 95%CI: (0.3945146, 3.384624), P < 0.01]. In contrast, lymphovascular and microvascular invasion and grade 3 patients between histologic types were comparable, the respective rank order of the predictors of lymph node positivity was: Grade 3, lymphovascular invasion (L+), microvascular invasion (V+), submucosal (Sm) 3 invasion, Sm2 invasion and Sm1 invasion. Histologic type (ADC/SCC) was not included in the model. The best predictors for SCC lymph node positivity were Sm3 invasion and (V+). For ADC, the most important predictor was (L+). CONCLUSION: Local tumor recurrence is predicted by grade 3, metachronous cancer by the carcinoma in-situ component, and lymph node positivity by L+. T1b cancer should be treated with surgical resection.	
除外	非合致				23528657	eng	Cassani L, Sumner E, Slaughter JC, Yachinski	Directional distribution of neoplasia in Barrett's esophagus is not influenced by distance from the gastroesophageal junction.	Gastrointest Endosc	2013	77(6)	877-82	Journal Article	BACKGROUND: Accurate endoscopic detection and staging are critical for appropriate management of Barrett's esophagus (BE)-associated neoplasia. Prior investigation has demonstrated that the distribution of endoscopically detectable early neoplasia is not uniform but instead favors specific directional distributions within a short BE segment; however, it is unknown whether the directional distribution of neoplasia differs with increasing distance from the gastroesophageal junction, including in patients with long-segment BE. OBJECTIVE: To identify whether directional distribution of BE-associated neoplasia is influenced by distance from the gastroesophageal junction. DESIGN: Retrospective cohort study. SETTING: Tertiary-care referral center. PATIENTS: Patients with either short-segment or long-segment BE undergoing EMR. INTERVENTION: EMR. MAIN OUTCOME MEASUREMENTS: Directional distribution of BE-associated neoplasia stratified by distance from gastroesophageal junction. RESULTS: EMR was performed on 80 lesions meeting study criteria during the specified time period. Pathology demonstrated low-grade dysplasia in 22% (13/60), high-grade dysplasia in 38% (23/60), intramucosal (T1a) adenocarcinoma in 23% (14/60), and invasive (\geq T1b) adenocarcinoma in 17% (10/60). Directional distribution of lesions was not uniform (P < .001), with 62% of lesions (37/60) located between the 1 o'clock and 5 o'clock positions. When circular statistics methodology was used, there was no difference in the directional distribution of neoplastic lesions located within 3 cm of the gastroesophageal junction compared with \geq 3 cm from the gastroesophageal junction. LIMITATIONS: Single-center study may limit external validity. CONCLUSION: The directional distribution of neoplastic foci within a BE segment is not influenced by distance of the lesion from the gastroesophageal junction. Mucosa between the 1 o'clock and 5 o'clock locations merits careful attention and endoscopic inspection in individuals with both short-segment BE and long-segment BE.	

除外	review				23480400	eng	Koike T, Nakagawa K, Iijima K, Shimosegawa	Endoscopic resection (endoscopic submucosal dissection/endoscopic mucosal resection) for superficial Barrett's esophageal cancer.	Dig Endosc	2013	25 Suppl 1	20-8	Comparative Study; Journal Article; Review	Recently developed endoscopic resection (endoscopic submucosal dissection [ESD]/ endoscopic mucosal resection) has dramatically changed the therapeutic approach for Barrett's esophageal cancer. The rationale for endoscopic resection is that lesions confined to the mucosal layer have negligible risk for developing lymph node metastasis and can be successfully eradicated by endoscopic treatment as a curative treatment with minimal invasiveness. According to some reports that analyzed the rate of lymph-node involvement relative to the depth of mucosal or submucosal tumor infiltration, endoscopic resection is clearly indicated for intramucosal carcinoma and might be extended to lesions with invasion into the submucosa (<200 μm, sm1) because of the low risk for lymph node metastasis. Most Japanese experts recommend ESD for Barrett's esophageal cancer after accurate diagnosis of the margin of cancer using narrow band imaging with magnifying endoscopy because of its high curative rate. However, few studies have evaluated the long-term outcomes of endoscopic resection for Barrett's esophageal cancer in Japan. Further investigations should be conducted to establish endoscopic resection for Barrett's esophageal cancer.	
全文取り寄せ		可	否	MM症例数不明	23472998	eng	Saligram S, Chennat J, Hu H, Davison JM, Fasanella KE, McGrath	Endotherapy for superficial adenocarcinoma of the esophagus: an American experience.	Gastrointest Endosc	2013	77(6)	872-6	Journal Article; Observational Study	BACKGROUND: EMR and ablation are increasingly being used alone or in combination for treatment of Barrett's neoplasia. Given a very low rate of lymph node metastasis, endotherapy has become an accepted treatment option for T1a esophageal adenocarcinoma (EAC) with low-risk features. OBJECTIVE: To report our experience of endoscopic management of T1a EAC in a large, tertiary-care center. DESIGN: Retrospective review. SETTING: Tertiary-care referral center. PATIENTS: Patients treated endoscopically for low-risk T1a EAC at our center. INTERVENTION: EMR and endoscopic ablation. MAIN OUTCOME MEASUREMENTS: Death related to esophageal cancer, remission of adenocarcinoma, dysplasia, and intestinal metaplasia. RESULTS: A total of 54 patients underwent endotherapy for low-risk T1a EAC from 2008 to 2012. Mean (+/- SD) follow-up was 23 (+/- 16) months, mean (+/- SD) size of resected adenocarcinoma was 7.1 (+/- 4.3) mm, and mean (+/- SD) Barrett's esophagus length was 4.5 (+/- 3.9) cm. Band-assisted, cap-assisted, and lift and cut EMR were performed in 85%, 11%, and 4% of patients, respectively; 81% underwent additional ablative therapy (radiofrequency ablation 95%, cryotherapy 9%, photodynamic therapy 2%). Complete remission from cancer was achieved in 96%, complete remission from dysplasia in 87%, and complete remission from intestinal metaplasia in 59%. The overall survival was 89%; there were no deaths related to esophageal cancer. LIMITATIONS: Retrospective study. CONCLUSION: Endotherapy for T1a EAC was safe and effective in our American cohort. Endotherapy should be considered primary therapy for appropriate patients with low-risk lesions. Complete Barrett's esophagus eradication after EMR is important to reduce the development of metachronous lesions.	
除外	非合致				23425230	eng	Sun G, Tian J, Gorospe EC, Johnson GB, Hunt CH, Lutzke LS, Leggett CL, Iyer PG, Wang	Utility of baseline positron emission tomography with computed tomography for predicting endoscopic resectability and survival outcomes in patients with early esophageal adenocarcinoma.	J Gastroenterol Hepatol	2013	28(6)	975-81	Journal Article	BACKGROUND and AIMS: Positron emission tomography with computed tomography (PET/CT) has been used to detect metastasis in the diagnosis of esophageal adenocarcinoma (EAC). However, the utility of PET/CT to assess primary tumor for endoscopic resectability and prognosis in early EAC remains unclear. We conducted a retrospective study to determine the association of PET/CT findings with histopathological tumor invasion depth and survival outcomes. METHODS: EAC patients who underwent PET/CT followed by endoscopic mucosal resection (EMR) were included. Pathology on EMR and survival outcomes from a prospectively maintained database was retrieved. Two radiologists independently reviewed the PET/CT using the following parameters: detection of malignancy, fluorodeoxyglucose (FDG) uptake intensity, FDG focality, FDG eccentricity, esophageal thickness, maximal standard uptake value (SUVmax), and SUVmax ratio (lesion/liver). RESULTS: There were 72 eligible patients: 42 (58.3%) had T1a lesions, and 30 (41.7%) had >= T1b. Only SUVmax ratio was associated with tumor invasion depth (odds ratio=2.77, 95% confidence interval 1.28-7.73, P=0.0075). Using a cut-off of 1.48, the sensitivity and specificity of SUVmax ratio for identification of T1a lesions were 43.3% and 80.9%, respectively. Adjusting the SUVmax ratio to 2.14, 16.7% (5/30) of >= T1b patients were identified without any false-positive cases. Multivariate analysis showed SUVmax ratio, Charlson comorbidity index, and esophagectomy were independent predictors for survival. CONCLUSIONS: SUVmax ratio (lesion/liver) is more accurate in predicting endoscopic resectability and mortality for EAC than other PET/CT parameters and appears promising as a useful adjunct to the current diagnostic work-up.	
全文取り寄せ		可	採		23399555	eng	Yamashina T, Ishihara R, Nagai K, Matsuura N, Matsui F, Ito T, Fujii M, Yamamoto S, Hanaoka N, Takeuchi Y, Higashino K, Uedo N, Iishi	Long-term outcome and metastatic risk after endoscopic resection of superficial esophageal squamous cell carcinoma.	Am J Gastroenterol	2013	108(4)	544-51	Journal Article	OBJECTIVES: Long-term outcomes after endoscopic resection (ER) provide important information for the treatment of esophageal carcinoma. This study aimed to investigate the rates of survival and metastasis after ER of esophageal carcinoma. METHODS: From 1995 to 2010, 570 patients with esophageal carcinoma were treated by ER. Of these, the 402 patients with squamous cell carcinoma (289 epithelial (EP) or lamina propria (LPM) cancer, 70 muscularis mucosa (MM) cancer, and 52 submucosal (SM) cancer) were included in our analysis. Seventeen patients had cancer invading into the submucosa up to 0.2 mm (SM1) and 35 patients had cancer invading into the submucosa more than 0.2 mm (SM2). RESULTS: The mean (range) follow-up time was 50 (4-187) months. The 5-year overall survival rates of patients with EP/LPM, MM, and SM cancer were 90.5, 71.1, and 70.8%, respectively (P=0.007). Multivariate analysis identified depth of invasion and age as independent predictors of survival, with hazard ratios of 3.6 for MM cancer and 3.2 for SM cancer compared with EP/LPM cancer, and 1.07 per year of age. The cumulative 5-year metastasis rates in patients with EP/LPM, MM, SM1, and SM2 cancer were 0.4, 0.7, 7.7, and 38.2%, respectively (P<0.001). Multivariate analysis identified depth of invasion as an independent risk factor for metastasis, with hazard ratios of 13.1 for MM, 40.2 for SM1, and 196.3 for SM2 cancer compared with EP/LPM cancer. The cumulative 5-year metastasis rates in patients with mucosal cancer with and without lymphovascular involvement were 46.7 and 0.7%, respectively (P<0.0001). CONCLUSIONS: The long-term risk of metastasis after ER was mainly associated with the depth of invasion. This risk should be taken into account when considering the indications for ER.	
全文取り寄せ		可	否	MM症例数不明	23389078	eng	Ayers K, Shi C, Washington K, Yachinski	Expert pathology review and endoscopic mucosal resection alters the diagnosis of patients referred to undergo therapy for Barrett's esophagus.	Surg Endosc	2013	27(8)	2836-40	Comparative Study; Journal Article	BACKGROUND: Endoscopic therapy has emerged as an alternative to surgical esophagectomy for the management of Barrett's esophagus (BE)-associated neoplasia. Accurate pretreatment staging is essential to ensure an appropriate choice of therapy and optimal long-term outcomes. This study aimed to assess the frequency with which expert histopathologic review of biopsies combined with endoscopic mucosal resection (EMR) would alter the pretreatment diagnosis of BE-associated neoplasia. METHODS: Patients referred to the Vanderbilt Barrett's Esophagus Endoscopic Treatment Program (V-BEET) were retrospectively identified. Demographic, histopathologic, and endoscopic data were extracted from the medical record. RESULTS: For this study, 29 subjects referred for endoscopic staging of BE fulfilled the entry criteria. The referral diagnosis was low-grade dysplasia (LGD) in 3 % (1/29), high-grade dysplasia (HGD) in 62 % (18/29), intramucosal adenocarcinoma (T1a) adenocarcinoma in 17 % (5/29), and invasive adenocarcinoma in 17 % (5/29) of the subjects. Expert histopathologic review of available referral biopsy specimens altered the diagnosis in 33 % (5/15) of the cases. Further diagnostic staging with EMR showed BE without dysplasia in 10 % (3/29), LGD in 14 % (4/29), HGD in 34 % (10/29), T1a adenocarcinoma in 28 % (8/29), and invasive adenocarcinoma in 14 % (4/29) of the patients. The combination of expert histopathologic review and EMR altered the initial diagnosis for 55 % (16/29) of the subjects, with 56 % (9/16) upstaged to more advanced disease and 44 % (7/16) downstaged to less advanced disease. CONCLUSIONS: The practice of combined expert histopathologic review and EMR alters the pretreatment diagnosis for the majority of patients with BE-associated neoplasia. Caution is advised for those embarking on endoscopic or surgical treatment for BE-associated neoplasia in the absence of these staging methods.	
除外	非合致				23357492	eng	Manner H, Pech O, Heldmann Y, May A, Pohl J, Behrens A, Gossner L, Stolte M, Vieth M, Ell	Efficacy, safety, and long-term results of endoscopic treatment for early stage adenocarcinoma of the esophagus with low-risk sm1 invasion.	Clin Gastroenterol Hepatol	2013	11(6)	630-5; quiz	Journal Article	BACKGROUND & AIMS: Patients with early-stage mucosal (T1a) esophageal adenocarcinoma (EAC) are increasingly treated by endoscopic resection. EACs limited to the upper third of the submucosa (pT1b sm1) could also be treated by endoscopy. We assessed the efficacy, safety, and long-term effects of endoscopic therapy for these patients. METHODS: We analyzed data from 66 patients with sm1 low-risk lesions (macroscopically polypoid or flat, with a histologic pattern of sm1 invasion, good-to-moderate differentiation [G1/2], and no invasion into lymph vessels or veins) treated by endoscopic therapy at the HSK Hospital Wiesbaden from 1996 through 2010. The efficacy of endoscopic therapy was assessed on the basis of rates of complete endoluminal remission (CER), metachronous neoplasia, lymph node events, and long-term remission (LTR). Safety was assessed on the basis of rate of complications. RESULTS: Remissions were assessed in 61 of the 66 patients; 53 of the 61 achieved CER (87%). Of patients with small focal neoplasias <=2 cm, 97% achieved CER (for those with tumors >=2 cm, 77%; P = .026). Metachronous neoplasias were observed in 10 of 53 patients (19%); 9 of the 10 underwent repeat endoscopic resection. One patient developed a lymph node metastasis (1.9%). Fifty-one patients achieved LTR (84%); 90% of those with focal lesions <=2 cm achieved LTR after a mean follow-up period of 47 +/- 29.1 months (range, 8-120 months). No tumor-associated deaths were observed, and the estimated 5-year survival rate was 84%. The rate of major complications from endoscopic resection was 1.5%, and no patient died. CONCLUSIONS: Endoscopic therapy appears to be a good alternative to esophagectomy for patients with pT1b sm1 EAC, on the basis of macroscopic and histologic analyses. The risk of developing lymph node metastases after endoscopic resection for sm1 EAC is lower than the risk of surgery.	

全文取り寄せ		可	採		23108117	eng	Akutsu Y, Uesato M, Shuto K, Kono T, Hoshino I, Horibe D, Sasuka T, Takeshita N, Maruyama T, Isozaki Y, Akanuma N, Matsubara	The overall prevalence of metastasis in T1 esophageal squamous cell carcinoma: a retrospective analysis of 295 patients.	Ann Surg	2013	257(6)	1032-8	Journal Article	OBJECTIVES: T1 esophageal squamous cell carcinoma (ESCC) has a low, but still present, risk of lymph node (LN) metastasis. Endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD) is often applied for T1 ESCC. To achieve successful treatment by EMR/ESD, the risk of LN metastases, LN recurrence, and hematological recurrence need to be better understood. The aim of this study was to determine the precise risk for metastasis in T1 ESCC. METHODS: We divided 295 patients with T1 ESCC who underwent surgery and/or ESD/EMR into 6 categories (m1, m2, m3, sm1, sm2, and sm3). Their risks of LN metastasis, LN recurrence, hematological recurrence, and the outcome were determined. RESULTS: The rates of LN metastasis and LN recurrence were 0% in m1 and m2, 9% in m3, 16% in sm1, 35% in sm2, and 62% in sm3 cases. The incidence of hematological recurrence was 0% in m1, m2, m3, and sm1 cases; 9% in sm2 cases; and 13% in sm3 cases. The overall risk of metastasis was 9% in m3, 16% in sm1, 35% in sm2, and 64% in sm3 patients. The 5-year disease-specific survival rates were 100% in m1, m2, and m3; 90.9% in sm1; 78.8% in sm2; and 68.6% in sm3 patients. Statistically, both lymphatic and venous invasion were selected as predictive markers for metastasis. In m3 patients, positivity for either of these had an odds ratio for metastasis of 7.333 (P = 0.093). CONCLUSIONS: Our study provides a precise assessment of the comprehensive risk of metastasis and feasible predictive markers for T1 ESCC.	
除外	非合致				23082058	eng	Tahara K, Tanabe S, Ishido K, Higuchi K, Sasaki T, Katada C, Azuma M, Nakatani K, Naruke A, Kim M, Koizumi	Argon plasma coagulation for superficial esophageal squamous-cell carcinoma in high-risk patients.	World J Gastroenterol	2012	18(38)	5412-7	Evaluation Studies; Journal Article	AIM: To evaluate the usefulness and safety of argon plasma coagulation (APC) for superficial esophageal squamous-cell carcinoma (SESC) in high-risk patients. METHODS: We studied 17 patients (15 men and 2 women, 21 lesions) with SESC in whom endoscopic mucosal resection (EMR), endoscopic submucosal dissection (ESD), and open surgery were contraindicated from March 1999 through February 2009. None of the patients could tolerate prolonged EMR/ESD or open surgery because of severe concomitant disease (e.g., liver cirrhosis, cerebral infarction, or ischemic heart disease) or scar formation after EMR/ESD and chemoradiotherapy. After conventional endoscopy, an iodine stain was sprayed on the esophageal mucosa to determine the lesion margins. The lesion was then ablated by APC. We retrospectively studied the treatment time, number of APC sessions per site, complications, presence or absence of recurrence, and time to recurrence. RESULTS: The median duration of follow-up was 36 mo (range: 6-120 mo). All of the tumors were macroscopically classified as superficial and slightly depressed type (0-IIc). The preoperative depth of invasion was clinical T1a (mucosal cancer) for 19 lesions and clinical T1b (submucosal cancer) for 2. The median treatment time was 15 min (range: 10-36 min). The median number of treatment sessions per site was 2 (range: 1-4). The median hospital stay was 14 d (range: 5-68 d). Among the 17 patients (21 lesions), 2 (9.5%) had recurrence and underwent additional APC with no subsequent evidence of recurrence. There were no treatment-related complications, such as bleeding or perforation. CONCLUSION: APC is considered to be safe and effective for the management of SESC that cannot be resected endoscopically because of underlying disease, as well as for the control of recurrence after EMR and local recurrence after chemoradiotherapy.	
除外	非合致				23026272	eng	Li Z, Rice	Diagnosis and staging of cancer of the esophagus and esophagogastric junction.	Surg Clin North Am	2012	92(5)	1105-26	Journal Article; Review	Esophageal/esophagogastric junction cancer staging in the 7th edition of the AJCC staging manual is data driven and harmonized with gastric staging. New definitions are Tis, T4, regional lymph node, N, and M. Nonanatomic characteristics (histopathologic cell type, histologic grade, cancer location) and TNM classifications determine stage groupings. Classifications before treatment define clinical stage (cTNM or ycTNM). Current best clinical staging modalities include endoscopic ultrasonography for T and N and CT/PET for M. Classifications at resection define pathologic stage (pTNM or ypTNM). Accurate pathologic stage requires communication/cooperation between surgeon and pathologist. Classifications are defined at retreatment (rTNM) and autopsy (aTNM).	
除外	非合致				22941159	eng	Cardona K, Zhou Q, Gonen M, Shah MA, Strong VE, Brennan MF, Coit	Role of repeat staging laparoscopy in locoregionally advanced gastric or gastroesophageal cancer after neoadjuvant therapy.	Ann Surg Oncol	2013	20(2)	548-54	Journal Article	INTRODUCTION: Staging laparoscopy (SL) can identify occult, subradiographic metastatic (M1) disease in patients with gastric or gastroesophageal (G/GEJ) cancer who are unlikely to benefit from gastrectomy. The purpose of this study is to determine the yield of repeat SL following neoadjuvant therapy for G/GEJ adenocarcinoma after initial negative pretreatment SL. METHODS: Retrospective review of a prospective database identified patients with locoregionally advanced (T3-4Nany or TanyN+) G/GEJ adenocarcinoma who underwent pretreatment SL. The yield of repeat SL following neoadjuvant therapy was determined. RESULTS: From 1994 to 2010, 276 patients with locoregionally advanced G/GEJ adenocarcinoma were identified, of whom 244 proceeded to operation after neoadjuvant therapy, at a median time of 105 days. One hundred sixty-four patients (67 %) underwent repeat SL, and 80 patients (33 %) proceeded directly to laparotomy. Occult M1 disease was identified in 12 (7.3 %) and 6 (7.5 %) patients, respectively. In the repeat SL cohort, M1 disease was identified at laparoscopy in nine patients (5.5 %). M1 disease not identified by laparoscopy was discovered at laparotomy in three patients (1.8 %). The median follow-up for the study population was 31 months. For patients with M1 disease, median overall survival was 15 months, versus 41 months for patients resected without M1 disease (p < 0.0001). CONCLUSIONS: Occult, subradiographic M1 disease develops in approximately 7 % of patients following neoadjuvant therapy for locoregionally advanced G/GEJ adenocarcinoma. These patients have poor prognosis, and repeat SL can be a valuable tool in selecting patients with locoregionally advanced G/GEJ tumors for potentially curative resection after neoadjuvant therapy.	
除外	非合致				22899184	eng	Motoyama S, Jin M, Matsushashi T, Nanjo H, Ishiyama K, Sato Y, Yoshino K, Sasaki T, Wakita A, Saito H, Minamiya Y, Ohnishi H, Ogawa	Outcomes of patients receiving additional esophagectomy after endoscopic resection for clinically mucosal, but pathologically submucosal, squamous cell carcinoma of the esophagus.	Surg Today	2013	43(6)	638-42	Journal Article	PURPOSE: This study investigated the actual rate or extent of lymph node metastasis or the survival outcomes among patients that underwent esophagectomy with lymph node dissection after ESD for clinical mucosal, but pathological submucosal, esophageal cancer. METHODS: Seventeen patients that received esophagectomy with two- or three-field lymph node dissection as additional treatment after ESD for clinical mucosal, but pathological submucosal, esophageal cancer between 2006 and 2010 were analyzed. The rate and extent of lymph node metastasis and the patient outcomes were determined. RESULTS: The tumor depths were diagnosed as SM1 in 8 (47 %) patients and SM2 in 9 (53 %), based on the analyses of resected specimens. Lymphatic invasion was evident in 13 (76 %) patients, while venous invasion was detected in 5 (29 %). Five (29 %) patients had pathologically detected lymph node involvement. Seven (0.8 %) of the 890 dissected nodes showed cancer involvement. Three patients had one involved node in the mediastinum or abdomen, and 2 patients had 2 involved nodes in the abdomen. The patients were followed up for 11-71 months (median 23 months), and all were alive without recurrence at the final follow-up. CONCLUSION: Twenty-nine percent of the patients diagnosed with clinically mucosal, but pathologically submucosal, thoracic squamous cell esophageal cancer after ESD had 1-2 cancer-involved lymph nodes in the lower mediastinum and abdomen. Esophagectomy with lymph node dissection is therefore considered to be a necessary and effective additional treatment for these patients.	
除外	review				22790989	eng	Tangoku A, Yamamoto Y, Furukita Y, Goto M, Morimoto	The new era of staging as a key for an appropriate treatment for esophageal cancer.	Ann Thorac Cardiovasc Surg	2012	18(3)	190-9	Journal Article; Review	Fluorodeoxyglucose-positron emission tomography (FDG-PET) and computed tomography (CT) have become the gold standard for staging of esophageal cancer by detecting distant metastases, but metastatic lymph nodes are often difficult to diagnose from the size and standardized uptake value (SUV). If we compare the diagnostic performance of endoscopic ultrasonography (EUS), CT, and FDG-PET in staging of esophageal cancer, EUS is the most sensitive method to identify the detection of regional lymph node metastases, whereas CT and FDG-PET are more specific tests. Combination study with CT, EUS and PET/CT cannot make a precise diagnosis after neoadjuvant therapy (NAT). A precise staging might be determined by the fine needle aspiration biopsy (FNAB) under EUS and US screening in the neck and the abdomen even after NAT. Indication of endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) for superficial cancer is sensitive because of difficulty in T1b cancer diagnosis. Detailed examination about vessel invasion and the possibility of residual tumor with dissected specimen will offer an appropriate additional therapy. New strategy like sentinel lymph node (SLN) navigation could supply more information about lymphatic routes and metastatic nodes. SLN navigation with ESD might become a new less invasive strategy for superficial esophageal cancer.	
全文取り寄せ		可	否	MM症例数不明	22771501	eng	Fovos A, Jarral O, Panagiotopoulos N, Podas T, Mikhail S, Zacharakis	Does endoscopic treatment for early oesophageal cancers give equivalent oncological outcomes as compared with oesophagectomy? Best evidence topic (BET).	Int J Surg	2012	10(9)	415-20	Comparative Study; Journal Article; Review	A best evidence topic was written according to a structured protocol. The question addressed was whether endoscopic mucosal resection (EMR) for early oesophageal cancer gives equivalent oncological outcomes as compared to oesophagectomy. A total of 340 papers were found using the reported searches of which 7 represented the best evidence to answer the clinical question. The authors, date, journal, study type, population, main outcome measures and results are tabulated. Oesophagectomy with lymph node dissection for early oesophageal cancer is the standard to which every other treatment modality is compared to. However, the associated mortality and morbidity rates highlight the need for the development of effective, less invasive procedures. The evidence from the present review supports the use of EMR in this context as a first line treatment in T1a (mucosal) oesophageal cancer. The trade-off is a higher recurrence rate which can be dealt with successfully using a tight follow-up schedule and retreatment. The higher rates of lymph node involvement in T1b (submucosal) cancers preclude the use of endoscopic treatment in this setting except for patients unfit for surgery.	

全文取り寄せ		可	否	absence of pathological finding	22676622	eng	Yoshii T, Ohkawa S, Tamai S, Kameda	Clinical outcome of endoscopic mucosal resection for esophageal squamous cell cancer invading muscularis mucosa and submucosal layer.	Dis Esophagus	2013	26(5)	496-502	Journal Article	When a tumor invades the muscularis mucosa and submucosal layer (T1a-MM and T1b in Japan), esophageal squamous cell cancer poses 10-50% risk of lymph node metastasis. By this stage of esophageal cancer, surgery, although very invasive, is the standard radical therapy for the patients. Endoscopic mucosal resection (EMR) is the absolutely curable treatment for cancer in the superficial mucosal layer. Because of its minimal invasiveness, the indications of EMR may be expanded to include the treatment of T1a-MM and T1b esophageal carcinoma. To date, the clinical outcomes of EMR for T1a-MM and T1b patients have not been fully elucidated. Here, the retrospective analysis of the clinical outcomes is reported. Between January 1994 and December 2007, 247 patients underwent EMR at Kanagawa Cancer Center. Of these individuals, 44 patients with 44 lesions fulfilled the following criteria: (i) extended EMR treatment for clinical T1a-MM and T1b tumor; (ii) diagnosis of clinical N0M0; and (iii) follow up for at least: 1 year, and negative vertical margin. These patients were reviewed for their clinical features and outcomes. Statistical analyses were performed by the Kaplan-Meier methods, the Chi-square test, and the Cox proportional hazard model. P-value of <0.05 was considered statistically significant. The data were analyzed in February 2009. Based on the informed consent and their general health conditions, 44 patients decided the following treatments immediately after the EMR: 2 underwent surgery, 1 underwent adjuvant chemotherapy, and 41 selected follow up without any additional therapy. Of the 41 patients, 20 selected this course by choice, 12 because of severe concurrent diseases, 2 because of poor performance status, and 7 because of other multiple primary cancers. Twelve patients died; two were cause specific (4.5%), eight from multiple primary cancers, one from severe concurrent diseases, and one from unknown causes. No critical complications were noted. Median follow-up time was 51 months (12-126). Five patients ultimately developed lymph node metastasis. One patient with adjuvant chemotherapy required surgery, and another was treated with chemotherapy whose subsequent death was cause specific. The other three patients received chemoradiotherapy and have not shown cause-specific death. Overall and cause-specific survival rates at 5 years were 67.3% and 91.8%, respectively. Among 41 patients treated by EMR alone, only one died from primary esophageal cancer (2.4%), and overall and cause-specific survival rates at 5 years were 75.6% and 97.6%, respectively. Multivariate analysis revealed that severe concurrent diseases including multiple primary cancers and the administration of 5-fluorouracil-based chemotherapy for multiple primary cancers significantly influenced survival (P=0.025, hazard ratio [HR] 13.1 [95% confidence interval 1.5-114]) and (P=0.037, HR 0.213 [95% confidence interval 0.05-0.914]), respectively. Eight and six patients developed metachronous esophageal squamous cell cancer and local recurrence, respectively. With the exception of one patient, they could be retreated endoscopically. EMR is a reasonable option for the patients with T1a-MM and T1b esophageal carcinoma without clinical metastasis, especially for the individuals with severe concurrent diseases. The prognostic factors for the benefit of EMR in such cases should be further examined.	
除外	非合致				22229748	eng	Nakaminato S, Torihara A, Makino T, Kawano T, Kishimoto S, Shibuya	Prevalence of esophageal cancer during the pretreatment of hypopharyngeal cancer patients: routinely performed esophagogastroduodenoscopy and FDG-PET/CT findings.	Acta Oncol	2012	51(5)	645-52	Journal Article	BACKGROUND: The prevalence of esophageal cancer accompanied by hypopharyngeal cancer (HPC) is high and increasing rapidly in Asia. The purpose of this prospective study was to evaluate the prevalence of esophageal cancer during the pretreatment of HPC patients who were routinely examined using esophagogastroduodenoscopy (EGD) and 18F-fluorodeoxyglucose/computed tomography (FDG-PET/CT) and to discuss the utility of these examinations. MATERIAL AND METHODS: Between September 2005 and September 2010, 33 patients with newly diagnosed HPC (all with squamous cell carcinoma) underwent EGD (after a conventional endoscopy, iodine staining was performed) and FDG-PET/CT examinations. We evaluated the prevalence of esophageal cancer among HPC patients according to the EGD findings and determined the sensitivity of FDG-PET/CT for the detection of esophageal primary tumors for each clinical T classification. RESULTS: In 17 of the 33 patients (51.5%), 29 biopsy-proven esophageal squamous cell carcinomas were diagnosed using EGD. In eight of the 17 (47.1%) patients, two or more esophageal cancer lesions were diagnosed. Twenty-four of the 29 (82.8%) lesions were superficial esophageal cancers, and the remaining five (17.2%) lesions were advanced esophageal cancers. In six of the 29 (20.7%) esophageal cancer lesions that were detected using FDG-PET/CT, only one of the 29 (3.4%) lesions was evaluated as being equivocal; the remaining 22 (75.9%) lesions were not detected. The distribution of the clinical T classifications detected using FDG-PET/CT was as follows: T1a, 0/21 (0%); T1b, 1/3 (33%); and T3, 5/5 (100%). CONCLUSIONS: The prevalence of esophageal cancer during the pretreatment of HPC patients was 51.5%; this prevalence was higher than that in previous reports. We believe that the increasing proportion of superficial lesions (82.8%) detected using iodine staining and EGD may have led to the relatively high prevalence. FDG-PET/CT detected only 20.7% of the esophageal cancers, although FDG-PET/CT is capable of detecting unexpected primary malignant tumors other than esophageal cancer.	
除外	非合致				22115605	eng	Thosani N, Singh H, Kapadia A, Ochi N, Lee JH, Ajani J, Swisher SG, Hofstetter WL, Guha S, Bhutani	Diagnostic accuracy of EUS in differentiating mucosal versus submucosal invasion of superficial esophageal cancers: a systematic review and meta-analysis.	Gastrointest Endosc	2012	75(2)	242-53	Journal Article; Meta-Analysis; Review	BACKGROUND: The prognosis of esophageal cancer (EC) depends on the depth of tumor invasion and lymph node metastasis. EC limited to the mucosa (T1a) can be treated effectively with minimally invasive endoscopic therapy, whereas submucosal (T1b) EC carries relatively high risk of lymph node metastasis and requires surgical resection. OBJECTIVE: To determine the diagnostic accuracy of EUS in differentiating T1a EC from T1b EC. DESIGN: We performed a comprehensive search of MEDLINE, SCOPUS, Cochrane, and CINAHL Plus databases to identify studies in which results of EUS-based staging of EC were compared with the results of histopathology of EMR or surgically resected esophageal lesions. DerSimonian-Laird random-effects model was used to estimate the pooled sensitivity, specificity, and likelihood ratio, and a summary receiver operating characteristic (SROC) curve was created. SETTING: Meta-analysis of 19 international studies. PATIENTS: Total of 1019 patients with superficial EC (SEC). INTERVENTIONS: EUS and EMR or surgical resection of SEC. MAIN OUTCOME MEASUREMENTS: Sensitivity and specificity of EUS in accurately staging SEC. RESULTS: The pooled sensitivity, specificity, and positive and negative likelihood ratio of EUS for T1a staging were 0.85 (95% CI, 0.82-0.88), 0.87 (95% CI, 0.84-0.90), 6.62 (95% CI, 3.61-12.12), and 0.20 (95% CI, 0.14-0.30), respectively. For T1b staging, these results were 0.86 (95% CI, 0.82-0.89), 0.86 (95% CI, 0.83-0.89), 5.13 (95% CI, 3.36-7.82), and 0.17 (95% CI, 0.09-0.30), respectively. The area under the curve was at least 0.93 for both mucosal and submucosal lesions. LIMITATIONS: Heterogeneity was present among the studies. CONCLUSION: Overall EUS has good accuracy (area under the curve >=0.93) in staging SECs. Heterogeneity among the included studies suggests that multiple factors including the location and type of lesion, method and frequency of EUS probe, and the experience of the endosonographer can affect the diagnostic accuracy of EUS.	
除外	非合致				22057498	eng	Nava HR, Allamaneni SS, Dougherty TJ, Cooper MT, Tan W, Wilding G, Henderson	Photodynamic therapy (PDT) using HPPH for the treatment of precancerous lesions associated with Barrett's esophagus.	Lasers Surg Med	2011	43(7)	705-12	Journal Article; Randomized Controlled Trial; Research Support, N.I.H., Extramural; Research Support, Non-U.S. Gov't	BACKGROUND AND OBJECTIVES: Photodynamic therapy (PDT) with porfimer sodium, FDA approved to treat premalignant lesions in Barrett's esophagus, causes photosensitivity for 6-8 weeks. HPPH (2-[1-hexyloxyethyl]-2-devinyl pyropheophorbide-a) shows minimal photosensitization of short duration and promising efficacy in preclinical studies. Here we explore toxicity and optimal drug and light dose with endoscopic HPPH-PDT. We also want to know the efficacy of one time treatment with HPPH-PDT. STUDY DESIGN/MATERIALS AND METHODS: Two nonrandomized dose escalation studies were performed (18 patients each) with biopsy-proven high grade dysplasia or early intramucosal adenocarcinoma of esophagus. HPPH doses ranged from 3 to 6 mg/m ² . At 24 or 48 hours after HPPH administration the lesions received one endoscopic exposure to 150, 175, or 200 J/cm of 665 nm light. RESULTS: Most patients experienced mild to moderate chest pain requiring symptomatic treatment only. Six patients experienced grade 3 and 4 adverse events (16.6%). Three esophageal strictures were treated with dilatation. No clear pattern of dose dependence of toxicities emerged. In the drug dose ranging study (light dose of 150 J/cm at 48 hours), 3 and 4 mg/m ² of HPPH emerged as most effective. In the light dose ranging study (3 or 4 mg/m ² HPPH, light at 24 hours), complete response rates (disappearance of high grade dysplasia and early carcinoma) of 72% were achieved at 1 year, with all patients treated with 3 mg/m ² HPPH plus 175 J/cm and 4 mg/m ² HPPH plus 150 J/cm showing complete responses at 1 year. CONCLUSIONS: HPPH-PDT for precancerous lesions in Barrett's esophagus appears to be safe and showing promising efficacy. Further clinical studies are required to establish the use of HPPH-PDT.	
全文取り寄せ		可	否	T1b	22000793	eng	Tian J, Prasad GA, Lutzke LS, Lewis JT, Wang	Outcomes of T1b esophageal adenocarcinoma patients.	Gastrointest Endosc	2011	74(6)	1201-6	Clinical Trial; Comparative Study; Journal Article	BACKGROUND: Esophagectomy is usually recommended for patients with submucosal esophageal adenocarcinoma (T1b EAC) because of the potential for lymph node metastasis (LNM). Endoscopic management often differs based on the risk of metastasis. There is limited information on the difference in outcomes for T1b-EAC with and without esophagectomy. OBJECTIVES: To investigate (1) the outcomes of T1b EAC treatments with and without esophagectomy and (2) the percentage of LNM at esophagectomy for T1b-EAC. DESIGN: Retrospective cohort. SETTING: A tertiary Barrett's esophagus unit. PATIENTS: Sixty-eight T1b EAC patients based on EMR histology. INTERVENTIONS: Esophagectomy and endoscopic therapies. MAIN OUTCOME MEASUREMENTS: Survival duration and mortality rate. RESULTS: A total of 68 patients had T1b EAC; cumulative mortality rate was 30.9% and median survival duration was 39.5 months. Thirty-nine underwent esophagectomy and 29 did not. Among patients who underwent esophagectomy, 13 (33.3%) had LNM, and the mortality rate was 50.0% and 11.1% for those with and without LNM, respectively (P < .01). For those with and without esophagectomy, the cumulative mortality rates were 25.6% and 37.9%, and median survival duration was 48.9 and 34.8 months, respectively. There was no statistical difference in Charlson comorbidity index, number of EMRs, mortality rate, or survival duration. In Cox proportional hazard model analysis, the hazard ratio for esophagectomy was 0.5 (P = .21). LIMITATIONS: Retrospective, nonrandomized small sample size cohort. CONCLUSION: Among the patients with T1b EAC found in EMR specimens who underwent esophagectomy, one third had regional LNM. In our small series, patients who underwent esophagectomy did not have a significantly different survival duration from that of those who did not, indicating that these patients may have similar outcomes [corrected].	

全文取り寄せ		可	否	small sample size	21667194	eng	Moriya H, Ohbu M, Kobayashi N, Tanabe S, Katada N, Futawatari N, Sakuramoto S, Kikuchi S, Okayasu I, Watanabe	Lymphatic tumor emboli detected by D2-40 immunostaining can more accurately predict lymph-node metastasis.	World J Surg	2011	35(9)	2031-7	Comparative Study; Journal Article	BACKGROUND: Resected specimens of superficial squamous cell carcinoma of the esophagus (SSCOE) underwent D2-40 immunostaining to accurately assess lymphatic tumor emboli (LY) and to analyze correlations between LY and lymph node metastasis (N). This present study was designed to determine the accuracy of LY grade for predicting the risk of N. MATERIALS AND METHODS: We studied 75 patients with SSCOE who underwent surgical resection of their tumors. Resected specimens were sliced into continuous sections at 5 mm intervals. Intramucosal cancers are classified into three groups (m1, m2, m3), and submucosal cancers are also divided into three groups (sm1, sm2, sm3). The numbers of LY present in lymphatic ducts on D2-40 immunostaining, venous tumor emboli (V) on CD34 immunostaining, and lymphatic tumor emboli (ly) and V on hematoxylin-eosin staining (HE) and elastica van Gieson staining (EVG) were counted for each case. The presence of lymphatic tumor emboli was graded according to the total number of LY per case as follows: 0, LY0; 1 to 2, LY1; 3 to 9, LY2; and 10 or more, LY3. RESULTS: All m1 and m2 cases were LY- and N- Lymphatic tumor emboli were present in 54% of m3 cases, 70% of sm1 cases, 54% of sm2 cases, and 75% of sm3 cases. Determination of N was positive in 18% of m3 cases, 47% of sm1 cases, 36% of sm2 cases, and 62% of sm3 cases. The frequency of LY significantly correlated with the number of N ($p < 0.0001$). Multiple regression analysis showed that only LY and V significantly correlated with N. When the detection rate of N was compared between LY and ly, LY was superior to ly in terms of specificity, accuracy, positive predictive value, and false positive rate. As for LY grade, N was positive in 39.1% of LY1 cases, 81.8% of LY2 cases, and 100% of LY3 cases. Even in LY-, N was positive in one sm1 case and in two sm2 cases. In the sm1 case, the depth of invasion was 350 μ m from the lower margin of the muscularis mucosae. CONCLUSIONS: Evaluation of lymphatic invasion on the basis of LY is more accurate for the prediction of N than conventional techniques, and LY grade strongly correlates with N. In patients with SSCOE, mucosal cancers (m1, m2, and m3) and submucosal cancers with a depth of invasion of ≤ 200 μ m from the lower margin of the muscularis mucosae on endoscopic mucosal resection have a low risk of N if the number of LY is 0. Endoscopic mucosal resection alone can provide good treatment outcomes in such patients.
全文取り寄せ		可	否	T1b	21651355	eng	Gockel I, Sgourakis G, Lyros O, Polotzek U, Schimanski CC, Lang H, Hoppo T, Jobe	Risk of lymph node metastasis in submucosal esophageal cancer: a review of surgically resected patients.	Expert Rev Gastroenterol Hepatol	2011	5(3)	371-84	Journal Article; Review	OBJECTIVES: Endoscopic local procedures are increasingly applied in patients with superficial esophageal cancer as an alternative to radical oncologic resection. The objective of this article is to determine the risk of nodal metastases in submucosal (sm) esophageal cancer, comparing the two predominating histologic tumor types, squamous cell cancer (SCC) and adenocarcinoma (ADC). METHODS: A query of PubMed, MEDLINE, Embase and Cochrane Library (1980-2009) using predetermined search terms revealed 675 abstracts, of which 485 full-text articles were reviewed. A total of 105 articles met the selection criteria. A review of article references and consultation with experts revealed additional articles for inclusion. Studies that enrolled patients with submucosal esophageal cancer and provided adequate extractable data were included. RESULTS: The pooled outcomes of 7645 patients with esophageal cancer involving the sm level of infiltration were included in the analysis. Overall, the percentage of lymph node metastasis in submucosal cancer was 37%. Lymph node (N), lymphatic (L) and vascular (V) invasion in sm1 esophageal cancers was 27, 46 and 22%, respectively. Within sm2 lesions, N, L and V invasion were involved in 38, 63 and 38% of patients, respectively. Finally, N, L and V involvement in patients with sm3 lesions was 54, 69 and 47%, respectively. The rates of lymph node metastasis for sm1 and sm2 were higher in SCC compared with ADC, whereas the lymph node metastasis for sm3 was comparable, with $>50\%$ involvement in both histologic subtypes. SCC revealed an overall more aggressive behavior compared with ADC (N+: 45 vs 26%; L+: 57 vs 37%; V+: 40 vs 18%). DISCUSSION: While endoscopic therapy may be adequate in selected patients with 'low-risk' sm1 ADC, submucosal SCC necessitates esophageal resection and systematic lymphadenectomy because of its aggressive nature and tendency for early metastasis.
除外	非合致				21535207	eng	Kawahara Y, Uedo N, Fujishiro M, Goda K, Hirasawa D, Lee JH, Miyahara R, Morita Y, Singh R, Takeuchi M, Wang S, Yao	The usefulness of NBI magnification on diagnosis of superficial esophageal squamous cell carcinoma.	Dig Endosc	2011	23 Suppl 1	79-82	Case Reports; Journal Article	Reported herein is the case of a 80-year-old man who had small squamous cell carcinoma in the esophagus. The lesion was initially detected as a irregular reddish elevated and flat area depicted by non-magnified white light endoscopy and observed as a brownish area with the narrow-band imaging system (NBI). The depth of elevated and depressed area in the lesion was predicted to be LSM to MM due to Inoue's classification of morphologic change of intrapapillary capillary loop (IPCL) under magnified NBI observation. The depth of another flat area was not able to predicted by Inoue's classification, and we used Arima's classification. We predicted the depth of invasion to be MM to SM1 by this classification. Endoscopic submucosal dissection (ESD) was carried out for the lesion. As a result, the endoscopic diagnosis completely accorded with pathological diagnosis. We could diagnose correctly by adding Arima's classification to Inoue's classification.
全文取り寄せ		可	採		21392755	eng	Choi JY, Park YS, Jung HY, Ahn JY, Kim MY, Lee JH, Choi KS, Kim do H, Choi KD, Song HJ, Lee GH, Cho KJ, Kim	Feasibility of endoscopic resection in superficial esophageal squamous carcinoma.	Gastrointest Endosc	2011	73(5)	881-9, 889	Comparative Study; Journal Article	BACKGROUND: Endoscopic resection in patients with superficial esophageal squamous carcinoma (SESC) is limited by the presence of lymph node metastasis (LNM), highlighting the importance of determining which patients have virtually no risk of LNM. OBJECTIVE: To investigate the clinicopathological parameters predicting LNM in patients who underwent esophagectomy for SESCOs and to identify the best candidate patients for endoscopic resection. DESIGN: Retrospective, single-center study. SETTING: Tertiary-care center. PATIENTS: A total of 190 patients who underwent esophagectomy for SESCOs between 1991 and 2009. INTERVENTIONS: Esophagectomy with lymph node dissection. MAIN OUTCOME MEASUREMENTS: LNM. RESULTS: Of 190 patients, 39 (20.5%) had LNM. The rates of LNM in patients with m1, m2, m3, sm1, sm2, and sm3 lesions were 0.0% (0/18), 8.7% (4/46), 25.0% (6/24), 15.0% (3/20), 26.0% (7/27), and 37.3% (19/51), respectively. On multivariate analysis, lymphovascular invasion (LVI) ($P < .001$), superficial tumor size ($P = .004$), and lower LMM (lamina muscularis mucosae) invasion width ($P < .001$) were independent predictors of LNM in patients with SESC invading the LMM. Among 63 patients with mucosal or sm1 cancer 3 cm or smaller, only 1 had LNM without LVI showing a lower LMM invasion width greater than 3.0 mm. LIMITATIONS: Retrospective analysis. CONCLUSIONS: Endoscopic resection should be performed for mucosal cancer of 3 cm or less without positive lymph nodes. Moreover, if pathological examination of the endoscopically resected specimens shows invasion of the sm1 layer and a lower LMM invasion width of 3.0 mm or less, indicating an absence of LVI, the patient can be carefully observed without additional treatment.
除外	case report				21224579	jpn	Morimoto J, Kubo N, Tanaka H, Ohira M, Muguruma K, Sawada T, Yamada N, Yashiro M, Yamashita Y, Nishiguchi Y, Hirakawa	[Two cases of lymph node recurrence after endoscopic mucosal resection of esophageal cancer].	Gan To Kagaku Ryoho	2010	37(12)	2379-81	Case Reports; English Abstract; Journal Article	Here, we reported two cases of lymph node recurrence after endoscopic mucosal resection of esophageal cancer. Case 1: A patient was a 49-year-old man. Endoscopic mucosal resection (EMR) was performed to the 0-IIc type esophageal cancer in October 2005. The pathological findings were moderately differentiated squamous cell carcinoma, pT1b-SM3, ly0, and v0. Therefore, additional therapy of definitive chemoradiation was conducted. However, he complained a difficulty in swallowing in June 2007 and computed tomography (CT) revealed a lymph node measuring 4 cm in diameter at the right side of cardia (#1). Therefore, a radical operation to the lymph node recurrence was performed in August 2007. Pathological findings revealed metastases of cancer were not only in #1 LN but also in #8a. Unfortunately, the patient died on the 37th day after the operation due to a respiratory failure and anastomotic leakage. Case 2: A patient was a 68-year-old man. EMR was performed to the 0-IIa type esophageal cancer in August 2006. The pathological findings were poorly differentiated squamous cell carcinoma, pT1a-MM, ly0, v0. Therefore, adjuvant chemotherapy was added. However, in February 2009, a follow-up CT showed a metastatic lymph node measuring 2 cm in diameter at the right side of cardia (#1) and a radical operation was performed in June 2009. Pathological findings revealed the metastatic lymph nodes were at the right side of cardia (#1) and middle thoracic paraesophagus (#108).
全文取り寄せ		可	採		20960392	eng	Alvarez Herrero L, Pouw RE, van Vilsteren FG, ten Kate FJ, Visser M, van Berge Henegouwen MJ, Weusten BL, Bergman	Risk of lymph node metastasis associated with deeper invasion by early adenocarcinoma of the esophagus and cardia: study based on endoscopic resection specimens.	Endoscopy	2010	42(12)	1030-6	Journal Article; Research Support, Non-U.S. Gov't	BACKGROUND: Most risk estimations for lymph node metastasis in adenocarcinoma of the esophagus and cardia (AEC) with invasion into the muscularis mucosae (m3) or submucosal cancers are based on surgical series. This study aimed to correlate the lymph node metastasis rate with m3 and submucosal infiltration depth of AEC in endoscopic resection specimens. METHODS: Patients undergoing endoscopic resection for AEC between January 2000 and March 2008 at two centers were included if the endoscopic resection specimen showed m3 or submucosal cancer. Infiltration into the muscularis mucosae was defined as m3. Submucosal invasion was classified as sm1 (≤ 500 μ m) or sm2/3 (> 500 μ m). Exclusion criteria were chemotherapy or radiotherapy and nonradical endoscopic resection. RESULTS: 82 patients included 57 with m3, 12 with sm1, and 13 with sm2/3 cancers. Of the tumors, 13 were poorly differentiated and five showed lymphovascular invasion. After initial endoscopic resection, seven patients underwent surgery and 75 endoscopic therapy. No lymph node metastases were found in 158 lymph nodes of the esophagectomy specimens and none of the endoscopically treated patients were diagnosed with lymph node metastasis during a median follow-up of 26 months (interquartile range [IQR] 14-41). CONCLUSION: This study suggests that lymph node metastasis risk for m3 and submucosal AEC may be lower than has been assumed on the basis of surgical series, and that current guidelines are valid regarding suitability of m3 AECs for endoscopic therapy. It may also suggest that selected patients with submucosal cancers are also eligible for endoscopic management. Confirmation of these results is needed in larger series with longer follow-up.

除外	非合致				20454494	eng	Chaves DM, Maluf Filho F, de Moura EG, Santos ME, Arrais LR, Kawaguti F, Sakai	Endoscopic submucosal dissection for the treatment of early esophageal and gastric cancer—initial experience of a western center.	Clinics (Sao Paulo)	2010	65(4)	377–82	Journal Article	BACKGROUND: Endoscopic submucosal dissection is a new Japanese technique characterized by en-bloc resection of the entire lesion irrespective of size, with lower local recurrence when compared to endoscopic mucosal resection. OBJECTIVE: To evaluate the feasibility, early results and complications of the endoscopic submucosal dissection technique for treating early gastric and esophageal cancer at the Endoscopic Unit of Clinics Hospital and Cancer Institute of the Sao Paulo University. MATERIALS AND METHODS: Twenty patients underwent endoscopic resection using the endoscopic submucosal dissection technique for early gastric or esophageal cancer. The patients were evaluated prospectively as to the executability of the technique, the short-term results of the procedure and complications. RESULTS: Sixteen gastric adenocarcinoma lesions and six esophageal squamous carcinoma lesions were resected. In the stomach, the mean diameter of the lesions was 16.2 mm (0.6–3.5 mm). Eight lesions were type Ia + IIc, four were type IIa and four IIc, with thirteen being well differentiated and three undifferentiated. Regarding the degree of invasion, five were M2, seven were M3, two were Sm1 and one was Sm2. The mean duration of the procedures was 85 min (20–160 min). In the esophagus, all of the lesions were type Ib, with a mean diameter of 17.8 mm (6–30 mm). Regarding the degree of invasion, three were M1, one was M2, one was M3 and one was Sm1. All had free lateral and deep margins. The mean time of the procedure was 78 min (20–150 min) CONCLUSION: The endoscopic submucosal dissection technique was feasible in our service with a high success rate.	
全文取り寄せ		可	否	MM症例数不明	20347733	eng	Sepesi B, Watson TJ, Zhou D, Polomsky M, Little VR, Jones GE, Raymond DP, Hu R, Qiu X, Peters	Are endoscopic therapies appropriate for superficial submucosal esophageal adenocarcinoma? An analysis of esophagectomy specimens.	J Am Coll Surg	2010	210(4)	418–27	Journal Article	BACKGROUND: Endoscopic resection and ablation have advanced the treatment of intramucosal esophageal adenocarcinoma and have been promoted as definitive therapy for selected superficial submucosal tumors. Controversy exists regarding the prevalence of nodal metastases at various depths of mucosal and submucosal invasion. Our aim was to clarify this prevalence and identify predictors of nodal spread. STUDY DESIGN: An expert gastrointestinal pathologist retrospectively reviewed 54 T1 adenocarcinomas from 258 esophagectomy specimens (2000 to 2008). Tumors were classified as intramucosal or submucosal, the latter being subclassified as SM1 (upper third), SM2 (middle third), or SM3 (lower third) based on the depth of tumor invasion. The depth of invasion was correlated with the prevalence of positive nodes. Fisher's exact test and univariate and multivariate logistic regression were used to identify variables predicting nodal disease. RESULTS: Nodal metastases were present in 0% (0 of 25) of intramucosal, 21% (3 of 14) of SM1, 36% (4 of 11) of SM2, and 50% (2 of 4) of SM3 tumors. The differences were significant between intramucosal and submucosal tumors ($p < 0.0001$), although not between the various subclassifications of submucosal tumors ($p = 0.503$). Univariate logistic regression identified poor differentiation ($p = 0.024$), lymphovascular invasion ($p = 0.049$), and number of harvested lymph nodes ($p = 0.037$) as significantly correlated with nodal disease. Multivariate logistic regression did not identify any of the tested variables as independent predictors of the prevalence of positive lymph nodes. CONCLUSIONS: All depths of submucosal invasion of esophageal adenocarcinoma were associated with an unacceptably high prevalence of nodal metastases and a marked increase relative to intramucosal cancer. Accurate predictors of nodal spread, independent of tumor depth, are currently lacking and will be necessary before recommending endoscopic resection with or without concomitant ablation as curative treatment for even superficial submucosal neoplasia.	
除外	非合致				20304395	eng	Hatta W, Uno K, Koike T, Yokosawa S, Iijima K, Imatani A, Shimosegawa	Optical coherence tomography for the staging of tumor infiltration in superficial esophageal squamous cell carcinoma.	Gastrointest Endosc	2010	71(6)	899–906	Clinical Trial, Phase I; Clinical Trial, Phase II; Journal Article	BACKGROUND: Optical coherence tomography (OCT) is a noninvasive technology that can produce high-resolution cross-sectional images in real-time without acoustic coupling, enabling precise assessment of tumor invasion in superficial esophageal squamous cell carcinomas (SESCCs). OBJECTIVE: To elucidate the usefulness of in vivo OCT for the staging of SESCOs. DESIGN: A single-center, prospective study in 2 phases: phase I to establish the OCT criteria classified into 3 categories (epithelium or lamina propria mucosa [EP/LPM], muscularis mucosa [MM], submucosa [SM]) and phase II to evaluate these criteria. SETTING: An academic medical center. PATIENTS: Sixty-two patients with a histological diagnosis of SESCO by routine endoscopy. In the phase I study, 35 images from 16 patients were used. In the phase II study, 109 images from 46 subsequent consecutive patients enrolled from January 2007 to May 2009 were used. INTERVENTIONS: We performed OCT for preoperative staging followed by endoscopic submucosal dissection or a surgical procedure and compared precisely the visualized OCT sites with the corresponding tissue sections. MAIN OUTCOME MEASUREMENTS: The accuracy of OCT for the staging. RESULTS: The overall accuracy rate was 92.7% (EP/LPM, 94.9%; MM, 85.0%; SM, 90.9%). The OCT signal penetration depth was sufficient to depict the boundary of the deepest region of cancer, the thickness of which was less than 1.5 mm. LIMITATIONS: The small number of patients. CONCLUSIONS: To our knowledge, this is the first study demonstrating that OCT might be useful for the preoperative staging of SESCOs with a high degree of accuracy.	
除外	case report				20037452	jpn	Okamura H, Fujiwara H, Suchi K, Okamura S, Umehara S, Konishi H, Todo M, Kubota T, Ichikawa D, Kikuchi S, Okamoto K, Kuriu Y, Ikoma H, Nakanishi M, Ochiai T, Sakakura C, Kokuba Y, Sonoyama T, Otsuji	[Surgically resected local recurrence after endoscopic submucosal dissection of esophageal cancer—a case report].	Gan To Kagaku Ryoho	2009	36(12)	2448–50	Case Reports; English Abstract; Journal Article	We report a case of surgically resected esophageal cancer which was locally recurred after endoscopic submucosal dissection. A 66-year-old man was admitted to our hospital because of further examination and a treatment of superficial esophageal cancer. A type 0-IIb+IIa cancer occupying the whole circumference of the lumen of the middle to lower esophagus was revealed. The depth of the invasion was judged to be T1a-EP or LPM by endoscopic ultrasonography, and no metastasis to other organs or lymph nodes was detected. Endoscopic submucosal dissection (ESD) was performed. However, macroscopic residual cancer didn't seem to exist. Pathological diagnosis was squamous cell carcinoma, moderately differentiated, the depth of tumor invasion was T1a-LPM. The presence of the residual cancer of the horizontal cut margin could not be judged because en bloc resection could not be achieved. After that, endoscopic balloon dilatation of the esophageal stenosis was performed repeatedly for about one year. Then, he was diagnosed as the local recurrence of the squamous cell carcinoma of the esophagus. Thoraco-abdominal esophagectomy reconstructed by stomach tube via a retrosternal route was undergone. The final stage of the lesion was judged T3N1M0 (Stage III, UICC) by the histological examination from the resected specimen. After the operation, he is receiving adjuvant chemotherapy and alive without recurrence. When endoscopic resection of the esophageal cancer is performed to the lesion, which relatively indicated to endoscopic resection or outside the guideline criteria for endoscopic resection, it is important that we choose the appropriate treatment protocol obtaining an informed consent from the patient sufficiently.	
除外	非合致				19968747	eng	Shimizu Y, Yoshida T, Kato M, Hirota J, Ono S, Nakagawa M, Kobayashi T, Kubota K, Asaka	Low-grade dysplasia component in early invasive squamous cell carcinoma of the esophagus.	J Gastroenterol Hepatol	2010	25(2)	314–8	Journal Article	BACKGROUND AND AIMS: It has not been determined whether low-grade squamous dysplasia (LGD) of the esophagus is a precancerous lesion or not. If LGD progresses to squamous cell carcinoma, early carcinoma lesions that have such a natural history might contain a remaining LGD component. METHODS: The lesions in the 68 patients with early invasive squamous cell carcinoma who underwent endoscopic mucosal resection were examined for the presence of an LGD component. If LGD components were observed, the degrees of architectural and cytological abnormalities of LGD components and those of tumor invasive fronts in the same lesions were studied. The degrees of abnormalities of 28 small LGD lesions were also studied. RESULTS: Histological examination of resected specimens confirmed LGD components in 43% of the squamous cell carcinoma lesions. The lesions of lamina propria mucosae (m3) and submucosal layer (sm) cancer ($P = 0.037$). Mean score for the degrees of cytological abnormalities of LGD component was similar to that of tumor invasive front ($P = 0.457$) and significantly higher than that of small LGD lesions ($P < 0.001$). CONCLUSION: Our results indicate the possibility that the lesion was formed by a combination of small lesions that arose as a multicentric occurrence of squamous cell carcinoma and dysplasia. Our results also suggest that an LGD component would transform to carcinoma along with tumor progression. However, the concept of 'basal cell layer type carcinoma in situ' may be suitable for squamous cell lesions with a high degree of cytological abnormalities confined to the lower half of the epithelium.	
除外	非合致				19780887	eng	Iguchi Y, Niwa Y, Miyahara R, Nakamura M, Banno K, Nagaya T, Nagasaka T, Watanabe O, Ando T, Kawashima H, Ohmiya N, Itoh A, Hirooka Y, Goto	Pilot study on confocal endomicroscopy for determination of the depth of squamous cell esophageal cancer in vivo.	J Gastroenterol Hepatol	2009	24(11)	1733–9	Comparative Study; Journal Article	BACKGROUND AND AIM: Confocal endomicroscopy is ultra-high-magnification endoscopy with histological observation during ongoing endoscopy. We planned a pilot study of the diagnosis of the depth of esophageal cancer using confocal endomicroscopy for treatment strategies. METHODS: Patients had 14 superficial esophageal cancers and one dysplasia. The depth of neoplasms in 15 lesions was confirmed by endoscopic mucosal resection or surgery. We examined the rate of delineation and compared results of confocal imaging with histological findings. We classified two cellular and three microvascular patterns on confocal endomicroscopic images: CP-N for normal squamous mucosa and CP-Ga for cancerous lesion. VP-type A for normal squamous mucosa, VP-type B for T1a-EP and T1a-LPM cancers; and VP-type C for T1a-MM or a more invasive cancer pattern. We measured diameters of microvessels for the three patterns of confocal endomicroscopic images and histological specimens. RESULTS: The rate of delineation was 73.3% (11/15) for esophageal cancer. The results of confocal imaging coincided well with microvessel distribution on horizontal histology. Two endoscopists blindly diagnosed the two types by cellular pattern and the three types by vascular pattern: their overall accuracies were 96% and 89% for the cellular pattern and 85% and 85% for the vascular pattern, respectively. The k value of the cellular pattern and the vascular pattern diagnosis was 0.84 and 0.75, respectively. CONCLUSION: Scoring and quantification of confocal endomicroscopic images may be useful for the differential diagnosis and diagnosis of superficial invasion by squamous cell carcinoma.	

全文取り寄せ		可	否	design paper	19703839	eng	Kurokawa Y, Muto M, Minashi K, Boku N, Fukuda	A phase II trial of combined treatment of endoscopic mucosal resection and chemoradiotherapy for clinical stage I esophageal carcinoma: Japan Clinical Oncology Group Study JCOG0508.	Jpn J Clin Oncol	2009	39(10)	686-9	Clinical Trial, Phase II, Journal Article; Multicenter Study; Research Support, Non-U.S. Gov't	Standard treatment for clinical stage I esophageal cancer with submucosal invasion (T1b) has been surgical resection. We conducted a Phase II trial to evaluate the efficacy and the safety of combined treatment of endoscopic mucosal resection (EMR) and chemoradiotherapy for clinical stage I (T1b) esophageal cancer. Patients diagnosed as having clinical stage I (T1b) esophageal cancer which is considered to be resectable by EMR are eligible. When pathological examination of the EMR specimen confirms T1b tumor with negative or positive resection margin, the patient undergoes chemoradiotherapy. The study continues until 82 patients with T1b tumor with negative resection margin are enrolled from 20 institutions. The primary endpoint is 3-year overall survival (OS) in pT1b cases with negative resection margin. The secondary endpoints are 3-year OS and progression-free survival in all eligible cases. OS in pT1a-MM cases with margin-negative, complications of EMR and adverse events of chemoradiotherapy. The data from this trial will be expected to provide a non-surgical treatment option to the patients with clinical stage I (T1b) esophageal cancer.	
除外	非合致				19690526	eng	Chennat J, Konda VJ, Ross AS, de Tejada AH, Noffsinger A, Hart J, Lin S, Ferguson MK, Posner MG, Waxman	Complete Barrett's eradication endoscopic mucosal resection: an effective treatment modality for high-grade dysplasia and intramucosal carcinoma—an American single-center experience.	Am J Gastroenterol	2009	104(11)	2684-92	Comparative Study; Journal Article	OBJECTIVES: Complete Barrett's eradication endoscopic mucosal resection (CBE-EMR) is the endoscopic removal of all Barrett's epithelium with the curative intent of eliminating high-grade dysplasia (HGD)/intramucosal carcinoma (IMC) and reducing the risk of metachronous lesion development. We report our single tertiary referral center's long-term clinical experience using this modality in HGD/IMC management. METHODS: In this study, we retrospectively reviewed all patients who had CBE-EMR for Barrett's esophagus (BE) with HGD/IMC who had been entered into our center's prospectively collected database. High-definition white-light and narrow-band imaging examinations were used according to the protocol. Staging endoscopic ultrasound was done before CBE-EMR to exclude invasive disease or suspicious lymphadenopathy. High-dose proton pump inhibition was instituted after initial treatment, and Seattle-type surveillance biopsies were performed on follow-up every 6 months once the CBE-EMR procedure was completed. RESULTS: A total of 49 patients (mean age 67 years, median 65, s.d. 11; 75% men) with histologically confirmed BE and HGD (33), IMC (16), underwent CBE-EMR from August 2003 to August 2008. The mean BE segment length was 3.2 cm (median 2, s.d. 2.2). 26 patients had short-segment BE, and 30 had visible lesions. A total of 106 EMR procedures were performed. On initial EMR, two patients had superficial submucosal carcinoma invasion (sm1) and two had IMC with lymphatic channel invasion. All four patients were referred for esophagectomy, but one opted for continued endoscopic management, without evidence of residual or recurrent carcinoma. A total of 14 patients await completion of EMR (9) or first follow-up endoscopy (5). CBE-EMR therapy was completed in 32 patients by an average of 2.1 sessions (median 2, s.d. 0.9). Surveillance biopsies showed normal squamous epithelium in 31 of 32 (96.9%) patients (mean remission time 22.9 months, median 17, s.d. 16.7, interquartile range 11–38). In all, 10 of 46 patients who continued in the endoscopic protocol had subsquamous Barrett's epithelium on EMR specimens and/or treatment endoscopy biopsies. Overall, 1 of these 10 patients had Barrett's underneath squamous mucosa on most recent surveillance biopsies. CBE-EMR upstaged pre-EMR pathology results in 7 of 49 (14%) of patients and downstaged pathology in 15 of 49 (31%) patients. In all, 18 of 49 (37%) patients developed symptomatic esophageal stenosis after a mean of 24.4 days (median 13.5, s.d. 27.8); all were successfully managed by endoscopic treatment. No perforations or uncontrollable bleeding occurred. CONCLUSIONS: To our knowledge, this is the largest American single-center experience demonstrating that CBE-EMR with close endoscopic surveillance is an effective treatment modality for BE with HGD/IMC. Although the rate of stenosis development is significant, it is easily treated by endoscopic dilation. Patients considering endoscopic ablation should be counseled appropriately. The role of CBE-EMR in patients with lymphatic invasion or superficial submucosal invasion remains to be defined.	
除外	case report				19620806	eng	Makino T, Hirao M, Fujitani K, Takeda M, Mano M, Tsujinaka	Sustained complete response following combined nedaplatin+ adriamycin+5-fluorouracil therapy in a patient with superficial esophageal cancer –case report–.	Gan To Kagaku Ryoho	2009	36(7)	1151-4	Case Report; Journal Article	A 57-year-old man was admitted to our hospital with dysphagia. Endoscopic examination revealed a wide 0-II c 2/3-circumferential growth with negative iodine staining in the middle-third of the esophagus (25 approximately 32 cm from the incisors). Biopsy examination revealed moderately differentiated squamous cell carcinoma of the esophagus. The depth of invasion was suspected to be not beyond the mucosa (m2), and computed tomography and ultrasonography revealed neither lymph node nor distant metastasis. Esophagectomy or chemoradiation (CRT) was indicated according to the Japanese guidelines for the treatment of esophageal cancer, because endoscopic mucosal resection (EMR) would have been difficult due to the large width of the lesion (2/3 circumferential growth). Chemotherapy was administered with the combined regimen of nedaplatin+adriamycin+5-fluorouracil (NAF) because the patient desired strongly. After completion of two cycles, the cancer lesion disappeared entirely, as determined both clinically and pathologically by endoscopic examination with biopsy, without any major toxicity. At present, 3 years after the chemotherapy, the patient remains free of any evidence of recurrence.	
除外	非合致				19565442	eng	Ono S, Fujishiro M, Niimi K, Goto O, Kodashima S, Yamamichi N, Ometa	Predictors of postoperative stricture after esophageal endoscopic submucosal dissection for superficial squamous cell neoplasms.	Endoscopy	2009	41(8)	661-5	Journal Article	BACKGROUND AND STUDY AIMS: Although endoscopic submucosal dissection (ESD) is becoming accepted as an established treatment for superficial esophageal squamous cell neoplasms, the risks for developing postoperative stricture have not been elucidated. PATIENTS AND METHODS: This was a retrospective study at a single institution. From January 2002 to October 2008, 65 patients with high-grade intraepithelial neoplasms (HGINs) or m2 carcinomas treated by ESD were enrolled. Predictors of postoperative stricture were investigated by comparing results from 11 patients who developed strictures with those from 54 patients who did not. RESULTS: Significant differences between the two groups were observed in longitudinal diameter (45.0 +/- 15.9 mm vs. 31.5 +/- 13.6 mm) and circumferential diameter (37.2 +/- 8.8 mm vs. 26.8 +/- 8.7 mm) of the resected specimens, and the proportion of extension to the whole circumference of the lumen (< 1 / 2 / 3 / 4 : 2 / 4 : 2 / 4 : 5 vs. 40 / 13 / 1), histologic depth (HGIN/m2 : 2 / 9 vs. 41 / 13), and procedure time (85.6 +/- 42.8 minutes vs. 53.3 +/- 30.1 minutes). Multivariate analysis revealed that circumferential extension of > 3 / 4 (odds ratio [OR]: 44.2; 95 % confidence interval [CI]: 4.4 - 443.6) and histologic depth to m2 (OR: 14.2; 95 %CI: 2.7 - 74.2) are reliable risk factors. Subanalysis for each category by combinations of these risk factors revealed that patients with lesions in > 3 / 4 of the circumferential area were associated with a high rate of postoperative stricture. By contrast, patients with HGIN lesions in < 3 / 4 extension have no probability of postoperative strictures. Additionally, subanalysis of patients with m2 lesions in < 3 / 4 circumferential extension revealed that circumferential diameter can be a reliable predictor for postoperative stricture. CONCLUSIONS: Circumferential extension and histologic depth are the reliable risk factors for postoperative strictures. In combination with circumferential diameter, we can perform effective and appropriate preventive balloon dilations after esophageal ESD.	
全文取り寄せ		可	否	MM症例数不明	19524578	eng	Prasad GA, Wu TT, Wigle DA, Buttar NS, Wongkeesong LM, Dunagan KT, Lutzke LS, Borkenhagen LS, Wang	Endoscopic and surgical treatment of mucosal (T1a) esophageal adenocarcinoma in Barrett's esophagus.	Gastroenterology	2009	137(3)	815-23	Comparative Study; Journal Article; Research Support, N.I.H., Extramural; Research Support, Non-U.S. Gov't	BACKGROUND & AIMS: Endoscopic therapy is emerging as an alternative to surgical therapy in patients with mucosal (T1a) esophageal adenocarcinoma (EAC) given the low likelihood of lymph node metastases. Long-term outcomes of patients treated endoscopically and surgically for mucosal EAC are unknown. We compared long-term outcomes of patients with mucosal EAC treated endoscopically and surgically. METHODS: Patients treated for mucosal EAC between 1998 and 2007 were included. Patients were divided into an endoscopically treated group (ENDO group) and a surgically treated group (SURG group). Vital status information was queried using an institutionally approved internet research and location service. Statistical analysis was performed using Kaplan-Meier curves and Cox proportional hazard ratios. RESULTS: A total of 178 patients were included, of whom 132 (74%) were in the ENDO group and 46 (26%) were in the SURG group. The mean follow-up period was 64 months (standard error of the mean, 4.8 mo) in the SURG group and 43 months (standard error of the mean, 2.8 mo) in the ENDO group. Cumulative mortality in the ENDO group (17%) was comparable with the SURG group (20%) (P = .75). Overall survival also was comparable using the Kaplan-Meier method. Treatment modality was not a significant predictor of survival on multivariable analysis. Recurrent carcinoma was detected in 12% of patients in the ENDO group, all successfully re-treated without impact on overall survival. CONCLUSIONS: Overall survival in patients with mucosal EAC when treated endoscopically appears to be comparable with that of patients treated surgically. Recurrent carcinoma occurs in a limited proportion of patients, but can be managed endoscopically.	
除外	非合致				19461188	jpn	Mizutani H, Hihara J, Okada	[GDDP+CPT-11 therapy is useful for stage IVb esophageal small cell carcinoma].	Gan To Kagaku Ryoho	2009	36(5)	831-4	Case Reports; English Abstract; Journal Article	The patient was a 59-year-old man who suffered from discomfort during swallowing. An esophageal small cell carcinoma was pointed out at another clinic by gastrointestinal fiberoscopy. He was hospitalized in our hospital on May 15, 2003. He was diagnosed as esophageal small cell carcinoma with mediastinum lymph node, pancreas and multiple liver metastasis by CT scan. Then he was administered CDDP+CPT-11 therapy. CDDP 60 mg/m2 (day 1) and CPT-11 60 mg/m2 (day 1, 8, 15) were infused once a week for 3 weeks followed by 1-week interval as one cycle. At one cycle after the first infusion therapy, primary tumor, pancreas and liver metastasis were markedly reduced. His quality of life was greatly improved. No particular toxic events occurred. Five cycles after the first infusion therapy, he was diagnosed with a lymph node recurrence around the pancreas on January 19, 2004. Then we started CBDCA and VP-16 combination therapy as second-line chemotherapy. But obstructive jaundice and skull metastasis occurred, and he died on July 21, 2004.	

全文取り寄せ		可	否	MM症例数不明	19324126	eng	Pennathur A, Farkas A, Krasinskas AM, Ferson PF, Gooding WE, Gibson MK, Schuchert MJ, Landreneau RJ, Luketich		Ann Thorac Surg	2009	87(4)	1048-54; d	Journal Article; Research Support, N.I.H., Extramural	OBJECTIVES: Esophagectomy is the standard treatment for T1 esophageal cancer (EC). Interest in endoscopic therapies, particularly for T1 EC, is increasing. We evaluated the long-term outcomes after esophagectomy and examined the pathologic features of T1 cancer to determine the suitability for potential endoscopic therapy. METHODS: We reviewed the outcomes of esophagectomy in 100 consecutive patients with T1 EC. The primary end points studied were overall survival (OS) and disease-free survival (DFS). In addition to detailed pathology review, we evaluated prognostic variables associated with survival. RESULTS: Esophagectomy was performed in 100 patients (79 men, 21 women; median age, 68 years) for T1 EC, comprising adenocarcinoma, 91; squamous, 9; intramucosal (T1a), 29; and submucosal (T1b), 71. The 30-day mortality was 0%. Resection margins were microscopically negative in 99 patients (99%). N1 disease was present in 21 (T1a, 2 of 29 [7%]; T1b, 19 of 71 [27%]), associated high-grade dysplasia in 64 (64%), and angiolymphatic invasion in 19 (19%). At a median follow-up of 66 months, estimated 5-year OS was 62% and 3-year DFS was 80% for all patients (including N1). Nodal status and tumor size were significantly associated with OS and DFS, respectively. CONCLUSIONS: Esophagectomy can be performed safely in patients with T1 EC with good long-term results. Many patients with T1 EC have several risk factors that may preclude adequate treatment with endoscopic therapy. Further prospective studies are required to evaluate endoscopic therapies. Esophagectomy should continue to remain the standard treatment in patients with T1 EC.	
除外	非合致				19106516	jpn	Yoshino S, Takeda S, Nishimura T, Tokunou K, Oka	[A case of esophageal cancer with recurrent lymph-node metastasis successfully treated with chemo-radiotherapy after mediastinoscopy-assisted transhiatal esophagectomy].	Gan To Kagaku Ryoho	2008	35(12)	2039-41	Case Reports; English Abstract; Journal Article	A 63-year-old man who was diagnosed T1b esophageal cancer, for which trans thoracic esophagectomy was indicated, received mediastinoscopy-assisted transhiatal esophagectomy because of the previous right thoracotomy for pulmonary tuberculosis. OT study revealed an upper mediastinal lymph-node metastasis 3 years after surgery. He was treated with chemotherapy of daily continuous 5-FU infusion (500 mg/day) and daily nedaplatin (5 mg x 5 days/week) for 4 weeks combined with concurrent radiotherapy (44 Gy). A partial response was achieved for the metastatic lymph-node lesion after chemo-radiotherapy, so boost radiotherapy (16 Gy) was given to the patient. He is still alive now without a re-growth of the lymph-node metastasis. It is important to follow-up the patient with advanced esophageal cancer carefully who received mediastinoscopy-assisted transhiatal esophagectomy.	
全文取り寄せ		可	否	T1b	18785950	eng	Manner H, May A, Pech O, Gosserer L, Rabenstein T, Gunter E, Vieth M, Stolte M, Ell	Early Barrett's carcinoma with "low-risk" submucosal invasion: long-term results of endoscopic resection with a curative intent.	Am J Gastroenterol	2008	103(10)	2589-97	Comparative Study; Journal Article	BACKGROUND: Endoscopic therapy (ET) has become a less risky alternative to open surgery in mucosal Barrett's cancer (BC) because of the very low risk of lymph node (LN) metastasis. Recently published surgical series demonstrated that even in case of minimal submucosal invasion of BC, the risk for LN metastasis is very low. In consequence, also these patients might be eligible for curative ET. The aim of this study was to prospectively evaluate the efficacy and safety of endoscopic resection (ER) in these patients. METHODS: From September 1996 to September 2003, the suspicion or definite diagnosis of submucosal BC was made in 80 patients referred to our department. Of those, 21 patients (20 male [95%], mean age 62 +/- 9 yr; range 47-78) fulfilled the definition of "low-risk" submucosal cancer: invasion of the upper submucosal third (sm1), absence of infiltration into lymph vessels/veins, histological grade G1/2, and macroscopic type I/LI. ET was carried out using ER with the suck-and-cut technique with or without an additive ablation of non-neoplastic remnants of Barrett's esophagus. RESULTS: One of the 21 patients was referred to surgery directly after the detection of sm1 invasion at the beginning of the study. One patient died (not tumor-related) before completion of ET. Using definitive ET, complete remission (CR) was achieved in 18 of 19 patients (95%) after a mean of 5.3 months (range 1-18) and a mean of 2.9 resections (range 1-9). Only one minor complication (bleeding without drop in hemoglobin level >2 g/dL) occurred (5% of patients). During a mean follow-up (FU) of 62 months (range 45-89), recurrent or metachronous carcinomas were found in 5 patients (28%). Repeat ET was carried out successfully using ER (4 patients) and argon plasma coagulation (1 patient). In one of the 19 patients (5%), tumor freedom had not been achieved after a total of 2 ER. This patient died of a heart attack before surgery could be performed. The calculated 5-yr survival rate of all 21 patients was 66%. No tumor-related death occurred. CONCLUSIONS: As in mucosal BC, ER is associated with favorable outcomes even in case of "low-risk" submucosal BC. Further and larger clinical trials are required before a general recommendation for ER as the treatment of choice in "low-risk" submucosal BC can be given.	
全文取り寄せ		可	採		18726651	eng	Ancona E, Rampado S, Cassaro M, Battaglia G, Ruol A, Gastoro C, Portale G, Cavallin F, Rugge	Prediction of lymph node status in superficial esophageal carcinoma.	Ann Surg Oncol	2008	15(11)	3278-88	Journal Article	BACKGROUND: Esophageal carcinoma is among the cancers with the worst prognosis. Real chances for cure depend on both early recognition and early treatment. The ability to predict lymph node involvement allows early curative treatment with less invasive approaches. AIMS: To determine clinicopathological criteria correlated with lymph node involvement in patients with early esophageal cancer (T1) and to identify the best candidate patients for local endoscopic or less invasive surgical treatments. METHODS: A total of 98 patients with pT1 esophageal cancer [67 with squamous cell carcinomas (SCC) and 31 with adenocarcinomas (ADK)] underwent Ivor-Lewis or McKeown esophagectomy in the period between 1980 and 2006 at our institution. Based on the depth of invasion, lesions were classified as m1, m2, or m3 if mucosal, and sm1, sm2, or sm3 if submucosal. RESULTS: The rates of lymph node metastasis were 0% for the 27 mucosal carcinomas (T1m) and 28% for the 71 submucosal (T1sm) carcinomas (P < 0.001). Sm1 carcinomas were associated with a lower rate of lymph-node metastasis (3.3% versus 49 % sm2/3, P = 0.003). As for histotype, the rates of lymph node metastasis for sm1 were 0% for ADK and 12.5% for SCC; for sm2/3 there were no significant differences. On multivariate analysis, depth of infiltration, lymphocytic infiltrate, angiolymphatic and neural invasion were significantly associated with lymph node involvement. Neural invasion was the single parameter with the greatest accuracy (82%); depth of infiltration and angiolymphatic invasion had 75% accuracy. Altogether these three parameters had an accuracy of 97%. Five-year survival rate was 56.7% overall; 77.7% for T1m and 53.3% for T1sm (P = 0.048). CONCLUSIONS: The most important factors for predicting lymph node metastasis in early esophageal cancer are depth of tumor infiltration, angiolymphatic invasion, neural invasion and grade of lymphocytic infiltration. The best candidates for endoscopic therapy are tumors with high-grade lymphocytic infiltration, no angiolymphatic or neural invasion, mucosal infiltration or sm1 (only for ADK), and tumor <1 cm in size. For sm SCC and sm2/3 ADK the treatment of choice remains esophagectomy with standard lymphadenectomy.	
全文取り寄せ		可	否	MM症例数不明	18376186	eng	Altorki NK, Lee PC, Liss Y, Mehnerally D, Korst RJ, Christos P, Mazumdar M, Port	Multifocal neoplasia and nodal metastases in T1 esophageal carcinoma: implications for endoscopic treatment.	Ann Surg	2008	247(3)	434-9	Journal Article	OBJECTIVE: There has been an increase in interest in endoscopic therapy (ET) for intramucosal (T1a) or submucosal (T1b) esophageal carcinoma. The objective of the present study was to determine the prevalence of nodal metastases, lymphatic vascular invasion, and multifocal neoplasia in patients with pT1 esophageal carcinoma who underwent esophagectomy without preoperative therapy and assess their potential implication for ET. METHODS: We retrospectively reviewed the records of all patients who underwent esophagectomy without preoperative therapy for pT1 esophageal cancer. A detailed review of all pathology reports was performed to identify relevant pathologic criteria including depth of invasion (T1a or T1b), cell type (adenocarcinoma/squamous), tumor differentiation (poor vs. well/moderate), extent of Barrett esophagus (short segment [SSBE] and long segment [LSBE]), nodal status, lymphovascular invasion (LVI), and the presence of multifocal neoplasia (MFN) (high-grade dysplasia or invasive carcinoma). Overall, survival and disease-specific survival were determined by the Kaplan-Meier method. RESULTS: There were 75 consecutive patients (58 men, 17 women) between January 1994 and September 2006. Median age was 68 years. Hospital mortality was 2.6% (2 of 75). Thirty patients had T1a and 45 had T1b. Sixty patients had adenocarcinoma. Nodal metastases were present in 2 of 30 (6%) T1a and 8 of 45 (17.5%) T1b tumors. MFN was present in 30% (9 of 30) of T1a tumors and 29% (13 of 45) of T1b tumors. All 9 patients with LVI had T1b tumors. Collectively, 10 of 30 (33.3%) patients with T1a and 25 of 45 (58%) with T1b had MFN, LVI, or nodal metastases. Forty-nine patients had adenocarcinoma with associated BE (23 SSBE, 26 LSBE). There was no difference between patients with SSBE and those with LSBE in the incidence of nodal disease (2 of 23 vs. 2 of 26) but a significant difference in the incidence of MFN (3 of 23 vs. 13 of 26, P = 0.006). Four patients with squamous carcinoma had nodal metastases and 5 had MFN. Overall 5-year survival was 78% (T1a:90% T1b: 71%, P = 0.07). Five-year disease-specific survival was 86.5% (T1a: 96.7%, T1b: 79.6%, P = 0.06). CONCLUSION: The combined high incidence of MFN, LVI, and occult nodal metastases does not support the use of ET in patients with T1 esophageal cancer regardless of depth of invasion, cell type, differentiation or extent of BE. ET may be of value in patients in whom surgical risk is considered prohibitive.	
除外	非合致				18226703	eng	Saito Y, Takisawa H, Suzuki H, Takizawa K, Yokoi C, Nonaka S, Matsuda T, Nakanishi Y, Kato	Endoscopic submucosal dissection of recurrent or residual superficial esophageal cancer after chemoradiotherapy.	Gastrointest Endosc	2008	67(2)	355-9	Journal Article	BACKGROUND: Treatment of local recurrent or residual superficial esophageal squamous-cell carcinoma (SCC) with conventional EMR often results in a piecemeal resection that requires further intervention. OBJECTIVE: The aim of this study was to evaluate the efficacy of endoscopic submucosal dissection (ESD). DESIGN: A case series. PATIENTS: Between January 2006 and September 2006, 4 local recurrent or residual superficial esophageal SCCs were treated by ESD. INTERVENTIONS: ESD procedures were performed by using a bipolar needle knife and an insulation-tipped knife. After injection of glycerol into the submucosal (sm) layer, a circumferential incision was made, and an sm dissection was performed. All lesions were determined to be intramucosal or sm superficial, without lymph-node metastasis by EUS before treatment. MAIN OUTCOME MEASUREMENTS: Tumor size, en bloc resection rate, tumor-free lateral margin rates, and complications were recorded. RESULTS: All 4 ESD cases were successfully resected en bloc, and the tumor-free lateral margin rate was 75% (3/4) by histopathology examination. The mean tumor size of the resected specimens was 35 mm (range, 15-50 mm). There were no complications. LIMITATIONS: The number of ESDs in our series was limited, and there are no long-term follow-up data. CONCLUSIONS: ESD for recurrent or residual superficial esophageal tumors after chemoradiotherapy achieves the goal of an en bloc resection, with a low rate of incomplete treatment without any greater risk than the EMR technique.	

除外	非合致				21318958	eng	Chino O, Shimada H, Kise Y, Nishi T, Hara T, Yamamoto S, Tanaka M, Kajiwara H, Kijima H, Makuuchi	Early carcinoma of the esophagus associated with achalasia treated by endoscopic mucosal resection: report of a case.	Tokai J Exp Clin Med	2008	33(1)	13-6	Case Reports; Journal Article	A case of endoscopically resected early esophageal carcinoma associated with achalasia is reported. A 63-year-old woman was made diagnosis of esophageal achalasia, sigmoid type and grade III. The patient was operated by Tokai University method, Heller's long esophagomyectomy. Hill's posterior cardiopexy, fundoplication and selective proximal vagotomy using a laparotomy. Two years and six months after the operation, an early carcinoma of type 0-Ib, 1cm in size, was detected in the upper thoracic esophagus, and treated by endoscopic mucosal resection using EEMR-tube method. Pathological examination revealed proliferation of squamous cell carcinoma in situ (Tis: m1). The entire esophageal mucosa around the carcinoma demonstrated hyperplastic changes of stratified squamous epithelium and foci of dysplastic changes. In the patient of achalasia, food stasis in esophagus is thought to induce chronic hyperplastic esophagitis, converting eventually to malignant transformation. Achalasia is known as a risk factor of esophageal carcinoma. Early operation or good drainage of the esophageal lumen might reduce the risk. Long-term follow-up for patients of achalasia by endoscopic screening is recommended.	
全文取り寄せ		可	採		18086118	eng	Kim DU, Lee JH, Min BH, Shim SG, Chang DK, Kim YH, Rhee PL, Kim JJ, Rhee JC, Kim KM, Shim	Risk factors of lymph node metastasis in T1 esophageal squamous cell carcinoma.	J Gastroenterol Hepatol	2008	23(4)	619-25	Journal Article	BACKGROUND AND AIM: To perform endoscopic mucosal resection (EMR) for T1 esophageal cancer, it is essential to estimate the lymph node status exactly. In order to evaluate the feasibility of EMR for esophageal cancers, we evaluated the clinicopathological features of T1 esophageal squamous carcinomas with an emphasis on the risk factors and distribution patterns of lymph node metastasis. METHODS: From 1994 to 2006, a total of 200 patients with T1 esophageal carcinoma were treated surgically in our institution. Among them, clinicopathological features were evaluated for 197 consecutive patients with T1 squamous cell carcinoma. RESULTS: The frequency of lymph node involvement was 6.25% (4/64) in mucosal cancers and 29.3% (39/133) in submucosal cancers (P < 0.001). In patients with M1 (n = 32) and M2 (n = 14) cancers, no lymph node metastasis was found. In multivariate analysis, size larger than 20 mm, endoscopically non-flat type, and endo-lymphatic invasion were significant independent risk factors for lymph node metastasis. The differentiation of tumor cell was not a risk factor for lymph node metastasis. CONCLUSIONS: We suggest that EMR may be attempted for flat superficial squamous esophageal cancers smaller than 20 mm. After EMR, careful histological examination is mandatory.	
除外	case report				17611925	eng	Fu K, Ishikawa T, Ooyanagi H, Kaji Y, Shimizu	Multimodality treatments for nodal relapse after endoscopic mucosal resection of a superficial esophageal squamous cell carcinoma.	Endoscopy	2007	39(7)	669-71	Case Reports; Journal Article	Patients with esophageal intraepithelial carcinoma (m1) and carcinoma invading the lamina propria (m2) are generally considered good candidates for endoscopic mucosal resection (EMR) in Japan, as hardly any of them show lymph node metastasis. Although a few cases of esophageal carcinoma invading the lamina propria have been reported to show nodal involvement, lymph node metastasis and subsequent death due to carcinoma after EMR of m1 or m2 esophageal carcinoma has never been reported in the English literature. Here we describe a patient who suffered relapse of lymph node metastasis after EMR of an esophageal carcinoma invading the lamina propria without any of the reported risk factors associated with lymph node metastasis, including vascular invasion. Unfortunately, the patient died due to disease recurrence, despite receiving multimodality treatments including chemoradiotherapy and salvage surgery.	
除外	非合致				17565242	jpn	Maeda Y, Sasaki E, Sasaki	[Discussion of the treatment of esophageal carcinoma, especially in the point of non-surgical treatments, from the viewpoint of medical oncology].	Gan To Kagaku Ryoho	2007	34(6)	831-5	English Abstract; Journal Article	Recently, remarkable advances of non-surgical treatments such as endoscopic treatment and chemoradiotherapy (CRT) are made in the treatment of esophageal carcinoma. Endoscopic treatment is recognized a standard for m 1, m 2 esophageal carcinoma, and it's indication is being extended for sm esophageal carcinoma in combination with chemoradiotherapy. In stage I and stage II, treatment result of CRT is comparative with that of surgical resection. In patients with T 4 esophageal carcinoma, it is already accepted that CRT is a standard therapy. This progress of non-surgical treatments contributes to preservation of esophagus in the treatment of esophageal carcinoma. But various problems such as technical problems, complication of CRT and salvage surgery for non-CR or recurrent case also remain. To improve results in treatment of esophageal carcinoma, it is necessary that we make an effort to cooperate with surgeons and radiation oncologists, further.	
全文取り寄せ		可	否	LN不明	17337344	eng	Little SG, Rice TW, Bybel B, Mason DP, Murthy SC, Falk GW, Rybicki LA, Blackstone	Is FDG-PET indicated for superficial esophageal cancer?	Eur J Cardiothorac Surg	2007	31(5)	791-6	Journal Article	OBJECTIVE: To ascertain whether fluorodeoxyglucose positron emission tomography is indicated for clinical staging of superficial cancer, we sought to determine if it accurately classifies tumor (T), regional nodal (N), and distant metastases (M), including distinguishing high-grade dysplasia (Tis) from invasive cancer (T1). METHODS: Fifty-eight superficial esophageal cancer patients had preoperative positron emission tomography, 53 (91%) fused with computed tomography. Tumor characteristics, esophagoscopy findings, and pTNM were compared with positron emission tomography cTNM. pT1 was subdivided into intramucosal cancers with lamina propria or muscularis mucosa invasion and submucosal cancers with inner or outer invasion. RESULTS: Fluorodeoxyglucose uptake increased with pT, from 5/11 (45%) for pTis to 11/16 (69%) for pT1 (outer submucosa), P=0.07, as it did for standardized uptake value, median 0 for pTis to 2.7 for pT1 (outer submucosa), P=0.06. Positron emission tomography could not differentiate Tis (5/11, 45%) from T1 (26/47, 55%; P=0.03). Regional nodal fluorodeoxyglucose uptake in three patients (standardized uptake value 2.8, 4.9, 11) was false positive; in six pN1 patients, it was false negative. Positron emission tomography had 0% sensitivity and positive predictive value for N1. There were no distant metastases; one patient developed a pulmonary metastasis 15 months postoperatively. Positron emission tomography detected three (5%) distant hypermetabolic sites, all synchronous tumors (papillary thyroid cancer, adrenal pheochromocytoma, rectal adenoma). Only increasing tumor length was related to greater fluorodeoxyglucose uptake (P=0.004) and higher standardized uptake value (P=0.001). CONCLUSIONS: Because positron emission tomography can neither differentiate pTis from T1 nor classify T, N, and M, it is not indicated in staging superficial esophageal cancer. Finding a synchronous primary tumor in approximately every 20th patient is its only benefit. Better, less expensive screening tools are available for common synchronous malignancies.	
除外	非合致				17258554	eng	Rice TW, Mason DP, Murthy SC, Zuccaro G Jr, Adelstein DJ, Rybicki LA, Blackstone	T2N0M0 esophageal cancer.	J Thorac Cardiovasc Surg	2007	133(2)	317-24	Comparative Study; Journal Article	OBJECTIVE: The study objective was to develop a treatment algorithm for cT2N0M0 esophageal cancer by determining (1) errors in clinical staging and (2) consequences of overtreatment and undertreatment of incorrectly clinically staged patients. METHODS: Of 742 clinically staged patients, 61 (8.2%) had cT2N0M0 cancer; 45 underwent surgery alone; 8 underwent surgery and postoperative adjuvant therapy; and 8 underwent induction therapy, then surgery. As reference, 31 of 666 patients (4.7%) who underwent surgery first had pT2N0M0 cancer and a 5-year survival of 61% +/- 9.3%. Referent values were calculated from 445 clinically staged patients who underwent surgery first. Unmatched and matched survival comparisons were made using the log-rank test. RESULTS: Only 7 of 53 cT2N0M0 cancers treated with surgery first were pT2N0M0 (13% positive predictive value). Of incorrectly staged cT2N0M0 cancers (46/53), 29 (63%) were overstaged and 17 (37%) were understaged. Most overstaged cancers were pT1 (11 [38%] T1a and 15 [52%] T1b), and most understaged cancers were pN1 (13 [76%]). Matched overstaged patients treated by surgery alone (25/28) had a 5-year survival similar to that of patients with pTNM (69% +/- 9.8% vs 63% +/- 13%, P = .8). Understaged patients did better at 5 years than patients with pTNM if they had postoperative adjuvant therapy, not surgery alone (43% +/- 22% vs 10% +/- 9.5%, P = .17). Induction therapy decreased 5-year survival compared with all other treatment strategies (13% +/- 12% vs 52% +/- 7.4%, P < .05). CONCLUSIONS: Patients with cT2N0M0 cancers should undergo surgery first with lymphadenectomy. Clinically understaged patients should receive postoperative adjuvant therapy. In the unlikely event that patients with cT2N0M0 cancers are found to have an uncommon pT2N0M0 cancer, they will have acceptable survival with surgery alone.	
全文取り寄せ		可	否	small sample size	17252458	eng	Higuchi K, Tanabe S, Koizumi W, Sasaki T, Nakatani K, Saigenji K, Kobayashi N, Mitomi	Expansion of the indications for endoscopic mucosal resection in patients with superficial esophageal carcinoma.	Endoscopy	2007	39(1)	36-40	Comparative Study; Journal Article	BACKGROUND AND STUDY AIMS: Endoscopic mucosal resection (EMR) is a minimally invasive local treatment for superficial esophageal carcinoma (SEC). The use of EMR in patients with m3 or sm1 SEC remains controversial, however. The aim of this retrospective study was to evaluate the histopathological risk factors for lymph-node metastasis and recurrence in patients with m3 or sm1 SEC. PATIENTS AND METHODS: The study subjects were 43 patients with m3 or sm1 esophageal squamous-cell carcinomas: 23 patients were treated surgically (the surgery group), and 20 were treated by EMR (the EMR group). We assessed the following variables of the specimens resected by surgery or EMR: tumor depth, maximal surface diameter of the tumor (superficial size), maximum diameter of tumor invasion at the lamina muscularis mucosae (LMM invasion width), and lymphatic invasion. The relationships of these variables to lymph-node metastasis and recurrence were examined. RESULTS: In the surgery group, lymph-node metastasis was found in four patients, all of whom had tumors with lymphatic invasion, a superficial size of at least 25 mm, and an LMM invasion width of at least 2500 micron. In the EMR group, no patient met all three of these criteria, and there was no evidence of lymph-node metastasis or distant metastasis on follow-up after EMR (median follow-up 39 months). CONCLUSIONS: In patients with m3 or sm1 SEC, tumors that have lymphatic invasion, larger superficial size, and wider LMM invasion are associated with a high risk for lymph-node metastasis. EMR might be indicated for the treatment of patients with m3 or sm1 SECs without these characteristics.	

全文取り寄せ		可	否	LN不明	17252456	eng	Ciocirlan M, Lapalus MG, Hervieu V, Souquet JC, Napoleon B, Scoazec JY, Lefort C, Saurin JC, Ponchon	Endoscopic mucosal resection for squamous premalignant and early malignant lesions of the esophagus.	Endoscopy	2007	39(1)	24-9	Journal Article	BACK AND STUDY AIDS: Endoscopic mucosal resection (EMR) is used to treat premalignant and malignant digestive tract lesions. This report presents the efficacy and safety of EMR for squamous superficial neoplastic esophageal lesions. PATIENTS AND METHODS: A retrospective cohort study presented data from 51 patients with 54 lesions over an 8-year period, between November 1997 and September 2005. Dysplasias or mucosal (m) T1 carcinomas were treated with repeated EMR until there was a complete local remission. Patients with submucosal (sm) T1 carcinomas were treated with repeated EMR until there was a complete local remission. Patients with submucosal (sm) T1 carcinomas or more advanced stage were offered surgery or chemoradiotherapy. RESULTS: There was no mortality, perforation, or major hemorrhage, and there were three easily dilated stenoses. Of the patients, 16 had lesions graded as T1sm or more advanced and one patient was found to have normal tissue post-EMR. Complete local remission was achieved in 31 of the 34 patients with dysplasia or T1 m cancers (91%). There was no distant relapse and there was local disease recurrence in eight (21 of the 31 patients (26%). The 5-year survival rate was 95%. CONCLUSIONS: EMR for squamous superficial neoplastic lesions of the esophagus is safe and provides satisfactory survival results.	
除外	非合致				17048995	spa	Miquel JM, Abad R, Souto J, Fabra R, Vila M, Bargallo D, Vazquez-Iglesia JL, Varas Lorenzo	EUS-guided mucosectomy for gastrointestinal cancer.	Rev Esp Enferm Dig	2006	98(8)	591-6	Comparative Study; Journal Article	INTRODUCTION: the only way of improving prognosis and survival in gastrointestinal cancer is early diagnosis, with intramucosal localization as confirmed by endoscopic ultrasonography (EUS) or 20-MHz miniprobes (MPs) (T1) being most appropriate. Endoscopic mucosal resection (EMR) has proven effective in the treatment of this sort of lesions. PATIENTS AND METHOD: in a group (18 cases) with 15 cases of superficial gastrointestinal cancer and 3 cases of severe gastric dysplasia, 9 cases (3 esophageal, 4 gastric, 2 rectal) underwent a classic EMR following EUS or a 7.5- and 20-MHz miniprobe exploration. RESULTS: ultrasonographic studies showed a T1 in all but one esophageal case (Tis), and in both gastric dysplasias, with no changed layer structure being demonstrated in the latter (T0). No complications arose with classic EMR, and all 9 patients are alive and free from local or metastatic recurrence, except for one esophageal case, which recurred distally to the esophageal lesion (metachronous). CONCLUSIONS: echoendoscopically-assisted EMR is a safe, effective technique in the endoscopic management of superficial gastrointestinal (esophageal, gastric, colorectal) cancer. Recurrence most likely depends upon cancer multiplicity.	
除外	非合致				16896560	ita	Fiore D, Baggio V, Ruol A, Bocus P, Casara D, Corti L, Muzzio	Multimodal imaging of esophagus and cardia cancer before and after treatment.	Radiol Med	2006	111(6)	804-17	Journal Article	PURPOSE: Prognosis and treatment of esophagus and cardia cancer (ECC) depend on the precision with which the disease is staged according to the American Joint Committee of Cancer (AJCC) criteria. Imaging modalities normally used in clinical staging are esophagography, esophagoscopy, endoscopic ultrasound (EUS), computed tomography (CT) and positron emission tomography-CT fusion (CT-PET). The combination of these methods is crucial in determining not only the right diagnosis but also the stage and follow-up after multimodal treatment. The purpose of our investigation was to define the role of each imaging modality in determining the most appropriate treatment options in patients with ECC. MATERIALS AND METHODS: Fifty-six patients with ECC diagnosed by X-ray of the upper digestive tract, endoscopy and biopsy were staged using EUS, chest and abdomen CT scan, and CT-PET. Thirty-four patients in stage II and 18 patients in stage III underwent surgery after neoadjuvant chemotherapy; four patients in stage IV were treated with the positioning of an endoprosthesis after chemoradiotherapy. In the 52 patients who had surgery, follow-up included digestive tract X-ray, endoscopy and CT of the chest and abdomen every 6-8 months for the first 3 years. CT-PET was only performed in patients with a clinical suspicion of recurrence and/or CT findings suspicious of persistent disease (12 cases). RESULTS: In all 56 patients, endoscopy, EUS, CT and CT-PET in combination were crucial in determining the site of disease, locoregional extent and depth of esophageal wall penetration (T), and any involvement of the mediastinal lymph nodes (N1), extrathoracic lymph nodes (M1) or hepatic metastases. In the locoregional staging of ECC before chemotherapy, we were able to differentiate T2-T3 from T4 in 40 patients; T4 disease was found in 12 potentially resectable cases. We were able to distinguish N0 from N1 in 12 patients. In four cases, the presence of small lymph node and/or liver metastases prompted positioning of an endoprosthesis. The specificity of CT in detecting small lymph nodes in the mediastinum was less than 50% while for CT-PET was more than 80%; EUS revealed sensitivity higher than 90% but a low specificity in seven cases. Only CT-PET revealed metastatic subdiaphragmatic lymph nodes (diameter <15 mm) in three cases. Presurgical restaging of the 18 patients (stage III) who had chemotherapy was based on endoscopy, EUS, CT of the chest and abdomen and CT-PET (only in suspected cases) and was compatible with surgery. Anastomotic recurrence was diagnosed in 16 patients by endoscopy with associated biopsy; any intramediastinal spread from anastomotic recurrences was evaluated by chest CT, and CT-PET in suspected cases. CONCLUSIONS: X-ray of the upper digestive tract and chest and abdomen CT scan are useful in preliminary evaluation of ECC. Endoscopy is particularly indicated for evaluating tumour morphology, taking biopsies for a histological diagnosis and the early diagnosis of anastomotic recurrences. EUS is indicated mainly for evaluating T stage before and after chemotherapy or chemoradiotherapy. CT-PET is extremely useful in identifying small mediastinal metastatic lymph nodes (N1) or extrathoracic lymph nodes (M1) and hepatic metastases (<=1 cm), which may escape multislice CT. PET alone is useful for identifying residual or recurrent tumour in the esophageal wall when an endoprosthesis is in place.	
全文取り寄せ		可	採		16444191	eng	Eguchi T, Nakanishi Y, Shimoda T, Iwasaki M, Igaki H, Tachimori Y, Kato H, Yamaguchi H, Saito D, Umemura	Histopathological criteria for additional treatment after endoscopic mucosal resection for esophageal cancer: analysis of 464 surgically resected cases.	Mod Pathol	2006	19(3)	475-80	Journal Article	No previous reports on lymph-node metastasis (LNM) from superficial squamous cell carcinoma of the esophagus have proposed definite criteria for additional treatment after endoscopic mucosal resection (EMR). We investigated the association between histopathological factors and LNM in 464 consecutive patients with superficial squamous cell carcinoma of the esophagus who had undergone a radical esophagectomy with lymph-node dissection (14 M1 lesions: intraepithelial tumors, 36 M2 lesions: tumors invading the lamina propria, 50 M3 lesions: tumors in contact with or invading the muscularis mucosa, 32 SM1 lesions: tumors invading the most superficial 1/3 of the submucosa and 332 SM2/3 lesions: tumors invading deeper than SM1 level). Histopathological factors including invasion depth, size, lymphatic invasion (LY), venous invasion, tumor differentiation, growth pattern, degree of nuclear atypia and histological grade were assessed for their association with LNM in 82 M3 or SM1 lesions to determine which patients need additional treatment after EMR. LNM was found in 0.0, 5.6, 18.0, 53.1 and 53.9% of the M1, M2, M3, SM1 and SM2/3 lesions, respectively. A univariate analysis showed that each of the following histopathological factors had a significant influence on LNM: invasion depth (M3 vs SM1), LY, venous invasion and histological grade. Invasion depth and LY were significantly associated with LNM in a multivariate analysis. Four out of 38 patients (10.3%) with M3 lesions without LY had LNM, whereas five out of 12 patients (41.7%) with M3 lesions and LY had LNM. Only patients with M1/2 lesions are good candidates for EMR. Invading the muscularis mucosa (M3) is a high-risk condition for LNM the same as submucosal invasion, but M3 lesions without LY can be followed up after EMR without any additional treatment.	
除外	非合致				16337389	eng	Foroulis CN, Thorpe	Photodynamic therapy (PDT) in Barrett's esophagus with dysplasia or early cancer.	Eur J Cardiothorac Surg	2006	29(1)	30-4	Evaluation Studies; Journal Article	OBJECTIVE: Esophagectomy is the standard treatment for high-grade dysplasia (HGD) and intramucosal adenocarcinoma (IMC) arising within Barrett's esophagus. Results of photodynamic therapy (PDT) were retrospectively studied to evaluate the effectiveness of PDT in ablating HGD and/or IMC complicating Barrett's esophagus. METHODS: Thirty-one patients unfit for or refusing esophagectomy (male: 20, mean age: 73.4 +/- 9.3 years) underwent Porfimer sodium PDT ablation of their HGD (15 patients), HGD plus IMC (10 patients) or submucosal/limited T2 adenocarcinoma (6 patients). The mean Barrett's length was 5.8 +/- 2.2 cm. Pre-PDT endoscopic mucosal resection or Nd:YAG laser ablation of mucosal nodularity within Barrett's segment was offered in six patients. RESULTS: The main PDT complications were esophagitis (16.1%), photoreactions (12.9%) and stricture requiring dilatation (6.25%). The median post-PDT follow-up was 14 months. The long-term results were (a) for HGD/IMC: initial complete response (endoscopic and histologic absence of HGD-IMC) to PDT was observed in 80.95% of patients, partial response (no endoscopic abnormality, residual IMC-HGD on biopsy) in 9.52%, no response in 9.52% (the recurrence rate after an initial complete response was 17.64%) and (b) for T1b/limited T2 tumors: two patients died from cancer after 24 and 46 months, no evidence of tumor was found in two patients after 12 and 19 months and tumor recurrence was seen in two after 15 and 17 months. The mean survival was 22.1 +/- 12.3 months. CONCLUSIONS: PDT is effective in ablating HGD/IMC complicating Barrett's esophagus in the majority of cases, while it also seems to be quite effective in treating T1b/limited T2 carcinomas.	
全文取り寄せ		可	否	MM症例数不明	16333557	eng	Portale G, Peters JH, Hsieh CC, Hagen JA, DeMeester SR, DeMeester	Can clinical and endoscopic findings accurately predict early-stage adenocarcinoma?	Surg Endosc	2006	20(2)	294-7	Journal Article	BACKGROUND: The presentation and management of esophageal cancer are changing, as more patients are diagnosed at an earlier stage of the disease in which endoscopic treatment methods may be contemplated. Therefore, we conducted a study to determine whether symptomatic and endoscopic findings can accurately identify node-negative early-stage adenocarcinoma. METHODS: A total of 213 consecutive patients (171 men and 42 women) with resectable esophageal adenocarcinoma seen from 1992 to 2002 were evaluated. None of these patients received neoadjuvant chemotherapy or radiation therapy. Using a multivariable model, model-based probabilities of early-stage disease (T1 in/sm N0) were calculated for each combination of the following three features: no dysphagia as main symptom at presentation, tumor length <or=2 cm, and noncircumferential lesion. RESULTS: Eighty-two percent of the patients with all three characteristics presented with early-stage disease. Even in the setting of small, visible, noncircumferential tumors/nodules in patients without dysphagia, 14% of the patients harbored node metastasis. CONCLUSIONS: Simple clinical and endoscopic findings predicted early-stage disease in 82% of cases, whereas a small but significant percentage had node metastasis. Because node metastasis predisposes to local failure in nonresectional treatment options such as endoscopic mucosal resection and photodynamic therapy, such findings should have a significant bearing on treatment decisions.	

全文取り寄せ		可	否	MM症例数不明	16013002	eng	Oyama T, Tomori A, Hotta K, Morita S, Kominato K, Tanaka M, Miyata	Endoscopic submucosal dissection of early esophageal cancer.	Clin Gastroenterol Hepatol	2005	3(7 Suppl	S67-70	Comparative Study; Evaluation Studies; Journal Article	In Japan, the majority of esophageal cancers are squamous cell carcinomas. Because no lymph node metastasis was reported in squamous cell carcinomas limited to the intraepithelial layer (m1) or proper mucosal layer (m2), the Japanese Esophageal Association recommended endoscopic mucosal resection (EMR) as the treatment of choice for these cancers. However, these lesions often spread laterally, exceeding the limits of en bloc resectability with conventional EMR methods such as the EMR cap method. The lesions resected in piece-meal manner with conventional EMR methods are prone to recur locally. Therefore, we developed a method of mucosal resection with a hook-knife that enables endoscopic submucosal dissection safely and achieves a high rate of en bloc resection for larger lesions. The median size of the resected specimen and cancer by our method was 32 mm (range, 8-76 mm) and 28 mm (range, 4-64 mm), respectively. The en bloc resection rate was 95% (95 of 102) and the local recurrence rate was 0% (0 of 102). This procedure was safe, with only 6 cases (6%) of mediastinal emphysema, which improved with conservative treatment. Endoscopic submucosal dissection with the hook knife is a method of endoluminal surgery enabling large en bloc resections without increased surgical risks.	
除外	非合致				15990814	eng	Larghi A, Lightdale CJ, Memeo L, Bhagat G, Okpara N, Rotterdam	EUS followed by EMR for staging of high-grade dysplasia and early cancer in Barrett's esophagus.	Gastrointest Endosc	2005	62(1)	16-23	Comparative Study; Journal Article	BACKGROUND: Accurate staging of high-grade dysplasia and of early cancer in Barrett's esophagus is important in the selection of patients for endoscopic therapy. METHODS: Patients with Barrett's esophagus and biopsy specimen proven high-grade dysplasia and adenocarcinoma in focal nodular lesions or in endoscopically unapparent flat lesions in short-segment Barrett's esophagus were initially staged with EUS. In patients with disease limited to the mucosa on EUS, cap-assisted EMR was performed. The depth of tumor invasion on EMR specimens was classified in a similar manner to squamous-cell cancer of the esophagus: m1 (epithelial layer, dysplasia), m2 (lamina propria invasion), m3 (muscularis mucosae invasion), sm (submucosal invasion). RESULTS: EUS was performed in 48 consecutive patients (27 with focal nodular lesions and 21 with microscopic lesions), and submucosal invasion was diagnosed in 8 (confirmed in 7/8 at surgery). EMR was carried out in the remaining 40 patients without significant complications. In the 25 patients with high-grade dysplasia on prior biopsy specimens, EMR confirmed m1 disease in 19; whereas in 6 (24%), invasive adenocarcinoma was detected (to m2 in 4; to m3 in 2). In the 15 patients with invasive cancer on prior biopsy specimens and staged as intramucosal cancer on EUS, intramucosal carcinoma was confirmed in 9 (m2 in 3, m3 in 6), whereas, in 6 patients (40%), submucosal invasion was found. Overall, EUS provided accurate staging in 41/48 patients (85%) with one patient overstaged and 6 patients understaged compared with pathologic staging obtained by surgery or EMR. Of the 34 patients with m1 to m3 staging after EMR, 29 were treated endoscopically and had no evidence of cancer after a mean follow-up of 22.9 months (standard deviation 9.2 months). CONCLUSIONS: EMR provides pathologic staging information that, in addition, may be helpful after EUS if a stage-determined approach is used in the management of high-grade dysplasia and of early cancer in Barrett's esophagus. EMR may be particularly useful for staging of focal nodules or in short-segment Barrett's esophagus with microscopic lesions when endoscopic therapy is an option.	
除外	非合致				15557945	eng	Buskens CJ, Westerterp M, Lagarde SM, Bergman JJ, ten Kate FJ, van Lanschot	Prediction of appropriateness of local endoscopic treatment for high-grade dysplasia and early adenocarcinoma by EUS and histopathologic features.	Gastrointest Endosc	2004	60(5)	703-10	Journal Article	BACKGROUND: Endoscopic techniques are being developed for the local treatment of early stage esophageal cancer. However, such therapy is not appropriate for patients with lymph node metastasis. The aim of this study was to analyze the histopathologic features of high-grade dysplasia and early stage adenocarcinoma and to relate these to lymph node involvement. METHODS: Pathology reports were reviewed for all 367 patients who underwent subtotal esophagectomy for high-grade dysplasia or adenocarcinoma of the esophagus or the gastroesophageal junction between January 1993 and December 2001. Patients with histopathologically confirmed high-grade dysplasia or T1 carcinoma were included (n = 77). Pre-operative EUS results were assessed. All lesions were histopathologically subdivided in 6 different stages (mucosal 1-3 and submucosal 1-3). RESULTS: EUS staged 61 patients as N0. EUS correctly predicted the absence of positive lymph nodes in 57 (93%) of these patients. Histopathologically, m1, m2, m3, and sm1 cancers never had lymph node metastases, whereas 3 of 13 sm2 tumors (23%) and 9 of 13 sm3 tumors (69%) had lymph node involvement. Lymphatic invasion was present exclusively in sm2 and sm3 cancers. Factors that predicted the presence of lymph node metastasis were the following: tumor diameter greater than 3 cm, infiltration of malignancy beyond sm1, poor differentiation grade, and lymphatic invasion, although only infiltration beyond sm1 remained significant in the definitive multivariate analysis. CONCLUSIONS: EUS and the histopathologic features of high-grade dysplasia and early stage adenocarcinoma of the esophagus or the gastroesophageal junction can predict the presence of lymph node involvement. These data can be used to identify patients for whom local endoscopic treatment may be appropriate.	
除外	非合致				15082579	eng	May A, Gunter E, Roth F, Gossner L, Stolte M, Vieth M, Ell	Accuracy of staging in early esophageal cancer using high resolution endoscopy and high resolution endosonography: a comparative, prospective, and blinded trial.	Gut	2004	53(5)	634-40	Comparative Study; Evaluation Studies; Journal Article	BACKGROUND AND AIMS: The increasing use of endoscopic resection for curative treatment of early oesophageal cancers requires accurate staging before therapy. In a prospective blinded trial, we compared staging of early oesophageal carcinoma using high resolution endoscopy (HR-E) with staging using high resolution endosonography (HR-EUS). PATIENTS AND METHODS: A total of 100 patients (89 men, 11 women; mean age 63.9 (10.8) years (range 31-91)) with a suspicion of early oesophageal adenocarcinoma (n = 81) or squamous cell carcinoma (n = 19) were enrolled in the study. After endoscopic staging with high resolution video endoscopy by two experienced endoscopists, HR-EUS was performed by an experienced endosonographer who was blinded to the endoscopic assessment. Results of the staging examinations were correlated with the histology of the resected tumours. RESULTS: Overall rates for accuracy of the endoscopic and endosonographic staging were 83.4% and 79.6%, respectively. Sensitivity for mucosal tumours (n = 68) was more than 90% (EUS 91.2%, endoscopy 94.1%) while sensitivity for submucosal tumours (n = 25) was lower, at 48% for EUS and 56% for endoscopic staging. A combination of the two techniques increased the sensitivity for submucosal tumours to 60%. Submucosal tumours in the tubular oesophagus were significantly better staged with HR-EUS than submucosal tumours close to the oesophagogastric junction (10/11 v 2/14; p<0.001). Tumours infiltrating the second and third submucosal layers were also more correctly diagnosed than tumours with slight infiltration of the first submucosal layer (sm1). CONCLUSIONS: The overall diagnostic accuracy of both HR-E and HR-EUS with a 20 MHz miniprobe in early oesophageal cancer was high (approximately 80%), with no significant differences between the two techniques. HR-E and HR-EUS provide a high level of diagnostic accuracy for mucosal tumours and submucosal tumours located in the tubular part of the oesophagus. With submucosal tumours located at the oesophagogastric junction or with infiltration of the first third of the submucosa however, the diagnostic accuracy of both techniques is not yet satisfactory.	
全文取り寄せ		可	採		14601903	eng	Endo M, Yoshino K, Kawano T, Nagai K, Inoue	Clinicopathologic analysis of lymph node metastasis in surgically resected superficial cancer cases of the thoracic esophagus.	Dis Esophagus	2000	13(2)	125-9	Journal Article	We examined lymph node metastasis clinicopathologically in 236 cases of superficial cancer (T1, Tis) of the thoracic esophagus surgically resected at our department without adjuvant treatment. Mucosal cancer was observed in 112 cases (47%) and submucosal cancer in 124 cases (53%). Lymph node metastasis was present in 3% of mucosal cancer cases and 41% of submucosal cancer cases. By the recent pathologic subclassification of the extent of the cancerous invasion in superficial esophageal cancer, mucosal cancer and submucosal cancer were each divided into three subtypes according to the extent of invasion, i.e. m1, m2, m3, sm1, sm2 and sm3 cancers. There was no case of lymph node metastasis in m1 and m2 cases, but it was observed in 8% of m3 cases, in 11% of sm1 cases, in 30% of sm2 cases and in 61% of sm3 cases. The number of involved nodes was three or less in m3 and sm1 cases, however four or more involved nodes were observed in 14% of sm2 cases and in 24% of sm3 cases. Positive lymph nodes were found only in the mediastinum in m3 and sm1 cases. On the contrary, they were found extensively in the mediastinum, the abdomen and the neck and in two or more regions in 27% of sm2 cases and in 38% of sm3 cases. Considering the location of positive nodes, the recurrent nerve lymph nodes were most frequently involved, followed by the cardiac lymph nodes. A similar tendency was observed in cases with single node metastasis. The 5-year survival rate of cases from m1 to sm1 was similar. That of sm3 cases was significantly worse than that of other groups. Based on the clinical results, the therapeutic guidelines for superficial cancer of the thoracic esophagus are considered to be as follows: (i) in m1 and m2 cancer, endoscopic mucosal resection is generally indicated in principle, although transhiatal esophagectomy may be indicated in some cases; (ii) in m3 and sm1 cancer, endoscopic mucosal resection is performed initially, then subsequent treatment is selected if necessary; (iii) in sm2 and sm3 cancer, conventional transthoracic esophagectomy with systematic lymph node dissection is indicated.	

除外	非合致				12894703	jpn	Momma K, Yoshida	[Endoscopic mucosal resection for esophageal cancer].	Gan To Kagaku Ryohe	2003	30(7)	914-9	English Abstract; Journal Article; Review	Lymph node metastasis or microvascular permeation is rare among esophageal cancer which remains within the epithelium or the lamina propria mucosae. Endoscopic mucosal resection (EMR) is recommended for them as a radical treatment. Radical esophagectomy had been indicated for esophageal cancer reaching to the muscularis mucosae for their incidence of lymph node metastasis (10%). Recently, number of m3 or sm1 cancer cases treated by EMR has been increased. For some clinical trial succeeded to show that there is no significant difference between the prognosis of patient treated by EMR and by surgery. Thirty one patients (14%) have been lost among 219 patients who underwent EMR (mucosal cancer: 196 and submucosal cancer: 23). Four cases (13% of all patients lost after EMR) died of esophageal cancer. (one case with m3 cancer was lost by lymph node metastasis, one with sm2 cancer by liver metastasis, and two patients who refused surgical treatment by local recurrence after EMR), nineteen by other diseases than esophageal cancer and eight by cancer at other organs (lung: 3, hypopharynx: 2, mesopharynx: 1, stomach: 1, ureter: 1). Three of them were found concomitantly and 5 metachronously. Local recurrence was found in 8.3% of all patients treated by EMR. All patients with recurrence had received piecemeal resection. Sixty seven percents of all lesion of local recurrence was detected by endoscopic surveillance within one year after EMR. All recurred lesions were treated by EMR and pathological studies on resected specimens revealed that all recurred lesions were mucosal cancer. Metachronous esophageal cancer was found in 11% of all EMR cases. Sixty five percent of all metachronous cancer were detected in one to three years after EMR. Metachronous esophageal cancer after EMR was frequently found among cases with esophageal mucosa which has many small unstained areas. Malignant lesions were found in 33 cases (15%) of all patients treated by EMR synchronously and 37 (17%) metachronously. The stomach and the head and neck are most frequent site of associated cancers.	
除外	review				12607948	jpn	Nemoto	[Future perspective of radiation therapy for superficial esophageal cancer].	Nihon Igaku Hoshasen Gakkai Zasshi	2002	62(14)	801-7	English Abstract; Journal Article; Review	Superficial esophageal cancer (SEC) is defined as esophageal cancer limited to the submucosal layer, and includes mucosal and submucosal cancer. Based on the criteria of the Japanese Society for Esophageal Disease, mucosal and submucosal cancer are classified according to location: epithelial layer (m1); proper mucosal layer (m2); muscularis mucosa (m3); upper third of the submucosal level (sm1); middle third of the submucosal layer (sm2); and lower third of the submucosal level (sm3). Irrespective of the treatment method, the depth of invasion is one of the most important prognostic factors of SEC because lymph node metastasis markedly increases in lesions infiltrating the lamina muscularis mucosa (m3). The best management technique for small m1 and m2 esophageal cancers is generally endoscopic mucosal resection (EMR). For m3-sm3 SEC, extensive lymph node dissection has been the most widely used form of treatment. However, a recent study has shown that for m3 and sm1 cancer, EMR seems to be as effective as surgery. Therefore, EMR may become the standard therapy for m3 and sm1 cancer. The role of radiation therapy in the treatment of SEC has not been established, and radiation therapy has tended to be used for SEC patients who are not suitable for EMR or surgery. The treatment outcomes of radiation therapy are encouraging and seem to be comparable with those of other treatment modalities. Radiation therapy is a promising method for treating SEC and may become standard therapy for certain subgroups of SEC. However, many problems concerning radiation therapy, including optimal radiation dose, optimal radiation field, and the role of intracavitary irradiation, remain to be solved. Thus, standardization of radiotherapy is an urgent issue.	
除外	review				12510224	eng	Moreto	Diagnosis of esophagogastric tumors.	Endoscopy	2003	35(1)	36-42	Journal Article; Review	It has been suggested that certain histological criteria may serve to indicate a good prognosis in patients with esophageal carcinoma. These include absence of subepithelial extension of the carcinoma cells, stage no higher than m2, and no neoplastic involvement near the resection margin. As endoscopic mucosal resection is becoming an accepted treatment option in this type of tumor, prognostic parameters of this type are of particular interest. By contrast, when metastases are detected in the celiac lymph nodes, it implies that the tumor is unresectable and that palliative treatment is required. Endoscopic ultrasound (EUS)-guided fine-needle aspiration has been found to be the most cost-effective option in this setting. Although autofluorescence endoscopy is being tested as a new technique for endoscopic diagnosis, its value is at present unclear. However, such developments may lead to improved diagnosis in the future, particularly in relation to the initial stages of carcinoma. For the moment, EUS is still the most widely accepted method for early diagnosis and staging. Esophageal squamous-cell carcinoma appears to be commonly associated with head and neck cancer, but the cost-effectiveness of surveillance is a matter of controversy. With regard to Barrett's esophagus and adenocarcinoma, p53 staining in areas of low-grade dysplasia appears to be helpful for predicting progression to high-grade dysplasia. The prevalence of short-segment Barrett's esophagus increases with age, but the length of the segment does not increase with time; the length probably depends on individual conditions, not merely on elapsed time. Helicobacter pylori infection appears to be associated with intestinal metaplasia at the esophagogastric junction. However, the most recent data appear to suggest that this scenario (usually termed "carditis") may be different from intestinal metaplasia in the lower esophagus, related to acid reflux. A follow-up program might be able to detect Barrett's esophagus adenocarcinoma at earlier stages, but only a minority of Barrett's esophagus patients are likely to be detected before neoplasia has developed. Gastric cancer appears to develop in individuals with H. pylori infection, but not in uninfected persons. In addition, those with severe gastric atrophy, corpus-predominant gastritis, and intestinal metaplasia may be at greater risk for gastric cancer. This again raises the question of H. pylori eradication in asymptomatic individuals with infection, and surveillance of patients with severe intestinal metaplasia. The most recent data appear to support the notion that healing of MALT lymphoma depends not only on H. pylori eradication and on the stage of the tumor, but also on individual factors (possibly immunology-related).	
除外	非合致				12444997	eng	Makino H, Tajiri T, Onda M, Sasajima K, Miyashita M, Nomura T, Maruyama H, Nagasawa S, Tsuchiya Y, Hagiwara N, Yamashita K, Takubo	Effectiveness of preoperative chemotherapy using carboplatin (CBDCA) and surgery against an esophageal small cell carcinoma.	Dis Esophagus	2002	15(3)	237-41	Case Reports; Journal Article	A 63-year-old man presented to our hospital with persistent dysphagia. Radiologic and endoscopic examination disclosed a 2.0-cm exophytic tumor in the middle third of the esophagus. An endoscopically obtained biopsy specimen was found to represent undifferentiated small cell carcinoma. Computed tomography of the chest, abdomen, and cervical region was performed, as were gallium and bone scintigraphy. Metastasis to an adjacent lymph node was detected, without metastasis to distant organs. After neoadjuvant chemotherapy with carboplatin (CBDCA) (400 mg/m2) and etoposide (VP-16) (100 mg/m2), endoscopy and barium-swallow esophagography showed regression. Thoracic esophagectomy then was performed with mediastinal, abdominal and cervical lymph node dissection. The resected tumor was polypoid, measuring 0.5 x 0.5 cm. The lesion consisted mainly of small anaplastic cells, but included a small focus of squamous cell carcinoma. The patient has survived for more than 7 months with no further treatment and no evidence of recurrent disease.	
除外	非合致				12429966	eng	Fujii T, Sudo T, Sueyoshi S, Tanaka T, Fujita H, Shirouzu K, Ban S, Toyonaga A, Kato S, Yamana	Clinicopathologic study of neovascularization and VEGF expression in superficial esophageal carcinoma.	Int J Oncol	2002	21(6)	1181-7	Journal Article	Among superficial esophageal carcinomas (SECs), mucosal carcinoma (m) and submucosal carcinoma (sm) markedly differ regarding the presence or absence of lymph node metastases and long-term survival. To clarify differences in the growth pattern of these two superficial carcinomas, we investigated neovascularization around the site of tumor growth and expression of vascular endothelial growth factor (VEGF) in tumor cells, in patients undergoing radical esophagectomy or endoscopic mucosal resection (EMR). Moreover, we investigated whether these factors were related to the prognosis in patients undergoing treatment of SEC. This study included 90 SEC patients undergoing radical esophagectomy (surgery group) and 35 patients undergoing EMR (EMR group). For immunohistochemical staining antibodies against factor VII-related antigen and against VEGF were used. The microvessels around the tumor were counted to calculate the vascular index (VI). VI and VEGF expression in the tumor were compared in relation to clinicopathologic findings. In the surgery group, the VI and the percent of VEGF-positive cells were significantly higher in the case of sm carcinomas. Furthermore, tumors with a high VI showed a significantly worse prognosis. In the EMR group, the VI and percent of VEGF-positive cells increased with the depth of the tumor. The VI and VEGF expression were significantly higher in sm carcinomas. This may in part explain the difference in cancer progression between m and sm carcinomas. In patients undergoing resection or EMR, examination of neovascularization using VI may be potentially useful in evaluating the prognosis of SEC.	

全文取り寄せ		可	否	T1b	12417599	eng	Himeno S, Yasuda S, Shimada H, Tajima T, Makuuchi	Evaluation of esophageal cancer by positron emission tomography.	Jpn J Clin Oncol	2002	32(9)	340-6	Evaluation Studies; Journal Article	BACKGROUND: A retrospective study was performed to determine the indications for positron emission tomography (PET) using [¹⁸ F]fluorodeoxyglucose (FDG) in patients with esophageal cancer, including those with early cancer, and to investigate whether the tumor-to-normal ratio (T/N ratio) could be used as a substitute for the standardized uptake value (SUV). METHODS: Thirty-six patients were included in the study. Thirty-one patients who had 38 biopsy-proven lesions (35 squamous cell carcinomas and one small cell carcinoma) underwent PET study prior to treatment. PET images were evaluated visually and the relationship between the depth of invasion and the PET findings were examined in 22 lesions of 19 patients from whom specimens were obtained from the primary tumor by surgery or endoscopic mucosal resection. PET results were also compared with computed tomography (CT) and endoscopic ultrasonography (EUS) for detection of regional lymph node metastases in 18 patients who underwent extended lymph node dissection. Five patients underwent PET studies for the detection of recurrence and the PET findings were compared with their CT findings. The T/N ratio and the SUV were calculated for 20 primary tumors. RESULTS: Among the 15 tumors that were pT1b or greater, all 15 were positive on PET and all seven of the lesions confined to the mucosa (Tis or T1a) were negative. The sensitivity, specificity and accuracy of detecting nodal involvement were, respectively, 37.5, 96.1 and 88.3% by CT, 30.8, 88.5 and 81.0% by EUS and 41.7, 100 and 92.2% by PET. More sites of recurrence were detected by PET than by CT. There was no statistically significant correlation between the SUV and the T/N ratio. CONCLUSIONS: PET imaging can detect primary esophageal cancer with a depth of invasion of T1b or greater, but Tis and T1a tumors are undetectable. PET seems to be more accurate than CT or EUS for diagnosing lymph node metastasis. The T/N ratio cannot be used as a substitute for the SUV.	
除外	非合致				12193812	eng	Krasna MJ, Jiao X, Mao YS, Sonett J, Gamliel Z, Kwong K, Burrows W, Flowers JL, Greenwald B, White	Thoracoscopy/laparoscopy in the staging of esophageal cancer: Maryland experience.	Surg Laparosc Endosc Percutan Tech	2002	12(4)	213-8	Evaluation Studies; Journal Article	Precise clinical staging of esophageal cancer before treatment is important. Thoracoscopic/laparoscopic (Ts/Ls) staging has been proposed as a promising staging method. This study was conducted to evaluate the potential benefits of Ts/Ls staging over conventional noninvasive clinical staging in patients with esophageal cancer. From 1991 to 1999, 111 patients with esophageal cancer underwent Ts/Ls staging by the University of Maryland Medical System. Pretreatment staging workup included computed tomography, magnetic resonance imaging, and esophageal ultrasonography, followed by Ts/Ls surgical staging. Thoracoscopy was successfully performed in 102 patients and was aborted in 4 patients because of pleural adhesions. Laparoscopy was successfully done in 76 patients and was aborted in 1 patient because of peritoneal adhesion. Sixty-seven patients had both Ts and Ls staging, whereas 35 patients and 9 patients, respectively, had only Ts or Ls staging. Thirteen of 19 patients with clinical T4 disease were downstaged to T3 disease, and 8 patients with clinical T3 disease were upstaged to T4 by Ts/Ls staging. No clinical T1-2 disease was found to be associated with local invasion (T4) by Ts/Ls. Forty-eight and 19 patients had mediastinal and celiac lymph node metastases clinically diagnosed, respectively. Nine (18.8%) and 12 (63.2%) of them were proved by Ts and Ls, respectively. An additional 5 and 16 patients were found to have unexpected mediastinal and celiac lymph node metastases, respectively, by Ts/Ls. Biopsy specimens of pleura, lung, or liver were obtained by Ts/Ls procedures in 17 patients because of suspicious findings of routine imaging studies or unexpected findings during the staging operation. Five patients were found to have distant metastasis, and the presence of metastases in others was excluded. The correlation between Ts/Ls staging and conventional noninvasive clinical staging in the diagnosis of T4 disease, mediastinal lymph node metastasis, celiac lymph node metastasis, and M1 disease was 18.8%, 14.5%, 25.5%, and 20.0%, respectively. Ts/Ls provides more accurate information for evaluating local invasion, lymph node metastasis, and distant metastasis. The poor correlation of staging diagnosis between Ts/Ls and conventional noninvasive clinical examinations suggests that the accuracy of current noninvasive clinical staging is questionable and needs to be improved.	
除外	非合致				11993221	jpn	Yoshida M, Momma	[Endoscopic evaluation of the depth of invasion in cases of superficial esophageal cancer in determining indications for endoscopic mucosal resection].	Nihon Geka Gakkai Zasshi	2002	103(4)	337-42	English Abstract; Journal Article	Endoscopic mucosal resection (EMR) should be performed for the treatment of squamous cell carcinoma of the esophagus limited to the lamina propria mucosae (m1 and m2 cancers), because lymph node metastasis is rare in these cases. The lymph node metastasis rate is 0% when cancers reach the muscularis mucosae(m3) or slightly invade the submucosa (sm1). Lymph node metastasis is noted in 47% of esophageal cancers moderately or severely invading the submucosa(sm2 and sm3). Radical esophagectomy is recommended for sm2 and sm3 disease. Type 0-II cancers are candidates for EMR, because 86% remain within the mucosa, while 90% of type 0-I lesions and 96% of type 0-III lesions are submucosal cancers. Among type 0-II cancers, most type 0-IIb lesions are m1 cancer. Among type 0-IIa cancers, 96% are mucosal. Type 0-Ic lesions are frequent among superficial esophageal cancers and 19% reach the submucosa. Endoscopic differentiation of m1 and m2 cancers is reliable, since 96% of all m1 and m2 cancers were correctly diagnosed before treatment. In cases with type 0-Ic lesions which is most frequent among superficial esophageal cancers, m1 cancer showed very slight depressions with a smooth surface and reddening. Sometimes fine granular changes are seen. They are also delineated as an unstained area by endoscopic toluidine blue-iodine double staining. They showed very slight depressions with a smooth surface and reddening. Sometimes fine granular changes are seen. They are also delineated as an unstained area by endoscopic toluidine blue-iodine double staining. Dark blue dots, spots, or reticular staining are frequently identified in m2 cancers. In cases with m3 or sm1 cancer, coarse granular changes, small nodular elevations, or slightly deeper depressed areas in the m1 and m2 lesions suggest sites of deeper invasion.	
除外	非合致				11967675	eng	Incabone R, Bonavina L, Saino G, Bona D, Peracchia	Outcome of esophageal adenocarcinoma detected during endoscopic biopsy surveillance for Barrett's esophagus.	Surg Endosc	2002	16(2)	263-6	Journal Article; Research Support, Non-U.S. Gov't	BACKGROUND: In an attempt to reduce mortality from esophageal adenocarcinoma, it has been recommended to enroll patients with Barrett's esophagus in endoscopic surveillance programs in order to detect malignant degeneration at an early and possibly curable stage. The aim of this study was to assess the impact of endoscopic biopsy surveillance on outcome of Barrett's adenocarcinoma. METHODS: Between November 1992 and June 2000, 312 patients with histologically proven esophageal adenocarcinoma were referred to our department. Ninety-seven of these patients had Barrett's adenocarcinoma. In 12 (12.2%) patients, cancer was discovered during endoscopic surveillance for Barrett's metaplasia. RESULTS: The prevalence of gastroesophageal reflux disease in the Barrett's group was 38.8% versus 8% (p < 0.01) in non-Barrett's patients. In the surveyed group, there were 9 (75%) early stage tumors (Tis-1/N0) versus 9 (10.6%, p < 0.01) in the nonsurveyed patients. Three of 5 surveyed patients operated on for high-grade dysplasia proved to have invasive carcinoma in the esophagectomy specimen. All surveyed patients were alive at a median follow-up of 48 months; the median survival in the nonsurveyed group was 24 +/- 3 months (p < 0.01). CONCLUSION: Endoscopic surveillance of Barrett's esophagus provides early detection of malignant degeneration and a better long-term survival than in nonsurveyed patients.	
全文取り寄せ		可	否	T1b	11927013	eng	Nakajima Y, Nagai K, Miyake S, Ohashi K, Kawano T, Iwai	Evaluation of an indicator for lymph node metastasis of esophageal squamous cell carcinoma invading the submucosal layer.	Jpn J Cancer Res	2002	93(3)	305-12	Evaluation Studies; Journal Article; Research Support, Non-U.S. Gov't	Lymph node metastasis is a major prognostic factor for esophageal squamous cell carcinoma (ESCC). In recent years, endoscopic mucosal resection (EMR) has been developed with excellent results for the treatment of the superficial ESCC. To make the EMR treatment successful, it is important to establish a good indicator to identify ESCC patients at a high risk of lymph node metastasis. In this study, we examined clinicopathological and immunohistochemical factors to investigate the factors involved in lymph node metastasis of ESCC invading to the submucosal layer (sm-ESCC). Surgical specimens from 84 sm-ESCC patients were examined. Among 84 sm-ESCC patients, 33 (39.3%) had lymph node metastases. Clinicopathologically, tumor depth, lymphatic invasion and blood vessel invasion showed significant correlations with lymph node metastasis by univariate analysis. Tumor depth and lymphatic invasion showed significant correlations by multivariate analysis of these factors. Immunohistochemically, P53 accumulation was observed in 45 cases (53.6%), cyclin D1 overexpression in 25 (29.8%), and pRB in 65 (77.4%). P53 accumulation, cyclin D1 overexpression and MIB-1 Labeling Index were significantly associated with lymph node metastasis by univariate analysis, and P53 accumulation showed a significant correlation with lymph node metastasis by multivariate analysis. Among tumor depth, lymphatic invasion and P53 accumulation, tumor depth and lymphatic invasion were significantly correlated with lymph node metastasis (P = 0.0023 and P = 0.0092, respectively) by multivariate analysis. These data suggest that tumor depth and lymphatic invasion can be considered as good indicators for lymph node metastasis among patients with sm-ESCC. In addition, P53 accumulation could be helpful to identify the patients who need additional treatment after EMR.	
全文取り寄せ		可	採		11900242	eng	Araki K, Ohno S, Egashira A, Saeki H, Kawaguchi H, Sugimachi	Pathologic features of superficial esophageal squamous cell carcinoma with lymph node and distal metastasis.	Cancer	2002	94(2)	570-5	Journal Article	BACKGROUND: Endoscopic mucosal resection (EMR) is a less invasive localized treatment for patients with esophageal carcinoma. However, indications for EMR use in cases of superficial esophageal carcinoma are controversial. The authors evaluated histopathologic risk factors for lymph node metastasis and recurrence. METHODS: In the specimens resected, the authors examined depth, the superficial area and the area attached to or infiltrating the lamina muscularis mucosa. RESULTS: The authors found that the superficial area and the attached or infiltrated area reflected the depth of the tumor. However, there was a recurrence of esophageal carcinoma even in m3 cases attached only to the lamina muscularis mucosa. CONCLUSIONS: The authors concluded that m1 and m2 esophageal carcinoma had almost no risk of lymph node metastasis and recurrence no matter how extensive the superficial area. In addition, sm2 and sm3 carcinoma have a high frequency of lymph node metastasis and recurrence. M3 and sm1 carcinoma run the risk of lymph node metastasis and recurrence however small the superficial area and the area attached to or infiltrating the lamina muscularis mucosa. Treatment strategies for patients with superficial esophageal carcinoma, including EMR, should take the above findings into account.	

除外					11778747	eng	Makuuchi	Endoscopic mucosal resection for mucosal cancer in the esophagus.	Gastrointest Endosc Clin N Am	2001	11(3)	445-58	Journal Article	Endoscopic mucosal resection of the esophagus was found to be safe and easy to perform. Efforts must be made to detect early m1 to m2 cancers, which are indicated for EEMR. It is necessary to perform periodic endoscopic examination. During endoscopic examination, it is important to wash the inside of the esophagus with water and perform careful observation. Also, in high-risk patients and patients with abnormalities, such as erythema, turbidity, or hypervascularity, iodine staining should be performed frequently. Patients at high risk for esophageal cancer include (1) men more than 55 years old who are heavy smokers and drinkers; (2) patients with cancer of the head and neck region; and (3) individuals with a family history of cancer and those with achalasia, corrosive esophagitis, or Barrett's esophagus.	
除外					11379331	eng	Takeo Y. Yoshida T. Shigemitsu T. Yanai H. Hayashi N. Okita	Endoscopic mucosal resection for early esophageal cancer and esophageal dysplasia.	Hepatogastroenterology	2001	48(38)	453-7	Journal Article	BACKGROUND/AIMS: Advances in diagnostic technology have led to increased detection of early esophageal cancer, which is suitable for endoscopic treatment. We performed endoscopic esophageal mucosal resection of such cancer and dysplasia using the endoscopic esophageal mucosal resection tube and evaluated the clinical benefit of this technique. METHODOLOGY: Twenty-nine patients with esophageal mucosal cancer (27 cases with 33 lesions) or dysplasia (2 cases with 2 lesions) diagnosed between September 1992 and March 1998 were assessed endoscopically for the depth and extent of invasion by double staining with toluidine blue and iodine. Endoscopic ultrasonography was also performed to assess the depth of invasion in 22 cases with 22 lesions. RESULTS: The 35 esophageal lesions comprised 27 esophageal carcinomas and 8 areas of dysplasia. Twenty of the 35 lesions were resected en bloc and 15 were resected piecemeal. Subsequent surgery was performed for 5 cases with 7 lesions out of 10 cases with 15 lesions that were histopathologically diagnosed as m3 or more invasive. No recurrence has been detected in 24 evaluable cases (including 1 who died of another disease, 2 in whom surgery could not be performed due to complications, and 3 who refused subsequent surgery). No patients died of esophageal cancer after a mean follow-up period of 30.9 +/- 18.9 months. The 4-year survival rate was 100% in the m2 or less invasive group of 19 cases with 20 lesions, 75% in the m3 or higher invasive group of 5 cases with 8 lesions and 100% in the surgery group of 5 cases with 7 lesions (NS). No serious complications occurred except for 1 patient. Circumferential mucosal resection was done in this patient, resulting in esophageal stenosis, which responded to esophageal dilation. CONCLUSIONS: Esophageal mucosal resection using the endoscopic esophageal mucosal resection tube is safe and beneficial for early esophageal cancer and dysplasia.	
全文取り寄せ		可	否	Tstage unknown	11308139	eng	Krasna MJ, Reed CE, Nedzwicki D, Hollis DR, Luketich JD, DeCamp MM, Mayer RJ, Sugarbaker	CALGB 9380: a prospective trial of the feasibility of thoracoscopy/laparoscopy in staging esophageal cancer.	Ann Thorac Surg	2001	71(4)	1073-9	Clinical Trial; Clinical Trial, Phase II; Comparative Study; Journal Article; Multicenter Study	BACKGROUND: The staging of esophageal cancer is imprecise. Thoracoscopic/laparoscopic (TS/LS) staging has been proposed as a more accurate lymph node (LN) staging method. We report the experience of an Intergrup NCI trial (CALGB 9380) evaluating the feasibility and accuracy of this staging modality. PATIENTS AND METHODS: From February 1995 to September 1999, 134 patients were entered in the study. This study represents the analysis of final data on 113 patients. TS/LS was considered feasible if TS and 1 LN sampled at least 3 LN by TS: a confirmed positive node was found; or T4 or M1 disease was documented. If this was accomplished in more than 70% of patients, TS/LS was believed to be feasible. RESULTS: The LN stations most frequently sampled in the thorax (134 patients) were levels 2 (33%), 3 (38%), 4 (40%), 7 (76%), 8 (69%), 9 (55%), and 10 (43%) and in the abdomen levels 17 (70%) and 20 (55%). The frequency of positive LN by level were as follows: 2 (10%), 3 (8%), 4 (10%), 7 (10%), 8 (25%), 9 (10%), 10 (10%), 17 (34%), and 20 (27%). Noninvasive tests (computed tomographic scan, magnetic resonance imaging, esophageal ultrasound scan) each incorrectly identified TN staging as noted by missed positive or false-negative LN or metastatic disease found at TS/LS staging in 50%, 40%, and 30% of patients, respectively. Median operating time was 210 minutes (range, 40 to 865 minutes). Median postoperative hospital stay was 3 days (range, 1 to 35 days). There were no deaths or major complications. Seventy-three percent of patients met the definition for feasibility. In 30 patients TS was not feasible. Positive LN disease was found in 43 patients; 32 were deemed N0. Ten patients had T4/M1 disease. Of the 32 potentially resectable N0 patients, 14 patients had preoperative induction therapy; 13 patients went directly to operation with N0 confirmed in 9 patients, NX in 1 and N1 in 3. Three patients were unresectable, 1 patient died, and 1 was lost to follow-up. CONCLUSIONS: In summary, the feasibility of TS/LS was confirmed. It doubled the number of positive LNs identified by conventional, noninvasive staging. The overall accuracy remains to be defined by analysis of the LN negative group in follow-up. Although the positive predictive value was high, further study is warranted to confirm the role of TS/LS in the staging algorithm of esophageal cancer.	
全文取り寄せ		可	探		11147906	eng	Noguchi H, Naomoto Y, Kondo H, Haiba M, Yamatsui T, Shigemitsu K, Aoki H, Isozaki H, Tanaka	Evaluation of endoscopic mucosal resection for superficial esophageal carcinoma.	Surg Laparosc Endosc Percutan Tech	2000	10(6)	343-50	Evaluation Studies; Journal Article	Esophageal superficial carcinoma safely can be resected surgically or endoscopically. We evaluated indications for endoscopic mucosal resection (EMR) and optimal treatment modality for superficial carcinoma of the esophagus based on clinical and pathologic analyses. Between January 1, 1984, and September 30, 1999, 113 patients with superficial cancer of the esophagus underwent surgical or endoscopic resection (n = 33 patients, 36 lesions). The two-channel method, esophageal EMR-tube method or EMR cap-fitted panendoscope was used. Mucosal and submucosal cancers were classified to be epithelial layer (m1), proper mucosal layer (m2), muscularis mucosae (m3), upper third of the submucosal level (sm1), middle third of the submucosal level (sm2), or the lower third of the submucosal level (sm3) cancers, according to criteria of the Japanese Society for Esophageal Disease. Absolute indication for EMR was restricted to m1 or m2 cancers, and relative indications for EMR included m3 or sm1 lesions. In our department, indications for EMR were not related to size or circumference of lesions. Lymph vessel invasion and lymph node metastasis markedly increased in lesions that infiltrated the lamina muscularis mucosa (m3). All lesions resected with use of EMR were 0-II (flat), and the depth of invasion in 10 0-IIa or 0-IIb lesions was m1 or m2. Twenty-one 0-IIc lesions were distributed widely from m1 to sm1. All 0-IIa-IIc lesions were m3 or sm1. Preoperative diagnosis accurately was established preoperatively in 61% of patients. Complications related to EMR were detected in 21% of patients and included perforation, stenosis, and hemorrhage. Ten patients also received radiotherapy, chemotherapy, or esophagectomy with lymph node dissection after use of EMR. No such combination therapy was administered in six patients with m3 lesions, but without lymph vessel invasion. All patients treated with use of EMR, including patients with m3 cancer who did not receive additional treatment, are living without recurrence. Local resection with use of EMR could be regarded to be the preferred treatment of superficial esophageal cancers limited to the lamina propria mucosae. Endoscopic mucosal resection also could be regarded to be the preferred treatment of m3 cancer without lymph vessel invasion. Use of additional therapy, such as radiotherapy, allows the use of EMR for m3 cancer with lymph vessel invasion or sm1 cancers.	
除外	非合致				11115904	eng	Narahara H, Iishi H, Tatsuta M, Uedo N, Sakai N, Yano H, Otani	Effectiveness of endoscopic mucosal resection with submucosal saline injection technique for superficial squamous carcinomas of the esophagus.	Gastrointest Endosc	2000	52(6)	730-4	Clinical Trial; Comparative Study; Journal Article	BACKGROUND: Intraepithelial cancers (m1 cancer) and cancers that penetrate the basement membrane but do not approach the muscularis mucosae (m2 cancer) do not have lymph node metastasis and thus can be removed completely with mucosal resection. Therefore, in this study, the effectiveness of endoscopic mucosal resection with submucosal saline injection for removal of superficial esophageal cancers was investigated prospectively. METHODS: Twenty-five superficial esophageal cancers in 21 patients were removed with submucosal saline injection. When it was thought that a tumor had not been completely resected en bloc, it was removed completely in piecemeal fashion. Endoscopy was repeated 1, 3, 6, 12 months or more after endoscopic resection. RESULTS: All superficial esophageal cancers were completely removed: 18 (72%) en bloc and 7 (28%) by piecemeal resection. No recurrence was found during a mean observation period of 2.0 years (range 0.8 to 3.6) after resection. Bleeding occurred in 5 cases (24%) during or after resection but was successfully treated with the endoscopic alginate or thrombin spray technique. There was no perforation. CONCLUSION: Endoscopic mucosal resection with submucosal saline injection is effective for removal of superficial cancers of the esophagus.	
除外	case report				11115580	eng	Mukai M, Makuuchi H, Mukohyama S, Oida Y, Himeno S, Nishi T, Nakazaki H, Satoh	Quintuple carcinomas with metachronous triple cancer of the esophagus, kidney, and colonic conduit following synchronous double cancer of the stomach and duodenum.	Oncol Rep	2001	8(1)	111-4	Case Reports; Journal Article; Research Support, Non-U.S. Gov't; Review	A patient who had undergone radical gastrectomy for synchronous gastric cancer (T(1)N(0)M(0), stage I) and duodenal cancer (Tis, stage 0) in November 1987 was found to have esophageal cancer in November 1994, and underwent radical thoracolaparotomy at our hospital (T(1)N(0)M(0), stage I). After follow-up for about 3.5 years, renal cancer was detected in April 1998, and radical nephrectomy was performed (T(1)N(0)M(0), stage I). Two years later, in April 2000, the patient was found to have a polypoid lesion in the colonic conduit used for reconstruction after esophagectomy, and endoscopic mucosal resection was performed (Tis, stage 0). The patient remains under careful follow-up, including observation of the colonic conduit and the residual large intestine.	

除外	非合致				11051353	eng	Pfau PR, Ginsberg GG, Lew RJ, Faigel DO, Smith DB, Kochman	Esophageal dilation for endosonographic evaluation of malignant esophageal strictures is safe and effective.	Am J Gastroenterol	2000	95(10)	2813-5	Journal Article	OBJECTIVE: Endoscopic ultrasound (EUS) is accepted as the most accurate modality for T- and N-staging of esophageal cancer, but some malignant strictures prevent passage of the echoendoscope beyond the level of the tumor. This incomplete evaluation may decrease staging accuracy. Previous studies have yielded conflicting results regarding the safety and efficacy of esophageal dilation for EUS. METHODS: We prospectively evaluated 267 consecutive patients undergoing EUS for esophageal carcinoma staging at our institution over a 66-month period to determine the number of patients requiring dilation for EUS examination, the success of dilation, safety of dilation, and clinical importance. RESULTS: Among 267 endosonographic examinations of the esophagus, 81 (30.3%) required dilation to advance the echoendoscope beyond the level of the stricture. After dilation was performed, the echoendoscope could be passed through the stricture in 69 patients (85.2%), and in 63 of 67 of the patients dilated to ≥ 14 mm (94.0%). No complications have occurred secondary to the dilations performed to permit completion of the endosonographic examination. Tumor staging by EUS after dilation was T2 (14.8%), T3 (56.8%), and T4 (21.0%), nodal staging N0 (14.6%) and N1 (9.9%). CONCLUSIONS: We conclude that incremental, stepwise dilation of malignant strictures to 14 mm is safe and effective in permitting echoendoscope passage beyond the stenosis. The presence of a malignant stricture does not seem to diminish the utility of EUS staging of esophageal cancer.	
除外	非合致				10693252	eng	Lambert	Endoscopic mucosectomy: an alternative treatment for superficial esophageal cancer.	Recent Results Cancer Res	2000	155	183-92	Journal Article; Review	Recent trends in the management of superficial esophageal cancer consist of improved detection, pretherapeutic staging and reliable criteria for curative endoscopic therapy. The endoscopic treatment is legitimate when the cancer is at an early stage, intra-epithelial or microinvasive (m1 or m2) and N0. Submucosal cancer should not be treated with a curative intent by endotherapy. Concerning squamous cell cancer, the oriental and occidental pathologists include high-grade dysplasia in the same group as intramucosal cancer. The distinction is however maintained for adenocarcinoma in the Barrett's esophagus. Indications of endoscopic rather than surgical treatment rely on: (1) the small size of the tumor (not more than 2 cm in diameter); (2) the endoscopic morphology in the type 0 of the Japanese classification with the flat subtypes IIa and IIb rather than type IIc—there is high risk of submucosal invasion for the polypoid (type I) or ulcerated superficial cancer (type III); and (3) the endoscopic ultrasound staging, with confirmed integrity of the hyperechoic submucosal layer. The high-frequency (20 MHz) miniprobe is preferred to the standard (7.5 MHz) instrument. The elective procedure for tumor eradication is endoscopic mucosectomy. The technique is associated with a 6.8% risk of severe complications (hemorrhage or perforation) and a recurrence rate of 3%-7%. The 5-year survival rate is similar to that of surgery (over 80%). In the small group of patients with superficial esophageal cancer (less than 10% of the disease) endoscopic treatment may now be proposed in about 30% of cases, surgery is preferred for submucosal cancer and for neoplasia with a large surface. Areas of high-grade dysplasia in the Barrett's esophagus offer a new and increasing sector of indications. The concurrent endoscopic procedure of destruction—photodynamic therapy—is preferred for the destruction of lesions with poorly delineated limits.	
除外	非合致				10089952	eng	Satoh T, Tsumishima K, Saitoh S, Hizawa Y, Tamura Y, Fukuda S, Yamada Y, Tohno H, Takasugi T, Sakata Y, Munakata	A case of advanced esophageal cancer showing a long-term complete response with chemotherapy with nedaplatin alone.	Jpn J Clin Oncol	1999	29(2)	106-8	Case Reports; Journal Article	We describe a case of advanced esophageal cancer treated successfully by chemotherapy with nedaplatin alone. A 60-year-old male with type 2 advanced esophageal cancer, which was located in the upper part of the esophagus and had invaded adjacent organs, was treated with nedaplatin 150 mg/body (100 mg/m ²) given intravenously every 4 weeks from January 6, 1991. He achieved a partial response (PR) and was discharged in March 1991. Subsequently, he received nedaplatin 75 mg/body in an out-patient setting almost every month until August 1992. Toxicities were tolerable and included mild thrombocytopenia and nausea/vomiting. From serial evaluation in October 1993, the esophageal tumor was not observed. After 7 years since initial chemotherapy was administered, he still survives without the disease.	
除外	非合致				10071806	eng	Loviscek LF, Cenoz MC, Badaloni AE, Agarinakazato	Early cancer in achalasia.	Dis Esophagus	1998	11(4)	239-47	Journal Article	Esophagus achalasia is considered by many authors a preneoplastic disease and, for this reason, they propose a follow-up with endoscopies and brush cytology. For others, the possibility of cancer in achalasia is very low and the surveillance is not justified owing to its fallibility and high cost. Generally, cancer in achalasia has a late diagnosis as a consequence of megaeosophagus and of many years of symptoms attributed to achalasia disease. The rate of resectability is low and 5-year survival is very poor. To define the patients who have a high disease. The rate of resectability is low and 5-year survival is very poor. To define the patients who have a high risk of cancer in achalasia and to perform an early diagnosis is the challenge to improve resectability and to increase survival. The search of cancer in achalasia with endoscopies and lugol vital staining was performed in 18 out of 76 patients with achalasia. The 18 patients had enlarged esophagus and more than 10 years of evolution. Lugol negative endoscopic areas were found in 10 out of 18 patients and four out of 10 were carcinomas. Two were circular superficial erosive lesions (Tis N0 M0 and T1 N0 M0), one was an elevated multifocal lesion of less than 1 cm diameter (T2 N0 M0) and the last one was a longitudinal central ulcer of less than 1 cm diameter (T1 N0 M0). In the remaining 6 out of 10 patients the diagnosis was esophagitis. In the other 58 patients, three carcinomas were diagnosed, two advanced tumors, with endoscopy and biopsy (T3 and T4 N1) and the third one (T1 N0 M0) was a pathological finding in a resected specimen for recurrent achalasia and megaeosophagus. The global prevalence was of 9.21% (7/76). The prevalence in advanced stages of achalasia was of 18.92% (7/37). The resectability rate was of 85.71%. CONCLUSION: Achalasia patients with more than 20 years of evolution, enlarged esophagus with 'knees' and with marked retention must be considered to be of high risk for developing cancer. In this group, the surveillance with endoscopy and lugol vital staining or brush cytology is justified. Other common risk factors of esophageal cancer that must be considered are patients aged over 60 years who are smokers and regular consumers of alcohol.	
除外	case report				9851625	eng	Shimoyama S, Konishi T, Kawahara M, Hojo K, Takeda Y, Nagayama	Complete response of esophageal cancer achieved by combination therapy with 5-fluorouracil, low-dose cisplatin, and radiation: report of a case.	Surg Today	1998	28(11)	1163-7	Case Reports; Journal Article	To improve the survival rate of patients with esophageal cancer, several protocols of a preoperative combination of chemotherapy and radiotherapy, known as chemoradiation therapy, have been developed, recently characterized by the combination of 5-fluorouracil (5-FU), cisplatin, and radiation. Although some of these combinations have been demonstrated to be effective, the optimal chemoradiation dose and schedule are not yet precisely established. Recent investigations have elucidated that the radiosensitizing effects of cisplatin are able to be achieved more effectively by the daily administration of cisplatin before each fraction of radiation. Based on these investigations, we report herein the case of a patient with esophageal cancer with direct invasion to the trachea, in whom a complete response was achieved by the continuous administration of 5-FU, 600 mg/m ² per day, from days 1-5 combined with the daily administration of low-dose cisplatin, 10 mg/m ² per day before each fraction of radiation, given as 20y each time, throughout the entire treatment period of 3 weeks beginning on day 1. The benefits of our preoperative chemoradiation therapy included no severe side effects, down-staging and resectability of the tumor, as well as a pathological complete response, which could prolong the survival time. Our experience of this case prompts us to recommend the concurrent daily preoperative chemoradiation therapy for patients with locally advanced esophageal cancer.	
除外	非合致				9755985	eng	Massari M, De Simone M, Cioffi U, Gabrielli F, Boccasanta P, Bonavina	Endoscopic ultrasonography in the evaluation of leiomyoma and extramucosal cysts of the esophagus.	Hepatogastroenterology	1998	45(22)	938-43	Journal Article	BACKGROUND/AIMS: Leiomyoma is the most common type of benign esophageal tumor, whereas extramucosal cysts of the esophagus are congenital anomalies frequently asymptomatic in the adult and in most cases detected incidentally on chest x-ray. It is worthwhile considering these conditions together, because they present similar diagnostic and surgical problems. Conventional imaging tests do not lead to a precise diagnosis. The purpose of this study was to evaluate the use of endoscopic ultrasonography in the diagnosis of, and planning of treatment modalities for, these conditions. METHODOLOGY: Fifteen patients with esophageal leiomyoma and seven patients with extramucosal esophageal cysts were studied with endoscopic ultrasonography using an Olympus GF-EU-M3 instrument with a 7.5-12 MHz echoprobe. In all patients, the results of endoscopic ultrasonography were compared with the histology of the resected specimens. RESULTS: The histology of the resected specimens confirmed the endosonographic diagnosis in all patients. No malignancy was found in any specimen. CONCLUSIONS: Endoscopic ultrasonography is very accurate in visualizing these lesions and differentiating cystic from solid submucosal esophageal masses; in addition, the test can establish the exact location of the mass in relation to the esophageal wall and mediastinum. Therefore, endoscopic ultrasonography has a great impact in confirming the diagnosis of leiomyoma and extramucosal cysts of the esophagus and facilitates therapeutic decision-making because of its capacity to clearly define the size, layer of the origin, and pattern of the mass.	
除外	非合致				9725040	jpn	Kouzu T, Suzuki Y, Yoshimura S, Yoshimura N, Hishikawa E, Arima	[Feature of screening-detected cancer and progress of treatment—esophageal cancer].	Gan To Kagaku Ryoho	1998	25(10)	1499-504	English Abstract; Journal Article; Review	The recent increase in the detection of esophageal mucosal cancer has been changing the direction of treatment. The rate of esophageal cancer detection in mass screening by X-ray is 0.008%, which is 1/13 that of gastric cancer. Moreover, the rate by endoscopy is higher: the former is 0.1% and the later is 0.6%. Further, endoscopic screening using iodine staining for a high risk group like alcoholism has 3.6% detectability on esophageal cancer and 1.7% on gastric cancer. The rate of cancer-detection of upper intestinal organs comes to 5.35% in all. Most of the esophageal cancer detected by endoscopy is mucosal cancer, which is treatable by endoscopic mucosal resection (EMR). The result of the treatment is 100% 5 year-survival in cases of m1 and 2 esophageal cancer. EMR of esophagus-preserving treatment is truly effective for patients. Endoscopic examination using iodine staining for the high risk group is excellent for mass screening of esophageal cancer.	

全文取り寄せ		可	否	small sample size	9560056	eng	Natsugoe S, Baba M, Yoshinaka H, Kijima F, Shimada M, Shirao K, Kusano C, Fukumoto T, Mueller J, Aikou	Mucosal squamous cell carcinoma of the esophagus: a clinicopathologic study of 30 cases.	Oncology	1998	55(3)	235-41	Journal Article	A clinicopathologic study was carried out on 30 patients with mucosal esophageal cancer (MEC). The depth of cancer invasion was subdivided histologically into three categories: m1 = carcinoma in situ (intraepithelial carcinoma) or carcinoma with questionable invasion beyond the basal membrane; m2 = cancer invasion confined to the lamina propria, and m3 = cancer reaching to or infiltrating into the muscularis mucosae. Lymph node metastases and lymphatic invasion were found only in the tumors reaching or infiltrating the muscularis mucosae (m3). The maximum histologic vertical extent of the tumors was more than 1 mm in 4 of 5 patients with lymph node metastasis or lymphatic invasion. None of the patients died of recurrent esophageal disease, and 3 of the 6 patients who had a second primary tumor died of this other malignancy. It is critical to distinguish between m1, m2 and m3 tumors to plan a treatment strategy, including an endoscopic mucosal resection.	
除外	非合致				9468549	eng	Kohakura M, Ban S, Harada H, Toyonaga A, Tanikawa	Local recurrence of early esophageal carcinoma after endoscopic mucosal resection.	Oncol Rep	1998	5(2)	321-4	Journal Article	We performed endoscopic mucosal resection on 25 patients with early esophageal carcinoma where the depth of invasion was limited to in the lamina propria mucosae (m2) and we observed local recurrent cancer in 2 patients (8%). To reduce the rate of local recurrent cancer, the method of resection was aimed at pathological negative stumps and establishment of a strict standard of judgement on clinically complete resection were considered to be necessary. Furthermore, complete cure was possible even in patients with pathologically positive stumps in cases where no recurrent cancer was observed over a 1 year period following endoscopic mucosal resection.	
除外	非合致				9354170	eng	Murata S, Kato H, Tamura H, Tachimori Y, Watanabe H, Yamaguchi H, Nakanishi	Second primary carcinoma in the residual cervical esophagus after thoracic esophagectomy: report of five cases.	J Surg Oncol	1997	66(2)	130-3	Case Reports; Journal Article; Research Support, Non-U.S. Gov't	BACKGROUND AND OBJECTIVES: Development of second primary carcinomas after thoracic esophagectomy has become of much concern, because recently the prognosis of thoracic esophageal carcinoma after esophagectomy with extended lymph node dissection has been improving. We report our experience of diagnosing and treatment second primary carcinomas arising in the remaining esophagus after thoracic esophagectomy. METHODS: Among 253 patients who underwent esophagectomy for thoracic esophageal carcinoma more than 2 years previously, second primary esophageal carcinomas developed in five (2.0%), and these five patients were examined. RESULTS: All second primary carcinomas were found by endoscopy, and were diagnosed as superficial carcinoma (Tis or T1) of the residual cervical esophagus. One patient underwent laser irradiation, another endoscopic mucosal resection, two had surgical mucosotomy, and one segmental resection of the esophagus. After the second treatment, three patients were disease free for 37-38 months, one died of recurrent disease of the first carcinoma 36 months later, and one died of distant metastases of the second carcinoma 8 months later. There have been no local recurrences after treatments for the second primaries. CONCLUSIONS: A variety of low-trauma treatments were employed for the second carcinomas because they were found at an early stage. Endoscopic follow-up is proposed to detect second lesions at an early stage.	
除外	非合致				9035294	eng	Chino O, Makuuchi H, Machimura T, Mizutani K, Shimada H, Kanno K, Nishi T, Tanaka H, Sasaki T, Tajima T, Mitomi T, Sugihara	Treatment of esophageal cancer in patients over 80 years old.	Surg Today	1997	27(1)	9-16	Journal Article	A total of 828 patients with esophageal cancer were treated at the Second Department of Surgery of Tokai University in the 20-year period from 1975 to June 1994, including 45 patients over 80 years old. We reviewed these elderly patients to assess the optimum therapeutic approach for such individuals. In recent years, the number of elderly patients with esophageal cancer has steadily been increasing. Advanced cancer is more common among this group, but early cancer has also been detected more frequently in recent years. Of the 45 elderly patients (80%) in our series, 36 were encountered in the last 10 years. As 28.9% of the patients had multiple cancers, a careful workup was necessary preoperatively. Since most patients (88.9%) had complications and were also in a poor general condition, limited surgery was recommended in consideration of the postoperative quality of life. The indications for endoscopic mucosal resection (EMR) may be able to be extended to submucosal (sm1) cancer without lymph node swelling. Postoperative complications occurred in 60% of those undergoing surgical resection or esophageal bypass, although death only resulted in 1 case. The 5-year survival rate after surgical resection was 30.8%. These results therefore support the use of surgical treatment for selected elderly patients with esophageal cancer.	
除外	非合致				8905819	jpn	Kodama M, Kakegawa	[Treatment of superficial carcinoma of the esophagus--a review of responses to questionnaire on superficial carcinoma of the esophagus collected at the 49th conference of Japanese Society for Esophageal Diseases].	Nihon Geka Gakkai Zasshi	1996	97(8)	683-90	English Abstract; Journal Article	Histopathological characteristics and optimal treatment modality for superficial esophageal carcinoma were reevaluated by the way of nationwide questionnaires to the members of the Japanese Society for Esophageal Diseases. A questionnaire was designed for patients with preoperatively untreated superficial carcinoma of the esophagus who had undergone either surgical or endoscopic treatment between January 1, 1990 and December 30, 1994. As the results, the incidence of positive lymphatic invasion or lymphnode metastases tended to increase markedly as cancer infiltration reached the lamina muscularis mucosa. The majority of the cases with 0-I or 0-III components were sm. cancer. The indication of endoscopic mucosal resection (EMR) was limited to m1 and m2 superficial carcinoma in 76% of the institutions surveyed. Tumors measuring 2cm or more in diameter were resected piecemeal in 94% of the patients. The complications of EMR were observed in approximately 6.8% of patients, which denoted perforation, stenosis, and hemorrhage on most of the cases. As for the result of the treatment, almost all patients with m1 or m2 cancer survived. There was no significant difference in prognosis between m3 cancer and m1 or m2 cancer, but sm1 cancer showed worse prognosis than mucosal carcinoma. From this review, further study was advocated to refine the treatment strategy against m3 or sm1 cancer in the future.	
除外	非合致				8965367	jpn	Sakaki N, Momma K, Yoshida M, Katou	[Early esophageal cancer--concept, diagnosis and treatment].	Nihon Rinsho	1996	54(5)	1366-70	English Abstract; Journal Article; Review	In spite of the conventional definition of early esophageal cancer which includes mucosal and submucosal cancers without lymph node metastasis, esophageal mucosal cancers are now considered as the early cancer in clinical field. The esophageal mucosal cancers are subclassified into m1 (intraepithelial cancer), m2(lamina propria mucosae) and m3(muscularis mucosae) in clinical view points. M1 and m2 esophageal cancers which had no lymph node metastasis could be treated completely by endoscopic mucosal resection. On the other hand, the patients with m3 cancer which showed lymph node metastasis in 10% of the cases should be treated by esophagectomy with lymph node dissection. For the diagnosis of the depth of carcinoma invasion, now, endoscopy with dye iodine stain and toluidine blue stain were most useful. Fundamentally, macroscopic appearance of lesions classified by Japanese Society for Esophageal Diseases are well related to the depth of invasion. Almost all mucosal cancers showed the superficial and flat type (0-IIc type). Subclassification of m1, m2 and m3 were easily differentiated by endoscopic observation of their characteristic appearances. In the evaluation of the methods of treatment for mucosal cancer, endoscopic mucosal resection and esopagostomy showed a complete resectability. While, the former was superior in the quality of life after treatment.	
全文取り寄せ		可	否	Tstage unknown	8893343	eng	Rau B, Hunerbein M, Reingruber B, Hohenberger P, Schlag	Laparoscopic lymph node assessment in pretherapeutic staging of gastric and esophageal cancer.	Recent Results Cancer Res	1996	142	209-15	Journal Article	In gastric cancer lymph node metastases at the hepatoduodenal ligament and in esophageal cancer, metastases at the celiac axis are classified as distant metastases (M1 LYMPH) and implying a poor prognosis. In pretherapeutic staging, imaging procedures such as computed tomography of the abdomen or transcutaneous ultrasonic examination are of limited value in the assessment of enlarged or metastatic lymph nodes. Conversely, laparoscopic staging with subsequent biopsy of suspicious lymph nodes provides essential diagnostic information. After exclusion of distant metastases (liver, lung, bone) in 73 patients with esophageal-(n = 21) and gastric cancer (n = 52), staging laparoscopy, including laparoscopic ultrasound, were performed during an 18-month-period (July/93-December/94). After laparoscopic exclusion of peritoneal seedings, the hepatoduodenal ligament was examined and enlarged lymph nodes were biopsied. In a total of 73 patients, laparoscopy revealed previously undiagnosed liver metastases in 14 and peritoneal carcinosis in 19 patients. Additionally, in eight (esophageal cancer; n = 3, gastric cancer; n = 5) of the remaining 40 patients, lymph nodes in the M1-position were regarded suspicious and biopsied. In six of these, malignant spread was observed. Thus, in a further six of 40 patients, surgically incurable situations could be detected. In esophageal and gastric cancer, staging laparoscopy, including laparoscopic ultrasound and biopsy, is a sensitive technique to assess local tumor spread and distant metastases. The detection of M1- lymph node metastases is facilitated by the use of laparoscopic ultrasound. Tumor spread, which limits surgical curability, can be properly assessed and exploratory laparotomy avoided.	

除外	非合致				8558191	eng	Bates BA, Detterbeck FC, Bernard SA, Qaqish BF, Tepper	Concurrent radiation therapy and chemotherapy followed by esophagectomy for localized esophageal carcinoma.	J Clin Oncol	1996	14(1)	156-63	Journal Article; Review	PURPOSE: A prospective study was performed to determine the outcome of patients with esophageal cancer who received preoperative radiation therapy and chemotherapy followed by esophagectomy, and to determine the role of preresection esophagoduodenoscopy (EGD) in predicting the patients in whom surgery could possibly be omitted, and the impact of surgery on survival. MATERIALS AND METHODS: Thirty-five patients with localized carcinoma of the esophagus received concurrent external-beam radiotherapy and chemotherapy followed by esophagectomy. Patients received 45 Gy in 25 fractions. Chemotherapy consisted of continuous infusion fluorouracil (5-FU; 1,000 mg/m ² /d) on days 1 through 4 and 29 through 32 and cisplatin (100 mg/m ²) on day 1. Patients underwent an Ivor-Lewis esophagectomy 18 to 33 days after completion of radiotherapy. RESULTS: Eighty percent of the patients had squamous cell carcinoma and 20% had adenocarcinoma. In addition, 51% had a pathologic complete response (CR). Twenty-two of the 35 underwent a preresection EGD before resection. Seventeen of the 22 (77%) had negative pathology from the preresection EGD, but seven of the 17 (41%) had residual tumor at surgery. The median survival and disease-free survival rates for all patients were 25.8 months and 32.8 months, respectively. Eighteen patients (51%) had no tumor at resection. The median survival for these patients was 36.8 months; the median disease-free survival time has not been reached. The median survival and disease-free survival rate for the patients with residual tumor in the surgical specimen were 12.9 months and 10.8 months, respectively. CONCLUSION: Preresection EGD is not reliable for determining the presence of residual disease or the patients in whom surgery could be omitted. Twenty-five percent of the patients with residual tumor in the resected surgical specimen were long-term survivors; this suggests a benefit from esophagectomy after concurrent radiotherapy and chemotherapy.	
除外	非合致				8548467	jpn	Shimao H, Hiki	[Photodynamic therapy for esophageal cancer].	Gan To Kagaku Ryocho	1996	23(1)	36-40	English Abstract; Journal Article; Review	Evaluation of resected cases of esophageal superficial cancer have shown that lymph node metastasis was absent, and radical local treatment would be possible for m1 and m2 cancer. However, the depth of cancer invasion is difficult to diagnose before treatment. Endoscopic mucosal resection (EMR) is useful for not only treating but also diagnosing cancer. Therefore, EMR is recommended as the treatment of choice for m1 or m2 lesions. On the other hand, treatment of esophageal superficial cancer by PDT is effective even for deep sm cancers. In particular, the use of excimer dye laser increases light transmittance, there by improving the treatment results for sm cancer. EMR was not effective for treating sm cancer or diagnosing the depth of its invasion. In sm cancer, since lymph node metastasis is observed in 30-50% of the cases, local treatment cannot be radical. Therefore, PDT is best indicated as a local treatment for sm cancer that cannot be treated by operation. Local healing after PDT prevents dysphagia caused by stenosis due to cancer, which may allow medical management at home.	
除外	非合致				7582209	eng	Bemelman WA, van Delzen OM, van Lanschot JJ, de Wit LT, Smits NJ, Fockens P, Gouma DJ, Obertop	Laparoscopy and laparoscopic ultrasonography in staging of carcinoma of the esophagus and gastric cardia.	J Am Coll Surg	1995	181(5)	421-5	Journal Article	BACKGROUND: The objective of this prospective study was to assess the contribution of laparoscopy combined with laparoscopic ultrasonography (LLU) in the preoperative staging of patients with carcinoma of the esophagus and cardia. STUDY DESIGN: Preoperative LLU was performed in 56 patients who were selected for curative resection of carcinoma of the esophagus (n = 38) or gastric cardia with involvement of the distal esophagus (n = 18) after routine preoperative workup. During LLU, the peritoneal cavity was scrutinized for metastatic disease, and ultrasonography of the liver and celiac axis was performed. In all patients without histologically proven metastases, laparotomy was then performed. RESULTS: The morbidity rate of the procedure was 3.5 percent (two superficial wound infections). In three (5 percent) of the 56 patients, laparotomy was excluded by the presence of intra-abdominal metastases. In three other patients, laparotomy was necessary to confirm the suspected hepatic or peritoneal metastases, or both, because histologic proof was not obtained at laparoscopy. In one patient, LLU failed to detect a small hepatic metastasis in segment VII. The preoperative stage was altered by laparoscopy in nine (17 percent) patients (M1 in six, T4 in three). Laparotomy was avoided in two (11 percent) and the preoperative stage changed in seven patients (41 percent), all of whom had carcinoma of the gastric cardia, as occurred in one (3 percent) and two (6 percent) patients with middle and distal carcinoma of the esophagus, respectively. CONCLUSIONS: Preoperative staging by LLU is of little value in patients with carcinoma of the middle and lower esophagus. The probable role of LLU in the staging of patients with carcinomas of the gastric cardia remains to be confirmed in larger series.	
除外	非合致				8565661	eng	Liu J, Wang Q, Li B, Meng X, Zhang Y, Du X, Yan J, Ping Y, Li	Superficial carcinomas of the esophagus and gastric cardia. A clinicopathological analysis of 141 cases.	Chin Med J (Engl)	1995	108(10)	754-9	Journal Article	From January 1970 to June 1992, 141 patients with superficial esophageal and cardiac carcinomas (SEC and SCO) underwent surgical treatment. Of the 141 patients 128(90.8%) had slight symptoms related to swallowing, and the remaining 13(9.2%) were asymptomatic. Balloon cytology and esophagoscopy proved very useful for the diagnosis of SEC and SCO, and Lugol's solution staining technique was an effective auxiliary diagnostic measure. Lymph node metastasis was not found in patients with epithelial (EP) cancer. However, it was present in one (2.9%) of 34 patients with muscularis mucosae (MM) invasion, and in 5 (8.6%) of 58 patients with submucosal (SM) cancer. The 5-year survival rates of the patients with SEC and SCO were 75.5% and 71.4%, respectively (P > 0.05). The different depth of tumor invasion including EP, MM and SM cancers showed significant differences in the 5-year survival rate (P < 0.05). Although the prognosis for the patients with lymph node metastasis is poor, we should advocate extended lymph node dissection in surgical treatment of the patients in whom MM and SM cancers are suspected.	
除外	非合致				7569560	eng	Overholt BF, Panjehpour	Photodynamic therapy in Barrett's esophagus: reduction of specialized mucosa, ablation of dysplasia, and treatment of superficial esophageal cancer.	Semin Surg Oncol	1995	11(5)	372-6	Journal Article	Twelve patients with Barrett's esophagus and dysplasia were treated with photodynamic therapy. Five patients also had early, superficial esophageal cancers and five had esophageal polyps. Light was delivered via a standard diffuser or a centering esophageal balloon. Patients were maintained on omeprazole and followed for 6-54 months. In patients with Barrett's esophagus, photodynamic therapy ablated dysplastic mucosa and malignant mucosa in patients with superficial cancer. Healing and partial replacement of Barrett's mucosa with normal squamous epithelium occurred in all patients and complete replacement with squamous epithelium was found in three patients. Side effects included photosensitivity and mild-moderate chest pain and dysphagia for 5-7 days. In four patients with extensive circumferential mucosal ablation in the mid or proximal esophagus, healing was associated with esophageal strictures which were treated successfully by esophageal dilation. Strictures were not found in the distal esophagus. Photodynamic therapy combined with long-term acid inhibition provides effective endoscopic therapy of Barrett's mucosal dysplasia and superficial (Tis-T1) esophageal cancer. The windowed centering balloon improves delivery of photodynamic therapy to diffusely abnormal esophageal mucosa.	
除外	非合致				7672546	eng	Birmoeller KF, Seifert H, Seitz U, Izbicki JR, Kida M, Soehendra	Ultrasonic esophagoprobe for T1M staging of highly stenosing esophageal carcinoma.	Gastrointest Endosc	1995	41(6)	547-52	Journal Article	BACKGROUND: Endosonographic staging of esophageal carcinoma may be limited in one third of cases by tumor stenoses that cannot be traversed with conventional echoendoscopes. We designed and evaluated a new endosonographic instrument (ultrasonic esophagoprobe) for T1M staging of highly stenosing esophageal carcinomas. METHODS: Eighty-seven consecutive patients (64 men, mean age 61 years) with highly stenosing esophageal carcinomas were studied with the esophagoprobe (features: diameter of 7.9 mm, bougie-shaped tip, no fiber optics, insertion over a guide wire). RESULTS: The esophagoprobe was successfully inserted past the stenosis without complication in all patients. Nine patients (10%) required preliminary bougienage to 33 F. The imaging quality was high and allowed for complete T and N staging in all patients. M staging was indeterminate in 15 patients because of inadequate visualization of the celiac axis region. Histopathologic correlation in 38 patients who underwent surgery showed an overall T stage accuracy rate of 89% (T2 = 80%, T3 = 95%, T4 = 87%), and N and M stage accuracies of 79% (N0 = 44%, N1 = 90%) and 91% (M0 = 94%, M1 = 75%), respectively. CONCLUSIONS: The esophagoprobe enables safe passage of highly stenosing esophageal carcinomas for T1M staging. Accuracy rates are similar to those reported for conventional echoendoscopes.	
全文取り寄せ		可	否	T1b	7850702	eng	Nagawa H, Kaizaki S, Seto Y, Tominaga O, Muto	The relationship of macroscopic shape of superficial esophageal carcinoma to depth of invasion and regional lymph node metastasis.	Cancer	1995	75(5)	1061-4	Journal Article	BACKGROUND: There has been considerable controversy with regard to surgical strategies for the treatment of superficial esophageal carcinoma, which is characterized by tumor confined within the epithelium (EP), muscularis mucosae (MM), or submucosa (SM). The relationships among macroscopic shape, depth of invasion, and lymph node involvement in superficial tumors were investigated to devise therapeutic strategies for patients with such disease. METHODS: Thirty-three patients with superficial primary esophageal cancer underwent esophagectomy with regional lymph node dissection (3 EP, 6 MM, and 24 SM). Tumors were divided into two types according to macroscopic characteristics: (1) tumors with elevated components and (2) flat or depressed tumors without an elevated component. RESULTS: Tumors with an elevated component (n = 19) showed invasion of the deep layer, and a high incidence of lymph node metastasis. Conversely, tumors without an elevated component (n = 14) showed varied depths of invasion, and, with one exception, had no lymph node involvement. CONCLUSIONS: The existence of an elevated component in superficial esophageal cancer is an important macroscopic feature suggesting submucosal invasion and a high probability of lymph node involvement. More intensive treatment should be adopted for such tumors, whereas localized resection may be feasible for tumors without an elevated component.	

全文取り寄せ		可	否		7745825	jpn	Fujita M, Hosokawa M, Ohhara M, Shimizu	[Mucosal carcinoma of the esophagus—the pathological point of view by subclassification of depth of invasion].	Rinsho Byori	1995	43(3)	211-20	English Abstract: Journal Article	We studied 58 cases of mucosal carcinoma of the esophagus and 21 cases of submucosal carcinoma to evaluate the macroscopic features and histological risk factors (lymphatic and venous permeations and lymph node metastasis) by subclassification of depth of invasion (m1, m2, m3, sm1, sm2, sm3). Carcinoma of m1 and m2 invasion revealed neither venous permeation nor lymph node metastasis. One case of m2 carcinoma (5%) showed lymphatic permeation. 2 cases of m3 carcinomas (20%) showed lymphatic permeation and 3 cases (27%) had lymph node metastasis. Otherwise "sm" carcinoma revealed a high percentage of lymphatic permeation and lymph node metastasis. Also venous permeation were seen in some cases of "sm" carcinoma. The macroscopic appearance of all mucosal carcinomas was 0-II type and most of the 0-III type carcinomas were "m1" carcinoma. Clinicopathologically it is useful to subclassify mucosal carcinoma as m1, m2, m3, and "m1" and "m2" carcinomas are indications for endoscopic mucosal resection.	
全文取り寄せ	reviewer追加	可	否	MM症例数不明		eng	Ishikawa H1, Sakurai H, Tamaki Y, Nonaka T, Yamakawa M, Saito Y, Kitamoto Y, Higuchi K, Hasegawa M, Nakano T.	Radiation therapy alone for stage I (UICC T1N0M0) squamous cell carcinoma of the esophagus: indications for surgery or combined chemoradiotherapy.	J Gastroenterol Hepatol.	2006	21(8)	1290-6		BACKGROUND AND AIM: The aim of this study was to clarify the efficacy and limitations of radiation therapy (RT) for superficial esophageal carcinoma, and to explore the indications for more aggressive therapy, such as combined chemo-radiotherapy. METHODS: Sixty-eight patients with stage I (UICC T1N0M0) esophageal squamous cell carcinoma treated by definitive RT alone were analyzed. Brachytherapy was administered in 36 patients as a boost, and the prescribed doses were 10 Gy (5 Gy x 2 times) at a low dose rate (19 patients) and 9 Gy (3 Gy x 3 times) at a high dose rate (17 patients). Recurrence patterns and survival rates were assessed and the factors predisposing to recurrences after RT were statistically investigated by univariate analysis. RESULTS: The 5-year cause-specific survival rate and the locoregional control rate were 79.9% and 82.1%, respectively. No case of recurrence or disease-related death was observed in any of the patients with mucosal cancer. Among the cases with the cancer invading the submucosa, there were 12 cases with locoregional recurrence and two cases with distant metastases. In cases of submucosal esophageal cancer, the tumor length was the only statistically significant factor predicting locoregional control. The 5-year locoregional control rate in cases with a short length of the tumor (<or=5 cm) was 83.3%, whereas the corresponding rate in cases with the tumor measuring >5 cm in length was 57.8% (P = 0.036). Patients treated by additional brachytherapy exhibited better cause-specific survival and locoregional control rates than those receiving external RT alone, however, the addition had no statistically significant influence on the outcome. CONCLUSIONS: RT was a successful treatment for stage I esophageal cancer, and the treatment outcome using RT was nearly comparable to that of surgery. However, it is suggested that chemo-radiation should be considered in inoperable cases of submucosal cancer when the tumor is more than 5 cm in length.	
全文取り寄せ	reviewer追加	可	否	MM症例数不明		eng	Yamada K1, Murakami M, Okamoto Y, Okuno Y, Nakajima T, Kusumi F, Takakuwa H, Matsusue S.	Treatment results of chemoradiotherapy for clinical stage I (T1N0M0) esophageal carcinoma.	Int J Radiat Oncol Biol Phys.	2006	64(4)	1106-11		PURPOSE: In 1991, we started a clinical prospective trial for operable esophageal carcinoma, foreseeing organ preservation, to assess the treatment results after definitive chemoradiotherapy (CRT) for clinical stage I (T1N0M0) esophageal cancer. PATIENTS AND METHODS: Between 1992 and 2003, 63 patients were enrolled in this study. Tumor depth was mucosal cancer (T1a) in 23 and submucosal cancer (T1b) in 40. CRT consisted of 55-66 Gy/50-60 fractions (median, 59.4 Gy); from 1 to 3 cycles (median, 2) of concurrent chemotherapy (Cisplatin and 5-fluorouracil), followed by high-dose-rate intraluminal brachytherapy 10-12 Gy/2-3 fractions. RESULTS: The 5-year overall and cause-specific and disease-free survival rates were 66.4%, 76.3%, and 63.7%, respectively. The 5-year cause-specific survival rates for T1a and T1b cancer patients were 85.2% and 70.0%, respectively (p = 0.06). The 5-year disease-free survival rates for T1a and T1b were 84.4% and 50.5%, respectively (p < 0.01). Esophageal fistula as a late toxicity occurred in 2 patients (G4: 1; G5: 1), and esophageal stricture requiring a liquid diet occurred in 2 patients. Pericardial effusion was observed in 3 patients. CONCLUSION: We confirmed that patients with T1N0M0 esophageal carcinoma had their esophagus preserved in 89.2% of cases after definitive CRT, and the survival rates were equivalent to those of previous reports of surgery.	
全文取り寄せ	reviewer追加	可	否	MM症例数不明		eng	Tanaka T, Matono S, Mori N, Shirouzu K, Fujita H.	T1 squamous cell carcinoma of the esophagus: long-term outcomes and prognostic factors after esophagectomy.	Ann Surg Oncol	2014	21(3)	932-8		BACKGROUND: Mucosal (T1a) and submucosal (T1b) squamous cell carcinoma of the esophagus (ESCC) have often been analyzed together and are staged as the same category in the UICC/TNM staging system. The difference in surgical outcomes between T1a and T1b ESCC therefore remains unclear. The purpose of this study was to examine the differences in surgical outcomes between T1a and T1b ESCC, and to investigate the prognostic factors in T1 ESCC. METHODS: A prospectively maintained database identified 145 previously untreated patients with pT1 ESCC who underwent radical transthoracic (n = 134) or transhiatal esophagectomy (n = 11). Median follow-up was 106 months. RESULTS: Of the 145 patients, 35 (24 %) had pT1a cancer and 110 (76 %) had pT1b cancer. Lymph node metastasis was present in 45 patients (31 %); 3 patients with pT1a cancer and 42 patients with pT1b cancer (P = 0.0003). The 5-year survival rate for the whole group was 77 %. The 5-year survival rate of the T1a patients was 94 % compared with 72 % for the T1b patients (P = 0.0282). In multivariate analysis, only the depth of tumor invasion (pT1a vs. pT1b) was an independent prognostic factor (hazard ratio 2.358; 95 % confidence interval 1.009-5.513; P = 0.0477). CONCLUSIONS: After esophagectomy, the prognosis of patients with pT1b ESCC is significantly worse than that of patients with pT1a ESCC. Infiltration into the submucosa is the only independent prognostic factor affecting survival. These findings suggested that T1a and T1b ESCC could be staged separately in the next version of UICC/TNM staging system.	
全文取り寄せ	reviewer追加	可	採				Leers JM1, DeMeester SR, Oezcelik A, Kipfel N, Ayazi S, Abate E, Zehetner J, Lipham JC, Chan L, Hagen JA, DeMeester TR.	The prevalence of lymph node metastases in patients with T1 esophageal adenocarcinoma a retrospective review of esophagectomy specimens.	Ann Surg.	2011	253(2)	271-8.		Knowledge of the risk of lymph node metastases is critical to planning therapy for T1 esophageal adenocarcinoma. This study retrospectively reviews 75 T1a and 51 T1b tumors and correlates lymph node metastases with depth of tumor invasion, tumor size, presence of lymphovascular invasion, and tumor grade. OBJECTIVES: Increasingly, patients with superficial esophageal adenocarcinoma are being treated endoscopically or with limited surgical resection techniques. Since no lymph nodes are removed with these therapies, it is critical to have a clear understanding of the risk of lymph node metastases in these patients. The aim of this study was to define the risk of lymph node metastases for intramucosal and submucosal (T1) esophageal adenocarcinoma and to analyze factors potentially associated with an increased risk of lymph node involvement. METHODS: We reanalyzed the pathology specimens of all patients that had primary esophagectomy for T1 adenocarcinoma of the distal esophagus or gastroesophageal junction from January 1985 to December 2008. The prevalence of lymph node metastases was correlated with tumor size, depth of invasion, presence of lymphovascular invasion, and degree of tumor differentiation. RESULTS: There were 126 patients, 102 men (81%) and 24 women (19%), with a mean age of 64 (± 10) years. Tumor invasion was limited to the mucosa (T1a) in 75 patients (60%), whereas submucosal invasion (T1b) was present in 51 patients (40%). Tumors that had poor differentiation, lymphovascular invasion, and size ≥2 cm were significantly more likely to be invasive into the submucosa. Lymph node metastases were rare (1.3%) with intramucosal tumors but increased significantly with submucosal tumor invasion (22%) [P = 0.0003]. Lymph node metastases were also significantly associated with poor differentiation (P = 0.0015), lymphovascular invasion (P < 0.0001), and tumor size ≥2 cm (P = 0.01). Division of the submucosa into thirds did not show a layer with a significantly decreased prevalence of node metastases. CONCLUSIONS: Adenocarcinoma invasive deeper than the muscularis mucosa is associated with a significant increase in the prevalence of lymph node metastases and there is no "safe" level of invasion into the submucosa. Lymphovascular invasion, tumor size ≥2 cm, and poor differentiation are associated with an increased risk of submucosal invasion and lymph node metastases and should be factored into the decision for endoscopic therapy or esophagectomy.	

全文取り寄せ	reviewer追加	可	採				Barbour AP1, Jones M, Brown I, Gotley DC, Martin I, Thomas J, Clouston A, Smithers BM.	Risk stratification for early esophageal adenocarcinoma: analysis of lymphatic spread and prognostic factors.	Ann Surg Oncol	2010	17(9)	2494-502		BACKGROUND: Knowledge of factors related to outcome is vital for the selection of therapeutic alternatives for patients with early (T1) esophageal adenocarcinoma. This study was undertaken to determine predictors of lymphatic spread and prognostic factors for T1 esophageal adenocarcinoma following esophagectomy.MATERIALS AND METHODS: A prospectively maintained database identified 85 patients with T1 esophageal adenocarcinoma who underwent esophagectomy without neoadjuvant therapy. Depth of tumor invasion (T stage) was subdivided into mucosal (T1a) or submucosal invasion (T1b). Median follow-up was 59 months.RESULTS: Thoracoscopically assisted 3-phase esophagectomy was performed in 73 of 85 patients (86%). Lymph node metastases (N stage) were identified in 9 of 85 patients (11%). Depth of tumor invasion (T stage), lymphovascular invasion (LVI), and poor differentiation were associated with N stage. The patients could be stratified into 4 risk groups for lymph node metastases: group I—T1a (0 of 35 patients [0%] with positive nodes); group II—T1b, well/moderate differentiation and no LVI (1 of 28 patients [4%] with positive nodes); group III—T1b, poor differentiation and no LVI (2 of 9 patients [22%] with positive nodes); and group IV—T1b any grade with LVI (6 of 13 patients [46%] with positive nodes). Survival analyses found T stage, N stage, LVI, and poor differentiation to be significant prognostic factors.CONCLUSIONS: Risk stratification is possible for patients with T1 esophageal adenocarcinoma. Local resection techniques without lymphadenectomy may be alternatives for T1a tumors. Esophagectomy should remain the standard of care for patients with T1b tumors and those with LVI or poor differentiation considered for neoadjuvant therapy.	
全文取り寄せ	reviewer追加	可	否	MM症例数不明			Dubecz A1, Kern M2, Solymosi N3, Schweigert M4, Stein HJ2.	Predictors of Lymph Node Metastasis in Surgically Resected T1 Esophageal Cancer.	Ann Thorac Surg	2015	99(6):	1879-86		BACKGROUND: The application of endoscopic therapies for early cancers of the esophagus is limited by the possible presence of regional lymph node metastases. Our objective was to determine the prevalence and predictors of lymph node metastases in patients with pT1 carcinoma of the esophagus and the gastric cardia.METHODS: The National Cancer Institute's Surveillance Epidemiology and End Results Database (2004 to 2010) was used to identify all patients with pT1 carcinomas who underwent primary surgical resection for squamous cell carcinoma (SCC) or adenocarcinoma (EAC) of the esophagus and of the esophagogastric junction (AEG). Prevalence of lymph node metastases was assessed, and survival in all types of cancer was calculated. Multivariate logistic regression was used to identify factors predicting positive lymph node status.RESULTS: There were 1,225 patients (84% male), with a mean age of 64 ± 10 years, and 90% were white. Intramucosal disease was present in 44% of patients, and submucosal invasion (T1b) was present in 692 (56%). Prevalence of lymph node metastases in EAC, SCC, and AEG was 6.4%, 6.9%, and 9.5% for pT1a tumors and 19.6%, 20%, and 22.9% for pT1b tumors, respectively. In patients with more than 23 lymph nodes removed during resection, prevalence of lymph node metastases in EAC, SCC, and AEG was 8.1%, 25%, and 7.4% for pT1a tumors and 27.8%, 33.3%, and 22% for pT1b tumors, respectively. Positive lymph node status was associated with worse overall 5-year survival in EAC (N0 vs N+: 78% vs 52%) and AEG (N0 vs N+: 83% vs 44%) but did not have a significant effect on the long-term survival of patients with SCC. Infiltration of the submucosa, tumor size exceeding 10 mm, and poor tumor differentiation were independently associated with the risk of nodal disease. Prevalence of lymph node metastasis negative for these three risk factors was only 4.8%.CONCLUSIONS: Prevalence of lymph node metastasis in early esophageal cancer is high in patients with T1 cancer. Inadequate lymphadenectomy underestimates lymph node status. Endoscopic treatment can be considered only in a select group of patients with early esophageal cancer.	
全文取り寄せ	reviewer追加	可	否	absence of pathological finding			Tsujii Y1, Nishida T1, Nishiyama O2, Yamamoto K3, Kawai N4, Yamaguchi S4, Yamada T5, Yoshio T5, Kitamura S6, Nakamura T7, Nishihara A8, Ogiyama H9, Nakahara M10, Komori M11, Kato M1, Hayashi Y1, Shinzaki S1, Iijima H1, Michida T12, Tsujii M1, Takehara T1.	Clinical outcomes of endoscopic submucosal dissection for superficial esophageal neoplasms: a multicenter retrospective cohort study.	Endoscopy	2015	Mar 31. [epub ahead of print]		groud and study aims: The safety and efficacy of endoscopic submucosal dissection (ESD) for superficial esophageal neoplasms (SENs) have not been evaluated in a multicenter survey. The aim of this study was to investigate the clinical outcomes in a multicenter study that included municipal hospitals. Patients and methods: Of 312 consecutive patients with 373 esophageal lesions treated by ESD at 11 hospitals from May 2005 to December 2012, a total of 368 SENs in 307 patients were retrospectively analyzed. Results: The median tumor size was 18mm (range 2-85mm). The median procedure time was 90 minutes (range 12-450 minutes). The en bloc resection and complete resection rates were 96.7% (95% confidence interval [CI] 94.4%-98.1%) and 84.5% (95%CI 80.5%-87.8%), respectively. Perforation (including mediastinal emphysema), postoperative pneumonia, bleeding, and esophageal stricture, occurred in 5.2% (95%CI 3.3%-7.9%), 1.6% (95%CI 0.7%-3.5%), 0%, and 7.1% (95%CI 4.9%-10.2%) of patients, respectively. All of these complications were cured conservatively. No procedure-related mortality occurred. Early treatment periods (odds ratio [OR]=4.04; P<0.01) and low volume institutions (OR=3.03; P =0.045) were significantly independent risk factors for perforation. The circumference of the lesion was significantly associated with postoperative stricture (OR=32.3; P<0.01). The procedure times significantly decreased in the later period of the study (P<0.01). Follow-up data (median 35 months; range 4-98 months) showed significant differences in overall survival (P=0.03) and recurrence-free survival (P<0.01) rates between patients with curative and noncurative resections. Conclusions: Esophageal ESD has become feasible with acceptable complication risks and favorable long term outcomes.		
全文取り寄せ	reviewer追加	可	採				Katada C, Muto M, Momma K, Arima M, Tajiri H, Kanamaru C, Ooyanagi H, Endo H, Michida T, Hasuike N, Oda I, Fujii T, Saito D.	Clinical outcome after endoscopic mucosal resection for esophageal squamous cell carcinoma invading the muscularis mucosae—a multicenter retrospective cohort study.	Endoscopy	2007	39(9)	779-83		BACKGROUND AND STUDY AIMS: Endoscopic mucosal resection (EMR) is now commonly indicated for esophageal squamous cell carcinoma (ESCC) within the lamina propria mucosa. However, EMR for ESCC that has invaded the muscularis mucosa is controversial because the risk of lymph node metastasis is not negligible. We conducted a multicenter retrospective cohort study to investigate the incidence of lymph node metastasis and survival after EMR for ESCC invading the muscularis mucosa.PATIENTS AND METHODS: A total of 104 patients with 111 lesions invading the muscularis mucosa, were retrospectively studied at eight institutes. No patients exhibited evidence of metastasis of lymph nodes or distant organs prior to EMR. Overall and cause-specific survival rates were calculated from the date of EMR to the date of death or the most recent follow-up visit. Survival curves were plotted according to the Kaplan-Meier method.RESULTS: In total, 86 patients (82.7%) who did not receive further treatment such as chemotherapy, irradiation therapy, chemoradiotherapy, or esophagectomy after EMR were followed up. Only two patients (1.9%) developed lymph node metastasis after EMR. With a median follow-up period of 43 months (range, 8-134 months), overall and cause-specific survival rates at 5 years after EMR were 79.5% and 95.0%, respectively.CONCLUSIONS: EMR for ESCC that invades the muscularis mucosa has curative potential as a minimally invasive treatment option	
全文取り寄せ	reviewer追加	可	採				Kato H1, Sato A, Fukuda H, Kagami Y, Udagawa H, Togo A, Ando N, Tanaka O, Shinoda M, Yamana H, Ishikura S.	A phase II trial of chemoradiotherapy for stage I esophageal squamous cell carcinoma: Japan Clinical Oncology Group Study (JCOG9708).	Jpn J Clin Oncol.	2009	39(10)	638-43		OBJECTIVE: The study objective was to evaluate the efficacy and toxicity of chemoradiotherapy with 5-fluorouracil (5-FU) plus cisplatin in patients with Stage I esophageal squamous cell carcinoma (ESCC). The primary endpoint was proportion of complete response (%CR). METHODS: Patients with Stage I (T1N0M0) ESCC, aged 20-75 years, without indication of endoscopic mucosal resection were eligible. Treatment consisted of cisplatin 70 mg/m(2) (day 1) and 5-FU 700 mg/m(2)/day (days 1-4) combined with 30 Gy radiotherapy (2 Gy/day, 5 days/week, days 1-21). The cycle was repeated twice with 1-week split. Salvage surgery was recommended for residual tumor or local recurrence.RESULTS: From December 1997 to June 2000, 72 patients were enrolled. No ineligible patient or major protocol violation was observed. There were 63 CRs for %OR of 87.5% [95% confidence interval (CI): 77.6-94.1]. Six patients with residual tumor successfully underwent esophagectomy. There was no Grade 4 toxicity. Four-year survival proportion was 80.5% (95% CI: 71.3-89.7), and 4-year major relapse-free survival proportion was 68% (95% CI: 57.3-78.8) (mucosal recurrence removed by endoscopy was not counted as an event). CONCLUSIONS: High CR proportion and survival proportion with mild toxicity suggest that this regimen could be considered as a candidate of new standard treatment to be compared with surgery in patients with Stage I ESCC.	

全文取り寄せ	reviewer追加	可	採				Shimizu Y1, Kato M, Yamamoto J, Nakagawa S, Tsukagoshi H, Fujita M, Hosokawa M, Asaka M.	EMR combined with chemoradiotherapy: a novel treatment for superficial esophageal squamous-cell carcinoma.	Gastrointest Endosc.	2004	59(2)	199-204		<p>BACKGROUND: Esophagectomy or chemoradiotherapy (CRT) are the procedures of choice for patients with superficial esophageal squamous-cell carcinoma. However, esophagectomy is highly invasive, and CRT is associated with the risk of local failure. A study was conducted of a novel treatment, EMR combined with CRT, for patients with superficial esophageal carcinoma. EMR was performed for the purpose of complete local tumor control and chemoradiotherapy was performed for regional and distant control.METHODS: EMR combined with CRT was performed for patients with esophageal carcinoma invading the muscularis mucosae or upper submucosa who refused esophagectomy. The planned treatment after EMR was 40 to 46 Gy of external beam radiation to the mediastinum, including the supraclavicular fossa or cardia. Chemotherapy was given during weeks 1 and 5 (5-fluorouracil, 700 mg/m(2) per 24 hours in a 120-hour infusion, and cisplatin 15 mg/m(2) per day intravenously on days 1 to 5).</p> <p>RESULTS:</p> <p>During the study period, 16 patients underwent EMR combined with CRT (EMR plus CRT group) and 39 patients with similar stage cancer underwent esophagectomy (surgical resection group). None of the patients in the EMR plus CRT group have had local recurrence or metastasis. Overall survival rates at 5 years in the EMR plus CRT and surgical resection groups were estimated to be, respectively, 100% and 87.5%.</p> <p>CONCLUSIONS:</p> <p>Although this study was not randomized, the results suggest that EMR combined with CRT is a safe and effective method for treating patients with superficial esophageal carcinoma. The results were equivalent or, in view of the lower degree of invasiveness, superior to surgical resection.</p>
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CQ番号	CQ名	検索式	文献数	検索DB	検索担当者	検索実行日	保存ファイル名	メモ
CQ18	食道表在癌に対して内視鏡治療を行いpT1a-MMであった場合、追加治療は有用か？	(((((((esophageal neoplasms[MH] OR esophageal cancer[TIAB] OR oesophageal cancer[TIAB] OR (esophageal* AND cancer)))) AND ((T1a-EP[TIAB] OR T1a[TIAB] AND EP[TIAB]) OR M1[TIAB] OR T1a[TIAB] OR T1a-LPM[TIAB] OR (T1a[TIAB] AND LPM[TIAB]) OR M2[TIAB] OR T1a[TIAB] OR T1a-MM[TIAB] OR (T1a[TIAB] AND MM[TIAB]) OR M3[TIAB] OR T1b[TIAB] OR pT1a-MM[TIAB] OR T1b[TIAB] OR SM[TIAB] OR SM1[TIAB] OR SM2[TIAB] OR SM3[TIAB] OR T1b-SM[TIAB]))) AND ((esophagoscopy[MH] OR endoscopy[MH] OR thoracoscopy[MH] OR laparoscopy[MH] OR endoscopy, digestive system[MH] OR catheterization[MH] OR endoscopic mucosal resection[TIAB] OR endoscopic submucosal dissection[TIAB] OR endoscopy, gastrointestinal[MH] OR EMR[TIAB] OR ESD[TIAB]))) AND (((mucous membrane[MH] OR gastric mucosa[MH]) AND surgery))) AND ((("1995/01/01"[DP] : "2015/04/30"[DP] AND "humans"[MeSH Terms] AND (English[LA] OR Japanese[LA])))) OR ((((((esophageal neoplasms[MAJR] OR esophageal cancer[TIAB] OR oesophageal cancer[TIAB] OR (esophageal* AND cancer)))) AND ((T1a-EP[TIAB] OR T1a[TIAB] AND EP[TIAB]) OR M1[TIAB] OR T1a[TIAB] OR T1a-LPM[TIAB] OR (T1a[TIAB] AND LPM[TIAB]) OR M2[TIAB] OR T1a[TIAB] OR T1a-MM[TIAB] OR (T1a[TIAB] AND MM[TIAB]) OR M3[TIAB] OR T1b[TIAB] OR pT1a-MM[TIAB] OR T1b[TIAB] OR SM[TIAB] OR SM1[TIAB] OR SM2[TIAB] OR SM3[TIAB] OR T1b-SM[TIAB]))) AND ((esophagoscopy[MH] OR endoscopy[MH] OR thoracoscopy[MH] OR laparoscopy[MH] OR endoscopy, digestive system[MH] OR catheterization[MH] OR endoscopic mucosal resection[TIAB] OR endoscopic submucosal dissection[TIAB] OR endoscopy, gastrointestinal[MH] OR EMR[TIAB] OR ESD[TIAB]))) AND ((("1995/01/01"[DP] : "2015/04/30"[DP] AND "humans"[MeSH Terms] AND (English[LA] OR Japanese[LA])))) AND ((disease-free survival[MH] OR survival rate[MH] OR Survival Analysis[MH] OR treatment outcome[MH] OR prognosis OR survival OR mortality) OR (neoplasm recurrence, local[MH] OR cocarcinogenesis[MH] OR recurrence[MH] OR neoplasms, second primary[MH] OR neoplasm metastasis[MH] OR metachronous[TIAB] OR metastatic disease[TIAB] OR subsequent primary cancer[TIAB])))	121	PubMed	園原	2015/06/26	食道癌CQ18PM	<p>以下の2通りの組み合わせをネ스팅しております。</p> <ul style="list-style-type: none"> ・食道癌 (MH) × 深達度 × 内視鏡 × 粘膜 (術) ・食道癌 (MAJR) × 深達度 × 内視鏡 × 予後 <p>いただいた参考文献は2件とも検索結果に含まれます。</p>

文献	研究デザイン	P	I	C	O	除外	コメント
Katada C. Endoscopy 2007	症例集積	104例111MM病変、8施設、全例SCC	EMR	なし	リンパ節転移再発2例(1.9%)、原病死2例(1.9%)	-	リンパ管侵襲9例(8.1%)静脈侵襲8例(7.2%) EMR後、追加治療なし86例(82.7%)追加治療あり18例(17.3%) 3年疾患特異生存割合追加治療あり92.9% vs追加治療無し100%
Endo M. Dis of Esophagus 2000	症例集積	236例中MM36病変、単施設、全例SCC	手術	なし	手術標本リンパ節転移3例(8%)原病死なし	-	脈管侵襲9例(25%) MM例5年全生存割合86%、死亡は全例他病死 手術関連死データなし
Araki K. Cancer 2002	症例集積	98例中MM22病変、単施設、全例SCC	手術	なし	手術標本リンパ節転移0例(0%)、リンパ節再発4例(18.2%)	-	リンパ管侵襲4例(18.2%)静脈侵襲0例 生存成績無し 手術関連死データ無し
Noguchi H. Surg Laparosc 2000	症例集積	117例中MM17病変、単施設、全例SCC	手術	なし	手術標本リンパ節転移1例/9例(11.1%)、再発例なし	-	リンパ管侵襲7例(41.2%)静脈侵襲0例 再発例なし
Eguchi T. Modern Pathol 2006	症例集積	MM50病変、単施設、全例SCC	手術	なし	手術標本リンパ節転移9例(18%)、	-	リンパ管侵襲12例(24%) リンパ節転移率LY(-) 4/38(10.3%) vs LY(+) 5/12 (41.7%) SM132例を併せた82例での多変量解析で、LY(+)がOR3.83、V(+)がOR3.02 生存成績なし 術後30日死亡6例(0.2%)
Yamashina T. America J of Gastro 2013	症例集積	402例中MM70病変、単施設、全例SCC	EMR	なし	原病死1/70 (1.4%)リンパ節または遠隔転移3例 (4.2%)	-	追加治療(主にCRT)あり:13例(18.6%) 5年全生存割合:71.1% 5年疾患特異生存割合:98.0% EMR後転移のリスクについて多変量解析の結果 EPLPMをreferenceとするとMMのHazard ratio 13.1 (1.3-133.7), p=0.03 粘膜内癌 LY(+)vs LY(-) 累積転移発生割合46.7% vs 0.7%(p<0.0001)
Herrero LA Endoscopy 2010	症例集積	82例中MM57例、単施設、adeno	EMR	なし	リンパ節転移再発0例	-	リンパ管侵襲3例(5.2%)
Choi JY GIE 2011	症例集積	190例中MM24例、単施設、SCC	手術	なし	手術標本リンパ節転移6例(25%)	-	MMのリンパ管侵襲例数不明、T1全例でリンパ節転移のリスク、LVIのオッズ比6.11手術関連死データ無し
Leers JM. Annals of Surg 2011	症例集積	126例中MM57例、単施設、adeno	手術	なし	手術標本リンパ節転移1例(1.3%)	-	粘膜内癌の5年全生存割合92%、疾患特異生存割合98%
Kim DU. J Gastro Hepatol 2007	症例集積	197例中MM19例、単施設、SCC	手術	なし	手術標本リンパ節転移4例(21.1%)	-	T1全例で、リンパ節転移のリスク、リンパ管侵襲のオッズ比3.63,p=0.007
Ancona E. Annal of Surg Oncol. 2008	症例集積	98例中MM12病変、単施設、全例adeno/SCC	手術	なし	手術標本リンパ節転移0例(0%)	-	T1全例で、リンパ節転移のリスク、リンパ管侵襲のハザード比 0.134(95%CI 0.024-0.747),p=0.04、術後合併症による60日以内 死亡2例(2%)
Barbour AP. Annals of Surg Oncol. 2010	症例集積	85例中MM15病変、単施設、全例adeno	手術	なし	手術標本リンパ節転移0例(0%)	-	T1全例で、リンパ管侵襲陽性vs 陰性の5年DSS 47% vs 89%, p<0.001
Kato H. Jpn J Clin Oncol. 2009	単一群試験	72例、cStage I (T1N0M0)、多施設、全例SCC	CRT	なし	CR割合87.5%、リンパ節または遠隔再発照射内1例、照射野外13例	-	EMR適応のない病変のみが対象。4年全生存割合80.5%、無再発(majorのみ)生存割合68%。有害事象grade4はないがGrade3の心虚血1% 呼吸不全2.8%
Yamada K. Int J Rad Oncol Biol.Phys. 2006	単一群試験	63例、cStage I (T1N0M0)、単施設、全例SCC	CRT	なし	リンパ節再発または遠隔再発7例、全例cT1b	-	5年全生存割合66.4%、疾患特異生存割合76.8%,T1aでは疾患特異生存割合85.2%,重篤な晩期毒性は食道瘻2、食道狭窄(液体のみ)2例
Merkow RP. JNCI 2014	症例集積	5390例、cStageI (T1N0M0)、多施設、90%Adeno	手術、EMR	なし	T1aに対する手術例リンパ節転移91/1810 (5.0%)	-	T1a 54% T1b 46%, 手術後30日以内死亡139/3963 (3.5%)
Tanaka T. Ann Surg Oncol 2014.	症例集積	145例 pT1中pT1a 35例、単施設 全例SCC	手術	なし	T1aの手術標本内リンパ節転移3例(8.6%)術後リンパ節再発2例 (5.7%)	-	T1a 5年疾患特異生存割合 100% 術後合併症による死亡2例(3.6%)
Akutsu Y. Annals of Surgery 2013	症例集積	295例中pT1aMM57例	手術、EMR	なし	手術標本中リンパ節転移4/15 (27%)、術後リンパ節再発1例(6%) EMRリンパ節再発0%(0/42)	-	MMのリンパ管侵襲手術例6/15 EMR例 0/42 脈管陰性でのリンパ節転移3/47 (6%) 陽性では 2/6(33%)オッズ比7.333 MM疾患特異5年生存全生存ともに 100%
Shimizu Y. GIE 2004	症例集積	16例pT1aMM SM1	EMR+CRT	なし		-	5年全生存割合100%、疾患特異生存割合100% 重篤な有害事象や治療関連死亡は報告無し

