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<th>Surgical Treatment for Carcinoma of the Esophagus Involving the Trachea, Bronchus and Lung in Terms of its Prognosis and Pathological Study</th>
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**Abstract**

The study was designed to evaluate the surgical outcomes and long-term survival of patients with esophageal cancer involving the trachea, bronchus, and lung. The analysis included a pathological study of the specimens collected during the surgical procedures. The results indicated that the presence of involvement significantly affected the prognosis, with a lower survival rate observed in patients with advanced disease. Further research is needed to improve surgical techniques and patient selection criteria.
Surgical Treatment for Carcinoma of the Esophagus Involving the Trachea, Bronchus and Lung in Terms of its Prognosis and Pathological Study

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Key word: Carcinoma of the esophagus, A3 involving the trachea, bronchus, lung, pathology, prognosis.

A total of 10 patients with carcinoma of the esophagus involving the trachea, bronchus and lung were operated upon. Their clinical features and histological patterns of cancer invasion were evaluated.

In 5 patients involving the lung, the preoperative irradiation therapy was histologically effective in encircling the cancer lesions by induced scar formation. It was possible to render the resection to enhance its radicality.

In 5 patients involving the trachea or the bronchus, it has become apparent that the membranous portion is more susceptible to cancer invasion and the structures of the cartilages on the tracheal and bronchial walls have a strong resistance to cancerous spread. The extent of cancer invasion on the trachea or bronchus was considerably limited.

The sharp dissection at the site of occurrence of cancer invasion as an operative procedure of choice is sometimes beneficial in attempt to enhance the operative radicality when cancer invasion reaches to the adventitial layer.

The prognosis, however, was not improved by an extended resection. It seems to be closely related to n-factor. None of them survived exceeding one year after surgery.

INTRODUCTION

Despite advancing the diagnostic techniques for carcinoma of the esophagus to de-
tect in early stage, we have not infrequently experienced far advanced patients with cancer invasion to the surrounding organs such as the trachea, bronchus and lung.

This study was undertaken to clarify the operability and its validity in 10 cases with carcinoma of the esophagus involving the trachea, bronchus and lung in view of clinical features and pathophysiology.

MATERIAL AND METHOD

During the period of 10 years from 1969 to 1978, a total of 106 cases with carcinoma of the esophagus were admitted in our clinics. Among of them, only 58 cases (54.7%) underwent surgical resection of the esophagus.

Five patients with carcinoma of the esophagus involving the trachea and bronchus were included, 4 males and 1 female. Table 1 summarized their clinical features. The other 5 patients with carcinoma of the esophagus involving the lung were also subjected, 3 males and 2 females. Table 2 also summarized their clinical features.

The surgical specimens were histologically examined as to the modality and extent of cancer invasion.

RESULT

The tumor of the esophagus in 5 cases involving the trachea and bronchus were located in the cervical and upper intrathoracic esophagus (Ce+Iu) in one, in the upper intrathoracic esophagus (Iu) in one, in the upper and middle intrathoracic esophagus (Iu+Im) in two and in the middle intrathoracic esophagus in one. They ranged in age from 53 years to 66. The main symptoms consisted of dysphagia and bloody sputum. According to the findings of the esophagogram, the spiral type was seen in 4 and the serrated type in the remaining one. The shadow defect on the esophagogram varied in length from 6.0cm to 10.0cm. On the esophagoscopy examination, one showed the complete stenotic type, three revealed the ill-defined-depressed-stenotic types and the other one was the tumorous type.

Bronchoscopic examination was performed in three cases. In one case, it failed to identify the lesion intensity due to an existence of stenosis. In another case, there was the stenotic lesion in the right middle bronchus. In the other case, the protrusive changes in the membranous portion of both the trachea and the left main bronchus were revealed. Three cases of them underwent preoperative irradiation of 4000 rads of Co$^{60}$. The lymph node involvements were ranged from $n_2$ to $n_4$ except for undermind one case from the operative record. The term, $A_3$, were based on a presence of cancer invasion to the trachea in three, to the right main bronchus accompanying the involved pleura in one and to the right middle bronchus with involved pleura and pericardium. The additional operative procedures for the involved sites of carcinoma were dissection only in three, combined resection with the lung in two respectively.
Table 1. Clinical features and pathological findings in 5 patients with carcinoma of the oesophagus involving the trachea and bronchus.

<table>
<thead>
<tr>
<th>case</th>
<th>age</th>
<th>sex</th>
<th>tumor location</th>
<th>symptom</th>
<th>esophagogram type defect</th>
<th>length</th>
<th>esophagoscopy</th>
<th>bronchoscopy</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>66y</td>
<td>M</td>
<td>Ce+Iu</td>
<td>dysphagia</td>
<td>spiral</td>
<td>8cm</td>
<td>stenosis</td>
<td>not visible due to stenosis</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>61y</td>
<td>M</td>
<td>Iu</td>
<td>dysphagia</td>
<td>spiral</td>
<td>6cm</td>
<td>ulceration circumference</td>
<td>n4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>53y</td>
<td>M</td>
<td>Iu+Im</td>
<td>dysphagia</td>
<td>spiral</td>
<td>7cm</td>
<td>ulceration circumference</td>
<td>n2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>55y</td>
<td>M</td>
<td>Iu+Im</td>
<td>dysphagia</td>
<td>spiral</td>
<td>10cm</td>
<td>ulceration circumference</td>
<td>n3</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>56y</td>
<td>F</td>
<td>Im</td>
<td>cough, bloody sputum, nausea</td>
<td>spiral</td>
<td>7cm</td>
<td>tumorous</td>
<td>obstruction in the right middle bronchus</td>
<td>n4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>case</th>
<th>histology</th>
<th>A2 involved organ</th>
<th>operation for involved organ</th>
<th>reconstruction for resected esophagus</th>
<th>recurrence</th>
<th>survival time (cause of death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sq moderately</td>
<td>trachea</td>
<td>trachal resection</td>
<td>non</td>
<td>unknown</td>
<td>13days (cardiac failure)</td>
</tr>
<tr>
<td>2</td>
<td>Sq poorly</td>
<td>trachea</td>
<td>dissection</td>
<td>non</td>
<td>neck mediastinum esophagus</td>
<td>3M (gastric bleeding)</td>
</tr>
<tr>
<td>3</td>
<td>Sq poorly</td>
<td>trachea aorta</td>
<td>dissection</td>
<td>retrosternal gastric tube</td>
<td>lung bone abdomen</td>
<td>3M (cachexia)</td>
</tr>
<tr>
<td>4</td>
<td>Sq poorly</td>
<td>r-main bronchus pleura</td>
<td>partial resection</td>
<td>antesternal gastric tube</td>
<td>remained esoph neck</td>
<td>3M (pneumonia)</td>
</tr>
<tr>
<td>5</td>
<td>Sq poorly</td>
<td>r-middle bronchus pericardium pleura</td>
<td>lung resection (middle lower lobectomy)</td>
<td>retrosternal gastric tube</td>
<td>lung diaphragm</td>
<td>4M (pneumonia pyothorax)</td>
</tr>
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</table>
Histological examination from the surgical specimens showed squamous cell carcinoma in all 5 cases. One was moderately differentiated type, and the other four were poorly differentiated.

According to INF classification, α was seen in one, β in two and γ in two. All specimens showed a presence of the lymph node involvement.

The modes of cancer invasion at the site of A3 were histologically examined. Except for one without preoperative irradiation therapy, two of five cases showed R-a2 and the remaining two revealed R-a3. Three of them had the cancer lesions in the scar tissues probably produced by irradiation. In one of them, the fistula between the esophagus and the trachea was formed by advanced cancer. The invasion patterns of carcinoma were histologically evaluated in all five cases. The fistulous communication between the esophagus and the trachea was seen in one as shown Fig. 1. It was accompanying the cancer invasion into both the mucosal membranes and it was nearly situated in their centers, reflecting the resultant necrosis in the central portion of cancer involvement. The affected site of the involved bronchus was the membranous portion of the right middle bronchus.

Fig. 2. indicated that involved bronchus had become occluded with the development of an excess of the tumor mass.

According to histological examination, the fistulous communication caused by cancer accompanied the extensively growing cancer cells around it (Fig. 3). The other specimen involving the trachea indicated that the invaded cancer to the trachea extended throughout the tracheal wall and it avoided reaching the cartilages itself (Fig. 4). When cancer inva-
Fig. 2. Gross specimen showing complete occlusion with growing tumor mass in the right upper bronchus.

Fig. 3. Histological findings, showing the growth of cancer mass into the mucosal face accompanying fistulous communication.
Fig. 4. Histological findings, showing the resistance of the cartilage to cancer invasion.

Fig. 5. Histological finding of scattered cancer invasion into the scar caused by irradiation.
sion extended to the mucosal membrane, it gradually entailed the ensuing tracheal stenosis.

The intramusocal cancer extension and the dysplastic changes were histologically demonstrated in the mucosal membrane surrounding cancer invasion. These findings were consistent with those of metastatic cancer, distinguishing from those of primary cancer.

The ages of 5 cases involving the lung ranged from 56 years to 71, 3 males and 2 females, as shown in Table 2. The tumors were located in Im + Iu in 2, Im in 1, Im+ Ei in 1 and Ei in 1. The symptoms composed dysphagia and chest pain in all of them. The findings on the esophagogram were the spiral type in all but one who was impossible to determine from the record and the lesions on the esophagoscopy showed infiltrative ulceration situated circumferentially. A total of 4000 rads of preoperative irradiation therapy were carried out in 4 cases. The sites of the involved lung were the right S6 in 3, the right S7 in 1 and the left S8 in 1.

The segment resection of the lung was performed in the right S6 in 3 and the left S8 in 1. The remaining one underwent dissection only. The lymph node involvements were N1 in one, N2 in two and N4 in two. None of them had the pleural involvement. The type of histology was squamous cell carcinoma in all. One was well differentiated, two moderately, and the remaining two poorly. According to INF classification, α was seen in one, β in two and γ in two. The cancer invasion to the surrounding organs was histologically examined in all of five. There were the fistulous communication with the lung in one, and the concomitant involvement of the pericardium in one and the remaining three had cancer invasions into the surrounding scar tissues (Fig. 5).

The prognosis of A3 directly involving the trachea, bronchus and lung was very poor. All of them died within 1 year following surgery. In 5 cases involving the trachea and the bronchus, the operative death was encountered in one, and deaths within 6

<table>
<thead>
<tr>
<th>age</th>
<th>sex</th>
<th>symptom</th>
<th>esophagogram defect length</th>
<th>esophagoscopy</th>
<th>involved organ</th>
<th>n</th>
<th>histology differentiation</th>
<th>survival time cause of death</th>
</tr>
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<tbody>
<tr>
<td>71</td>
<td>M</td>
<td>dysphagia</td>
<td>spiral 11 cm</td>
<td>ulceration circumference</td>
<td>γ-S6 lung pleura</td>
<td>n2</td>
<td>Sq moderately</td>
<td>6M lung meta.</td>
</tr>
<tr>
<td>72</td>
<td>M</td>
<td>dysphagia</td>
<td>spiral 8 cm</td>
<td>ulceration circumference</td>
<td>γ-S6 lung aorta, pleura</td>
<td>n4</td>
<td>Sq moderately</td>
<td>4M bone meta. pleurisy</td>
</tr>
<tr>
<td>65</td>
<td>F</td>
<td>dysphagia</td>
<td>spiral 7.5 cm</td>
<td>ulceration circumference</td>
<td>γ-S8 lung pericardium pleura</td>
<td>n2</td>
<td>Sq well</td>
<td>op. death (bleeding)</td>
</tr>
<tr>
<td>58</td>
<td>F</td>
<td>dysphagia</td>
<td>spiral 6 cm</td>
<td>ulceration circumference</td>
<td>t-S8 lung pericardium aorta</td>
<td>n1</td>
<td>Sq poorly</td>
<td>op. death (circulat, collapse)</td>
</tr>
<tr>
<td>56</td>
<td>M</td>
<td>dysphagia</td>
<td>spiral 8 cm</td>
<td>ulceration circumference</td>
<td>γ-S7 lung aorta</td>
<td>n4</td>
<td>Sq poorly</td>
<td>4M lung meta pleurisy</td>
</tr>
</tbody>
</table>
months after surgery in three and the remaining one alived a maximum of 7 month
duration. In 5 cases involving the lung, two were the operative deaths due to bleeding
diathesis and circulatory collapse with high fever and the remaining three survived 4
months in two and 6 months in 1 respectively.

**DISCUSSION**

It is well known that the prognosis of carcinoma of the esophagus is associated with
either the degree of the advancing cancer indicated by A and N number or the host
resistance demonstrated as an immunocompetence.

According to advances in diagnostic procedures, carcinoma of the esophagus has
come to be detected in early stage as in other cancers. Most of patients undergoing op-
eration for carcinoma of the esophagus were still the advanced cases. The A3 patients oc-
cupy as many as 13 to 34% of the cases operated upon\(^\text{133}\) .

It is impossible to determine as to A3 prior to surgery\(^\text{133}\) . We have experienced on
occasion that the a-number determined by histological examination is not in concord with
the A-one determined by gross appearance if preoperative irradiation is indicated. Then
the surgical treatment for carcinoma of the esophagus must not be abandoned on the basis
of preoperative evaluation. The ultimate goal of this study is to assess as to whether or
not the surgical excision is beneficial in enhancing the cure rate. From our experiences
of surgical treatments with 5 cases involving the trachea and bronchus, and 5 cases in-
volving the lung, the resultant prognosis was not satisfactory\(^\text{49}\) . These factors were clini-
cally analyzed.

The modes of cancer extension including n-factor and histological cell differentiation
are not so different in cases of carcinoma of the esophagus involving the trachea or bron-
chus, and the lung. In the cases with the involved lung, preoperative irradiation was ef-
fective in preventing a prevalence of cancer extension. It was well established by histo-
logical examination that scar formation caused by irradiation benefited from the extension
of cancer to the surrounding tissues. In the cases with the involved trachea and bronchus,
it was shown that the membranous portions of the trachea and the bronchus was very su-
sceptible to cancer invasion and it affected throughout the tracheal and bronchial walls.
When cancer invasion reaches into the lumen through the tracheal wall, it causes some
degree of stenosis accompanying the cancer spread into the lumen through the tracheal
wall, some degree of stenosis accompanying the cancer spread into the mucosal mem-
brane and the changes of dysplasia in the mucosa adjacent to carcinoma. The cartilages,
however, are strongly resistant to cancer invasion. Based on the results of histological
examination, it is clear that moderate and poor cell differentiations are the contributing
factor causing A3 with involvement of the trachea and bronchus.

In advancing stage of A3 with involvement of the trachea, bronchus and lung, the
presence of lymph node metastases among 9 cases were \( n_4 \) in four (50%), \( n_3 \) in one
(12.5%) \( n_2 \) in three (37.5%), \( n_1 \) in one (12.5%). Most of these patients already had a
presence of lymph node metastases exceeding n2G).

Reliability of surgical resection for esophageal cancer involving the trachea, bronchus and lung was documented either due to the development of scar formation encircling cancer lesion by means of preoperative irradiation therapy or due to the evidence of histologically limited cancer invasion on the tracheal and bronchial walls. It is considered advisable to remove extensively for increased survival even though Nnumber is increasing as seen in the advanced cancer137). The outcome of an aggressive resection for A3-patients is poor and our results are not necessarily encouraging. It, however, is concluded that an extended resection is mandatory for a longterm survival even in less frequency8). It is worthwhile to note that an extended resection is contemplated to achieve the prolonged survival whenever feasible. The chief evidence in supporting of this view is based on the histologically limited involvement of the trachea, bronchus and lung.

REFERENCE