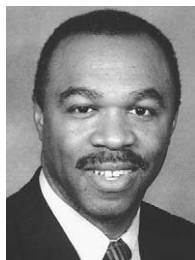


Preface



Martin S. Karpeh, Jr, MD
Guest Editor

The enigmatic rise in incidence of adenocarcinoma of the distal esophagus and gastroesophageal (GE) junction has become a major oncologic challenge facing health care providers in the Western world. Confusion over the classification of a disease that involves two organs, each with their own established staging and nomenclature, has slowed progress in our understanding of many aspects of the disease, which is now widely recognized as a formidable challenge throughout the medical community. This issue of the *Surgical Oncology Clinics of North America* thoroughly addresses the critical aspects supporting our understanding of the epidemiology, etiology, staging, and treatment of this tumor.

Murray F. Brennan, as Professor and Chairman of Surgery at Memorial Sloan-Kettering Cancer Center, developed one of the world's largest clinical databases of patients with adenocarcinoma of the GE junction. His insights into how the treatment demands of this disease have impacted the surgical oncologist will be of value for some time to come.

Epidemiologists have struggled to explain the relatively sudden rise in incidence of this entity over the past few decades. In the opening article of this issue, Scott Keeney and Thomas Bauer chronicle the changing pattern of dominant histopathologic type from squamous carcinoma to adenocarcinoma affecting the esophagus and GE junction. Data for and against risk factors such as gastroesophageal reflux disease, intestinal metaplasia, *Helicobacter pylori*, and smoking are discussed thoroughly in this article.

Professors Fatima Carneiro and Paul Chaves from the Universities of Porto and Lisbon, respectively, have contributed a scholarly review of the

evidence defining our current understanding of the normal and abnormal pathology of the GE junction. They have devoted a significant portion of their careers to the identification of the pathologic and molecular changes at the GE junction that lead to adenocarcinoma. Two major pathways of neoplastic development (*Barrett's pathway* and the *gastric pathway*) are highlighted with insights into potential targets for therapy and prevention. Most pathologists in the West are familiar with Barrett's pathway, but few sources cover the gastric pathway with such depth. Drs. Tang and Klimstra from Memorial Sloan-Kettering Cancer Center detail the history, classification, and molecular pathology of Barrett's esophagus and offer practical advice for the pathologist and surgeon on the safety and danger of diagnosing dysplasia.

Proper classification, staging, and complete resection highlight the cornerstone of curative treatment. ^{18}F -fluorodeoxyglucose positron emission tomography has taken on an important role in the staging and management of esophageal and GE junction cancers. Drs. Hung Dam, Timothy Manzone, and Vidya Sagar from the Department of Nuclear Medicine at Christiana Care Health System review the growing literature supporting the routine use of positron emission tomography in planning treatment for these patients.

The group from the Technische University of Munich under the leadership of Professor J.R. Siewert has greatly contributed to our understanding of the classification and surgical treatment of tumors involving the GE junction. In this issue, Drs. Feith, Stein, and Siewert share their experience with over 1600 patients, highlighting the differences between disease types I, II, and III. Dr. Valerie Williams and Jeffrey Peters from the University of Rochester Medical Center address the role of performing an extended lymphadenectomy. The surgeon will find important practical advice on patient selection and the technical steps used in performing an en bloc esophagectomy. The extent of resection for adenocarcinoma of the esophageal and GE junction is controversial, however. Drs. Vrouenraets and van Lanschot from the University of Amsterdam agreed to share insights learned from designing and executing the best available prospective randomized trial to date comparing transhiatal and transthoracic esophagectomy.

Pushing the envelope toward a minimalist approach to early cancers of the GE junction, Professors Kitagawa and Kitajima from Keio University in Tokyo present an in-depth analysis of published data and their own experience with sentinel lymph node mapping and function-preserving surgery. They lay out an evidence-based rationale for selective lymphadenectomy guided by lymphoscintigraphy.

In the West, most patients present to their surgeon with advanced stages of disease. Unfortunately, surgery alone continues to fall short of providing long-term survival. The use of multimodality therapeutics has now become an accepted standard. Dr. David Ilson from Memorial Sloan-Kettering thoughtfully covers the evidence for and against this evolution. Increasingly,

neoadjuvant chemotherapy and radiation have become part of the mainstay of modern treatment. The results have been encouraging, but we have a ways to go.

The authors featured in this issue have come together to provide the surgical oncologist with an outstanding source of information on arguably the fastest-growing gastrointestinal malignancy in the past millennium. I would like to personally thank each one of them for their outstanding contributions.

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