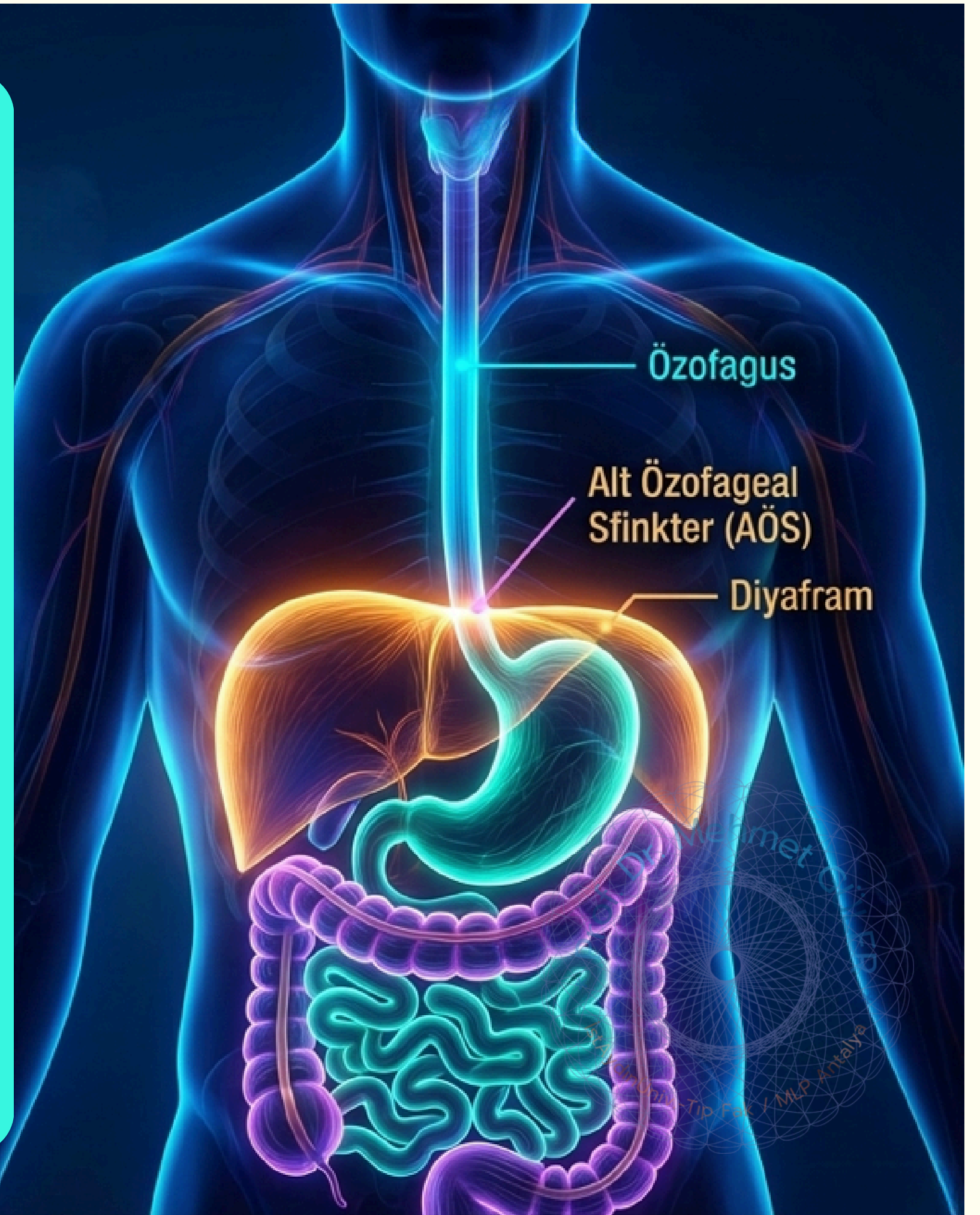


# Özefagus Neoplazmları

Prof. Dr. Mehmet GÜLER  
İAÜ Tıp Fakültesi



# ★ Özefagus Neoplazmları Hakkında ?

## Ne Öğrenmeli, Ne Bilmeli?

Özefagus anatomi/histoloji/fizyoloji

Disfajili hastaya yaklaşım

Özefagus tümörleri ayrımı/etiopatogenezi

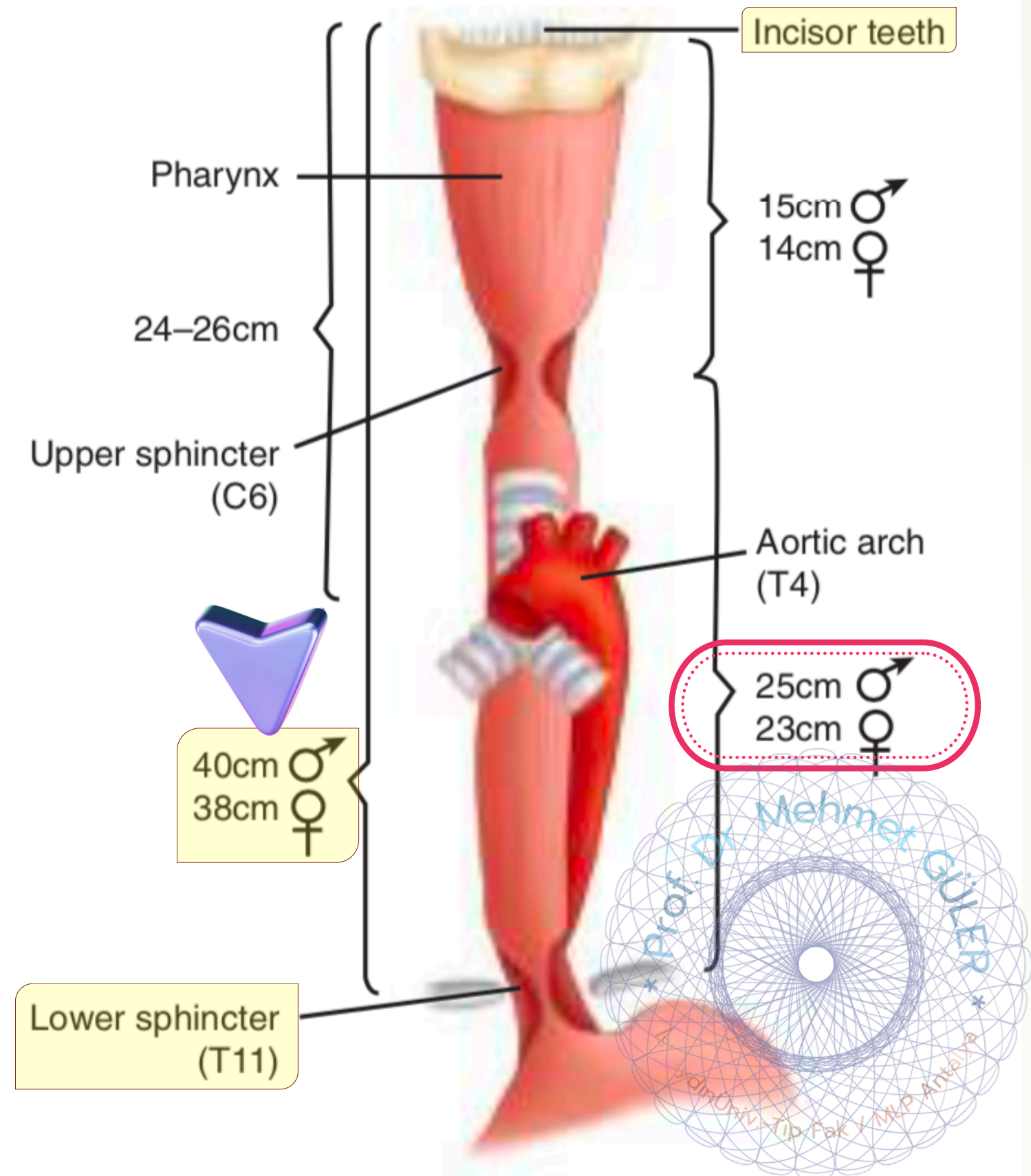
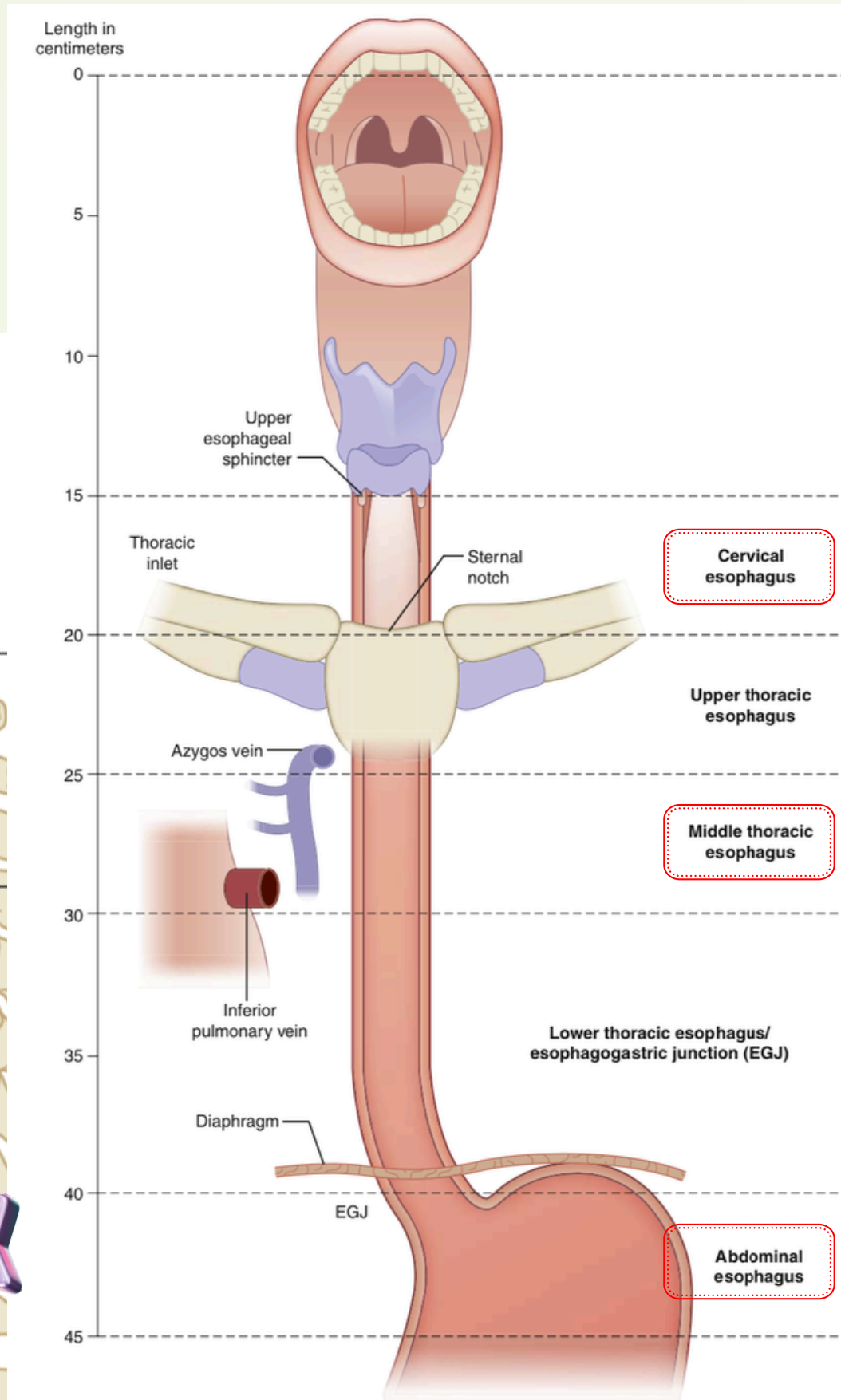
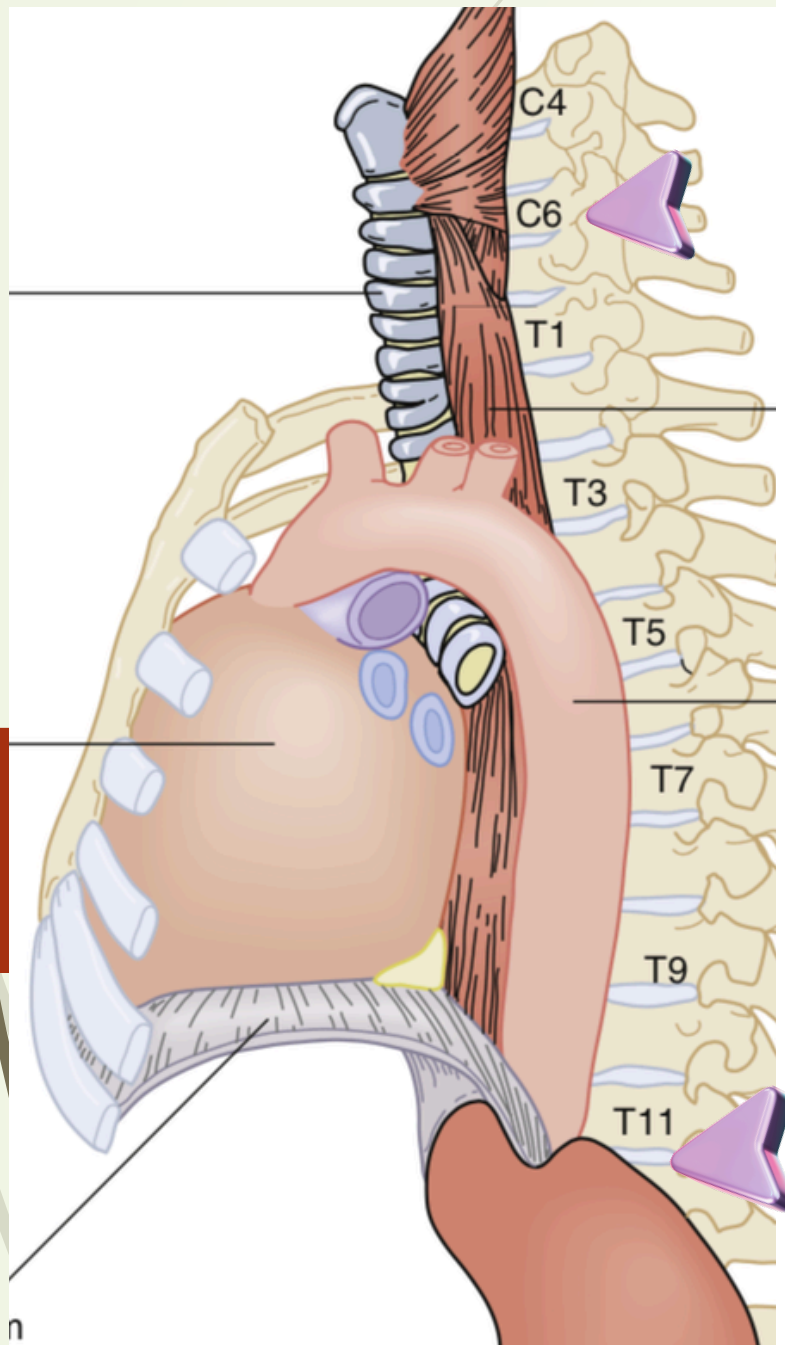
Barret özefagus anlamı/takibi

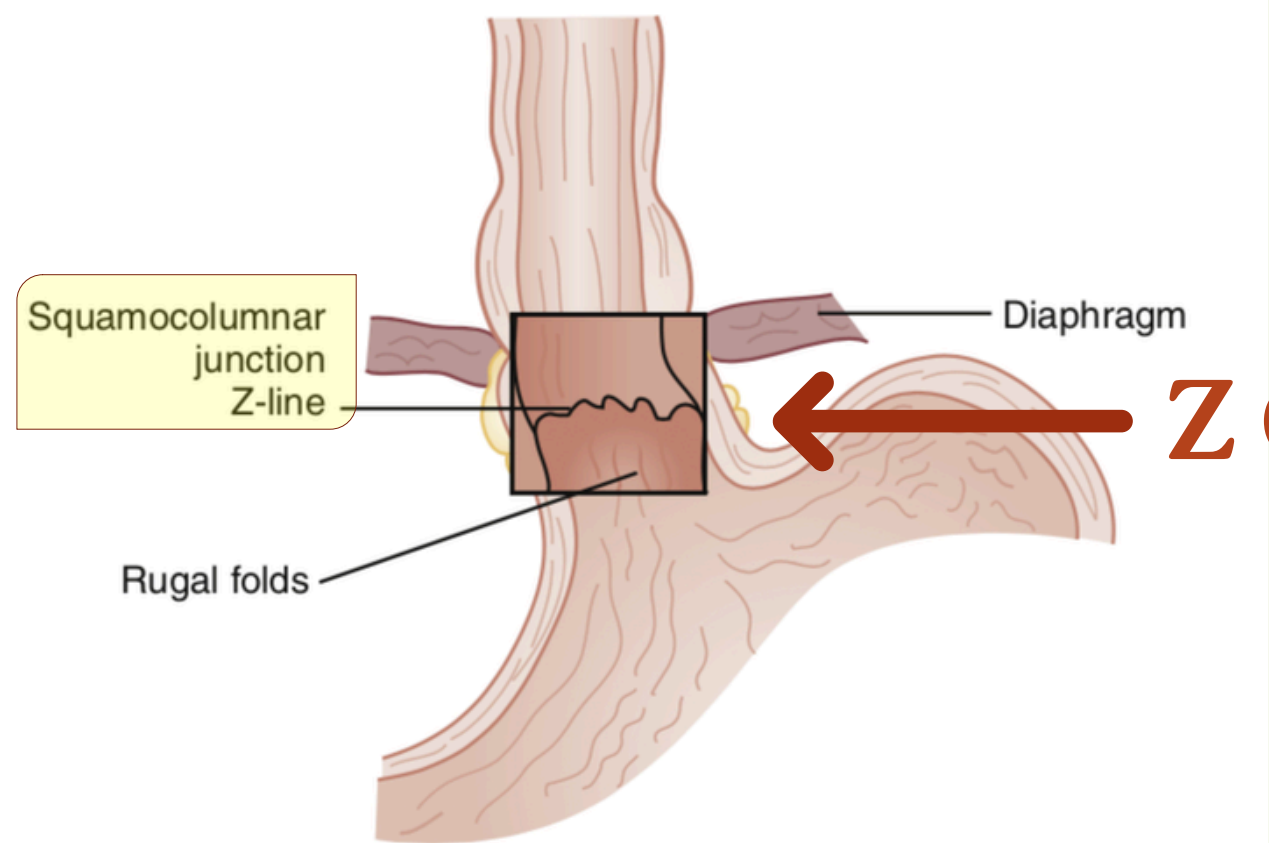
Tanısal yaklaşımların özellikleri

Tümörlerin evrelemesi

Evrelere özgü tedavi yaklaşımları







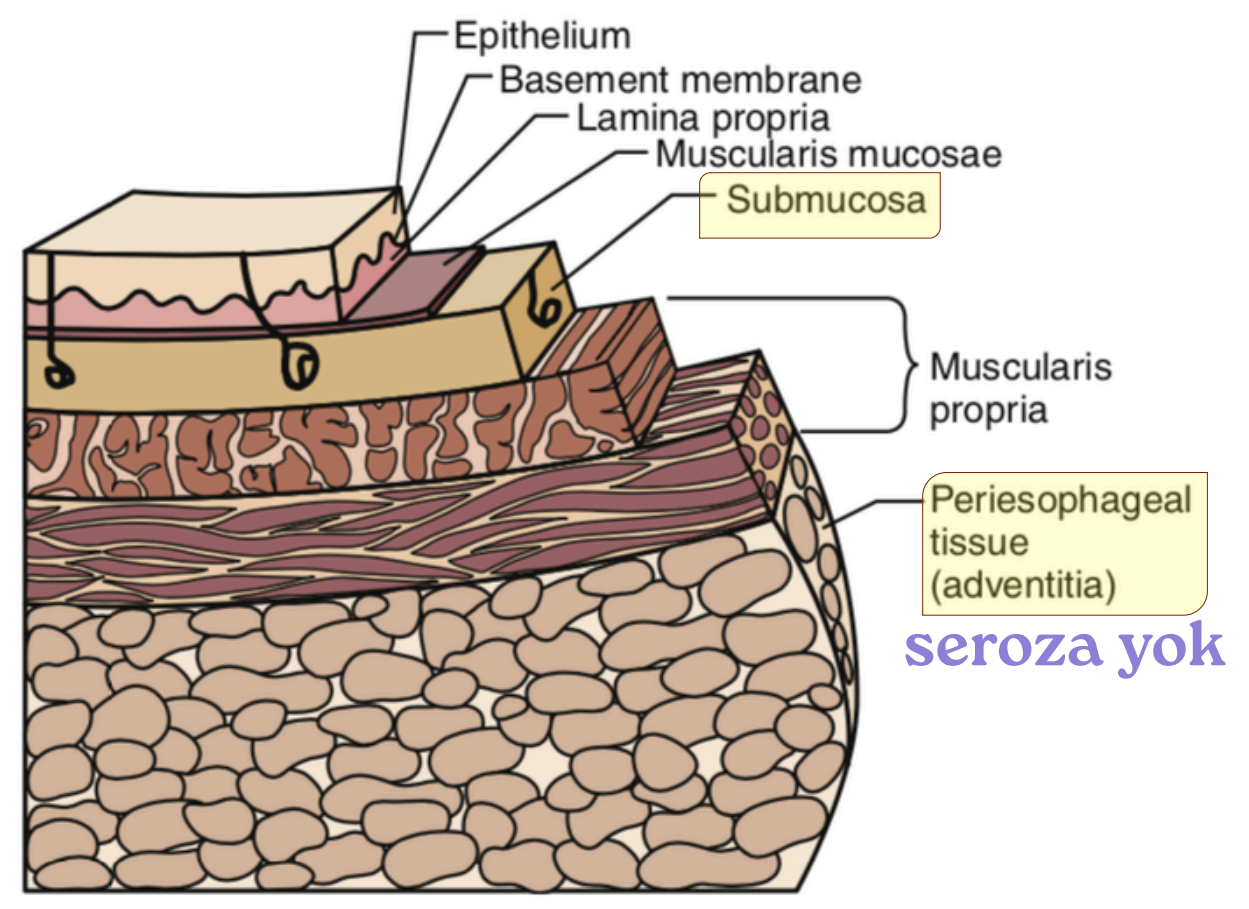
Squamocolumnar junction  
Z-line

Diaphragm

Rugal folds

Z Çizgisi

FIG. 42.2 Z-line.



Epithelium

Basement membrane

Lamina propria

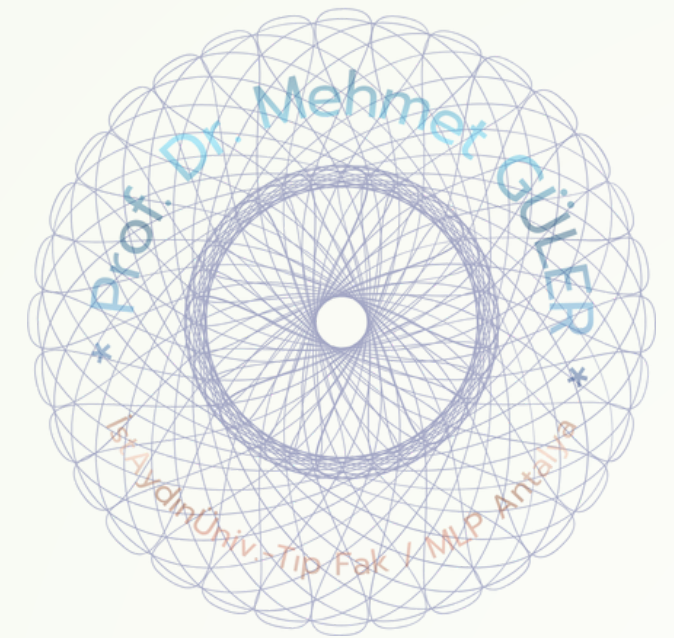
Muscularis mucosae

Submucosa

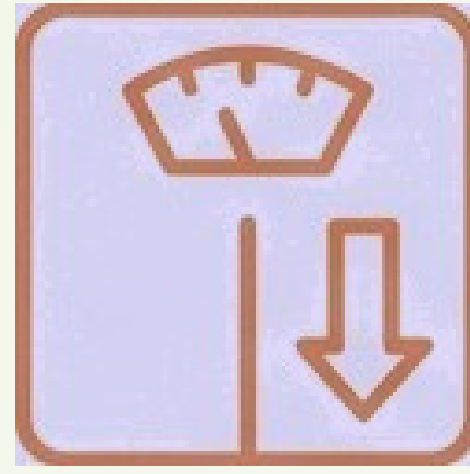
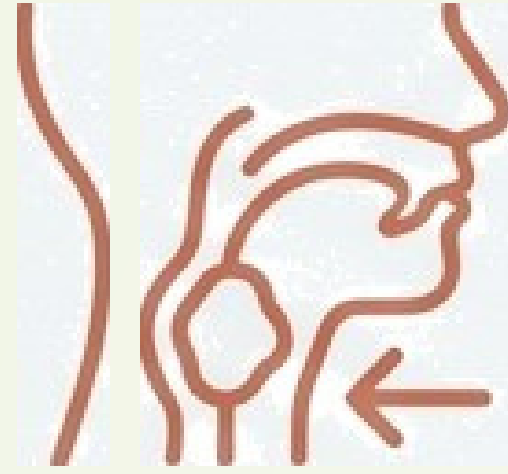
Muscularis propria

Periesophageal tissue (adventitia)

seroza yok



## 65 Y E, Yakınması: Yutma Güçlüğü



- 65 Y E
- 3 aydır katı gıdalara karşı artan yutma güçlüğü (ilerleyici **disfaji**) ✓
- Son 2 ayda (istemeyen) 10 kg **kilo kaybı**.
- Uzun yıllardır GÖRH semptomları (heartburn, regürjitasyon)

### Olası Tanılar (Öncelik sırasıyla)

- Malign Neoplazm (Özefagus Kanseri)
- Benign Neoplazm (Leiomyom, GIST)
- Peptik Striktür (GÖRH öyküsü nedeniyle)
- Motilite Bozukluğu (örn. Akalazya)



- **Disfaji**, genellikle tümör lümenin önemli bir kısmını tıkadığında ortaya çıkan **geç bir semptomdur**.
- Erken evre hastalıklar genellikle asemptomatiktir.

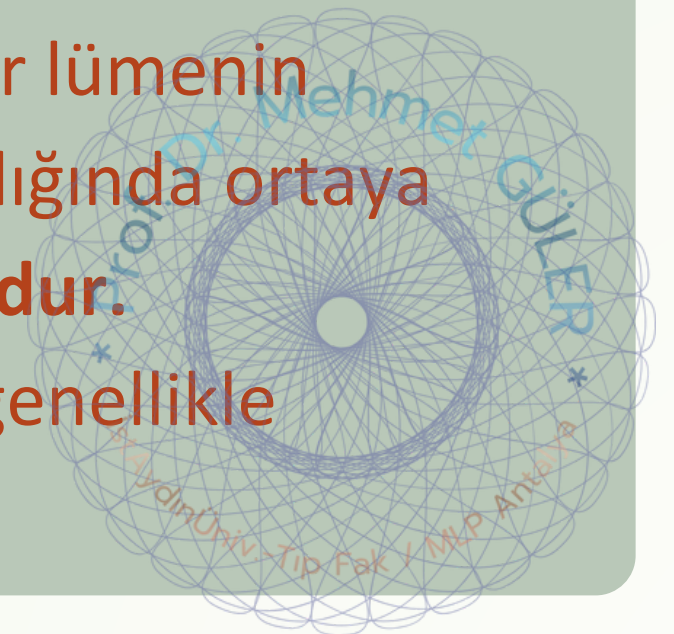
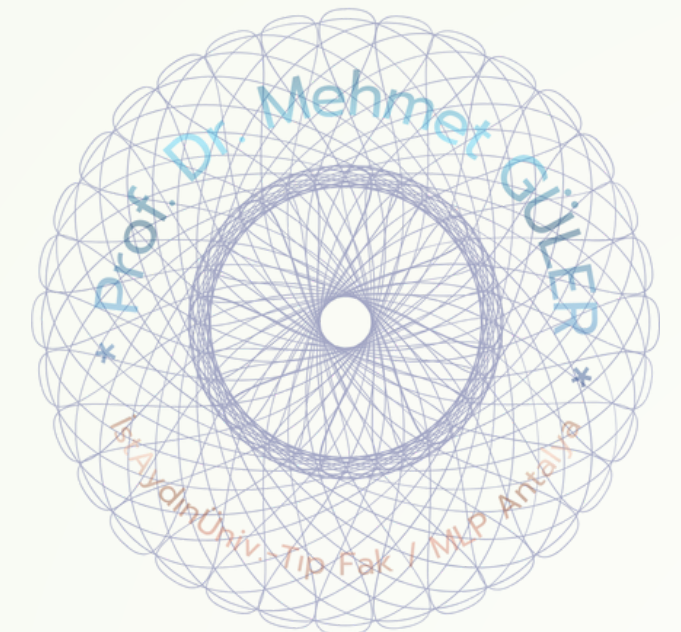


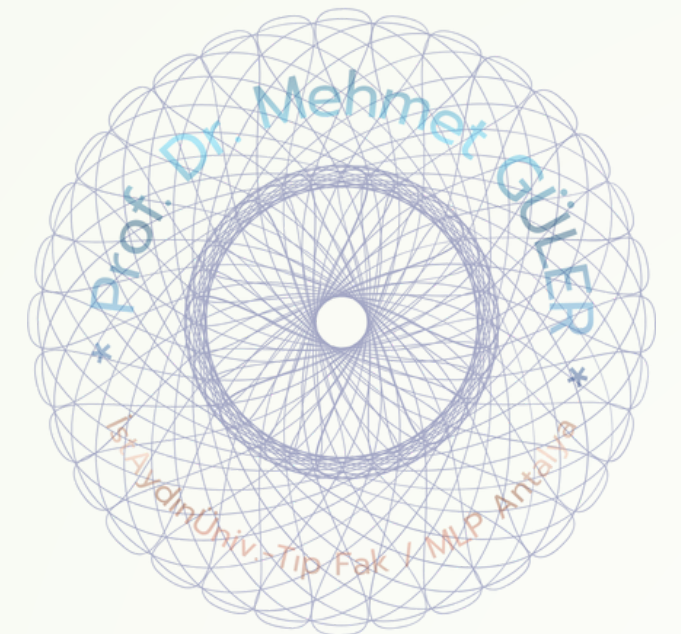
Table 13.1 Causes of dysphagia

Intraluminal	Intramural	Extrinsic
<b>Pharynx/upper oesophagus</b>		
Foreign body	Pharyngitis/tonsillitis Moniliasis Sideropenic web Corrosives Carcinoma Myasthenia gravis Bulbar palsy	Thyroid enlargement Pharyngeal pouch
<b>Body of oesophagus</b>		
Foreign body	Corrosives Peptic oesophagitis Carcinoma	Mediastinal lymph nodes Aortic aneurysm
<b>Lower oesophagus</b>		
Foreign body	Corrosives Peptic oesophagitis Carcinoma Diffuse oesophageal spasm Systemic sclerosis Achalasia Post-vagotomy	Para-oesophageal hernia



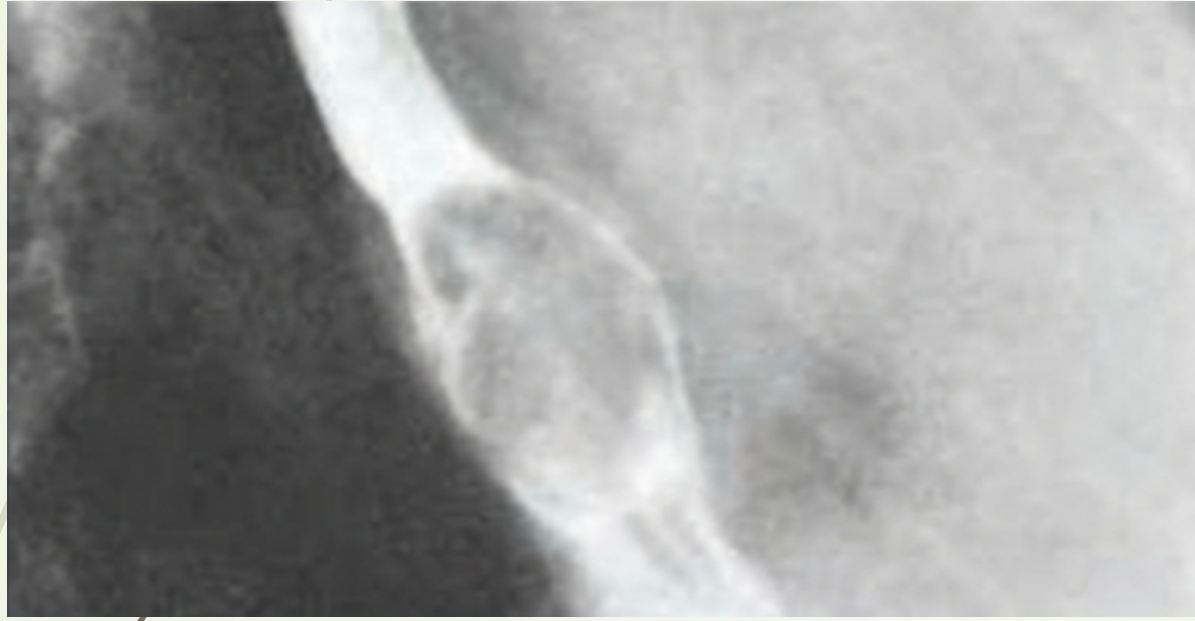
## Functional grades of dysphagia

GRADE	DEFINITION	INCIDENCE AT DIAGNOSIS (%)
I	Eating normally	11
II	Requires liquids with meals	21
III	Able to take <b>semisolids</b> but unable to take any solid food	30
IV	Able to take <b>liquids only</b>	40
V	Unable to take liquids, but able to swallow saliva	7
VI	Unable to swallow saliva	12



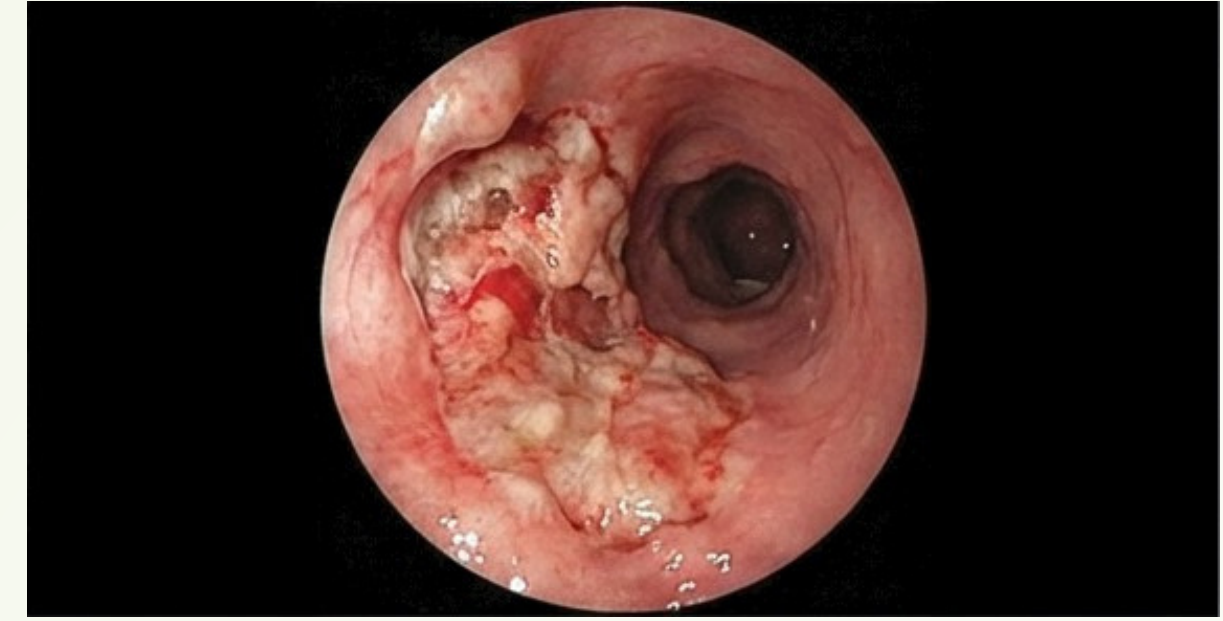
# İlk İkilem: Lezyon Benign mi, Malign mi?

## Benign Tümörler (Çok Nadir)



- Genellikle asemptomatiktir ve tesadüfen saptanır.
- Çoğu **submukozal** kaynaklıdır (epitelyal kökenli değil).  
Leiomyom, Gastrointestinal Stromal Tümör (GIST).
- Endoskopik Görünüm: Mukoza altından köken alan, üzeri **düzensiz** mukozayla kaplı kabarıklık
- Maligniteyi ekartasyonu, **biyopsi** ?? **EUS**, lezyonun **hangi duvar katmanından** kaynaklandığını göstermekte yardımcı

## Malign Tümörler (Daha Sık ve Önemli)



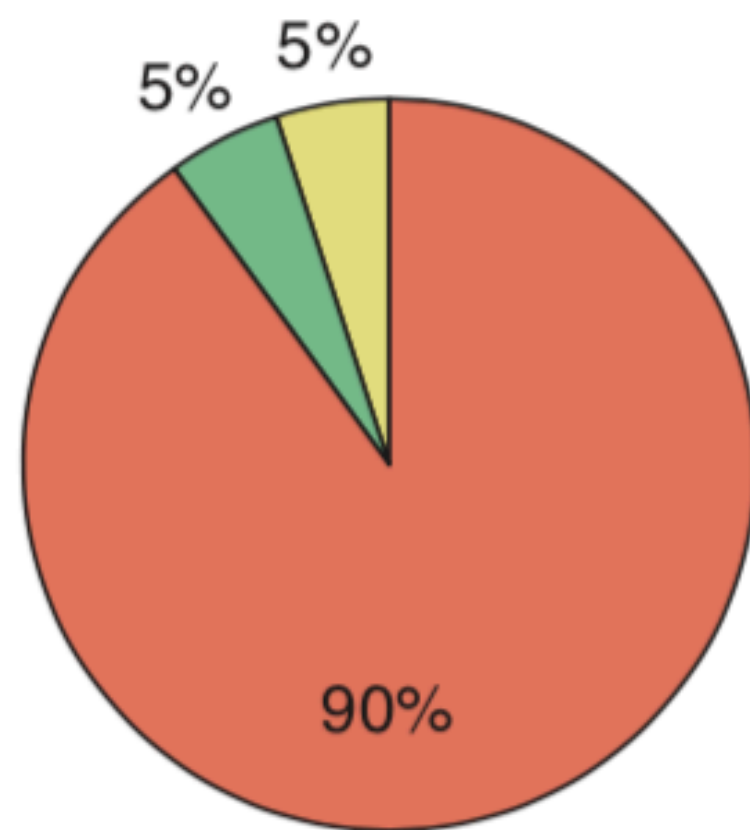
- Olguların >%95'i **Skvamöz Hücreli Karsinom (SCC)** veya **Adenokarsinom**
- Prognozları ciddidir; 5 yıllık **sağkalım** oranı yaklaşık **%20**'dir. Erken tanı hayati önem taşır.
- Endoskopide friabl (kolay kanayan), **ülserleşmiş kitleler** veya düzensiz **darlıklar**



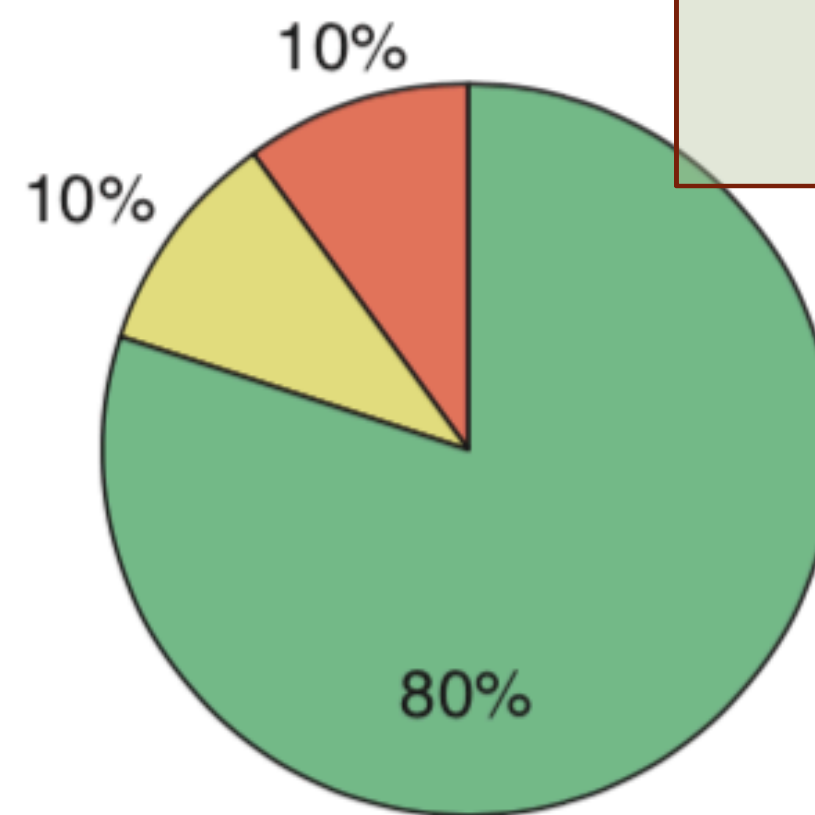
Most Common Type in the **World** – **SCCA** (90%)

### TRENDS IN ESOPHAGEAL CANCER CELL TYPE 1970 VS. 2010

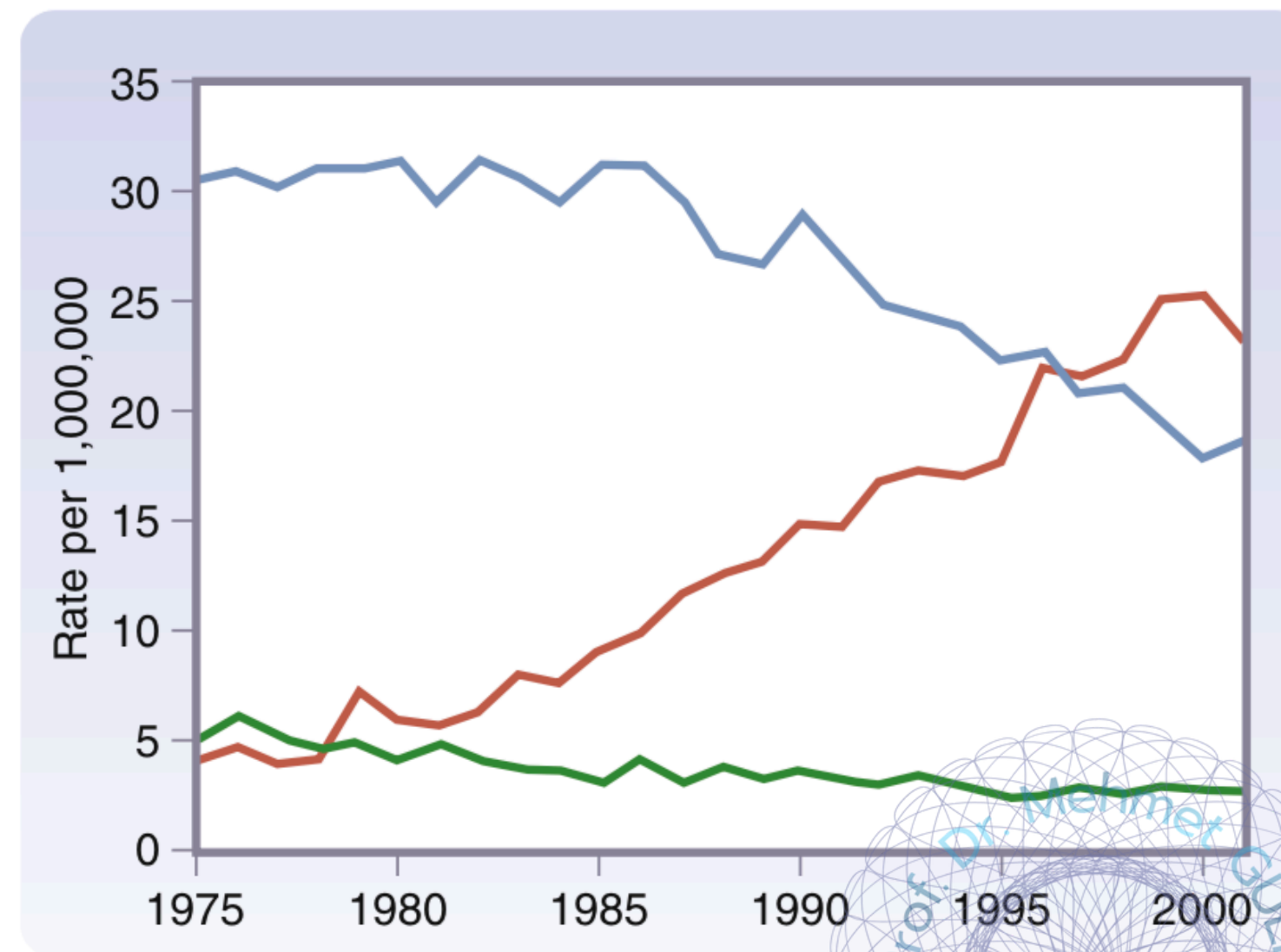
Esophageal cancer U.S.  
1970s



Esophageal cancer U.S.  
2010



■ SCCA ■ AdenoCA ■ Other

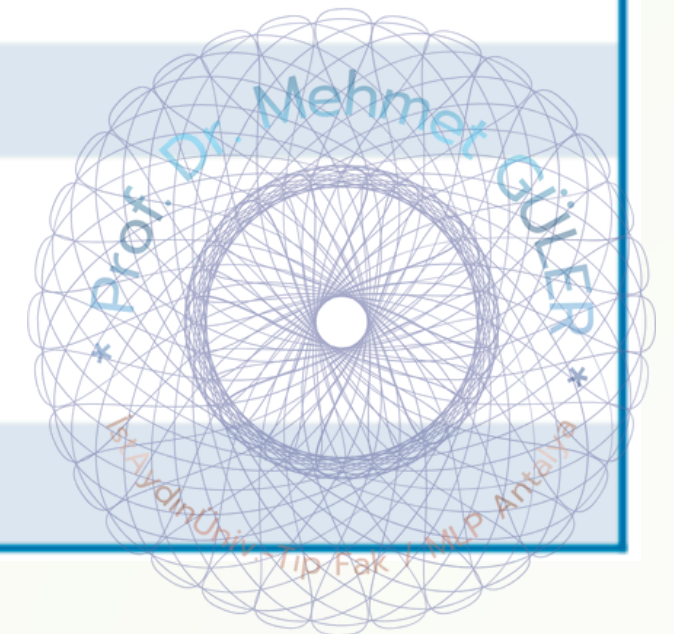


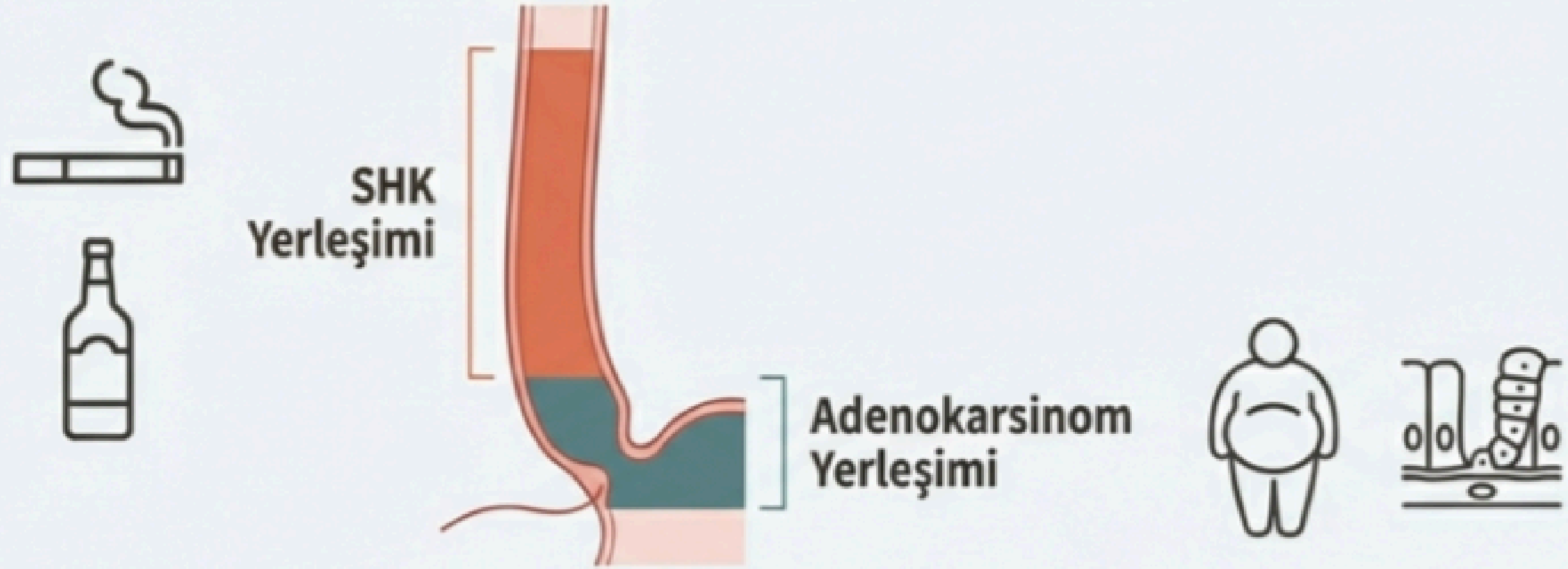
**FIG. 42.28** Trends in incidence of esophageal cancer histologic types (1975-2001). Red line, Adenocarcinoma; blue line, squamous cell carcinoma; green line, not otherwise specified. (From Pohl H, Welch HG. The role of overdiagnosis and reclassification in the marked increase of esophageal adenocarcinoma incidence. *J Natl Cancer Inst.* 2005;97:142-146.)



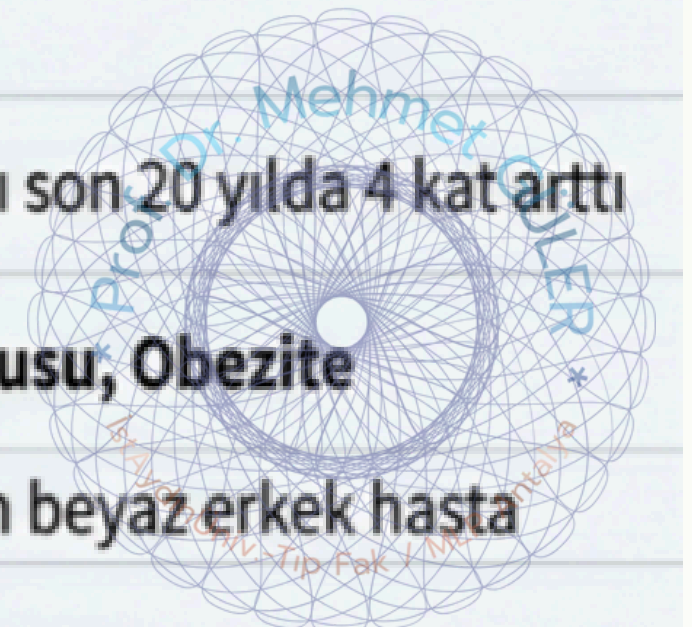
**Table 5-2. Risk Factors for Esophageal Cancer**

<b>RISK FACTOR</b>	<b>SQUAMOUS CELL CARCINOMA</b>	<b>ADENOCARCINOMA</b>
Tobacco use	+	+
Alcohol use	+	-
Barrett's esophagus	-	+
Frequent gastroesophageal reflux	-	+
Body mass index > 30	-	+
Low socioeconomic status	+	-
Prior caustic lye ingestion	+	-
Diet: high N-nitroso compounds, pickled vegetables, toxic fungi, areca nuts or betel quid, hot beverages, low selenium and zinc	+	-
Human papilloma virus	+	?





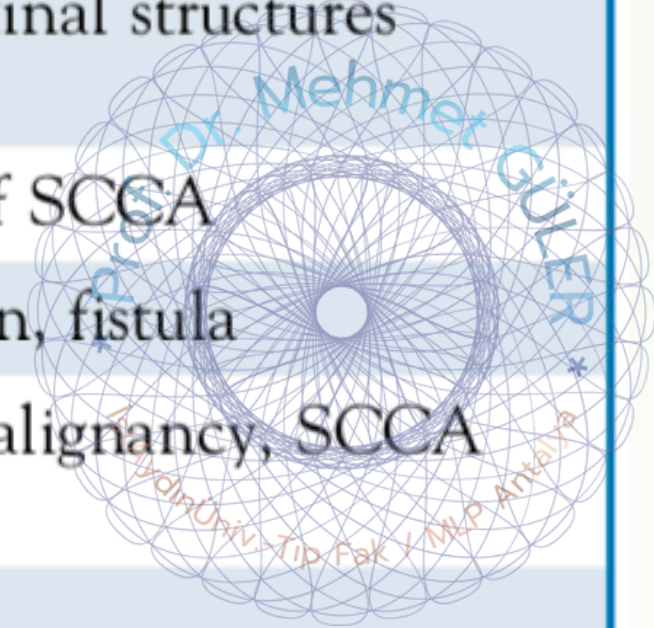
Özellik	Skvamöz Hücreli Karsinom (SHK)	Adenokarsinom
Yerleşim	Genellikle üst ve orta 2/3	Genellikle alt 1/3, GEJ
Epidemiyoloji	Dünya genelinde en sık; 'Asya Kanser Kuşağı'nda (İran'dan Çin'e) endemik	Batı'da en sık; insidansı son 20 yılda 4 kat arttı
Risk Faktörleri	<b>Tütün &amp; Alkol (sinerjistik etki)</b> , Kostik yanıklar, Akalazya, Plummer-Vinson	<b>GÖRH, Barrett Özefagusu, Obezite</b>
Tipik Hasta	Sigara ve alkol kullanan erkek hasta	Obez, reflü öyküsü olan beyaz erkek hasta
İrk	Siyah ırkta daha sık	Beyaz ırkta daha sık





**Table 5-1. Clinical Features of Esophageal Cancer**

CLINICAL FEATURE	FREQUENCY (%)	SIGNIFICANCE
Peak age at onset	65-75	Comorbidities often preclude operability
Gender (♂ ♀)	4:1	Much more common in men
Race (black: white)	50:50	SCCA > black men AdenoCA > white men
Dysphagia (Yutma Güçlüğü)	90	Often advanced disease
Anorexia and weight loss	75	
Odynophagia (Yutarken Ağrı)	50	Suggests tumor ulceration
Chest pain, often radiates to back	Less frequent	Implies invasion of neuromediastinal structures
Vocal cord paralysis	Less frequent	Suggests invasion more typical of SCCA
Cough and pneumonia	Less frequent	Esophageal obstruction, aspiration, fistula
Hoarseness (Ses Kısıklığı)	Less frequent	High GERD, coincident ENT malignancy, SCCA invasion
Hiccups (Hiçkırık)	Less frequent	Diaphragmatic involvement



# Şüphenin Kanıtlanması: Görüntüleme ve Biyopsi



## Endoskopi: Altın Standart

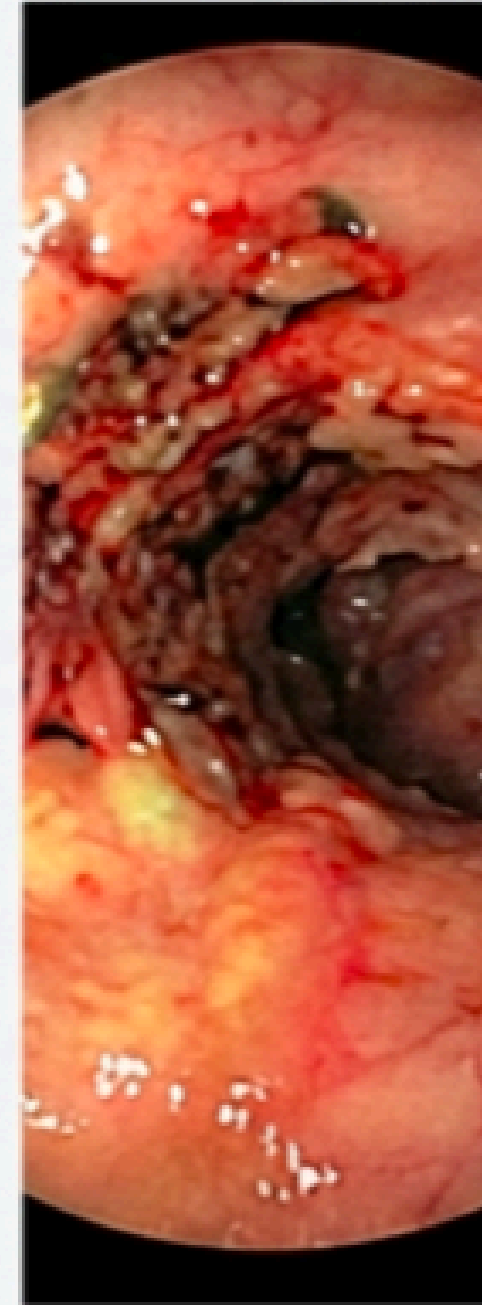
- Lezyonun doğrudan görülmesini, yerinin ve boyutunun saptanmasını sağlar.
- **Biyopsi ve Sitoloji:** Histopatolojik tanıyı kesinleştirir. Tanısal doğruluk oranı, her ikisi birleştirildiğinde %95'in üzerindedir.
- Tüm şüpheli lezyonlardan, ne kadar önemsiz görünürse görünsün, mutlaka biyopsi alınmalıdır.



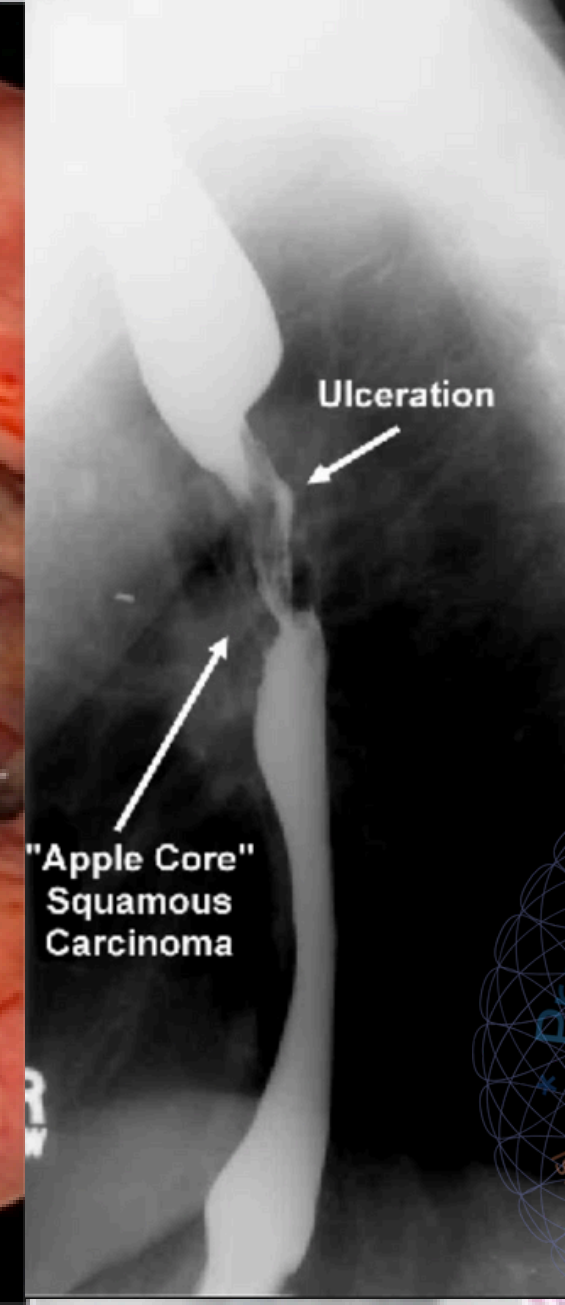
## Baryumlu Özefagus Grafisi

- Disfaji etiyolojisini araştırmak için sıkça yapılan ilk tetkiklerden biridir.
- Klasik bulgular: Düzensiz darlık, dolma defekti, 'omuzlu kenarlar' (shouldering) ve 'elma koçanı' (apple-core) görünümü.

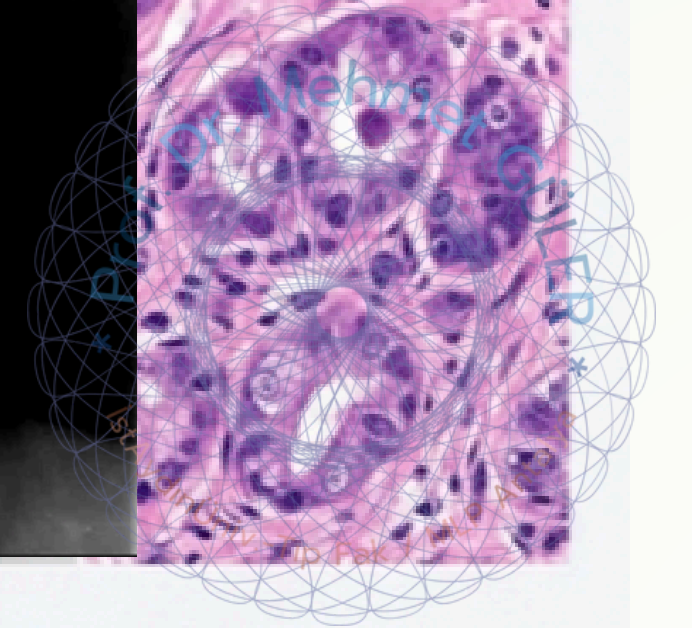
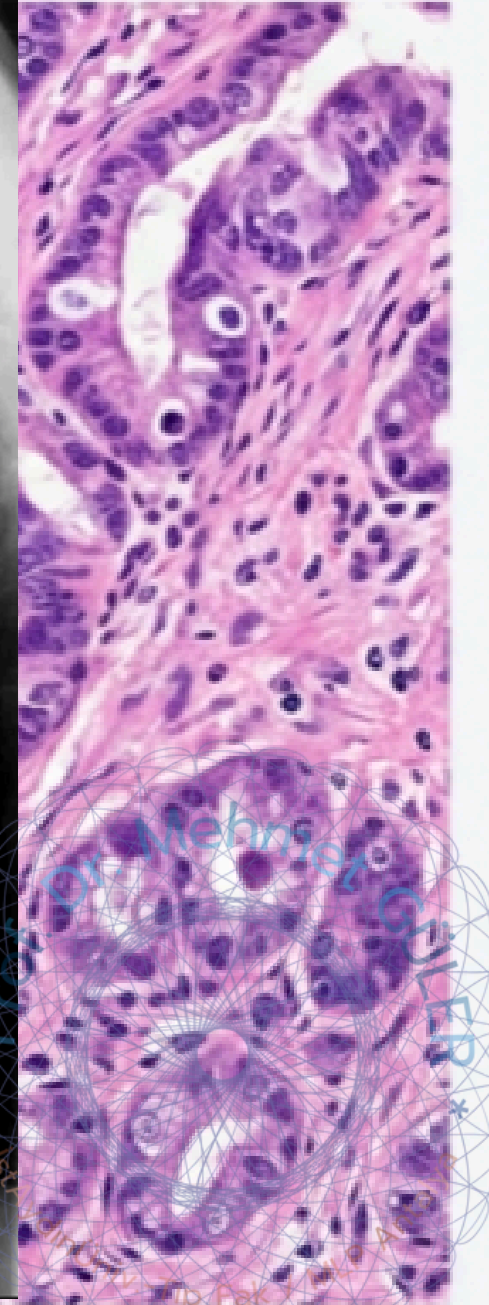
Endoskopi



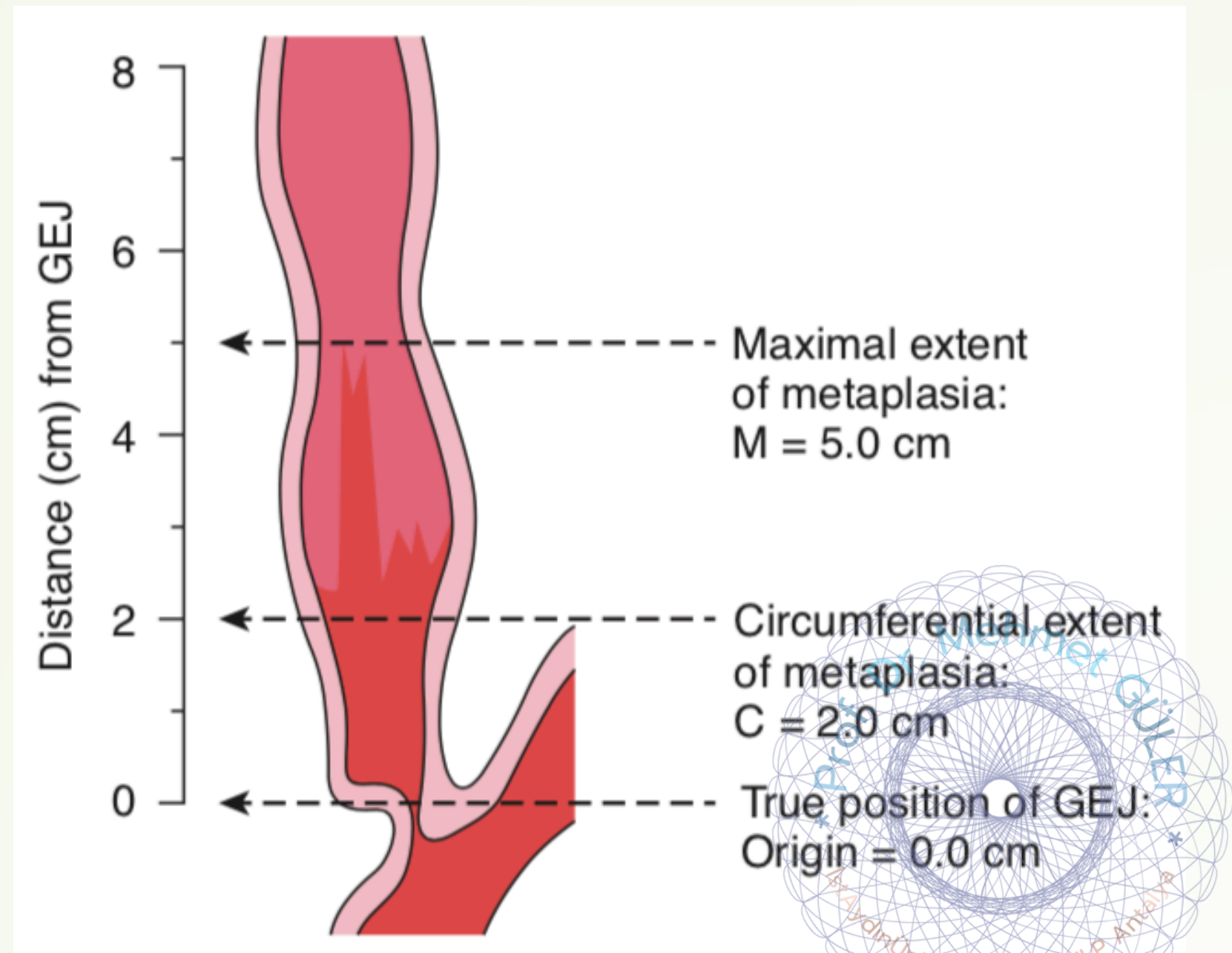
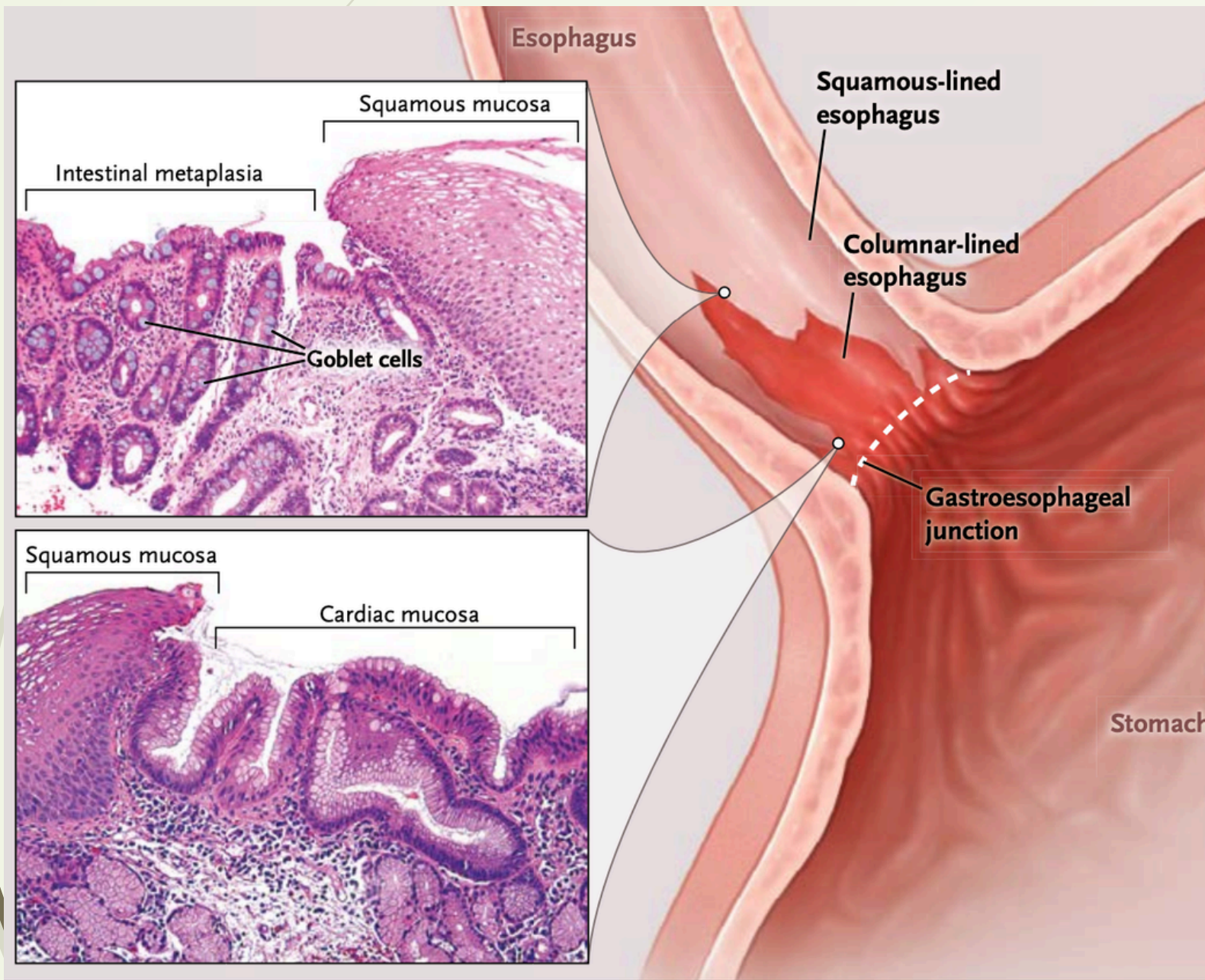
Baryumlu Grafi



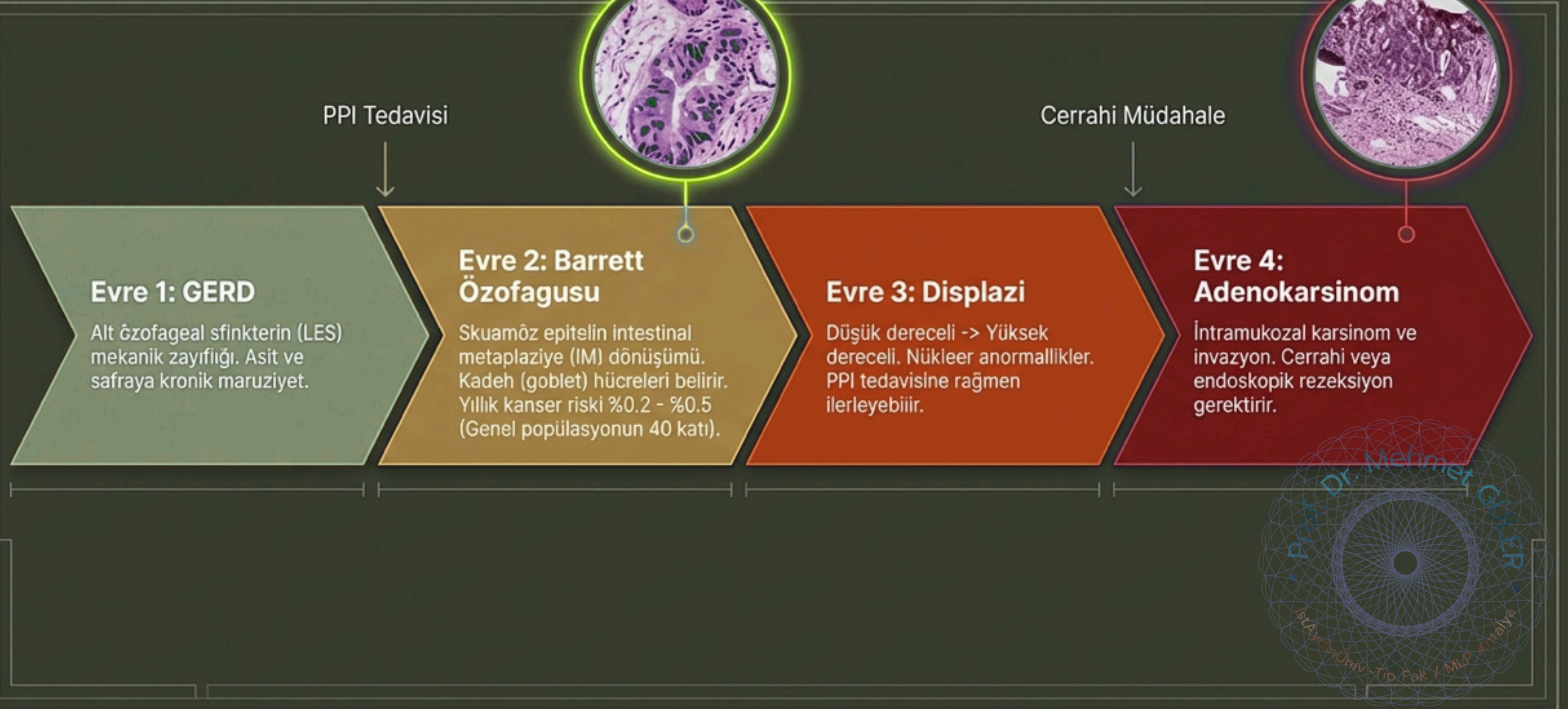
Histopatoloji

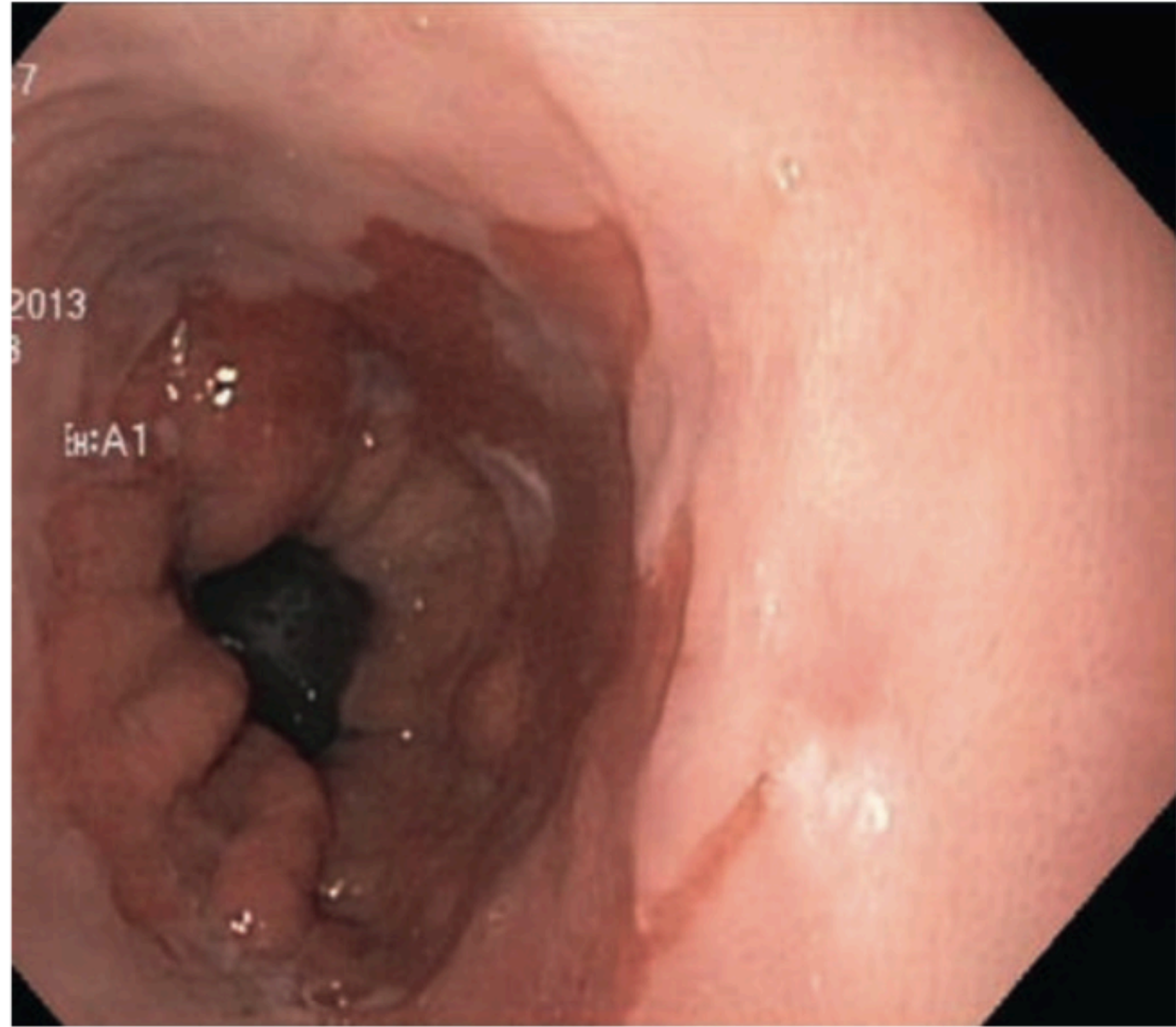


Barrett Özefagus(+) → Ömür Boyu Özefagus Ca Riski **x40**

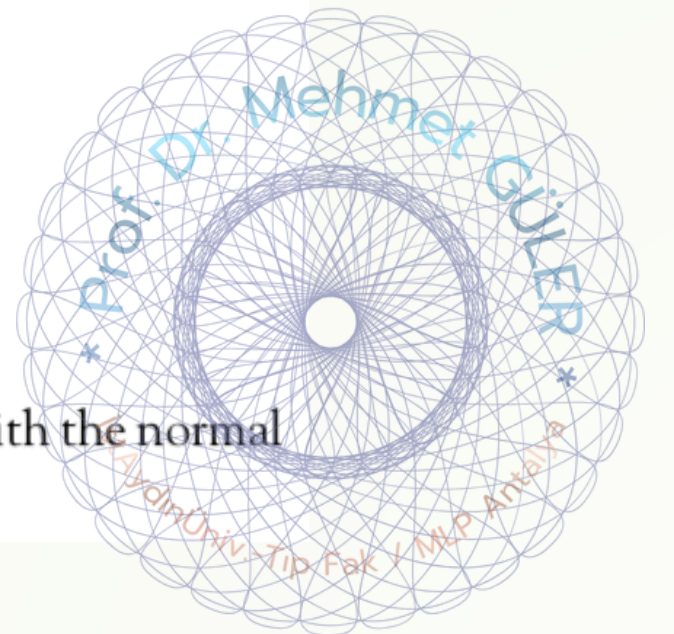


# Reflü Sürekliliği: Mekanik Hasardan Hücresel Dejenerasyona



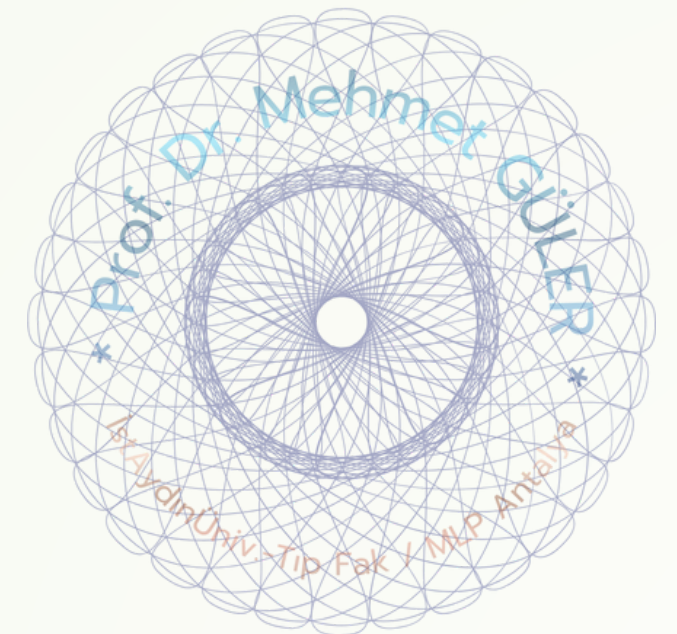


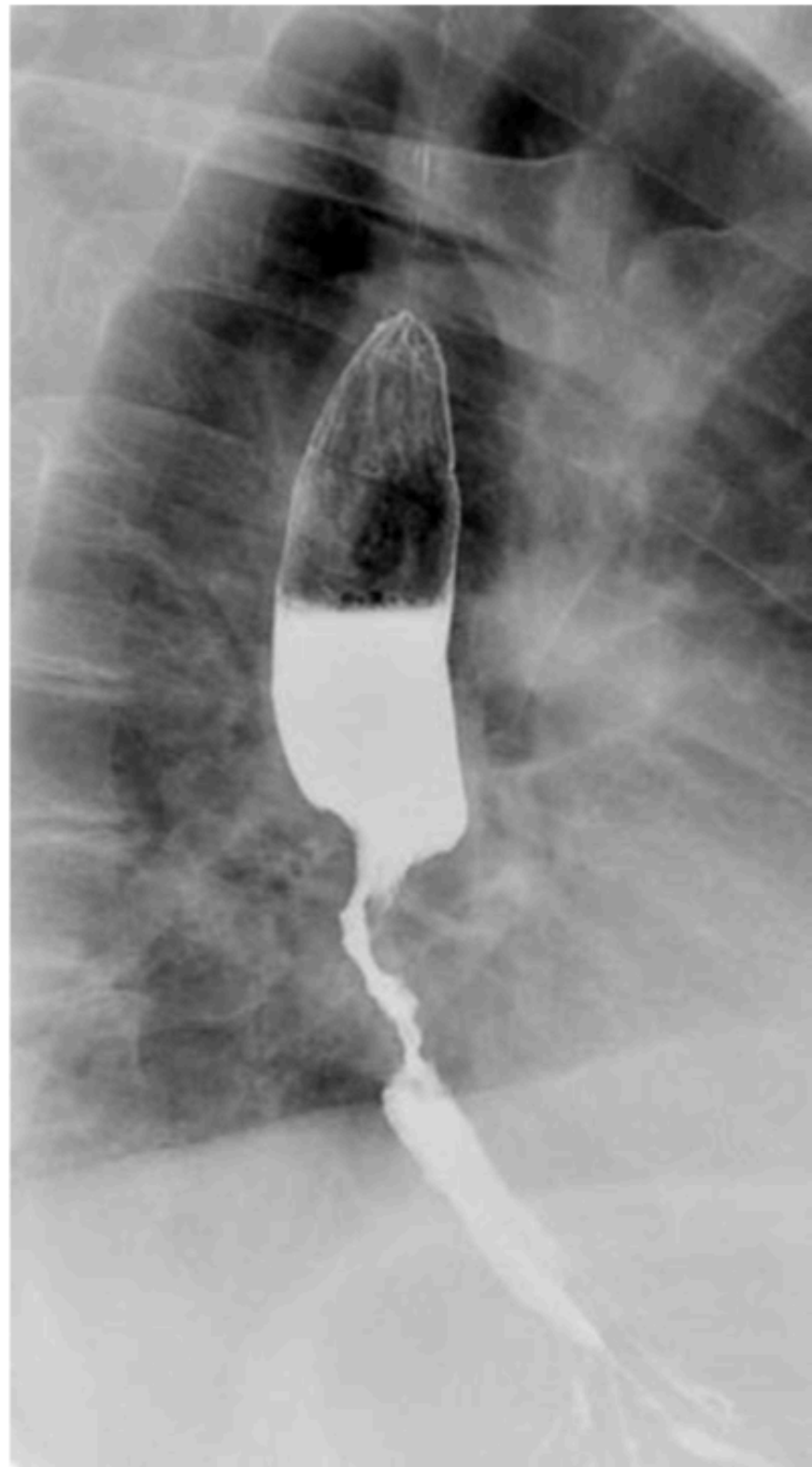
**Figure 7-1.** Barrett's esophagus seen at conventional endoscopy. Note the salmon-colored epithelium that contrasts with the normal gray epithelial lining of the esophagus.



Location	Incidence
Cervical	8%
Upper thoracic	3%
Middle thoracic	32%
Lower thoracic	25%
Cardia	32%

**Figure 25-68.** Incidence of carcinoma of the esophagus and cardia based on tumor location.

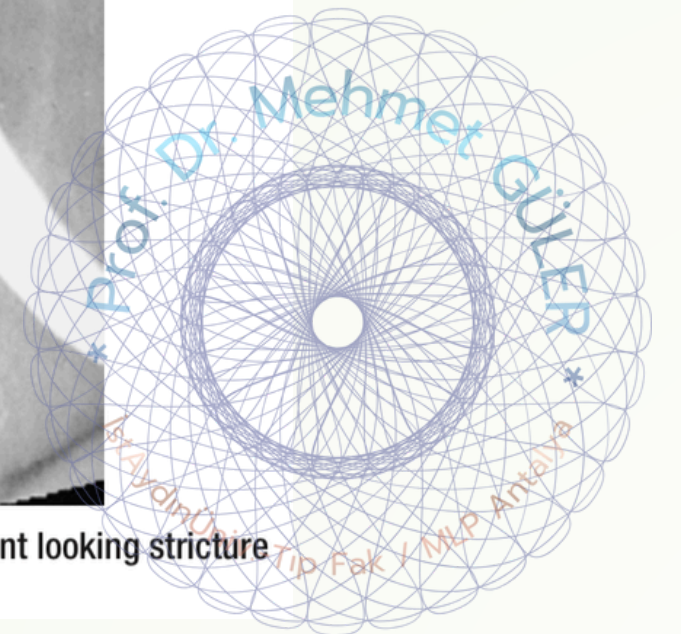




**FIG. 42.29** Barium esophagram demonstrating advanced carcinoma with abrupt, irregular narrowing in the distal esophagus with more proximal dilatation and air-fluid level.



**Fig. 13.6** Barium swallow showing a malignant looking stricture of the mid-oesophagus.



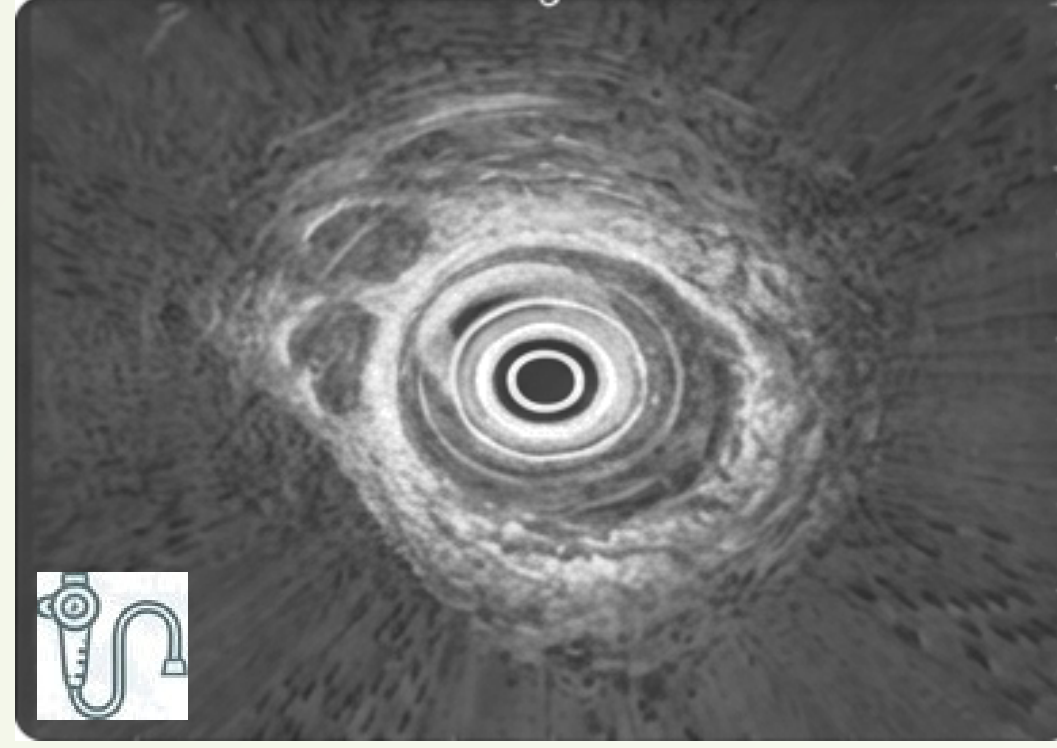
## BT



Kontrastlı Toraks/Abdomen BT  
Uzak metastazları ve gros lenf  
nodlarını saptamak için ilk adım.

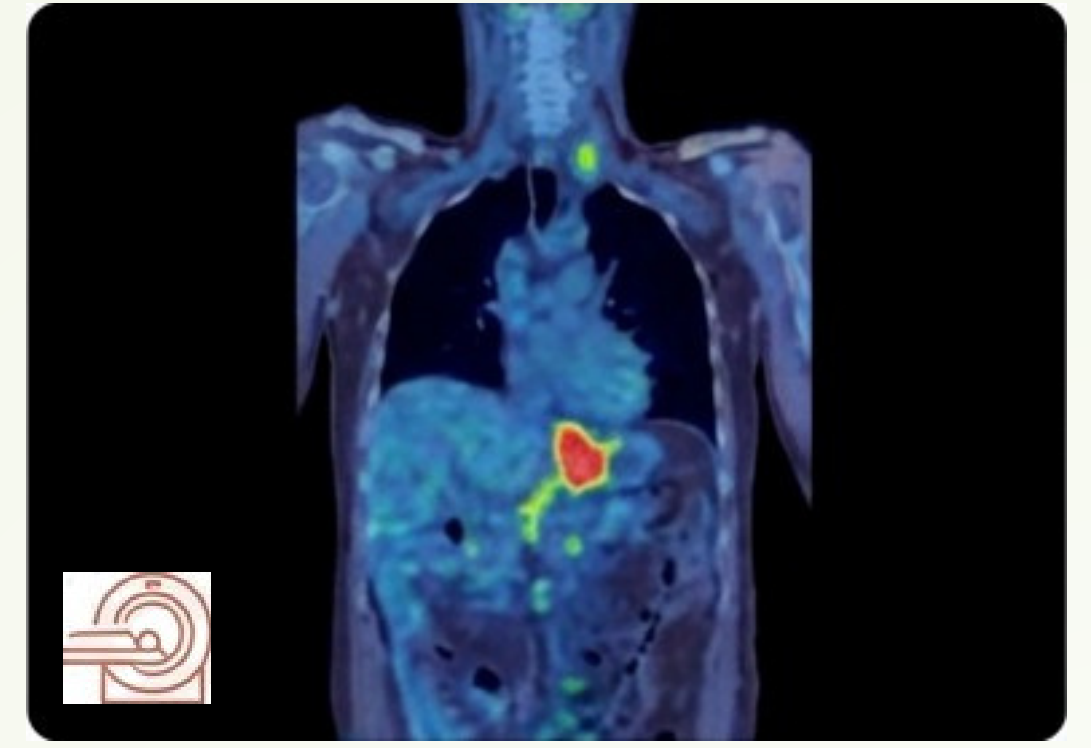
**Karaciger ve akciğer** metastazlarını  
yüksek doğrulukla gösterir. Ancak  
lokal invazyon derinliğini için  
yetersizdir.

## EUS

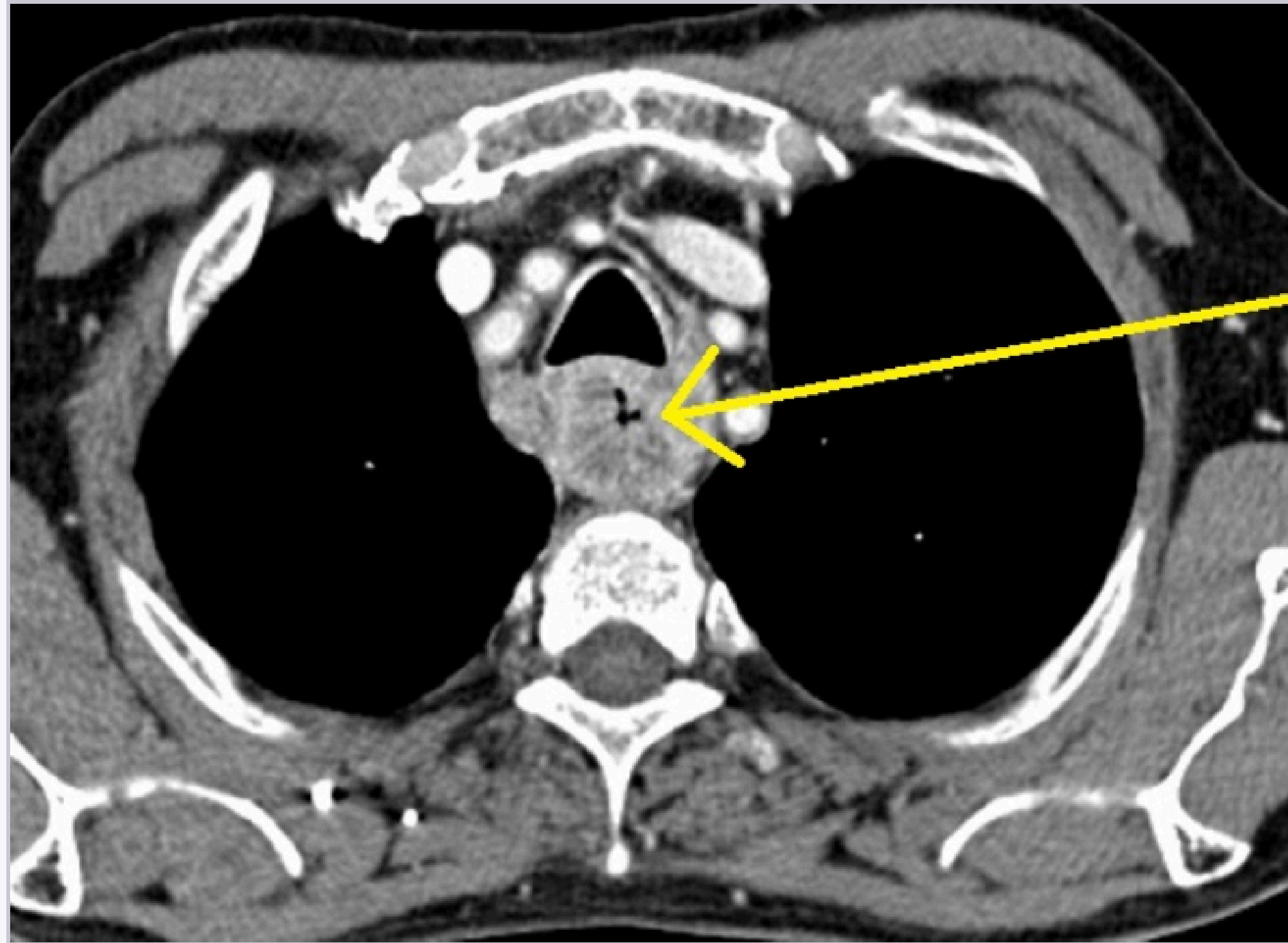


Endoskopik Ultrasonografi (EUS)  
Tümör invazyon derinliğini (T  
evresi) ve bölgesel lenf nodu  
tutululumunu (N evresi) belirlemede  
**en hassas** yöntemdir. Şüpheli lenf  
nodlarından iğne aspirasyon  
biyopsisi (**FNA**) alma imkanı sunar.

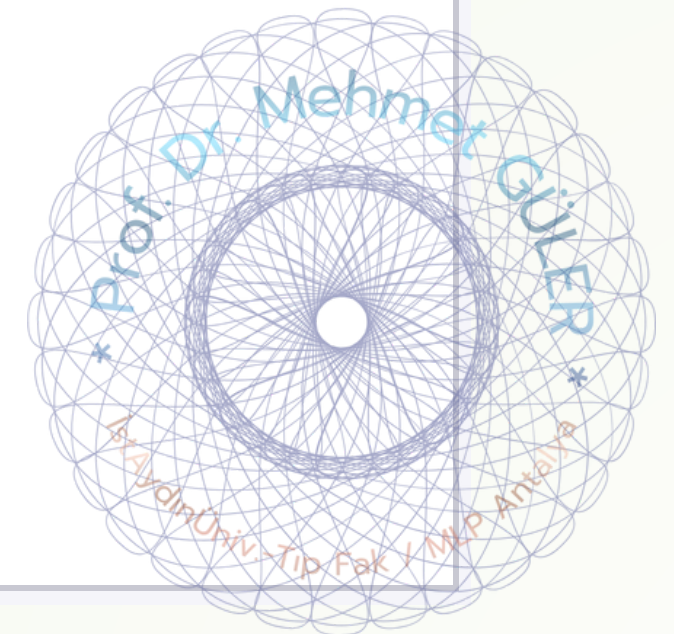
## PET-BT

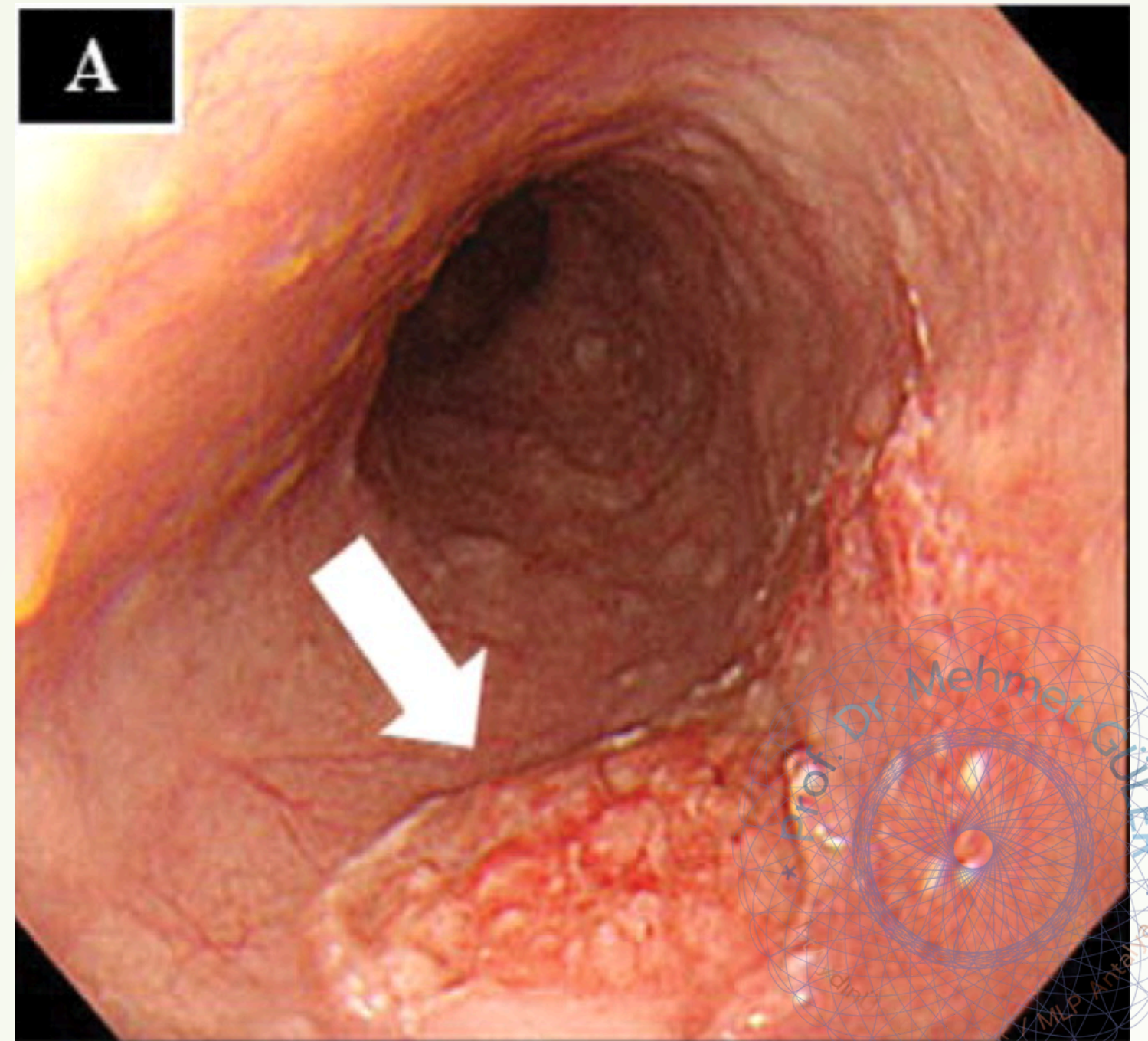
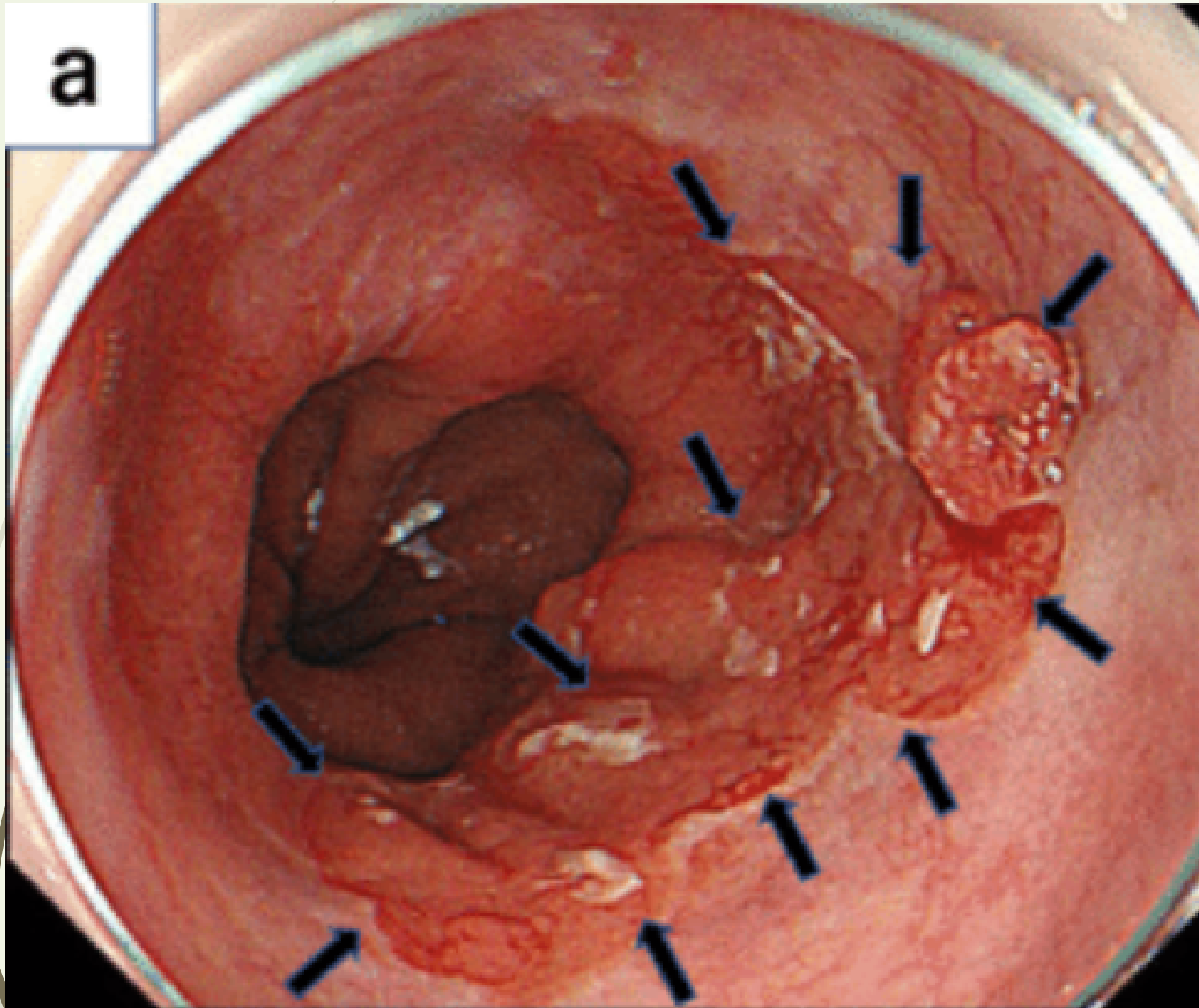


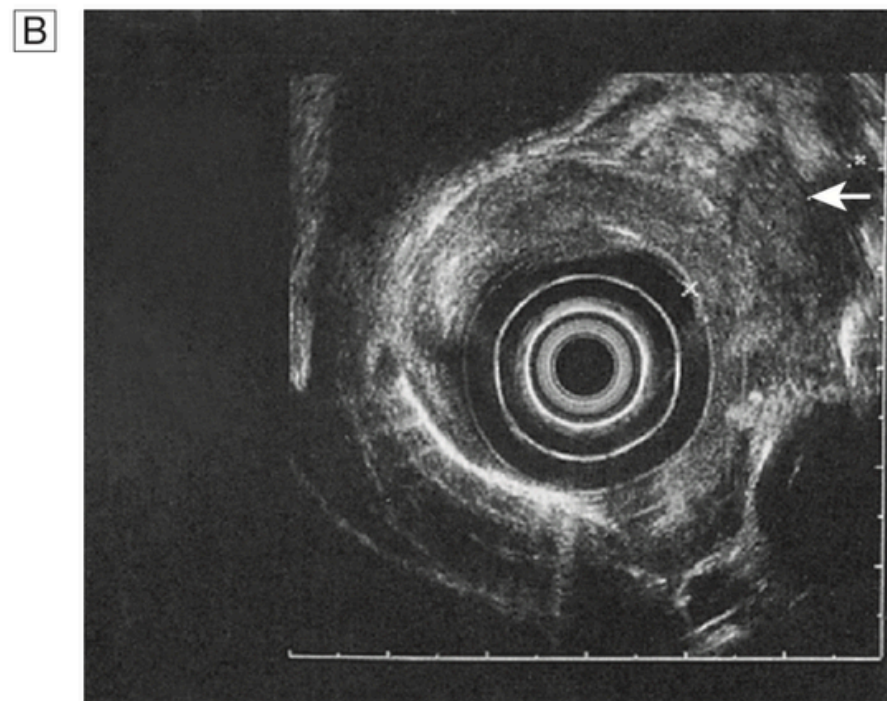
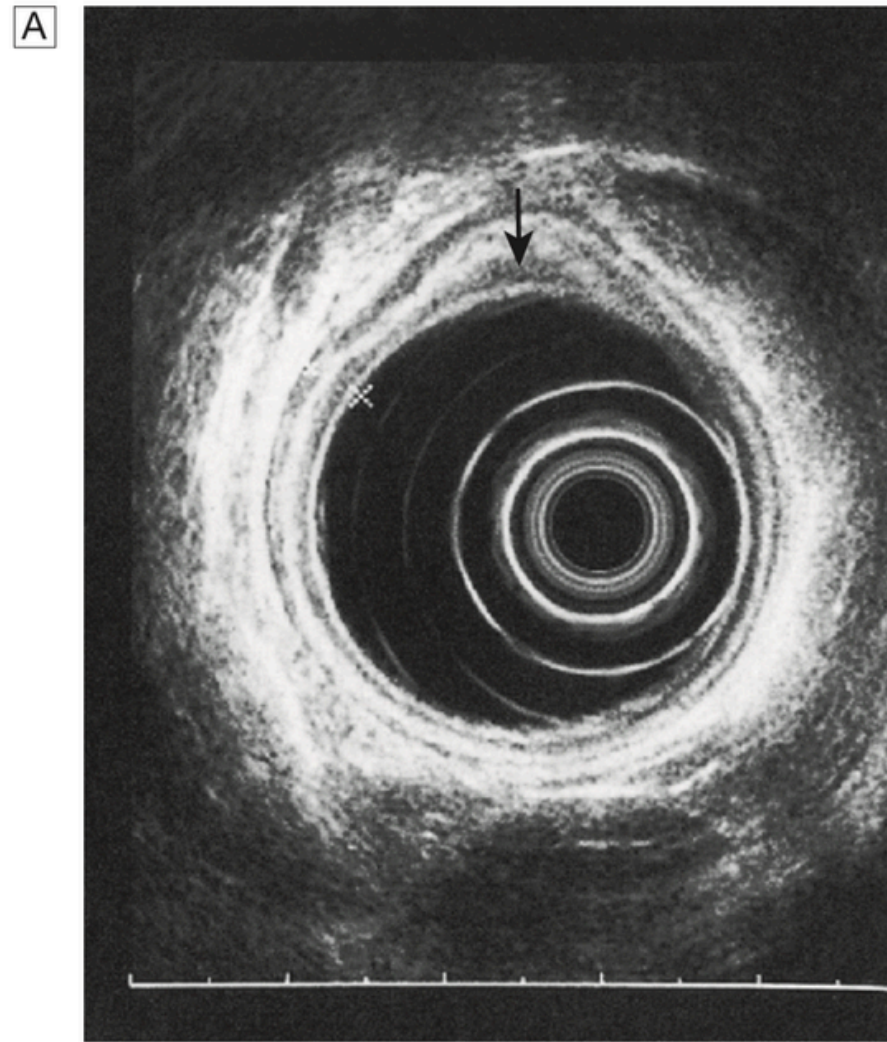
PET-BT Standart BT'de  
saptanmayan küçük uzak  
metastazları veya lenf nodlarını  
tespit etmede çok değerlidir.  
Hastaların yaklaşık %15'inde  
evreyi ve tedavi planını etkiler.  
Ayrıca **tedaviye yanıtı** gösterir.



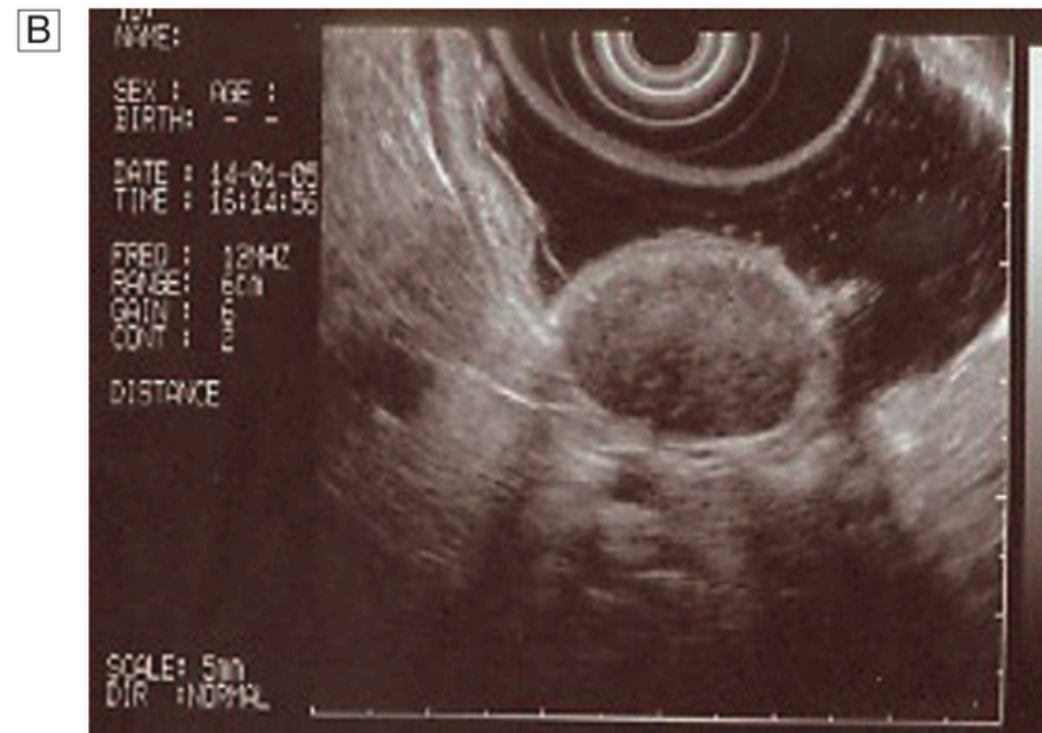
Esophageal cancer **invading** surrounding mediastinal structures



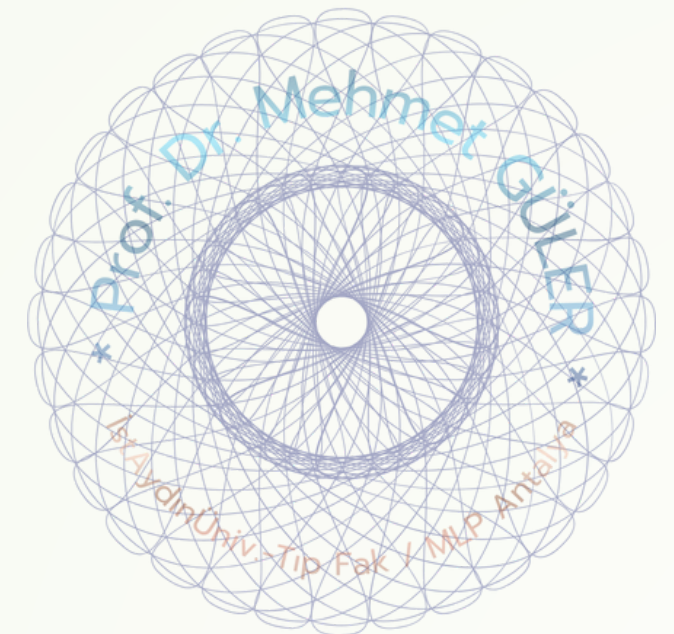




**Fig. 13.8 Endoscopic ultrasound (EUS).** **A** The normal layers of the oesophagus and a small T1 cancer confined to the mucosa marked with an arrow. **B** A full-thickness T3 tumour of the oesophagus. Note the complete destruction of the normal oesophageal layers.



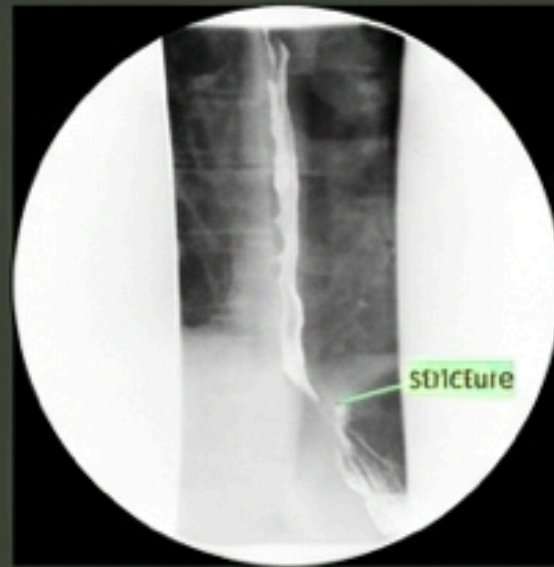
**Fig. 13.9** **A** Endoscopic view of a 2-cm diameter polypoid submucosal gastric lesion. **B** EUS confirms the lesion is arising from the muscularis propria and likely to be a GIST.



# Onkolojik İş Akışı: Teşhis ve Evreleme

## Adım 1: Baryum

Disfajinin ilk değerlendirmesi. Düzensiz dolun defekti ve darlık (striktür) gösterir.



## Adım 2: Endoskopi ve Biyopsi

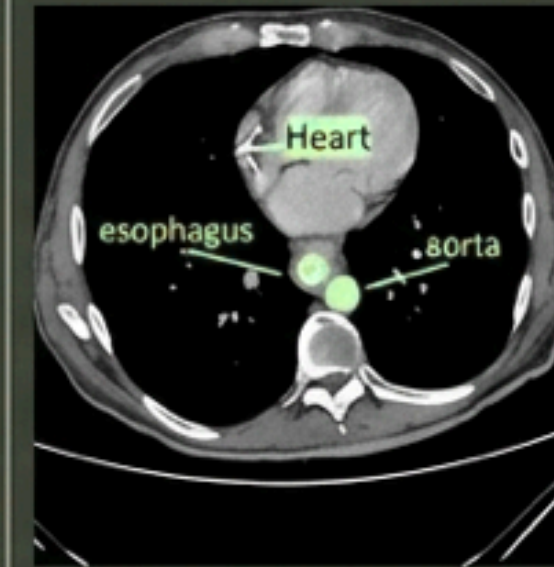
Kesin histolojik tanı ve Barrett displazisi sürveyansı için zorunludur.

## Adım 3: EUS

Tümörün duvar içi derinliğini (T evresi) ve şüpheli lenf nodlarını değerlendirir.

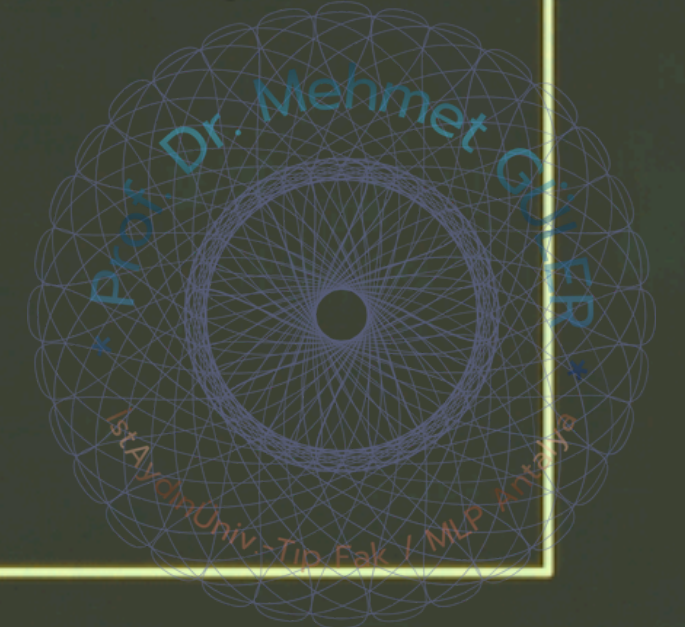
## Adım 4: PET/CT ve Bronkoskopi

Sistemik metastaz taraması. Üst tümörlerde trakeobronşiyal invazyon kontrolü.



## Adım 5: Neoadjuvan Tedavi

- Ameliyat öncesi tümörü küçültmek için Kemoradyoterapi (5-FU ve Sisplatin + 45 Gy).
- Tam yanıt sağkalımı dramatik şekilde artırır.

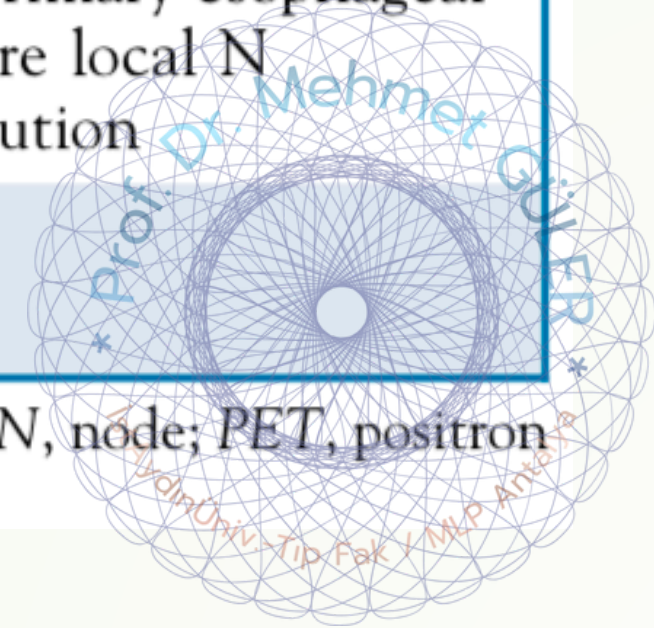


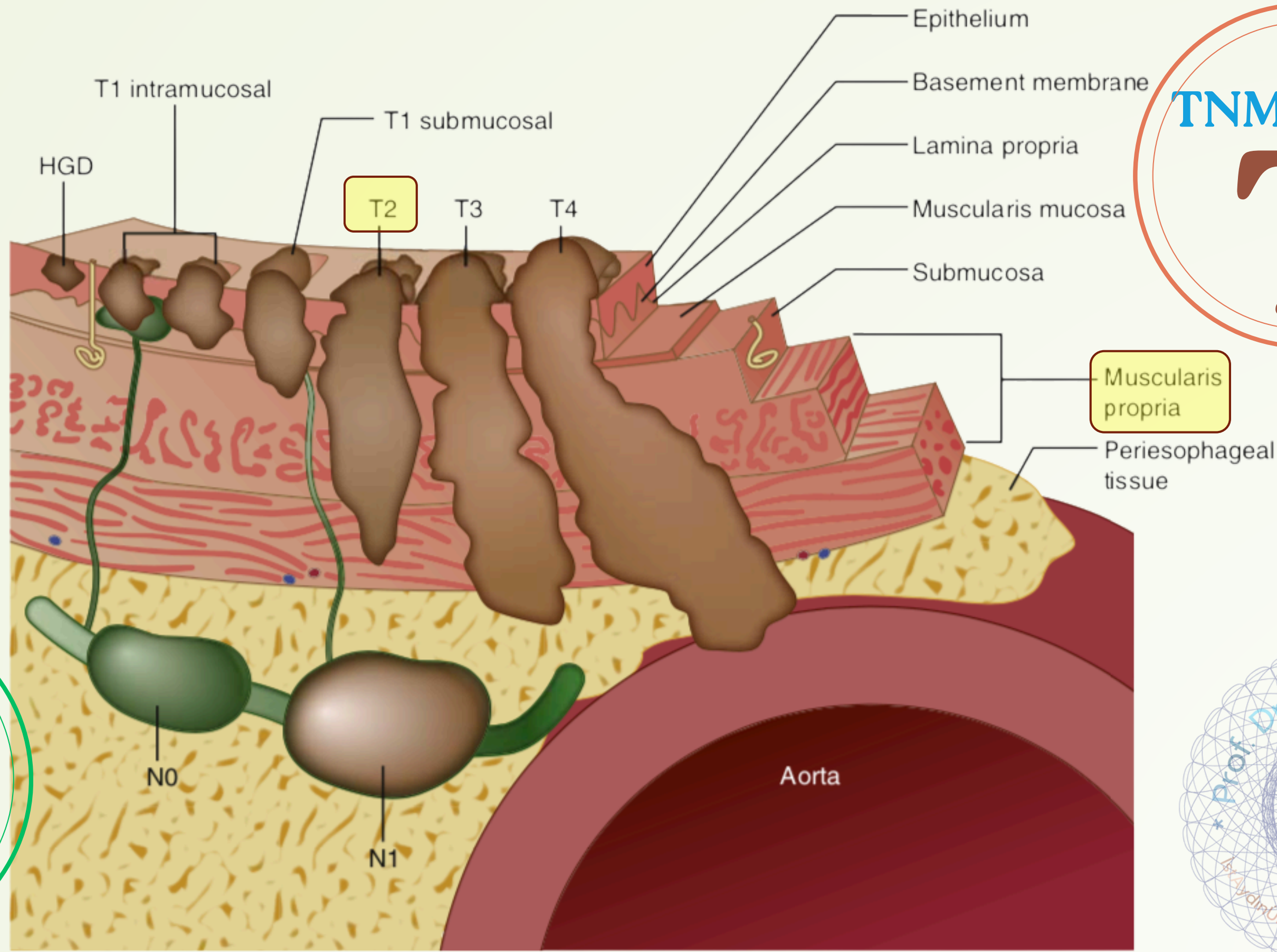


**E-Table 5-3. Methods of Esophageal Cancer Staging**

<b>METHOD</b>	<b>STRENGTH</b>	<b>WEAKNESS</b>
Endoscopy	Tissue sampling Location (cervical, thoracic, abdominal) Tumor > 5 cm, poor prognosis	No N or M staging
CT chest and abdomen	Readily identified significant metastasis	Limited value for celiac axis nodal involvement Limited for small metastasis
EUS	Best for T and N staging	Limited for M staging Limited by obstructing tumors (30% of esophageal cancers)
FDG-PET PET scan +/- integrated CT	Complements EUS and CT Most cost effective for detecting occult metastasis	FDG uptake by primary esophageal tumor may obscure local N Poor spatial resolution
Bronchoscopy	Esophageal cancers of the proximal esophagus, at or above the carina	

CT, Computed tomography; EUS, endoscopic ultrasound; FDG, (18 F)-2-deoxy-D-glucose; M, metastasis; N, node; PET, positron emission tomography; T, tumor.





TNM'in T'si  
**T**

TNM'in N'si  
**N**

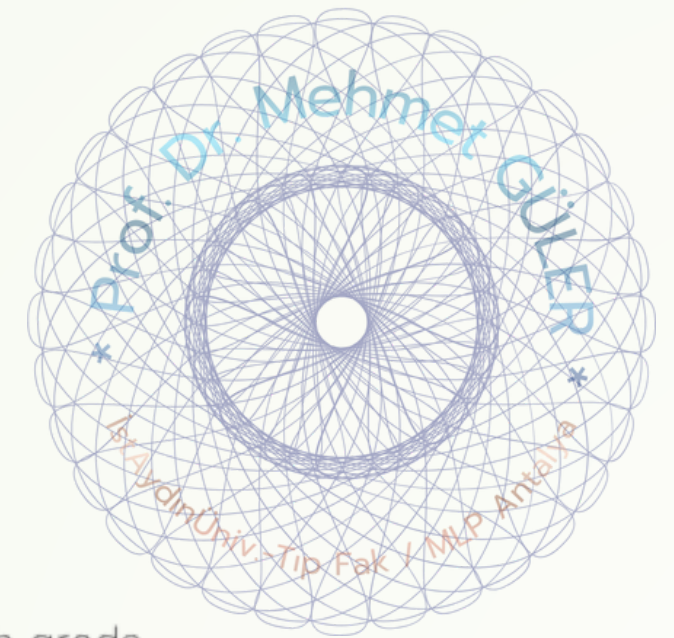
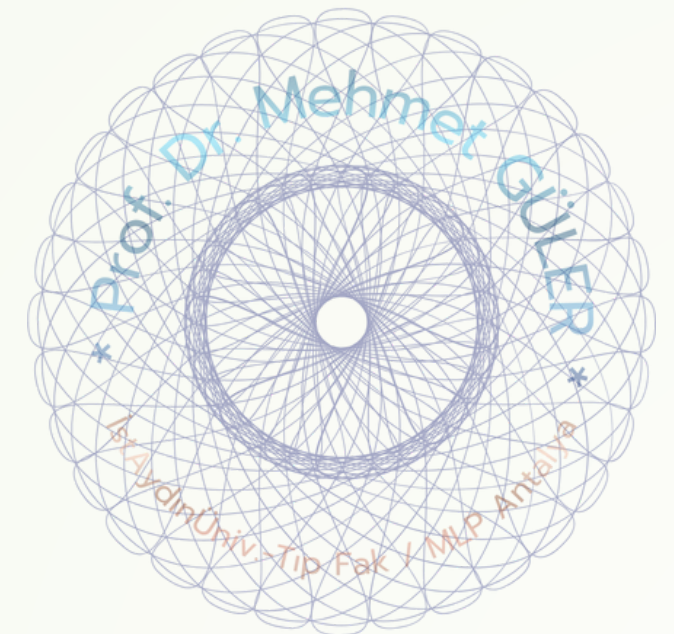


FIG. 42.31 Tumor classification for esophageal carcinoma as defined by depth of invasion. *HGD*, High-grade dysplasia.



**TABLE 62.2** TNM staging scheme for oesophageal cancer.

Tis	High-grade dysplasia
T1	Tumour invading lamina propria or submucosa
T2	Tumour invading muscularis propria
T3	Tumour invading beyond muscularis propria
T4a	Tumour invading adjacent structures (pleura, pericardium, diaphragm)
T4b	Tumour invading adjacent structures (trachea, bone, aorta)
N0	No lymph node metastases
N1	Lymph node metastases in 1–2 nodes
N2	Lymph nodes metastases in 3–6 nodes
N3	Lymph node metastases in 7 or more lymph nodes
M0	No distant metastases
M1	All other distant metastases
Stage	1A: T1N0M0; 1B: T2N0M0; 2A: T3N0M0; 2B: T1/2N0M0; 3A: T4aN0M0, T3N1M0, T1/2N2M0
Stage	3B: T3N2M0; 3C: T4aN1/2M0, T4bN0–3M0, T1–4N3M0; 4T:1–4N1–3M1



# Tedavi Stratejisi ? Prognoz?



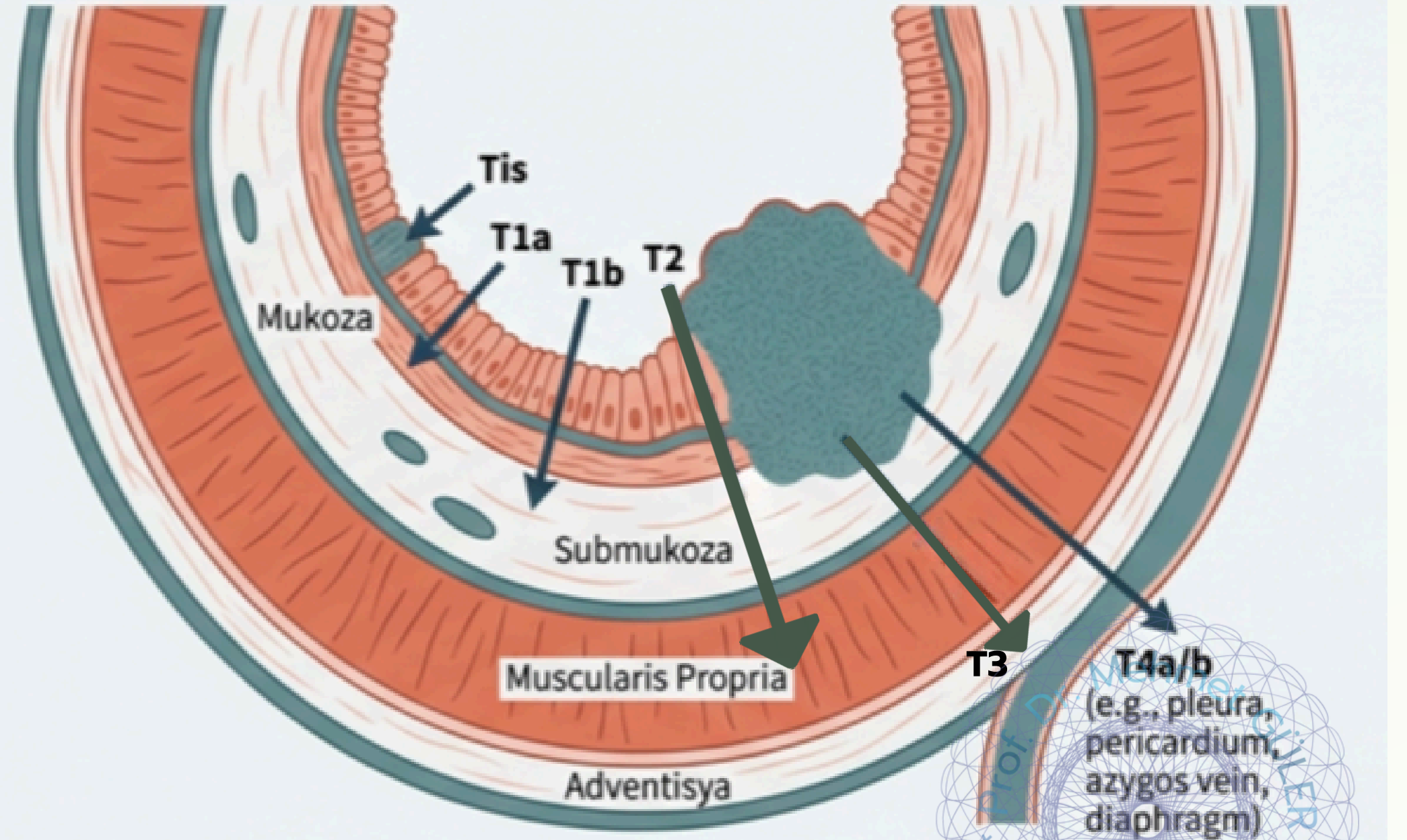
# T - N - M Evreleme

## Amaç

Tedavi stratejisini belirlemek ve prognozu öngörmek için hastalığın anatomik yaygınlığını (evre) anlamak.

## TNM Sistemi (AJCC 8. Versiyon)

- **T (Tümör):** Tümörün özefagus duvarındaki invazyon derinliği.
- **N (Nodül):** Bölgesel lenf nodu metastaz sayısı. (N0: Yok, N1: 1-2, N2: 3-6, N3:  $\geq 7$ )
- **M (Metastaz):** Uzak organ yayılımı. (M0: Yok, M1: Var - en sık karaciğer, akciğer)



**Tis:** Yüksek dereceli displazi (bazal membranı geçmemiş)

**T1a:** Lamina propria veya muscularis mucosa invazyonu

**T1b:** Submukoza invazyonu

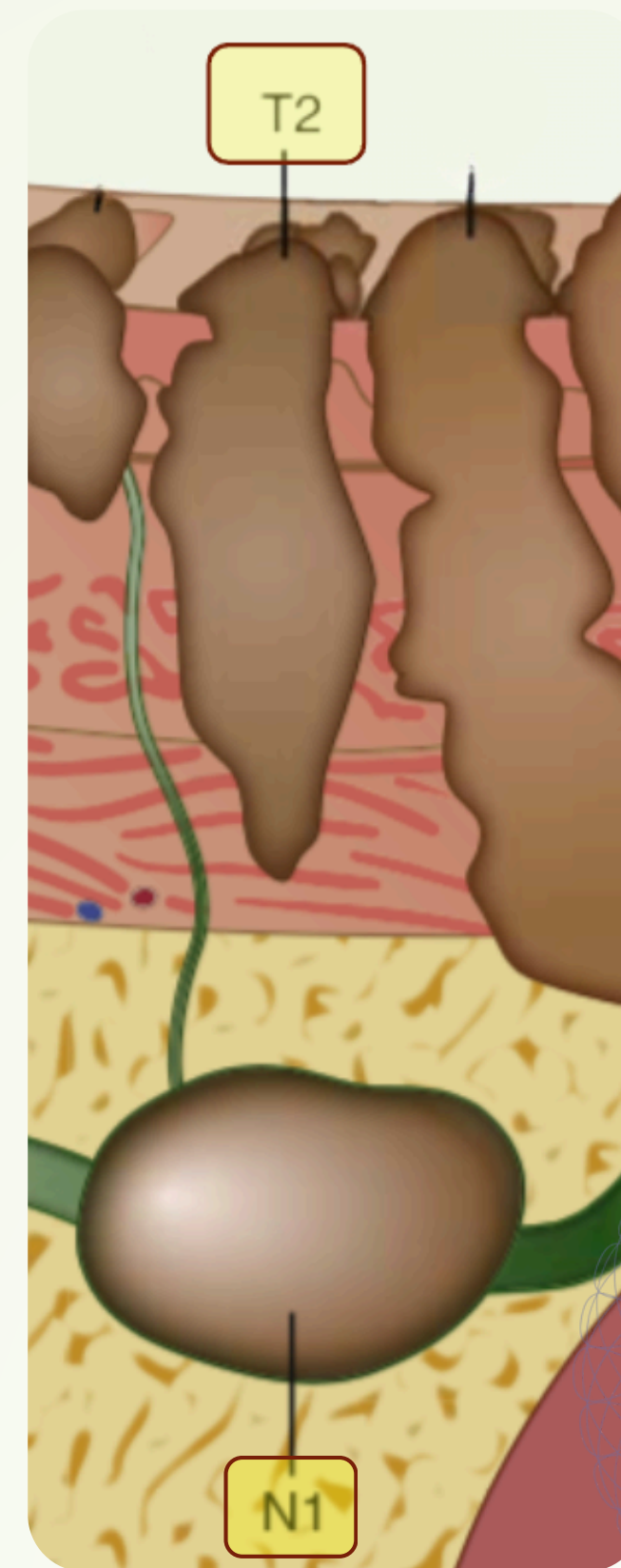
**T2:** Muscularis propria invazyonu

**T3:** Adventisya invazyonu

**T4a/b:** Komşu yapılara invazyon (a: rezektabl, b: unrezektabl)

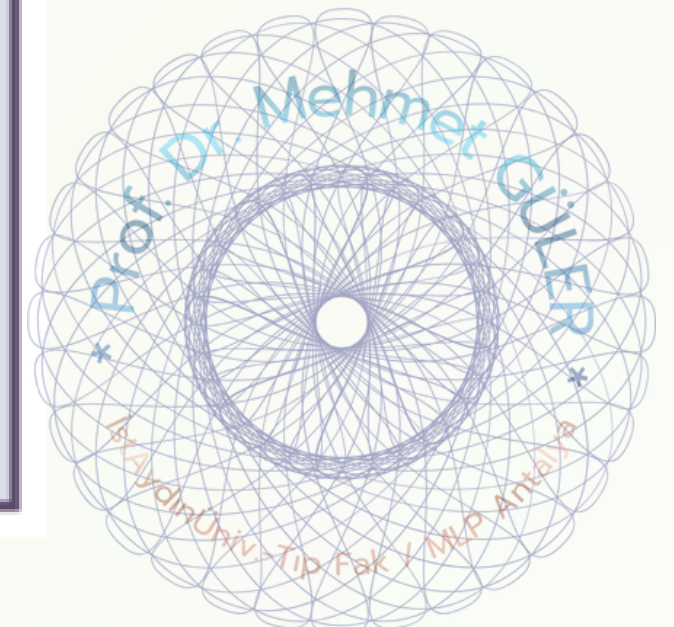
**Table 5-4. American Joint Committee on Cancer Esophageal Cancer Staging Guidelines**

<b>Primary Tumor (T-Stage)</b>	
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis	High-grade dysplasia (Note: this includes <i>carcinoma in situ</i> , a term no longer used)
T1	Tumor invades lamina propria, muscularis mucosa, or submucosa
T1a	Tumor invades lamina propria or muscularis mucosa
T1b	Tumor invades submucosa
T2	Tumor invades muscularis propria
T3	Tumor invades adventitia
T4	Tumor invades adjacent structures
T4a	Resectable tumor invading pleura, pericardium, or diaphragm
T4b	Unresectable tumor invading other adjacent structures: aorta, vertebrae, trachea
<b>Regional Lymph Nodes (N)</b>	
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph nodes
N1	Metastasis in 1-2 regional lymph nodes
N2	Metastasis in 3-6 regional lymph nodes
N3	Metastasis in $\geq 7$ regional lymph nodes
Note: 2010 TNM staging no longer classifies (+) celiac axis lymph node M1a; it is just N (+).	
<b>Distant Metastasis (M)</b>	
M0	No distant metastasis
M1	Distant metastasis
<b>Histologic Grade (G)</b>	
GX	Grade cannot be assessed—stage in grouping as G1
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated—stage in grouping G3
<b>Stage</b>	
Stage 0	Tis, N0, M0
Stage I	T1, N0, M0
Stage IIA	T2, N0, M0; T3, N0, M0
Stage IIB	T1, N1, M0; T2, N1, M0
Stage III	T3, N1, M0; T4, any N, M0
Stage IVA	Any T, any N, M1a
Stage IV B	Any T, any N, M1b



**TABLE 42.7 Clinical stage groupings (cTNM) for esophageal adenocarcinoma.**

	<b>T</b>	<b>N</b>	<b>M</b>
Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage IIA	T1	N1	M0
Stage IIB	T2	N0	M0
Stage III	T2	N1	M0
	T3	N0-1	M0
	T4a	N0-1	M0
Stage IVA	T1-4a	N2	M0
	T4b	N0-2	M0
	Any T	N3	M0
Stage IVB	Any T	Any N	M1



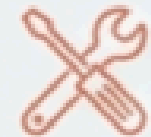
# T1 Olgu EMR (Endoskopik Mukozal Rezeksiyon)



**Hedef Hasta Grubu:** T1a (mukoza ile sınırlı) ve seçilmiş T1b (yüzeysel submukozal invazyonlu) tümörler.



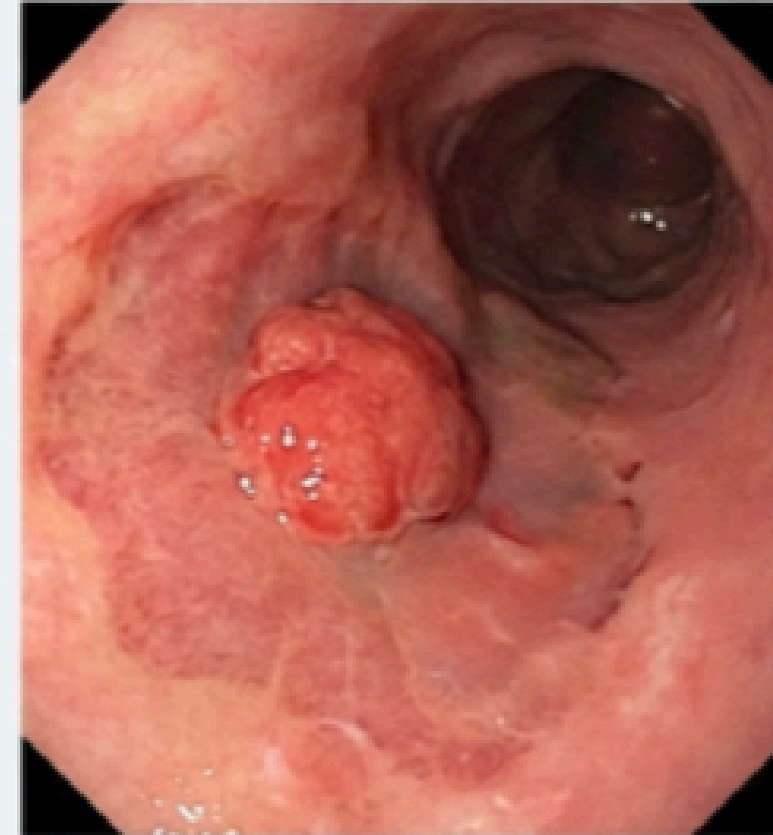
**Temel Prensiptir:** T1a lezyonlarda lenf nodu metastaz riski  $<2\%$ 'dir. Bu nedenle, yüksek morbiditeli özefajektomi ameliyatından kaçınılabılır.



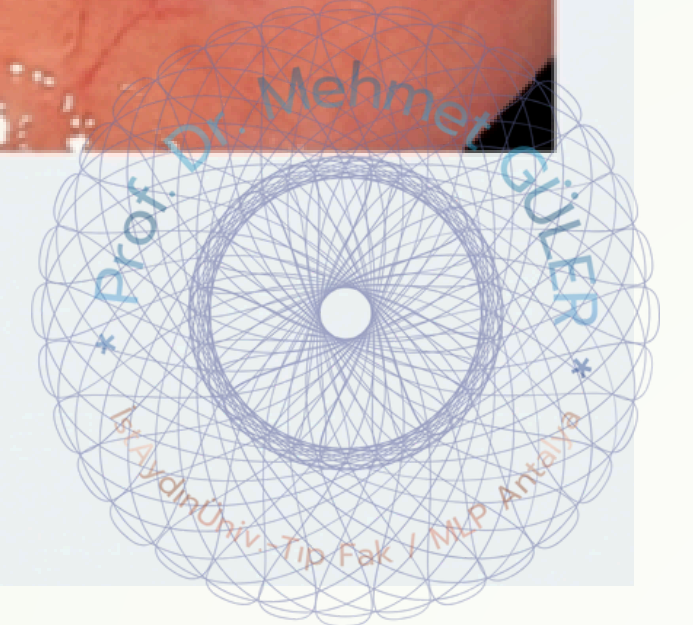
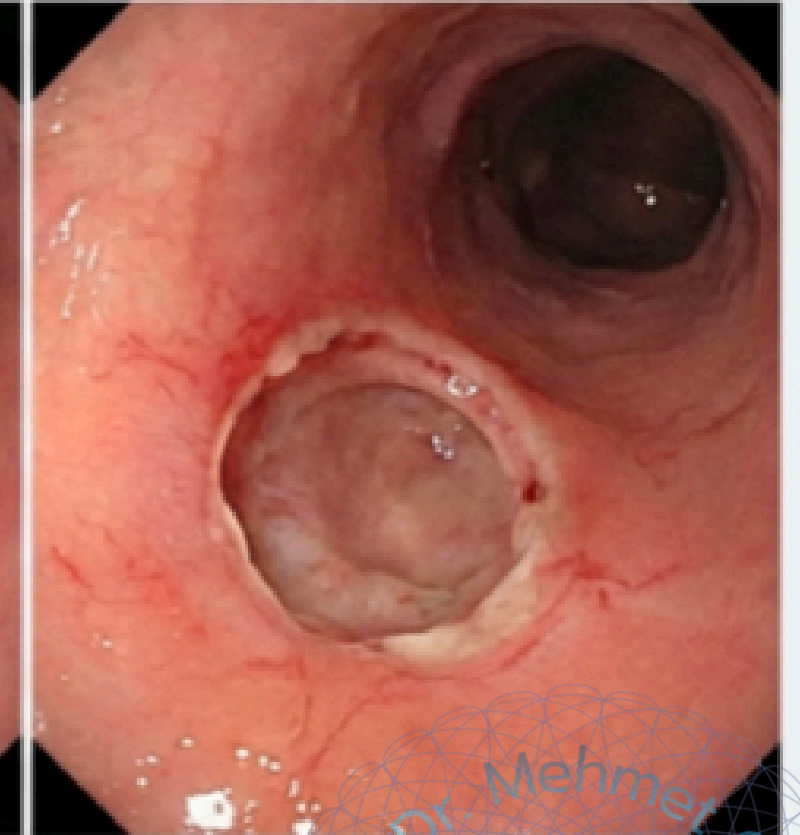
## Yöntemler:

- **Endoskopik Mukozal Rezeksiyon (EMR):** Lezyon, submukozaya sıvı enjekte edilerek yükseltildikten sonra bir snare (tel halka) ile kesilerek çıkarılır. Hem tanısal (invazyon derinliğini netleştirir) hem de tedavi edicidir.
- **Ablasyon Terapileri (Radyofrekans Ablasyon - RFA / Kriyoterapi):** EMR sonrası kalan displastik Barrett mukozasını yakarak (RFA) veya dondurarak (Kriyo) yok etmek için kullanılır.

ÖNCE

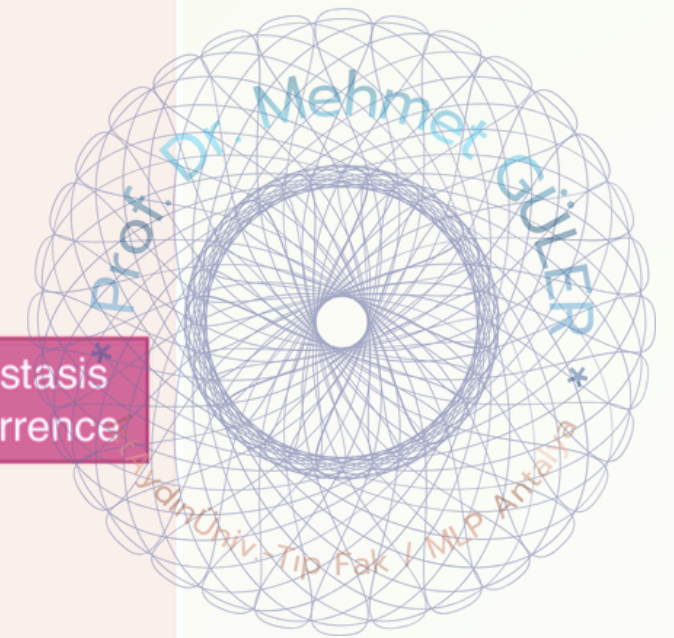
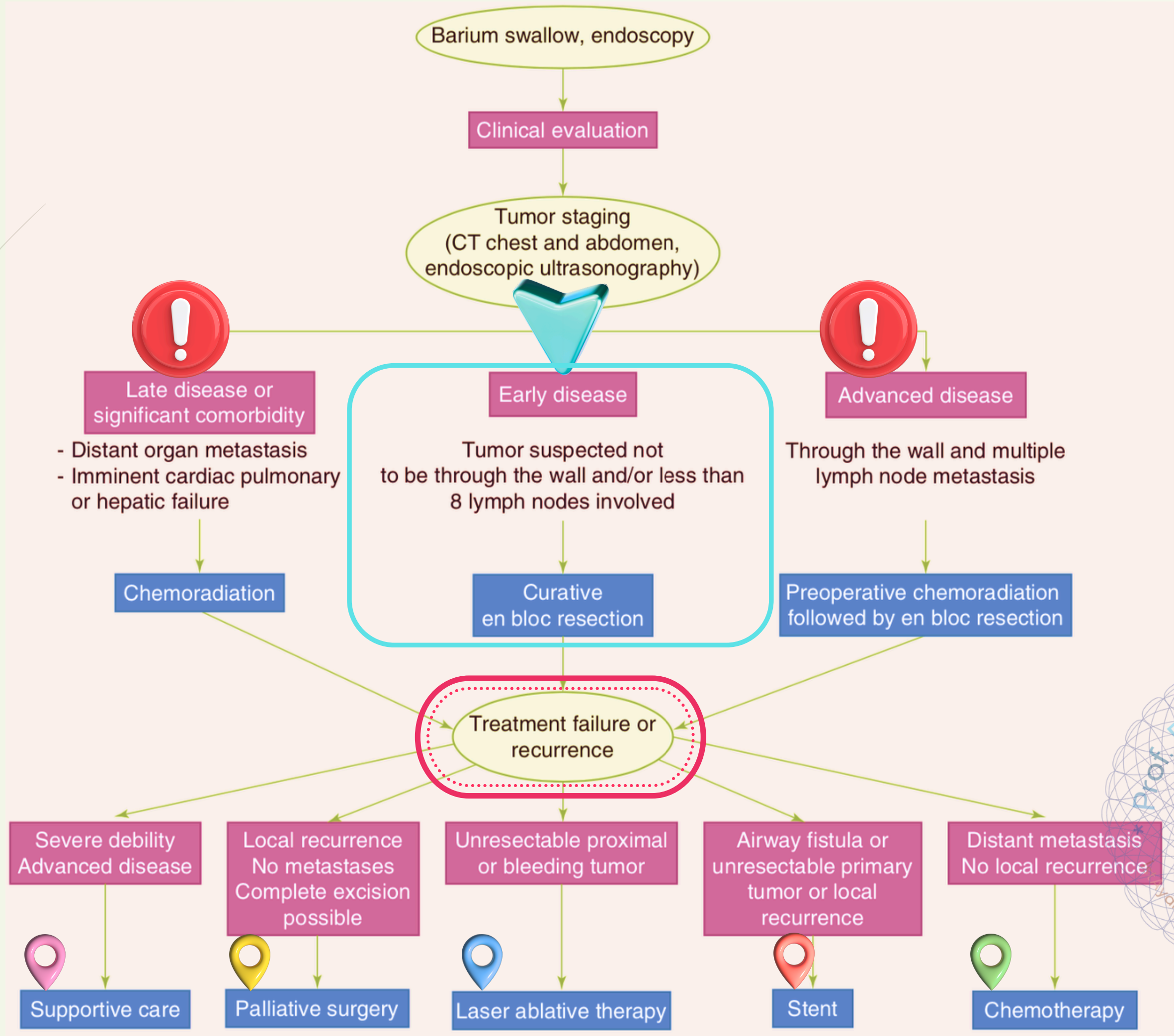


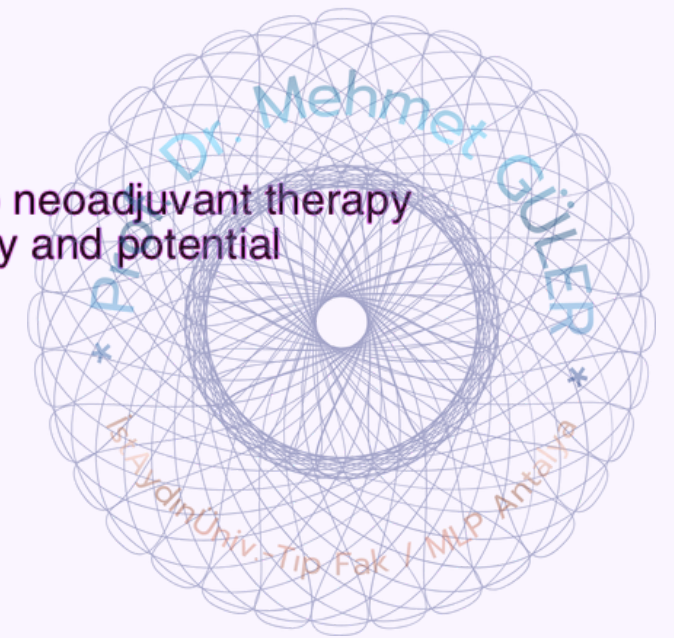
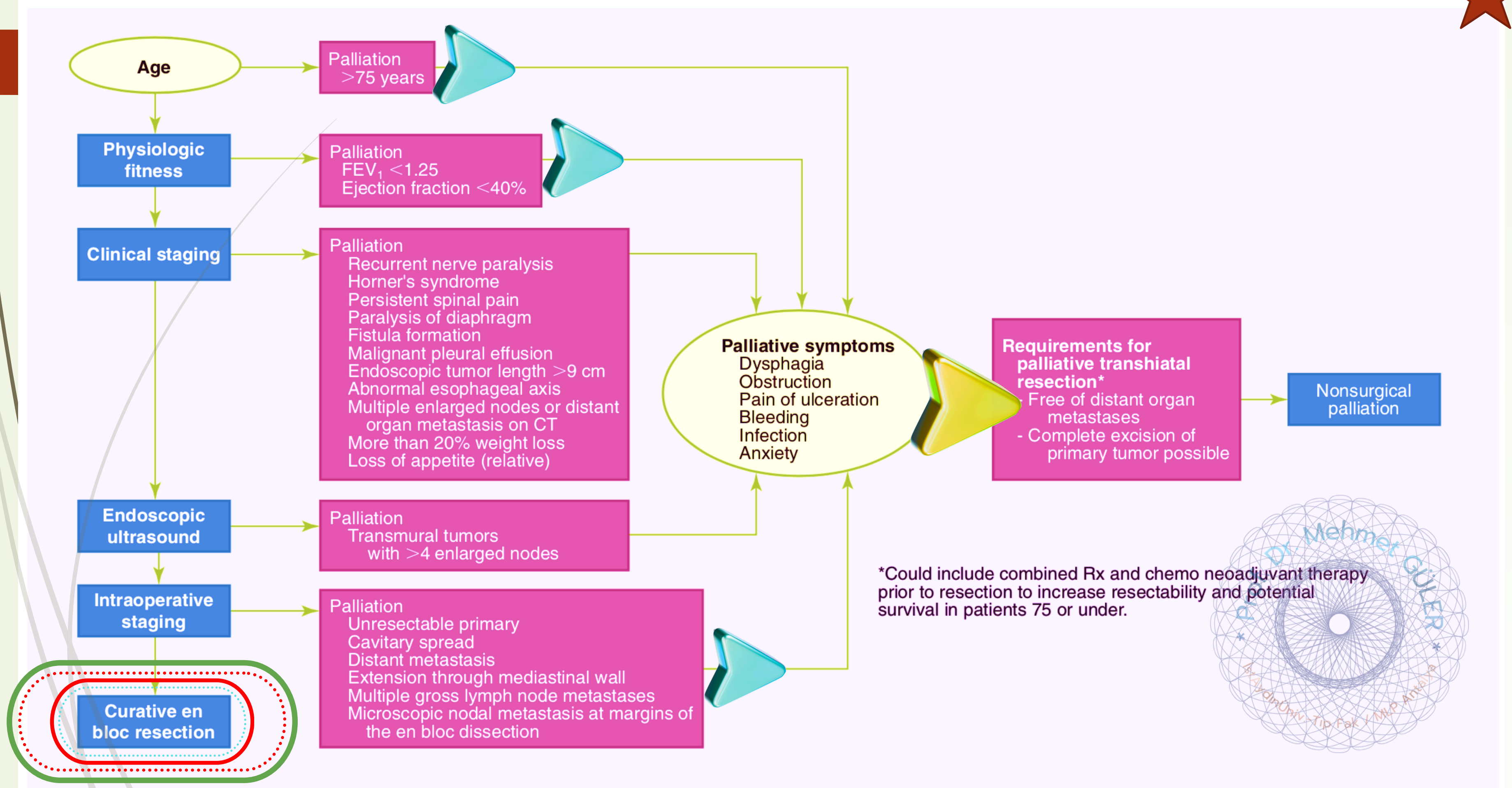
SONRA

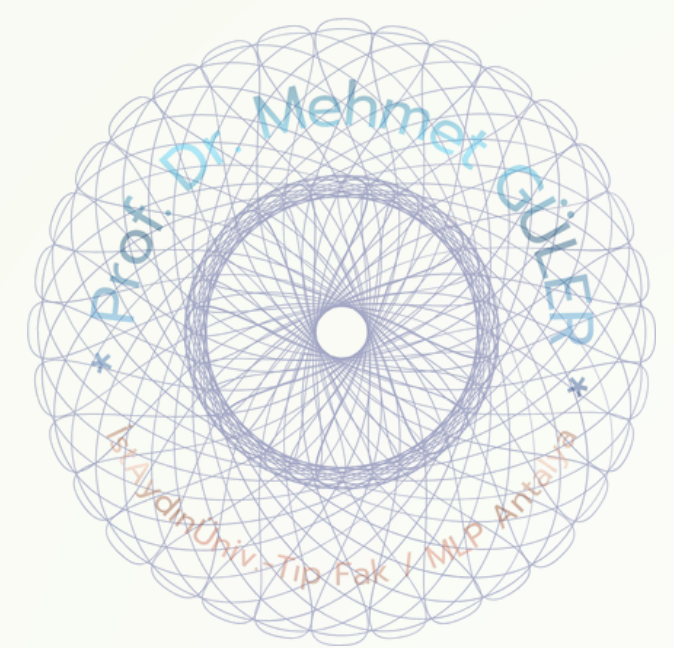
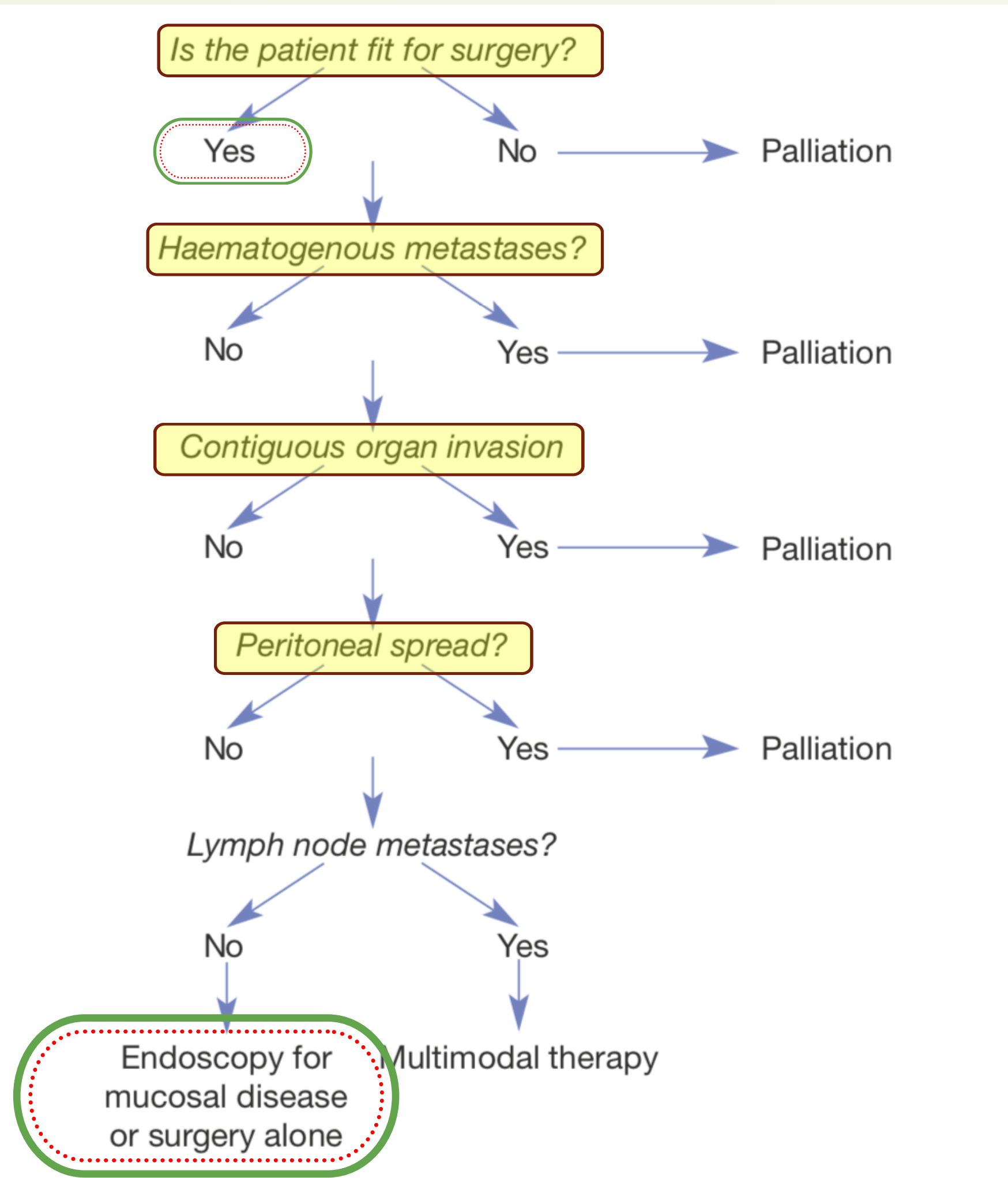




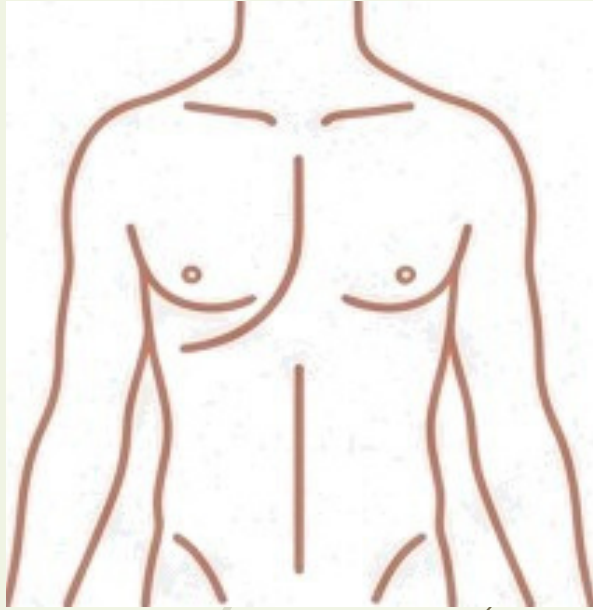
**FIG. 42.36** A superficial T1a adenocarcinoma arising in the setting of Barrett esophagus (*left*) and submucosal defect after endoscopic mucosal resection (*right*).



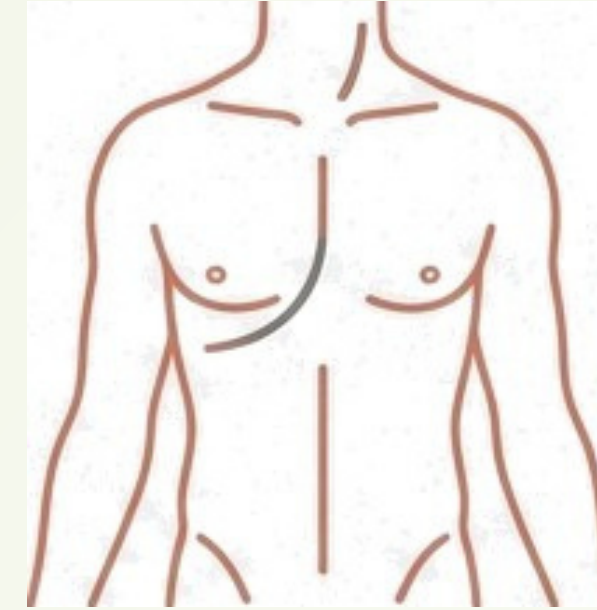




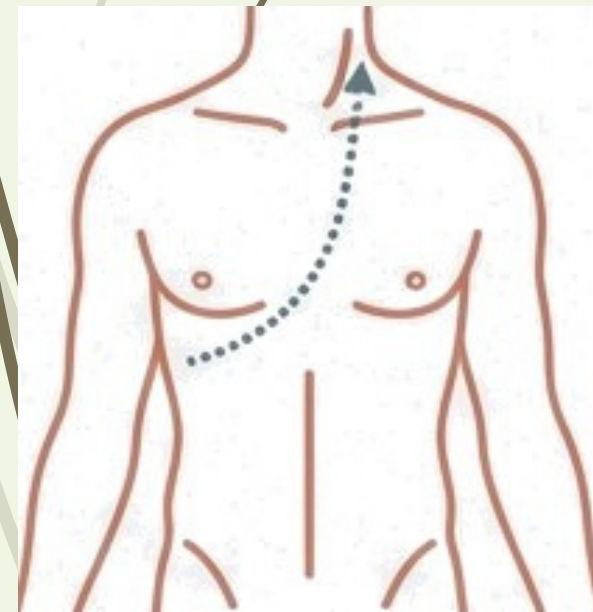
# Cerrahi - Özefajektomi



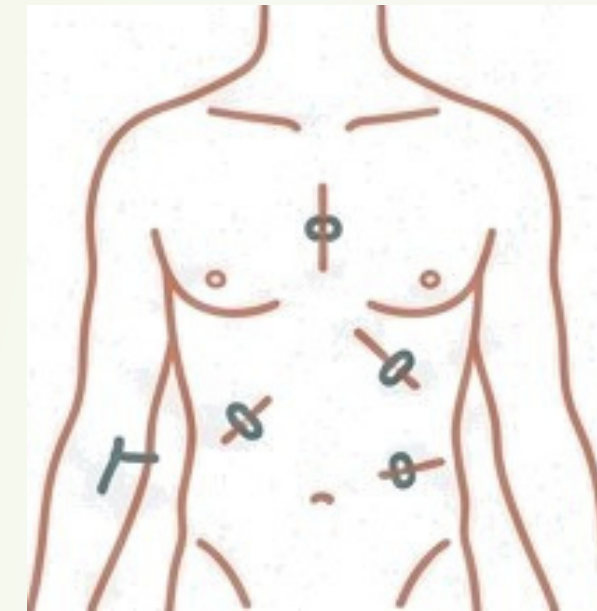
**Ivor Lewis (İki Evreli):** Abdominal (mideyi hazırlama) ve sağ torakotomi (özefagusu çıkarma) insizyonları. **En sık** kullanılan yöntemdir. Mediastinal lenf nodu diseksiyonu için mükemmel görüş sağlar. Anastomoz toraksta



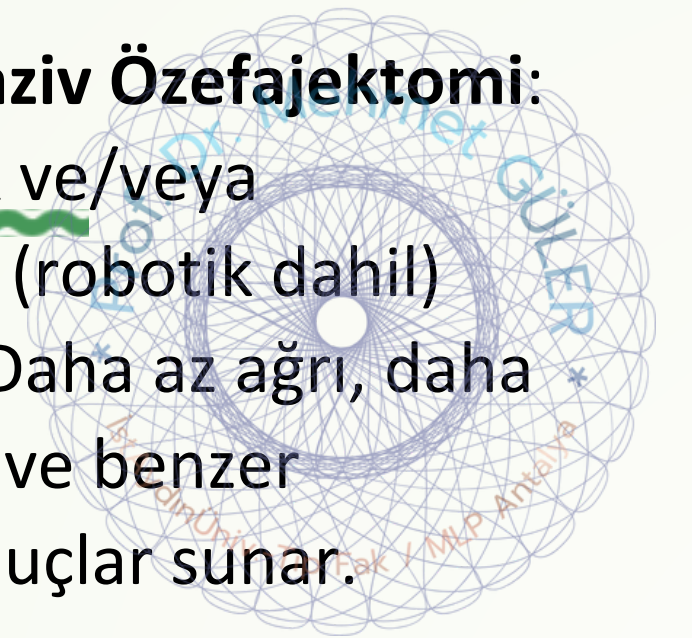
**McKeown (Üç Evreli):** Ivor Lewis'e ek olarak boyun insizyonu. **Üst torasik tümörlerde**, anastomozu boyunda, sızıntı fazla, riski daha da riski daha az

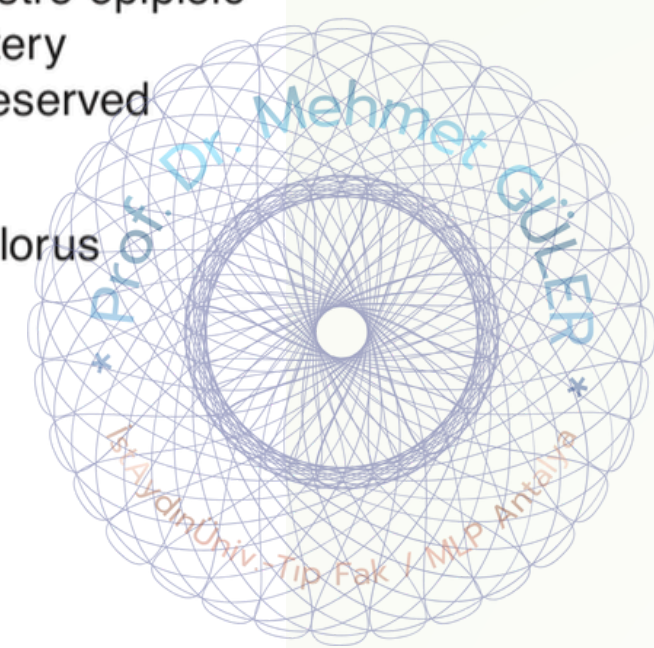
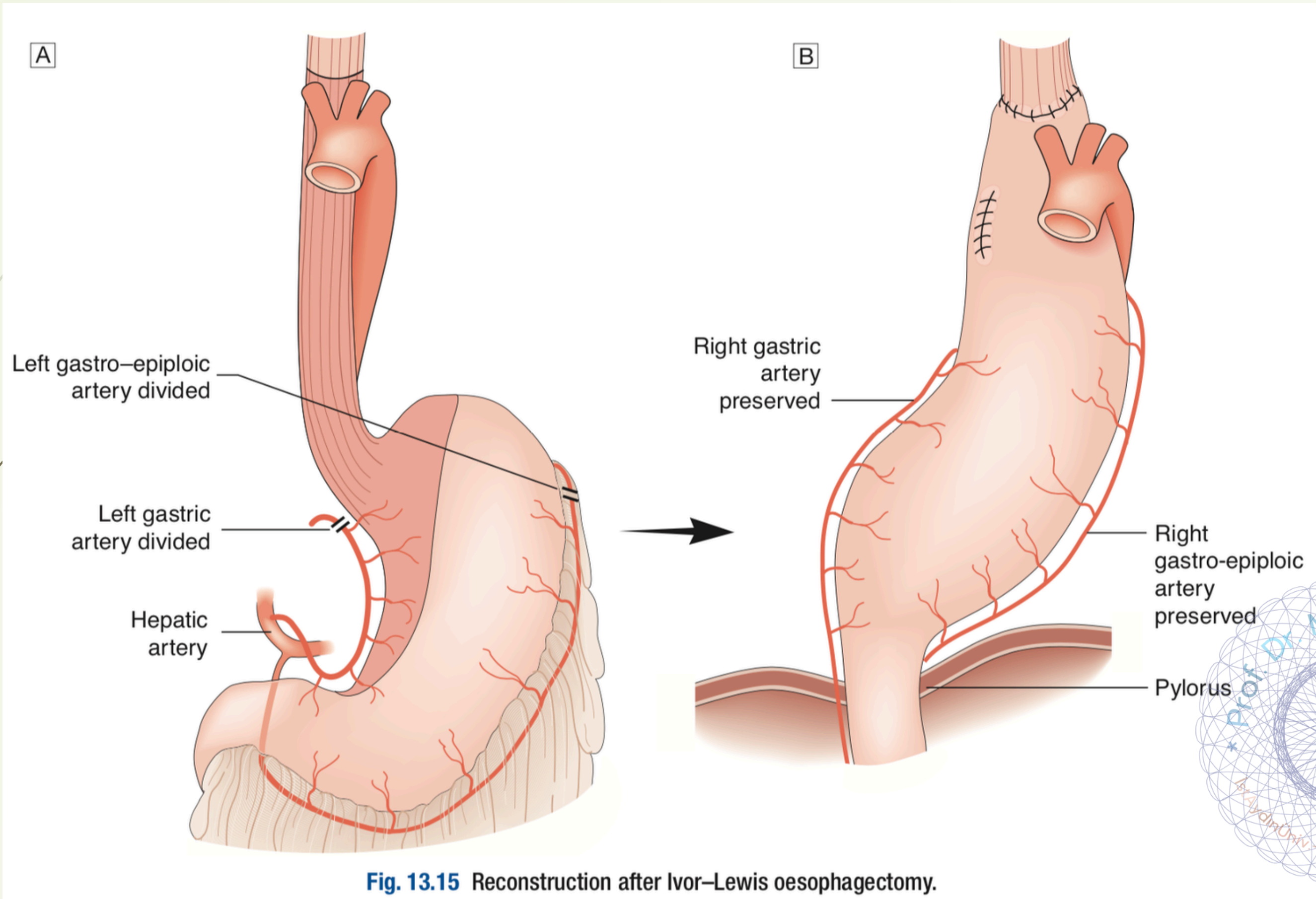


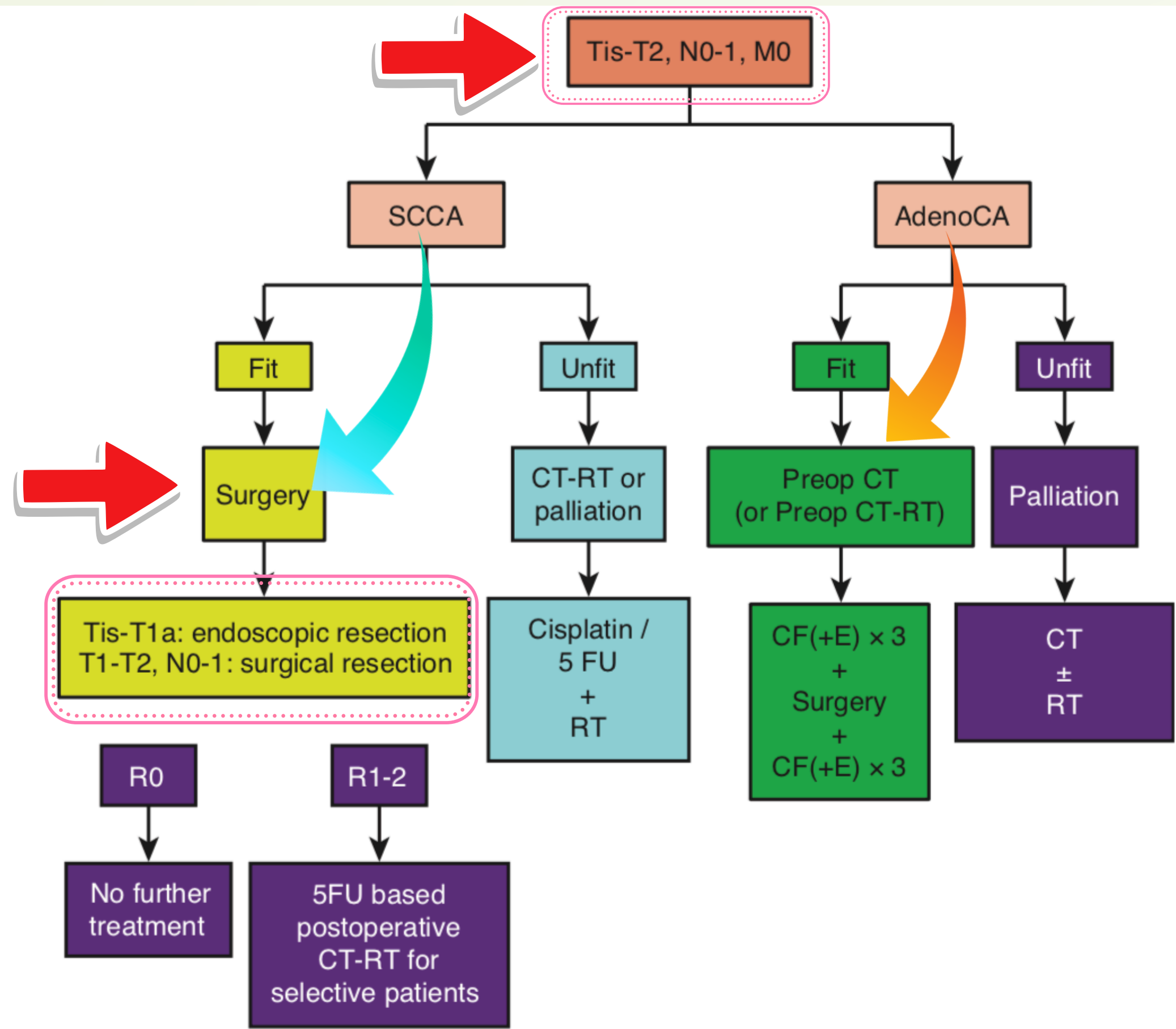
**Transhiatal (Torakotomisiz):** Abdominal ve boyun insizyonları ile toraks açılmadan, kör diseksiyonla yapılır. Daha az pulmoner komplikasyon, ancak orta/üst **lenfadenektomi yetersiz** Sadece distal özefagus tm için



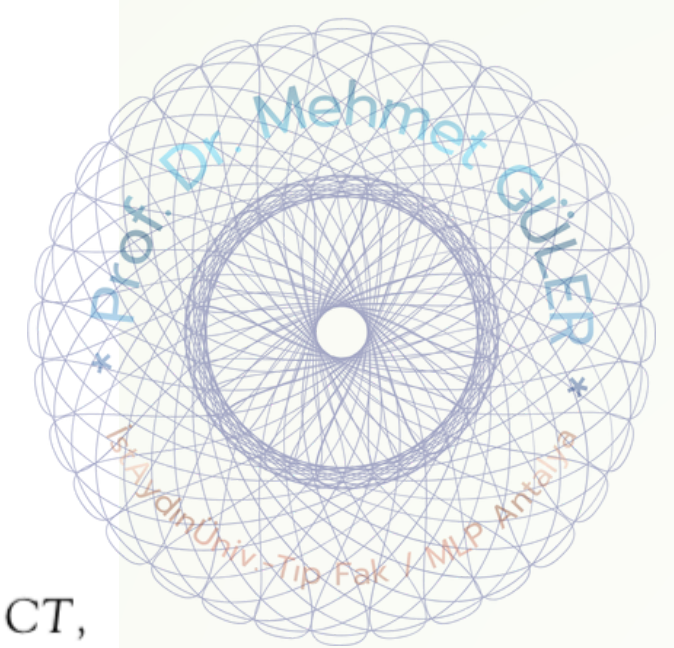
**Minimal İnvaziv Özefajektomi:** Laparoskopik ve/veya torakoskopik (robotik dahil) yaklaşımlar. Daha az ağrı, daha hızlı iyileşme ve benzer onkolojik sonuçlar sunar.

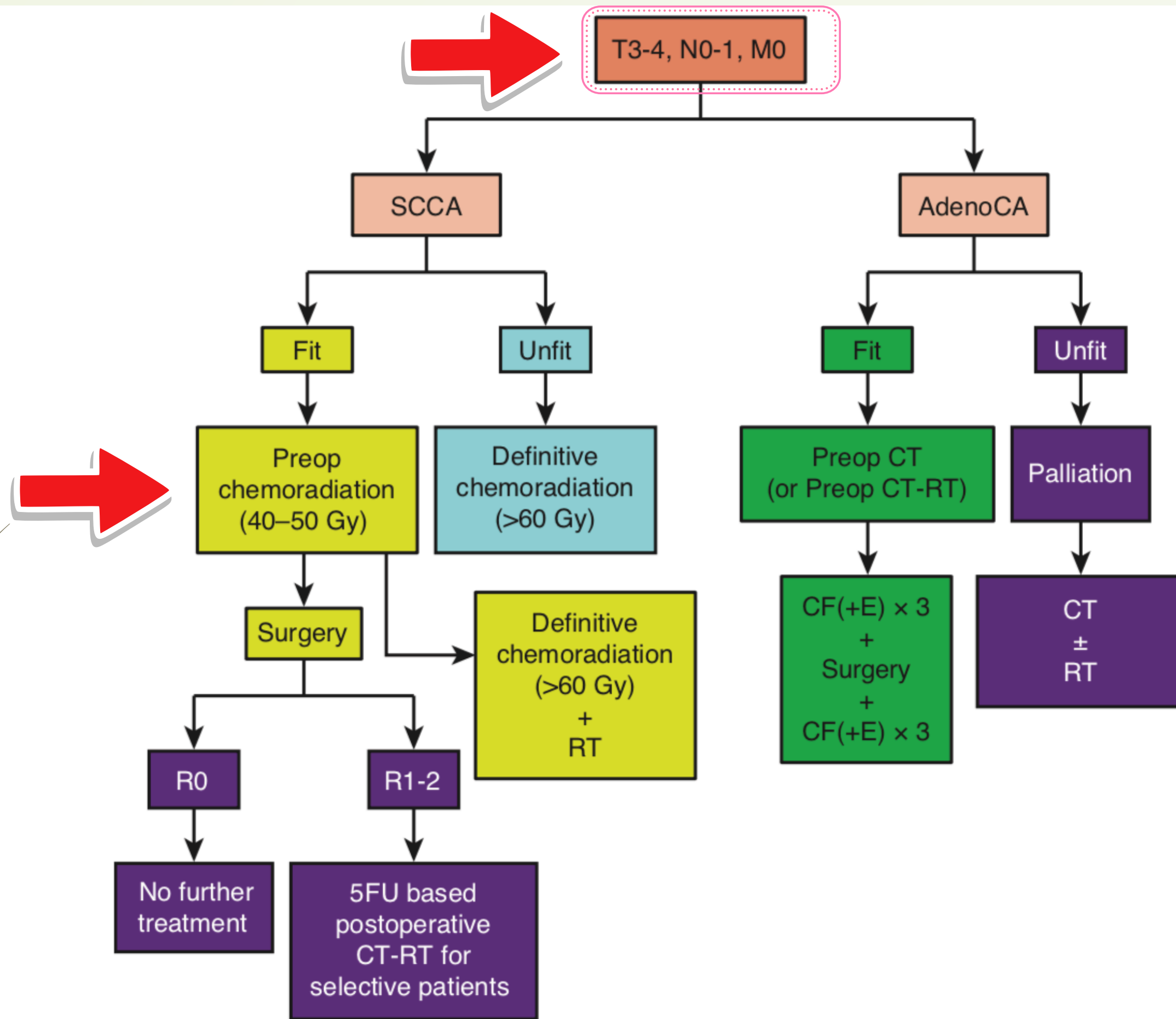




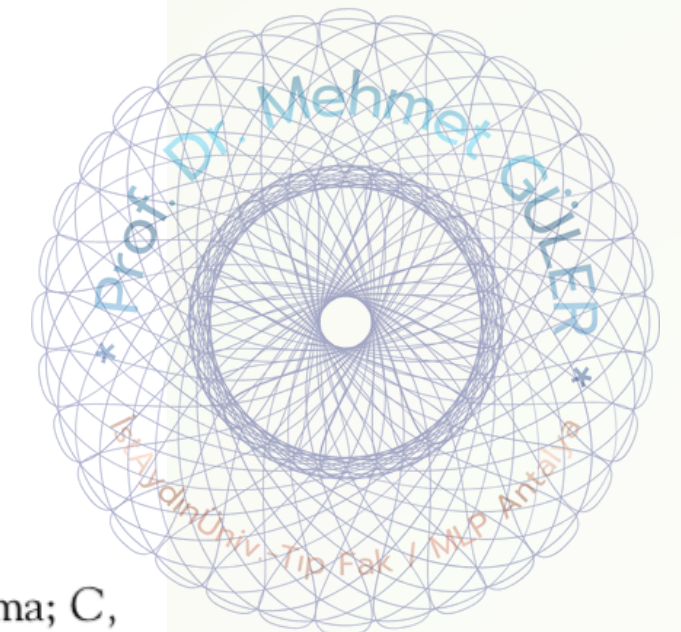


**Figure 5-2.** Esophageal cancer treatment algorithm for limited disease (stage I). AdenoCA, Adenocarcinoma; C, cisplatin; CT, chemotherapy; E, epirubicin; F, fluorouracil; R0, complete resection; R1-2, incomplete resection; RT, radiation therapy; SCCA, squamous cell carcinoma.





**Figure 5-3.** Esophageal cancer treatment algorithm for locally advanced disease (stage II-III). AdenoCA, Adenocarcinoma; C, cisplatin; CT, chemotherapy; E, epirubicin; F, fluorouracil; R0, complete resection; R1-2, incomplete resection; RT, radiation therapy; SCCA, squamous cell carcinoma.



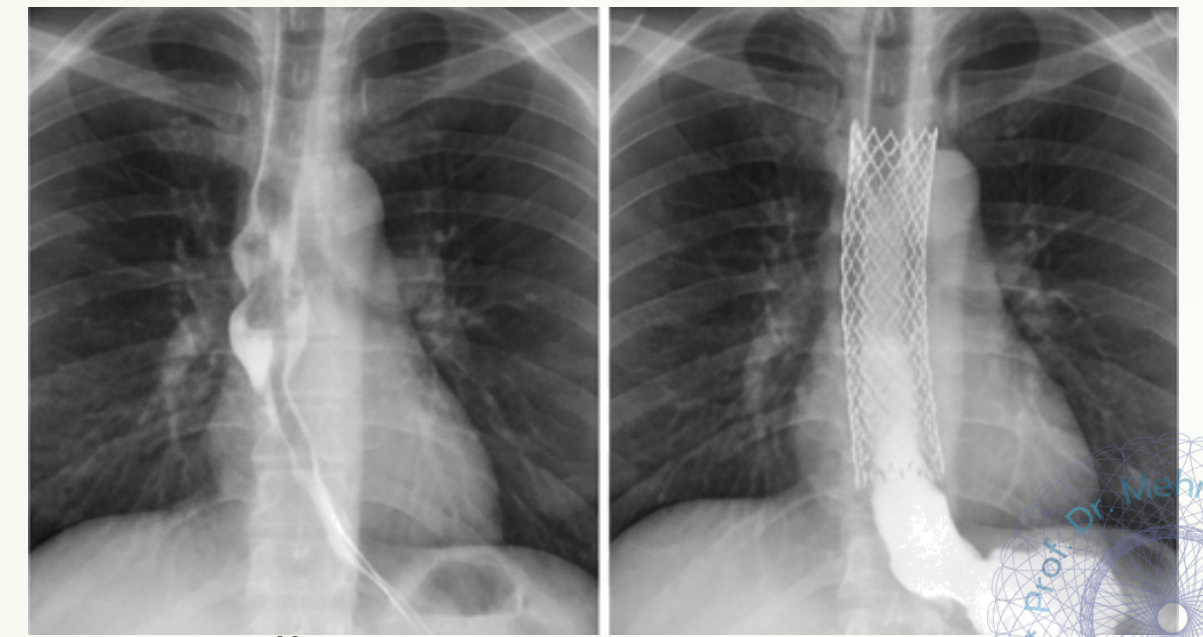
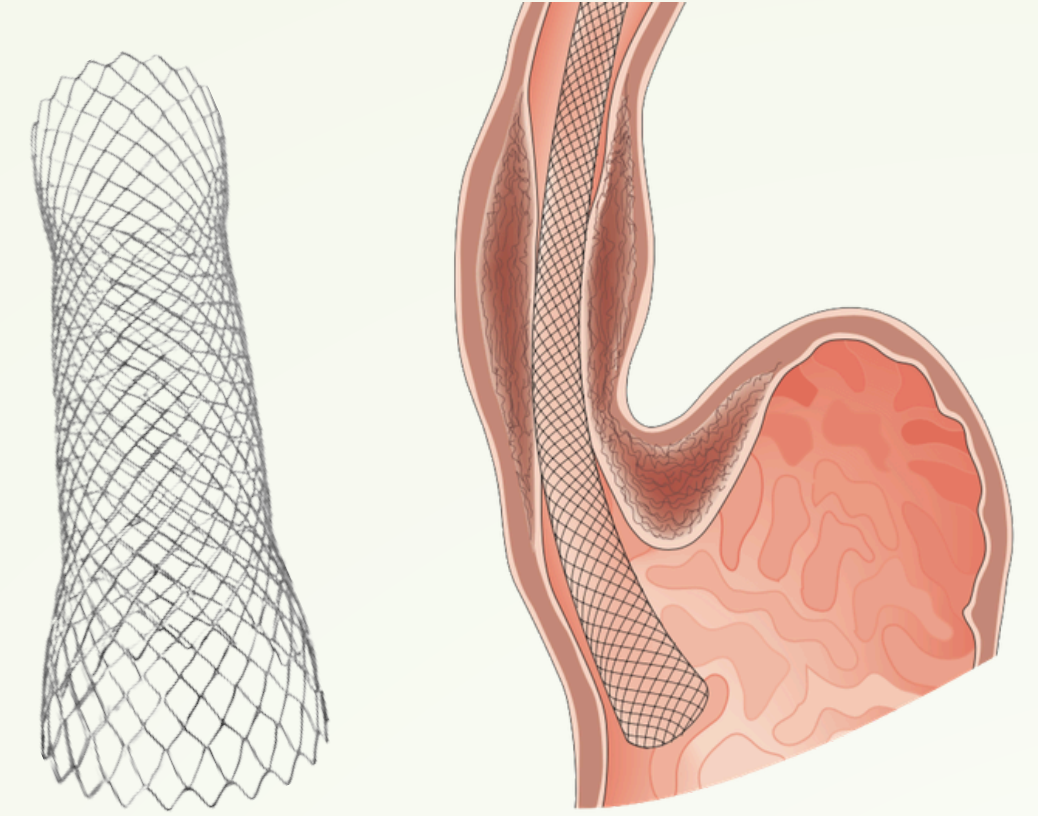
# Unrezekeable - Palyatif Tedavi

## Amaç

Evre IV veya cerrahiye uygun olmayan hastada, Semptomları (özellikle disfajiyi) hafifletmek, Hastanın yaşam kalitesini artırmak.

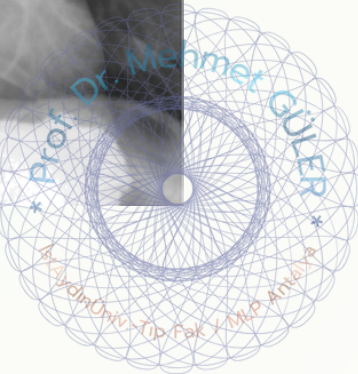
## Palyasyon Yöntemleri

- **Özefageal Stent** (Genişleyebilir Metal Stentler): Tıkanıklığı açmak için en hızlı ve etkili yöntemdir.
- **Endoskopik Ablasyon** (Lazer, Argon Plazma Koagülasyonu): Tümör yükünü azaltarak lümeni açmak için kullanılır. Etkisi geçicidir ve tekrarlayan seanslar gerektirir.
- **Palyatif Radyoterapi/Kemoterapi**: Semptom kontrolü için daha uzun süreli bir çözüm. Özellikle ağrı ve kanama kontrolünde
- **Beslenme Desteği**: Enteral beslenme için jejunostomi tüpü

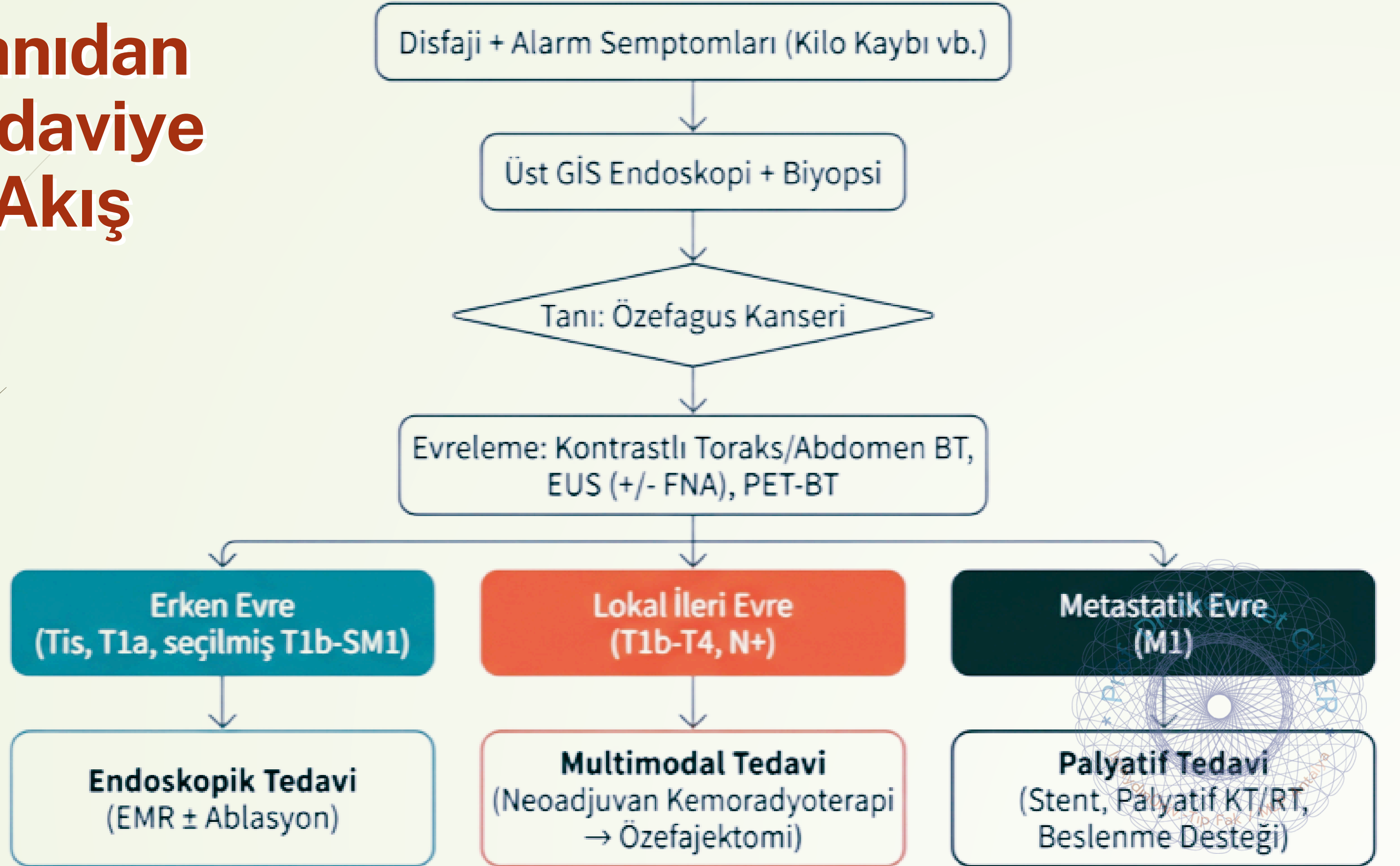


ÖNCESİ

SONRASI



# Tanıdan Tedaviye Akış



## Özefagus Kanseri ..

**Disfaji** her zaman araştırılmalı

GÖRH, Barrett ve özefagiyal adeno karsinom birbiriyle ilişkili

**Erken teşhis,** küratif endoskopik ve cerrahi tedaviye olanak

sağlayabilir

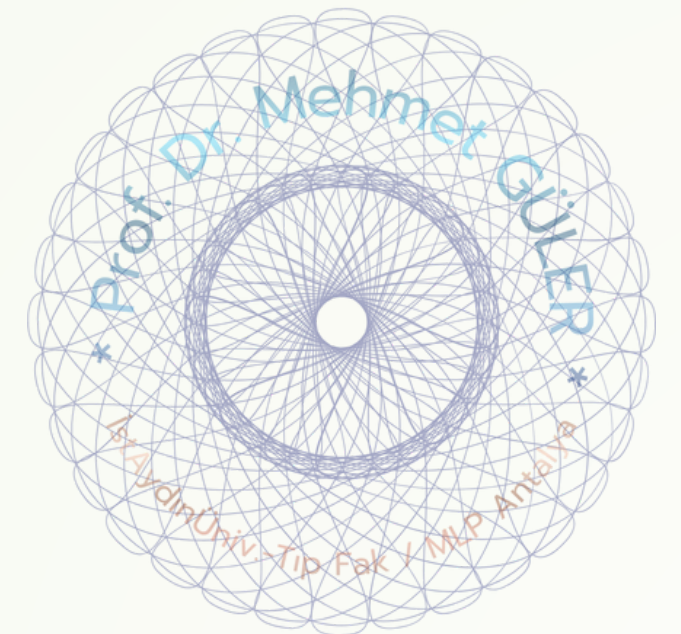
Geç tanı kötü prognoza yol açar

Küratif tedavi genellikle **multimodaldır**

Yüksek volümlü merkezlerde sonuçlar daha iyidir

### Oesophageal cancer

- Always investigate dysphagia
- GORD, Barrett's and oesophageal adenocarcinoma are linked
- Early diagnosis can allow curative endoscopic or surgical therapy
- Late diagnosis (the norm) results in poor prognosis
- Curative treatment now usually multimodal
- Surgical outcomes better in high volume centres.



# Özefagus Kanseri ...

## Carcinoma of the oesophagus

- Squamous cell usually affects the upper two-thirds; adenocarcinoma usually affects the lower third
- Common aetiological factors are tobacco and alcohol (squamous cell), GORD and obesity (adenocarcinoma)
- The incidence of adenocarcinoma is increasing
- Lymph node involvement is a bad prognostic factor
- Dysphagia is the most common presenting symptom, but is a late feature
- Accurate pretreatment staging is essential in patients thought to be fit to undergo 'curative' treatment

Yerleşim - SCC genellikle proksimal 2/3, **AdenoCa distal 1/3** te

Yaygın **etiyojik** faktörler – SCC'de Tütün, Alkol,

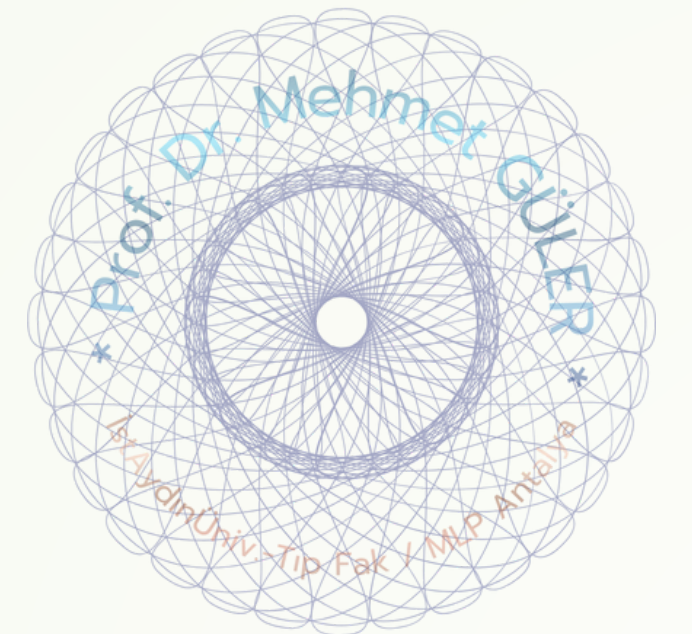
Adeno Ca'da GÖRH, Obezite

Adeno Ca insidansı artıyor

**Lenf nodu** tutulumu – Kötü prognostik faktör

Disfaji – En sık semptom, ancak geç farkediliyor

Küratif tedavi için erken teşhis ve **doğru evreleme** şart



### Treatment of carcinoma of the oesophagus

- Radical oesophagectomy is the most important aspect of curative treatment
- Neoadjuvant treatments before surgery may improve survival in a proportion of patients
- Chemoradiotherapy alone may cure selected patients, particularly those with squamous cell cancers
- Useful palliation may be achieved by chemo-/radiotherapy or endoscopic treatments

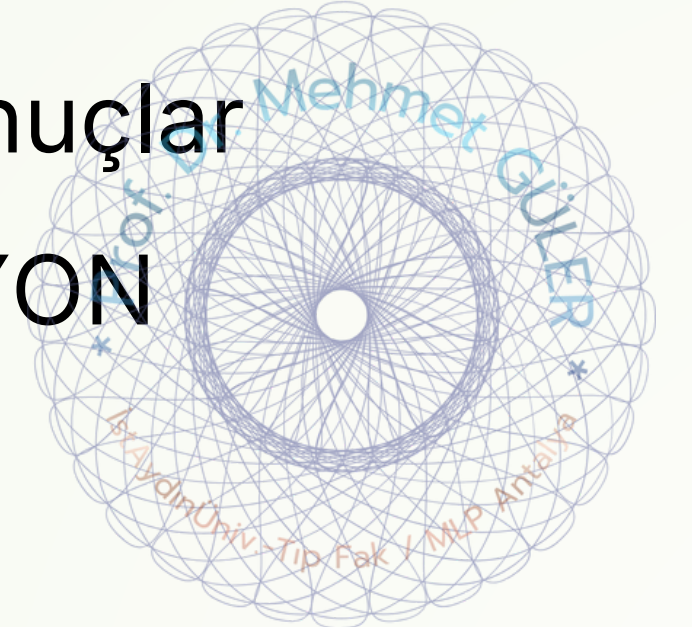
## Özefagus Karseri .

**KÜRATİF TEDAVİ** Şansı – Radikal özefajektomi

Ameliyat öncesi **(neoadjuvan)** KT sağkalımı artırabilir

Seçilmiş SCCA olgularında – Tek başına KT ile olumlu sonuçlar

**İleri olgu** – KT/RT veya Endoskopik tedaviler ile PALYASYON



# Konunun Anahatları



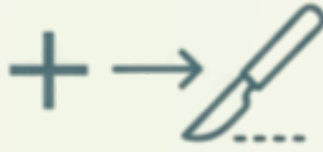
1. **Disfaji geç bir semptomdur.** Özefagus kanseri genellikle lümeni önemli ölçüde daralttığına, yani ileri evrede belirti verir.



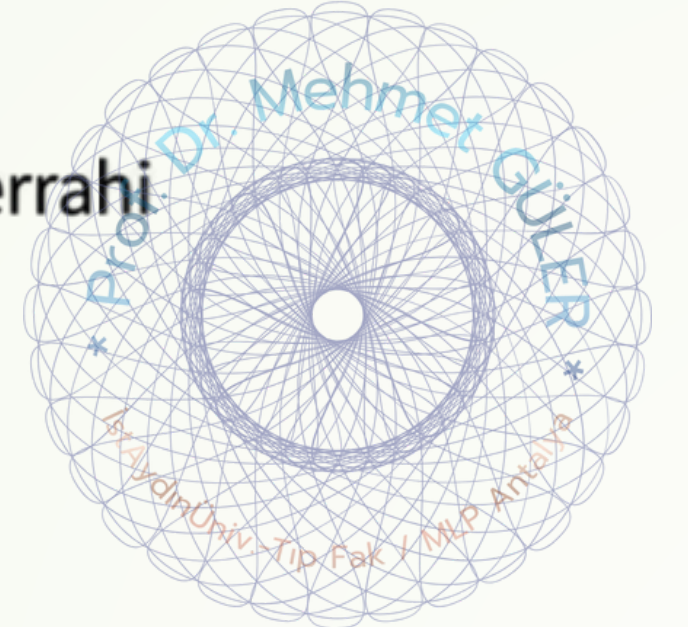
2. Epidemiyoloji değişiyor: Batı ülkelerinde **Adenokarsinom** artık daha siktir. GÖRH, Barrett ve Obezite gibi risk faktörlerini sorgulamak kritiktir.

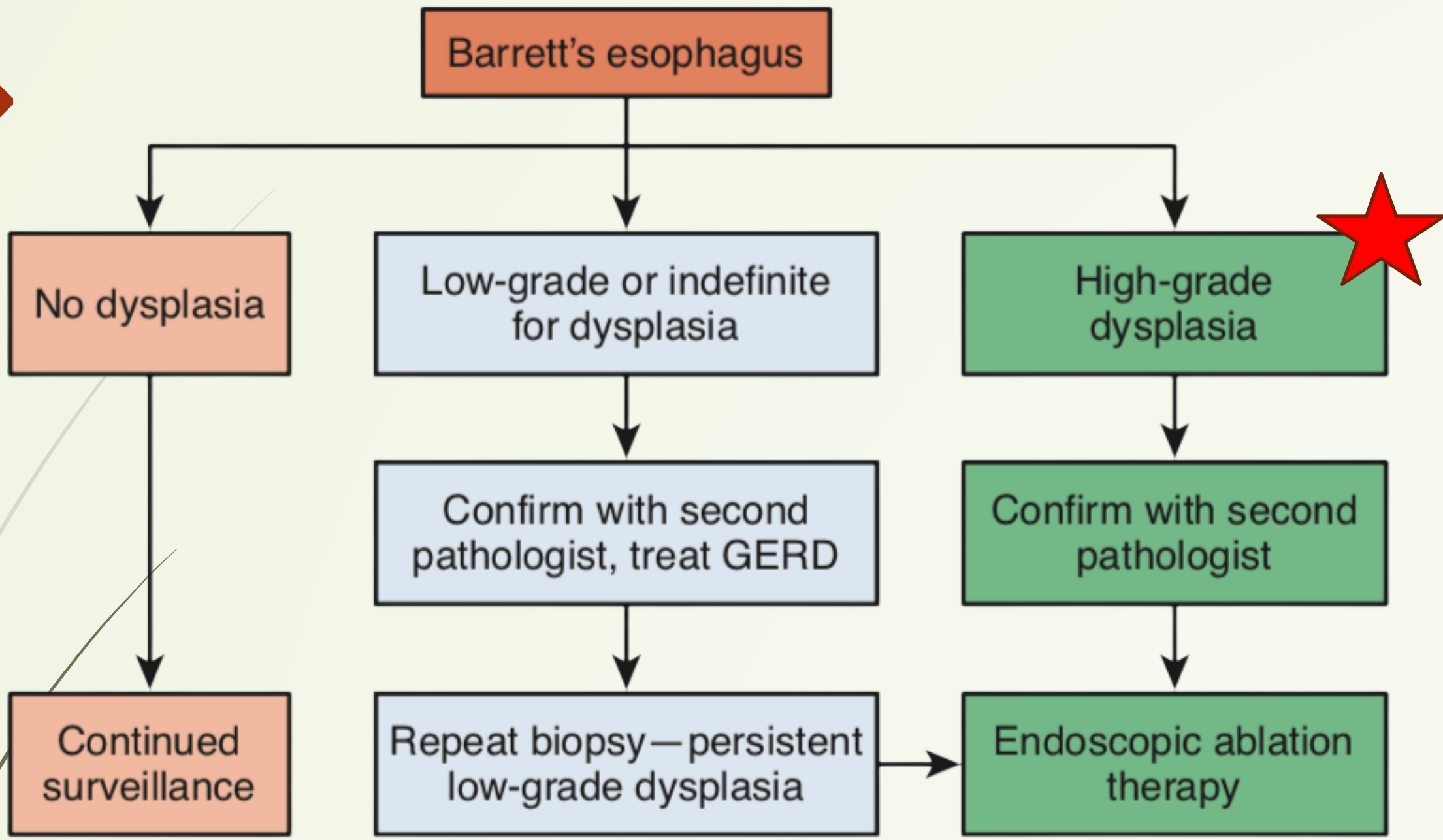


3. Tedavi **evreye özeldir** ve mutlaka **multidisipliner** bir ekip (Genel Cerrahi, Medikal Onkoloji, Radyasyon Onkolojisi, Gastroenteroloji) tarafından yönetilmelidir.



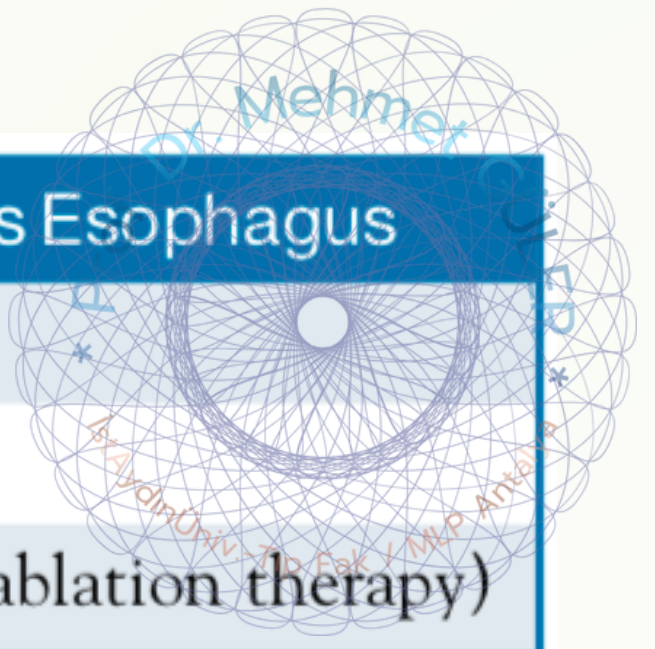
4. Lokal ileri hastalıkta (hastaların çoğunluğu) güncel standart tedavi, **neoadjuvan tedavi sonrası cerrahidir.** Tek başına cerrahi bu grup için yetersizdir.

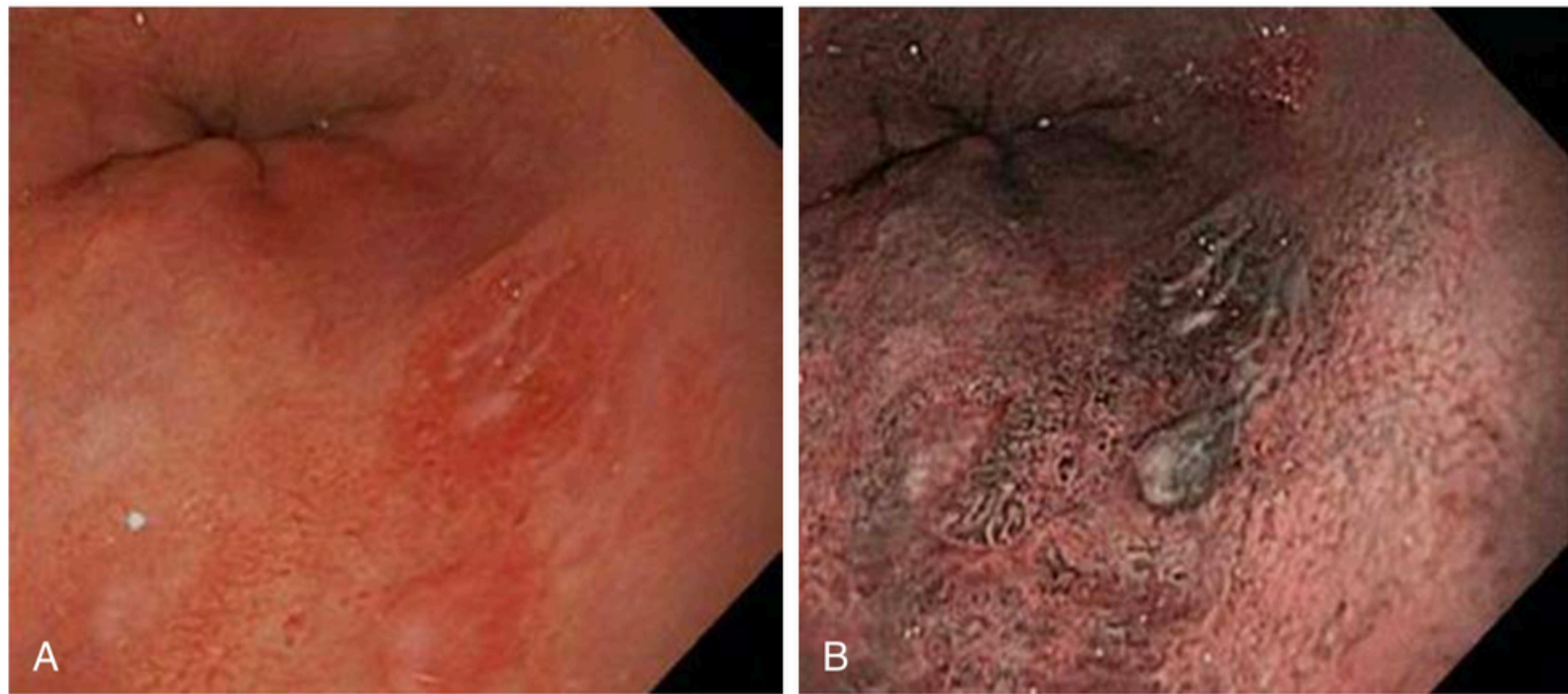




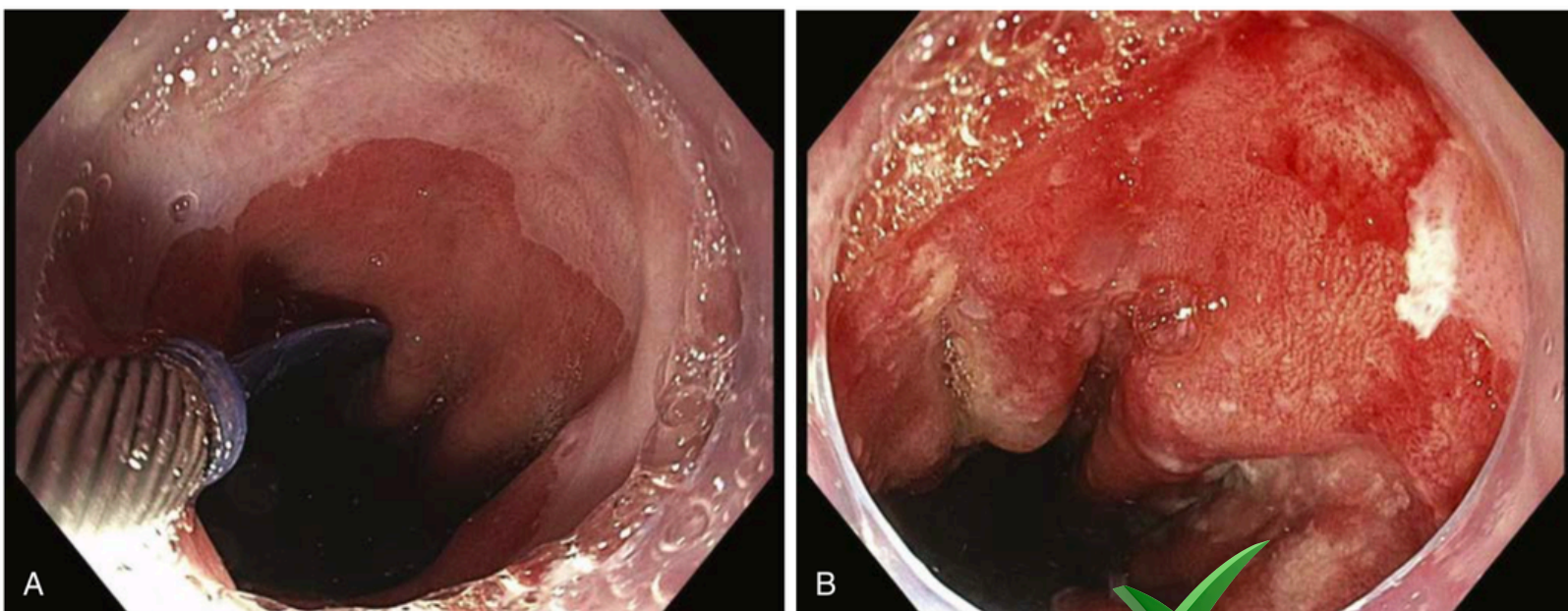
**Table 7-1. Recommended Surveillance Intervals for Barrett's Esophagus**

No dysplasia	3-5 years
Low-grade dysplasia	6-12 months
High-grade dysplasia	3 months (in the absence of ablation therapy)

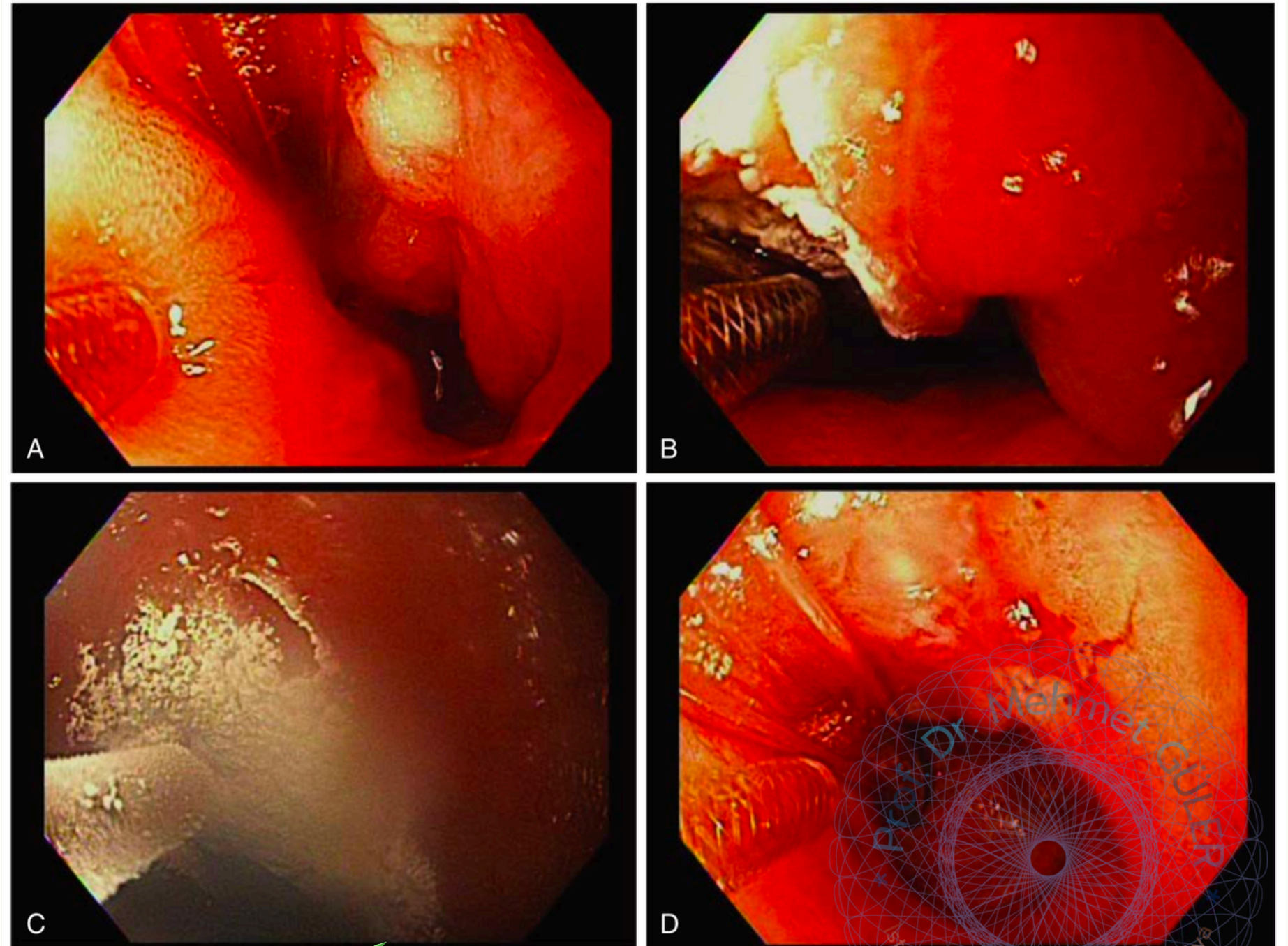




**FIG. 42.33** Traditional, white light view of Barrett esophagus with high-grade dysplasia (A) and narrow-band imaging of the same area (B).



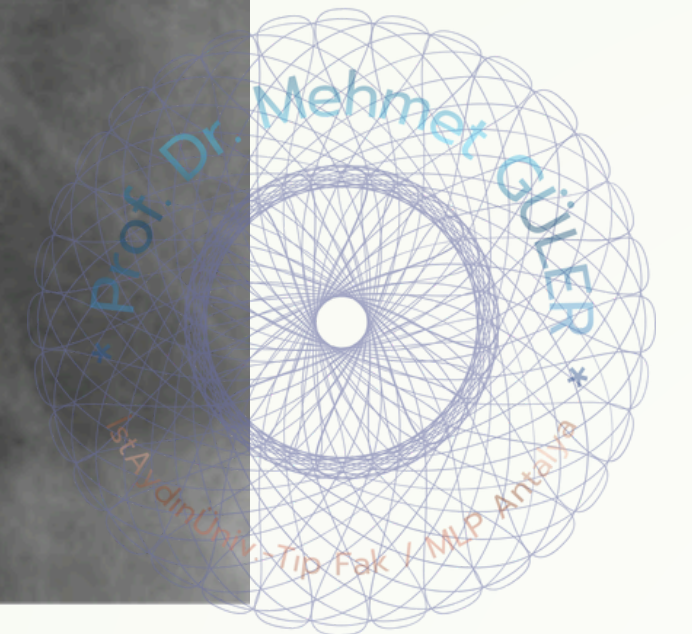
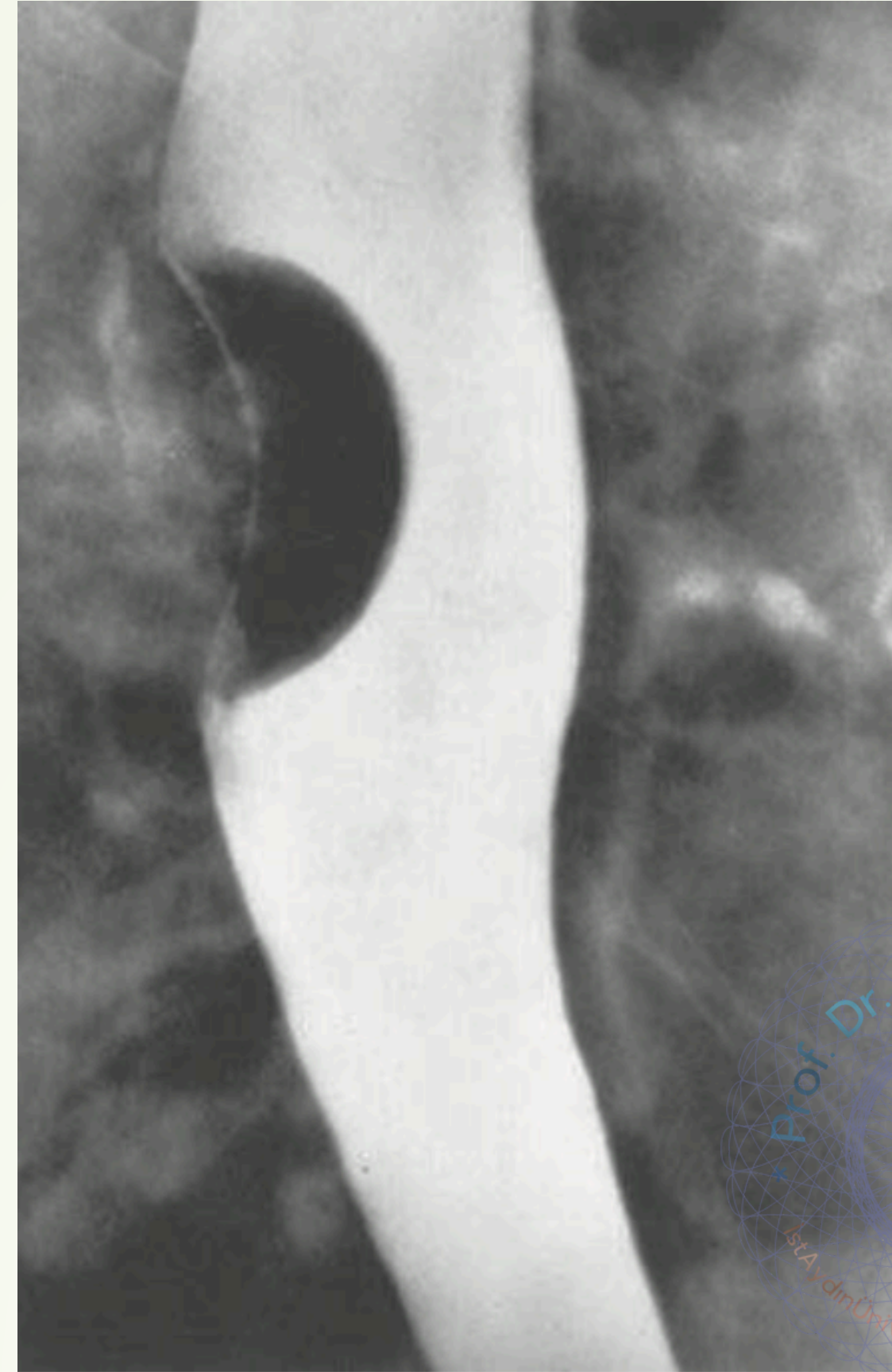
**FIG. 42.34** Radiofrequency ablation performed in a patient with Barrett esophagus. (A) Ablation with catheter seen adjacent to area of metaplastic disease. (B) Posttreatment after radiofrequency ablation. (From Rajaram R, Hofstetter WL. Mucosal ablation techniques for Barrett's esophagus and early esophageal cancer. *Thorac Surg Clin.* 2018;28:473–480.)



**FIG. 42.35** Liquid nitrogen spray cryotherapy performed in a patient with Barrett esophagus and dysplasia. (A) Dysplastic segment in background of Barrett esophagus seen anteriorly. (B) and (C) Targeted delivery of liquid nitrogen spray cryotherapy. (D) Posttreatment after liquid nitrogen spray cryotherapy. (From Rajaram R, Hofstetter WL: Mucosal ablation techniques for Barrett's esophagus and early esophageal cancer. *Thorac Surg Clin.* 2018;28:473–480.)

## LEIOMYOMA

- En sık görülen Benign tm
- Ortalama Yaş 38
- Erkek x2
- %90'ı Distal 2/3'te
- Düzgün konturlu
- Genellikle tek
- Yavaş büyüyen tm
- Biyopsi - Önerilmez
- Tedavi – Torakotomi Enükleasyon



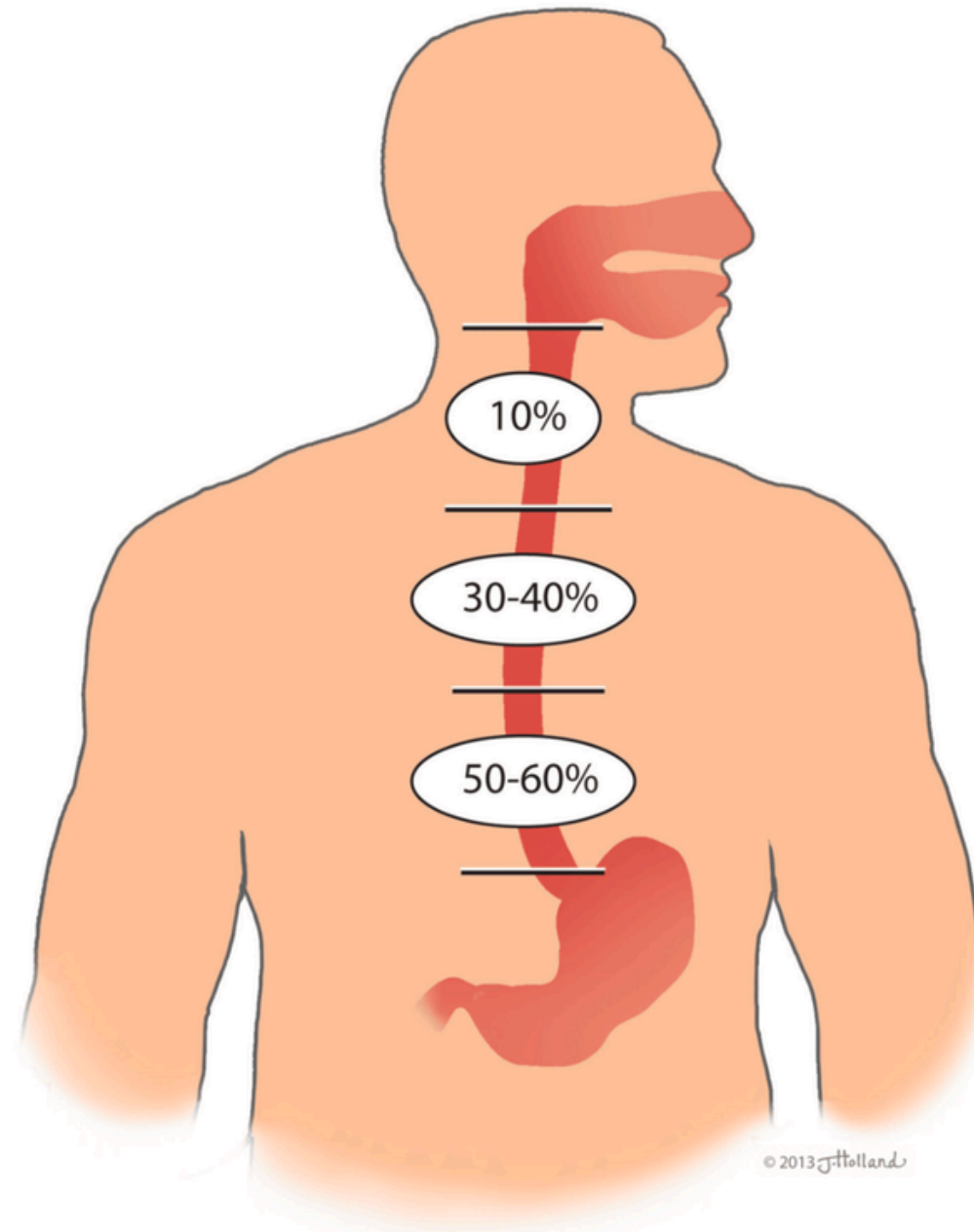


Figure 2: Distribution of esophageal leiomyomas based on anatomical location.

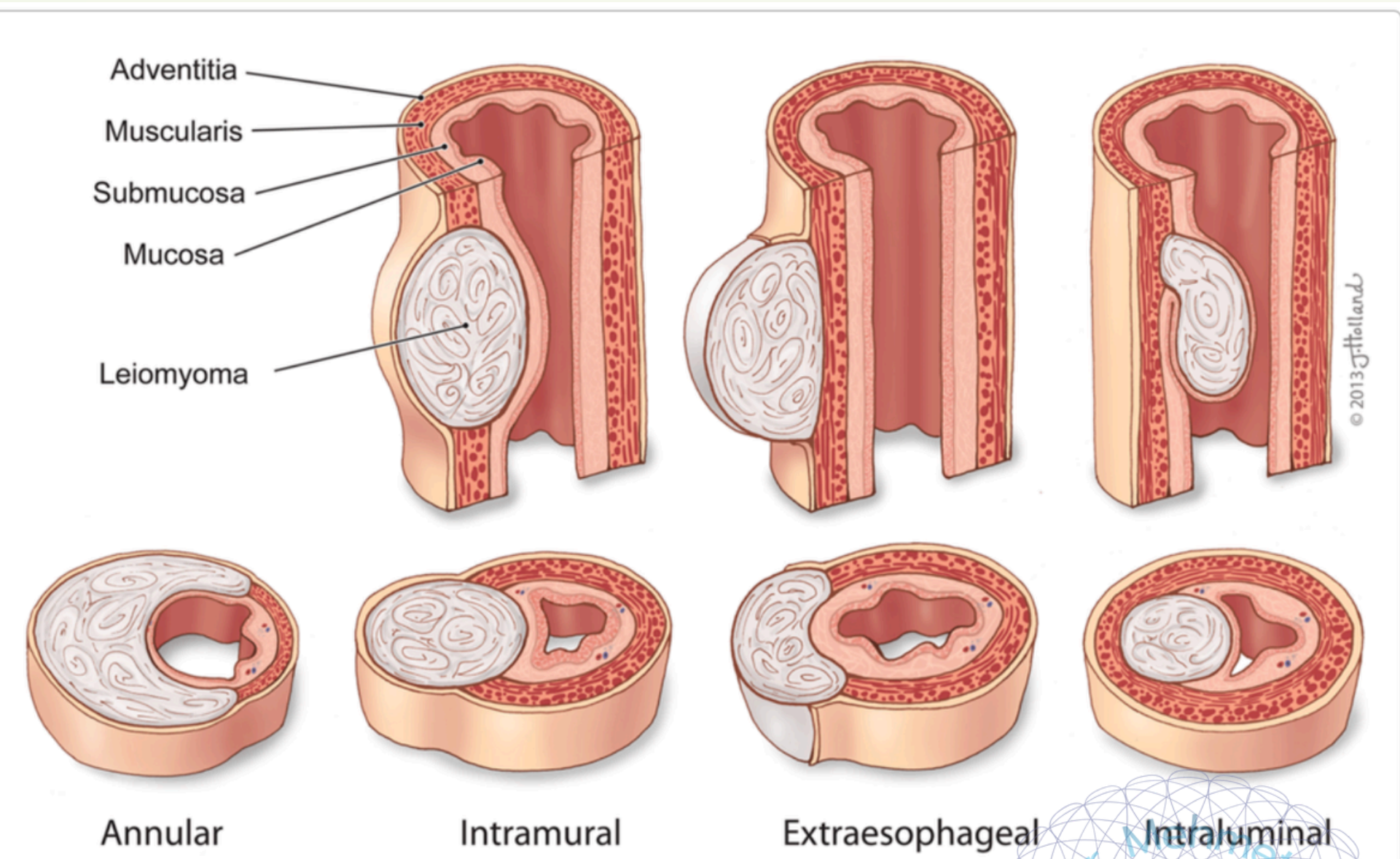
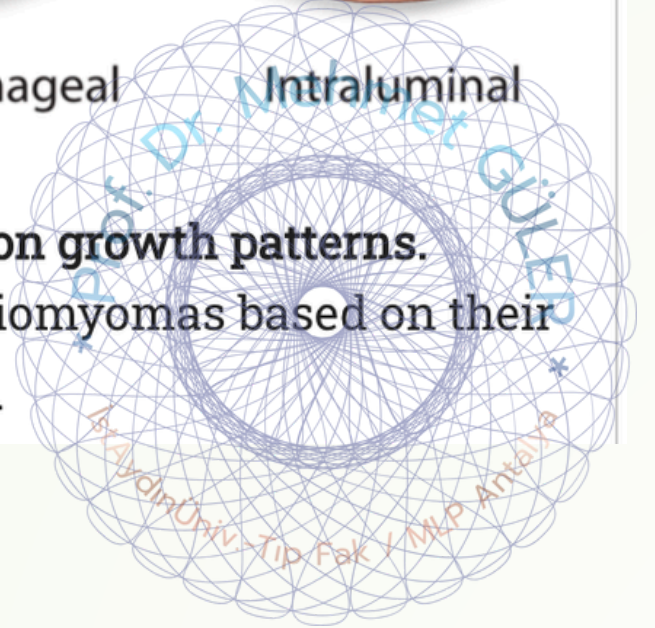
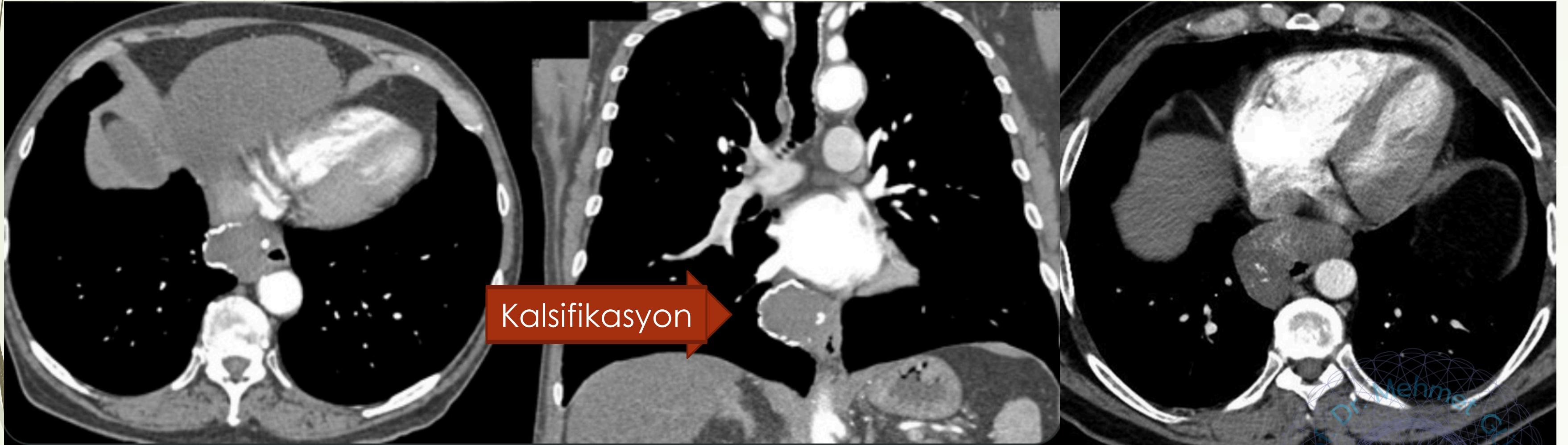
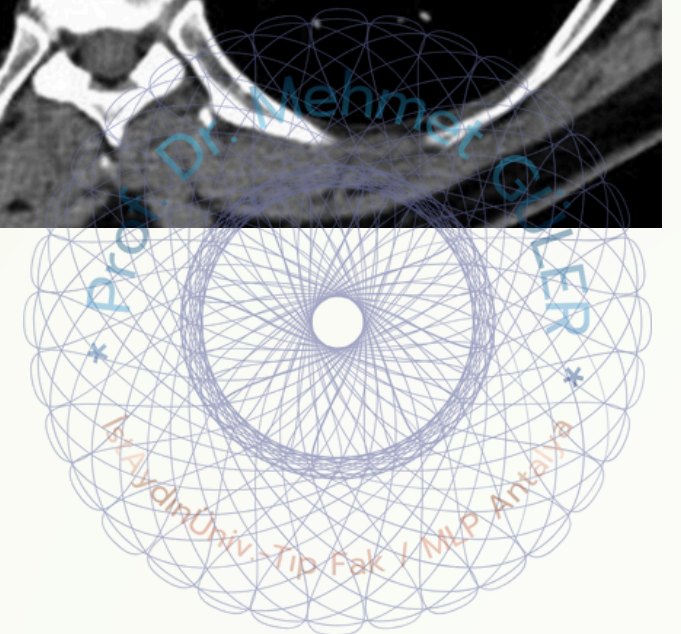


Figure 1: Classification of esophageal leiomyomas based on growth patterns. A diagram illustrating the classification of esophageal leiomyomas based on their growth patterns (intraluminal, extraluminal, and mixed).





Kalsifikasyon



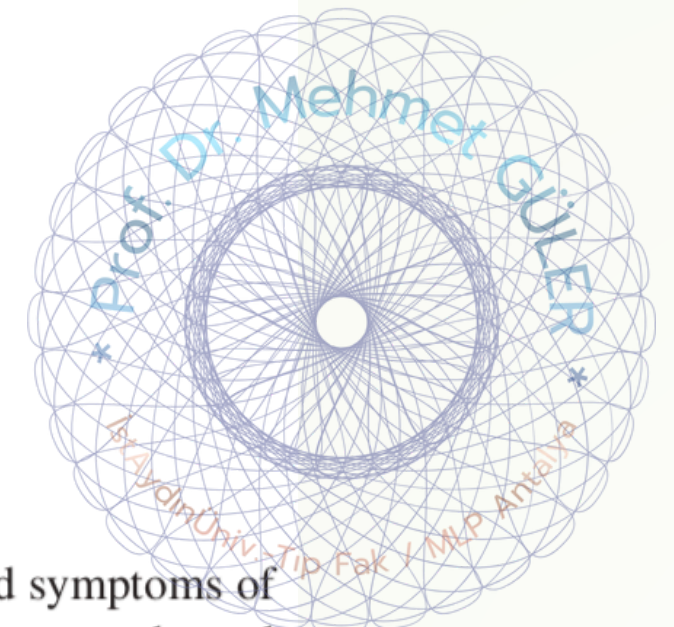


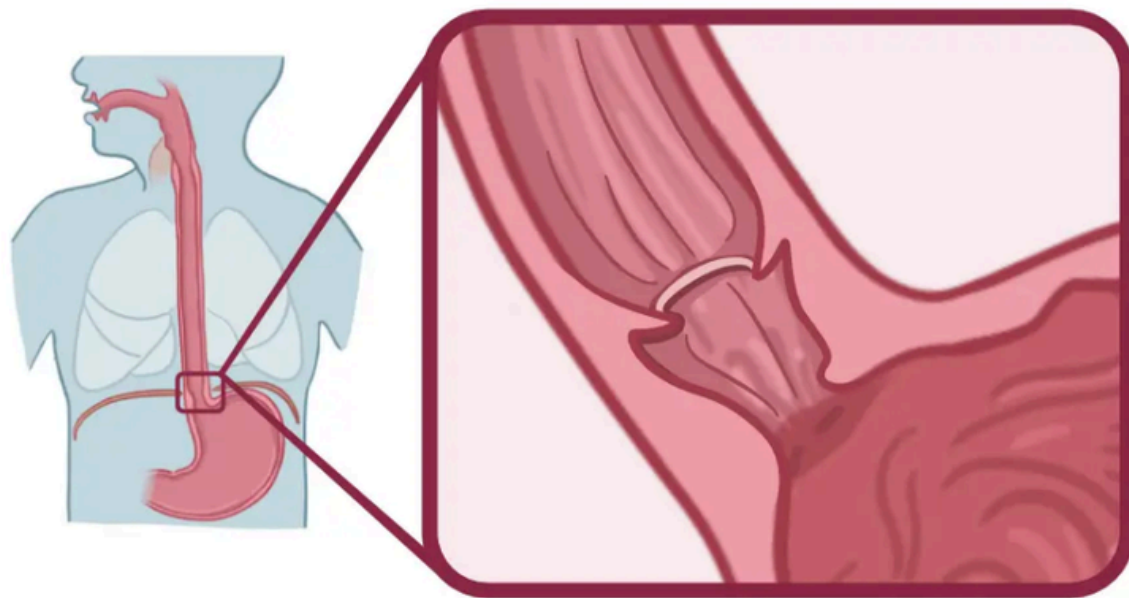
A



B

**Figure 25-71.** A. Computed tomographic scan of a leiomyosarcoma (*black arrow*) that caused compression of the heart and symptoms of syncope. B. Surgical specimen of leiomyosarcoma shown in A with a pedunculated luminal lesion (*white arrow*) and a large extraesophageal component (*black arrow*). There was no evidence of lymph node metastasis at the time of operation.



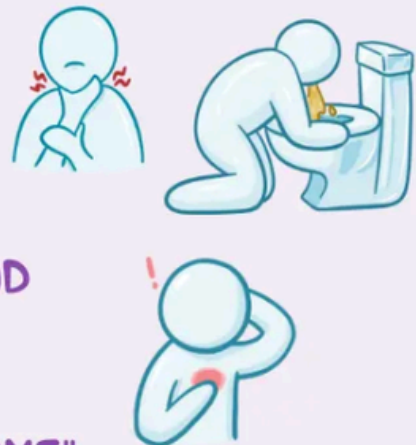


## BACKGROUND

- \* THIN, CIRCULAR MEMBRANE of TISSUE that FORMS in LOWER ESOPHAGUS
- \* CAUSES NARROWING of CANAL of ESOPHAGUS
- \* **MOST COMMON CAUSE** of EPISODIC SOLID FOOD DYSPHAGIA & FOOD IMPACTION in ADULTS

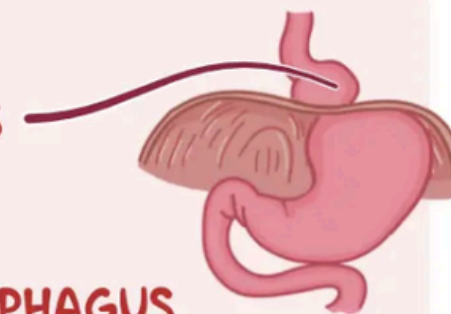
## SYMPTOMS

- \* **> 25mm DIAMETER** → ASYMPTOMATIC
- \* **< 13mm DIAMETER**
  - ~ DYSPHAGIA
  - ~ HEARTBURN
  - ~ REGURGITATION of FOOD
  - ~ FOOD IMPACTION → ODYNOPHAGIA
  - ~ "STEAKHOUSE SYNDROME" → SEVERE CHEST PAIN



## CAUSES

- \* **NONHEREDITARY**
  - ↳ BUT UNDERLYING CAUSES CAN BE
- \* HIATAL HERNIAS
- \* ACID REFLUX
- \* BARRETT'S ESOPHAGUS



## TREATMENT

- \* TARGETED at ↑↑↑ DIAMETER of RING to ALLOW FOOD PASSAGE & REDUCE SYMPTOMS
  - ~ BALLOON DILATION
- \* PROTON PUMP INHIBITORS
  - ↳ ↓↓↓ SYMPTOMS



