No human malignancy has a more ominous presentation than cancer of the esophagus, as almost all patients cannot swallow. When dysphagia leads to a diagnosis of esophageal cancer, most patients are rightly frightened for their lives. Even with modern surgical techniques, long-term survival after esophagectomy is relatively rare, a fact that has led some investigators to conclude that operations for esophageal cancer are palliative by definition.

Now comes an epidemic of new cases of adenocarcinoma in patients with Barrett’s esophagus. The incidence of Barrett’s esophagus itself is burgeoning, and there has been a concomitant rapid increase in incidence of adenocarcinoma of the esophagus in patients with Barrett’s epithelium. This phenomenon is most striking for white men in the United States.

The most commonly held theories about the pathogenesis of Barrett’s esophagus involve some sort of putative duodenogastric reflux, followed by erosion of the normal esophageal squamous epithelium and subsequent replacement with a metaplastic columnar epithelium. In many patients, the abnormal epithelium becomes dysplastic and then malignant.

There is much we do not understand about Barrett’s dysplasia and carcinoma, however. Why do many patients with reflux disease not demonstrate the characteristic changes of Barrett’s epithelium? Why do some patients with Barrett’s progress to dysplasia and carcinoma, while others do not? If all cases of Barrett’s are thought to come from reflux disease, why do we see adenocarcinoma of the distal esophagus, along with Barrett’s, in patients who have never had reflux symptoms? What explains the cases of adenocarcinoma with Barrett’s seen in very young patients who have no history of reflux symptoms? Why do most patients with cancer in the setting of Barrett’s epithelium have a history of drinking and smoking? Finally, how is it that patients without reflux history can have Barrett’s changes from the distal esophagus right up to the base of the tongue? These are just some of the fascinating biological puzzles that challenge those interested in disorders of the esophagus.

Once a cancer has been diagnosed, pretreatment staging is important for prognosis and for making decisions about the kinds of therapy to be used. H. Worth Boyce, MD, FACP, MACG, has one of the largest experiences in the world with endoscopic ultrasound, and he describes his findings in this issue. Surgeons are well advised to pay close attention to the stage and location of disease as determined by endoscopy, endoscopic ultrasound, and computed tomography because the feasibility of operation can be accurately predicted.

Patients and surgeons have a number of surgical options to consider when planning an esophageal resection. Steven Teng, MD, describes the commonly employed procedures and their respective advantages and results.

The most excitement in the esophageal cancer field has been generated by teams that have found improved survival with the use of neoadjuvant combination therapy. Despite initial optimism about some of these reports, careful reading of published series leaves one without a definitive conclusion about the efficacy of neoadjuvant combination therapy. The studies described in this issue by Robert J. Green, MD, and Daniel G. Haller, MD, provide a good perspective to the debate about these types of approaches to esophageal cancer.

Obvious as it may seem, nutritional assessment and support are vitally important to patients undergoing big operations or big operations with multimodal therapy for esophageal cancer. However, nutritional assessment and support are often overlooked in the excitement about treatment. Any experienced clinician who treats patients with esophageal cancer knows the fallacy of making nutritional assumptions in this group. Almost all patients have lost significant amounts of weight by the time they present for definitive therapy, and many are significantly malnourished.

Another important consideration in patients undergoing treatment for esophageal cancer is the presence of comorbid conditions. Most patients, regardless of type of esophageal cancer, have a history of alcohol intake and tobacco abuse. Often, concomitant liver and lung disease are important considerations in the management of these patients, which may preclude aggressive therapy.

Finally, what can be done for the patient for whom no curative therapy is possible? Dr Boyce’s description of the palliative treatment of malignant dysphagia distills a long and thoughtful career in the management of these problems. Significant palliation can be achieved with peroral dilation, thermal laser, photodynamic laser, chemical ablation, and the placement of stents. Patients often will require more than one type of palliative method. Given the fact that most patients are not cured of esophageal cancer, these palliative methods are often the most important contributions to their care.

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