A Hard Pill to Swallow

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There is little doubt that esophagectomy, even as we exit the second decade of the 21st century, remains a challenging and morbid intervention for patients stricken with esophageal cancer. Moreover, given the increase in the frequency of the disease, no effective screening program, and lack of efficacious nonoperative treatments for locally advanced disease, esophagectomy will remain a mainstay in the armamentarium of treatment for the foreseeable future. This submission by Dr Geller et al[1] tries to give us all a sense of how any complication of this procedure can impact not simply a patient's recovery, but from a more global healthcare delivery standpoint, the cost of that patient's care.

Now, this is a difficult study to conduct, especially given the 15+ years of longitudinal data accrual. It should be appreciated that over this time, patient selection, radiographic imaging, and surgical techniques have dramatically changed (not to mention we're on our third president and 6 new Supreme Court justices have been confirmed). So what has changed since 2002 in regard to esophageal cancer care? We now very seldom perform esophagectomy for superficial cancers, essentially all cancers are staged with PET scans, and many patients are now offered less invasive surgical approaches for their esophagectomy. Also, ICU care has likely improved, and use of esophageal stents for leak or stenosis has emerged as a GOLD standard. Consequently, trying to compare patients treated at the beginning of this "revolution of care" to those managed now is, to some degree, impossibly confounded by time. However, if we can look past this issue, there are some important lessons we can abstract.

Nothing is cheap. But some things can get really costly, very quickly. For esophagectomy, it is not surprising that anastomotic leak is devastating for patient and health care system alike, and unfortunately, likely becomes the unwelcome gift that keeps on taking, as dealing with late stricture can extend well beyond the 90-day time frame of this study. Postoperative renal failure, respiratory failure, and transfusion requirement also make this "naughty list." I would suspect that ANY postoperative complication that increases length of stay would be detrimental to a cost containment strategy, and these authors clearly demonstrate this point.

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Central Message

A complication following esophagectomy is a hard pill to swallow. Making this operation safer and thriftier should be a priority.

So what do we do with this information? All surgeons try to avoid any complication already, don't we? Is there really something we can modify to reduce complications? Is it a patient selection issue? Should we be assessing preoperative frailty more thoroughly and picking treatments more judiciously on something more than just an eyeball test? Should we change our techniques to reduce the risk? The authors propose a fairly weak argument to suggest that minimally invasive esophagectomy might be a way to reduce complications, but there are other data suggesting that the contrary might be true . . . so who really knows? What is clear is that a complication following esophagectomy is a hard pill to swallow, and making this operation safer for our patients, and thriftier for our health care systems, should be a priority.

REFERENCE

1. Geller A, Zheng H, Gaissert H, et al: Relative incremental cost of postoperative complications of esophagectomy. Semin Thorac Cardiovasc Surg 31:290–299, 2019

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Funding: The study was funded in part by the Daniel and Karen Lee Endowed Chair in Thoracic Surgery, held by Dr Murthy.

Disclosures: Dr Murthy has no relationship with industry to report.

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DOI of original article: http://dx.doi.org/10.1053/j.semtcvs.2018.10.010.

1043-0679/$–see front matter © 2019 Published by Elsevier Inc.
https://doi.org/10.1053/j.semtcvs.2019.03.005