differences in the surgical results and early operative complications according to the patients' position.

Methods. A total of 20 patients underwent thoracoscopic esophagectomy. The group L included 12 patients consisted of 8 male and 4 females with median age of 72 between 2015 and 2017. The group P included 8 patients consisted of 5 male and 3 females with median age of 70 between 2017 and 2020. The surgical results and postoperative complications were compared between the two groups.

Results. The operative time was 504 minutes in the group L, 614 minutes in the group P ($p = 0.043$), and the blood loss was 55 mL in the group L and 65 mL in the group P ($p = 0.615$). Recurrent laryngeal nerve palsy was observed in 2 cases in the group L and none in the group P. And, the pneumonia was observed in 1 case of the group L. In our hospital, the operative time was longer in the prone position than in the left lateral position, but the complication tended to be little.

Conclusion. Although sample number was small in our study, the prone position might have some advantages because no pneumonia and recurrent laryngeal nerve palsy occurred in the group P. Furthermore, we experienced better ergonomics in the prone position because movement of the forceps was easier in the prone position.

255 OUTCOME OF ADDITIONAL ESOPHAGECTOMY AFTER NON-CURATIVE ENDOSCOPIC SUBMUCOSAL DISSECTION FOR C-MM-SM1ESOPHAGEAL CANCER.

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For patients diagnosed cT1(MM-SM1)N0 esophageal cancer, we perform endoscopic submucosal dissection (ESD) as a primary treatment. Furthermore, additional treatments were performed for the patients diagnosed pT1b(SM) in resected tumor by ESD. Our aim of this study is to investigate whether additional esophagectomy after non-curative ESD can be considered a valid treatment.

Methods. Forty-four patients who received esophagectomy with lymph node (LN) dissection in neck, mediastinum and upper abdomen as additional surgery after non-curative ESD between 2006 and 2019 were enrolled. Histological examination revealed that squamous cell carcinoma in 41 and adenocarcinoma in 3 patients. We examined the rate of pathological LN metastasis and outcomes of patients received esophagectomy.

Results. The cT was LPM in 9(20%), MM-SM1 in 35 (80%) patients. However, the pT was MM in 3(7%), SM1 in 14 (32%) and SM2 in 27 (61%) patients. Lymphatic invasion was positive in 32 (73%) and venous invasion was positive in 16(36%) patients. Seven patients had pathological metastatic LN (1–2 LNs/case) (total 10 metastatic LNs). The metastatic LNs existed in neck, mediastinum and upper abdomen. The recurrences were occurred in 2 patients (No.106recL LN and No. 112ao-A LN). One patient died by esophageal cancer (LN recurrence, 38 months alive). One patient died of gastric tube ulcer perforation (16 months).

Conclusion. We showed that esophagectomy with extended LN dissection is sufficient as additional treatment for the patients treated non-curative ESD. To expand the indications of ESD for pSM esophageal cancer, new methods are needed, such as the risk diagnosis of LN metastasis using genetic analysis.

256 DRAINAGE OF ANASTOMOTIC LEAKAGE AFTER ESOPHAGECTOMY: THROUGH THE FISTULA OR NOT, WHICH IS BETTER?

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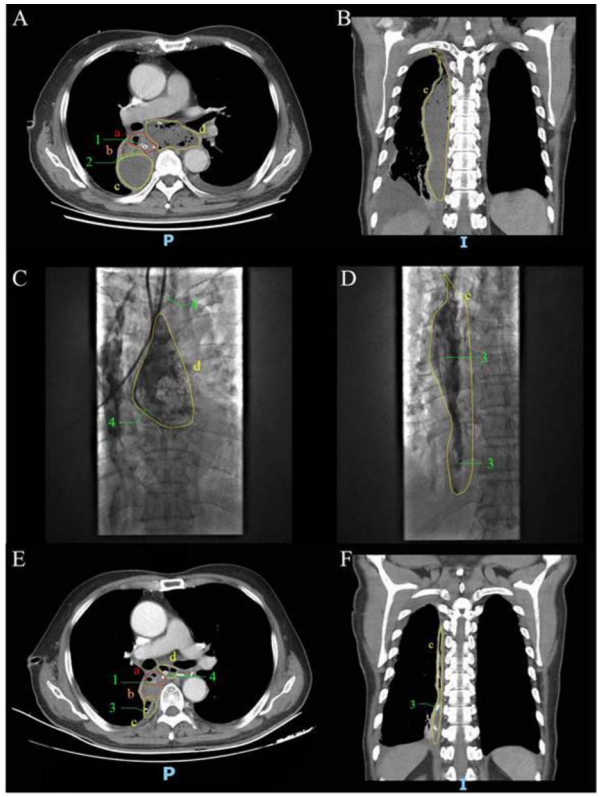
Thoracic abscess and/or mediastinal abscess due to anastomotic leakage after esophagectomy are very serious postoperative complications, and adequate surgical drainage is of critical importance to treatment. In this study, we compared the treatment efficacies of two drainage methods (through-the-fistula or not-through-the-fistula).



Methods. We retrospectively collected the esophageal cancer patients who underwent surgery from Jan 2016 to Aug 2019 who had complications of anastomotic leakage which was above grade III according to Lerut grading system. The drainage methods of thoracic/mediastinal abscess were drainage tube through-the-fistula (TF) (with the aid of X-ray or endoscope) and not-through-the-fistula (nTF) (via thorax or neck). According to the time from drainage tube placed to stable of the fistula, the patients were divided into fast stable group (<14 days) and slow stable group (≥14 days), and the differences of clinical characteristics and drainage methods were compared.

Results. Among the 495 cases underwent surgery, 43 (8.7%) had anastomotic leakage, 20 (4.0%) of which were grade III. 8 obtained fast stable and 12 were slow stable. As to drainage efficacy, there were 87.5% and 16.7% of the cases adopted TF drainage in fast stable group and slow stable group, respectively ($P = 0.002$). As to safety, there were 1 case in TF group that needed repeated drainage, whereas in nTF group, there were 2 cases died of bleeding and 2 cases needed repeated drainage ($P = 0.319$). Furthermore, there were 2 residual cavity cases after recovery in the nTF group.

Conclusion. TF drainage is safe and reliable for the thoracic/mediastinal abscess caused by anastomotic leakage after esophagectomy, which was better compared to nTF drainage, and facilitated recovery of the anastomosis.

257 CHEMORADIOTHERAPY FOLLOWED BY ACTIVE SURVEILLANCE VERSUS SURGERY FOR ESOPHAGEAL CANCER: A SYSTEMATIC REVIEW AND INDIVIDUAL PATIENT DATA META-ANALYSIS

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