131 PRACTICES IN PERIOPERATIVE NUTRITION PRECEDING OR FOLLOWING OESOPHAGECTOMY: RESULTS OF A EUROPEAN SURVEY

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The route and type of peri-operative feeding after oesophagectomy varies widely across centres, usually based on local experiences and standing orders. The aim of this survey on perioperative nutrition after oesophagectomy (PONOS) was to create a snapshot the way perioperative nutrition preceding or following oesophagectomy is established across reference centres in Europe, and what the reasons are for preferring one method over another.

Methods: A survey consisting of four parts was distributed to the membership of 3 European, mainly surgical oriented scientific societies between October 2019 and January 2020. The first part contained some general questions regarding demographics of the participants and type of performed surgery. In the second section, centres were asked about practices in preoperative nutrition. The third section questioned participants about their practices in postoperative nutrition; in the last part the daily practice was reflected against the current available ESPEN guidelines.

Results: Fifty-one surgeons from 49 centres in 16 countries participated. The majority had a structured nutrition team in their institution. An Enhanced Recovery Pathway was implemented in 2/3 of centres. ESPEN guidelines were followed in 50% of centers. Routine preoperative nutritional assessment was performed in 84%. Preoperative nutritional support consisted mainly of enteral and oral support; immediate postoperatively mostly a combination of oral and enteral or enteral only; at discharge mostly a combination of oral and enteral or only oral nutritional supplementation were used. Timing, definition and means of postoperative oral intake also seemed to differ widely across centres.

Conclusion: The PONOS survey confirmed our assumption that perioperative feeding after oesophagectomy exists in a wide variety across European centres performing oesophageal resections for cancer. Survey based feedback to the surgical community draws attention to this often underexposed part of the surgical pathway of a patient. As such, this might further enhance the exchange of experiences in order to try to harmonise peri-operative feeding regimen.

142 A RANDOMIZED TRIAL: THREE-FILED LYMPHADENECTOMY COMPARED WITH TWO-FIELD LYMPHADENECTOMY FOR MIDDLE AND LOWER THORACIC ESOPHAGEAL CANCER

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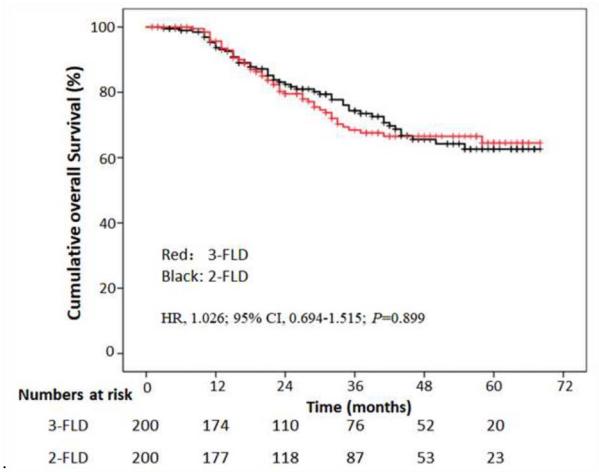
Esophagectomy combined with radical lymphadenectomy is widely accepted, but the role of three-field lymphadenectomy (3-FLD) remains unclear.

Methods: We performed an open-label, randomized, controlled trial involving patients with resectable cancer of the middle or lower third of the esophagus. Patients were randomly assigned to undergo esophagectomy with either 3-FLD (cervical-thoracic-abdominal lymphadenectomy) or two-field lymphadenectomy (thoracic-abdominal lymphadenectomy, 2-FLD) at a 1:1 ratio. The primary endpoint was overall survival (OS). Analysis were done according to the intent-to-treat principle.

Results: Postoperative complications were similar in the two arms. More lymph nodes were resected in 3-field arm (Median, 37 vs. 24 [2-FLD], $P < 0.001$), 43 (21.5%) patients had cervical LNM. More pN3 patients were identified in the 3-FLD arm (10.5%, 21/200 vs. 5.0%, 10/200 [2-FLD], $P = 0.040$). The cumulative probability of disease-free survival (DFS) was comparable between the two arms (HR, 1.021, 95%CI, 0.735–1.417, $P = 0.903$), as well as the OS (HR, 1.026, 95%CI, 0.694–1.515, $P = 0.899$). The cumulative 5-year DFS was 52% in the 3-FLD arm, as compared with 53% in the 2-FLD arm; 5-year OS rates were 64% and 62%.

Conclusion: Three-field lymphadenectomy offered more accurate nodal staging without increasing the surgical complications. Comparing with radical 2-FLD, there was no improvement in OS or DFS after 3-FLD for patients with middle and lower thoracic esophageal cancer.



145 ADVANTAGES OF MINIMALLY INVASIVE TRANSMEDIASTINAL ESOPHAGECTOMY IN ELDERLY PATIENTS WITH ESOPHAGEAL CANCER

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Esophagectomy for esophageal cancer (EC) is one of the most invasive surgical procedures and, especially for elderly patients, postoperative respiratory complication (PRC) is still frequent and life-threatening. We started esophagectomy by a laparoscopic transhiatal approach in 2009, and single-port mediastinoscopic cervical approach in 2014. Nowadays, we have performed total mediastinal lymph node dissection without thoracic approach. The purpose of this study was to evaluate transmediastinal esophagectomy (TME) for the prevention of PRC in elderly patients.

Methods:

1) Patients with EC performed TME (n = 238) were compared with those performed the right thoracotomy (n = 185).
2) Outcomes of TME for elderly patients (75 years and older, n = 48) was evaluated by comparing with non-elderly patients (n = 190).
3) Elderly patients performed subtotal esophagectomy were divided into 2 groups according to the presence (n = 12) or absence (n = 51) of PRC. The two groups were compared about clinicopathological factors, and risk factors of PRC were analyzed.

Results:

1) Percentage of elderly patients was higher in TME group (20.2% vs 8.1%). The operative time and bleeding were decreased by TME. The number of resected LNs and pR0 rate were not different between two groups. In TME groups, the occurrence of PRC was significantly reduced (10.1% vs 28.1%).
2) 81.3% of elderly patients were able to extubation on 0POD, and there was no significant difference in PRC between two groups.
3) Univariate analysis showed that surgical approach was significantly different between two groups. Multivariate analysis showed that thoracotomy was the strongest risk factor of PRC for elderly patients.

Conclusion: This study showed that our surgical procedure was less invasive during operation and resulted in a safe en-bloc mediastinal lymph node dissection. For elderly patients, TME was the effective minimally invasive approach and was able to reduce the occurrence of PRC.

149 DIFFERENCES IN TRANSABDOMINAL ULTRASONOGRAPHIC PARAMETERS AMONG PATIENTS COMPLAINING OF ESOPHAGEAL DYSPHAGIA

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Dysphagia is a symptom suggestive of severe underlying pathology, although its causes include organic and non-organic disorders. A balance must be struck between the potential complications of any invasive investigation and its diagnostic utility, especially for elderly patients with dysphagia. The aim