leakage (13.6% vs. 13.6%) and hospital stay (36.3 days vs 27.5 days) were no differences in both groups.

Conclusion: TEP can be feasible and safe for the patients with obstructive ventilation disorder and low respiratory function.

444 CORRELATION BETWEEN PATHOLOGIC COMPLETE RESPONSE TO NEOADJUVANT THERAPY AND RECURRENCE IN PATIENTS WITH ESOPHAGEAL CANCER

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Multimodal treatment options in carcinoma esophagus include neoadjuvant chemoradiotherapy or chemotherapy followed by surgery. The degree of pathologic response to different neoadjuvant options and its impact on the oncologic outcome is a matter of debate.
With this background we carried out this study to analyze the rate of pathologic complete re-sponse (pCR) and its effect on recurrence in patients with carcinoma esophagus treated with various combinations of neoadjuvant chemotherapy/radiotherapy and surgery.

Methods: The records of all patients with carcinoma esophagus registered in our clinics between June 2012 and December 2014 were retrieved from a prospectively maintained database and were analyzed. of the 70 patients with histologically proven esophageal cancer who were treated with curative intent during this period, those with pCR (15) were followed up for a minimum of 5 years. These 15 patients are the subjects of this study.

Results: Forty eight (48) patients received neoadjuvant chemotherapy (NACT), 16 were treated with short course radiotherapy (SRT), and 3 patients received neoadjuvant chemoradiation (CRT). Four patients developed metastatic disease on neoadjuvant therapy.
66 patients (63 after neoadjuvant therapy and 3 upfront) underwent transtho-racic esophagect-omy. Pathological CR was seen 12 patients (25%) in NACT-surgery arm, 2 (12%) in SRT-surgery and 1 (33%) in CRT-surgery groups. Three patients had postoperative mortality due to pulmo-nary complications. At 5 yrs, 14 out of 15 patients with pathological CR are alive and disease free. One patient developed brain metastases after 3 years and died.

Conclusion: Neoadjuvant therapy followed by radical surgery is a safe and effective treatment option for the management of carcinoma esophagus. Pathologic CR strongly correlates with recurrence-free survival. The relative significance of pCR after different types of neoadjuvant therapies need to be tested in future studies.

450 FACTORS AFFECTING CIRCUMFERENTIAL RESECTION MARGIN AFTER ESOPHAGECTOMY AND ITS PROGNOSTIC SIGNIFICANCE-LARGE SINGLE CENTRE EXPERIENCE

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The evidence regarding the importance of circumferential resection margin (CRM) as a prognostic factor after esophagectomy is inconclusive in the era of neoadjuvant therapy. We retrospectively analysed our prospectively maintained database for factors that affect CRM positivity, and whether a positive CRM affects event free and overall survival. 2843 patients underwent esophagectomy with curative intent from October 2004 to 2019 at our centre. CRM was analysed as negative, close but technically free (<1 mm) and involved.

Methods: Data on the following variables was retrospectively extracted from prospective database. CRM status was noted for clinic-radiological T and N stage, level of growth, histology, differentiation grade and neoadjuvant treatment. Intra-operative details such as surgical procedure, approach, surgeon grade, lymphadenectomy and resection status were analysed. On final histopathology; proximal and distal margins, lymph node positivity, lymphovascular invasion(LVI), tumour regression grade(TRG) were analysed. The effect of CRM on development of recurrence and overall survival was evaluated. CRM data was available for 2439 (85.78%) patients. 71.2% of the patients received neoadjuvant chemotherapy. Factors were analysed separately for both close and positive margins.

Results: 75.8% had negative, 15.6% close and 8.6% positive CRM. Univariately, T stage, adenocarcinoma, poor differentiation, transhiatal approach, R+ resection, positive margins, TRG > 3, LVI and upfront surgery predicted positive CRM. On multivariate, negative CRM was seen in T1/T2 stage [OR 0.325, 95% CI-0.144-0.732, p = 0.007], squamous carcinoma [OR 0.574, 95% CI-0.351-0.958, p = 0.027], R0 resection [OR 0.228, 95% CI-0.086-0.599, p = 0.003] while positive CRM was seen in upfront surgery [OR 2.32, 95% CI-1.55-3.46, p < 0.001], positive nodes [OR 1.748, 95% CI-1.19-2.56, p = 0.004] and LVI [OR 2.73, 95% CI-1.87-3.98, p < 0.001]. Median event-free survival in CRM negative was 64 months compared to 14 months in CRM positive (p < 0.001).

Conclusion: Positive CRM involvement is a prognostic indicator in patients undergoing esophagectomy and associated with worse event-free and overall survival. CRM-positive disease in esophageal cancer may represent residual tumor, advanced disease, aggressive biology, or poor response to neoadjuvant treatment. All attempts should be made to achieve a clear circumferential resection margin. More evidence is needed to evaluate if adjuvant therapy is justified in these patients and the type of therapy also needs to be determined.

464 IS OPEN LEFT THORACO-ABDOMINAL ESOPHAGECTOMY A VIABLE OPTION IN THE ERA OF MINIMALLY INVASIVE ESOPHAGECTOMY?

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The aim of the study was to evaluate short-term and oncological outcomes of left thoracoabdominal esophagectomy (LTE) compared to minimally invasive esophagectomy for cancer of the esophagus and gastroesophageal junction.
LTE facilitates complete resection of esophageal cancer particularly for bulky tumors, but there are concerns that this approach is associated with significant morbidity.

Methods: Prospectively entered esophagectomy databases from two high volume North American centers were reviewed for patients undergoing LTE or MIE in the 2012–2018. Patient demographics, tumour characteristics, operative outcomes, postoperative outcomes, and pathologic surrogates of oncologic efficacy (R0 resection rate, and number of resected lymph nodes)