

## Gastroesophageal Cancers: Progress and Problems

Approximately 38,000 new patients will be diagnosed with gastroesophageal cancer in 2008.<sup>1</sup> Although this number may be trivial compared with more common cancers, the incidence of esophageal and gastroesophageal junction adenocarcinoma has been steadily climbing over the past 20 years ([www.cancer.org](http://www.cancer.org); accessed June 10, 2008). Although obesity, gastroesophageal reflux, and Barrett's metaplasia may contribute some or great extent to this alarming increase, some of the reasons for this increase remain elusive.<sup>2</sup> The global health burden imposed by gastroesophageal cancer parallels that imposed by lung cancer, with approximately 1.4 million new cases and 1.1 million deaths per year.<sup>3</sup> Furthermore, the mortality is likely to remain high because early detection of gastroesophageal cancer is not commonly practiced in most countries.

Nevertheless, we have witnessed some definite progress in staging and therapy of patients with gastroesophageal cancer. For localized gastroesophageal cancer, progress has been made with the implementation of multidisciplinary approaches that lead to better selection of therapy for a specific patient, formulation of long-term strategies, and emergence of new standards.<sup>4-6</sup> Multidisciplinary interactions can lead to new research strategies and improved understanding of the philosophies used by individual disciplines for treatment decisions.

Progress in the treatment of early gastroesophageal carcinomas using endoscopic therapies is also worth mentioning.<sup>7-10</sup> Endoscopic therapy of early cancer seems to be spreading in non-academic centers as well. In addition to these improvements, progress in imaging techniques can improve patient selection.

Despite these improvements, considerably more progress must be made. To reduce morbidity and mortality, gastroesophageal surgeries should be performed only by experienced surgeons working in high-volume centers. Further, advantages from combining cytotoxic chemotherapies with radiation therapy seem to have reached a plateau.<sup>11,12</sup> Adding biologic therapies to chemoradiation will hopefully provide additional advantages, but we must be smarter than just empirically adding another agent to the mix, because biologic agents seem to be more active in enriched populations.<sup>13-15</sup>

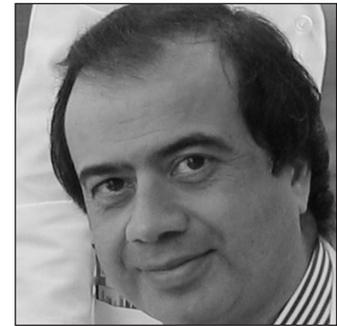
For advanced gastroesophageal cancers, our list of successes is short and our list of areas that lack progress (or "to do" items) is very long. Clearly, our focus in this patient population with incurable cancer should be on developing effective therapies that have favorable safety profiles and that preserve or improve that quality of life, prolong survival meaningfully, and enhance patient convenience.

Although, unfortunately, these goals are more easily stated than accomplished, I believe that we can meet every one of them by improving our global research infrastructure for high-quality trials that are well executed. The uneven distribution of research resources throughout the world adds length to this process. Oncology training is suboptimal in many countries.

In this issue of *JNCCN*, a group of experienced investigators summarize the most relevant issues in gastroesophageal cancer. These include modern imaging, minimally invasive surgical approaches, principles of radiation therapy, modern considerations for gastric cancer surgery in areas where gastric cancer is uncommon, and therapy for patients with advanced cancers. In addition, this issue includes the most recent updates of the esophageal cancer guidelines. (The most recent updates of the NCCN Clinical Practice Guidelines: Gastric Cancer are available online at [www.nccn.org](http://www.nccn.org).) I hope you find this issue of *JNCCN* educational and that it helps you to improve the care of your patients with gastroesophageal cancer.

### References

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Jaffer A. Ajani, MD, an internationally recognized expert on gastrointestinal cancers, is Professor of Gastrointestinal Medical Oncology at M. D. Anderson Cancer Center and the Chair of the NCCN Clinical Practice Guidelines in Oncology Gastroesophageal Cancers Panel. He has participated over the past 20 years in numerous trials using innovative combined modality therapies for localized gastric and esophageal cancers, and some of his work led to the development of strategies of pre-operative therapy for resectable upper gastrointestinal cancers. His current research focus is on developing programs to research the molecular markers for progression of Barrett's metaplasia to adenocarcinoma. These research efforts involve multi-institutional collaboration with investigators at the University of Chicago, University of Pennsylvania, Mayo Clinic, and Yonsei University, in Seoul, Korea.

In addition to his work with NCCN, Dr. Ajani participates actively in the International Society of Gastrointestinal Oncology is the editor of the Society's journal, *Gastrointestinal Oncology Research*.

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of the NCCN.

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