From April 2020 to March 2022, 35 patients with newly-diagnosed H&N cancer had routine screening endoscopy for synchronous esophageal cancer. All patients with H&N cancer were referred to our department prior to the treatment for H&N cancer.

The locations of H&N cancers were oral/oropharyngeal/hypopharyngeal/laryngeal/other H&N cancer; 9/6/9/9/2 respectively. Image-enhanced endoscopy using BLI (blue laser imaging) was performed in all patients. Lugol staining was used in 20 patients and multiple Lugol voiding lesions were detected in 9 patients. Among all patients, abnormal endoscopic findings in esophagus were detected in 15 patients (45%), and biopsy was performed in 11 patients (31%). Biopsy revealed SCC in 5 patients and atypical epithelium in 2 patients. Esophageal lesions were all found in early stage within indication of endoscopic treatment. 3 patients underwent endoscopic treatment after treatment of H&N cancer.

Routine endoscopic screening for patients with H&N cancer is effective in early detection of synchronous esophageal cancer with minimally invasive treatment for esophageal neoplasm. The treatment of chemotherapy for H&N cancer may be effective for esophageal lesions, therefore, careful surveillance is required during the treatment of H&N cancer. Routine endoscopy should be continued further for these patients for screening of metachronous cancer.

471. OUTCOMES OF RETROSTERNAL RECONSTRUCTION ROUTE FOR ESOPHAGECTOMY IN ESOPHAGEAL CANCER PATIENTS IN OUR HOSPITAL
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In cervical esophagogastric anastomosis after esophagectomy for esophageal cancer, the main reconstructive routes are retrosternal and posterior mediastinal. Since April 2019, the retrosternal route has been the standard procedure at our hospital. We report on the results of reconstruction by a retrosternal route at our hospital.

This study included 38 patients with esophageal cancer (squamous cell carcinoma) who underwent resection and reconstructed by the retrosternal route between April 2019 and March 2021. We evaluated the short-term postoperative outcomes of these patients.

All the reconstructed organs were the gastric tube. The anastomosis method was a Circular stapler: 33 cases and a Linear stapler: 5 cases. The median start of oral intake after surgery was 3 days, and the median postoperative length of stay was 16 days. Perioperative complications of Clavien-Dindo classification grade 3 or higher occurred in 4 cases: anastomotic leakage grade IIIa: 3 cases and grade IVA: 1 case. Complications within 1 month after the operation were anastomotic stenosis grade IIIa in 1 case, and within 6 months were anastomotic stenosis grade IIIa in 2 cases.

In our department, anastomotic leakage of a retrosternal route reconstruction was about 10%, which was similar to the domestic data (all reconstruction routes). The stylization of surgical techniques and instruments was about 10%, which was similar to the domestic data (all reconstruction routes). In our department, anastomotic leakage of a retrosternal route reconstruction was about 10%, which was similar to the domestic data (all reconstruction routes).

In histopathological examination, the rate of positive proximal resection margin was significantly higher in H group. (34.8 vs. 5.6% (P=0.028). 3-year recurrence-free survival rate and 3-year survival rate were similar in the two groups. The anastomotic recurrence rates did not differ between the two groups. (5.0 vs 5.9% (P=0.715))

In the H group, the rate of positive proximal resection margin was significantly higher. However, there was no difference in the anastomotic recurrence rate and the 3-year survival rate between the two groups. Therefore, we believe that larynx-preserving high-level cervical anastomosis is useful to maintain QOL in cervical esophageal cancer patients with the oral edge of the primary tumor is less than 2 cm from the esophageal entrance.

472. ROUTINE PLACEMENT OF FEEDING TUBES SHOULD BE AVOIDED IN ESOPHAGEAL CANCER PATIENTS UNDERGOING SURGERY
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Perioperative nutritional optimization of patients undergoing esophagectomy for cancer is important as this population is prone to malnutrition associated with poor outcomes. Nutritional supplementation has been achieved via enteral nutrition through percutaneous feeding tubes such as gastrostomy tubes (G-tubes) and jejunostomy tubes (J-tubes). These are not benign and are associated with adverse events including infections, dislodgement, increased healthcare visits, among others. We aim to determine factors associated with adverse outcomes after feeding tube placement.

Patients who underwent esophagectomy for carcinoma and had at least one feeding tube placed from November, 2017 to October, 2021 at a single institution were retrospectively reviewed. Subgroup analyses were performed testing for revelant characteristics. Wilcoxon rank sum test was used to analyze non-parametric continuous data, and Chi-Square and Fisher's exact test for categorical variables. Univariate and multivariate logistical regression analyses were conducted evaluating outcomes of interests. The primary outcome was the overall rate of tube-related complications.

136 patients were included with 201 feeding tubes placed. The rate of adverse events related to feeding tubes was 39%. Of these, 11% were wound infections, 16% required procedural intervention, 11% visited the Emergency Department due to feeding tube-related complications. Smoking history was a significant factor. Among complications compared to never-smokers (44% vs. 24%, p=0.011). Females had increased complications compared to males (58% vs. 35%, p=0.010). Comorbid patients (Charlson Comorbidity Index 5-6) were more likely to suffer from tube-related complications (OR=4.47, p<0.038). There were no significant differences seen in complications rates comparing G- and J-tubes (32% vs. 43%, p=0.11).

There is significant morbidity related to feeding tubes. The risk profile of these tubes should be carefully discussed. Routine use of feeding tubes in esophagectomy patients should be avoided.

473. SAFETY AND USEFULNESS OF LARYNX-PRESERVING HIGH-LEVEL CERVICAL ANASTOMOSIS FOR CERVICAL ESOPHAGEAL CANCER
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In cases of cervical esophageal cancer, total Pharyngo-Laryngo- Esophagectomy is often performed when the oral edge of the primary tumor is less than 2 cm from the esophageal entrance. In our hospital, we provide neo-adjuvant chemotherapy for cervical esophageal cancer and perform larynx-preserving esophagectomy whenever possible. The aim of this study was to evaluate the safety and efficacy of larynx-preservation high-level cervical anastomosis for cervical esophageal cancer.

41 patients underwent larynx-preserving esophagectomy for cervicothoracic esophageal cancer between January 2009 and September 2021 at our hospital were included. The distance from the oral edge of the primary tumor to the esophageal entrance was measured by esophagography and endoscopy. Patients with the distance of 2 cm or less were classified as the high cervical anastomosis group (H group: n=23), and patients with the distance of 2.1 cm or more were classified as the low cervical anastomosis group (L group: n=18). We compared the short-term and long-term results between the H and L groups.

There were no differences between H and L groups in terms of patient characteristics, such as clinical depth of tumor invasion, grading of lymph node metastasis, frequency neo-adjuvant chemotherapy. The incidence of postoperative complications was similar in the two groups such as pneumonia, anastomotic leakage, anastomotic stenosis, recurrent nerve palsy. In histopathological examination, the rate of positive proximal resection margin was significantly higher in H group (34.8 vs. 5.6% (P=0.028). 3-year recurrence-free survival rate and 3-year survival rate were similar in the two groups. The anastomotic recurrence rates did not differ between the two groups. (5.0 vs 5.9% (P=0.715))

In the H group, the rate of positive proximal resection margin was significantly higher. However, there was no difference in the anastomotic recurrence rate and the 3-year survival rate between the two groups. Therefore, we believe that larynx-preserving high-level cervical anastomosis is useful to maintain QOL in cervical esophageal cancer patients with the oral edge of the primary tumor is less than 2 cm from the esophageal entrance.

474. ESOPHAGEAL CANCER SURGERY AND ITS CHALLENGES: A STEP AHEAD WITH THE INTRODUCTION OF ROBOT-ASSISTED SURGERY
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We introduced robot-assisted thoracoscopic surgery for esophageal cancer surgery in 2018 and have performed 143 cases so far. Compared with thoracoscopic surgery, robot-assisted surgery is overwhelmingly more stable and precise, however there are concerns about the safety because there is no vision from the forearms. Here, we will show a video of a standardized procedure utilizing the characteristics of da Vinci and its application to advanced cancer, and discuss the safe use of da Vinci.