Patients undergoing open (OE, n=350), hybrid (HE, n=368), and MIE for esophageal cancers were identified from the Oesophago gastric Anastomosis Audit (OGAA). Primary outcome was PPC and secondary outcomes were anastomotic leaks (AL) and 90-day mortality.

PPC rates were lower after MIE compared to OE and HE (38% vs 39% vs 31%, p=0.002), even on adjusted analyses compared to OE (odds ratio (OR): 0.57, CI95%: 0.44 - 0.74).

On adjusted analyses, MIE was not associated with higher AL (OR: 2.05, CI95%: 1.26 - 3.34) and 90-day mortality (OR: 4.55, CI95%: 2.70 - 7.69) compared to OE. Stratified analyses demonstrated lower PPC rates after MIE compared to HE in patients operated in high volume centers and high-income countries.

In contrast to previous reports, global adoption of MIE is associated with reduced PPC with no compromise in AL or overall complications. Introduction of MIE in standardized fashion with guidance from expert, high-volume surgeons justify benefits of MIE.

605. NEOADJUVANT FLOT FOR LOCALLY ADVANCED ESOPHAGEAL CANCERS: A SYSTEMATIC REVIEW AND META-ANALYSIS
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Whilst multimodality treatment is established as standard of care for locally advanced esophageal cancers the precise choice of oncological neoadjuvant treatment remains unclear. Uptake of FLOT is increasing, yet collective experience in patients with esophageal cancer is unclear. This study aimed to assess the effectiveness of FLOT as first-line treatment in this patient population.

A systematic review was performed using Embase, MEDLINE (OvidSP), Web of Science, Scopus, PubMed Publisher, Cochrane, and Google Scholar until 28th December 2021, for studies of treatment-naive patients of any age who received FLOT as first-line treatment of locally advanced esophageal or gastric cancer. The primary outcome was overall survival. Secondary outcomes were progression-free survival, rates of grade 3 or 4 adverse events; and oncological outcomes

This systematic review included six studies comprising 895 patients, of which 479 (54%) patients received FLOT. All studies included patients with distal or gastroesophageal junction esophageal and 441 (92%) had esophageal adenocarcinoma. Pooled overall survival at 1-year, 2-year and 3-year were 81.7% (CI95%: 71.1% - 88.9%), 59.2% (CI95%: 47.4% - 69.9%), and 49.8% (CI95%: 28.9 - 70.8%). Pooled recurrence rates from three studies were 22.6% (CI95%: 12.3% - 37.7%). Oncological outcomes were reported for margin-negative resections (overall: 94.1%, CI95%: 88.1% - 97.2%), complete pCR (overall: 15.2%, CI95%: 7.1% - 29.7%), major pathological response (overall: 41.6%, CI95%: 24.6% - 60.8%).

There is limited evidence on FLOT for patients with esophageal or gastroesophageal cancers, despite the increasing use of FLOT in clinical practice. Standardisation in reporting oncological and surgical outcomes following FLOT are needed and future research and randomised controlled trials comparing FLOT are required.

607. COMPARISON OF RECURRENT PATTERN AND SURVIVAL AFTER NEOADJUVANT CHEMORADIOThERAPY VS. CHEMOTHERAPY FOR ESOPHAGEAL CANCER, A MULTI-CENTER EUROPEAN COHORT STUDY
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Whilst multimodality treatment is established as standard of care for locally advanced esophageal cancers, despite the increasing use of FLOT in clinical practice. This study aimed to establish the effectiveness of FLOT as first-line treatment of locally advanced esophageal or gastric cancer. The primary outcome was overall survival. Secondary outcomes were progression-free survival, rates of grade 3 or 4 adverse events; and oncological outcomes following esophagectomy in a population of patients undergoing curative intended treatment of esophageal cancer.

A systematic review was performed using Embase, MEDLINE (OvidSP), Web of Science, Scopus, PubMed Publisher, Cochrane, and Google Scholar until 28th December 2021, for studies of treatment-naive patients of any age who received FLOT as first-line treatment of locally advanced esophageal or gastric cancer. The primary outcome was overall survival. Secondary outcomes were progression-free survival, rates of grade 3 or 4 adverse events; and oncological outcomes following esophagectomy in a population of patients undergoing curative intended treatment of esophageal cancer.

606. INCIDENCE AND IMPACT OF PREOPERATIVE Hiatal Hernia in Patients With Esophageal Carcinoma Undergoing Curative Surgical Resection
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Hiatal hernia (HH) and gastroesophageal reflux disease (GERD) are risk factors for esophageal adenocarcinoma. High positive margin rates and poor survival were previously described among HH patients undergoing esophagectomy. We sought to describe incidence and impact of HH on outcomes following esophagectomy in a population of patients undergoing predominantly cervical anastomosis.

Patients who underwent esophagectomy 2012-2019 for esphago-junctional carcinoma were included. CT studies were blindly reviewed by two radiologists. A third radiologist reviewed cases of disagreement. Hernias > 3 cm were included in the HH group.

Overall, 66 patients (33%) had HH > 3 cm. The control group included 12 patients (6%) with <3 cm HH and 106 (53%) without HH. Patients with HH had higher Charlson Comorbidity Index (CCI) (p=0.017). Location of anastomosis was similar among cohorts (cervical anastomosis 82.2% vs 92.4%, p=0.113). HH patients had higher incidence of atrial dysrhythmia (16.7% vs 5.1%, p=0.015). Rates of R0 resections were similar (95.8% vs 93.9%, p=0.724). Subgroup analysis on adenocarcinoma patients confirmed higher rates of signet ring cell features among HH patients (28.6% vs 12.3%, p=0.034). HH was not associated with poor disease free survival (p=0.274).

Patients with preoperative HH had higher CCI, higher rates of postoperative atrial dysrhythmias and signet ring cell features on pathology. In a population with predominant cervical anastomosis, positive margin rates were low and survival comparable among cohorts.

609. MINIMALLY INVASIVE CERVICAL ESOPHAGECTOMY (MICE): FIRST RESULTS OF A DUTCH PILOT STUDY
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Surgical resection remains the cornerstone of curative treatment for patients with esophageal cancer. Transthoracic minimally invasive esophagectomies have reduced the occurrence of pulmonary complications, however it is still associated with significant morbidity. The Minimally Invasive Cervical Esophagectomy (MICE) is a novel surgical technique. To date this technique is not routinely performed in European esophageal cancer patients. We aim to assess the safety and efficacy of the MICE procedure in Dutch patients with esophageal carcinoma.