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Summary

# Panel discussion: Cutting through the layers: Advances in diagnosis and treatment of oesophageal squamous cell carcinoma

Postgraduate Teaching Programme Barcelona 2026 | Presentation

Surgery | Oesophagus | Endoscopy | Digestive Oncology

October 17, 2026

**Multidisciplinary panel discussion addressed surgical techniques, endoscopic management, and follow-up strategies for oesophageal cancer, with emphasis on lymphadenectomy extent, quality of life, and evolving watch-and-wait approaches after chemoradiation.**

KEY POINTS

- The speakers' centres do not routinely perform pyloroplasty, though some centres do to improve conduit function; thoracic duct is always visualised, clipped, and oversutured, with chyle leak reported as rare
- Lymphadenectomy for positive common hepatic or splenic hilar nodes is considered regional and resectable, including coeliac trunk, left gastric, splenic artery, and lesser curvature stations
- Oesophageal sponge swab cytology for early cancer detection is still very preliminary with no current clinical role; if screening is performed, it would be endoscopic screening in high-risk populations
- Classification systems for squamous dysplasia have moderate accuracy and help determine whether to perform endoscopic submucosal dissection for low-grade, high-grade, and T1 lesions
- Patients require nearly one year to fully adapt post-operatively, with quality of life after six months to one year reported as equivalent to unoperated patients; follow-up includes assessment of conduit function and potential pyloric dilatation
- Watch-and-wait strategy after chemoradiation is described as a hot topic, though the speaker's current practice is to operate regardless of restaging results; no evidence supports that intense follow-up improves survival when recurrence is detected

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