

Treatment of Esophageal Cancer in Men

Darshini Arpi*

Department of Pharmacy, GD Goenka University, India

Abstract

Esophageal cancer (EC) is a malignancy that affects a large percentage of people; at the time of diagnosis, 50% of cases already had distant metastases, and most patients are male. This study evaluated the clinicopathological characteristics and metastatic patterns of male (MEC) and female (FEC) EC (FEC). Additionally, risk factors related to the prognosis for MEC were looked at. The database for Surveillance Epidemiology and End Results served as the study's population. To evaluate MEC characteristics and variables associated with prognosis, the descriptive analysis, Kaplan-Meier method, and Cox regression model were applied.

Keywords: Esophagus • Cancerous cells • Surgery

Introduction

12,558 MEC patients in all participated in the study, and 3454 of them had distant organ metastases. The proportion of patients having distant organ metastases in the total population was roughly 27.5 percent. Patients with metastatic MEC were more likely than non-metastatic MEC patients to be older than 60 years, to be Black and White, to have a primary lesion in the overlapping oesophagus segments, to have been diagnosed with an adenocarcinoma of poorly differentiated and undifferentiated grade that was treated with radiotherapy and chemotherapy rather than surgery, and they were also more likely to have this diagnosis [1]. Additionally, patients with MEC had a higher likelihood than patients with FEC of being over 60 years old, White, having a primary lesion in the lower oesophagus and overlapping esophageal segments, and receiving no chemotherapy. In addition, patients in the former group were more likely than those in the latter to be single and only have lung and bone metastases. A poor outcome was seen by MEC patients who had identifiable liver, lung, and bone metastases as well as concurrent liver and lung metastases. Metastatic patterns and clinicopathological characteristics linked to metastatic MEC are distinct from those linked to nonmetastatic MEC. The only treatment option for people with resectable perihilar cholangiocarcinoma is surgical resection (PHC). There is currently little agreement on the efficacy of lymphadenectomy despite evidence that lymph node (LN) status is a strong predictive factor for postoperative long-term survival. In order to summarise the information already available on the advantages of lymphadenectomy in PHC surgical patients, we decided to do a meta-analysis. Comprehensive searches were conducted in PubMed (OvidSP), Embase, and the Cochrane Library for studies published before July 2020 that discussed lymphadenectomy performed concurrently with surgery for PHC after curative surgery [2]. Cancer arises from a single cell through a series of acquired mutations and epigenetic alterations. The microenvironment of the tumour, which is composed of non-cancerous cells and cancer cell populations with a variety of phenotypes, becomes more complicated as tumours develop. The diversity of biological states encourages tumour growth, permits metastasis, and makes effective cancer therapy challenging. Finding methods to therapeutically manipulate cancer heterogeneity would therefore have significant clinical ramifications.

*Address for Correspondence: Darshini Arpi, Department of Pharmacy, GD Goenka University, India, E-mail: arpi.d369@gmail.com

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One of the main challenges in the field is how to functionally evaluate tumour heterogeneity in cancer patients. This article examines the potential applications of mouse cancer models for the study of tumour heterogeneity and the advancement of therapeutic approaches [3].

Description

The muscular, hollow tube that carries food and drink from the throat to the stomach is called the oesophagus. Multiple layers of tissue, including mucous membrane, muscle, and connective tissue, make up the esophageal wall. As it develops, esophageal cancer spreads from the inner lining of the oesophagus through the other layers [4,5].

According to the kind of cells that develop into malignant (cancerous) cells, the two most prevalent types of esophageal cancer are named:

Squamous cell carcinoma: A type of cancer that develops in the flat, flimsy cells that line the oesophagus. Although it can develop anywhere throughout the oesophagus, this cancer is most frequently discovered in the upper and middle region of the oesophagus. Additionally known as epidermoid carcinoma.

Cancer that starts in glandular cells is known as adenocarcinoma. The lining of the oesophagus has glandular cells that generate and secrete liquids like mucus. Adenocarcinomas typically develop in the lower oesophagus, close to the stomach.

Conclusion

Anything that raises your probability of contracting an illness like cancer is considered a risk factor. Risk factors for various malignancies vary. Smoking is one risk factor that can be altered. Others, such as an individual's age or family history, are unchangeable. Numerous variables have been identified by researchers as having an impact on esophageal cancer risk. Some are more likely to raise the risk of esophageal adenocarcinoma, whereas others are more likely to raise the risk of esophageal squamous cell carcinoma. However, having one or more risk factors does not guarantee that you will get esophageal cancer. Additionally, not all individuals with the condition have known risk factors.

Acknowledgement

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Conflict of Interest

None.

References

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