

Cancer of the Oesophagus, from Bad to Worse

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The paper "Carcinoma of the esophagus in Tamil Nadu (South India): 16-year trends from a tertiary center" by Cherian et al. in this issue of the *Journal of Gastrointestinal and Liver Diseases* (1), describes a histological pattern of oesophageal malignancy which would not have given rise to comment in Western countries during the nineteen-sixties. An exception could be made for the adenocarcinoma of the cardia which, although relatively common in the West, was not usually included in studies of oesophageal cancer. An exception was a survey by Miller of 405 patients treated between 1942 and 1956 in Liverpool (UK). These included 247 (61%) squamous cell carcinomas (SCC) and 154 (38%) adenocarcinomas originating in the cardia (AGC), leaving 4 (1%) cases of adenocarcinoma of the oesophagus (ACO) (2). In the current study these percentages were 92%, 8% and 1.7% respectively. Therefore in both studies ACO played a very minor role. Over the past 30 years there has been a well publicised dramatic rise in the incidence of ACO in Western industrialised countries (3). Although the incidence rate of ACO in The Netherlands may be exceptionally high (4), it is interesting to note that between 1989 and 2003, The Netherlands Cancer Registry counted 4811 (27.3%) cases of SCC, 6538 (37%) of ACO and 6304 (35.7%) of AGC. While the incidence rates of both SCC and AGC showed a declining trend, that of ACO rose by at least 5% per annum (5).

It is obviously tempting, and possibly correct, to conclude that the current epidemiology of oesophageal cancer in South India reflects that of Britain and other Western industrialised countries half a century ago. There can, however, be no doubt about the radical change which has occurred in Western countries during this period, where the incidence rates of AGC and ACO combined now regularly exceed those of SCC (3,6). The causes of this epidemic of adenocarcinoma are currently uncertain (7). There can be no doubt that Barrett's oesophagus and, consequently,

reflux oesophagitis, are pre-malignant conditions for ACO. Obesity has been implicated in the aetiology of these three conditions, however, its relationship with AGC is more tenuous (8-11). Besides its obvious mechanical effect (12), excess visceral adipose tissue may in itself be carcinogenic (13,14). For AGC, smoking appears to be an aetiological factor (5,15).

Unfortunately, there are no published data on the incidence of cancer of the oesophagus in Romania. However, a recent study of Eastern European countries, including Romania, indicated SCC to be the most common oesophageal malignancy (16), implying that the oesophageal adenocarcinoma epidemics there is still at an early stage. Consequently, countries such as Romania are in a favourable position for prospectively studying the epidemiological factors involved in the development of Barrett's oesophagus, ACO and AGC. A promising start was made by the recently announced plan to register all cases of Barrett's oesophagus in a number of Romanian endoscopy units (17).

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