Prof. Miguel A. Cuesta: my experience to being a surgeon on gastrointestinal surgery (specially in esophageal cancer)

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Editor's note

The 2017 Shanghai International Forum on the Standard Treatment of Thoracic Tumors was successfully held in Shanghai, China from October 19th, 2017 to October 21st, 2017. Gathering renowned experts at home and abroad, the focus of this forum was the current progress of standard treatment of thoracic cancer, specially discussing the hot issues on lung cancer and esophageal cancer by academic reports, surgery video and etc. During the forum, Prof. Cuesta has given an impressive talk to the audience. The editorial office of *Journal of Thoracic Diseases* (*JTD*) seized the great opportunity to have an interview with Prof. Cuesta about his stories being a surgeon and his experience on esophageal cancer (*Figure 1*).

Figure 1 Editor Miss Silvia L. Zhou with Prof. Cuesta.

Expert's introduction

Prof. Cuesta (*Figure 2*) is currently Emeritus Professor of Gastrointestinal (GI) Surgery especially dedicated to Minimally Invasive Surgery at the Vrije University Medical Centre (Vumc) in Amsterdam, the Netherlands and received his medical degree from the Universidad de Navarra School of Medicine, Pamplona, Spain. He completed his surgical residence at the VUmc at Amsterdam, the Netherlands.

In 1988, Prof. Cuesta joined the faculty staff at the VUmc where he became professor and chief of the Gastrointestinal and Minimally Invasive Surgery Unit in 2001. Since 2014 he works in the Reinier de Graaf Hospital in Delft, Netherlands, exclusively dedicated to upper GI surgery.

Prof. Cuesta's research focuses on the implementation of digestive oncological diseases in minimally invasive surgery, with special dedication to upper GI oncological surgery. He has been principal investigator or Co-PI on over ten funded control randomized trials in which a comparison is made between open conventional and minimally invasive approaches, but also investigating the role of neoadjuvant therapy in esophageal and gastric cancer.

Figure 2 Prof. Miguel A. Cuesta

He has published over 300 papers, has written over ten book chapters and was the editor in chief of four books about minimally invasive approach of digestive cancer, upper GI cancer and postoperative major complications. Recently a new book has been published about minimally invasive surgery for upper abdominal cancer.

Interview

Clinical and research work on esophageal cancer

JTD: Incidence of esophageal cancer is increasing all over the world. In your opinion, what are the influence factors of this trend?

Prof. Cuesta: Esophageal cancer is increasing in Europe, but also in China. People say the esophageal squamous-cell carcinoma is influenced by the combination of tobacco, alcohol, and very hot drinks. The incidence is different in various areas of China. Some areas have much higher incidence, while some areas have smaller incidence. So I think it is also influenced by the ground, culture, and food. In Europe, it is very different. One third of the patients are obese with esophageal adenocarcinoma. The cause of esophageal adenocarcinoma is a combination of smoking tobacco, obesity and gastroesophageal reflux disease. The cause is different in the Eastern and the Western.

JTD: For gastro-esophageal junction cancers, what is the best minimally invasive approach?

Prof. Cuesta: This is a good question. First of all, we need to classify the stages of esophagogastric junction tumors (EGJ). We use the Siewert classification, which divides tumors in types I–III based on anatomical criteria (1). Type I is adenocarcinoma of the distal esophagus with the center located within 1 to 5 cm above the anatomic EGJ, type II is true cardia carcinoma infiltrating from 1 centimeter on the side of the esophagus up to 2 cm below the EGJ in the stomach, and type III is subcardial gastric carcinoma with the tumor center between 2–5 cm below the EGJ. In my opinion, a minimally invasive total gastrectomy is best for type III and minimally invasive Ivor Lewis is the best for type I–II.

JTD: Could you share with us your experience on hybrid and total minimally invasive?

Prof. Cuesta: A lot of discussions have been held for this question. What we have done last year is the total minimally invasive esophagectomy. But in different countries in Europe, surgeons still recommend to start with hybrid form, which means performing the laparoscopy in combination with right thoracotomy for an Ivor Lewis esophagectomy. The total minimally invasive way require more practice.

JTD: Implementation of a minimally invasive esophagectomy program is technically demanding and requires a significant learning curve. How did you overcome the learning curve?

Prof. Cuesta: In my opinion, the only way to overcome the learning curve is time and experience. First of all, to observe the minimally invasive McKeown procedure, total gastrectomy, Ivor Lewis, etc. Secondly, I think it is very important to have a mentor. Someone with wide experiences who can help you. You can observe how your mentor does and learn the basic acknowledges from him/her, and then you could start those interventions in your own operating room under the supervision of your mentor, in order to achieve good outcome and avoid mistakes.

JTD: What's your view on the best treatment for esophageal cancer?

Prof. Cuesta: It is very difficult to say what is the best treatment for esophageal cancer. In our experience, we prefer the chemoradiotherapy as neoadjuvant therapy before surgery, which I think it is the best thing we could do. When patients have recovered from the chemoradiotherapy after about 8 weeks, we do the minimal invasive surgery. Some people concern that the risk of chemoradiotherapy can cause fibrosis. But I think the esophagus can be dissected properly.

Personal experiences and thoughts

JTD: I learned that you have your medical degree from the Universidad de Navarra School of Medicine, and completed your surgical residence at the VUmc. During your experience in school, who had the greatest influence on you? Why?

Prof. Cuesta: My father had the greatest influence on me. You can be intelligent or less intelligent, but you should have the will to work and to learn, which I learned from my father. So that you could overcome all the problems. During the residency years, I worked in VUmc and I became interested in gastrointestinal surgery and wanted to become oncological surgeon. I was very happy with the choice.

JTD: When or where is the turning point for you focusing on esophageal cancer?

Prof. Cuesta: At the beginning, I did all the GI surgery by minimal invasive surgery. About 10 or 15 years ago, I started the esophageal surgery with high interest. It's very complex anatomy involving the esophagus and stomach motivate me to think and to figure out the best treatment for patients. I would like to increase the survival and quality of life for the patients with esophageal cancer.

Figure 3 Professor Miguel A. Cuesta: my experience to being a surgeon on gastrointestinal surgery (specially in esophageal cancer) (2). Available online: http://asvidett.amegroups.com/article/view/22659

JTD: Since 1988 you joined the faculty staff at the Vumc, it has been about 29 years. It is a pretty long time. What makes you keep working as a surgeon? And why you would like to be a surgeon?
Prof. Cuesta: Because I think surgery is a combination of factors. To train your brain in combination with your hands in order to perform the surgical technique is very important. At the same time, the contact with the patients is also very important. I like the communication with people and the patients. In my opinion, the combination of these two things, surgical technique and communication with patients, are very important for therapy. In my career, I always try to do research to improve the survival rate and outcome of the patients. So I have a lot impetus.

JTD: It is said that "Patients are the teachers for doctors". During your practice in medicine, are there some cases which impress you a lot?
Prof. Cuesta: I am always impressed by the patients. If you are a physician, you treat the patients with pills or injections. But in my case, serving as a surgeon, I treat the patients by surgeries. A lot of complications could occur after surgery, which I should communicate with the patients and their family. Doctors are just human beings. We should work together with the patients to solve the complications. The most impressed moments in my life is to solve the scare and crying of the patients.

JTD: How many patients you need to treat per day?
Prof. Cuesta: If I am on the out-patient clinic in the morning, I see about 20 patients. For the new patients to be operated, I will leave each of them 20 minutes or half an hour. What I will do is to tell everything of the surgery to them and to answer their questions.

JTD: What you would like to do in the next 10 years both in life and in work?
Prof. Cuesta: I hope to work a couple of years more, as long as possible, because I am very interested in the esophageal surgery. First of all, I will still write some papers, also perhaps a new book concerning the minimal invasive surgery. I am writing a book about my experience in surgery. For the private time, I enjoy staying with my friends and my family. I like the art and culture of China and Japan. I think I have a lot of things to do.

JTD: Thank you.

For more about the interview, please click the video here (*Figure 3*).

Acknowledgements

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

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