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**EDITORIAL**

- 2867 Oncolytic virotherapy for hepatocellular carcinoma: A potent immunotherapeutic landscape  
*Xiao R, Jin H, Huang F, Huang B, Wang H, Wang YG*
- 2877 Can the preoperative prognostic nutritional index be used as a postoperative predictor of gastric or gastroesophageal junction adenocarcinoma?  
*Feng YW, Wang HY, Lin Q*
- 2881 Esophageal cancer: A global challenge requiring tailored strategies  
*Cheng CY, Hao WR, Cheng TH*
- 2884 Effectiveness of transarterial chemoembolization in combination with lenvatinib and programmed cell death protein-1 inhibition for unresectable hepatocellular carcinoma  
*Chisthi MM*
- 2888 Maximizing therapeutic outcomes in hepatocellular carcinoma: Insights into combinatorial strategies  
*Ilhan Y, Ergun Y*
- 2894 Human  $\beta$ -defensin-1 activates autophagy in human colon cancer cells *via* regulation of long non-coding RNA TCONS\_00014506  
*Eid N, Davamani F*

**REVIEW**

- 2902 Role of molecular biology in the management of pancreatic cancer  
*Boileve A, Smolenschi C, Lambert A, Boige V, Tarabay A, Valery M, Fuerea A, Pudlarz T, Conroy T, Hollebecque A, Ducreux M*

**MINIREVIEWS**

- 2915 Advances in immunotherapy of M2 macrophages and gastrointestinal stromal tumor  
*Wang XK, Yang X, Yao TH, Tao PX, Jia GJ, Sun DX, Yi L, Gu YH*

**ORIGINAL ARTICLE****Case Control Study**

- 2925 Disparities in the diagnosis and treatment of colorectal cancer among patients with disabilities  
*Kim KB, Shin DW, Yeob KE, Kim SY, Han JH, Park SM, Park JH, Park JH*

**Retrospective Study**

- 2941 Effectiveness and safety of sequential transarterial chemoembolization and microwave ablation for subphrenic hepatocellular carcinoma: A comprehensive evaluation  
*Zhu ZY, Qian Z, Qin ZQ, Xie B, Wei JZ, Yang PP, Yuan M*

2952 Combined use of dexmedetomidine and nalbuphine in laparoscopic radical gastrectomy for gastric cancer  
*Zhao GG, Lou C, Gao RL, Lei FX, Zhao J*

2960 Development and validation of a nomogram for predicting lymph node metastasis in early gastric cancer  
*He JY, Cao MX, Li EZ, Hu C, Zhang YQ, Zhang RL, Cheng XD, Xu ZY*

### Observational Study

2971 Comprehensive serum proteomics profiles and potential protein biomarkers for the early detection of advanced adenoma and colorectal cancer  
*Tan C, Qin G, Wang QQ, Li KM, Zhou YC, Yao SK*

### Clinical and Translational Research

2988 Network pharmacology- and molecular docking-based exploration of the molecular mechanism underlying Jianpi Yiwei Recipe treatment of gastric cancer  
*Chen P, Wu HY*

2999 Survival disparities among racial groups with hepatic malignant tumors  
*Han D, Zhang ZY, Deng JY, Du HB*

3011 Adipocytes impact on gastric cancer progression: Prognostic insights and molecular features  
*Shang JR, Zhu J, Bai L, Kulabiek D, Zhai XX, Zheng X, Qian J*

3032 Integrated single-cell and bulk RNA sequencing revealed an epigenetic signature predicts prognosis and tumor microenvironment colorectal cancer heterogeneity  
*Liu HX, Feng J, Jiang JJ, Shen WJ, Zheng Y, Liu G, Gao XY*

3055 Causal effects of genetic birth weight and gestational age on adult esophageal diseases: Mendelian randomization study  
*Ruan LC, Zhang Y, Su L, Zhu LX, Wang SL, Guo Q, Wan BG, Qiu SY, Hu S, Wei YP, Zheng QL*

3069 Prognostic significance of exportin-5 in hepatocellular carcinoma  
*Li H, Li F, Wang BS, Zhu BL*

3082 BCAR3 and BCAR3-related competing endogenous RNA expression in hepatocellular carcinoma and their prognostic value  
*Shi HQ, Huang S, Ma XY, Tan ZJ, Luo R, Luo B, Zhang W, Shi L, Zhong XL, Lü MH, Chen X, Tang XW*

3097 Glycolysis-related five-gene signature correlates with prognosis and immune infiltration in gastric cancer  
*Meng XY, Yang D, Zhang B, Zhang T, Zheng ZC, Zhao Y*

### Basic Study

3118 Kombo knife combined with sorafenib in liver cancer treatment: Efficacy and safety under immune function influence  
*Cao Y, Li PP, Qiao BL, Li QW*

3158 Yiqi Jiedu Huayu decoction inhibits precancerous lesions of chronic atrophic gastritis by inhibiting NLRP3 inflammasome-mediated pyroptosis  
*Zhou P, Zheng ZH, Wan T, Liao CW, Wu J*

- 3169** Multi-Omics analysis elucidates tumor microenvironment and intratumor microbes of angiogenesis subtypes in colon cancer  
*Yang Y, Qiu YT, Li WK, Cui ZL, Teng S, Wang YD, Wu J*
- 3193** Baitouweng decoction suppresses growth of esophageal carcinoma cells through miR-495-3p/BUB1/STAT3 axis  
*Yang H, Chen XW, Song XJ, Du HY, Si FC*
- 3211** Weiwei Decoction alleviates gastric intestinal metaplasia through the olfactomedin 4/nucleotide-binding oligomerization domain 1/caudal-type homeobox gene 2 signaling pathway  
*Zhou DS, Zhang WJ, Song SY, Hong XX, Yang WQ, Li JJ, Xu JQ, Kang JY, Cai TT, Xu YF, Guo SJ, Pan HF, Li HW*
- 3230** Aldehyde dehydrogenase 2 family member repression promotes colorectal cancer progression by JNK/p38 MAPK pathways-mediated apoptosis and DNA damage  
*Yu M, Chen Q, Lu YP*
- 3241** RBM5 suppresses proliferation, metastasis and glycolysis of colorectal cancer cells *via* stabilizing phosphatase and tensin homolog mRNA  
*Wang CX, Liu F, Wang Y*
- 3256** Immune effect and prognosis of transcatheter arterial chemoembolization and tyrosine kinase inhibitors therapy in patients with hepatocellular carcinoma  
*Guo Y, Li RC, Xia WL, Yang X, Zhu WB, Li FT, Hu HT, Li HL*
- 3270** N6-methyladenosine modification of hypoxia-inducible factor-1 $\alpha$  regulates *Helicobacter pylori*-associated gastric cancer *via* the PI3K/AKT pathway  
*An TY, Hu QM, Ni P, Hua YQ, Wang D, Duan GC, Chen SY, Jia B*
- 3284** Canopy FGF signaling regulator 3 affects prognosis, immune infiltration, and PI3K/AKT pathway in colon adenocarcinoma  
*Gao XC, Zhou BH, Ji ZX, Li Q, Liu HN*

**META-ANALYSIS**

- 3299** Clinical and pathological features of advanced rectal cancer with submesenteric root lymph node metastasis: Meta-analysis  
*Wang Q, Zhu FX, Shi M*
- 3308** Clinical benefits of transarterial chemoembolization combined with tyrosine kinase and immune checkpoint inhibitors for unresectable hepatocellular carcinoma  
*Han F, Wang XH, Xu CZ*

**SCIENTOMETRICS**

- 3321** Research trends and hotspots in the immune microenvironment related to hepatocellular carcinoma: A bibliometric and visualization study  
*Zhang DY, Bai FH*

**CASE REPORT**

- 3331** Gastric cancer metastatic to the breast: A case report  
*Liu JH, Dhamija G, Jiang Y, He D, Zhou XC*
- 3341** Rare infiltrative primary hepatic angiosarcoma: A case report and review of literature  
*Lin XJ, Luo HC*
- 3350** Metachronous multifocal carcinoma: A case report  
*Wan DD, Li XJ, Wang XR, Liu TX*
- 3357** BRAF K601E-mutated metastatic colorectal cancer in response to combination therapy with encorafenib, binimetinib, and cetuximab: A case report  
*Sasaki M, Shimura T, Nishie H, Kuroyanagi K, Kanno T, Fukusada S, Sugimura N, Mizuno Y, Nukui T, Uno K, Kojima Y, Nishigaki R, Tanaka M, Ozeki K, Kubota E, Kataoka H*

**LETTER TO THE EDITOR**

- 3364** Challenges in early detection and endoscopic resection of esophageal cancer: There is a long way to go  
*Liu S, Chen LX, Ye LS, Hu B*

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## Challenges in early detection and endoscopic resection of esophageal cancer: There is a long way to go

Shuang Liu, Liu-Xiang Chen, Lian-Song Ye, Bing Hu

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### Abstract

The publication by Qu *et al* provided a comprehensive discussion about the epidemiology, etiology, histopathology, early detection, and endoscopic treatment of esophageal carcinoma (EC) and summarized the progress in the advanced technologies for screening and endoscopic resection for EC. In this editorial, we will provide deeper insight into the challenges that hinder practical application of these advanced technologies along with the role of these technologies in upper endoscopy quality. More efforts need to be made to overcome the challenges and add the value of these technologies in upper endoscopy quality. Clinical outcomes of management strategies after noncurative endoscopic dissection for early EC patients need further investigation. The experiences with noncurative endoscopic resection of other organs may have certain implications for noncurative resection of early EC.

**Key Words:** Esophageal cancer; Early detection; Endoscopic submucosal dissection; Noncurative endoscopic submucosal dissection

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**Core Tip:** Challenges remain in practical application of advanced technologies in the detection of esophageal carcinoma (EC), and it is also important to add the value of these technologies in upper endoscopy quality. For early EC patients, the clinical outcomes of management strategies after noncurative endoscopic resection need to be further studied and the clinical experiences with noncurative endoscopic resection of other organs are helpful.

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## TO THE EDITOR

We read with interest the publication by Qu *et al*[1] in which the epidemiology, etiology, histopathology, early detection, and endoscopic treatment of esophageal carcinoma (EC) were thoroughly discussed. The authors emphasized the geographical disparities in the distribution of histological subtypes and the corresponding variations in early EC screening policies and treatment modalities across different regions. Then the authors summarized the achievements that have been made and the challenges faced in the early detection and endoscopic resection of EC.

For the screening of early EC, the authors mentioned the prospect of advanced technologies, such as confocal laser endomicroscopy (CLE), volumetric laser endomicroscopy (VLE), and artificial intelligence (AI)[1]. Compared with conventional techniques, the above technologies have shown favorable performance, but challenges remain. Here, we provide deeper insight into their practical implications. First, these advanced technologies depend on sophisticated equipment, which limits their widespread use in remote institutions. Second, some of these technologies, such as CLE, cannot be used alone to distinguish tissue differentiation[2], but combining CLE with other technologies may increase the burden of EC screening. It is reasonable to evaluate these advanced technologies from the perspective of cost-effectiveness. In addition, their role in upper endoscopy quality is also a critical issue.

CLE and VLE lengthen training sessions because they require endoscopists to be proficient in reading images. However, these technologies can provide high-resolution real-time images under endoscopy to improve the detection rate[3,4]. Overall, CLE and VLE may enhance upper endoscopy quality. AI has profoundly improved upper endoscopy quality by supervising the procedure and reducing interobserver variability[5]. At present, uneven access to these advanced technologies across regions is inevitable, but we should make ongoing efforts to add their value in terms of upper endoscopy quality.

For the treatment of early EC, Qu *et al*[1] acknowledged the advantages and curability of endoscopic resection, particularly endoscopic submucosal dissection (ESD). However, we cannot merely emphasize the success of endoscopic resection, and it is also important to explore noncurative endoscopic resection in early EC. Notably, there is still controversy regarding ESD for stage T1b EC. Stage T1b EC is a risk factor for noncurative resection[6-8]. The risk of lymph node metastasis (LNM) and tumor recurrence is high in patients with stage T1b EC after noncurative ESD, and additional treatment is usually needed. A retrospective study demonstrated that patients with T1 esophageal squamous cell carcinoma (ESCC) who underwent primary surgery did not have favorable overall or recurrence-free survival outcomes compared to those who underwent salvage esophagectomy after noncurative ESD[9]. Therefore, although T1b ESCC patients often need salvage esophagectomy following noncurative ESD, they may have similar survival benefits to those who undergo surgery as primary treatment. Another retrospective study showed no difference in overall survival outcomes between follow-up alone and salvage surgery after noncurative ESD in T1b esophageal adenocarcinoma (EAC) patients[10]. This means that salvage surgery may not be the only option for patients with T1b EAC after noncurative ESD, especially those who are not surgical candidates, and follow-up may serve as an alternative. Given that chemoradiotherapy (CRT) has been used to control esophageal cancer, we agree that CRT may be effective for treating residual cancer after noncurative resection. Additional CRT after noncurative ESD may decrease cancer occurrence[11] and enable elderly patients with a high risk of LNM to obtain good survival benefits[12]. However, the high incidence of CRT-related adverse events deserves attention and the risk-benefit ratio of additional CRT in EC patient treated with noncurative ESD needs further investigation. In conclusion, current studies on the postoperative management for early EC with noncurative ESD patients have mainly involved small-scale retrospective studies. The safety and efficacy of different intervention strategies after noncurative ESD (salvage surgery, follow-up only, and additional CRT) still need to be explored in more large-sample prospective studies.

There is much research space in noncurative esophageal ESD and turning to noncurative ESD of other organs may provide us with new insights. The risk of LNM is the most important prognostic factor[13], and the eCure system[14] was recommended for quantifying the risk of LNM after noncurative gastric ESD. Morais *et al*[15] modified the eCure system and subsequently developed the W-eCura system, which outperformed the eCure. Currently, there is no evaluation system for noncurative esophageal ESD. Drawing on the eCura and W-eCura models, designing and validating a tool to evaluate the risk of LNM and residual cancer after noncurative esophageal ESD are helpful for selecting patients who are more likely to benefit from salvage surgery and avoiding unnecessary salvage surgery. We also expect that this assessment tool include items regarding patient age, which is an important factor in evaluating general conditions and predicting complications associated with additional treatment.

Noncurative colorectal ESD also faces the problems of weighing the benefits and risks of additional treatment. A multicenter retrospective study compared the benefits and risks between follow-up alone and salvage surgery after noncurative T1-colorectal ESD[16]. The results showed that at a median follow-up of 30 mo, cancer recurrence and disease-specific survival did not differ between the two groups, but the risk of death was increased in the follow-up group[16]. These findings may help guide the management of noncurative colorectal ESD in elderly patients with relatively limited life expectancy. The long-term outcomes of intervention strategies after noncurative ESD are also expected. These clinical experiences with noncurative colorectal ESD will help us carry on a series of studies on non-



curative esophageal ESD.

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## CONCLUSIONS

We are grateful to Qu *et al*[1] for their valuable review of early detection and endoscopic resection of early EC. Although encouraging results have been achieved, it is still necessary to further promote the practical application of the advanced technologies in the diagnosis of early EC, and their value in improving upper endoscopy quality. In addition, the management strategies for early EC after noncurative ESD should be further explored, so that patients with early EC can benefit more from endoscopic techniques.

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## FOOTNOTES

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