ASU FC
Azienda sanitaria universitaria Friuli Centrale

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

OMCeO Udine

IL PAZIENTE CON DISFAGIA: LE NEOPLASIE E I DISORDINI MOTORI DELL'ESOFAGO

Le neoplasie dell'esofago, dalla diagnosi al programma terapeutico: cosa c'è di nuovo?

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Udine, 13.05.2025

SISME
Società Italiana per lo Studio delle Malattie dell'Esofago

INCIDENZA E PREVALENZA DEI TUMORI PER SEDE

Numero di casi incidenti nel 2022, in Friuli Venezia Giulia

ICD10	Sede / età	TOTALE FVG (popolazione: 1,194,341)
C00-C96, D09.0, D41.4	***Tutte le sedi***	***12.011***
	0-19 anni	*35*
	20-49 anni	*981*
	50-69 anni	*4.207*
	70+ anni	*6.788*
C00-C43, C45-C96, D09.0, D41.4	**Tutte le sedi esclusa la pelle non melanoma**	**8.632**
C44	Pelle non melanoma	3.379
C50	Mammella	1.233
C61	Prostata	1.155
C33-C34	Polmone	848
C18-C21	Colon, retto, ano	839
C43	Melanoma cutaneo	546
C67, D09.0, D41.4	Vescica	490
C25	Pancreas	371
C81-C85, C96	Linfomi	369
C64-C66, C68	Rene e vie urinarie	317
C16	Stomaco	282
C01-C06, C09-C14, C32	Vie aerodigestive superiori	272
C73	Tiroide	224
C54	Utero, corpo	220
C22	Fegato	191
C91-C95	Leucemie	148
C88-C90	Mieloma	132
C70-C72	Encefalo e altre parti del SI	122
C56	Ovaio	120
C15	Esofago	74
C45	Mesotelioma	59
C53	Utero, collo	40
C62	Testicolo	37

Persone che vivono dopo diagnosi di tumore nei precedenti 25 anni (casi prevalenti) in Friuli Venezia Giulia al 1.1.2023

ICD10	Sede	TOTALE FVG (popolazione: 1,194,341)
C00-C96, D09.0, D41.4	Tutte le sedi	**104.797**
C00-C43, C45-C96, D09.0, D41.4	**Tutte le sedi esclusa la pelle non melanoma**	**75.232**
C44	*Pelle non melanoma*	*37.197*
C50	Mammella	19.328
C61	Prostata	13.415
C18-C21	Colon, retto, ano	9.015
C43	Melanoma cutaneo	5.599
C67, D09.0, D41.4	Vescica	5.243
C81-C85, C96	Linfomi	4.112
C64-C66, C68	Rene e vie urinarie	3.172
C73	Tiroide	3.161
C54	Utero, corpo	2.803
C33-C34	Polmone	2.321
C01-C06, C09-C14, C32	Vie aerodigestive superiori	2.287
C91-C95	Leucemie	1.446
C16	Stomaco	1.360
C56	Ovaio	946
C62	Testicolo	878
C88-C90	Mieloma	764
C53	Utero, collo	761
C22	Fegato	733
C25	Pancreas	513
C70-C72	Encefalo e altre parti del SNC	420
C15	Esofago	215
C45	Mesotelioma	91
	Altre	2.859

ARCS Azienda Regionale di Coordinamento per la Salute

REGIONE AUTONOMA FRIULI VENEZIA GIULIA
ISTITUTO DI RICOVERO E CURA A CARATTERE SCIENTIFICO
CRO di Aviano - Istituto Nazionale Tumori

CRO AVIANO

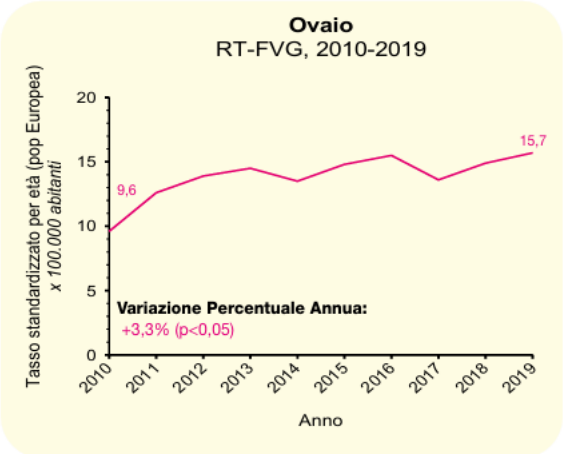
i Tumori in Friuli Venezia Giulia

25 Anni di registrazione: 1998-2023

Registro Tumori del Friuli Venezia Giulia

1. INCIDENZA: ANDAMENTI

Figura 1d: Andamento dei tassi di incidenza dei tumori in Friuli Venezia Giulia dal 2010 al 2019 per sedi selezionate e sesso. Registro tumori del Friuli Venezia Giulia, 2023.



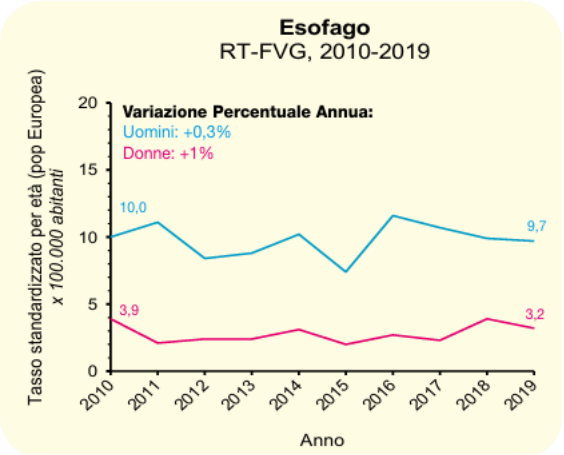
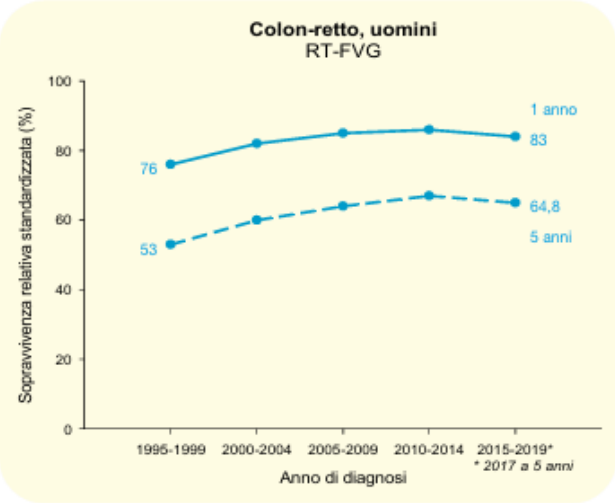


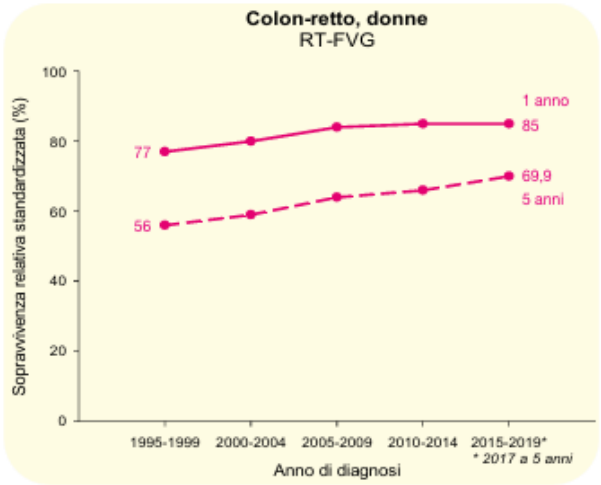
Tabella 11: Sopravvivenza osservata a 5 anni dalla diagnosi per periodo di incidenza, sede e sesso. Registro tumori del Friuli Venezia Giulia, 2023.

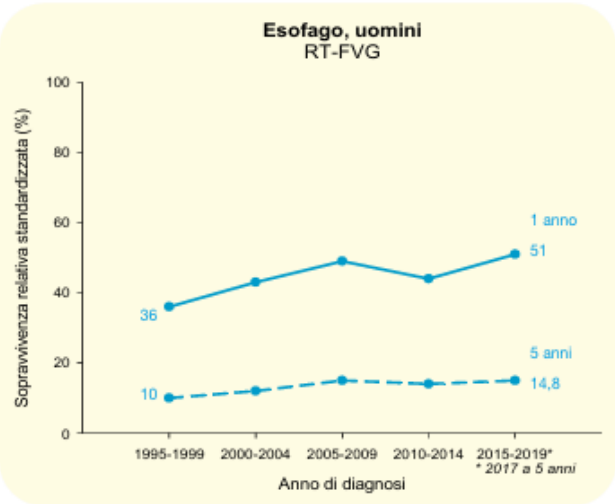
Sedi	Periodo di incidenza									
	1995-1999		2000-2004		2005-2009		2010-2014		2015-2017	
	Uomini %	Donne %	Uomini %	Donne %	Uomini %	Donne %	Uomini %	Donne %	Uomini %	Donne %
Tutte le sedi (cute non melanoma esclusa)	37,5	48,6	45,1	51,9	49,3	54,7	49,6	57,2	50,5	59,6
Esofago	10,3	11,9	10,7	9,0	12,3	13,8	11,7	14,3	12,6	7,9

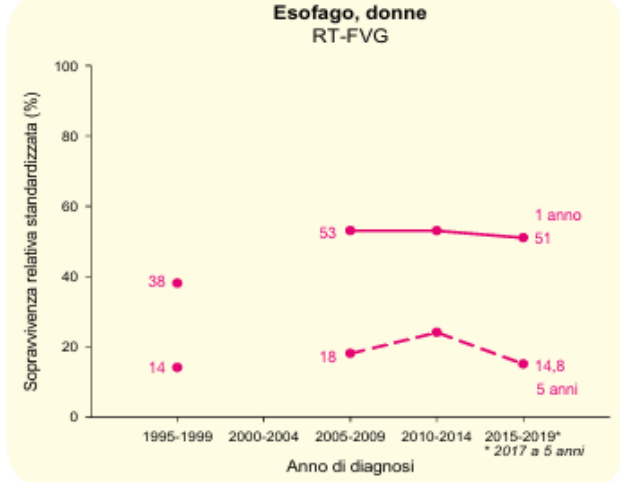
3. SOPRAVVIVENZA RELATIVA

Figura 2b: Sopravvivenza relativa a 1 e 5 anni dalla diagnosi di tumore per periodo di diagnosi e sesso. Registro tumori del Friuli Venezia Giulia, 2023.





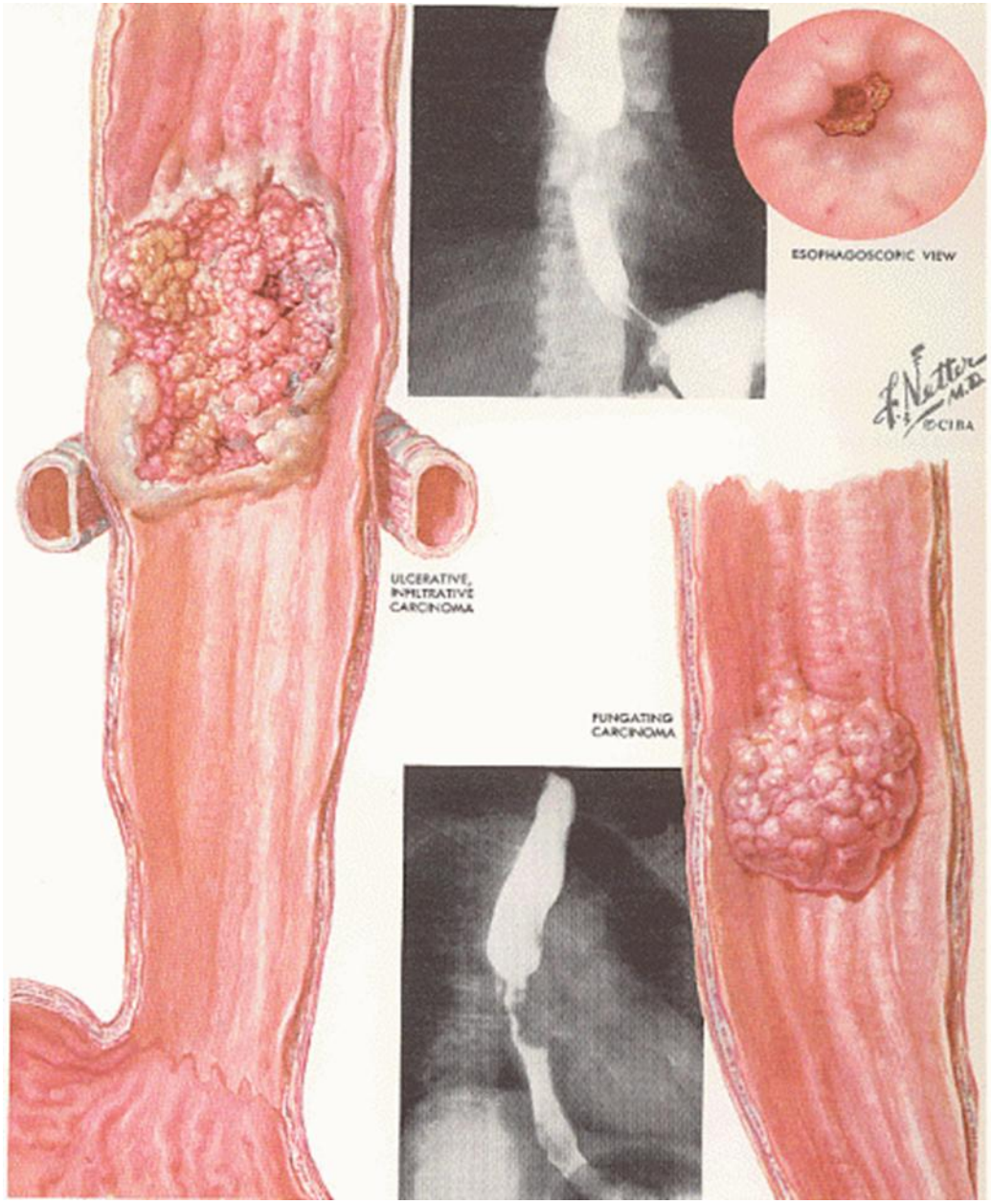


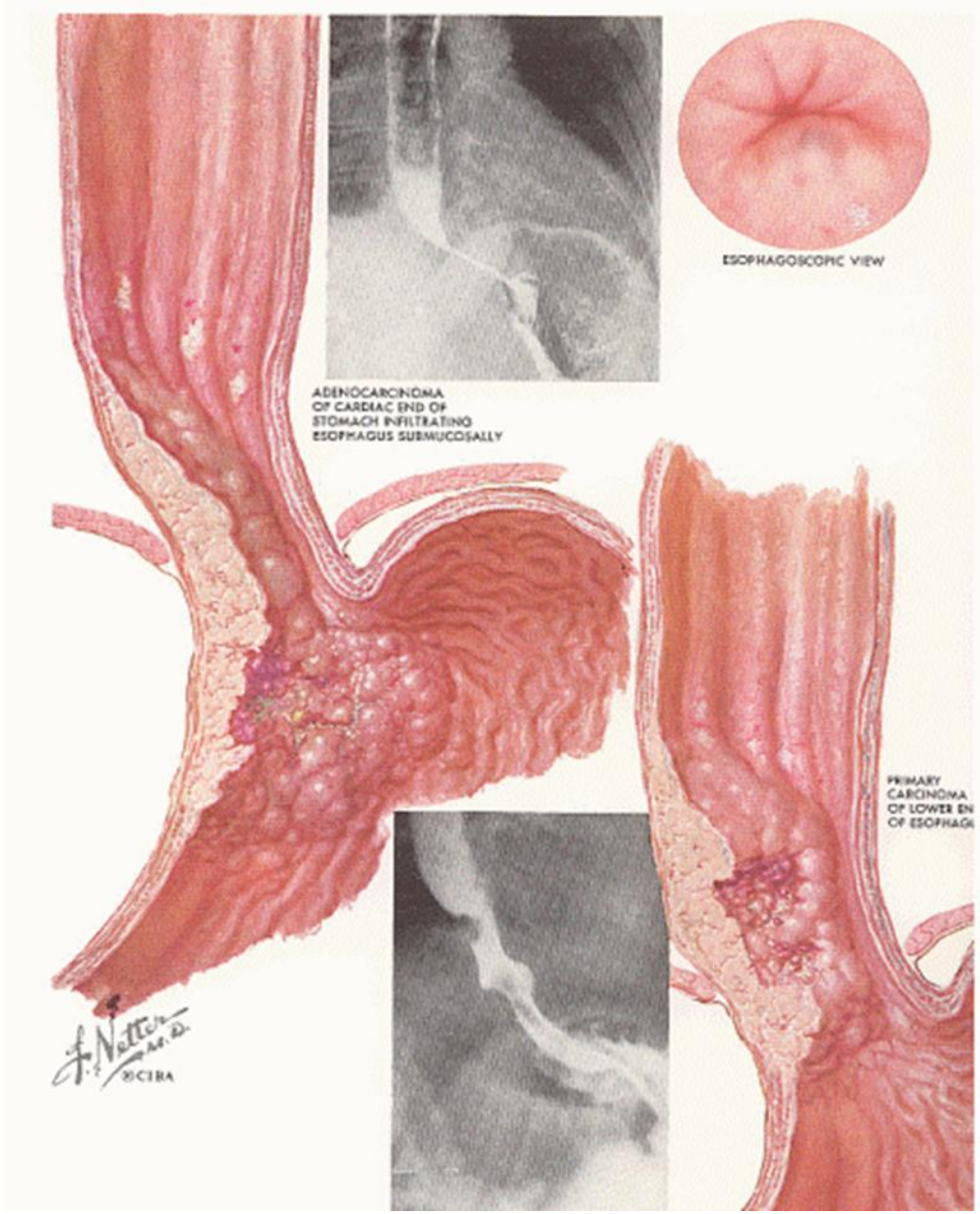


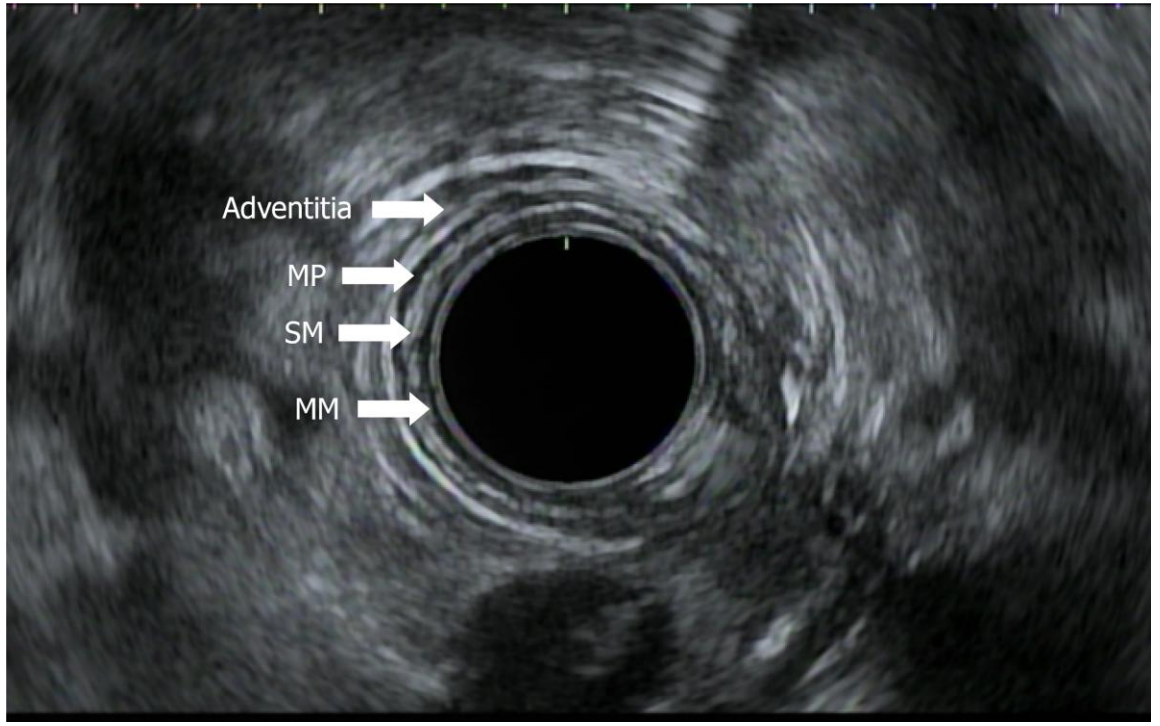
5. MORTALITÀ

Tabella 14: Numero medio annuo di morti per tumore nei cittadini del Friuli Venezia Giulia. Dati di mortalità ISTAT per gli anni 2010-2019, per sesso.

Sede tumorale	Uomini N. (%)	Donne N. (%)	Totale N. (%)
Tutte le sedi	2.200 (100)	1.889 (100)	4.089 (100)
Mammella		315 (16,7)	315 (7,7)
Colon e retto	247 (11,2)	212 (11,2)	459 (11,2)
Prostata	166 (7,5)		166 (4,6)
Polmone	490 (22,3)	260 (13,8)	750 (18,3)
Vescica	73 (3,3)	29 (1,5)	102 (2,5)
Melanoma cutaneo	33 (1,5)	26 (1,4)	59 (1,4)
Pancreas	148 (6,7)	171 (9,1)	319 (7,8)
Stomaco	142 (6,5)	96 (5,1)	238 (5,8)
Rene	78 (3,5)	44 (2,3)	122 (3,0)
Fegato	163 (7,4)	71 (3,8)	234 (5,7)
Utero, corpo e cervice		36 (1,9)	36 (0,9)
Leucemie	71 (3,2)	54 (2,9)	125 (3,1)
Sistema nervoso centrale	54 (2,5)	40 (2,1)	94 (2,3)
Mieloma	39 (1,8)	43 (2,3)	82 (2,0)
Ovaio		74 (3,9)	74 (1,8)
Esofago	55 (2,5)	21 (1,1)	76 (1,9)
Mesotelioma	46 (2,1)	9 (0,5)	55 (1,3)
Linfoma non-Hodgkin	57 (2,6)	51 (2,7)	108 (2,6)
Cute, non melanoma	11 (0,5)	9 (0,5)	20 (0,5)
Altri tipi/altre sedi	327 (14,7)	328 (17,2)	655 (15,8)


ESOPHAGOSCOPIC VIEW
F. Netter M.D.
©CIBA
ULCERATIVE, INFILTRATIVE CARCINOMA
FUNGATING CARCINOMA


ADENOCARCINOMA OF CARDIAC END OF STOMACH INFILTRATING ESOPHAGUS SUBMUCOSALLY
ESOPHAGOSCOPIC VIEW
PRIMARY CARCINOMA OF LOWER EN OF ESOPHAG
F. Netter M.D.
©CIBA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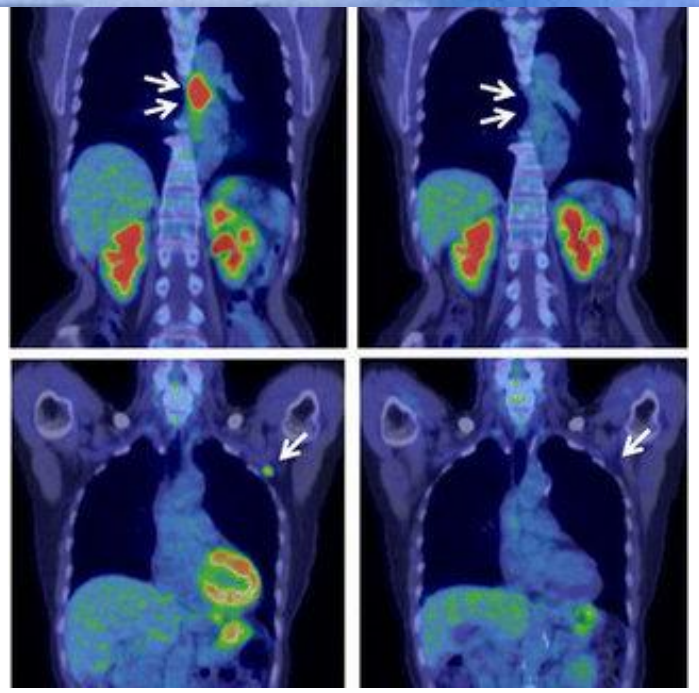
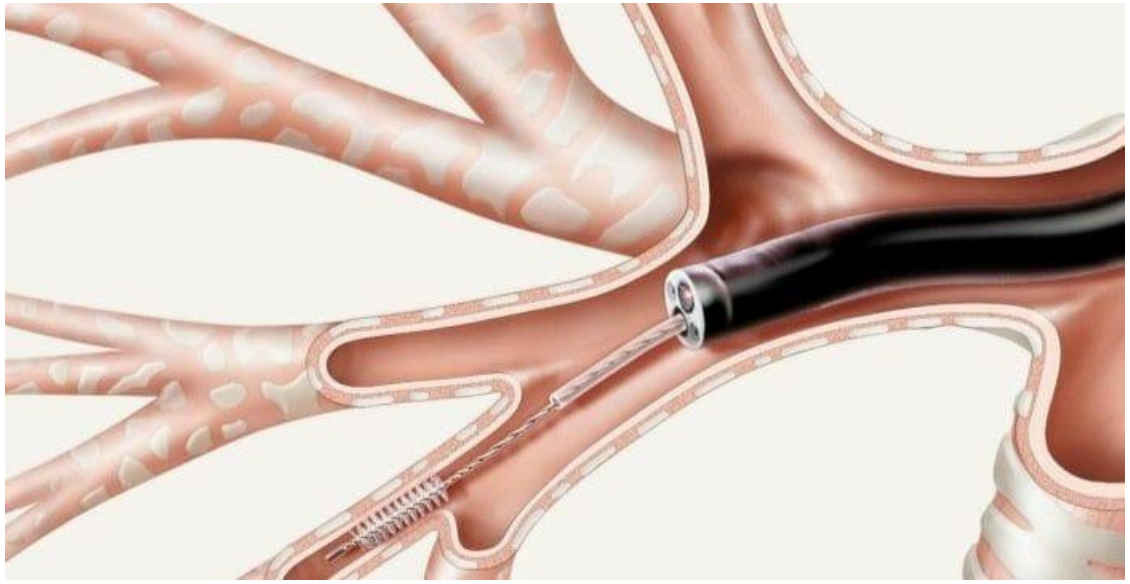




ARTICLE

OPEN

doi:10.1038/nature20805

Integrated genomic characterization of oesophageal carcinoma

The Cancer Genome Atlas Research Network*

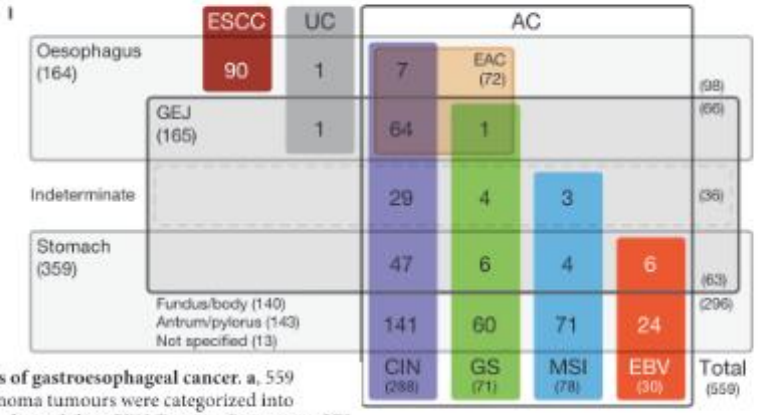
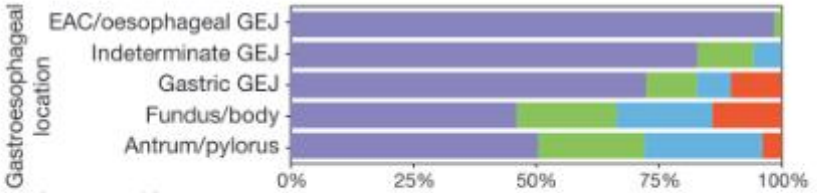
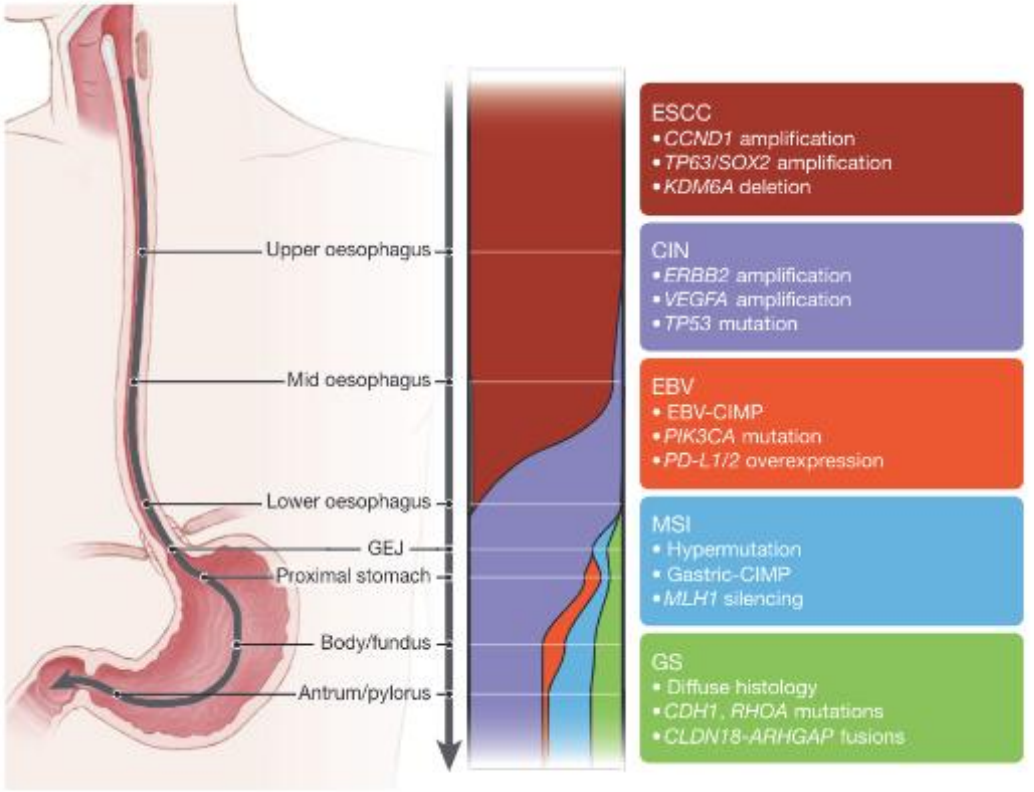


Figure 1 | Major subdivisions of gastroesophageal cancer. a, 559 oesophageal and gastric carcinoma tumours were categorized into sample sets. CIN, chromosomal instability; EBV, Epstein–Barr virus; GEJ, gastroesophageal junction; GS, genomically stable; MSI, microsatellite instability. UC, undifferentiated carcinoma.



b, Distribution of gastric molecular subtypes by anatomic location across gastroesophageal adenocarcinomas

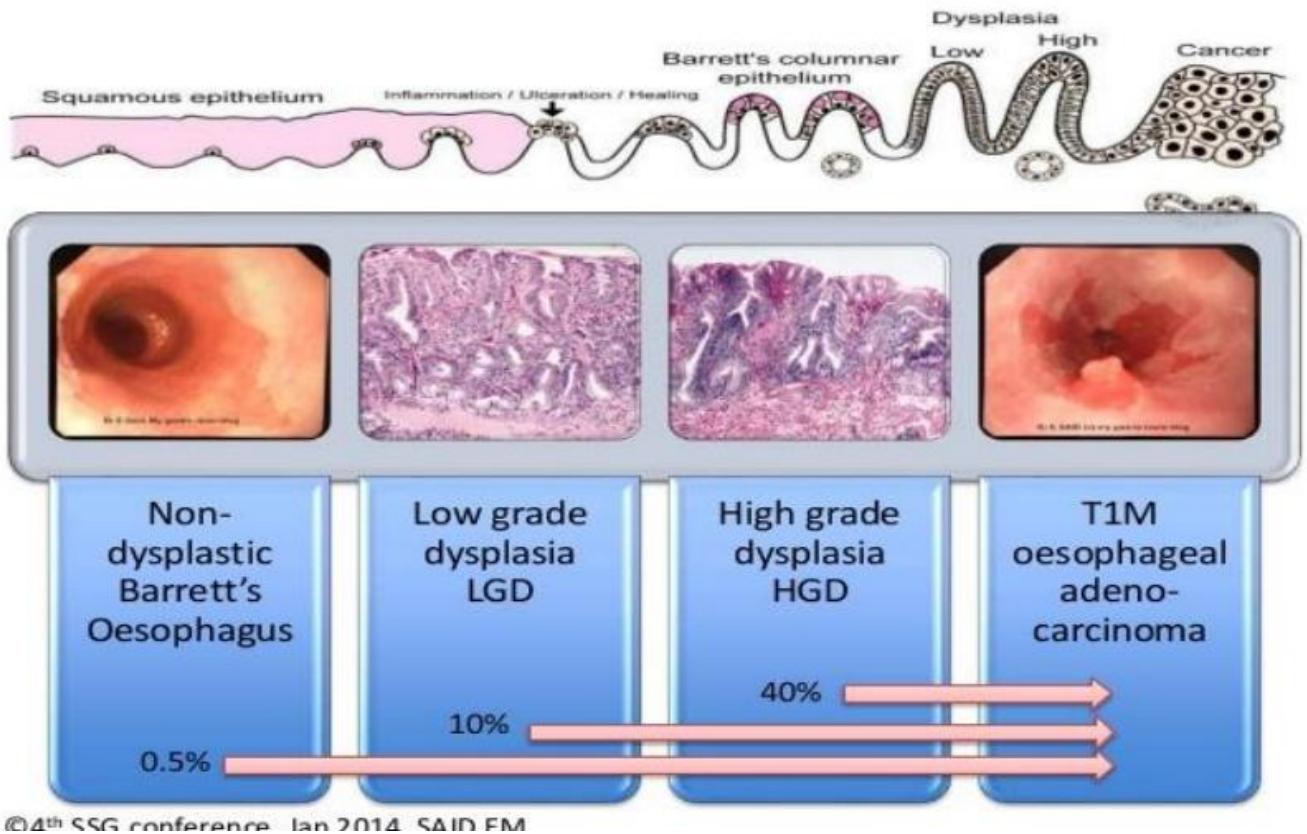


Profilo Molecolare

MSS, PDL1, HER 2

ESOFAGO DI BARRETT

Definizione ed epidemiologia



Esofago di Barrett (BE)

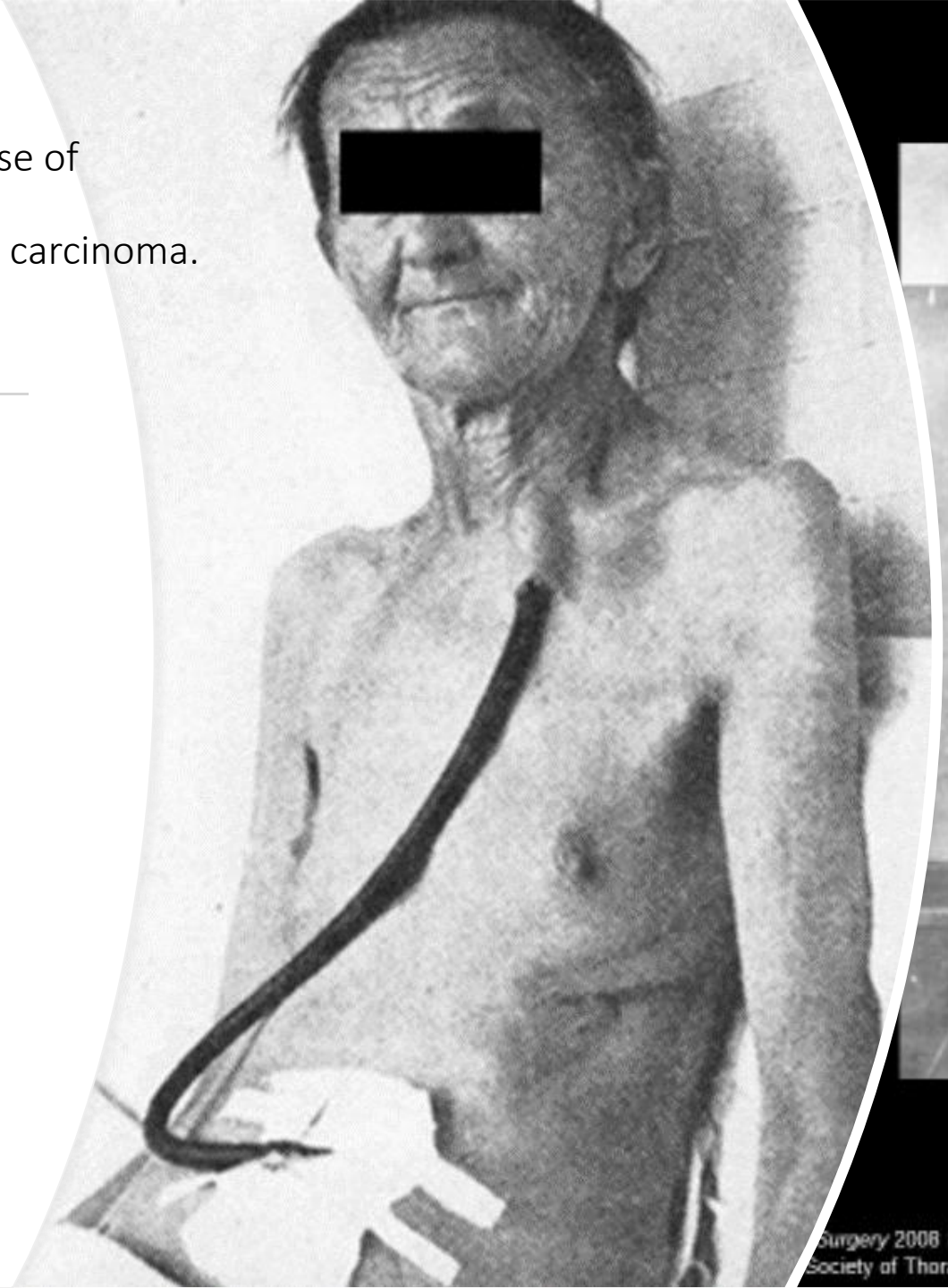
- Esofago distale rivestito da epitelio colonnare (metaplasico)
- Lunghezza min 10 mm
- unico precursore conosciuto dell'adenocarcinoma esofageo (EAC)

Rischio di progressione annua ad EAC

- BE senza displasia 0.33%/anno
- BE con LGD 0.7-1%/anno
- BE con HGD 8%/anno

Mayo Clinic Proceedings
Volume 99, Issue 3, March 2024, Pages 459-473

Torek F. The first successful case of resection of the thoracic portion of the oesophagus for carcinoma. Surg Gynecol Obstet 1913;16:614-7



GENERAL THORACIC SURGERY:

The Annals of Thoracic Surgery CME Program is located online at http://www.annalsthoracicsurgery.org/cme/home. To take the CME activity related to this article, you must have either an STS member or an individual non-member subscription to the journal.

Improved Clinical and Survival Outcomes After Esophagectomy for Cancer Over 25 Years

Annelijn E. Slaman, MD, Giovanni Pirozzolo, MD, Wietse J. Eshuis, MD, PhD, Jacques J. G. H. M. Bergman, MD, PhD, Maarten C. C. M. Hulshof, MD, PhD, Hanneke W. M. van Laarhoven, MD, PhD, Sybren L. Meijer, MD, PhD, Suzanne S. Gisbertz, MD, PhD, and Mark I. van Berge Henegouwen, MD, PhD

Department of Surgery, Amsterdam UMC, Location AMC, University of Amsterdam, Amsterdam, the Netherlands; Department of Surgery, dell'Angelo Hospital, Venice, Italy; Department of Gastroenterology, Amsterdam UMC, Location AMC, University of Amsterdam, Amsterdam, the Netherlands; Department of Radiotherapy, Amsterdam UMC, Location AMC, University of Amsterdam, Amsterdam, the Netherlands; Department of Medical Oncology, Amsterdam UMC, Location AMC, University of Amsterdam, Amsterdam, the Netherlands; and Department of Pathology, Amsterdam UMC, Location AMC, University of Amsterdam, Amsterdam, the Netherlands

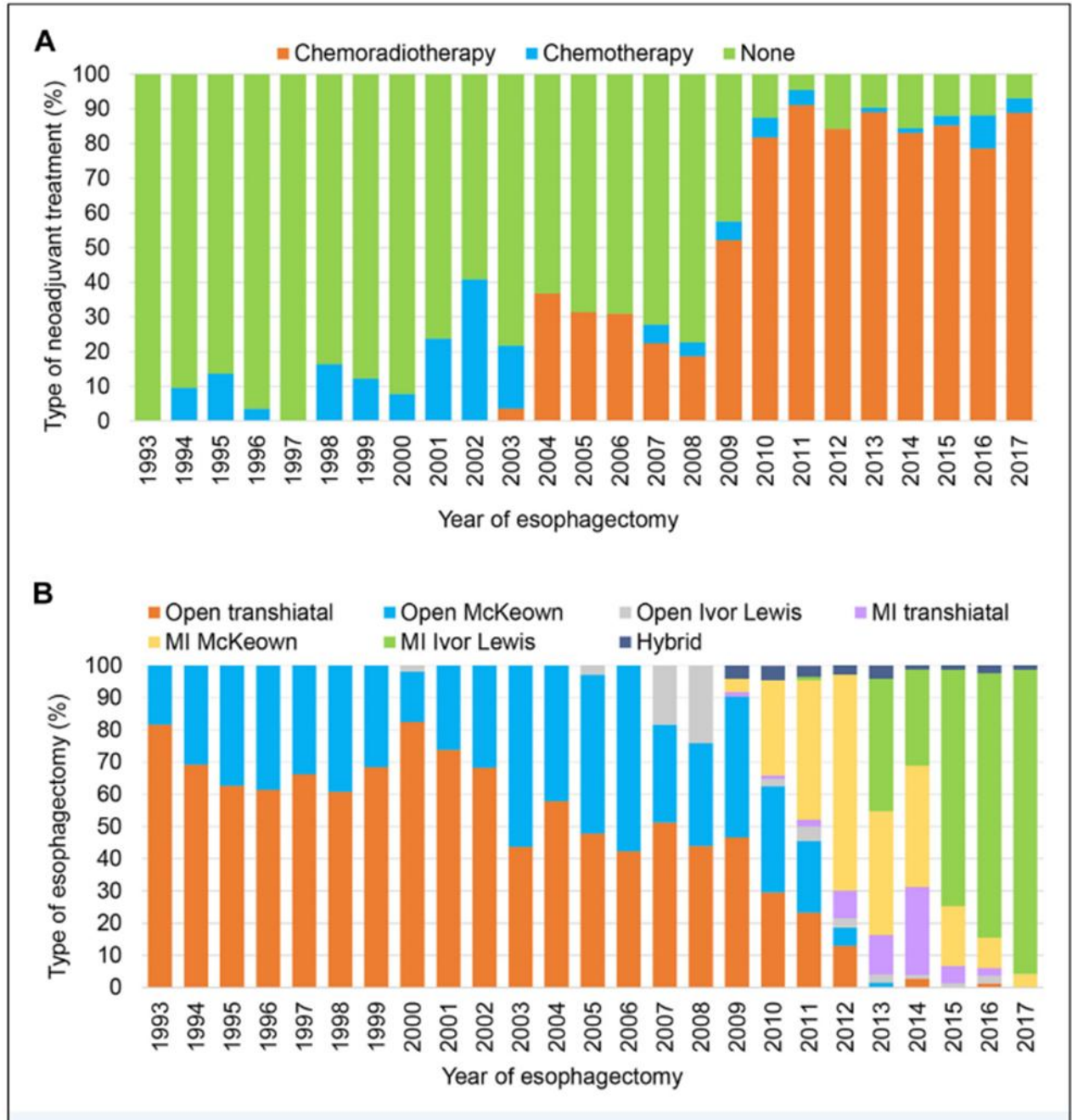


FIGURE 1 Type of (A) neoadjuvant treatment and (B) esophagectomy per year. (MI, minimally invasive.)

Trends in Distal Esophageal and Gastroesophageal Junction Cancer Care

The Dutch Nationwide Ivory Study

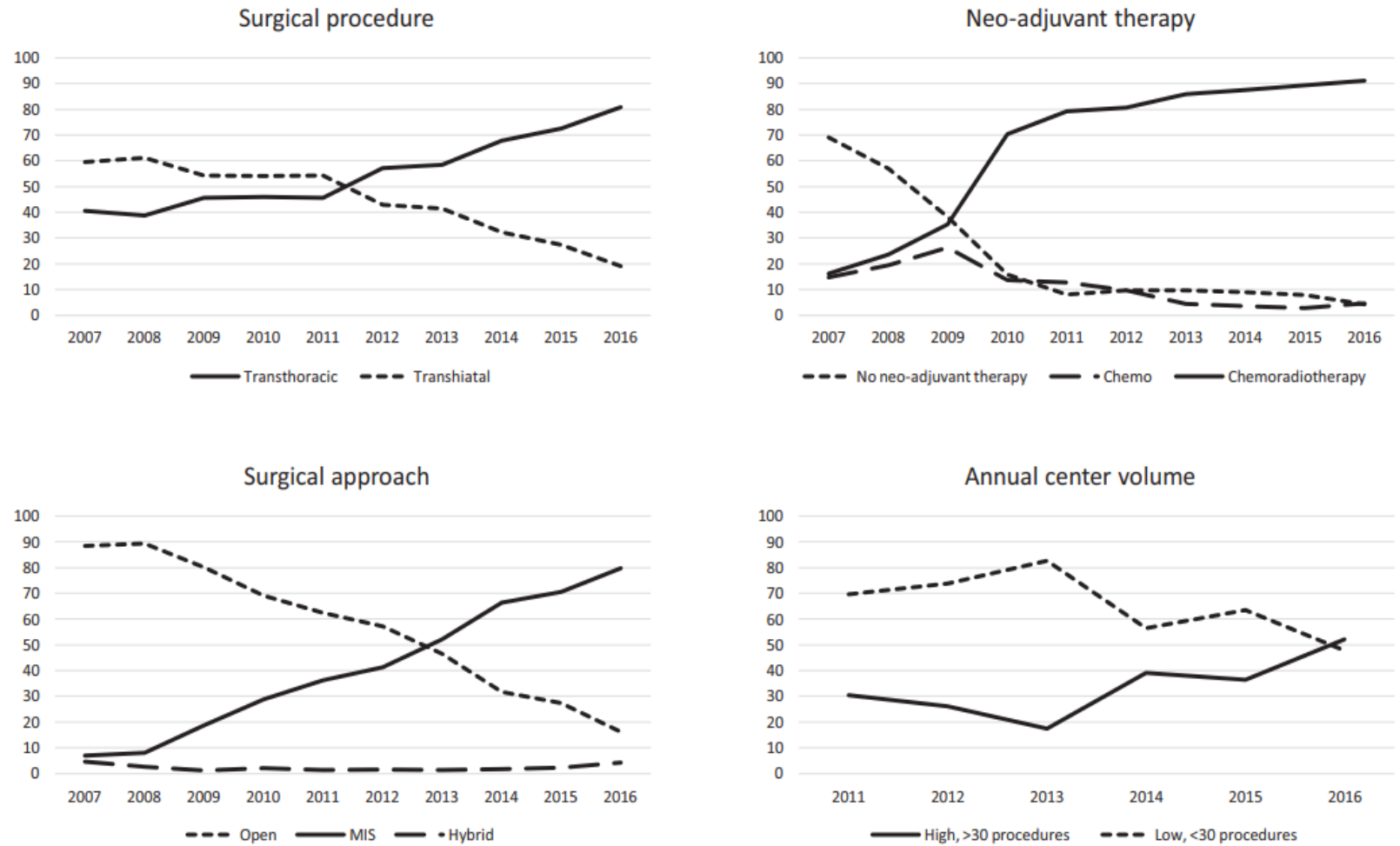


FIGURE 1. Trends in distal esophageal and gastroesophageal junction cancer care in the Netherlands. MIS indicates minimally invasive surgery.

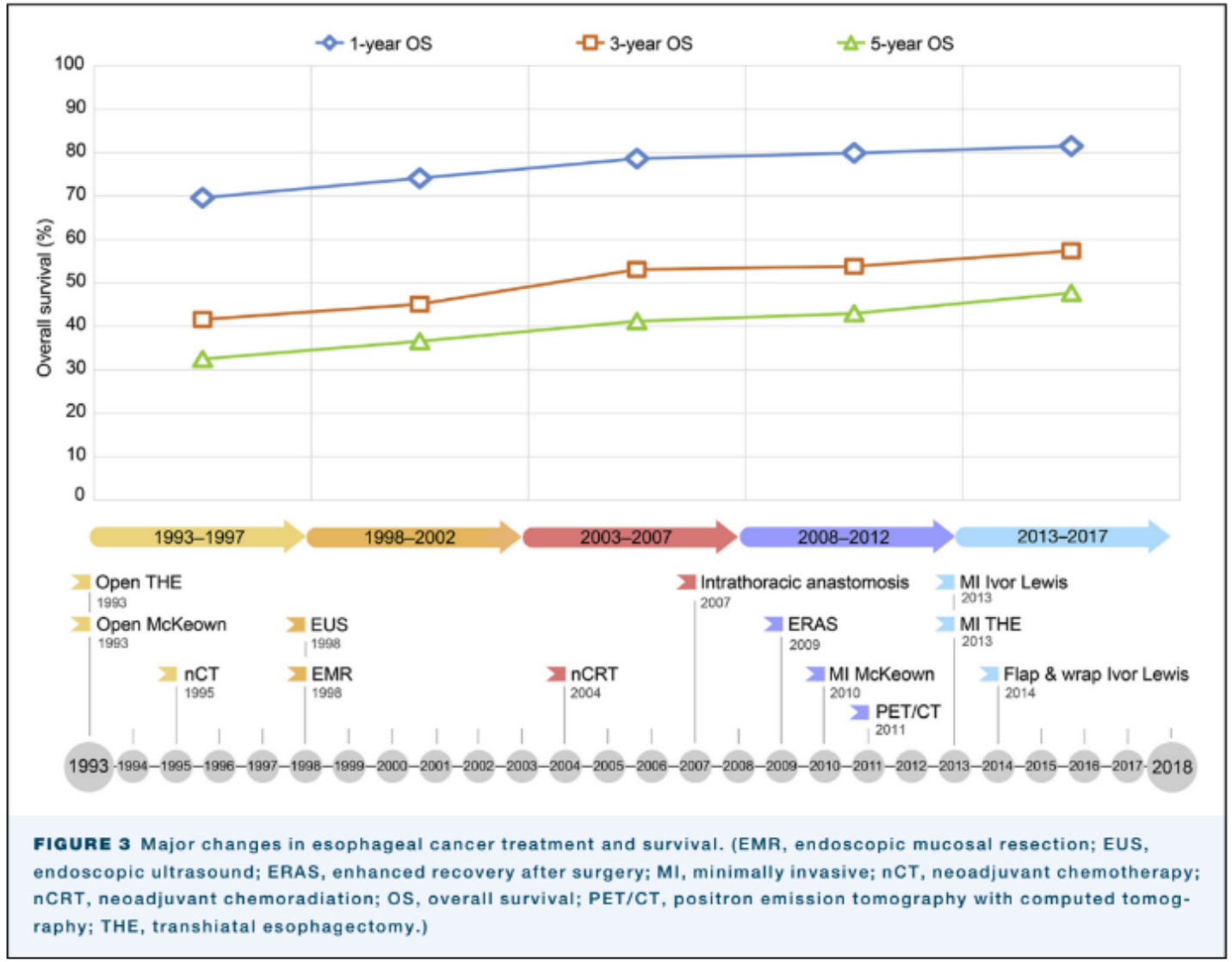


FIGURE 3 Major changes in esophageal cancer treatment and survival. (EMR, endoscopic mucosal resection; EUS, endoscopic ultrasound; ERAS, enhanced recovery after surgery; MI, minimally invasive; nCT, neoadjuvant chemotherapy; nCRT, neoadjuvant chemoradiation; OS, overall survival; PET/CT, positron emission tomography with computed tomography; THE, transhiatal esophagectomy.)

VOLUME 36 · NUMBER 3 · JANUARY 20, 2018

JOURNAL OF CLINICAL ONCOLOGY | ORIGINAL REPORT

Effect of Neoadjuvant Chemoradiotherapy on Health-Related Quality of Life in Esophageal or Junctional Cancer: Results From the Randomized CROSS Trial

Bo Jan Noordman, Mathilde G.E. Verdam, Sjoerd M. Lagarde, Maarten C.C.M. Hulshof, Pieter van Hagen, Mark I. van Berge Henegouwen, Bas P.L. Wijnhoven, Hanneke W.M. van Laarhoven, Grard A.P. Nieuwenhuijzen, Geke A.P. Hospers, Johannes J. Bonenkamp, Miguel A. Cuesta, Reinoud J.B. Blaisse, Olivier R. Busch, Fiebo J.W. ten Kate, Geert-Jan M. Creemers, Cornelis J.A. Punt, John Th.M. Plukker, Henk M.W. Verheul, Ernst J. Spillenaar Bilgen, Herman van Dekken, Maurice J.C. van der Sangen, Tom Rozema, Katharina Biermann, Jannet C. Beukema, Anna H.M. Piet, Caroline M. van Rij, Janny G. Reinders, Hugo W. Tilanus, Ewout W. Steyerberg, Ate van der Gaast, Mirjam A.G. Sprangers, and J. Jan B. van Lanschot

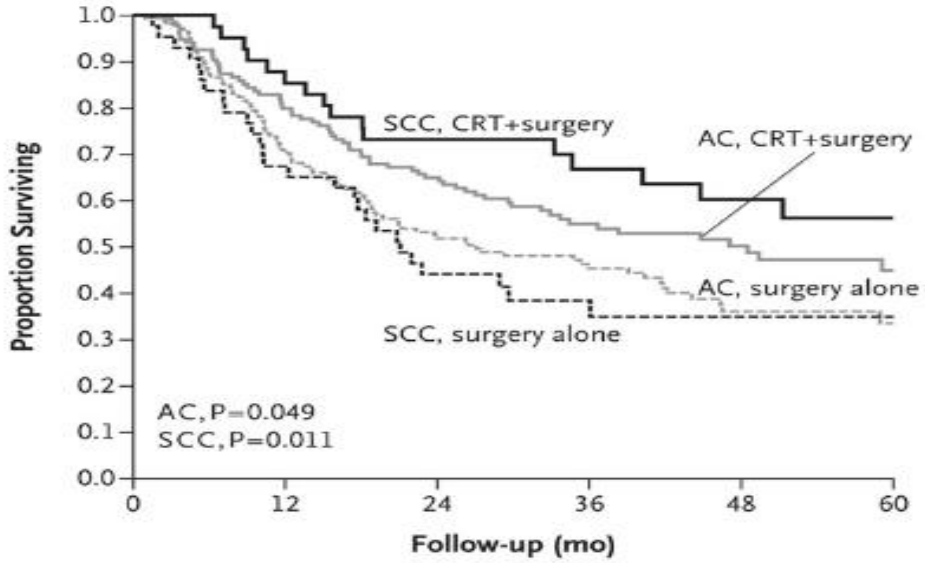
ypT0N0 (29%)

AC 81/121 (23%)

SCC 18/37 (49%)

P=0.008

B Survival According to Tumor Type and Treatment Group



No. at Risk

AC, CRT+surgery	134	107	87	53	34	18
AC, surgery alone	141	99	73	50	25	10
SCC, CRT+surgery	41	35	30	21	15	8
SCC, surgery alone	43	29	19	11	8	4
Total	359	270	209	135	82	40

J Gastrointest Surg (2013) 17:1375–1381
DOI 10.1007/s11605-013-2269-3

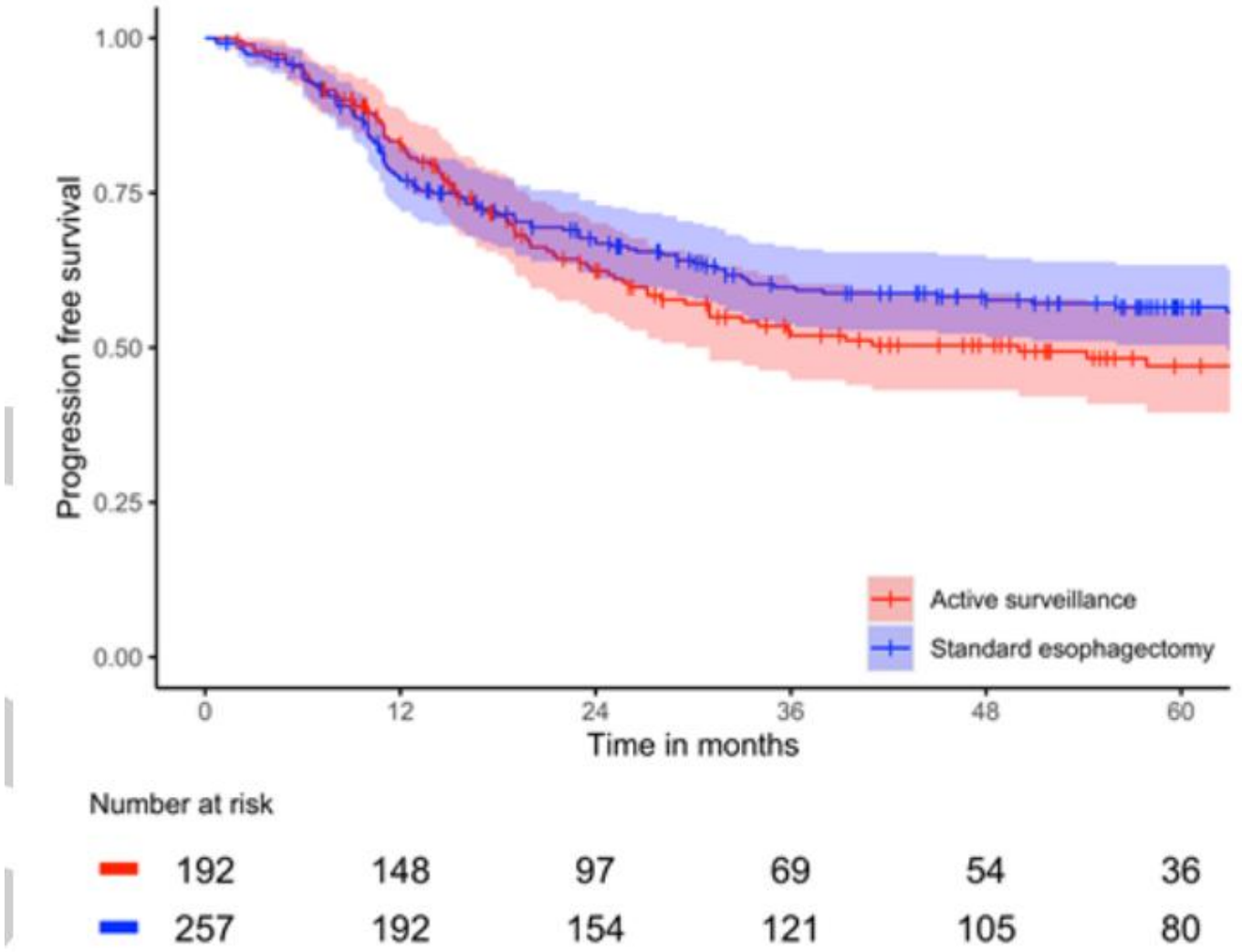
ORIGINAL ARTICLE

Complete Clinical Response After Neoadjuvant Chemoradiotherapy for Squamous Cell Cancer of the Thoracic Oesophagus: Is Surgery Always Necessary?

Carlo Castoro · Marco Scarpa · Matteo Cagol · Rita Alfieri · Alberto Ruol · Francesco Cavallin · Silvia Michieletto · Giampietro Zanchettin · Vanna Chiarion-Sileni · Luigi Corti · Ermanno Ancona

CONCLUSION: In our group of patients with clinical CR after neoadjuvant CT-RT for SCC of the thoracic oesophagus, waiting for recurrence and then using salvage surgery did not negatively impact their survival compared to patients treated with surgery. More accurate restaging protocols are warranted to improve decision making after CR with neoadjuvant CT-RT.

788 patients
Overall survival was comparable in patients with cCR after chemoradiotherapy undergoing active surveillance or standard esophagectomy.



Chemoradiotherapy followed by active surveillance versus standard esophagectomy for esophageal cancer: a systematic review and individual patient data meta-analysis

Annals of Surgery. 2022 mag 11

ORIGINAL ARTICLE

OPEN

Active Surveillance Versus Immediate Surgery in Clinically Complete Responders After Neoadjuvant Chemoradiotherapy for Esophageal Cancer

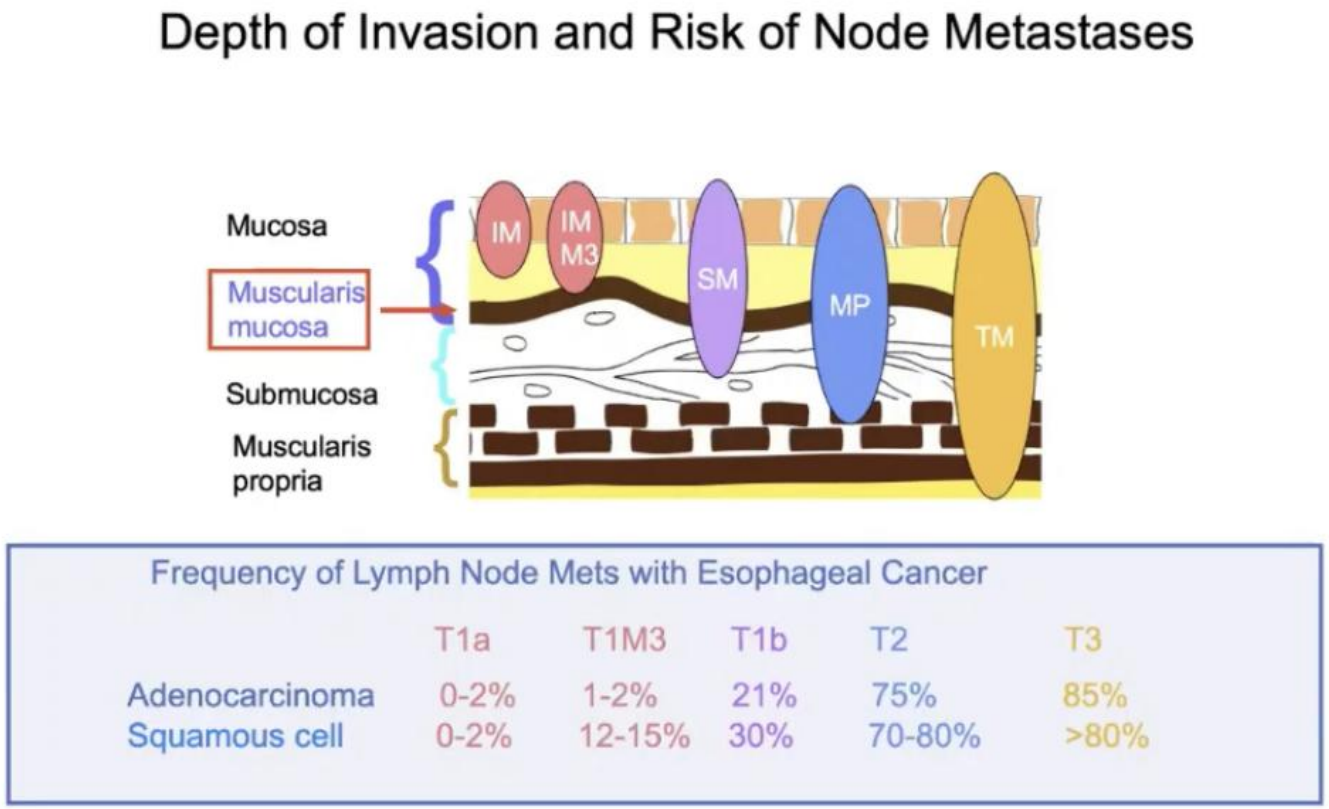
A Multicenter Propensity Matched Study

SANO (Surgery As Needed for Oesophageal cancer) trial

Based on current retrospective studies and short term results of the SANO, to date there is no evidence that active surveillance is unsafe.

……to offer active surveillance as an alternative treatment option in a controlled setting, there is a demand for a tailored surgery approach after neoadjuvant chemoradiotherapy until results of the SANO trial are available.

Early cancer



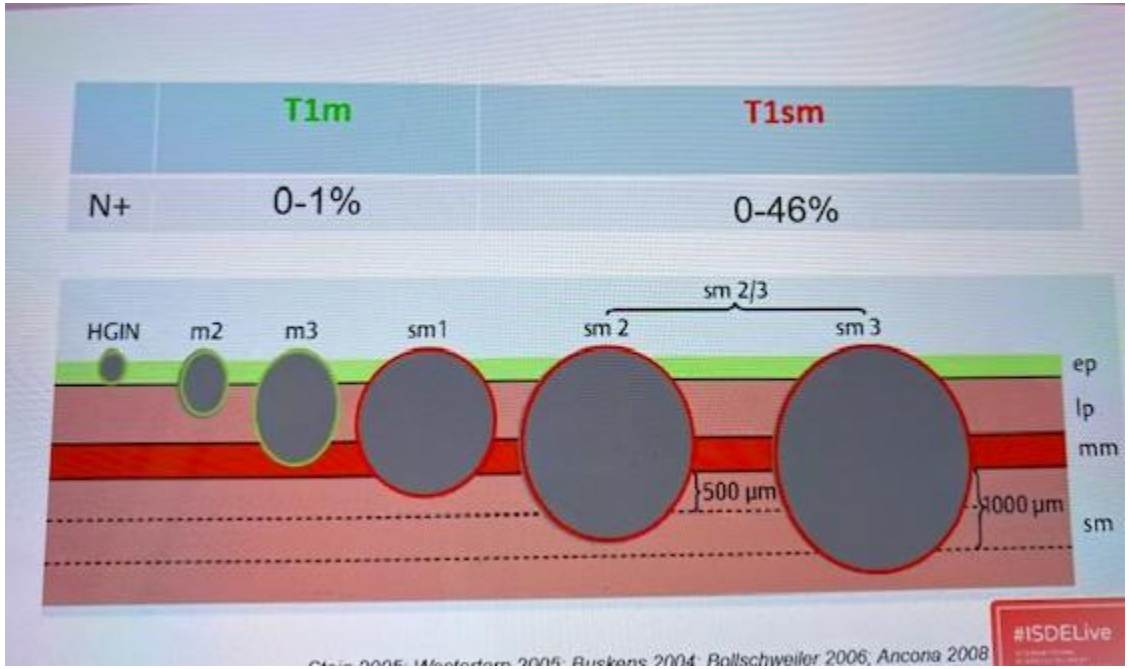
Early SCC

T1am1-m2 N+<2%

T1am3 N+>10%

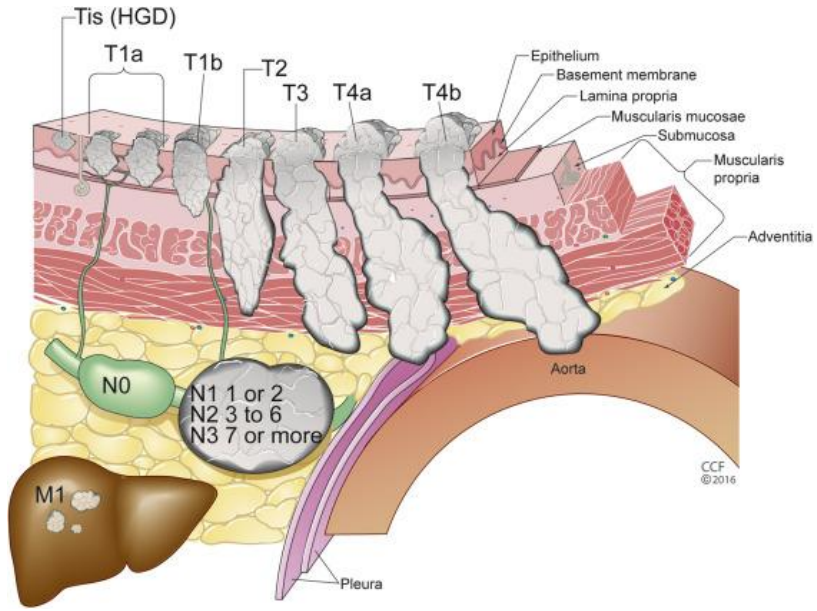
Early Adenocarcinoma

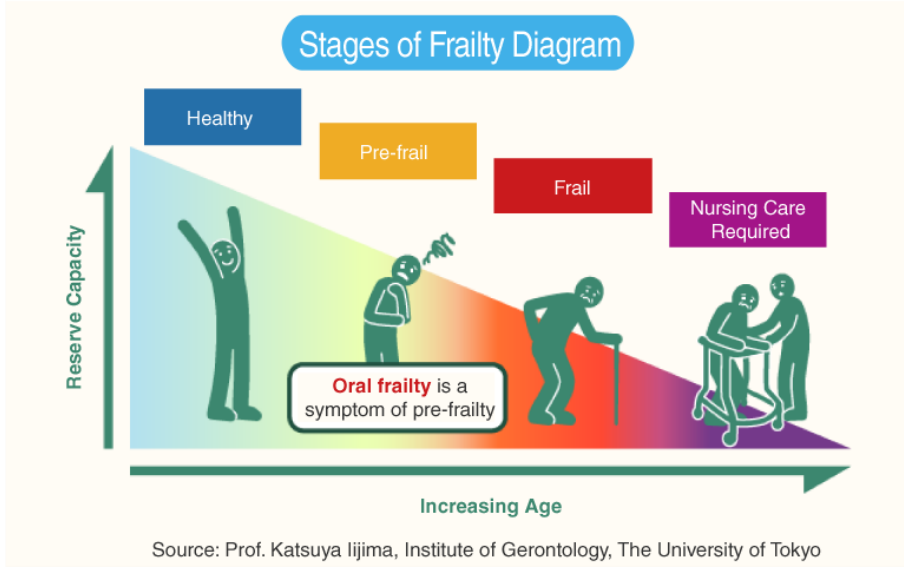
- < 2% in low risk T1b cancer (invasion< 500 nm, no Lv invasion, G1-2)
- 15-25% in high risk T1 b cancer (invasion> 500 nm, Lv invasion, G3-4)



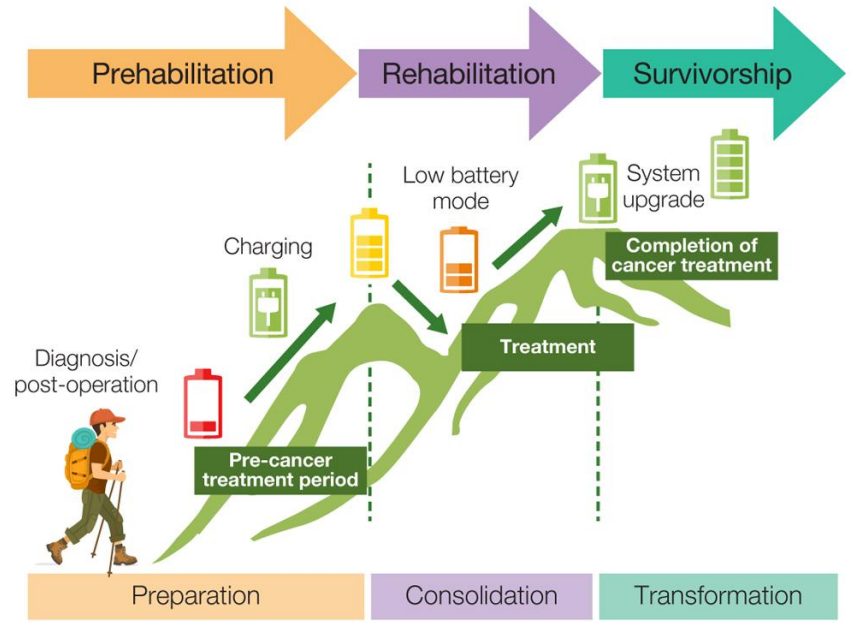
T1b low risk: endoscopic treatment

T1b high risk: Ivor lewis



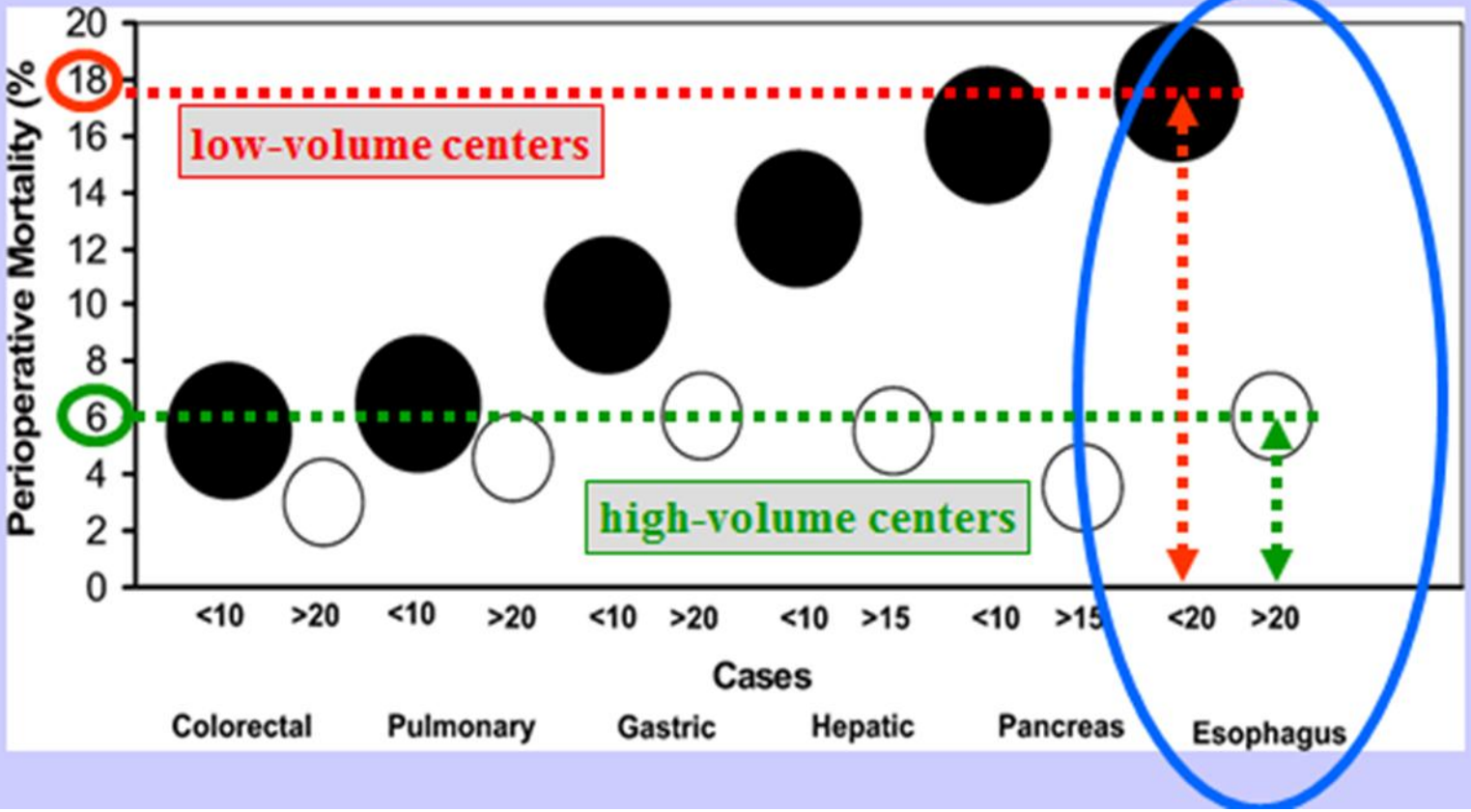


Source: Prof. Katsuya Iijima, Institute of Gerontology, The University of Tokyo



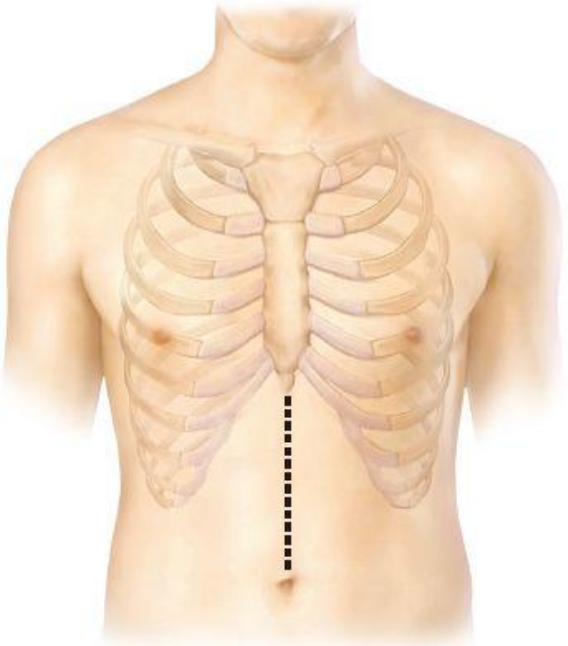
(Fig.1) Oncology Rehabilitation Journey

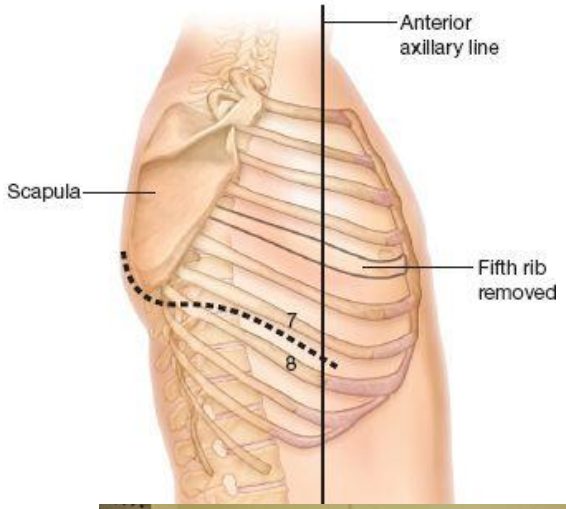
Perioperative mortality
for low- and high-volume centers by operation *Bentrem, 2005*

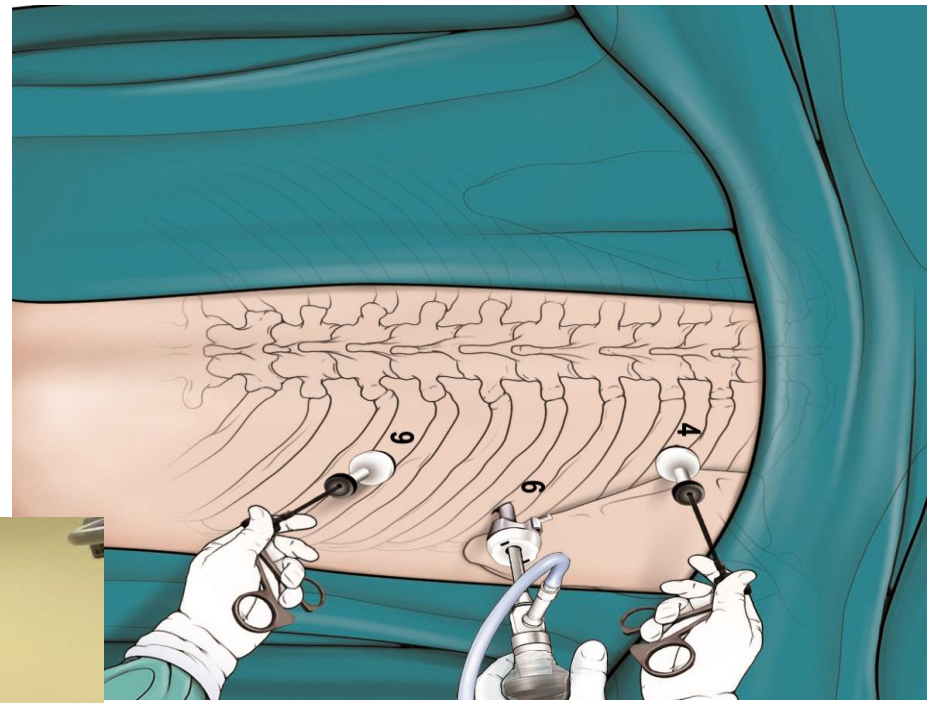


Pre-habilitation

Surgical visit	**Multidisciplinary board** Possible further illustration	CT/RT The end 6/8 weeks	Baseline visit, Respiratory and motor physiotherapist, nutrizionist, psychologist	Re-staging Pre-operative exam 2 weeks before	Rivalutation The day before surgery	Recovery **habilitation**




Anterior
axillary line
Scapula
Fifth rib
removed
7
8


6
9
4

Guidelines for Perioperative Care in Esophagectomy: Enhanced Recovery After Surgery (ERAS) Society Recommendations

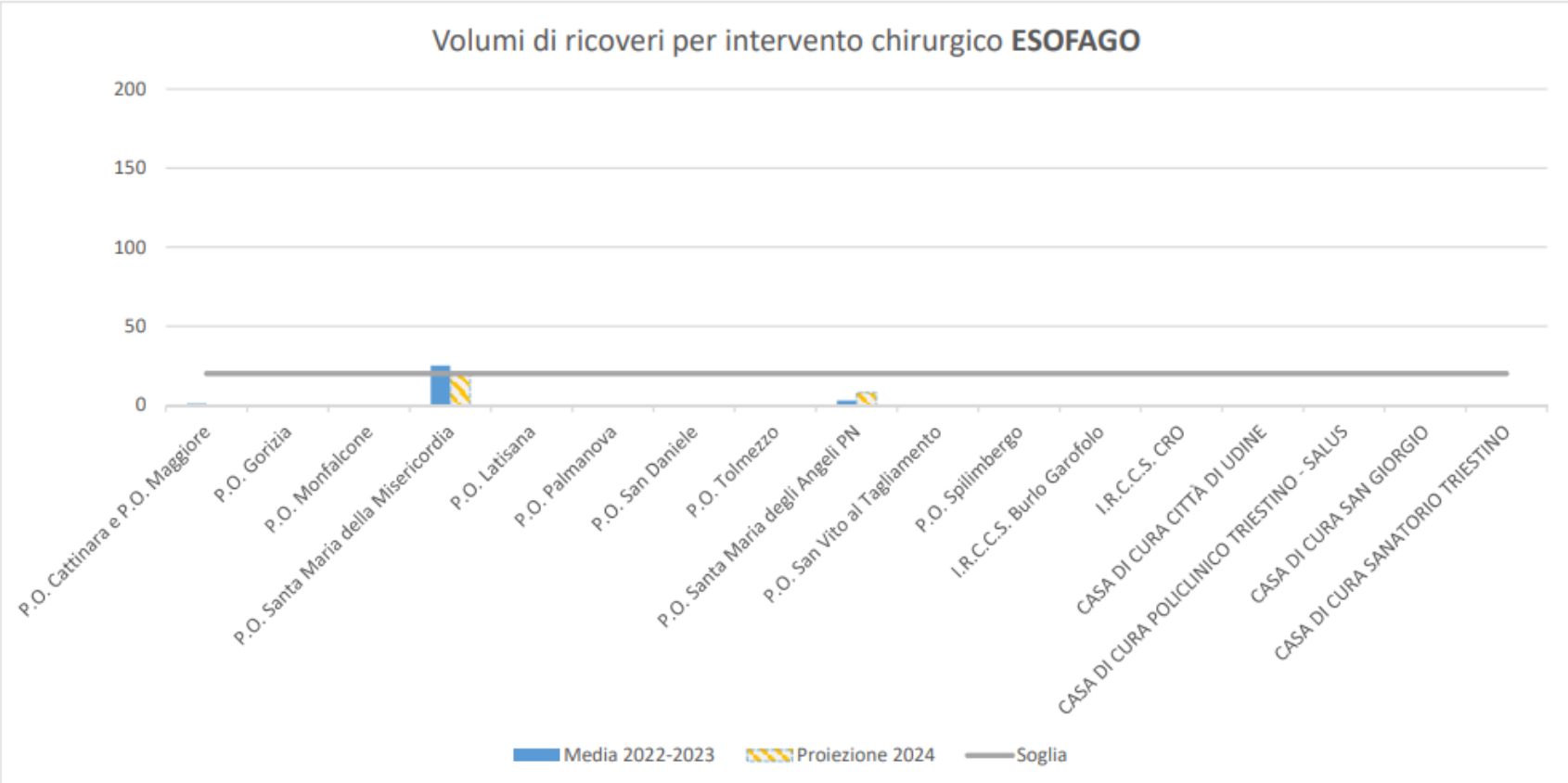
Element	Recommendation	Level of evidence	Recommendation grade
Procedure-specific components			
Preoperative nutritional assessment and treatment	Nutritional assessment should be undertaken in all patients with a view to detecting and optimizing nutritional status before surgery	Low	Strong
Preoperative nutritional intervention	In high-risk cases enteral support is indicated preferably using the GI tract with selective use of feeding tubes	Low	Strong
Preoperative oral pharmaconutrition	Evidence in support of pharmaconutrition for patients undergoing surgery for esophageal cancer is conflicting and its routine use cannot be supported at this time	Moderate	Strong
Multidisciplinary tumor board	There is limited data to support an improvement in overall survival. MDTs should be fundamental to management planning for all patients with esophageal cancer. MDTs ensure appropriate multidisciplinary input into patient care and improve the quality of that care	Moderate	Strong
Prehabilitation programs	Evidence from small studies supports the use of prehabilitation programs for major abdominal surgery, however there is limited data for esophagectomy. Patients undergoing esophagectomy may benefit from a multimodal prehabilitation program and ongoing assessments may provide additional information to direct future recommendations	*(Extrapolated, Small Studies)*: Low	Moderate

Operative components			
Timing of surgery following neoadjuvant therapy	The optimum time for surgery following neoadjuvant chemotherapy is 3–6 weeks following completion of chemotherapy. The optimum time for surgery following neoadjuvant chemoradiotherapy is 6–10 weeks following the last day of radiotherapy	Moderate	Moderate
Access: minimally invasive or open	Both open and minimally invasive approach to esophagectomy can yield acceptable outcomes. Recent assessments suggest that minimally invasive access during esophagectomy is feasible and safe and seems to be associated with some beneficial outcomes such as less perioperative blood loss, reduced rate of pulmonary infections and a shorter hospital stay without any clear significant disadvantages	Moderate	Moderate
Choice of conduit	The stomach, colon and jejunum are all viable options for conduit reconstruction after an esophageal resection. There is no single option or substitute appropriate for all patients and circumstances. The decision needs to be based on an awareness of the possibilities and limitations as well as short-term and long-term advantages and disadvantages of each organ as an esophageal substitute. Due to its reliable vascularity and relative simplicity a tubulized gastric conduit is recommended as the first option	*Gastric conduit*: Low *Tubulized stomach*: Moderate	Strong Strong
Role of pyloroplasty	The evidence for pyloroplasty and other pyloric drainage procedures is limited, with no strong evidence of effect on outcome. No specific recommendation on the role of pyloroplasty can be made at this time	Low	Strong

Postoperative early nutrition: oral vs jejunostomy	Introduction of early enteral nutrition is beneficial in patients undergoing surgery for esophageal cancer	Moderate	Strong
Early mobilization	Postoperatively, early mobilization should be encouraged as soon as possible using a standardized and structured approach with daily targets	Moderate	Strong
The role of multidisciplinary standardized clinical pathways	Evidence supports multidisciplinary care using a standardized pathway in the perioperative care of patients undergoing esophagectomy	Low	Strong
Audit	Continuous institutional audit of outcomes alongside key care processes should be part of daily practice. Audit contributing to institutional, regional, national or international datasets for benchmarking should be a targeted goal	Moderate	Strong
Non-procedure-specific components			
Preoperative counseling patient/family	Patients undergoing esophagectomy, and their family or care taker, should receive pre-operative counseling with emphasis on perioperative and postoperative targets and goals	Low	Strong
Smoking–alcohol cessation	Smoking should be stopped 4 weeks prior to surgery and regular high alcohol consumers should abstain at least 4 weeks before surgery to reduce postoperative complications	*(Extrapolated)*: Moderate	Strong

DESCRIZIONE STRUTTURA OSPEDALIERA-CHIRURGICA		ESOFAGO			
		Volume di ricoveri per intervento chirurgico ESOFAGO dal 2022 e PROIEZIONE 2024		Classificazione Regionale	Presenza GAMO
		Media 2022-2023	2024		
ASUGI	P.O.U. Cattinara e Maggiore	1	0	Hub	X
	P.O. Gorizia	-	-	Spoke	X
	P.O. Monfalcone	-	-	Spoke	X
I.R.C.C.S. Burlo Garofolo	I.R.C.C.S. Burlo Garofolo	-	-	I.R.C.C.S.	
ASUFC	P.O.U. Santa Maria della Misericordia di Udine	25	20	Hub	X
	P.O. Latisana-Palmanova – Sede di Latisana	-	-	Spoke	X
	P.O. Latisana – Palmanova – Sede Palmanova	-	-	Spoke	X
	P.O. San Daniele del Friuli – Tolmezzo – Sede San Daniele	-	-	Spoke	X
	P.O. San Daniele del Friuli –Tolmezzo- Sede Tolmezzo	-	-	Spoke	X
ASFO	P.O. Santa Maria degli Angeli di Pordenone	3	8	Hub	X
	P.O. San Vito al Tagliamento	-	-	Spoke	X
	P.O. Spilimbergo	-	-	Spoke	X
I.R.C.C.S. CRO	I.R.C.C.S. CRO	-	-	I.R.C.C.S.	X
CASA DI CURA CITTÀ DI UDINE		-	-		
CASA DI CURA POLICLINICO TRIESTINO – SALUS		-	-		
CASA DI CURA SAN GIORGIO		-	-		
CASA DI CURA SANATORIO TRIESTINO		-	-		
Fuga fuori Regione		1	n.r.		

Nei grafici successivi sono riportati i volumi degli interventi chirurgici distribuiti per struttura ospedaliera nell'anno media 2022-2023 e proiezione 2024 con evidenza del rapporto rispetto alla soglia standard ove presente.

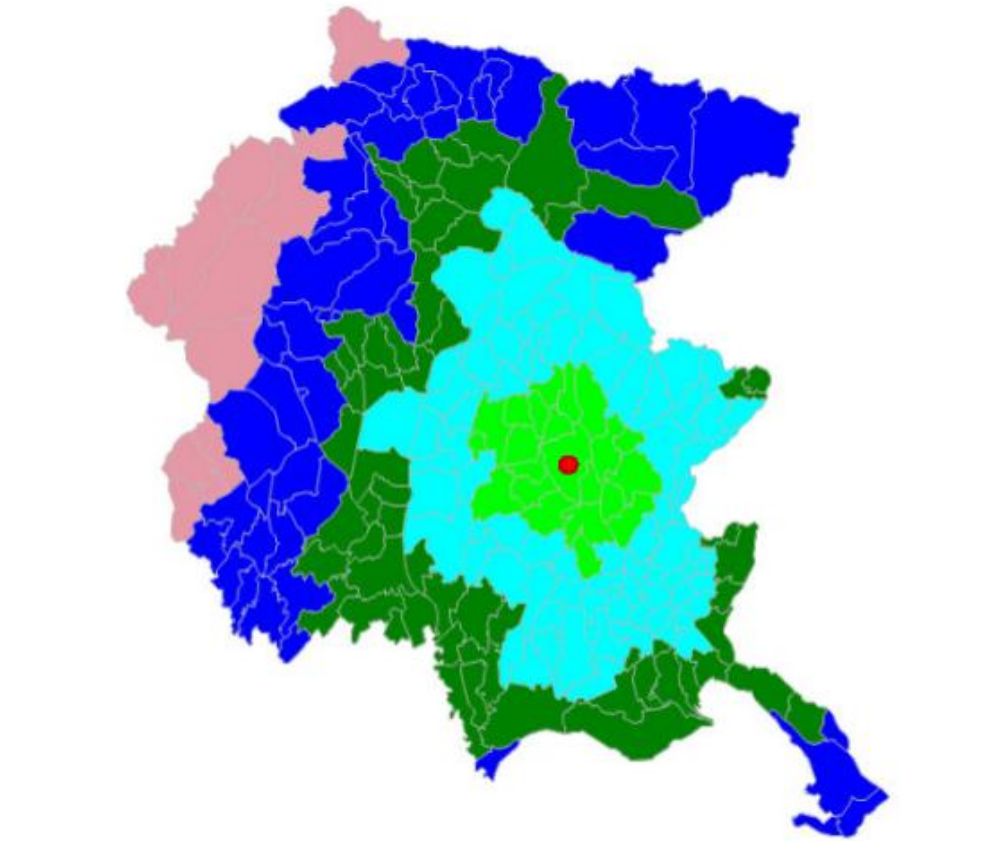


Di seguito vengono riportati per la media anni 2022-2023 I P.O. sopra soglia (indicatore PNE) e il numero interventi effettuati presso I P.O. con volumi appropriati.

	CASISTICA	FRIULI VENEZIA GIULIA
K. ESOFAGO	P.O.>soglia 20 interventi/aa	1
	P.O.totali	15

SELEZIONE DI FUNZIONI SPECIALISTICHE A SUPPORTO DELLA CHIRURGIA ONCOLOGICA (OSPEDALI HUB E PRESIDI SPECIALIZZATI IRCCS)					
TIPOLOGIA PRESIDIO (ex LR 22/2019)	**IRCCS Burlo Garofolo**	**IRCCS CRO**	**Presidio S. Maria degli Angeli**	**Presidio Cattinara**	**Presidio S. Maria della Misericordia**
	presidio specializzato	presidio specializzato	presidio di primo livello	presidio di secondo livello	presidio di secondo livello
FUNZIONE ex DGR 1965/2021					
emodinamica			X	X	X
chirurgia toracica				X	X
broncoscopia interventistica			X	X	X
UTIR				X	X
stroke unit			X	X	X
neurofisiopatologia				X	X
neurochirurgia				X	X
degenze malattie infettive				X	X
chirurgia vascolare			X	X	X
chirurgia plastica		X	X	X	X
gastroenterologia - endoscopia digestiva per procedure complesse (es. ERCP)		X*	X	X	X
medicina nucleare		X		X	X
radiologia inteventistica			X	X	X
neuroradiologia				X	X
radioterapia		X		X	X

TEMPI DI PERCORRENZA DAI COMUNI REGIONALI ALL'OSPEDALE SMM DI UDINE



tempo medio di percorrenza espresso in minuti:	33,94
tempo mediano di percorrenza espresso in	30,78
75° percentile nel tempo di percorrenza espresso in	45,8

Piano della
Rete Oncologica Regionale FVG
2025-2027

REGIONE AUTONOMA FRIULI VENEZIA GIULIA
Giunta Regionale

Delibera n° 117

Estratto del processo verbale della seduta del
31 gennaio 2025

oggetto:
LR 22/2019, ART 43 – "PIANO DELLA RETE ONCOLOGICA REGIONALE FVG 2025-2027". APPROVAZIONE DEFINITIVA.

ARCS
Azienda Regionale di Coordinamento per la Salute

Coordinamento della Rete Oncologica Regionale

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

RETE ONCOLOGICA REGIONALE DEL RIULI VENEZIA GIULIA

PIANO DI RETE

ALLEGATO 11 (Riorganizzazione attività chirurgica oncologica)

Riferimenti normativi specifici

DM 2 aprile 2017 n° 70: Regolamento recante definizione degli standard qualitativi, strutturali, tecnologici e quantitativi relativi all'assistenza ospedaliera:

art. 2 Classificazione delle strutture ospedaliere

art. 3 Standard minimi e massimi di strutture per disciplina

art. 4 Volumi ed esiti

art. 5 Standard generali di qualità

OGGETTO: Composizione GDL PDTA regionali – nomina componenti. RISCONTRO.

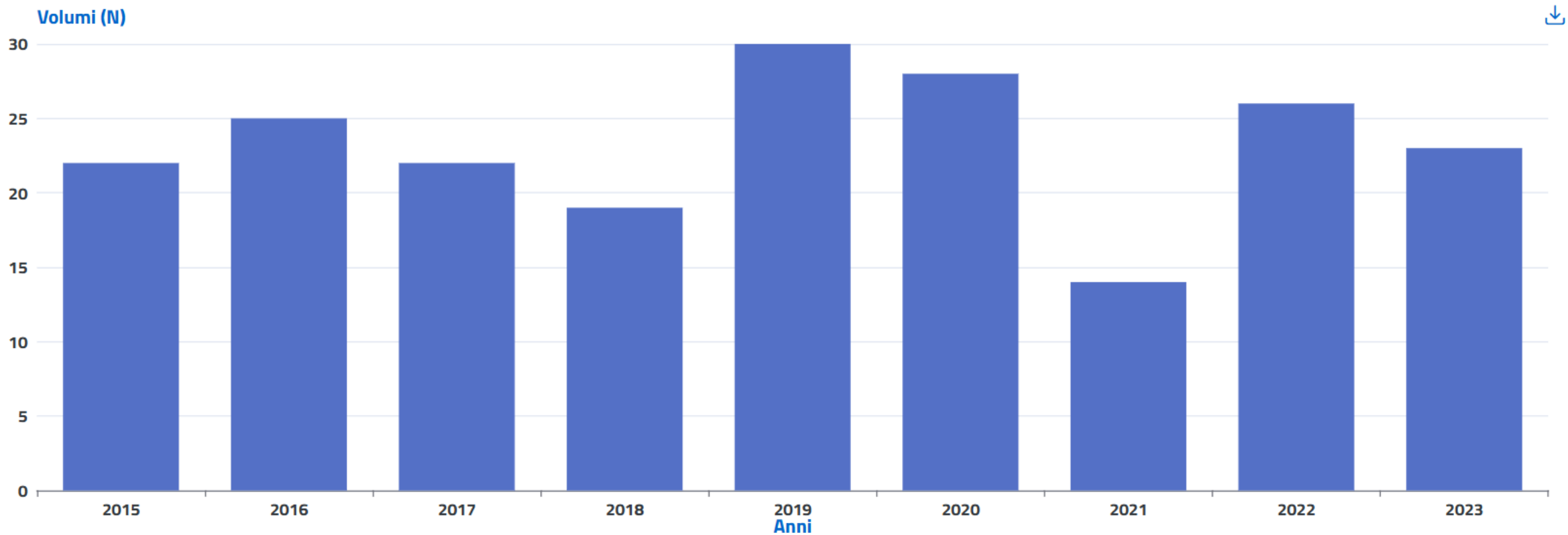
Spett.le Azienda Regionale,

a riscontro della nota ricevuta via mail e acquisita a protocollo con nr. 32069 in data 27.02.2025, in ottemperanza alla DGR 117/2025 (paragrafo 5.4 pag. 17) Piano della Rete Oncologica Regionale si comunicano, in qualità di componenti del GdL PDTA regionali, i nominativi dei professionisti individuati da questa Azienda in base alle specifiche competenze:

- Tumore esofago e giunzione esofago gastrica:

  Medico chirurgo - dr. Massimo Vecchiato (massimo.vecchiato@asufc.sanita.fvg.it);
  Medico gastroenterologo - dr. Daniele Macor (daniele.macor@asufc.sanita.fvg.it);

Presidio Ospedaliero Smm - Sede Udine - Intervento chirurgico per TM esofago: volume di ricoveri (2023)



Ambulatorio “CHIRURGIA ESOFAGO E STOMACO”

Pad 15 piano Terra il Lunedì dalle ore 11 alle 13:30

Alcuni esempi di quesiti diagnostici riportati sull'impegnativa:

- neoformazione, o neoplasia, o tumore dell’esofago, del cardias e dello stomaco
- carcinoma o adenocarcinoma dell’esofago, del cardias e dello stomaco
-GIST o leiomioma dell’esofago, del cardias e dello stomaco
- ernia jatale, ernia paroesofagea, ernia diaframmatica
-malattia da reflusso, MRGE, reflusso gastroesofageo
- acalasia esofagea
-diverticolo esofageo, diverticolo di Zenker


ADIGLIONE
15

The end