The Role of Radiation Therapy for Resectable Adenocarcinoma of the Gastroesophageal Junction

Ashraf and colleagues have recently published a review article on the adjuvant therapy of gastric cancer with a special focus on chemotherapy versus radiation [1]. The authors addressed the highly debatable question of the role of radiation therapy for resectable gastroesophageal junction adenocarcinoma. The authors cited the results of the MAGIC trial [2] of perioperative chemotherapy for stomach cancer and the CROSS study [3] of neoadjuvant chemoradiation for esophageal cancer (squamous cell and adenocarcinoma types). Both trials prolonged survival, but only small groups of junctional tumors (11%–24%) were included.

I thank the authors for the interesting and comprehensive article [1]. Adenocarcinoma of the gastroesophageal junction has become a very important subentity because of its rapidly rising incidence around the globe [4, 5]. Unfortunately, the authors did not mention the most relevant adjuvant phase III study for this group of patients, the French FNCLCC/FFCD 9703 study [6]. I believe that this study is essential for obtaining a complete picture of how to provide the most optimal multidisciplinary management for patients with gastroesophageal junction adenocarcinoma. In contrast to all other trials, the FNCLCC/FFCD 9703 study was dominated by gastroesophageal junction tumors. Sixty-four percent of all 224 patients had junctional tumors, 11% had lower esophageal tumors, and 24% had gastric adenocarcinoma. Patients received two or three cycles of cisplatin/5-fluorouracil followed by surgery or received surgery alone. After surgery, patients in the chemotherapy arm who responded to the preoperative therapy received additional cycles of chemotherapy. The perioperative chemotherapy resulted in significantly improved overall survival (5-year rate: 38% vs. 24%; hazard ratio [HR]: 0.69; 95% confidence interval [CI]: 0.50–0.95; $p = .02$). The gastroesophageal junction tumors derived the highest benefit from perioperative chemotherapy, with an HR of 0.57 (95% CI: 0.39–0.83). Interestingly, patients with gastroesophageal adenocarcinoma in the MAGIC trial seemed to derive a similarly high benefit from perioperative

chemotherapy (HR for death: 0.49; 95% CI: 0.28–0.88). In terms of the CROSS trial, the specific results for the subgroup of junctional tumors were not presented, but the adenocarcinoma group (HR: 0.741; 95% CI: 0.536–1.024; $p = .07$) benefited less than the squamous group (HR: 0.422; 95% CI: 0.226–0.788; $p = .007$) from neoadjuvant chemoradiation.

Based on the results of the FNCLCC/FFCD 9703 and the MAGIC trials, perioperative chemotherapy is associated with a relative risk reduction of death of around 40%–50%. Local recurrence in the FNCLCC/FFCD 9703 was observed in only 8%–12% of the patients. Taken together, in my opinion, it is unlikely that the addition of radiation therapy will easily improve patient outcome of this specific subgroup. The role of radiation therapy for adenocarcinoma of gastroesophageal junction remains unclear.

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Disclosures

The author indicates no financial relationships.

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