Comments on Radical Esophagectomy after Neoadjuvant Chemoradiation: Single Institutional Experience from Tertiary Cancer Centre in India

Arvind Krishnamurthy¹ • Vijayalakshmi Ramshankar²

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Sir,

I read with interest the manuscript entitled “Radical Esophagectomy after Neoadjuvant Chemoradiation: Single Institutional experience from Tertiary Cancer Centre in India” [1]. The management of esophageal cancers has indeed seen a paradigm shift from upfront surgery to either neoadjuvant chemoradiation (NACT-RT) or neoadjuvant chemotherapy (NACT) over the last decade. The authors experience in the present study definitely adds to the limited data available for NACT-RT followed by radical esophagectomy in developing nations. With a pCR rate of close to 40 % and an acceptable toxicity profile, the results of the retrospective study seem promising.

It is however worthwhile to note that the authors have used weekly cisplatin as the choice of chemotherapy in the NACT-RT regimen. Majority of the earlier published studies have used cisplatin and 5-fluorouracil-based NACT-RT [2], whereas the more recent ones have used a chemotherapy combination of paclitaxel and carboplatin [3, 4]. The National Comprehensive Cancer Network (NCCN) guideline recommends NACT-RT with either carboplatin/paclitaxel or cisplatin/fluorouracil or oxaliplatin/fluorouracil (category 1). NACT-RT with weekly cisplatin alone does not find a mention either in the current NCCN or in the European Society of Medical Oncology (ESMO) clinical practice guidelines.

Further, we would like to share our preliminary experience with NACT-RT in a selected cohort of locally advanced resectable esophageal cancers from another tertiary regional cancer center in India. The patient cohort comprised of the first 15 patients (performance status 0–1) of resectable mid and lower third esophageal cancers with TNM stages cT1-4a, N0-1, and M0 (pilot study on-going since June 2013). The NACT-RT schedule was as follows: days 1, 8, 15, 22, and 29, carboplatin targeted at an area under the curve (AUC) of 2 mg per milliliter per minute and intravenous paclitaxel at a dose of 50 mg per square meter of body-surface area. A total radiation dose of 41.4 gray in 23 # of 1.8 gray each, starting on the first day of the first chemotherapy cycle. The patients were taken up for surgery (either a transhiatal or McKeown transthoracic esophagectomy with two field lymphadenectomy) within 8 weeks following the completion of NACT-RT.

The incidence of grade 3/4 adverse events in our cohort was 20 %. Two patients progressed and were deemed inoperable on exploration (both T4a lower esophageal adenocarcinomas, one due to extensive serosal involvement and local infiltration and the other due to para-aortic nodal positivity). The remaining 13 patients underwent uneventful radical esophagectomies, with no major morbidities. A minor leak was seen in one patient, which settled on conservative treatment. Eleven out of the 13 patients had a pathological complete response, [tumor regression grade (TRG) 1] one patient had microscopic disease (TRG 2), and the other had residual ypT2N1 disease (TRG 4). Our data is not mature for survival analysis; however, it mirrors the experience of the authors of the present study in demonstrating the safety and feasibility of NACT+RT in a carefully selected cohort of patients of carcinoma esophagus from the Indian subcontinent.

The results of the trials of NACT-CT should however be viewed with a bit of caution, as not every patient with resectable carcinoma esophagus is a medically fit for this aggressive

✉ Arvind Krishnamurthy
drarvindkrishnamurthy@yahoo.co.in

¹ Surgical Oncology, Cancer Institute (WIA), 38, Sardar Patel Rd, Adyar, Chennai 600036, India

² Preventive Oncology, Cancer Institute (WIA), 38, Sardar Patel Rd, Adyar, Chennai 600036, India

trimodality treatment, and case selection plays a very crucial role. This is especially true in developing nations wherein a great majority of the patients are already nutritionally compromised with generally poor performance status at the time of diagnosis.

Finally, it is clear that based on survival data from several randomized controlled trials (RCTs) and meta-analyses that neoadjuvant treatment is the new standard of care for locally advanced resectable esophageal cancers [3–12]. A major unanswered question remains as to whether NACT-RT is clearly superior to NACT alone and how to select patients to receive one treatment over the other. This can be answered only by well-designed RCTs which directly compare NACT-RT versus NACT.

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