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Invited Commentary

When East Meets West, Understanding Is a 2-Way Street

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The 5-year outcomes of the Neoadjuvant Chemoradiotherapy for Esophageal Cancer 5010 (NEOCRTEC₅₀₁₀) trial, the largest multi-institutional trial to our knowledge to compare neoadjuvant chemoradiotherapy (NCRT) followed by surgery with surgery alone for patients with esophageal squamous cell carcinoma (ESCC), were reported by Yang and colleagues¹ in this issue of *JAMA Surgery*. The authors previously reported that 83% of patients in this study who were randomized to receive NCRT successfully underwent surgical resection, with the rate of R0 resection increasing from 91.2% without NCRT to 98.4% with NCRT.² Moreover, with the exception of postoperative atrial fibrillation, postoperative complications, anastomotic leak rates, and 30-day mortality rates were equivalent between the 2 groups. In the follow-up study, the authors report an absolute benefit in 5-year disease-free survival of 20.6% and 5-year overall survival of 10.8%. Furthermore, rates of locoregional and distant recurrence were both significantly lower in the NCRT group.

Whereas NCRT followed by surgical resection is considered the standard of care for esophageal cancer in European and North American countries, it is not yet widely used in Asia, where surgical resection alone remains the cornerstone treatment for this disease. Prior studies have reported similar results for NCRT plus surgery; however, the number of patients with ESCC in these series was small and perhaps insufficient to change practice in Asia, where very high volumes of this disease are seen.³ Although there are important differences in

study design, the results of the NEOCRTEC₅₀₁₀ trial confirm those of the ChemoRadiotherapy for Oesophageal cancer followed by Surgery Study (CROSS) trial and now support a practice change in Asia.⁴ Perhaps most striking is the impressive 5-year overall and disease-free survival for both groups (59.9% and 63.6% for those receiving NCRT plus surgery and 49.1% and 43.0% for those receiving surgery alone). In Europe and North America, the high rate of complete pathological response after NCRT has led to an approach of surgery as needed in the management of ESCC.^{5,6} However, the results of NEOCRTEC₅₀₁₀ validate the role of surgery in the treatment of this disease and serve as a testament to the value of a high-quality procedure. The surgical procedure in NEOCRTEC₅₀₁₀ was strictly controlled, with the requirement for a transthoracic approach and a 3-field lymphadenectomy in all patients. The results of this surgical standardization suggest we can do even better by combining NCRT with a well-executed, planned esophagectomy and thereby avoid the increased postoperative complications and poor oncologic outcomes that come with a salvage procedure.⁷

We look forward to the results of the ongoing SANO trial, which is randomizing patients to either active surveillance or surgical resection after NCRT.⁸ Hopefully, this trial will provide definitive answers to this East-West debate on the role of surgery in the management of ESCC. Until then, we should perhaps follow the lead of Asian colleagues and opt for planned optimal surgery after NCRT to avoid recurrence and prevent the harsh outcomes of salvage esophagectomy for patients with ESCC.

ARTICLE INFORMATION

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