Stent insertion for incurable oesophageal carcinoma: what is the optimal treatment? – Authors' reply

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We thank Dong Tian and colleagues for their interest in the ROCS trial.[1] The primary outcome of patient-reported differences in dysphagia recurrence is in keeping with the demand for studies which address quality of life in this palliative group, rther than survival.[2, 3] The trial was stratified for those preplanned to receive chemotherapy, but was not powered to detect a difference in overall survival on the basis of chemotherapy receipt.

In response to the first question, as reported of those preplanned to have chemotherapy, 29 (81%) of 36 in the usual care group and only 15 (44%) of 34 in the external beam radiotherapy group actually received chemotherapy post-stent. The numbers are too small to reliably assess for differences in overall survival between groups. For completeness, post-hoc analysis shows median overall survival for those receiving post-stent chemotherapy of 34·7 weeks (95% CI 27·6–82·9) in the usual care group versus 26·7 weeks (15·4–34·4) in the external beam radiotherapy group (HR 1·67, 95% CI 0·79–3·5; p=0·18). Therefore, there was no trend of benefit from the adjuvant radiotherapy–chemotherapy combination.

In response to the second question, post-hoc analysis shows median overall survival for all those who received post-stent chemotherapy (n=50) of 30·3 weeks (95% CI 26·7–39·1) versus 14·7 weeks (12·3–18·4) in those who did not (n=149; adjusted HR 0·41, 95% CI 0·28–0·60; p<0·0001). Notably, there was no intent to standardise chemotherapy—various regimens were used—and chemotherapy appears to have been offered to fitter patients, reflected by a much lower death rate before 12 weeks post-stent in the chemotherapy group (one [2%] of 50) than in the no-chemotherapy group (55 [37%] of 149).

The data from ROCS therefore does not provide any reliable evidence of additional survival benefit for chemotherapy in the participant group. UK audit findings showing poor completion rates for patients with oesophagogastric cancer offered palliative chemotherapy[4] emphasise the importance of careful selection in this palliative group.

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References

1. Adamson D, Byrne A, Porter C,et al.**Palliative radiotherapy after oesophageal cancer stenting (ROCS): a multicentre, open-label, phase 3 randomised controlled trial.** *Lancet Gastroenterol Hepatol.* 2021; **6**: 292-303.
2. Shenfine J, McNamee P, Steen N, Bond J, Griffin SM. **A randomized controlled clinical trial of palliative therapies for patients with inoperable esophageal cancer.** *Am J Gastroenterol.* 2009; **104**: 1674-1685
3. Dai Y, Li C, Xie Y et al. **Interventions for dysphagia in oesophageal cancer.** *Cochrane Database Syst Rev.* 2014; **10**CD005048
4. Healthcare Quality Improvement Partnership. An audit of the care received by people with oesophago-gastric cancer in England and Wales 2019 Annual Report. London, 2019.