Letter to the Editor

Pan-endoscopic tumor length as the marker to predict response to neoadjuvant therapy for ESCC warrants additional investigation

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Submitted Jan 18, 2018. Accepted for publication Mar 20, 2018.
doi: 10.21037/jtd.2018.03.144
View this article at: http://dx.doi.org/10.21037/jtd.2018.03.144

We read the report by Lin and colleagues on the predictive value of tumor length for patients with resectable esophageal squamous cell carcinoma with great interest (1). A survival benefit among patients with esophageal cancer receiving neoadjuvant chemoradiotherapy has been consistently reported (2). However, the lack of predictive markers associated with neoadjuvant concurrent chemoradiotherapy (nCCRT) sensitivity represents a major challenge for the development of nCCRT, which has attracted significant interest in recent years (3). Lin and colleagues should be commended for their efforts in establishing criteria based on initial pan-endoscopic tumor length to select appropriate esophageal squamous cell carcinoma (ESCC) patients for nCCRT followed by esophagectomy. Upper gastrointestinal (GI) endoscopy is routinely performed in every patient with ESCC. Therefore, this predictive model for nCCRT efficacy is readily available and highly practical. However, some points of the manuscript warrant discussion.

First, the tumor length estimated endoscopically may sometimes fail to represent the actual tumor length. According to the Paris Classification of superficial neoplastic lesions in the digestive tract, the endoscopic morphology of esophageal neoplastic lesions can be divided into three categories: protruding lesions, non-protruding and non-excavated lesions, and excavated lesions (4). In addition, advanced esophageal cancer can be generally divided into four macroscopic types: fungating, ulcerated, medullary, and narrow. Correspondingly, different macroscopic morphologies imply different growth patterns: intramural, extramural, or mixed. For the latter two patterns, complete views of the tumor may be unattainable by endoscopy because the major part of the lesion may be hidden beneath the esophageal mucosal. Just as an iceberg appears to float in the water, its huge mass remains below the surface.

Second, the authors did not provide a process for addressing special cases, namely, multiple primary ESCC and severe luminal stenosis. For multiple primary lesions, two methods can be used to record tumor length: the sum of the lengths of multiple lesions or the length of the longest lesion. In addition, adequate visualization of the lesion cannot be achieved in the context of severe luminal stenosis because the endoscope cannot be advanced to the tumor site. Did any patients included in Lin's study exhibit this condition? These details should be added in the method section.

Third, an inter-observer bias may be inevitable because upper GI endoscopy cannot be performed by a single specialist. This limitation should be added in the discussion section.

In short, the author should provide readers with more information regarding measurement methods for different macroscopic morphologies and special cases.

Acknowledgements

None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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Cite this article as: Deng YF, Yuan TZ. Pan-endoscopic tumor length as the marker to predict response to neoadjuvant therapy for ESCC warrants additional investigation. J Thorac Dis 2018;10(Suppl 9):S1122-S1123. doi: 10.21037/jtd.2018.03.144

