IS NEOADJUVANT CHEMOTHERAPY REALLY BETTER THAN NEOADJUVANT CHEMORADIOThERAPY IN PATIENTS WITH ESOPHAGEAL SQUAMOUS CELL CARCINOMA?

To the Editor:

We read with great interest the article by Yu and colleagues.1 The authors conducted a single-center cohort study and utilized propensity score matching and the inverse probability of treatment weighting to adjust for confounding factors. This study comparing neoadjuvant chemotherapy combined with immunotherapy (NACI) versus neoadjuvant chemoradiotherapy in patients with locally advanced esophageal squamous cell carcinoma provides substantial insights into the evolving landscape of cancer treatment modalities. The authors suggest that NACI followed by surgery may be an effective treatment strategy for locally advanced esophageal squamous cell carcinoma. Although Yu and colleagues1 have conducted a well-matched and meaningful study, there are certain points that require further discussion.

Firstly, the authors describe that, “Regularly, the 2-field lymphadenectomy was conducted, whereas a 3-field lymphadenectomy was required for patients having suspected metastatic lymph nodes within the cervical area.” This implies that some patients with suspected metastatic lymph nodes underwent a 3-field lymphadenectomy. According to current staging criteria, a metastatic supraclavicular lymph node corresponds to the M1 stage in the TNM staging system of the Union for International Cancer Control/American Joint Committee on Cancer.2,3 Patients classified as stage M1 are categorized as stage IVB.4 However, these specific patients are not revealed in the article’s Tables 1 and 2. Furthermore, the flow diagram of the selection of eligible patients (the authors’ Figure 1) does not indicate that patients with metastatic supraclavicular lymph nodes were excluded from the study. As a result, the question arises as to whether metastatic supraclavicular lymph nodes became negative by neoadjuvant therapy, or if patients with suspected metastatic lymph nodes in this region had a low preoperative assessment accuracy (approaching 0). This requires an explanation.

Then, the univariate analysis in the authors’ Table 3 suggests that when NACI and neoadjuvant chemoradiotherapy are compared, a hazard ratio (HR) value of 2 indicates that NACI is more risky (HR, 2.732; 95% CI, 1.029-7.254), which contradicts the results in their Figure 3. Moreover, the authors’ Table 4 shows the same results. Univariate analysis suggested that smoking index > 400 and alcohol abuse were both protective factors, with HR values < 1.

In terms of overall survival, patients with stage IV in cTNM staging had an HR of 0.629 and so on. This should be corrected, otherwise such results are unbelievable.

Although this study holds clinical significance, it requires further refinement and discussion of the relevant details to improve the comprehensiveness of the conclusions. This will be crucial for advancing clinical practice and optimizing outcomes for patients with these challenging conditions. We look forward to further discussion and clarification on these points, and we believe that addressing these issues will enhance the quality and influence of this important research.

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References

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