LETTER to the EDITOR

Comments on - Neoadjuvant Chemo-radiation with IMRT in Resectable and Borderline Resectable Pancreatic Cancer

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Dear Editor

We read with interest the article by Kharofa et al (2014) about the neoadjuvant chemo-radiation with IMRT in resectable and borderline resectable (BLR) pancreatic cancer. It is encouraging to see that patients with borderline resectable disease who are successfully down staged by neoadjuvant chemoradiation, had improved rate of R0 resection and resulted in improved loco-regional control and therefore better survival outcome. However we would like to comment on few aspects of the article.

The authors have followed their own institutional criteria of borderline resectablility which is different from the NCCN guidelines (Lopez et al., 2014). The authors included tumour induced narrowing of >50% of SMV, PV, or SMV–PV confluence as a criteria for borderline resectability. The given criteria of patient stratification could have made heterogenous patient groups and inter institution comparisons may be difficult.

Computed tomography scan findings suspicious but not diagnostic of metastatic disease were also included as borderline resectable patients despite distant metastasis is a definite criteria for unresectability according to NCCN guidelines.Small liver lesions which are too small to characterize may have been missed which could have made the disease metastatic. Did this selection criteria influence the final result and if it did upfront laparoscopy and PET /CT could be justified. This is a limitation for comparative evaluation of the present article with other published literature.

Of the 7 patients who received upfront chemoradiation, only one could be resected post completion of treatment compared to 22 of the 32 who received induction chemotherapy. The induction chemotherapy regimens used were quite varied though the most common one was Gemcitabine/cisplatin followed by FOLFIRINOX. If the results of outcome were stratified as per the chemotherapy, a potential source of bias could be eliminated. The criteria and dosage of drugs used in the chemotherapy regimens are also not detailed. Was the decisions based demographic and clinico-pathological characteristics or physician's choice? The concomitant chemo-radiation regimen was also heterogeneous in nature. It is imperative to know whether such heterogeneity had an impact on final outcome.

We appreciate the use of intensity modulated radiotherapy (IMRT) with image guidance for radiation planning of the present study. However we have concern regarding in their target delineation. The authors have used a non-uniform approach of including the nodes along celiac axis in the clinical target volume (CTV). The authors while delineating the CTV for carcinoma of head of pancreas have not included the celiac group of nodes in select group of patients, the para-aortic group of nodes is not included in the CTV. However current guidelines recommend inclusion of these nodal basins for pre-operative radiation therapy in carcinoma pancreas (Caravatta et al., 2012).

Surgery remains the cornerstone in the management pancreatic cancer and R0 resection strongly relates to improved loco-regional control. This is reflected in the current study as the overall survival was superior in patients undergoing surgical resections. Considering patients with resectable and BLR disease who finally underwent a curative resection, was the survival outcome equivalent? There was no mention of the survival rates in the two groups.

References

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Sushmita Pathy*, Antony George Francis, Soumyajit Roy

*Department of Radiation Oncology, Dr.B.R.Ambedkar Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, Ansari Nagar, New Delhi, India *For correspondence: drspathy@gmail.com*