

# Number of Nodes Predicts Esophageal Ca Survival

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NEW YORK — The total number of lymph nodes removed during esophagectomy is a potent independent predictor of survival in esophageal cancer patients, according to a large prospective international study.

“To maximize the outcome of surgical therapy, a minimum of 23 nodes should be removed. And the operation most likely to achieve this goal is an en bloc esophagectomy,” Dr. Christian G. Peyre said at the annual meeting of the American Surgical Association.

The number of excised lymph nodes was the third-strongest predictor of survival in



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DR. HAGEN

the study, behind the number of cancer-positive nodes and depth of tumor invasion. Histologic cell type was another independent predictor, with squamous cell tumors being associated with worse survival.

Of note, the number of excised nodes is the only predictive factor a surgeon can influence, observed Dr. Peyre of the University of Southern California, Los Angeles.

He reported on 2,303 esophageal cancer patients at nine centers, including three in the United States. All of the patients underwent esophagectomy with negative tumor margins and were then followed for 5 years. None got adjuvant or neoadjuvant chemotherapy or had T4 disease.

Median overall survival was 89 months. Five-year survival in patients who had 23 or more lymph nodes removed was 43%, significantly better than the 37% figure in patients with fewer nodes removed. The benefit of a more aggressive lymphadenectomy was greatest among patients with advanced disease: 5-year survival was 24% in those with at least 23 nodes removed, nearly double the 13% rate in patients with fewer than 23 nodes excised.

Three-quarters of study participants had esophagectomy with thoracotomy. Among the procedures surgeons chose to perform were transhiatal, transthoracic, and thoracoabdominal esophagectomies. But en bloc resection had the highest success rate in removing at least 23 nodes. Two-thirds of patients with an en bloc esophagectomy had at least 23 lymph nodes removed; only a minority of patients who underwent any other type of operation achieved that benchmark, according to Dr. Peyre.

One of the discussants Dr. Stephen G. Swisher, professor and chairman of surgery at the University of Texas M.D. Anderson Cancer Center, in Houston, commented that the intriguing implication of this study is that the extent of lymphadenectomy is important not only for staging esophageal cancer—its traditional

purpose—but also for improving survival.

Another discussant, Dr. Murray F. Brennan, challenged that interpretation. Asserting that a minimum of 23 lymph nodes must be removed to maximize survival is “an extraordinarily strong statement,” he said.

“This paper addresses an association, which doesn’t prove causation,” argued Dr. Brennan, chairman of the department of surgery at Memorial Sloan-Kettering Cancer Center, New York.

Both discussants expressed skepticism that en bloc esophagectomy is superior.

Dr. Jeffrey A. Hagen, a senior coinvestigator on the study, replied that the findings are consistent with a report by other investigators based on Survival, Epidemiology, and End Results data showing that the number of nodes removed influences survival in gastric cancer.

As for the assertion that en bloc esophagectomy is superior, he conceded that the type of operation performed was

not an independent predictor of survival in the international study, but the study was not designed to look at that as an end point.

The investigators showed in a separate recent study that en bloc esophagectomy provided a survival advantage over transhiatal resection in esophageal cancer patients who had received neoadjuvant therapy (J. Thorac. Cardiovasc. Surg. 2008; 135:1228-36), added Dr. Hagen, chief of thoracic/foregut surgery at Los Angeles County Medical Center. ■

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