Salvage esophagectomy: "We made too many wrong mistakes"

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Is salvage esophagectomy the solution to failure of definitive chemoradiotherapy for esophageal cancer? Is the addition of a more extensive lymphadenectomy to salvage esophagectomy a therapeutic step forward or a further compounding of a therapeutic oversight? In considering the report by Wang and colleagues,[1] we are reminded of Yogi Berra's explanation for his team's failure: "We made too many wrong mistakes."

Wang and colleagues[1] reported a 14-year experience of salvage esophagectomy in 140 patients. Despite salvage surgery in all, 25% were excluded from the analysis. An additional problem in understanding the applicability of this experience is that the denominator for the entire experience with definitive chemotherapy for squamous cell esophageal cancer was unstated. In this highly select group of patients, not surprisingly, the ability to resect (R0) an early yp-stage cancer (ypN0M0) has been associated with improved survival.[2] As previously reported, tumor biology, reflected by the response to chemoradiotherapy (resection of recurrent cancer and not persistent cancer), was associated with improved survival.[2] After a vigorous multistep analysis that failed to demonstrate a cutoff for optimal lymphadenectomy (number of nodes excised), Wang and colleagues[1] arbitrarily chose to dichotomize this continuous variable. In the ensuing multivariable analysis, this "forced" variable ($\geq$15 resected nodes resected) was associated with improved survival. However, was this not using statistical manipulations until the desired answer had been obtained? Possibly, the relationship is nonlinear. Lymphadenectomy was the focus of their report; however, this potentially spurious finding does not answer the questions concerning salvage esophagectomy.

It is not unexpected from previous publications that an adequate R0 resection of a "recurrent" early yp-stage cancer has the potential for cure.[2] However, this clinical scenario represents a highly selected and uncommon patient after definitive chemoradiotherapy. Salvage esophagectomy and extended lymphadenectomy is not the answer: treatment planning in a multidisciplinary setting is. No extent of lymphadenectomy will remedy the lack of communication during the prescribing of therapy. Salvage esophagectomy is a marker of a serious failure of the medical system.

> Failing to prepare, you are preparing to fail.
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> —Benjamin Franklin

References

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