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LETTER – GASTROINTESTINAL ONCOLOGY

Letter to the Editor Regarding 'What is the Best Option Between Primary Diverting Stoma or Endoscopic Stent as a Bridge to Surgery with a Curative Intent for Obstructed Left Colon Cancer? Results from a Propensity Score Analysis of the French Surgical Association Multicenter Cohort of 518 Patients'

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Dear Editor,

We read with interest the recently published article "What is the Best Option between Primary Diverting Stoma or Endoscopic Stent as a Bridge to Surgery with a Curative Intent for Obstructed Left Colon Cancer? Results from a Propensity Score Analysis of the French Surgical Association Multicenter Cohort of 518 Patients" by Mege et al.[1]

We congratulate the authors on the results of their comparison of decompressing stoma and self-expandable metal stent (SEMS) placement. However, while reading the paper, a few questions arose, which we would like to address.

The stent group contained significantly more stage IV tumors (29% vs. 16%, $p = 0.04$). When considering the cause of death, evolution of the tumor is mentioned in 50% of patients in the diverting colostomy group versus 62% in the stent group. It is difficult to interpret if and how the authors exactly corrected for this important baseline difference. Correcting for TNM classification using the propensity score might have been complicated by missing values for at least 30 patients in the stent group. We also question what the separate T and N stages were as only the overall TNM stage was provided. From this perspective, it is remarkable that tumors in the stent group were larger (55% vs. 40% larger than 5 cm in diameter, $p = 0.03$), which could indicate a higher number of T4 tumors in the stent group. Furthermore, the authors did not mention completeness of resection (R0/R1/R2).

The authors report a 77% technical success rate for stent placement, with a bowel perforation rate of 11%, despite these procedures being performed by experienced gastroenterologists. The definition of experience in stenting may be variable, but has been defined as at least 20 procedures according to European Society of Gastrointestinal Endoscopy (ESGE) guidelines.[2] In addition to experience, patient selection may have been another crucial factor, given the fact that more than half of the tumors were larger than 5 cm. Furthermore, long strictures (< 4 cm) have been associated with stent failure.[3]

It is notable that even after excluding patients with palliative treatment intent, cumulative tumor resection rates were only 80% in the diverting colostomy group and 86% in the stent group. The authors specifically mention that palliative intent included "patients for whom the resection of the primary tumor was not considered". It would be interesting to know their reasons for not performing resection (e.g. progressive disease, complications of either deviating colostomy or endoscopic stent?) Unfortunately, the authors also did not report the bridging interval, which could have given some insight into the notably low primary anastomosis rates observed in the stent group (40%). Considering the diverting colostomy

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group, a perforation rate of 9% (Table 3) and 6% (text) is reported. As clinical signs of perforation are an indication for emergency resection, we question what type of perforations the authors meant.

Finally, the authors conclude that SEMS patients show better surgical outcomes. Although this patient group demonstrated a lower morbidity rate, fewer primary anastomoses were constructed, with similar permanent stoma rates compared with deviating colostomy patients. Considering oncological outcomes, it is difficult to interpret the absence of a disease-free survival (DFS) difference (both groups had a median DFS of 54 months), with a subsequent substantial difference in overall survival (124 months after colostomy and 59 months after stent). This suggests an important role of non-cancer-related deaths, and that there were probably important but unknown confounders, resulting in incomparability of the two groups despite adjusting for the propensity score.

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