Ann Surg Oncol (2019) 26:1954–1955
https://doi.org/10.1245/s10434-019-07281-3

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY



LETTER – COLORECTAL CANCER

# Response to Dr. Veld et al. Regarding the Manuscript Titled "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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**TO THE EDITORS:**

We read with great interest the comment on our paper by Veld et al. The use of endoscopic stent (ES) as a bridge to surgery, and its impact on survival, remains a matter of debate and a hot topic. Published data are contradictory, but several studies suggest a negative impact of ES on survival[1,2]; therefore, ES as a bridge to surgery is not recommended by the French and European guidelines.[3,4]

The aim of the present study was to evaluate ES in a large database of patients collected retrospectively at a national level. As underlined by Veld et al., this method is associated with some biases, which we attempted to reduce by using propensity score matching. It is true that the proportion of patients with metastases was higher in the ES group, therefore we included it in the propensity score matching. The T and N stages did not defer between the two groups and were not included in the propensity score. We decided to include patients with metastases in the analysis, as, according to the investigators, these patients were managed with curative intent. It also remains true that the propensity score might not exclude all types of biases, but is the most relevant methodology for a retrospective study. Veld et al. also underline that resection type was not reported, but, in all patients who underwent resection, the resection was described as being R0, with the exception of two patients in the ES group (R1 resection). This was not significantly different and was thus not included in the propensity score analysis.

As underlined by Veld et al., the perforation rate of 11% is high, but this is not surprising, according to the high failure and perforation rates observed in randomized trials, and is contrary to the high success rates reported in most single-center series.[5,6] This might reflect the exhaustivity of data and/or the real-life data provided by all participating centers.

As underlined by Veld et al., the rate of incomplete resection remains high in both groups, and is not only strictly related to the feasibility of only primary tumor resection but also to the resection of metastases. Metastases were considered resectable if they were resectable at the beginning of the treatment by each participating center.

Finally, the difference in overall survival, but not disease-free survival, might reflect different matters. First, this might be due to the lack of events related to the cancer during the follow-up period, and, second, as described in the paper, the cause of death was for one-quarter of subjects in both groups, and was related to medical conditions other than cancer.

In conclusion, it is highly improbable that another randomized controlled trial on ES is feasible as several one failed to include, mainly because of the occurrence of too many events in the ES group. We think that despite some



First Received: 25 February 2019;
Published Online: 6 March 2019

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limitations due to the methodology, the present multicenter study adds another word of caution regarding the use of ES as a bridge to surgery.

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