Reply to "Intensifying Neoadjuvant Therapy for Rectal Cancers Towards Watchful Waiting," by Chakrabarti, Deep, et al.

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LETTER – COLORECTAL CANCER

Reply to "Intensifying Neoadjuvant Therapy for Rectal Cancers Towards Watchful Waiting," by Chakrabarti, Deep, et al.

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We thank Dr. Chakrabarti and colleagues for their interest in our manuscript and their observations. During the period of the study, from 2009 to 2018, the institutional protocol of neoadjuvant chemoradiation for locally advanced rectal cancer remained the same. The larger number of locally advanced rectal cancers in the second period was related to the centralization of colorectal cancer care in a regional collaboration.

The watch-and-wait protocol (W&W) was started in 2015 in close collaboration with the Netherlands Cancer Institute, an expert center for W&W with all patients included in a Dutch prospective registry as well as in the International Watch and Wait Database (IWWD). Patients with a near clinical complete response are included because current diagnostic tests are not sufficiently accurate to detect true responders, and it has been shown that the majority of near-complete responses evolve into a complete response by a second evaluation.[1] Our series showed no difference in local regrowth between these two groups, with 4 (36%) of 11 patients exhibiting a complete response and 9 (31%) of 29 patients exhibiting a near-complete response.

The study was underpowered to evaluate any difference in oncologic outcomes between the two groups, but none of the findings support the notion of Chakrabarti and colleagues that a total mesorectal excision (TME) would have been better for the patients with a near-complete response.

We agree that tumor response is related to the interval between neoadjuvant chemoradiation and restaging. The first response evaluation was planned 8 weeks after the neoadjuvant chemoradiation, and indeed the range of this period was 5 to 22 weeks. However, the median time to the first response evaluation for cohort B (patients with structural response evaluation following neoadjuvant chemoradiation) was 8 weeks.

The location of the tumors is presented in the baseline characteristics of the original manuscript and did not differ significantly between the two cohorts.[2] Therefore, the decrease in the number of patients requiring a stoma seems directly related to the W&W strategy. We agree with Chakrabarti and colleagues. that chemoradiation may lead to poor functional outcome. A recent study reported major low anterior resection syndrome (LARS) for 33% of the patients after neoadjuvant chemoradiation.[3]

As correctly noted, the field of organ preservation is continuing to evolve, with many current studies on radiotherapy dose escalations and studies on incorporating systemic therapy. Although it currently is not clear which schedule provides the best response, one thing is certain: organ preservation is here to stay.

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