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Identification of risk-factors for perioperative morbidity and mortality during different phases in the treatment of esophageal cancer patients

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Identification of risk-factors for perioperative morbidity and mortality during different phases in the treatment of esophageal cancer patients

Dirk Bosch

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**rijksuniversiteit
groningen**

**Identification of risk-factors for perioperative morbidity and mortality
during different phases in the treatment of esophageal cancer patients**

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Rijksuniversiteit Groningen
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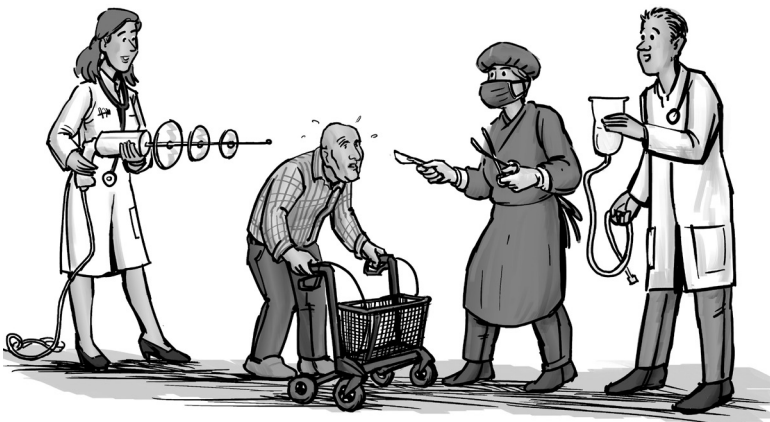
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1. General introduction

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1. Esophageal cancer (EC) belongs to the ten most common cancers in the Netherlands, and
2. accounts for 2.7% of all new cases in men and 1.1% in women^{1,2}. In 2010, approximately
3. 2000 new cases of EC were diagnosed in the Netherlands, an increase of 300% compared
4. to 1989^{1,2}. This is mainly caused by a higher prevalence of patients with gastroesophageal
5. reflux disease (GERD) and Barrett's dysplasia^{2,3}. Barrett's mucosa is a premalignant condi-
6. tion that is almost exclusively related to the formation of adenocarcinoma in the distal
7. one-third of the esophagus².
8. EC is often diagnosed in an advanced stage of the disease with local or systemic spreading
9. of cancer cells. Therefore, many patients are only eligible for palliative treatment with an
10. unfavorable survival rate.
11. In patients selected on the basis of their overall condition and oncologic stage, a multimo-
12. dality approach with neoadjuvant chemoradiotherapy (CRT) is currently standard of care
13. in a curative treatment policy⁴. Neoadjuvant CRT improves loco-regional control resulting
14. in an improved resectability and a 5-years survival benefit of 13%. CRT is associated with
15. a pathological complete response (pCR) of the tumor in 15-30% of patients^{4,5}. Neverthe-
16. less, surgical resection remains the most important potentially curative treatment, but is
17. associated with substantial perioperative morbidity (40-60%) and in-hospital mortality
18. (3-5%)^{6,7,8}. Moreover, as many EC patients are above the age of 65 years, they usually
19. present with co-morbidities and may be unfit for surgery.
20. The goal of the studies included in this thesis, is to identify the most important risk-factors
21. during the various treatment phases in patients with EC who are selected for esophagectomy.

22.

23.

24. **PREOPERATIVE EVALUATION**

25.

26. EC predominantly occurs in the last decades of life; approximately 70% of the newly
27. diagnosed patients were aged 65 years and over⁹. The predisposing factors for the devel-
28. opment of EC include smoking, GERD, obesity and alcohol consumption, which are also
29. associated with a range of cardio-pulmonary disorders⁹. Consequently, in these patients
30. a high prevalence of comorbidity exists, for example diabetes mellitus or chronic obstruc-
31. tive pulmonary disease, which can affect treatment outcome¹⁰. Surgeons will in general be
32. more reluctant to perform major surgery in fragile and elderly patients. Frailty is increas-
33. ingly used as an important determinant for postoperative outcome and can be defined
34. as the physiologic reserves and resistance to stressors of a patient¹¹. In **Chapter 2** the
35. relation between advanced age (i.e. ≥ 70 years), comorbidity and postoperative outcome
36. is evaluated.

37. Since esophagectomy is associated with considerable postoperative morbidity and
38. mortality, careful preoperative assessment of medical fitness and subsequent selection

1. of appropriate surgical candidates are important steps to improve short-term outcome.
2. Patients with an increased surgical risk and an expected prolonged recovery period might
3. be considered curative radiotherapy or palliative therapy instead, in order to ensure
4. quality of life. So it is pivotal for both the patient and the surgeon to realistically assess
5. the expected impact of the surgical insult. However, reliable individual risk stratifications
6. are still missing in daily practice. One of the most popular models in risk-assessment in
7. surgical literature is the American Society of Anesthesiologists (ASA) score, which is a
8. subjective estimate of organ system disease and preoperative fitness. In **Chapter 3** we
9. evaluated the ASA score and four other frequently used risk-prediction models to examine
10. their ability to predict short-term postoperative outcome.

11.

12.

13. **NEOADJUVANT CRT**

14.

15. The role of neoadjuvant CRT in patients with EC has been debated for decades. Several
16. trials have been published in recent years with conflicting results with regard to long-term
17. survival, but with a growing evidence for a beneficial effect of neoadjuvant CRT^{4,12-14}. In
18. particular, after publication of the CROSS trial, a large national randomized control trial
19. in which our center participated, demonstrated a survival benefit of 13% at 5 years after
20. neoadjuvant CRT⁴. Based on these results and previously published meta-analyses, most
21. centers have chosen for standardization of neoadjuvant CRT in conditionally and onco-
22. logically suitable patients. The function of chemotherapy is to enhance the locoregional
23. effect of radiotherapy, which lead to a potentially downsizing of the primary tumor, with
24. improved resectability, and an increased chance to achieve pCR. Chemotherapy might
25. also destroy possible micro-metastases leading to an improved long-term survival.

26. In contrast to these benefits, neoadjuvant CRT may be accompanied by a subsequently
27. increased risk for adverse events. Commonly known side effects of a temporary nature in-
28. clude nausea, hair loss and neuropathic pain. However, more severe and life-threatening
29. perioperative complications may also occur. Neoadjuvant CRT also seems to be associated
30. with an enhanced risk of developing thromboembolic events (TEE's)¹⁵. **Chapter 4** evalu-
31. ates the incidence and impact of preoperative and postoperative TEE's in patients treated
32. with currently used neoadjuvant platinum-based CRT.

33. It has been reported that a combined therapy of neoadjuvant CRT and subsequent sur-
34. gery is associated with an increased risk for postoperative cardiopulmonary complications
35. and anastomotic leakage¹⁶. By adding neoadjuvant CRT to a treatment that already has a
36. considerable effect on the patient's overall condition; concerns have been raised about
37. the impact of neoadjuvant CRT on the postoperative course. Thoracic chemoradiotherapy
38. might increase cardiopulmonary toxicity resulting in increase severity and incidence of

1. postoperative complications^{17, 18}. The objective of **Chapter 5** is to evaluate the effect of
2. CRT on short-term outcomes by comparing the incidence of postoperative complications
3. between patients with and without neoadjuvant CRT.

4.

5.

6. **SURGERY**

7.

8. Patients are considered for curative intended esophagectomy after a complete preop-
9. erative workup. Several surgical methods have been well explored, including transhiatal,
10. transthoracic, or minimal invasive esophagectomy. Selection of an appropriate procedure
11. depends on the location of the tumor, patient characteristics and preferences of the
12. surgeon. In general, transhiatal esophagectomy (THE) is associated with a lower rate of
13. (pulmonary) postoperative morbidity, while transthoracic esophagectomy (TTE) can be
14. combined with a two-field lymphadenectomy resulting in improved locoregional con-
15. trol¹⁹. Compared to THE, TTE is generally accepted as standard procedure, although the
16. pulmonary problems seem to be somewhat higher. The best preventable tool for pulmo-
17. nary-related problems remains an epidural anesthesia, even in the hands of surgeons
18. who advocated a minimal invasive method. The fact that esophagectomy is technically
19. challenging there is a need of state of the art diagnostic procedures, advanced surgical
20. skills and training. Therefore, performing these surgical resections in is one reason why
21. high volume centers have improved short-term and long-term outcomes²⁰.

22.

23.

24. **POSTOPERATIVE COMPLICATIONS**

25.

26. In order to minimize the impact of comorbidity on outcome, it is of great importance
27. to identify patients who are at the highest risk of developing a postoperative complica-
28. tion. Since we currently do not possess tools to reliably assess individual risk in daily
29. practice, clinicians have to rely on careful physical examination, and routine postoperative
30. diagnostics such as peripheral blood values. However, the value and degree of abnormal
31. peripheral blood values after esophagectomy and their association with postoperative
32. complications are not fully understood. Consequently, abnormal values after esophagec-
33. tomy could be expected to be due to malnutrition, comorbidity, the neoplasm itself, age,
34. neoadjuvant therapy, or surgery-related conditions. Identifying patients with postopera-
35. tive complications based on deranged peripheral blood results is difficult. In **Chapter 6**
36. our aim was to identify the prognostic value of early routine peripheral blood values in
37. predicting short-term outcome after esophagectomy.

38.

1. IMMUNOLOGICAL RESPONSE

2.

3. Neoadjuvant CRT and subsequent surgery are both associated with the release of dif-
4. ferent pro-inflammatory cytokines²¹⁻²³. However, the impact of a combined therapy on
5. patient's immunological response is not clear yet. Prognostic markers to assess the degree
6. of pathological response in EC patients are still missing and could be used as a tool to
7. individualize treatment strategy. Early response evaluation with functional imaging tech-
8. niques (PET/CT) are promising, but need further validation²⁴. It has been suggested that
9. cytokines could reflect the degree of pathological response from neoadjuvant CRT^{25,26}.
10. Patients with pCR might be spared from probably meaningless surgical resection since this
11. severe procedure is not related to improved long-term outcome in these patients^{27,28}. On
12. the other hand, patients without pathological response might have been treated too long
13. with CRT (early response evaluation) and may be planned earlier for definitive surgical re-
14. section. Furthermore, cytokine concentrations throughout different phases of treatment
15. seemed to be related to complications caused by either CRT or subsequent surgery. Al-
16. though, cytokine concentrations have been extensively investigated after esophagectomy,
17. their value in the context of multimodality treatment is far from clear^{29,30}. In **Chapter 7**
18. we analyzed nine different cytokines concentrations during different phases (from start
19. neoadjuvant CRT until the first postoperative week) in the treatment of EC patients to as-
20. sess the impact on patient's immunological response and to identify for prognostic value
21. on the degree of pathological response after CRT and complications caused by either CRT
22. or subsequent surgery.

23.

24.

25. AIM OF THE THESIS

26.

27. Patient characteristics and neoadjuvant CRT might interfere with short-term postop-
28. erative outcome. Appropriate selection of candidates for potentially curative treatment
29. options and individualizing treatment strategies are important steps to improve the
30. patient's quality of life. The aim of the thesis is to identify risk-factors contributing to
31. the development of perioperative complications throughout different phases in the treat-
32. ment of esophageal cancer patients. Early identification of these factors could provide us
33. additional information for a better selection of patients to different curative treatment
34. options.

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1 |

Extended esophagectomy in elderly patients with esophageal cancer: Minor effect of age alone in determining the postoperative course and survival

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Annals of Surgical Oncology. 2010 Jun;17(6):1572-80.

1. **ABSTRACT**

2.

3. **Background:** Elderly patients who undergo esophagectomy for cancer often have a high
4. prevalence of co-existing diseases, which may adversely affect their postoperative course.
5. We determine the relation of advanced age (i.e. ≥ 70 years) with outcome and evaluate
6. age as a selection criterion for surgery. Recommendations are given.

7. **Patients and Methods:** Between January 1991 and January 2007, we performed a cura-
8. tive intended extended transthoracic esophagectomy in 234 patients with cancer of the
9. esophagus. Patients were divided into two age-groups; < 70 years (group I; 170 pts) and
10. ≥ 70 years (group II; 64 pts).

11. **Results:** Both groups were comparable regarding comorbidity (ASA-classification), tu-
12. mor and surgical characteristics. The overall in hospital mortality rate was 6.2% (5% vs.
13. 11%, $p = 0.09$). Advanced age was not a prognostic factor for developing postoperative
14. complications (OR = 1.578; 95%CI = 0.857 to 2.904; $p = 0.143$). The overall number of
15. complications was equal with 58% in group I vs. 69% in group II ($p = 0.142$). Moreover,
16. the occurrence of complications in elderly patients did not influence survival ($p = 0.174$).
17. Recurrences developed more in patients < 70 years (58% vs. 42%, $p = 0.028$). The overall
18. 5-year survival was 35% and when included postoperative mortality 33% in both groups
19. ($p = 0.676$).The presence of comorbidity was an independent prognostic factor for survival
20. ($p = 0.002$).

21. **Conclusions:** Advanced age (≥ 70 years) has minor influence on postoperative course,
22. recurrent disease and survival in patients who underwent an extended esophagectomy.
23. Age alone is not a prognostic indicator for survival. We propose that a radical resection
24. should not be withheld in elderly patients with limited frailty and comorbidity.

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1. INTRODUCTION

2.

3. Esophageal cancer predominantly occurs in the last decades of life, with a median age
4. beyond 60 years.(1;2) Although important improvements have been achieved in the
5. multimodality treatment of these tumors, surgery remains the primary curative option.
6. (3;4) Esophagectomy is a high risk procedure with serious postoperative complications
7. and a reported mortality rate ranging from 2 to 6%.(1;3;5) Moreover, esophageal cancer
8. patients often present considerable risk factors for major surgery, including obesity, pul-
9. monary and cardiovascular diseases. (6;7)

10. Besides the increasing incidence of esophageal adenocarcinoma, the rising life expectancy
11. in the general population is responsible for a relatively large number of elderly patients
12. with esophageal cancer.(1) Elderly patients who undergo esophagectomy often have a
13. high prevalence of comorbidity and frailty, suggesting a negative effect on the outcome
14. and postoperative course. (8-12) Therefore, surgeons are in general more reluctant to
15. perform major surgery in these elderly patients.

16. There is a lack of evidence regarding the appropriate surgical treatment of esophageal
17. cancer in the elderly population. Some authors propose a transhiatal procedure for bet-
18. ter short-term outcome with less morbidity, while others perform a standard extended
19. esophagectomy with a two-field lymphadenectomy in all patients with esophageal car-
20. cinoma to achieve maximal oncologic control and minimizing the chance of recurrent
21. disease.(13-15)

22. In absence of an established definition on elderly patients regarding high risk surgery,
23. most studies defined advanced age as an age \geq 70 years of age. (8;10;11;16-22)

24. We report the results from an experienced high volume single center, in elderly patients
25. who underwent an extended transthoracic esophagectomy with a two field lymphadenec-
26. tomy for cancer of the esophagus. We performed several analyses to determine the effect
27. of advanced age on comorbidity, postoperative course, recurrent disease and survival.
28. We evaluated age as a selection criterion for surgery and make recommendations for the
29. optimal treatment policy in elderly patients.

30.

31.

32. PATIENTS AND METHODS

33.

34. Patients characteristics and Treatment

35. Between January 1991 and January 2007, 234 patients with cancer of the esophagus or
36. gastroesophageal junction (GEJ) underwent esophagectomy with curative intent. All pa-
37. tients underwent surgery in the same high-volume university medical center by the same
38. surgical group, consisting of two surgeons. All included patients were medically fit enough

1. to undergo surgery. Patients who underwent neo-adjuvant treatment in a nationwide
2. trial, starting from 2006 on, were excluded for evaluation to prevent a treatment bias
3. (n = 6). Patients who underwent exploration due to unforeseen extension of disease were
4. excluded.

5.

6. **Comorbidity**

7. Comorbidity was determined by The American Society of Anesthesiologists Physical Status
8. (ASA) classification. ASA is a readily available and widely accepted way to stratify surgical
9. patients according to their perioperative risk and varies between ASA 1 (very good condi-
10. tion) and ASA 5 (moribund patient).(23) ASA class was assigned by the anesthesiologist
11. after completing a structured review of physical status just prior to the esophagectomy.

12.

13. **Preoperative workup**

14. Patients were considered for curative esophagectomy after a complete preoperative
15. workup which included: physical examination, standard laboratory tests, digestive en-
16. doscopy, histopathological examination of taken biopsies and detailed preoperative risk
17. assessments. Staging of the tumors was performed by endoscopic ultrasonography (EUS)
18. + fine needle aspiration (FNA) and computed tomography (CT) of the chest, abdomen and
19. cervical region. In all patients newly diagnosed T3-4 or N1 esophageal cancer a ¹⁸F-fluoro-
20. 2-deoxy-D-glucose Positron Emission Tomography (FDG-PET) was performed. In case of
21. anatomical difficulties on PET assessment, a PET/CT fusion was performed. All patients
22. were discussed preoperatively in multidisciplinary meetings.

23.

24. **Surgery**

25. An extended esophageal resection was performed in all patients. This procedure consisted
26. of a subtotal esophageal resection through a left thoraco-laparotomy with intrathoracic
27. anastomoses for the distal and gastroesophageal cancers or through a right thoraco-mid
28. laparotomy with cervical anastomoses for the higher intrathoracic tumors. Both were
29. combined with a two-field lymphadenectomy of nodes at the celiac trunk, upper border
30. of the pancreas, para-aortic region and mediastinal nodes.

31.

32. **Histology**

33. All resected specimens and lymph nodes were examined according to the standard proce-
34. dures. Tumor stage and grade were classified according to the sixth edition of the tumor-
35. node-metastasis system and the residual tumor (R) classification of the International Union
36. Against Cancer and the American Joint Committee on Cancer. (24;25) Adenocarcinomas
37. seen on H&E staining were confirmed in all cases by keratin staining (immunohistochemic
38. analysis).

1. Mortality and Complications

2. Postoperative mortality was defined as any death within the first 90 days after operation
3. and deaths within the same hospital admission. A separate calculation was made of only
4. 90 days mortality (without in hospital deaths after 90 days) to compare these figures with
5. the data in literature. Major complications were divided into pulmonary complications:
6. respiratory insufficiency (prolonged need for mechanical ventilation), acute respiratory
7. distress syndrome (ARDS: acute and persistent lung inflammation with increased vascular
8. permeability and severe hypoxemia), pneumonia (infiltrate on X-ray, sepsis and positive
9. sputum culture, including bronchoalveolar lavage), atelectasis (collapse of lung lobe on
10. X-ray with hypoxemia for which intensive physiotherapy or bronchoscopy was needed),
11. pleural effusion (fluid seen on X-ray for which drainage was necessary because of hypox-
12. emia), empyema (positive culture or positive fluid) and pulmonary embolism (diagnosed
13. on CT); Cardiac complications; arrhythmia (diagnosed on ECG) and myocardial infarction
14. (diagnosed on ECG and positive laboratory tests); and other major complications; re-
15. bleeding (bleeding requiring transfusion or reoperation), subphrenic abscess and/or intra-
16. abdominal abscess (CT, drainage and positive culture), Systemic inflammatory response
17. syndrome (SIRS: deregulated host with inflammatory response without absent infection:
18. temperature $> 38.5\text{ }^{\circ}\text{C}$ or $< 35\text{ }^{\circ}\text{C}$, heart rate > 90 beats/min, respiratory rate > 20 breaths/
19. min or $\text{PaCO}_2 < 32$ mmHg and white blood cells $> 12,000$ cells/mm³), sepsis (the clinical
20. signs of SIRS, but with culture-proven infection or an infection identified by visual inspec-
21. tion), anastomotic leakage (CT with enteral contrast and amylase in the pleural fluid),
22. chylothorax (chyle defined by measuring triglycerides), renal failure (rising creatinine and
23. oliguria for which renal replacement therapy was necessary), liver failure (rising bilirubin,
24. liver enzymes, lactate and prothrombin time), deep venous thrombosis (of the distal or
25. proximal lower extremity) and ileus (absence of peristalsis with gastric retention and no
26. defecation, confirmed with abdominal X-ray). Minor complications were defined as wound
27. infections (positive wound culture with pus), wound dehiscence (spontaneous opening of
28. the fascia) and urinary tract infections (UTI: sepsis, urinary leucocytes and 10^5 bacteria/
29. ml in the urine). Infectious complications were subdivided in septic complications (sepsis),
30. intra-abdominal or subphrenic abscess eventually with anastomotic leakage, empyema,
31. pneumonia, severe wound infections and urinary tract infections. The use of antibiotics
32. and inotropes was scored during the postoperative period. The operation room (OR) time,
33. intensive care unit (ICU) stay and hospital stay were measured for comparison.
- 34.
35. **Follow-up**
36. All medical follow-up data was collected prospectively, in a patient research database. Pa-
37. tients were seen in the outpatient department every 3 months for the first postoperative
38. year, every 6 months for the next year and then annually for ten years. Data of deceased

1. patients was collected by consulting the general practitioners and the Comprehensive
2. Cancer Center North Netherlands. Follow-up was measured in months from the time of
3. operation until death (survival time) or end of follow-up with a minimum of two years.
4. For the calculation of long term cancer specific survival, patients without postoperative
5. mortality were selected (n = 219) and only cancer related death cause was scored. Death
6. of any other cause was scored as end of follow up. For all other survival calculations
7. postoperative mortality was included into the survival curves.
8. Recurrent disease was defined as loco-regional recurrence or distant metastases in the
9. follow-up period, determined by any cytologic or histologic proof, unequivocal radiologic
10. suspicion (CT, MRI, PET, bone-scan and Ultrasonography) and/or obvious clinical manifes-
11. tations.
12. The follow-up was ascertained in February 2009, and complete for all included patients.

13.

14. **Definitions and Statistical Analysis**

15. For calculations 'the elderly' were defined as patient of 70 years of age and older, as
16. generally used in literature. (8;10;11;16-22) Therefore, we discriminated between group I,
17. < 70 years and group II, ≥ 70 years of age, independently of other factors.
18. Variables were reflected as frequencies with means and/or median with percentages.
19. Continuous variables were compared by using the T-test and the Chi-Square test was used
20. for comparison of categorical variables. Survival and recurrence rates were calculated by
21. the Kaplan-Meier method and the log rank test. Survival calculations included postop-
22. erative mortality, except for the cancer specific survival. Prognostic factors for survival
23. were calculated with Cox regression univariate and multivariate analyses. Univariate and
24. multivariate logistic and linear regression analysis were used for calculating if advanced
25. age was influencing the occurrence of comorbidity and complications; group of complica-
26. tions (cardiac, pulmonary and infectious complications) were calculated as well as the
27. individual complications. Multivariate analysis was performed by incorporating factors as
28. covariates with a p-value ≤ 0.1 on univariate analysis.
29. For all calculations a p-value of < 0.05 was considered to be significant. Statistical compu-
30. tations and figuring were all performed by using the statistical package SPSS version 16.0
31. (SPSS Inc., Chicago, IL).

32.

33.

34. **RESULTS**

35.

36. **Patient characteristics**

37. The study population consisted of 234 consecutive patients; 196 males (84%) and 38
38. females (16%). The mean age at operation was 63 years with a range from 28 to 82 years

1. **Table 1.** Patients and tumor characteristics (n = 234)

2. Variable	< 70 years N = 170	≥ 70 years N = 64	P Value
3. Mean age	58.9	74.5	
4. Sex (M/F)	144/26	52/12	0.524
5. Histology			
6. Adenocarcinoma	145 (85)	56 (87)	
7. Squamous cell carcinoma	25 (15)	8 (13)	0.666
8. Localisation			
9. Midesophagus	14 (8)	4 (6)	
10. Distal esophagus	102 (60)	36 (56)	
11. GEJ	54 (32)	24 (38)	0.371
12. Tumor stage			
13. I	17 (10)	11 (17)	
14. IIa	46 (27)	17 (26)	
15. IIb	16 (9)	8 (13)	
16. III	80 (47)	25 (39)	
17. IVa	11 (7)	3 (5)	0.148
18. Comorbidity			
19. Diabetes Mellitus	17 (10)	8 (13)	0.582
20. Hypertension	28 (16)	15 (23)	0.221
21. Angina pectoris	12 (7)	5 (8)	0.843
22. Heart failure	1 (1)	2 (3)	0.125
23. Myocardial infarction	17 (10)	7 (11)	0.833
24. COPD	16 (9)	6 (9)	0.993
25. TIA/CVA	7 (4)	6 (9)	0.118

25. of age. Group I (< 70 years of age) consisted of 170 patients (73%) and group II (≥ 70
 26. years of age) of 64 patients (27%). Patients and tumor characteristics are summarized
 27. in table 1. Surgical characteristics such as year of surgery (p = 0.4) and type of resection
 28. (p = 0.9) were similar in both groups. Stage of disease was not statistically different in
 29. both groups (p = 0.148) although more advanced disease seems to occur in the younger
 30. patients (Table 1)

31. Comorbidity was not significantly different in both groups, respectively 65 patients (38%)
 32. with comorbidity in group I versus 32 patients (50%) in group II (p = 0.104). ASA scores did
 33. not differ between the two groups (p = 0.136).

34. **Mortality and comorbidity**

35. Postoperative mortality (90 days and within hospital admission) was 6.2% (15 patients),
 36. 8 patients (5%) in group I versus 7 patients (11%) in group II (p = 0.09). The 90 days
 37. mortality alone was 4,7% (11 patients), 5 patients (3%) in group I and 6 patients (9%)
 38.

1. in group II ($p = 0.08$). Of the 15 patients who died postoperatively, 10 (67%) had more
2. than one comorbidity ($p = 0.041$). Four patients had a history of myocardial infarction and
3. hypertension; one patient had diabetes with myocardial infarction; two patients had dia-
4. betes with hypertension; one patient had chronic obstructive pulmonary disease (COPD)
5. with transient ischemic attack (TIA), and two patients had a TIA with hypertension. Only
6. cardiovascular comorbidity in the elderly subgroup ($n = 24$; 38%) had a negative effect on
7. postoperative mortality ($p = 0.043$).

8.

9. **Complications**

10. Ninety-nine patients (58%) in group I and 44 patients (69%) in group II developed
11. postoperative complications, which was not statistically different between both groups
12. ($p = 0.142$). Pulmonary complications occurred in 72 patients (42%) in group I versus 36
13. patients (56%; $p = 0.06$) in group II, respectively. (Table 2) Respiratory insufficiency was the
14. most frequent complication, and occurred more in the elderly patients (25% versus 41%;
15. $p = 0.017$). Other major pulmonary complications atelectasis (14% vs. 28%; $p = 0.009$)
16. and pleural effusion (15% vs. 27%; $p = 0.036$) occurred more frequent in group II. Cardiac
17. complications, primarily consisting of arrhythmias, occurred in 27 patients (16%) versus
18. 24 patients (38%) in group II ($p = 0.001$). Pneumonia was the most common infectious
19. complication in 43 patients (18%), 16% in group I and 23% in group II ($p = 0.221$). There
20. were no differences between infectious and non-infectious complications between the
21. two groups ($p = 0.5$). Four abscesses developed in the elderly group (6%).

22. The postoperative use of antibiotics and inotropes did not differ statistically between both
23. age groups ($p = 0.4$ and $p = 0.13$).

24. In logistic regression analysis, age ≥ 70 years was no prognostic factor for develop-
25. ment of postoperative complications (Odd Ratio; OR = 1.578; 95% confidence interval;
26. 95%CI = 0.857 to 2.904; $p = 0.143$). For cardiac complications (OR = 3.178; 95%CI = 1.655
27. to 6.100; $p = 0.001$) and pulmonary complications (OR = 1.750; 95%CI = 0.980 to 3.126;
28. $p = 0.05$) as a group, age ≥ 70 years was a prognostic factor. (Table 3)

29. There was a higher rate of complications in the patients with comorbidity; 69 of the 97
30. patients who had comorbidity (71%) developed one or multiple postoperative complica-
31. tions ($p = 0.008$). However, of the 143 patients who had complications only 69 (48%) had
32. preoperative fixed comorbidity. In logistic regression analysis comorbidity was a prognos-
33. tic factor for developing postoperative complications (OR = 2.098, 95%CI = 1.207 to 3.647,
34. $p = 0.009$)

35.

36. **Postoperative course**

37. The operation time with a median of 6 hours was not different in both groups
38. (95%CI = -0.72 to 0.28; $p = 0.384$). The median ICU stay was 3 days with a range from 1 to

1. **Table 2.** Complications (n = 234)

2. Variable	Group 1 (< 70) N = 170	Group II (≥ 70) N = 64	P-value
3. Overall complications	99 (58)	44 (69)	0.142
4. Pulmonary complications	72 (42)	36 (56)	0.058
5. Respiratory insufficiency	42 (25)	26 (41)	0.017
6. ARDS	4 (2)	3 (5)	0.351
7. Pneumonia	28 (16)	15 (23)	0.221
8. Atelectasis	23 (14)	18 (28)	0.009
9. Pleural effusion	25 (15)	17 (27)	0.036
10. Empyema	16 (9)	9 (14)	0.306
11. Pulmonary embolism	4 (2)	3 (5)	0.351
12. Cardiac complications	27 (16)	24 (38)	< 0.001
13. Arrhythmia	27 (16)	23 (36)	0.001
14. Myocardial infarction	2 (1)	1 (2)	0.815
15. Other major complications			
16. Rebleeding	4 (2)	4 (6)	0.144
17. Subphrenic abscess	0 (0)	2 (3)	0.021
18. SIRS	3 (2)	4 (6)	0.073
19. Sepsis	14 (8)	9 (14)	0.183
20. Anastomotic leakage	31 (18)	8 (13)	0.295
21. Chylothorax	9 (5)	2 (3)	0.486
22. Intra-abdominal abscess	0 (0)	2 (3)	0.021
23. Renal failure	8 (5)	5 (8)	0.356
24. Liver failure	0 (0)	1 (2)	0.103
25. Deep venous thromb	2 (1)	0 (0)	0.385
26. Ileus	2 (1)	2 (3)	0.306
27. Minor complications			
28. Wound infection	9 (5)	9 (14)	0.025
29. Wound dehiscence	3 (2)	2 (3)	0.522
30. Urinary tract infection	0 (0)	4 (6)	0.001
31. Postoperative course			
32. Reoperation	17 (10)	12 (19)	0.064
33. OR-time (mean hours)	6.1	6.3	0.384
34. ICU stay (mean days)	2.5	5.0	< 0.001
35. Hospital stay (mean days)	21.0	27.0	0.014

36. 64 days. In group II the ICU stay was significantly longer with a median of 7 days (range 1
37. to 64 days) versus group I with a median of 3 days (range 1 to 56 days) (95%CI = -9.95 to
38. -1.86; p = 0.005). Re-operation was needed in 29 patients due to complications, including
39. anastomotic leakage, postoperative bleeding, subphrenic abscess and obstructive ileus
40. based on torsion at the jejunostomy site. The median hospital stay was 22 days, with 21
41. days in group I and 26 days in group II (95%CI = -11.03 to 0.17; p = 0.06).

1. **Table 3.** Prognostic value of advanced age on development of complications; with group of complications (overall, pulmonary and cardiac complications) and individual complications. np = not enough
 2. statistical power.
 3.

4.	Variable	Odds ratio	95%CI	P-value
5.	Overall complications	1.578	0.857 - 2.904	0.143
6.	Pulmonary complications	1.750	0.980 - 3.126	0.050
7.	Respiratory insufficiency	2.085	1.135 - 3.832	0.018
8.	ARDS	2.041	0.444 - 9.383	0.359
9.	Pneumonia	1.552	0.766 - 3.146	0.222
10.	Atelectasis	2.501	1.242 - 5.037	0.010
11.	Pleural effusion	2.098	1.043 - 4.218	0.038
12.	Empyema	1.575	0.658 - 3.770	0.308
13.	Pulmonary embolism	2.041	0.444 - 9.383	0.359
14.	Cardiac complications	3.178	1.655 - 6.100	0.001
15.	Arrhythmia	2.971	1.542 - 5.723	0.001
16.	Myocardial infarction	1.333	0.119 - 14.962	0.816
17.	Other major complications			
18.	Rebleeding	2.767	0.671 - 11.412	0.159
19.	Subphrenic abscess			np
20.	SIRS	3.711	0.807 - 17.066	0.092
21.	Sepsis	1.823	0.747 - 4.449	0.187
22.	Anastomotic leakage	0.641	0.277 - 1.479	0.297
23.	Chylothorax	0.577	0.121 - 2.746	0.490
24.	Intra-abdominal absces			np
25.	Renal failure	1.716	0.540 - 5.455	0.360
26.	Liver failure			np
27.	Deep venous thromb			np
28.	Ileus	2.710	0.374 - 19.655	0.324
29.	Minor complications			
30.	Wound infection	2.927	1.106 - 7.748	0.031
31.	Wound dehiscence	1.796	0.293 - 11.003	0.527
32.	Urinary tract infection			np

30. Long term outcome

31. Median follow-up was 26 months (range 0–199 months) and no patients were lost to
 32. follow-up. Follow-up time was not different between the groups ($p = 0.701$).
 33. Stage of disease had no impact on survival between the two groups (stage I, $p = 0.298$;
 34. stage II; $p = 0.834$; stage III; $p = 0.184$; stage IVa; $p = 2.09$).
 35. None of the individual complications had a significant impact on survival. Overall, compli-
 36. cations had no influence on both the long term survival including postoperative mortality
 37. ($p = 0.174$) and without mortality ($p = 0.655$).
 38.

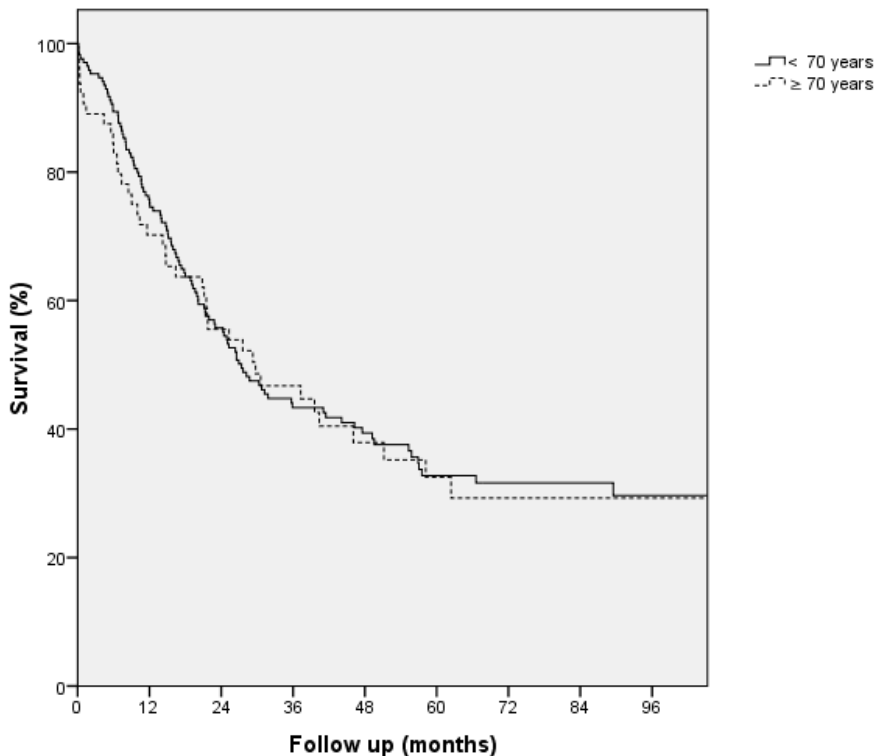


Figure 1. Kaplan Meier overall survival curve (n = 234) of patients in group I, < 70 years and group II, ≥ 70 years of age (n = 170 versus n = 64, p = 0.535), including postoperative mortality.

Recurrent disease occurred in 126 patients (54%); 99 patients (58%) in group I and 27 (42%) in group II (p = 0.028). Time to development of recurrent disease did not differ between the groups (p = 0.223).

For all 234 patients, including patients with postoperative mortality, the 1-year survival was 74% and the 5-year survival was 33%. There was no difference in survival between the two groups (p = 0.535), with a 1-year survival of 76% in group 1 versus 70% in group 2 (p = 0.282) and a 5-year survival of 33% in group I versus 33% in group II (p = 0.676). (Figure 1)

Age classification in < 70 and ≥ 70 years of age did not have any prognostic value for survival (OR = 1.117, 95%CI = 0.787 to 1.584; p = 0.535). Also a rising age as continuous variable did not have a prognostic value for worse survival (OR = 1.005, 95%CI = 0.990 to 1.021; p = 0.514).

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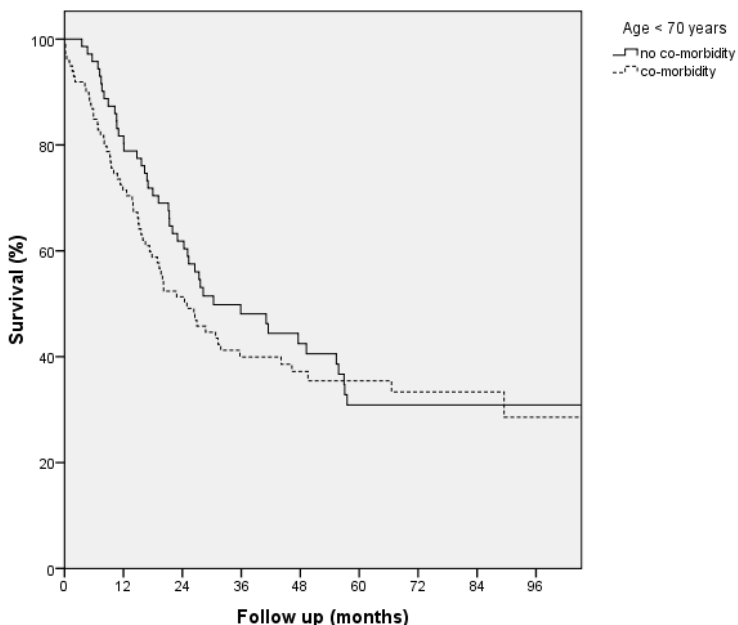


Figure 2A. Kaplan Meier survival curve of patients in group I (< 70 years) with preoperative comorbidity and those without (n = 65 versus n = 105, p = 0.472).

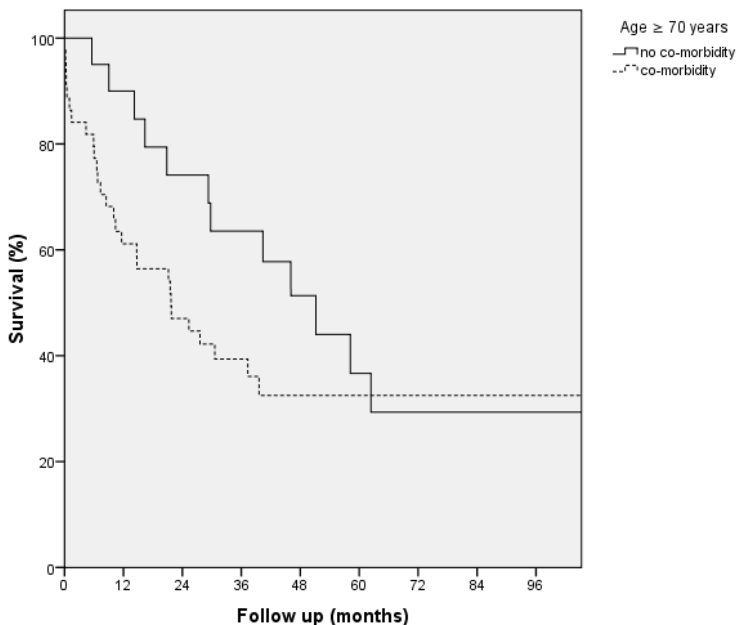


Figure 2B. Kaplan Meier survival curve of patients in group II (≥ 70 years) with preoperative comorbidity and those without (n = 32 versus n = 32, p = 0.087).

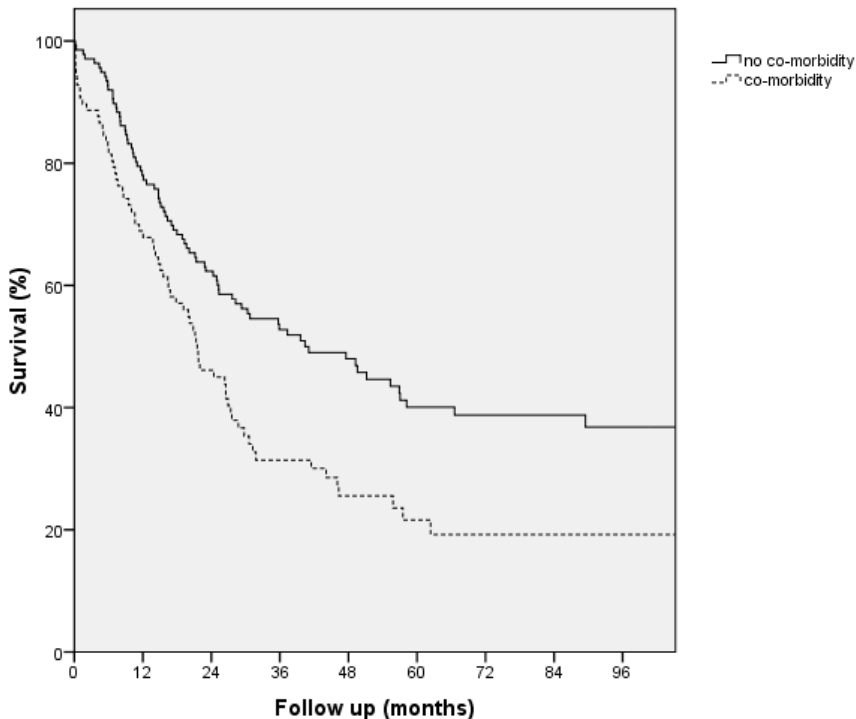


Figure 3. Kaplan Meier survival curve of patients with preoperative comorbidity and those without, regardless of age (n = 97 versus n = 137, p = 0.001).

Cancer related 5-year survival, in patients without postoperative mortality (n = 219) and cancer related cause of death, was 35% and did not differ between the groups (35% versus 37%, p = 0.874).

Survival curves of comorbidity versus age showed no difference between the two groups (p = 0.135). In group I and II separately, there was no statistical difference in survival of patients with and without comorbidity. (Figure 2A and 2B) Although there was a trend for worse survival in elderly patients with comorbidity (p = 0.087). (Figure 2B)

The presence of comorbidity was an independent prognostic factor for long term survival (OR = 1.679 95%CI = 1.219 to 2.314; p = 0.002. The Kaplan Meier curve showed significant better survival for patients without comorbidity in the long term (p = 0.001). (Figure 3).

1. DISCUSSION

2.

3. By applying a thoracotomy-based operative approach with extensive 2-field lymph node
4. dissection for esophageal cancer, we were able to effectuate a 5-year cancer specific
5. survival rate of 35% in a patient population with 49% stage III and IV disease, regardless
6. of age and comorbidity.

7. The median hospital stay was comparable with reported numbers in literature. (12) Hos-
8. pital stay is relative long because some patients with comorbidity in this relatively high-
9. aged population needed extensive pre-operative workup. Moreover, in our hospital most
10. patients with anastomotic leakage are usually treated conservatively with good results.

11. Advanced age (≥ 70 years) had no significant influence on mortality following extended
12. esophagectomy, even though there was a non-statistical trend of a higher postoperative
13. mortality. Overall, elderly patients had no higher postoperative complication rate than
14. the younger group. However, cardiac complications in particular arrhythmia, and pulmo-
15. nary complications, especially respiratory insufficiency, atelectasis and pleural effusion,
16. occurred more frequently in the elderly patients. Age ≥ 70 years was not a prognostic
17. factor for development of postoperative complications. Furthermore, the occurrence
18. of complications did not lead to a decreased survival. On the other hand comorbidity
19. was the strongest prognostic factor for the development of complications. In this study
20. cardiovascular comorbidity in the elderly subgroup had a negative effect on postoperative
21. mortality. Because of this relatively small sized subgroup, it is difficult to give specific
22. recommendations.

23. Compared with patients < 70 years recurrent disease was significant lower in the elderly
24. group. But the higher number of cardiopulmonary complications and the trend for a higher
25. postoperative mortality in the elderly is concerning.

26. Along with a general rise of incidence of esophageal adenocarcinoma, there is a rising
27. incidence in esophageal cancer in the elderly patients up to 600% in the last decades.(26)

28. Advances in treatment of esophageal cancer surgery have been remarkable; improved
29. staging modalities, perioperative management, surgical techniques and postoperative
30. care have reduced postoperative mortality and morbidity rates and enhanced better sur-
31. vival. Moreover, improvements in postoperative complications in the elderly are reported.
32. (19)

33. Our results reflect the improvement in overall outcomes following esophagectomy for
34. cancer over the last ten years and demonstrate that this improvement in short-term out-
35. come is evident in the elderly population.(20) Several studies reported worse postopera-
36. tive course in the elderly patients, with a high mortality rate and a decreased overall long
37. term survival with increasing age.(20;22) More recent studies showed acceptable results
38. regarding mortality and survival because of better surgical techniques, centralization and

1. more intensive perioperative care.(8;10-12;16-19;21;27) Therefore, some studies focus
2. on even older patients (> 75 or > 80 years). (9;12;16).
3. Preoperative risk assessment and estimation of prognostic risk factors in the elderly remain
4. controversial. Some studies found a strong association between high age and increased
5. risk of worse prognosis during and after esophagectomy.(7;28) Particularly cardiac and
6. pulmonary complications occur more frequently in the high age groups.(8;16;19;28) How-
7. ever, reliable individual risk analysis stratification for individual elderly patients is lacking.
8. This is mainly due to a reluctance to enroll elderly patients in clinical trials, which we think
9. is not appropriate.(29) This is of importance, because the elderly have more cardiopulmo-
10. nary complications which complicate the postoperative course. More research is needed
11. for adequate scoring systems identifying the elderly at risk for pulmonary and cardiac
12. complications.(8;16;19;28) This may permit preoperative intervention such as cardiac and
13. pulmonary support which can reduce the risk of postoperative complications.(12)
14. In the literature, a discussion is ongoing on the type of surgery required for elderly pa-
15. tients. Some surgeons advocate a limited resection due to postoperative complications
16. and co-existing disease in the elderly. However, transthoracic esophagectomy with two-
17. field lymph node dissection is not associated with increased mortality or reduced long
18. term survival in the elderly population.(20) In this study there was a higher mortality
19. rate in the elderly, although not significant, but elderly patients had an equally long term
20. survival after surgery. Further optimization in selection criteria and risk stratification for
21. the elderly will better clarify the supposed advantage of extended esophagectomy. Hence
22. we recommend thorough preoperative assessment in all patients. A threshold to deny
23. surgery based only on age seems not reasonable in this patient group, because of large
24. differences in comorbidity and clinical manifestations of cancer.
25. A larger study group might strengthen the non-statistical trends on postoperative mortal-
26. ity in this study, suggesting the need for a large prospective study. The choice to oper-
27. ate on elderly patients with comorbidity remains difficult, but the consequences to not
28. operate is even a greater dilemma. The strength of this study is the careful selection of
29. patients for surgery, the homogeneous groups for comparison and the complete follow
30. up. It quantifies what the risk is in an experienced center.
31. More attention is needed in prospective clinical trials for elderly patients, further improving
32. postoperative course and long term survival. Furthermore, individual risk analysis stratifi-
33. cation should be developed with a focus on patients with comorbidity. Centralization and
34. more intensive perioperative care for elderly patients are mandatory. Our data support
35. the view that esophageal resection within centralized organized care with a coordinated
36. multidisciplinary approach and multidisciplinary teamwork is feasible and appropriate for
37. all reasonably fit patients, regardless of age. The increased use of neo-adjuvant therapy
38. in the elderly patients is needed, especially in clinical trials, with the perception that

1. individualization of treatment will be the future standard. A subdivision based solely on
2. age is undesirable. Elderly patients with no preoperative risk factors may be more readily
3. tolerate chemo-radiotherapy and surgery than younger patients with comorbidity.
4. In conclusion, the increasing life expectancy in the general population will lead to a fur-
5. ther increasing incidence of elderly patients with esophageal cancer in the near future.
6. Therefore more attention is needed for the treatment of the elderly patients. As this study
7. showed no significant difference in short and long term survival for the elderly group, and
8. elderly patients had no substantial worse postoperative course, a radical resection should
9. not be withheld in the elderly patients. Although, age alone is not a prognostic indicator
10. for survival in patients who undergo an esophagectomy for cancer, co morbidity at any
11. age might be.
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Comparison of different risk-adjustment models in assessing short term surgical outcome following transthoracic esophagectomy in patients with esophageal cancer

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1. **ABSTRACT**

2.

3. **Background:** Different risk-prediction models have been developed, but none is gener-
4. ally accepted in selecting patients for esophagectomy. This study evaluated five most
5. frequently used risk-prediction models, including the American Society of Anaesthesiolo-
6. gists (ASA), P-POSSUM, O-POSSUM, Charlson and its age adjusted score (ACCI) to asses
7. postoperative mortality after transthoracic esophagectomy.

8. **Methods:** Data were obtained from 278 consecutive esophageal cancer patients between
9. 1991 and 2007. Performance in predicting postoperative mortality (in-hospital and 90-day
10. mortality), were analyzed regarding calibration (Hosmer and Lemeshow goodness-of-fit
11. (HLG) test) and discrimination (area under the Receiver Operator Curve (ROC)).

12. **Results:** The HLG test was applied to each model and showed a significant outcome for
13. only the P-POSSUM score ($p = 0.035$). The ROC curve indicated discriminatory power for
14. P-POSSUM (0.766) and for O-POSSUM (0.756) other models didn't exceed the minimal
15. surface of 0.7.

16. **Conclusion:** Postoperative mortality after esophagectomy was best predicted by O-
17. POSSUM. However, it still over-predicted postoperative mortality.

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1. INTRODUCTION

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3. Esophageal cancer is associated with high rates of perioperative morbidity and mortality
4. and a relatively low overall 5-year survival rate of approximately 25% [1]. The incidence
5. is increasing rapidly and appears to be most prominent in vulnerable and fragile elderly
6. of > 70 years who withstand major surgical insult as well[2]. Unfortunately, many elderly
7. patients have serious comorbidities interfering with the outcome of treatment [3,4].
8. Careful preoperative assessment of fitness and subsequent selection of appropriate surgi-
9. cal candidates are important steps improving short-term outcome for individuals who
10. undergo an esophagectomy.

11. New standard treatment methods, including neo-adjuvant chemoradiotherapy with re-
12. ported complete responses of 20-40% after resection, can be performed safely in a great
13. part of these patients[5]. Nevertheless, surgery remains the primary curative option[6,7].
14. However, esophagectomy as a high-risk complex surgical procedure has a severe postop-
15. erative complication rate of up to 50% with a relatively high postoperative mortality of
16. around 5% and in some cohorts even approaching 10-15% [6,8,9].

17. Preoperative risk stratification for postoperative mortality may help patients and families
18. address the magnitude of both the disease and the therapy. It is pivotal for both the pa-
19. tient and the surgeon to realistically assess the magnitude of the surgical insult. Therefore
20. we propose to assess several preoperative scoring systems that have each been validated
21. as predictive of severe postoperative morbidity and mortality[10-14].

22. These “risk stratification/adjustment systems” include the “Physiological and Operative
23. Severity Score for the enUmeration of Mortality and morbidity” (POSSUM), its Portsmouth
24. (P-POSSUM) and O-POSSUM modifications, the Charlson Comorbidity Index (CCI) with the
25. version of Age Adjusted Charlson Score (ACCI) and the standard American Society of Anes-
26. thesiologists (ASA) classification systems. In most of these systems age is not included as a
27. dominant predictor of morbidity that is uniquely relevant to esophageal cancer presenting
28. nowadays in more aging patients.[14]. Until now there are no published studies compar-
29. ing all these five comorbidity models (P- and O-POSSUM, Charlson-, ACCI- and ASA score)
30. for patients after esophagectomy. We examined which of these five most frequently used
31. comorbidity models could predict short-term surgical outcomes accurately following
32. curatively intended resection in esophageal cancer patients.

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1. PATIENTS AND METHODS

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3. Patient's characteristics

4. Between January 1991 and December 2007, 280 consecutive patients with cancer of the
5. esophagus underwent a surgical resection with curative intent. Two patients with missing
6. follow-up were excluded from the analysis. In the remaining group of 278 patients analy-
7. sis was performed based on prospectively registered data from a computerized database
8. of all esophageal procedures at our university hospital. (Table 1) Data of this study were
9. evaluated according to the rules of ethical board of our institute. There were no systemic
10. changes over the study period in the methods of acquiring patient comorbidity data.

11.

12. Preoperative work up

13. Preoperative evaluation consisted of physical examination, standard laboratory tests
14. and detailed preoperative risk assessments. Staging was performed by endoscopic
15. ultrasonography (EUS) with fine needle aspiration (FNA) of suspected lesions and 16-64
16. slice multidetector computed tomography (MDCT) of the chest, abdomen and cervical
17. region. From 1996 on all patients diagnosed as T3-4 or N1 were additionally staged
18. with ¹⁸F-fluoro-2-deoxy-D-glucose Positron Emission Tomography (FDG-PET) and PET/CT
19. fusion was applied in case of anatomical difficulties on PET assessment. Since 2007 neo-
20. adjuvant chemoradiotherapy consisting of paclitaxel 50mg/m² and carboplatin (AUC = 2)
21. on day 1,8,15,22 and 29 with concurrent radiotherapy of 41.4 Gy (23 fractions of 1.8 Gy),
22. was administered to ten patients, as a part of a randomized control trial with surgery
23. alone.

24.

25. Surgery

26. Surgery in our tertiary referral centre was performed by two experienced surgeons.
27. All patients underwent a curative intended open radical transthoracic esophagectomy
28. consisting of a subtotal esophageal resection including a two-field lymphadenectomy of
29. nodes at the celiac trunk, along the upper border of the pancreas, para-aortic region and
30. mediastinal nodes. Pathological staging was based according to the latest edition of the
31. TNM classification for esophageal cancer[15].

32.

33. Comorbidity and mortality indexes

34. Overall comorbidity severity was classified according to the modified Physiological and
35. Operative Severity Score for the enUmeration of Mortality and morbidity (P-POSSUM and
36. O-POSSUM), Charlson-, Age Adjusted Charlson- and ASA score.
37. The original POSSUM score overpredicted mortality in low-risk patients[16] and therefore
38. transformed into the Portsmouth predictor equation (P-POSSUM), with a different logistic

1. **Table 1.** Variables of P-POSSUM and O-POSSUM

2. Physiological score	Operative severity score
3. Age (years)	Operative severity
4. Glasgow coma score	Multiple procedures
5. Cardiac signs	Total blood loss *
6. Respiratory signs	Peritoneal soiling *
7. Electrocardiography	Presence of malignancy *
8. Systolic pressure (mmHg)	Mode of surgery
9. Pulse rate (beats/min)	
10. Haemoglobin (g/dl)	
11. White blood cell count ($\times 10^{12}/L$)	
12. Urea (mmol/L)	
13. Sodium (mmol/L)	
14. Potassium (mmol/L)	

15. * only in P-POSSUM

16. regression. Both risk prediction models are based on a preoperatively available 12-factor physiological score and a 6-factor operative severity score obtained after surgery. To provide in the need for a specialized risk prediction model for esophagogastric surgery, the adapted O-POSSUM equation was designed[17] (Table 1).

18. The nineteen conditions of the Charlson comorbidity index (CCI) were found to significantly influence survival and were given a weighted, risk-adjusted comorbidity index value, varying from 1 to 6 points, for the individual patient[18]. Patients with a low score were considered to have minimal co-morbid diseases in their medical history. In our study we used the modification by Romano et al[19], as it excludes cancer diagnosis in determining comorbidity and is commonly used in cancer outcomes research. The Charlson comorbidity index reflects both the number and gravity of co-morbid diseases. Besides the Charlson score, we also used the Age Adjusted Charlson Index (ACCI) scorings system, which characterized the impact of age and comorbidity on disease progression and survival after surgery[20]. Both models were initially developed for administrative databases and not for individual patient level data sets. The commonly used American Society of Anesthesiologists Physical Status (ASA) classification is a readily available and widely accepted to stratify surgical patients according to their perioperative risk. It varies from ASA 1 (normal healthy patient in good condition) to ASA 5 (moribund patient, not expected to survive) [21]. ASA class is assigned by the attending anaesthesiologist after completing a structured review of physical status just prior to the patient's surgical procedure. Although the ASA classification was initially not intended to predict survival beyond the perioperative period, several investigators demonstrated a prognostic value for the ASA classification beyond this period[21].

1. Statistical analysis

2. The primary outcome was postoperative mortality, hereby defined as death within 90 days
3. after esophagectomy or any death during admission in hospital where the resection was
4. performed. This time period was applied to include all operation-related deceased pa-
5. tients. The observed number of deceased patients was divided by the number of expected
6. deceased patients (O/E) and gave a standard mortality ratio (SMR). The performance of
7. P- and O-POSSUM, Charlson-, ACCI- and the ASA score in predicting postoperative mortal-
8. ity was analysed regarding calibration and discrimination. Calibration refers to the agree-
9. ment between observed outcomes and predicted probabilities and concerns the expected
10. mortality rate for a group of patients. Comparison between observed and expected (O-E)
11. deaths for each model was analysed with the Hosmer and Lemeshow (HL) goodness-of-fit
12. test. [22,23] Higher values of the HL statistic represent poorer model calibration. In this
13. analysis a value of $P < 0.05$ was considered to show a statistically significant lack of fit.
14. Discrimination refers to the ability to distinguish patients who will die from those who will
15. survive by computing the area under the receiver operating characteristic (ROC) curve
16. (AUC). Values between 0.7-0.8 suggest reasonable or moderate discrimination and values
17. exceeding 0.8 suggest good or excellent discrimination.
18. For a better applicability in clinical practice, both POSSUM models were divided into three
19. risk categories: group I (low risk) with a postoperative mortality rate: $0 - < 8\%$; group II
20. (intermediate risk): $8 - < 15\%$ and group III (high risk): $\geq 15 - 100\%$ [24].
21. To counteract the possibility of changes in hidden care over the study period (1991-2007)
22. of time we divided this period in three segments. The predictive powers of these models
23. were analyzed in each time segment and were compared with the overall predictive
24. power. All statistical analyses were conducted by the statistical software SPSS 16.0.2 (SPSS
25. Inc., Chicago IL, USA).

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28. RESULTS

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30. Clinicopathologic characteristics of the patients are summarized in Table 2. The 90-day
31. postoperative mortality was 6.5% (18 patients), including an in-hospital mortality of 5.4%
32. ($n = 15$). The overall comorbidity severity evaluated according to the five most commonly
33. used models was as follows.

34.

35. Evaluation of the POSSUM equation

36. The expected mortality ratio by P-POSSUM was 6.2% (17 patients) giving a standardized
37. mortality ratio (SMR) of 1.05 (18/17). O-POSSUM expected a postoperative mortality rate
38. of 9.7% (27 patients), which leads to a standard mortality ratio (SMR) of 0.67 (18/27). This

1. **Table 2.** Patient (N = 278) and tumor characteristics according to postoperative outcome.

2.		Postoperative survivors (N = 260) (%)	Postoperative deceased patients (N = 18) (%)
3.			
4.	Median age (years) (range)	63 (29-85)	70 (55-81)
5.	Sex (M/F)	214 / 46 (82.3/17.7)	15 / 3 (83.3/16.7)
6.	Histology		
7.	Adenocarcinoma	218 (83.9)	17 (94.4)
8.	Squamous cell carcinoma	42 (16.2)	1 (5.6)
9.	Localization		
10.	Midesophageal	22 (8.5)	1 (5.5)
11.	Distal esophagus	238 (91.5)	16 (94.5)
12.	Tumor stage		
13.	I	38 (14.7)	1 (5.6)
14.	Ila	68 (26.2)	2 (11.1)
15.	Ilb	34 (13.1)	0 (0.0)
16.	III	107 (41.2)	14 (77.8)
17.	Iva	13 (5.0)	1 (5.6)

17. value indicates an overestimation by O-POSSUM. The risk classification of both POSSUM
18. models, with subdivision in observed (O) and expected (E) mortality rates, are summa-
19. rized by Table 3.

20. Calibration of the Hosmer and Lemeshow statistic demonstrated no fit to the observed
21. data for P-POSSUM ($\chi^2 = 16.580$, 8df (degrees of freedom), $p = 0.035$), in contrast to the
22. calibration of O-POSSUM ($\chi^2 = 7.074$, 8df, $p = 0.529$; Table 4). The area under the ROC
23. curve for P-POSSUM was 0.766 (95% confidence interval (C.I) 0.67 to 0.86; $p = 0.000$),
24.

26. **Table 3.** Outcomes of P-POSSUM and O-POSSUM stratified for risk groups: observed and expected
27. mortality rates

28.	P-POSSUM Score (%)*	Patients (N)	Observed mortality % (N)	Expected mortality % (N)
29.	0 – < 8	219	3.7% (8)	3.5% (8)
30.	8 – < 15	41	12.2% (5)	10.6% (4)
31.	≥ 15 – 100	18	27.8% (5)	29.1% (5)
32.	Total	278	6.5% (18)	6.2% (17)
33.	O-POSSUM Score (%)*			
34.	0 – < 8	137	1.5% (2)	4.8% (7)
35.	8 – < 15	97	9.3% (9)	11.4% (11)
36.	≥ 15 – 100	44	15.9% (7)	20.8% (9)
37.	Total	278	6.5% (18)	9.7% (27)

38. *Possum Risk Group

1. **Table 4.** The five risk-adjustment models: calibration and discrimination

2. Risk-prediction Model	Hosmer and Lemeshow test (p)	Area under the ROC curve (95% CI)
4. P-POSSUM	0.035	0.766 (0.67 – 0.86)
5. O-POSSUM	0.529	0.756 (0.67 – 0.84)
6. Charlson score	0.659	0.567 (0.42 – 0.71)
7. ACCI score	0.270	0.684 (0.58 – 0.79)
7. ASA score	0.210	0.635 (0.51 – 0.76)

8.

9.

10. indicating discriminatory power for postoperative mortality. A similar result was found
 11. for O-POSSUM, ROC curve analysis revealed discriminatory capability for postoperative
 12. deaths with an AUC of 0.756 (95% CI: 0.67 to 0.84; p = 0.000).

13.

14. Evaluation of the Charlson and ACCI score

15. In our cohort the Charlson score ranged from 0 to a maximum of 4 points. Patients with a
 16. Charlson score of 0 points had an observed postoperative mortality of 5.6% (8 patients),
 17. score of 1 point: 4.9% (4 patients), score of 2 points: 11.4% (4 patients), score of 3 points:
 18. 12.5% (2 patients) and none with a score of 4 points (Table 5). The Age Adjusted Charlson

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21. **Table 5.** Outcomes of Charlson, ACCI and ASA score

22. Charlson score	Patients (N)	Observed mortality (%) (N)
23. 0	143	5.6% (8)
24. 1	82	4.9% (4)
25. 2	35	11.4% (4)
26. 3	16	12.5% (2)
26. 4	2	0.0% (0)
27. ACCI score		
28. 0	20	0.0% (0)
29. 1	55	0.0% (0)
30. 2	64	7.8% (5)
31. 3	71	7.0% (5)
32. 4	39	12.8% (5)
32. 5	15	0.0% (0)
33. 6	12	25.0% (3)
34. 7	2	0.0% (0)
35. ASA score		
36. 1	36	0.0% (0)
36. 2	177	6.2% (11)
37. 3	60	8.3% (5)
38. 4	5	40.0% (2)

1. score in the study group ranged from 0 to 7 points and showed similar postoperative
2. mortality rates; with in general increased risk of mortality with higher scores (Table 5).
3. The Hosmer and Lemeshow goodness of fit test, when applied to the Charlson score,
4. indicated a good fit to the observed postoperative deaths ($\chi^2 = 0.833$, 2df, $p = 0.659$),
5. as well as the ACCI score, which showed a similar fit to the observed data ($\chi^2 = 5.174$,
6. 4df, $p = 0.270$; Table 4). The area under the ROC curve for the Charlson score was 0.567
7. (95% CI: 0.42-0.71; $p = 0.344$) indicating no discriminatory power. Similar results were
8. found regarding the area under the ROC curve for the ACCI score, there was a same poor
9. discriminatory power; 0.684 (95% CI: 0.58-0.79; $p = 0.009$). Since neither of the models
10. showed a good fit with the observed data, they were not divided into risk categories.

11.

12. **Evaluation of the ASA score**

13. There was no postoperative death in the group of patients with an ASA score 1. Patients
14. with an ASA score of 2 had an observed postoperative mortality rate of 6.2% (11 patients)
15. and in the subsequent ASA 3 score, five deceased patients (8.3%) were observed. In the
16. highest ASA score 4, the observed mortality increased to 40.0% (two patients; Table 5).

17. Using the Hosmer and Lemeshow goodness-of-fit test, no significant difference could be
18. found between the observed and expected frequencies in the ASA classification ($\chi^2 = 1.570$
19. 1df, $p = 0.210$; Table 4). The area under the ROC curve (0.635, 95% CI: 0.51-0.76; $p = 0.055$)
20. did not indicate a discriminatory power. Therefore, the ASA score was not divided into risk
21. categories.

22.

23. **Specification of mortality incidence during the time period**

24. To identify possible differences related to changes in practice over the time, the study
25. time (1991-2007) was divided in three 5-year segments. The 90-day mortality rate was
26. not significantly different compared to the overall mortality of 6.5%: i.e 5.8% from 1991-
27. 1996 ($p = 0.854$), 8.8% from 1997-2002 ($p = 0.396$) and 5.7% from 2003-2007 ($p = 0.721$).
28. However, a significant part of the patients who deceased postoperatively had one or more
29. severe comorbidity ($p = 0.018$). Of cardiovascular disease which occurred frequently,
30. TIA/CVA ($p = 0.007$) was observed significantly more during 1991-1996, hypertension
31. ($p = 0.019$) more between 1997-2002 and angina pectoris ($p = 0.000$) more between
32. 2003-2007 (Table 6). Additionally, the predictive power of each model did not differ in
33. these three time periods and both POSSUM models had the strongest predictive power
34. in each time period.

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1. **Table 6.** Survival and comorbidity rates in patients during three time periods

	Postoperative survivors in periods (%)				Postoperative deceased patients in periods (%)			
	overall	91-96	97-02	03-07	overall	91-96	97-02	03-07
90-day mortality	260 (93.5)	81 (94.2)	62 (91.2)	119 (94.4)	18 (6.5)	5 (5.8)	6 (8.8)	7 (5.6)
Comorbidity								
Yes/No	114/146	24/57	27/35	63/56	13/5	2/3	4/2	7/0
Diabetes Mellitus	28 (10.8)	5 (6.2)	8 (12.9)	15 (12.6)	3 (16.7)	1 (20.0)	2 (33.3)	0 (0.0)
Hypertension	52 (20.0)	7 (8.6)	8 (12.9)	37 (31.1)	5 (27.8)	0 (0.0)	3 (50.0)	2 (28.6)
COPD	33 (12.7)	4 (4.9)	8 (12.9)	21 (17.6)	1 (5.6)	0 (0.0)	0 (0.0)	1 (14.3)
Angina pectoris	33 (12.7)	11 (13.6)	4 (6.5)	3 (2.5)	3 (16.7)	0 (0.0)	0 (0.0)	3 (42.9)
Congestive heart failure	3 (1.2)	0 (0.0)	0 (0.0)	3 (2.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Myocardial infarction								
TIA/CVA	28 (10.8)	10 (12.3)	4 (6.5)	14 (11.8)	3 (16.7)	1 (20.0)	0 (0.0)	2 (28.6)
	14 (5.4)	1 (1.2)	3 (4.8)	10 (8.4)	2 (11.1)	1 (20.0)	0 (0.0)	1 (14.3)

14. COPD: Chronic Obstructive Pulmonary Disease

15. TIA/CVA: Transient Ischaemic Attack/ Cerebro Vasculair Accident

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18. **DISCUSSION**

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20. Risk stratification in high-risk cancer surgery is pivotal in identifying patients who may
 21. benefit from specific perioperative management strategies. Although it is difficult to
 22. define risk factors associated with adverse outcome in individual patients, evaluation of
 23. postoperative mortality and morbidity is not only necessary for adequate preoperative
 24. selection of patients but also for a reliable auditing process comparing outcomes across
 25. surgeons and hospitals. In the present study from a single tertiary-care referral center,
 26. statistical analyses demonstrated the most accurate individual risk probabilities for O-
 27. POSSUM. Overall postoperative mortality was well predicted by the P-POSSUM equation
 28. with a low rate of underprediction (N = 1). Therefore, in our cohort the P-POSSUM equa-
 29. tion is the most powerful predictor when comparing different cohorts.

30. There seems to be a contradiction between the overestimated value of postoperative
 31. mortality by O-POSSUM and its accurate calibration and discriminatory power for an
 32. individual patient. However, predictive accuracy refers to the ability of a model to assign
 33. the correct probability of death to patients, whereas discriminatory power refers to the
 34. ability of a model to attribute the correct outcomes to patients[24].

35. External validation showed varied results regarding prognostic values for these risk-
 36. prediction models [11-13, 21-27]. Two studies, which compared the P-POSSUM and O-
 37. POSSUM equation, demonstrated a poor HLG of fit for O-POSSUM, while one suggested
 38. good predictive power for P-POSSUM [25,26]. Several studies evaluated the O-POSSUM

1. equation and found a variety of results ranging from moderate to good fit [13,24]. Only
2. a few studies were performed to validated the predictive power of Charlson-, ACCI-, and
3. ASA score after esophagectomy [11,12]. In a recent study, an association has been sug-
4. gested between a high Charlson score (> 2) and mortality [11], two other studies indicated
5. a relationship between mortality and ASA score [12,21].
6. These varied results may have several causes. In the first place, these risk-adjusted mod-
7. els could be interpreted in various ways by investigators. For example, the ASA score is
8. defined by an individual anaesthetist at a specific moment and assessments might be
9. influenced by variations in the clinical presentation. Moreover, the ASA score is interob-
10. server dependent and prone to allocation variation.
11. A second important difference lies in the definition of mortality. The majority of the
12. conducted studies used 30-day mortality as a determinant of surgical outcome, while
13. others used in-hospital mortality. In the present study we used the overall postoperative
14. mortality, defined as in-hospital and 90-day mortality. Most of the applied risk predic-
15. tion models are developed to calculate mortality risk, without any corrections regarding
16. post-admission death within a reasonable period. In applying the 90-day mortality, we
17. included all operation-related deceased patients. None of these patients deceased on
18. other circumstances rather than on the impact of the surgery. As many patients have a
19. predictable short life span we have to rethink the value of a therapeutic strategy, if much
20. time was spent to recuperate from major surgical stress.
21. Thirdly, since hospital volume appeared to be an import prognostic value [6], it would be
22. difficult to identify predictive risk factors, particularly in an heterogeneous group. There-
23. fore, we only examined patients who underwent a uniform surgical approach, including a
24. transthoracic esophagectomy with a 2-field lymphadenectomy in a tertiary referral centre
25. with a high hospital and surgeon volume. Although still prematurely, recent literature
26. showed a decrease in severity and frequency of morbidity in patients who underwent a
27. laparoscopic approach, but evidence for a reduced mortality has not been established
28. yet [27,28]. None of the patients in this study had a laparoscopic approach and further
29. research is necessary to examine the applicability of these risk prediction models in such
30. a cohort.
31. A drawback of this study lies in the time span of 16 years. A number of factors affecting
32. survival may have evolved over this period of time such as better patient selection or
33. newer technology, including neoadjuvant chemoradiation and surgical approaches. To
34. counteract the possibility of interfering factors over this period, we divided the time span
35. in three almost equal segments. Mortality rates didn't differ significantly over this period
36. and statistical analysis indicated the most predictive power for both POSSUM models in
37. each segment. The influence of neoadjuvant chemoradiation in this study was low as
38. there was no mortality in this rather small group of patients (n = 10).

1. Recently, new risk-adjusted models were developed, including the Rotterdam-, Phila-
2. delphia- and Munich score to compare cohorts, but they do not provide individual risk
3. stratification as was clearly concluded by Zingg et al [29].
4. So far a reliable individual risk analysis stratification to guide surgeons and oncologists in
5. the decision-making is missing and it should be done in the context of an overall clinical
6. judgment. With a more appropriate risk-prediction model, we might be able to identify
7. patients with high estimated morbidity and mortality. A careful selection based on such
8. models may be helpful to perform adequate preoperative interventions and reducing the
9. risk of postoperative complications.
10. Current centralization of this high-risk surgery has led to a relatively low postoperative
11. morbidity and better outcome has been observed in high-volume centers for moderate- to
12. high-risk patients. [30] Predicting the mortality risk in an individual patient is difficult. The
13. number of events is too few to justify clinical application of any scoring system without
14. further validation with prospective data in the setting of a clinical trial. To counteract
15. the impossibility of the current models in selecting the individual at-risk patient, we
16. subdivided the most accurate model into a low, intermediate and high-risk category. The
17. benefit of this subdivision for a model is no longer the identification of a rare event, but to
18. identify a group of patients with an increased mortality risk. Thereby, it would be a benefit
19. for the informed consent and usefulness of a model; since it is immediately obvious to
20. which risk group a patient belongs. To justify this distribution in clinical practice, more
21. research is necessary to validate this quantification.

22.

23.

24. **CONCLUSION**

25.

26. Each risk-adjusted model demonstrated a moderate relationship between postoperative
27. mortality and an increased risk score. We recommend the O-POSSUM for individual risk
28. stratification as it assessed the condition of the patient and the risk of surgery most ac-
29. curately in this study. In clinical practice we suggest dividing the O-POSSUM score into a
30. low, intermediate and high-risk category, but before general application more research is
31. needed to validate our findings.

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Increased risk of thromboembolism in esophageal cancer patients treated with neoadjuvant chemoradiotherapy

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1. **ABSTRACT**

2.

3. **Background:** Neoadjuvant chemoradiotherapy (CRT) in esophageal cancer (EC) patients
4. may increase the formation of thromboembolic events (TEE's). We analyzed the incidence
5. and impact of TEE's in EC patients treated with platinum-based CRT.

6. **Patient and methods:** A total of 336 patients with EC underwent an esophagectomy of
7. which 110 patients received neoadjuvant CRT (41.4Gy with concurrent Carboplatin/Paclitaxel). Patients were matched based on pre- and perioperative characteristics.

9. **Results:** Preoperatively, 9 (8.2%) patients with neoadjuvant CRT ($p = 0.004$) were diagnosed with TEE's. Despite delay until surgery ($p = 0.021$), the postoperative course did
11. not differ. In multivariate analysis, a history of DVT ($p = 0.005$) and neoadjuvant CRT
12. ($p = 0.004$) were identified as risk factors. Postoperatively, there was no differences in
13. TEE's ($p = 0.560$) observed. In multivariate analysis, a history of pulmonary embolism
14. ($p = 0.012$) was identified as risk factor for postoperative TEE's.

15. **Conclusion:** Preoperatively, EC patients treated with neoadjuvant CRT have an increased
16. risk to develop a TEE, especially those with a previous history of TEE. After surgery no
17. increased incidence was observed. We recommend secondary prophylaxis during neoadjuvant
18. treatment in this high-risk group.

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1. INTRODUCTION

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3. Neoadjuvant chemoradiotherapy (CRT) followed by surgical resection is a widely accepted
 4. curative intended treatment in patients with esophageal cancer (EC). Depending on onco-
 5. logical and conditional criteria, patients receive in our center radiotherapy (41.4Gy/5wks)
 6. and concurrent chemotherapy (Carboplatin and Paclitaxel) according to the CROSS regi-
 7. men. This platinum-based neoadjuvant CRT improves loco-regional control and overall
 8. survival with 13% at 5 years(1).

9. As distinct from this benefit, neoadjuvant CRT may subsequently be accompanied by an
 10. increased risk for adverse pre- and postoperative complications(2). It is known that cancer
 11. patients, especially those with gastro-esophageal cancer, generally have a high risk of
 12. venous thrombosis(3, 4). Moreover, the use of chemoradiotherapy seems to be associ-
 13. ated with a further enhanced risk of developing thromboembolic events (TEE's), including
 14. deep vein thrombosis (DVT) and pulmonary embolism (PE)(5-9).

15. In the mid-nineteenth century Virchow and Trousseau described the pathophysiology of
 16. TEE's in cancer patients. However, there still exist significant gaps in the understanding
 17. of cancer-associated TEE's in patients treated with chemotherapy alone or combined
 18. with radiotherapy. Reported incidences of TEE's during chemotherapy for EC are ap-
 19. proximately 10 to 12%, and partly depending on the type of chemotherapy(9). The risk
 20. of TEE's in currently used neoadjuvant CROSS regimen is, according to our knowledge,
 21. not previously described. The hypothesis in the present study was that neoadjuvant
 22. platinum-based CRT in esophageal cancer patients is accompanied with an increased
 23. incidence of TEE's.

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26. PATIENTS AND METHODS

27.

28. Patient's characteristics

29. In this study, we included all 336 patients who underwent a transthoracic esophagectomy
 30. with curative intent between January 2000 and December 2012. Of these patients 110
 31. (32.7%) received neoadjuvant CRT followed by surgery between January 2006 and De-
 32. cember 2012. Patients with unforeseen progression of their disease were excluded (N = 5).
 33. All data was collected prospectively, including: demographic and tumor characteristics,
 34. comorbidity, therapeutic information, details about neoadjuvant treatment, medication,
 35. pre- and postoperative complications, and survival data.

36. To reduce bias in selection criteria and interfering factors in developing TEE's, we created
 37. statistically comparable groups by propensity matching. The propensity score is used
 38. to balance covariates allowing two study subjects with the same propensity score to

1. be appreciably similar in observed dimensions (implemented in our SPSS package(10)).
2. Patients treated with neoadjuvant CRT (N = 110) were matched with 95 patients who
3. were treated between 2000 and 2012 with surgery alone. Patients were matched for:
4. sex, medical history of deep venous thrombosis (DVT), pulmonary embolism, myocardial
5. infarction, and TIA/CVA, ASA classification, and preoperative cTstage.

6.

7. **Neoadjuvant chemoradiotherapy**

8. Patients who were eligible for neoadjuvant CRT received Carboplatin, which was adminis-
9. tered weekly with a targeted area under the curve (AUC) of 2 mg per milliliter per minute
10. and Paclitaxel of 50 mg/m² for 5 weeks. Concurrent radiotherapy, which consisted of
11. 41-4 Gy in 23 fractions of 1.8 Gy, was administered five times per week. Radiotherapy
12. target volumes were delineated on a planning computed tomography (CT) scan by an
13. experienced radiation oncologist. Oncologic criteria consisted of a clinical tumor stage of
14. T1N1-3 or T2-T4aN0-3 without distant metastases (M0). Conditional requirements were
15. based on the judgment of the surgeon and both the medical and radiation oncologist and
16. were comparable to the eligibility criteria of the national CROSS study(1).

17.

18. **Preoperative evaluation and comorbidity**

19. All patients were staged with an endoscopic ultrasonography (EUS) including fine needle
20. aspiration (FNA) and 16-64 slice spiral multidetector computed tomography (MDCT)
21. with intravenous and oral contrast of the neck, chest, and abdomen. In locally advanced
22. tumors (T3-4a or N1-3), an 18F-fluoro-2-deoxy-D-glucose Positron Emission Tomography
23. (FDG-PET) was performed. For the final analysis, the available reports of every EC patient
24. were reviewed and discussed in a multidisciplinary tumor specific board to assess ap-
25. propriate management. Patients treated with surgery alone underwent an esophageal
26. resection within 4-8 weeks after staging. In patients treated with neoadjuvant CRT, a re-
27. staging MDCT with intravenous contrast of the neck, chest, and abdomen was performed
28. to exclude progressive disease in assessing resectability.
29. Comorbidity was classified according to the American Society of Anesthesiology (ASA)
30. score varying from ASA 1 (very good condition) to ASA 5 (moribund patient). The ASA
31. score is a readily available and widely accepted method to stratify surgical patients ac-
32. cording to their pre-operative risk.

33.

34. **Surgery**

35. All patients underwent, usually within 4-8 weeks after (re)staging, a transthoracic
36. esophagectomy with two-field lymphadenectomy by two experienced surgeons. Distal
37. tumors and those around the gastro-esophageal junction were approached through a left
38. thoraco-laparotomy and intrathoracic anastomoses by gastric-tube reconstruction. More

1. cranial located esophageal tumors were approached through a right thoraco-laparotomy
2. with cervical anastomoses.

3.

4. TEE prevention

5. Patients using preoperative anticoagulation and those diagnosed with a TEE during neoadjuvant CRT, were instructed to use a therapeutic dosage (11400 units a day) of low molecular weight heparin (LMWH), which was adjusted to a prophylactic dose (2850 units a day) 5 days before surgery. This was administered by specialized home care nurses. In all patients, LMWH was started perioperatively and continued until discharge. Dosage was dependent on patient's weight and risk-factors and varied between 2850 and 11400 units a day. In addition, all patients received compression stockings for the first 24 hours after surgery.

12.

13. Definition of outcome

14. The primary outcome was based on the occurrence of TEE's pre- and/or postoperative. Venous, arterial, symptomatic, and idiopathic TEE's were included. In patients treated with neoadjuvant CRT, a staging multidetector CT (MDCT) with intravenous and oral contrast was performed < 4 weeks before CRT. In all patients, regardless of treatment, a MDCT with intravenous and oral contrast was performed < 4-8 weeks before surgery. If pulmonary embolism was diagnosed, an upper and lower ultrasonography was performed. Patients presented with clinical symptoms of TEE underwent an additional triphasic CT-angiography to confirm the diagnosis. Clinical suspected TEE's of the extremities were confirmed by duplex ultrasonography. A preoperative TEE took place between diagnosis of esophageal cancer and surgery. Postoperative TEE's occurred during hospital admission and examination consisted of CT-angiography if central embolisms were suspected and duplex ultrasonography to confirm TEE's of the extremities. Thromboembolic events were scored according to the National Cancer Institute common toxicity criteria for adverse events (CTCAE version 4.03.13) (Table 1). Short-term mortality included in hospital mortality and/or mortality within the first 90 days after surgery.

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30. **Table 1.** Grading of thromboembolic events according to the Common Terminology Criteria for Adverse Events (CTCAE) definition:

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Grade	Definition
1	Venous thrombosis (e.g. superficial thrombosis)
2	Venous thrombosis (e.g. uncomplicated deep vein thrombosis), medical intervention indicated
3	Thrombosis (e.g. uncomplicated pulmonary embolism, non-embolic cardiac mural thrombus), medical intervention indicated
4	Life-threatening (e.g. pulmonary embolism, cerebrovascular event, arterial insufficiency) hemodynamic or neurologic instability, urgent intervention indicated
5	Death

1. **Statistical analysis**

2. Data is reflected as frequencies, means and/or median with percentages. Categorical
3. variables were analyzed with the χ^2 test, and continuous variables were analyzed with a
4. Student t test (normal distribution) or Mann Whitney U-test (skewed distribution). Univari-
5. ate regression analysis was used to determine risk factors for the development of TEE's.
6. Multivariate logistic regression was applied to correct for cofounders. A p-value < 0.05
7. was considered to be significant. Statistical analyses were conducted by the statistical
8. software from SPSS 20.0 (SPSS Inc., Chicago IL, USA).

9.

10.

11. **RESULTS**

12.

13. Median age in this cohort was 65.8 years and the majority was diagnosed with adeno-
14. carcinoma 83.3% (N = 280). Hypertension (30.4%) and diabetes mellitus (12.8%) were
15. the most frequently reported comorbidities. A considerable number of patients had a
16. thromboembolic event in medical history, including pulmonary embolism in 2.4% (N = 8)
17. and myocardial infarction in 12.2% (N = 41) (Table 2).

18. The majority (80.1%) of the patients underwent the full neoadjuvant treatment regimen.
19. For various reasons and complications during neoadjuvant CRT, 20 patients (18.2%) re-
20. ceived four out of five cycles of chemotherapy and three patients (2.7%) received three
21. cycles or less. Most frequently reported complications during neoadjuvant CRT consisted
22. of hematological toxicity (N = 11; 10.0%) (Table 3).

23.

24. **Matching**

25. No differences were observed in comorbidity, histology, localization, and side of thoracotomy
26. between patients with surgery alone and patients treated with neoadjuvant CRT followed
27. by surgery (Table 2). However, patients treated with neoadjuvant CRT had comprehensible a
28. lower ASA classification (p = 0.003). Besides, a significant difference in preoperative T stage
29. (p = 0.032) was observed. These variables might influence the development of TEE's. After
30. matching, statistically comparable groups were created, with 95 patients in the surgery
31. alone group and 110 patients in the neoadjuvant CRT followed by surgery group (Table 2).

32.

33. **Thromboembolic events**

34. In the whole cohort (N = 336), 24 patients (7.1%) were diagnosed with a TEE at some stage
35. during treatment, 10 (3.0%) events developed in the preoperative phase and 14 (4.2%)
36. arose postoperatively. Patients who were treated with neoadjuvant CRT were diagnosed
37. with 12 TEE's (10.9%) with a relative risk of 2.645 (95% confidence interval (CI); 1.105-
38. 6.329, p = 0.029).

1. **Table 2.** Patients and tumor characteristics; surgery alone vs. neoadjuvant CRT followed by surgery.

2. Characteristic	3. Surgery alone (%)		4. Neoadjuvant CRT followed by surgery (N = 110) (%)	5. p-value unmatched	6. p-value matched
	7. Unmatched (N = 226)	8. Matched (N = 95)			
9. Gender (M/F)	180/45	71/24	83/27	0.331	0.906
10. Age (years)	65.5	64.2	63.0	0.228	0.557
11. Smoking	70 (31.0)	34 (35.8)	48 (43.6)	0.258	0.375
12. Comorbidity					
13. Angina pectoris	20 (8.8)	5 (5.3)	10 (9.1)	0.942	0.294
14. Myocardial infarction	30 (13.3)	10 (10.5)	11 (10.0)	0.390	0.901
15. Heart failure	6 (2.7)	1 (1.1)	2 (1.8)	0.637	0.649
16. Hypertension	64 (28.3)	25 (26.3)	38 (34.5)	0.244	0.203
17. Diabetes mellitus	27 (11.9)	9 (9.5)	16 (14.5)	0.503	0.268
18. TIA/CVA	21 (9.3)	4 (4.2)	7 (6.4)	0.362	0.495
19. Pulmonary embolism	7 (3.1)	0 (0.0)	1 (0.9)	0.217	0.352
20. DVT	7 (3.1)	0 (0.0)	2 (1.8)	0.496	0.187
21. ASA classification					
22. ASA I	11 (4.9)	10 (10.5)	13 (11.8)		
23. ASA II	130 (57.5)	71 (74.7)	66 (60.0)		
24. ASA III	67 (29.6)	14 (14.7)	16 (14.5)		
25. ASA IV	5 (2.2)	0 (0.0)	0 (0.0)		
26. Missing	13 (5.8)	0 (0.0)	15 (13.6)	0.003	0.702
27. Histology					
28. Adenocarcinoma	190 (84.1)	75 (78.9)	90 (81.8)		
29. SCC	36 (15.9)	20 (21.1)	20 (18.2)	0.728	0.512
30. Clinical T stage					
31. T1	29 (12.8)	3 (3.2)	0 (0.0)		
32. T2	32 (14.2)	12 (12.6)	19 (17.3)		
33. T3	158 (69.9)	75 (78.9)	86 (78.2)		
34. T4	7 (3.1)	5 (5.3)	5 (4.5)	0.032	0.235
35. Localization					
36. Mid esophagus	25 (11.2)	14 (14.7)	14 (12.7)		
37. Distal esophagus	160 (71.4)	62 (65.3)	85 (77.3)		
38. GEJ	39 (17.4)	19 (20.0)	11 (10.0)	0.201	0.097
39. Thoracotomy					
40. Left sided	100 (44.2)	33 (34.7)	41 (37.3)		
41. Right sided	126 (55.8)	62 (65.3)	69 (62.7)	0.224	0.706

32. TIA/CVA: transient ischemic attack/ cerebrovascular accident, DVT: deep venous thrombosis, ASA: American Society of Anesthesiologists, SCC: Squamous cell carcinoma, GEJ: gastro-esophageal junction

34. In the matched cohort (N = 205), 16 patients (7.8%) were diagnosed with a TEE of which 9 (4.4%) occurred preoperatively and 7 (3.4%) postoperatively (Table 3). In this cohort, the relative risk to develop a TEE for patients treated with neoadjuvant CRT was 3.755 (95% CI: 1.027-13.734 p = 0.046).

1. **Table 3.** Complications during neoadjuvant CRT.

2. Complications	3. Neoadjuvant CRT followed by surgery (N = 110) (%)	4. Grade *			
		1	2	3	4
4. Thrombocytopenia	5 (4.5)	-	4	1	-
5. Leukopenia	7 (6.4)	1	3	3	-
6. Thromboembolic event	9 (8.2)	-	1	7	1
7. Fever	4 (3.6)	2	2	-	-
8. Fatigue	2 (1.8)	-	2	-	-
9. Dyspnea	1 (0.9)	-	1	-	-
10. Neurotoxic effects	3 (2.7)	2	1	-	-
11. Nausea	2 (1.8)	-	1	1	-
12. Anorexia	4 (3.6)	-	3	1	-
13. Aspiration pneumonia	1 (0.9)	-	1	-	-
14. Angina pectoris	2 (1.8)	-	2	-	-
15. None	80 (72.7)	-	-	-	-

16. * Grading according to CTCAE v3.0

17.

18.

19. Preoperative TEE

20. During the preoperative period in the unmatched cohort, 10 patients were diagnosed with

21. a TEE of which 9 patients were treated with neoadjuvant CRT ($p = 0.000$). In the matched

22. cohort all preoperative TEE's ($N = 9, 8.2\%$) were exclusively observed in the group treated

23. with neoadjuvant CRT ($p = 0.004$). Thromboembolic events consisted of DVT ($N = 2$), pul-

24. monary embolism ($N = 7$) and portal vein thrombosis (PVT; $N = 1$) (Table 4). One patient

25. was diagnosed with a DVT and pulmonary embolism at the same time.

26. The majority of the preoperative TEE's were asymptomatic (pulmonary embolism: $N = 6$

27. and PVT: $N = 1$, CTCAE 3; definition Table 1). None of these TEE's were diagnosed on the

28. first staging CT-scan, but were diagnosed on the second i.e restaging CT-scan after neoad-

29. juvant CRT. One patient experienced acute symptoms of a pulmonary embolism (CTCAE

30. 4).

31. Patients who were diagnosed with a preoperative TEE had a median of 60 days between

32. end of neoadjuvant CRT and surgical resection compared to 48 days for patients without

33. the presence of a TEE (minimum 41 days, maximum 236 days) ($p = 0.021$). This delay had

34. no influence on the surgical decision to perform a radical resection. None of these pa-

35. tients were excluded from surgery. Patients who were using anti-coagulation (i.a. heparin,

36. acenocoumarol or thrombocyte aggregation inhibitors) did not have a reduced risk on the

37. formation of TEE's ($p = 0.758$). Besides, the presence of TEE treated preoperatively had no

38. influence on postoperative complications, hospital stay or short-term mortality.

39. A multivariate analysis was performed to correct for cofounding factors for developing pre-

40. operative TEE's. History of DVT ($p = 0.005$; odds ratio (OR): 37.429; 95% CI: 3.025-463.117)

1. **Table 4.** Thromboembolic events during EC treatment.

2. Thromboembolic	3. Surgery alone		4. Neoadjuvant CRT followed by surgery (N = 110)	5. p-value unmatched	6. p-value matched
3. events	Unmatched (N = 226)	Matched (N = 95)			
4. <i>Preoperative</i>					
5. DVT	1	0	2	0.208	0.187
6. Pulmonary embolism	0	0	7	0.000	0.012
7. PVT	0	0	1	0.487	0.708
8. Patients with a TEE	1	0	9	0.000	0.004
9. <i>Postoperative</i>					
10. DVT	1	0	1	0.602	0.352
11. CVA	2	1	0	0.322	0.281
12. Myocardial infarction	1	0	0	0.845	-
13. Pulmonary embolism	7	3	2	0.496	0.535
13. Patients with a TEE	11	4	3	0.357	0.560

14. DVT: deep venous thrombosis, PVT: portal vein thrombosis, CVA: cerebrovascular accident

15.

16.

17.

18. and treatment with neoadjuvant CRT ($p = 0.004$; OR: 34.519; 95% CI: 3.086-386.101) were
19. identified as possible risk factors (matched cohort).

20.

21. Postoperative TEE

22. A thromboembolic complication in the postoperative course was a relatively rare event
23. (N = 14; 4.2%). In the unmatched cohort 11 patients (4.8%) with surgery alone developed
24. a TEE compared to 3 patients (2.7%) treated with neoadjuvant CRT ($p = 0.357$). These
25. events varied between DVT (surgery alone: N = 1 and neoadjuvant CRT followed by
26. surgery: N = 1), CVA (surgery alone: N = 2), myocardial infarction (surgery alone: N = 1)
27. and pulmonary embolism (surgery alone: N = 7 and neoadjuvant CRT followed by surgery:
28. N = 2) without significant differences between groups. The occurrence of a TEE in the
29. matched cohort was not significantly different between both groups (N = 4 vs. N = 3;
30. $p = 0.560$) (Table 4).

31. Two patients deceased within 90 days and/or in-hospital due to the consequences of a
32. TEE (myocardial infarction and pulmonary embolism, CTCAE 5). These events were exclu-
33. sively observed in patients who underwent surgery alone. Hospital- ($p = 0.936$) and ICU
34. stay ($p = 0.375$) did not differ between patients with and without TEE's (matched cohort).
35. Compared to preoperative risk factors, postoperative risk factors analyses for the develop-
36. ment of TEE's were extended with ICU/hospital stay and side of thoracotomy. However,
37. the only possible risk factor that exceeded the threshold in univariate analysis was a his-
38. tory of pulmonary embolism ($p = 0.012$; OR: 8.778; CI 95%: 1.602-48.095).

1. DISCUSSION

2.

3. Cancer patients generally present with a higher risk of thromboembolic events (TEE's) and
4. with the introduction of neoadjuvant chemoradiotherapy the incidence of TEE's seems to
5. increase further (6, 9, 11). In this study, we observed a higher risk of preoperative throm-
6. boembolic events in EC patients treated with platinum-based neoadjuvant CRT. Despite a
7. possible long-lasting effect of chemoradiotherapy, we could not demonstrate a different
8. postoperative incidence. Although the majority of the preoperative diagnosed TEE's were
9. idiopathic, one patient experienced acute and life-threatening symptoms of a pulmonary
10. embolism during neoadjuvant CRT (CTCAE 4).

11. The pathophysiological mechanism is not fully understood, but chemotherapy appears
12. to play a major role in pro-inflammatory and pro-coagulant response due to endothelial
13. disruption. Inflammatory response is initiated by cytokines, in particular TNF- α and IL-1,
14. which decrease the concentration of important anti-coagulant proteins, including anti-
15. thrombin and protein C. Pro-coagulant response is initiated by an increased tissue factor
16. expression(6, 12). Moreover, the activated pro-coagulant response is sustained for up to 6
17. months after induction of chemoradiotherapy, which implies an increased postoperative
18. risk for TEE's over a longer period of time(7).

19. Most scientific research concerning TEE's in cancer patients is related on patients with
20. advanced malignancies undergoing palliative treatment. Only a few studies focused on
21. the incidence of TEE's in patients who were treated with curative intent in a multimodality
22. approach(5, 7, 8). In a study of Verhage et al. patients with pre- and postoperative che-
23. motherapy showed a significant increased incidence of preoperative TEE's(5). In addition,
24. Byrne et al. gave the pathophysiological explanation for an increased risk of TEE's in a
25. multimodal treatment(7). In gastro-esophageal cancer patients treated according to the
26. CROSS regimen, the risk for TEE's is not previously described(1). Additional risk factors
27. for cancer-associated TEE's are well documented in the literature and are generally based
28. on cancer treatment –and patient related factors(4). In accordance to our results, a past
29. history of thrombotic events is a risk factor for developing TEE's.

30. In the current study, we applied perioperatively thromboprophylaxis with compression
31. stockings and low molecular weight heparin (LMWH), which was continued until dis-
32. charge. Nevertheless, 14 patients were diagnosed with postoperative TEE's of whom two
33. were fatal (surgery alone group). Generally, patients did not receive primary or secondary
34. thromboprophylaxis in the preoperative period. The value and safety of prophylaxis during
35. chemoradiotherapy is questionable, as it may contribute to an increased risk of bleeding
36. in combination with chemotherapeutic induced thrombocytopenia (13). The incidence
37. of thrombocytopenia in this study is probably underestimated due to the retrospective
38. nature of this research. In a Cochrane review the authors stated that the number needed-

1. to-treat to prevent a symptomatic TEE was 60 without any clear benefit in survival, but
2. with an increased risk of complications(13). Preoperative TEE's in the present study were
3. not only associated with chemoradiation, but also with a history of DVT. Hence, current
4. guidelines recommend secondary thromboprophylaxis in cancer patients with a history
5. of TEE's(14). Notwithstanding the lack of an appropriate study design, but based on the
6. results of present study and previous published guidelines, we recommend the use of sec-
7. ondary thromboprophylaxis during neoadjuvant CRT in EC patients with a history of TEE's.
8. In our opinion, it is preferable to start thromboprophylaxis with LMWH under adequate
9. hematological control(15).

10. The majority of preoperatively diagnosed TEE's in the present study were asymptomatic.
11. None of these TEE's in patients treated with neoadjuvant CRT were diagnosed at the first
12. staging CT-scan, but during the second i.e restaging CT-scan 4-8 weeks prior to surgery.
13. The staging CT-scan in patients within the surgery alone group also was performed < 4-8
14. weeks before surgery. We therefore do not expect an underestimated incidence of preop-
15. eratively diagnosed TEE's in patients without neoadjuvant CRT. In current study, patients
16. without clinical suspicion of TEE did not undergo a triphasic CT-angiography. However, the
17. diagnostic accuracy of currently used multislice MDCT with intravenous contrast seems
18. to be of sufficient quality in diagnosing pulmonary embolism, especially when combined
19. with an upper and lower ultrasonography(16-18). Therefore, we consider the impact of
20. neoadjuvant CRT on the development of TEE's plausible by this study and available litera-
21. ture(5, 7-9, 13). Nevertheless, with one symptomatic pulmonary embolism, the impact
22. of TEE's seems relatively moderate. And in spite of a significant delay until surgery, there
23. seemed to be no influence on surgical resection and postoperative course(8).

24.

25. In conclusion, patients treated with neoadjuvant CRT for esophageal cancer have an
26. increased risk to develop TEE's for surgical resection, especially with TEE's in medical his-
27. tory. Postoperatively we observed no difference in incidence. We therefore, make a plea
28. for secondary prophylaxis in this high-risk group with LMWH.

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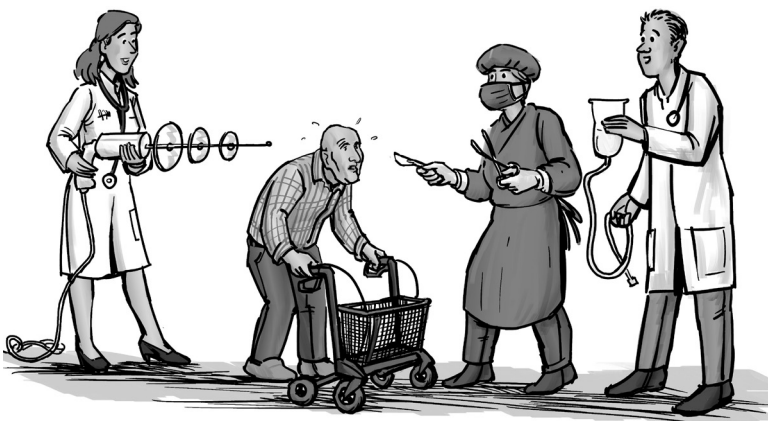
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4 |

Impact of neoadjuvant chemoradiotherapy on postoperative course after curative intended transthoracic esophagectomy in esophageal cancer patients

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1. **ABSTRACT**

2.

3. **Background:** Neoadjuvant chemoradiotherapy (CRT) improves loco-regional control and
4. overall survival in esophageal cancer patients. Although adverse events are relatively low
5. during neoadjuvant CRT, severe postoperative side-effects may occur leading to morbidity
6. and even mortality. We investigated the impact of a more frequently used neoadjuvant
7. CRT regimen of 41.4Gy/5wks radiotherapy with concurrent Carboplatin and Paclitaxel
8. (CROSS schedule) on the postoperative course.

9. **Methods:** Between 2006 and 2012, a total of 96 esophageal cancer patients (staged
10. cT1N+/T2-4a/N0-3 and M0) were treated according to the above neoadjuvant scheme. To
11. reduce bias in this single center study, we performed a propensity score matched analysis
12. with patients who underwent surgery alone (n = 230), from a prospectively maintained
13. database (n = 326).

14. **Results:** Baseline characteristics between both groups were equally distributed in the
15. matched cohort. In the neoadjuvant treated group significantly more patients were di-
16. agnosed with pneumonia (27.1% vs. 51.0%; p = 0.001), pleural effusion (12.5% vs. 24.0%;
17. p = 0.040), and arrhythmias (20.4% vs. 34.4%; p = 0.008). Besides, in the multivariate
18. analysis neoadjuvant CRT was significantly associated with an increased risk of pneumonia
19. (p = 0.001, odds ratio (OR) 2.896), pleural effusion (p = 0.041, OR 2.268), and arrhythmia
20. (p = 0.023, OR 2.215). Despite these outcomes, no differences were detected in ICU - or
21. hospital stay. Short-term mortality did not differ between both groups.

22. **Conclusions:** In this study, we observed an increase of cardiopulmonary complications
23. in the neoadjuvant CRT group, which has no effect on hospital or ICU stay and mortality.
24. Further research is warranted on limitation of chemoradiotherapy-induced cardiopulmo-
25. nary toxicity.

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1. INTRODUCTION

2.

3. Survival in esophageal cancer patients after curative intended surgery alone remains
4. poor with an average 5-year disease free survival between 15–25% [1]. To improve loco-
5. regional control and overall survival, a multimodality approach with neoadjuvant chemo-
6. radiotherapy (CRT) has become standard of care in most centers. Significant survival
7. benefit of 13% at 5 years after neoadjuvant CRT has been demonstrated in a multicenter
8. randomized clinical trial, the CROSS study [2]. Based on their results and the outcome
9. in the literature over the last decades, the authors make a plea for standardization of
10. preoperative CRT[2-15].

11. Transthoracic esophagectomy is generally considered to be a high-risk surgical procedure
12. with complication rates ranging between 40-60% [16]. With an even more onerous treat-
13. ment policy, concerns have been raised about the impact of neoadjuvant CRT on the
14. postoperative course. Chemotherapy prior to a radical esophagectomy may subsequently
15. be accompanied by the risk of acute and late toxicity. Adding thoracic radiotherapy to a
16. combined chemotherapy regimen will further increase cardiopulmonary toxicity [17, 18].
17. It might induce acute inflammation resulting in pneumonia, pleural effusion and finally
18. lung fibrosis and is associated with a significant cardiac toxicity [19].

19. Nevertheless, promising results for long term survival have led to several randomized
20. controlled trials (RCT's) and subsequent meta-analyses [2, 9-15, 20]. Some studies de-
21. scribed an increased postoperative morbidity and even mortality, which was not the case
22. in the CROSS trial. However, postoperative morbidity in that study was described without
23. further specification in postoperative complications.

24. With aging of the population and increased incidence of esophageal cancer in western
25. countries the use of neoadjuvant CRT will further increase. Especially in elderly patients
26. the prevalence of comorbidity is relatively high and we should consider whether long-
27. term survival benefits outweigh the potential disadvantages of higher complication rates
28. [4]. In addition, comorbidities contribute to complexity and restricting patients from CRT
29. in the pretreatment assessment remains difficult. In this study we aimed to investigate
30. the influence of neoadjuvant CRT on the short-term postoperative course after a curative
31. intended transthoracic esophagectomy.

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33.

34. PATIENTS AND METHODS

35.

36. Patient characteristics

37. From a prospectively maintained database we included all 326 esophageal cancer pa-
38. tients, who underwent an extended transthoracic esophagectomy with curative intent

1. between January 2000 and June 2012. From this group we collected the following data:
2. demographic characteristics, comorbidity, neoadjuvant treatment, tumor characteristics,
3. therapeutic information, complications, and survival data. Of these 326 patient,
4. 96 patients were treated with the CROSS regimen. To reduce bias in selection criteria and inter-
5. fering factors in postoperative complications, we created statistically comparable groups
6. by propensity matching. The propensity score is used to balance covariates allowing two
7. study subjects with the same propensity score to be appreciably similar in observed
- 8.
- 9.

10. **Table 1.** Patient characteristics

11. Variable	12. Surgery alone (%)		13. Neoadjuvant CRT followed by surgery N = 96 (%)	14. p-value unmatched	15. p-value matched
	16. unmatched N = 230	17. matched N = 96			
18. Median age (yrs)	65.0	63.1	62.7	0.427	0.432
19. Sex (M/F)	180/50	72/24	71/25	0.400	0.869
20. Smoker	30.6	34.7	42.7	0.205	0.258
21. Histology					
22. Adenocarcinoma	191 (83.0)	79 (82.3)	77 (80.2)	0.608	0.527
23. Squamous CC	37 (16.1)	16 (16.7)	19 (19.8)		
24. Other	2 (0.8)	1 (1.0)	0 (0.0)		
25. Localization					
26. Mid	25 (10.9)	10 (10.4)	13 (13.5)		
27. Distal	162 (70.4)	66 (68.8)	73 (76.0)		
28. GEJ	43 (18.7)	20 (20.8)	10 (10.4)	0.140	0.123
29. cT stage					
30. T1/T2	61 (26.5)	27 (28.1)	23 (24.0)		
31. T3/T4	169 (73.5)	69 (71.9)	73 (76.0)	0.844	0.492
32. Comorbidity					
33. Angina pectoris	18 (7.8)	10 (10.4)	6 (6.3)	0.619	0.296
34. Myocardial infarct	29 (12.6)	11 (11.5)	8 (8.3)	0.267	0.468
35. Heart failure	5 (2.2)	2 (2.1)	2 (2.1)	0.959	1.000
36. Hypertension	66 (28.7)	32 (33.3)	31 (32.3)	0.517	0.878
37. COPD	33 (14.3)	6 (6.3)	7 (7.3)	0.077	0.774
38. Diabetes mellitus	27 (11.7)	9 (9.4)	13 (13.5)	0.651	0.365
39. TIA/CVA	20 (8.7)	3 (3.1)	7 (7.3)	0.675	0.194
40. ASA classification					
41. ASA I	11 (5.1)	10 (11.2)	11 (13.6)		
42. ASA II	136 (62.7)	67 (75.3)	57 (70.4)		
43. ASA III	65 (30.0)	11 (12.4)	13 (16.0)		
44. ASA IV	5 (2.3)	1 (1.1)	0 (0.0)	0.006	0.649
45. Thoracotomy					
46. Right sided	129 (56.1)	56 (58.9)	59 (61.5)		
47. Left sided	101 (43.9)	39 (41.1)	37 (38.5)	0.285	0.767

1. dimensions (implemented in our SPSS package [21]). The 96 patients in the neoadjuvant
 2. CRT group were matched with 96 patients from the total 230 patients treated with surgery
 3. alone. Patients were matched for: age, sex, tumor characteristics, comorbidity (individu-
 4. ally scored: diabetes mellitus, hypertension, angina pectoris, heart failure, myocardial
 5. infarction, COPD, TIA/CVA), ASA score and side of thoracotomy (Table 1).

6.

7. **Neoadjuvant chemoradiotherapy**

8. Both squamous cell carcinoma and adenocarcinoma of the esophagus were considered
 9. suitable for neoadjuvant CRT. Oncologic criteria consisted of a clinical tumor stage of
 10. T1N1-3 or T2-T4aN0-3 without distant metastases (M0). During 2006-2008, a part of our
 11. cohort participated in the national CROSS study [2]. After 2008 neoadjuvant CRT was
 12. administered based on the judgment of the oncologist, on inclusion criteria similar to that
 13. used in the CROSS study. Carboplatin was administered weekly to achieve an area under
 14. the curve (AUC) of 2 mg per milliliter per minute and paclitaxel of 50 mg/m² for 5 weeks,
 15. with concurrent radiotherapy, which consisted of 41.4 Gy in daily fractions of 1.8 Gy (in
 16. 3 patients 45.0 Gy in 25 fractions), five times per week. Radiotherapy target volumes
 17. were delineated on a planning CT-scan by an experienced radiation oncologist using all
 18. diagnostic information.

19.

20. **Surgery**

21. All patients with cardiopulmonary history were seen by the cardio/pulmonologist for
 22. perioperative recommendations. After a restaging CT, 4 weeks after the end of CRT,
 23. patients were planned for a surgical resection, usually within 4-8 weeks after neoadju-
 24. vant treatment. All patients underwent a transthoracic esophagectomy with two-field
 25. lymphadenectomy by two experienced surgeons. Tumors around the gastroesophageal
 26. junction were approached through a left thoraco-laparotomy while more cranial located
 27. esophageal tumors were approached through a right-sided procedure.

28.

29. **Definitions of outcome**

30. Short-term mortality was defined as “surgical mortality” which included in hospital mor-
 31. tality and/or mortality within the first 90 days after operation. To simplify comparison
 32. with previous studies, 30-day mortality was also displayed. Complications during hospital
 33. admission were divided into pulmonary, cardiac, and other complications as can be seen
 34. in Table 2. Complications were scored on the same criteria as described previously [22],
 35. except for pneumonia, which was supplemented with the use of antibiotic treatment on
 36. clinical indications.

37. Comorbidity was classified according to the American Society of Anesthesiology (ASA)
 38. score varying from ASA 1 (very good condition) to ASA 5 (moribund patient) [23].

1. **Table 2.** Matched data; complications and post-operative course after esophagectomy

2. Variable	Surgery alone N = 96 (%)	Neoadjuvant CRT followed by surgery N = 96 (%)	p-value
3. Surgical mortality*	7 (7.3)	7 (7.3)	1.000
4. 30-day mortality	6 (6.3)	3 (3.1)	0.306
5. Overall complications	60 (62.5)	70 (72.9)	0.123
6. Pulmonary complications			
7. Respiratory failure	26 (27.1)	22 (22.9)	0.505
8. Pneumonia	26 (27.1)	49 (51.0)	0.001
9. ARDS	5 (5.2)	2 (2.1)	0.248
10. Atelectasis	10 (10.4)	9 (9.4)	0.809
11. Pleural effusion	12 (12.5)	23 (24.0)	0.040
12. Pulmonary embolism	3 (3.1)	2 (2.1)	0.650
13. Re-intubation	25 (26.0)	18 (18.8)	0.226
13. Cardiac complication			
14. Arrhythmias	20 (20.8)	33 (34.4)	0.036
15. Myocardial infarct	2 (2.1)	0 (0.0)	0.155
16. Other complications			
17. SIRS	5 (5.2)	4 (4.2)	0.733
18. Sepsis	9 (9.4)	7 (7.3)	0.602
19. Anastomotic leakage	13 (13.5)	11 (11.5)	0.663
20. Chylothorax	3 (3.1)	7 (7.3)	0.194
21. Wound infections	9 (9.4)	8 (8.3)	0.799
22. Wound dehiscence	4 (4.2)	2 (2.1)	0.407
23. Renal failure	4 (4.2)	4 (4.2)	1.000
24. Liver failure	0 (0.0)	1 (1.0)	0.316
25. Ileus	2 (2.1)	4 (4.2)	0.407
26. Postoperative course			
27. Reoperation	6 (6.3)	8 (8.3)	0.579
28. OR-time	7.8 hours	9.0 hours	0.158
29. ICU-stay	3.5 days	3.0 days	0.954
30. Hospital stay	16.0 days	16.0 days	0.986

31. * surg. mortality i.e in hospital and/or 90-day mortality

32. Statistical analysis

33. Data was reflected as frequencies, means and/or medians with percentages. Categorical variables were analyzed with the χ^2 test, and continuous variables were analyzed with a Student *t* test (normal distribution) or Mann Whitney *U*-test (skewed distribution). To determine the effect of neoadjuvant CRT on postoperative complications, we performed a multivariate analysis for complications with a p-value < 0.1 in the univariate analyses. A p-value < 0.05 was considered to be significant. All statistical analyses were conducted by the statistical software from SPSS 20.0 (SPSS Inc., Chicago IL, USA).

1. RESULTS

2.

3. Differences in demographic characteristics between patients who were treated with
 4. surgery alone (group 1, N = 230) and those treated with neoadjuvant CRT combined with
 5. surgery (group 2, N = 96), were only observed in ASA classification ($p = 0.006$) (Table 1).
 6. After matching, 96 patients were included in group 1 and 96 in group 2 with an equal
 7. distribution of demographic characteristics (Table 1). The majority (95.8%) of this cohort
 8. received at least 4 out of 5 cycles of the neoadjuvant CRT scheme.

9.

10. Mortality and morbidity

11. Short-term mortality was not significantly different between both groups. In the un-
 12. matched cohort we observed a 30-day mortality of 4.3% ($n = 14$), which was equally
 13. distributed between both groups. Surgical mortality in the unmatched cohort, including
 14. in-hospital and 90-day mortality, was 7.4% ($N = 17$) for group 1 and 7.3% ($N = 7$) for group
 15. 2 ($p = 0.975$). In the matched cohort, surgical mortality was 7.3% ($N = 7$) for both groups
 16. ($p = 1.000$). Overall morbidity rates in the matched cohort between group 1 (62.5%) and 2
 17. (72.9%) were not significantly different ($p = 0.123$) (Table 2).

18.

19. Pulmonary complications in the matched cohort

20. Overall pulmonary complications were observed more frequently, but not significantly
 21. different in patients treated with neoadjuvant CRT (46.9% vs. 59.4%; $p = 0.083$). Pneumo-
 22. nia was the most commonly reported complication, and occurred significantly more in
 23. patients treated with neoadjuvant CRT (27.1% vs. 51.0%; $p = 0.001$). The number of days
 24. between the end of neoadjuvant CRT and surgery had no influence on the occurrence of
 25. pneumonia (52 days vs. 53 days; $p = 0.137$). In addition to pneumonia, also pleural effu-
 26. sion was more frequently observed in patients treated with neoadjuvant CRT (12.5% vs.
 27. 24.0%; $p = 0.040$). The number of days between the end of neoadjuvant CRT and surgery
 28. was not significantly different (56 days vs. 52 days; $p = 0.958$). In contrast to pneumonia,
 29. pleural effusion was not significantly different ($p = 0.075$) in the unmatched cohort. Other
 30. pulmonary complications were not significantly different (Table 2).

31.

32. Cardiac complications in the matched groups

33. Cardiac complications consisted almost exclusively of arrhythmias and occurred in 20
 34. (20.8%) patients in group 1 versus 33 (34.4%) in group 2, which was significantly different
 35. ($p = 0.036$). Time between the end of neoadjuvant CRT and surgery seemed to have no in-
 36. fluence on the development of postoperative arrhythmias (52 days vs. 54 days; $p = 0.676$).
 37. Also in the unmatched cohort, arrhythmias were significantly more observed in the group
 38. treated with neoadjuvant CRT ($p = 0.008$).

1. Other complications in the matched groups

2. None of the other complications turned out to be significantly different between patients
3. treated with surgery alone compared to patients treated with neoadjuvant CRT followed
4. by surgery (Table 2).

5.

6. Postoperative course

7. Despite a higher incidence of pneumonia, patients treated with neoadjuvant CRT had a
8. slightly shorter median ICU stay (3.5 vs. 3.0 days; $p = 0.954$) and an identical in hospi-
9. tal stay (16.0 vs. 16.0 days; $p = 0.986$). The number of reoperations (6.3% versus 8.3%;
10. $p = 0.579$) appeared to be similar as well.

11.

12. Multivariate analysis

13. To determine the influence of neoadjuvant CRT on the development of postoperative
14. complications, we performed a multivariate analysis for complications with a p -value < 0.1
15. in univariate analyses. Neoadjuvant CRT ($p = 0.001$, odds ratio (OR): 2.896) and side of
16. thoracotomy, at the prejudice of a right-sided approach ($p = 0.020$, OR: 2.134) were
17. significantly associated with the development of pneumonia. Pleural effusion was associ-
18. ated with neoadjuvant CRT ($p = 0.041$, OR: 2.268) and side of thoracotomy ($p = 0.004$, OR:
19. 3.951). Risk factors for arrhythmias were neoadjuvant CRT ($p = 0.023$, OR: 2.215) and age
20. ($p = 0.000$, OR: 1.084) (Table 3).

21. Multivariate analysis in the unmatched data revealed similar results. In comparison to
22. the matched data, neoadjuvant CRT ($p = 0.001$, OR: 2.333) and side of thoracotomy at
23. the prejudice of a right-sided approach ($p = 0.009$, OR: 1.906) were associated with the
24. development of pneumonia. Pleural effusion was not significantly associated with neoad-
25. juvant CRT in the unmatched data, but with heart failure ($p = 0.010$, OR: 8.414), history of

26.

27.

28. **Table 3.** Significant outcomes in multivariate analyses

29.

Matched data	Pneumonia		Pleural effusion		Arrhythmias	
	OR	95% CI	OR	95% CI	OR	95% CI
Neoadjuvant CRT	2.896	1.566-5.357	2.268	1.035-4.969	2.215	1.114-4.403
Side of thoracotomy	2.134	1.127-4.042	3.951	1.540-10.141	-	-
Age	-	-	-	-	1.084	1.037-1.133
Unmatched data						
Neoadjuvant CRT	2.333	1.423-3.826	-	-	2.503	1.426-4.395
Side of thoracotomy	1.906	1.179-3.081	2.433	1.221-4.848	-	-
Heart failure	-	-	8.414	1.670-42.391	6.690	1.197-37.389
History of smoking	-	-	1.890	1.008-3.544	-	-
Age	-	-	-	-	1.066	1.032-1.101

38.

1. smoking ($p = 0.047$, OR: 1.890), and side of thoracotomy at the prejudice of a right-sided
2. approach ($p = 0.011$, OR: 2.433). Finally, arrhythmias were associated with neoadjuvant
3. CRT ($p = 0.001$, OR: 2.503), age ($p = 0.000$, OR: 1.066), and in contrast to the matched
4. data, also with heart failure ($p = 0.030$, OR: 6.690).

5.

6.

7. DISCUSSION

8.

9. Current study demonstrates an increased incidence of postoperative pneumonia, pleural
10. effusion, and arrhythmias by approximately twofold after the introduction of neoadjuvant
11. chemoradiotherapy. Although these outcomes suggest an increased risk for prolonged
12. ICU and/or hospital stay or even mortality risk, this was not confirmed by present data.
13. After the positive impact of neoadjuvant CRT in the multicenter randomized CROSS
14. trial, the acceptance in daily management has increased for the current used regimen
15. of radiotherapy with concurrent carboplatin and paclitaxel to improve overall survival
16. [2]. However, the role of CRT prior to the esophagectomy has been debated for several
17. decades. Part of this prolonged discussion was the occurrence of toxic cardiopulmonary
18. adverse events and consequently a raised postoperative risk for morbidity and mortality
19. [6]. Besides cardiopulmonary complications, inflammation and anastomotic leakage were
20. also feared [8].
21. The pathophysiological correlation between radiation dose to the lungs and the risk of
22. pulmonary complications has been demonstrated by several studies [17, 18]. Wang *et al.*
23. found that the volume of the lung spared from doses of ≥ 5 Gy was the only independent
24. dosimetric factor for the risk of postoperative pulmonary complications (defined as pneu-
25. monia or ARDS). This suggests that a lower dose of radiotherapy in a multimodality treat-
26. ment leads to a minimization of irradiated lung volume and might reduce the incidence
27. of pulmonary complications. The radiation dose to the heart in the neoadjuvant setting
28. of distal esophageal cancer is quite substantial, despite the relatively low total radiation
29. dose. Radiation to the pericardium increases the risk of pericardial effusion, which seems
30. to be dose-dependent [24]. Arrhythmia might display radiation-induced cardiac toxicity.
31. However, little is known about the correlation between arrhythmia and radiotherapy in
32. esophageal cancer patients. Moreover, paclitaxel may induce ventricular arrhythmias,
33. bradycardia and several degrees of atrioventricular conduction blocks [25]. It is essential
34. to reduce the amount of radiation on cardiopulmonary organs without compromising the
35. beneficial effect of radiotherapy. Improvements of advanced radiation technologies using
36. intensity modulated radiation therapy are promising and further research is warranted
37. [26].
- 38.

1. Conflicting data have been reported over the past years about the influence of neoadjuvant CRT on the postoperative course [2-8]. Merritt R.E. et al. concluded that major complications would not appear to increase due to neoadjuvant CRT, but were associated with the transthoracic approach and preoperative coronary artery disease [7]. Similar results were reported whereby neoadjuvant CRT did not appear to be an important predictor of major morbidity and mortality after esophagectomy, not even in elderly patients [4]. However, other reports did identify an increased incidence of pulmonary and septic complications after neoadjuvant CRT [6]. These different outcomes may be explained by considerable bias due to different neoadjuvant regimens in terms of dose or schedule for both chemotherapy and radiation. Chemotherapy based on cisplatin and/or 5-fluorouracil (5-FU) generally has more intense adverse side effects compared to the combination of carboplatin/paclitaxel [25, 27]. Additionally, there is a lack of uniformity in postoperative definitions and comparison of non-homogeneous groups without any correction for differences in surgical approach [28].

15. Besides uncertain effects of neoadjuvant CRT in developing postoperative complications, there is still doubt about the "ideal time period" after preoperative CRT and surgical resection. In this study, although it was not our main purpose, we could not demonstrate any correlation between these variable and postoperative complications. In rectal cancer, delayed surgery beyond 8 weeks after neoadjuvant CRT seemed to reduce postoperative morbidity without compromising prognosis [29].

21. Although significantly different between both groups, the cardiopulmonary complications in this study seemed to be relatively high. This might be explained by the fact that all patients underwent a transthoracic esophagectomy, which has a relatively higher morbidity and/or mortality rate [7]. Moreover, we used comprehensive definitions for postoperative complications, but the incidence of postoperative morbidity did not result in an increased mortality.

27. Awareness of clinicians could reduce postoperative complications when treatment is started earlier or even immediate postoperative as a preventive strategy [30, 31]. Currently, neoadjuvant CRT is given in our institution to patients with a comparable conditional status as was based on the inclusion criteria of the CROSS trial. Patients with a considerable frailty during pre-treatment assessment are excluded for neoadjuvant CRT. Indeed, our results underline a cautious use of neoadjuvant CRT in this group of patients, given the increased risk of cardiopulmonary complications. Therefore, we make a plea for an individualized treatment strategy in which neoadjuvant CRT plays an important role. Unfortunately, an objective measurement to properly assess the condition of the patient is still missing [23].

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1. CONCLUSION

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3. This study shows an increased incidence of pneumonia, pleural effusion and arrhythmia
4. after neoadjuvant chemoradiotherapy, without increasing the mortality risk in the treat-
5. ment of esophageal cancer patients. In multivariate analysis neoadjuvant chemoradio-
6. therapy was significantly associated with the risk of pneumonia and arrhythmia. Further
7. research should be focused on limitation of chemoradiotherapy-induced cardiopulmonary
8. toxicity.

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Early routine blood analyses within 48 hours after esophagectomy may reflect short-term outcome in patients with esophageal cancer

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Submitted

1. **ABSTRACT**

2.

3. **Introduction:** To reduce the severity of postoperative (p.o) complications after esophagec-
4. tomy in esophageal cancer (EC) patients, early identification is of great importance. We
5. evaluated the prognostic value of early (< 48 hrs) p.o routine peripheral blood measure-
6. ments for complications during hospital stay and short-term mortality (< 90 days) after
7. transthoracic esophagectomy (TTE).

8. **Methods:** Between 2006 and 2012, blood samples of 210 EC patients were analyzed on
9. three consecutive time points: 0 (T1), 24 (T2) and 48 (T3) hours after resection for albumin
10. (Alb), creatinine, C-reactive protein (CRP), lactate dehydrogenase (LDH), white blood cell
11. count (WBC), platelet count and hemoglobin (Hb). Multivariate analysis was performed on
12. factors with p-values ≤ 0.1 at univariate analysis. Significant results were further analyzed
13. by applying an area under the Receiver Operator Curve (AUC) to determine discriminatory
14. power.

15. **Results:** Sepsis and anastomotic leakage were moderately predicted by LDH at T2 (OR:
16. 1.012; AUC: 0.71 and OR: 1.008; AUC: 0.71 respectively), whereas CRP at T3 was associated
17. with sepsis (OR: 1.008; ROC: 0.72). Renal failure was strongly associated with creatinine at
18. T2 (OR: 1.039; ROC: 0.74). Short-term mortality (N = 12) was assessed by creatinine (T2)
19. (OR: 1.020), but without discriminatory power (0.52).

20. **Conclusion:** Early derangements of LDH (T2), creatinine (T2) and CRP (T3) may be helpful
21. in timely detection of serious complications after esophagectomy.

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1. INTRODUCTION

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3. In the last three decades and particularly in elderly patients, a rising incidence of esophageal cancer (EC) has been observed, resulting in the 7th most commonly diagnosed malignancy worldwide[1]. For patients presenting with localized disease, surgery, usually after neoadjuvant chemoradiotherapy (CRT), remains important in achieving potentially curative treatment. Even though postoperative mortality has decreased, this major surgical procedure is associated with substantial perioperative morbidity (40-60%) and in-hospital mortality (3-5%)[2, 3]. Postoperative complications are mainly pulmonary related, ranging from pneumonia to acute respiratory failure, or infectious from other origins[4, 5]. Neoadjuvant CRT seems to increase the susceptibility of both pulmonary and inflammation related complications[6].

13. It is important to identify early signs of a potentially complicated postoperative course after esophagectomy, which could lead to a more effective management with eventually lower mortality and shorter stay at the intensive care unit (ICU)[7]. Currently available individual risk stratifications are not reliable enough to be used in established pathways of care and in guiding clinical decision-making[7]. However, comprehensive clinical and biological parameters together may increase the awareness which could be useful in timely treatment decisions.

20. Several studies analyzed the value of routine blood examination to predict postoperative outcome as the result of both surgical trauma and preoperative patient-related risk factors[8-16]. Complement activation and acute phase response induced by surgery, with marked decrease levels of albumin and elevated levels of C-reactive protein (CRP) in the first postoperative days was shown to contribute to postoperative morbidity[8, 17]. However, data on the value and degree of deviation of postoperative routine blood tests and the association with other putative interfering factors in predicting postoperative complications and mortality are scarce or inconsistent. A correct interpretation of abnormal blood tests after esophagectomy could result in a better insight of the postoperative course in EC patients. In this study we analyzed the correlation between early routine peripheral blood values and the occurrence of postoperative morbidity and short-term mortality after esophagectomy.

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34. PATIENTS AND METHODS

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36. Patients

37. Between 2006 and 2012, 210 consecutive EC patients underwent a surgical resection with curative intent. In a prospectively maintained database, the following data was included;

1. demographic information, neoadjuvant treatment, tumor characteristics, therapeutic
2. information, complications and survival data. For the analysis, relevant data was entered
3. into a separate, anonymized database according to the rules of our Institutional Review
4. Board (www.ccmo.nl)
- 5.
6. **Neoadjuvant Chemoradiotherapy and surgery**
7. Since 2006, neoadjuvant CRT consisted of carboplatin and Paclitaxel, with concurrent
8. radiotherapy of 41.4 Gy in daily fractions of 1.8 Gy, five times per week was applied in
9. patients with tumors staged as T1N1-3 or T2-T4aN0-3 without distant metastases (CROSS
10. regimen) [18].
11. All patients underwent a transthoracic esophagectomy (TTE) with two-field lymphad-
12. enectomy by two experienced surgeons, in a tertiary referral center. Tumors around the
13. gastro-esophageal junction were generally approached through a left thoraco-laparotomy
14. with intrathoracic anastomosis, while more cranially located esophageal tumors were
15. approached through a right sided thoracotomy with cervical anastomoses. Patients went
16. postoperatively to the ICU, where they were usually extubated within 24 hours after
17. surgery.
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19. **Routine peripheral blood tests**
20. After surgery, EDTA blood samples were taken on routine base. For this study we evalu-
21. ated seven measurements drawn in each patient up to 48 hours postoperatively at three
22. different time points: immediately after surgery on arrival at the ICU (T1), ≥ 24 hours (T2)
23. and ≤ 48 hours (T3) after surgery. We evaluated a total of 3850 blood values, with 560
24. missing values, which were distributed randomly. The following routine serum blood mea-
25. surements were analyzed; hematological function tests (white blood cell count (WBC),
26. platelet count (PC) and hemoglobin (Hb)); inflammatory reactions (C-reactive protein:
27. CRP), albumin (Alb) and lactate dehydrogenase (LDH)); renal function test (creatinine,
28. which is also a measure of muscle mass) and liver function tests (levels of LDH and Alb).
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30. **Definitions of outcome**
31. The primary endpoints were early postoperative morbidity and short-term mortality.
32. For a real estimation of postoperative mortality after esophagectomy, we defined short-
33. term mortality as death within the first 90 days after surgery and/or within the same
34. hospital admission. Postoperative complications were identified and classified as follows:
35. Pulmonary complications were defined as: pneumonia (infiltrate on X-ray with positive
36. sputum culture or antimicrobial therapy on clinical indications), respiratory failure (ICU
37. re-admission for respiratory support and/or re-intubation), and acute respiratory distress
38. syndrome (ARDS: acute and persistent lung inflammation with increased vascular perme-

1. ability, bilateral infiltrates on x-ray and severe hypoxemia requiring the need for mechani-
2. cal ventilation). Infectious complications were defined as: sepsis (clinical signs of SIRS, but
3. with culture-proven infection or infection identified by visual inspection), anastomotic
4. leakage (on oral contrast esophagography or CT and elevated amylase in drainage pleural
5. fluid), renal failure (i.e. rising creatinine and oliguria requiring renal replacement therapy),
6. Cardiac complications; arrhythmia (diagnosed on ECG).

7.

8. Statistics

9. Results were presented as frequencies, means or medians with percentages and inter-
10. quartile range. Odds ratios (OR), confidence intervals (CI) and *p*-values between serum
11. values and morbidity/mortality rates were determined with univariate logistic regression
12. analysis. Significant outcomes with a threshold of *p*-value of ≤ 0.1 were further analyzed
13. with multivariate analysis through a backward selection and area under the Receiver Op-
14. erator Curve (AUC) to determine discriminatory power. Values between 0.7-0.8 suggest
15. moderate discrimination and values exceeding 0.8 suggest good discrimination. Statistical
16. analyses were performed by using the statistical package of SPSS version 20.0.0 (SPSS Inc.,
17. Chicago, IL USA).

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20. RESULTS

21.

22. Clinical characteristics, co-morbidities and complications after esophagectomy are sum-
23. marized in Table 1. Median age was 64.1 (range: 34.7-85.1) years. Almost half of the
24. patients in this cohort received neoadjuvant CRT (96 patients; 45.7%). As depicted, many
25. patients suffered from cardiovascular comorbidities. Most common postoperative compli-
26. cations were cardiopulmonary-related; 89 patients (42.4%) suffered from pneumonia, 45
27. (21.4%) had respiratory failure and 51 (24.3%) developed arrhythmia. Short-term mortal-
28. ity, including in-hospital and < 90-day mortality, was 5.7% (N = 12).

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30. Routine blood values and cardio-pulmonary complications

31. In addition to a number of laboratory parameters, age, neoadjuvant CRT, co-morbidity,
32. smoking and side of thoracotomy were associated at *p*-value < 0.1 in the univariate analy-
33. ses. After multivariate logistic regression analysis, postoperative albumin concentrations
34. (T1) (OR: 0.913; 95% confidence interval (CI): 0.851-0.979) and neoadjuvant CRT (OR:
35. 2.127; CI: 1.157-3.909) were independent prognostic factors in developing pneumonia
36. (Table 2). However, albumin at T1 had no discriminatory power in ROC analysis (0.63;
37. CI: 0.55-0.71). In predicting respiratory failure, only a right sided thoracic approach was
38. significantly associated (OR: 2.251; CI: 1.040-4.871).

1. **Table 1.** Patients characteristics, preoperative co-morbidity and complication rates after esophagec-
 2. tomy: N = 210 (%)

3.	Characteristics (%)		Comorbidity (%)		Complications (%)	
4.	Mean age (yrs)	64.1	Diabetes mellitus	28 (13.3)	Pneumonia	89 (42.4)
5.	Sex (M/F)	162/48	Heart failure	4 (1.9)		
6.	Histology		Myocardial infarction	25 (11.9)	Respiratory failure	45 (21.4)
7.	Adenocarcinoma	172 (81.9)	COPD	22 (10.5)		
8.	Squamous cell ca.	37 (17.6)	Smoking	85 (40.5)	ARDS	5 (2.4)
9.	Other	1 (0.5)			Pulmonary complications	101 (48.1)
10.	Localization		ASA classification		Sepsis	17 (8.1)
11.	Mid esophagus	37 (17.6)	ASA 1	13 (6.2)	Leakage	21 (10.0)
12.	Distal esophagus	141 (67.1)	ASA 2	116 (55.2)	Renal failure	8 (3.8)
13.	GEJ	32 (15.2)	ASA 3	51 (24.3)	Infectious complications	40 (19.0)
14.	Neoadjuvant CRT		ASA 4	2 (1.2)	Arrhythmias	51 (24.3)
15.	Yes/No	96/118	Missing	28 (13.3)	Re-operation	13 (6.2)
16.	Thoracotomy				Re-admission ICU	36 (17.1)
17.	Left/right	99/111			Short-term mortality: ≤ 90 days	12 (5.7)
18.					30-day mortality	7 (3.3)

17. GEJ: Gastroesophageal Junction. COPD: Chronic Obstructive Pulmonary Disease. ARDS: acute respiratory distress
 18. syndrome. ASA: American Society of Anesthesiologists

21. **Table 2.** Multivariate analysis of complications, only significant results in multivariate logistic regres-
 22. sion are displayed. OR (95% CI)

23.	Pneumonia	Respiratory failure	Arrhythmias	Renal failure
24.	Albumin T1	0.913 (0.851-0.979)		
25.	Creatinine T2			1.039 (1.016-1.062)
26.	Age		1.094 (1.039-1.153)	
27.	Neoadjuvant CRT	2.127 (1.157-3.909)	4.738 (1.902-11.802)	
28.	Myocardial infarction		0.076 (0.007-0.838)	
29.	COPD		5.312 (1.688-16.719)	
30.	Smoking		2.790 (1.204-6.465)	
31.	Side of thoracotomy		2.251 (1.040-4.871)	
32.		Sepsis	Leakage	Re-admission ICU
33.	Creatinine T2			1.020 (1.001-1.039)
34.	CRP T3	1.008 (1.001-1.016)		
35.	LDH T2	1.012 (1.003-1.021)	1.008 (1.001-1.016)	1.006 (1.001-1.012)
36.	COPD	4.879 (1.089-21-869)		
37.	Smoking			10.84 (1.97-59.50)
38.	Side of thoracotomy			5.49 (1.00-30.07)

1. Arrhythmias were only predicted by preoperative patient and treatment-related factors
2. including; age (OR: 1.094; CI: 1.039-1.153), neoadjuvant CRT (OR: 4.738; CI: 1.902-11.802),
3. myocardial infarction (OR: 0.076; CI: 0.007-0.838), COPD (OR: 5.312; CI: 1.688-16.719),
4. and smoking (OR: 2.790; CI: 1.204-6.465) (Table 2).

5.

6. Routine blood values and infectious complications

7. Sepsis was associated with elevated levels of CRP at T3 (OR: 1.008; CI: 1.001-1.016) with
8. moderate discriminatory power (0.72; CI: 0.61-0.83) (Table 2 and Figure 1) and LDH at T2
9. (OR: 1.012; CI: 1.003-1.021; AUC: 0.71; CI: 0.57-0.85) (Table 2 and Figure 2). In addition,

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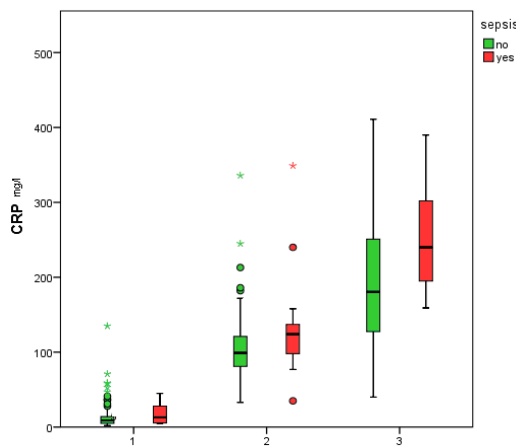
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24. **Figure 1.** Postoperative sepsis and CRP (mg/l) concentrations on three time points

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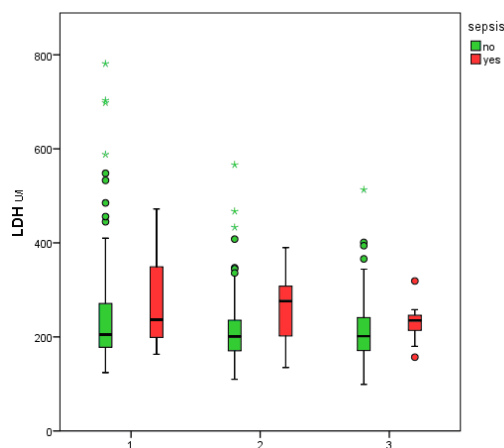
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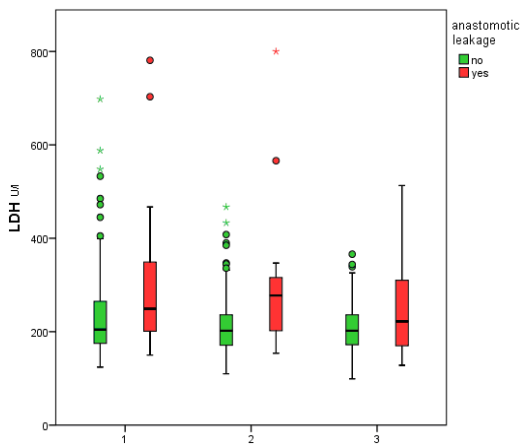
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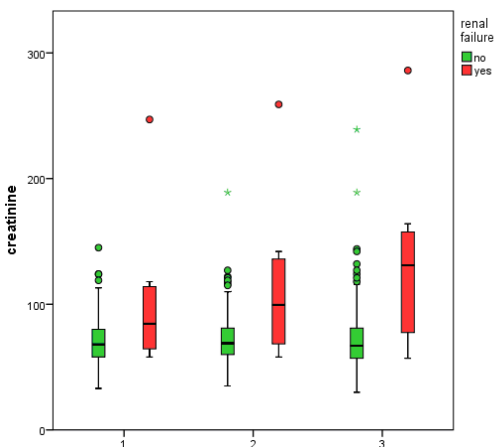
38. **Figure 2.** Postoperative sepsis and LDH (U/l) concentrations on three different time points

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13. **Figure 3.** Postoperative anastomotic leakage and LDH (U/l) concentrations on three different time points

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28. **Figure 4.** Postoperative renal failure and creatinine (µmol/l) concentrations on three different time points

31. LDH was also an independent prognostic marker in the event of anastomotic leakage (T2) (OR: 1.008; CI: 1.001-1.016; AUC: 0.71; CI: 0.54-0.88) (Table 2 and Figure 3). Renal failure was strongly associated with creatinine (T2) (OR: 1.039; CI 1.016-1.062; AUC: 0.74; CI: 0.52-0.95) (Table 2 and Figure 4).

36. **Routine blood values and postoperative course/short-term mortality**

37. Patients, who were re-admitted at the ICU, were predicted by elevated levels of LDH at 38. T2 (OR: 1.006; CI: 1.001-1.012) (Table 2). Independent prognostic values for short-term

1. mortality (in-hospital or within 90 days) were creatinine at T2 (OR: 1.020; CI: 1.001-1.039),
2. side of thoracotomy to the detriment of a right-sided approach (OR: 5.49; CI: 1.00-30.07),
3. and smoking (OR: 10.84; CI: 1.97-59.50) (Table 2). However, these peripheral blood mea-
4. surements showed to have insufficient discriminatory power in ROC analysis.
5. Patients with neoadjuvant CRT had significantly lower levels of creatinine ($p = 0.003$ mean:
6. 70,20 vs. 76,68), LDH ($p = 0.029$ mean: 218,28 vs. 238,07), WBC ($p = 0.000$ mean: 11,24
7. vs. 14,03), and platelet counts ($p = 0.000$ mean: 202,89 vs. 226,48). Besides, as previ-
8. ously described, neoadjuvant CRT was an independent prognostic marker for developing
9. postoperative pneumonia and arrhythmias.

10.

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12. DISCUSSION

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14. In improving quality of care, a better understanding in patient's response to surgical
 15. trauma, which might affect survival and postoperative complications, is essential. By fo-
 16. cusing on the first 48 hours after esophagectomy, we intended to increase the awareness
 17. by providing additional tools in early identification of postoperative complications, even
 18. before they were clinically manifest. In the present study, deranged measurements of
 19. LDH, creatinine and CRP showed to be of independent prognostic value and with sufficient
 20. discriminatory power in predicting serious postoperative complications after esophagec-
 21. tomy.

22. Most centers in the Western world will determine these examined measurements daily
 23. in the first postoperative days. However, the interpretation of deranged values is difficult
 24. in clinical practice. Besides, major complications may interact with different physiological
 25. mechanisms, resulting in various deranged laboratory values. The wide range of different
 26. significantly predicted postoperative complications underlies the non-specificity of these
 27. measurements.

28. Albumin was in current study in multivariate analysis associated with pneumonia, how-
 29. ever with insufficient discriminatory power. Generally albumin concentrations lower than
 30. 25 g/l, are associated with postoperative pulmonary complications[8]. Serum albumin
 31. levels rapidly decrease as part of the acute phase response and its association with post-
 32. operative complications may reflect as a marker of both malnutrition and the severity of
 33. host inflammatory response to the surgical insult[16]. Serum CRP and albumin levels, as
 34. incorporated into the Glasgow Prognostic Score, have shown to be an adequate prognos-
 35. ticator in different types of cancer[19, 20].

36. Induced by proinflammatory cytokines, CRP is mainly synthesized in hepatocytes but it
 37. can also be produced by many other cell types, including liver and lung macrophages,
 38. mononuclear cells and vascular endothelial cells[17]. The relatively high postoperative

1. levels of CRP after a TTE are a part of a massive and immediate activation of the innate
2. immunological response. However, it is difficult to distinguish between normal and abnor-
3. mal elevated CRP levels. However, in current study, the increased CRP levels compared to
4. baseline values after 48 hours were related to infectious (i.e septic) complications. These
5. results correspond to previous research, in which increased levels of CRP were associ-
6. ated with postoperative complications[10]. In a study of Noble et al., combined values of
7. albumin, CRP and WBC were related to the development of anastomotic leakage, but only
8. after the third postoperative day[11]. Since we analyzed up to 48 hours postoperatively,
9. we could not confirm these outcomes. Instead, we found that anastomotic leakage was
10. associated with raised LDH concentrations. This intracellular enzyme is present in all cell
11. types and elevated LDH levels are measured in a wide variety of conditions. LDH may be
12. also a useful marker to provide important information about ongoing cellular damage,
13. such as in anastomotic area after revascularization. But further research is warranted to
14. confirm this hypothesis.

15. In daily practice, creatinine is a fairly reliable indicator of renal function. In EC patients,
16. preoperative elevated creatinine levels were associated with pulmonary complications
17. and anastomotic leakage[15, 21]. And indeed a rising postoperative creatinine concentra-
18. tion reflects a poor hemodynamic condition, which makes it a strong prognostic marker.

19. In the treatment of EC patients, neoadjuvant CRT was found to be responsible for a more
20. aberrant postoperative course[6, 22]. It probably induces a more pronounced influence
21. on immunological function than surgery alone and should be part of further research[23].

22. In relation to peripheral blood values, neoadjuvant CRT was associated with decreased
23. levels of creatinine, LDH, and hematopoietic changes. Other important patient- and treat-
24. ment related conditions in predicting postoperative complications were: smoking and side
25. of thoracotomy.

26. Consequently, abnormal laboratory measurements after esophagectomy could be
27. expected due to malnutrition, co-morbidity, neoplasm, age, neoadjuvant therapy and
28. surgery-related conditions. In continuation with other studies in identifying complications
29. early in the postoperative course, our observations indicate a more aberrant biochemical
30. response in patients with postoperative morbidity and/or mortality. Moreover, we focused
31. on the first 48 hours after esophagectomy to avoid bias resulting from blood sampling for
32. specific complications or indications.

33. In conclusion, adequate interpretation of early deranged laboratory values after esopha-
34. gectomy remains difficult, but could indicate for a more aberrant postoperative course.

35. Clinicians should be aware of postoperative complications in patients with deranged lev-
36. els of LDH, creatinine, and CRP, since these measurements could support early decision-
37. making.

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Longitudinal analysis of cytokine expression during the different phases in the multimodal treatment of esophageal cancer patients

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Submitted

1. **ABSTRACT**

2.

3. **Objective:** We aimed to provide prognostic value for cytokines concentrations on the
4. degree of pathological response after neoadjuvant chemoradiotherapy (CRT) and oc-
5. currence of complications caused by either CRT or subsequent surgery at different time
6. points in esophageal cancer (EC) patients.

7. **Summary background data:** Both CRT and subsequent esophagectomy are associated
8. with release of multiple cytokines. This study provides more insight in the role of a num-
9. ber of cytokines throughout different phases in the multimodal treatment of EC patients.

10. **Patients and methods:** In a prospective observational study, 35 patients treated with plat-
11. inum-based neoadjuvant CRT followed by transthoracic esophagectomy were included.
12. Nine different cytokine concentrations were determined during the combined therapy of
13. neoadjuvant CRT with subsequent surgery and in the first postoperative week.

14. **Results:** Intestinal fatty acid binding protein (I-FABP) increased (36 vs. 194 pg/ml; $p < 0.001$)
15. during neoadjuvant CRT, but was not related to pathological response or complications.
16. High concentrations of platelet activating factor (PAF) before and after neoadjuvant CRT
17. were in ordinal logistic regression analysis associated with pathological response (OR:
18. 0.202; $p = 0.006$, respectively OR: 0.434; $p = 0.015$). Angiopoietin 1 (Ang-1) after neoad-
19. juvant CRT (OR: 0.382; $p = 0.006$), during surgical resection (OR: 0.687; $p = 0.033$ and OR:
20. 0.678; $p = 0.040$) and in the postoperative period (OR; 0.514; $p = 0.031$) was in multivari-
21. ate analysis associated with postoperative complications.

22. **Conclusion:** The unexpected rise of I-FABP after CRT point to early gastrointestinal dam-
23. age. High PAF concentrations before and after neoadjuvant CRT might have prognostic
24. value for pathological response, whereas decreased Ang-1 concentrations could indicate
25. postoperative complications.

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1. INTRODUCTION

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3. In esophageal cancer (EC) patients, a combined treatment of neoadjuvant chemoradio-
4. therapy (CRT) followed by curative intended esophagectomy with two-field lymphadenec-
5. tomy is now standard of care in most centers. The beneficial effect of neoadjuvant CRT is
6. based on the radio-sensitizing effect of combined chemotherapy, which allows improved
7. resectability and a pathological complete response (pCR) rate of 15-30%¹². Previous stud-
8. ies suggest that the prognosis of patients with pCR after neoadjuvant CRT may not benefit
9. from subsequent surgery, while surgery in patients with insufficient or no response may
10. be moved forward^{3,4}. Identifying these patients could be of great interest in further indi-
11. vidualizing treatment strategy. To date there are no useful biomarkers available related
12. to the degree of tumor response, although some pro-inflammatory cytokines seem to
13. play an active role^{5,6,7}. Induced immune response by preoperative CRT has been demon-
14. strated to change the levels of several soluble mediators, including interleukin (IL) 6 or
15. inflammatory lipid metabolites such as platelet activating factor (PAF), which are related
16. with both tumor response to treatment and tumor progression⁸⁻¹⁰. Furthermore, cytokine
17. concentrations through all phases of the multimodality treatment might be correlated
18. with the occurrence of complications caused by either CRT or surgery¹¹.
19. Esophageal resection is associated with a considerable rate of postoperative morbidity
20. (40-60%) and in-hospital mortality (3-5%)^{12,13}. This is partly due to extensive activation
21. of leucocytes, macrophages and endothelial cells with enhanced expression and release
22. of anti- and pro-inflammatory cytokines due to severe surgical trauma and the necessity
23. of prolonged one-lung ventilation (OLV)^{14,15}. Patients with markers of increased systemic
24. inflammation are known to have an increased risk for postoperative complications¹⁶.
25. Although reported toxicity was acceptable during neoadjuvant CRT, the correlation of
26. patient's immunologic response in a multimodality treatment with early complications
27. after subsequent surgery is not clear yet¹.
28. In current study, we aimed to provide prognostic value for a number of cytokines with
29. different pathophysiological mechanisms on the degree of pathological response on neo-
30. adjuvant CRT as well as the occurrence of complications caused by either CRT or subse-
31. quent surgery at different measure points. To our knowledge, this is the first longitudinal
32. observational study that will give us more insight in immunological responses throughout
33. different phases in the multimodal treatment of EC patients.

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1. PATIENTS AND METHODS

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3. Patients

4. Between November 2011 and April 2013, we prospectively included 35 patients with his-
 5. tologically proven EC selected for esophagectomy after approval by our multidisciplinary
 6. tumor board. Patient's characteristics are described in Table 1. All patients received rou-
 7. tine clinical care and no intervention was done for this study. In total, 262 blood samples
 8. were collected, with 53 (17%) missing values divided hazardly over the time points. The
 9. protocol was approved by the institutional review board (METC 2010.374) and all patients
 10. provided written informed consent.

11.

12. Study design

13. To identify potentially prognostic cytokines for pathological response on preoperative
 14. CRT and postoperative complications of subsequent surgery, we included cytokines with
 15. different pathophysiological mechanisms. These included the pro-inflammatory markers
 16. interleukin (IL) 1 β , IL-6, IL-8, tumor necrosis factor alpha (TNF- α), and procalcitonin, and
 17. the anti-inflammatory cytokine IL-10. Furthermore, two cytokines reflecting to endothe-
 18. lial function, angiotensin 1 (Ang-1) and platelet activating factor (PAF) were measured. As
 19. a marker of the integrity of the small and large intestine, we also measured the intestinal
 20. fatty acid binding protein (I-FABP) (Figure 1).

21. From all included patients, EDTA-serum samples (s) were obtained at nine predetermined
 22. time (T) moments (Figure 1); day 1, before neoadjuvant CRT (sT1), day 7 of CRT (sT2), prior
 23. before surgery (sT3), during two lung ventilation (sT4), during one lung ventilation (sT5),
 24. first (sT6), third (sT7), fifth (sT8), and seventh (sT9) postoperative day (Figure 1). Cytokine
 25. concentrations were determined by means of sandwich ELISA (Enzyme-Linked Immuno-
 26. sorbent Assay) based on capture and biotin-labelled detection antibodies. D Streptavidin-
 27. HRP and OPD substrate were used to quantify the amount of cytokines. Samples were
 28. diluted 1:1 in 0.1% BSA/PBS buffer, except for PAF, which was diluted 1:1000 in 0.1% BSA/
 29. PBS buffer.

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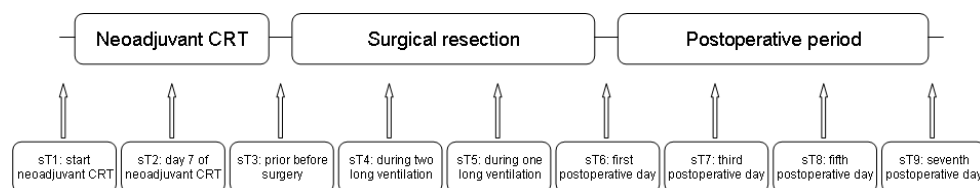
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38. **Figure 1.** Timeline of sampling throughout different phases of treatment

1. **Table 1.** Patient's characteristics

2. Variable	N = 35 (%)
3. Age in years (median)	64.9
4. Sex (M/F)	30/5
5. Histology	
6. Adenocarcinoma	32 (91.4)
7. Squamous CC	3 (8.6)
8. ASA classification	
9. ASA I	5 (14.3)
10. ASA II	23 (65.7)
11. ASA III	7 (20.0)
12. Surgery	
13. TTE right sided	22 (62.9)
14. TTE left sided	13 (37.1)
15. Complications after neoadjuvant CRT	
16. Minor complications	15 (42.9)
17. Moderate complications	2 (5.7)
18. Pathological response*	
19. Mandard 1	4 (11.4)
20. Mandard 2	6 (17.1)
21. Mandard 3	13 (37.1)
22. Mandard 4	11 (31.4)
23. Mandard 5	1 (2.9)
24. Complications	
25. Respiratory failure	5 (14.3)
26. Pneumonia	17 (48.6)
27. Re-intubation	5 (14.3)
28. Arrhythmias	12 (34.3)
29. Sepsis	2 (5.7)
30. Anastomotic leakage	1 (2.9)
31. Postoperative complications	18 (51.4)
32. Surgical mortality**	3 (8.6)
33. Postoperative course	
34. Reoperation	2 (5.7)
35. OR-time (mean)	8.89 hrs
36. ICU-stay (median)	1.0 days
37. Hospital stay (median)	14.0 days

38. ASA: American Society of Anesthesiologists. * According to the Mandard Classification

** surg. mortality i.e both in hospital and 90-day mortality

36. **Neoadjuvant chemoradiotherapy**

37. Preoperative CRT consisted of carboplatin and paclitaxel with concurrent radiotherapy
 38. (CROSS scheme according to Chemoradiotherapy for Oesophageal Cancer Followed

1. by Surgery Study¹). Oncologic criteria consisted of a clinical tumor stage of T1N1-3 or
2. T2-T4aN0-3 without distant metastases (M0), according to the 7th TNM AJCC edition.
3. Carboplatin (AUC 2) and paclitaxel 50 mg/m² were administered weekly for 5 weeks.
4. Radiotherapy consisted of 41.4 Gy in daily fractions of 1.8 Gy, five times per week.

5.

6. **Surgery**

7. Patients were planned for a surgical resection with curative intent, usually within 4-8
8. weeks after neoadjuvant CRT. All 35 patients underwent a transthoracic esophagectomy
9. with two-field lymphadenectomy by two experienced surgeons in a high-volume center.
10. All patients received orotracheal intubation using a double lumen tube for applying
11. selective one-lung ventilation, which was based on pressure controlled ventilation with
12. low tidal volumes (protective ventilation strategy). According to the protocol, all patients
13. were intubated at transfer to the intensive care department, where they usually were
14. detubated on indication and stay overnight.

15.

16. **Definitions of outcome**

17. Pathological response to treatment was classified according to the commonly used
18. Mandard classification varying from 1 (complete regression) to 5 (absence of regressive
19. changes)¹⁷. Major pathological response was defined as Mandard 1, moderate as Mandard
20. 2/3 and minor response as Mandard 4/5¹⁸. Complications from neoadjuvant CRT were
21. scored according to the National Cancer Institute common toxicity criteria for adverse
22. events (CTCAE version 4.03). Postoperative complications included pneumonia (defined
23. as infiltration on X-ray, positive sputum culture, antimicrobial therapy for therapeutic pur-
24. pose), respiratory insufficiency (prolonged need for mechanical ventilation, re-admission
25. on the ICU for respiratory support and/or re-intubation), sepsis (the clinical signs of SIRS
26. i.e. systemic inflammatory response syndrome with culture-proven infection or infection
27. identified by visual inspection), and anastomotic leakage (CT with oral contrast and el-
28. evated amylase in drainage fluid). Surgical mortality was defined as either death during
29. the same hospital stay (in-hospital mortality) or within the first 90 days after surgery.
30. Severity of co-morbidity was classified according to the American Society of Anesthesiol-
31. ogy (ASA) score varying from ASA 1 (very good condition) to ASA 5 (moribund patient).

32.

33. **Statistics**

34. Results were presented as frequencies with percentages, means or medians. To deter-
35. mine the effect of different interventions on cytokine concentrations, changes after
36. neoadjuvant CRT (sT1 vs. sT3), surgery (sT3 vs. sT6) and in the postoperative course (sT6
37. vs. sT9) were analyzed with a paired sample *t*-test (normal distribution of the changes)
38. or Wilcoxon signed rank test (skewed distribution). Furthermore to determine clinical

1. consequences, cytokine concentrations on sT1, sT2, and sT3 were in univariate analyses
2. related to the three degrees of pathological response and complications after neoadju-
3. vant CRT. In addition, all time points were assessed whether they were associated with
4. postoperative complications and outcomes with a p-value < 0.10 were further analyzed
5. with multivariate logistic regression analysis and corrected for age, histology, cT-stage,
6. ASA classification, and type of surgery. A p-value < 0.05 was considered to be significant.
7. Statistical analyses were performed by using the Statistical Package for Social Sciences:
8. SPSS version 20.0.0 (SPSS Inc., Chicago, IL USA).

9.
10.

11. RESULTS

12.

13. Major pathological response was observed in 11.4% (Mandard 1: N = 4), while 12 patients
14. (34.2%) had minor or no response at all (Mandard 4/5; Table 1). Mild complications from
15. neoadjuvant CRT occurred in 15 patients (42.9%), and two patients (5.7%) suffered from
16. moderate complications (both thromboembolic process). More than half of this cohort
17. suffered from postoperative complications (51.4%) (Table 1).

18.

19. 1. Cytokine concentrations during neoadjuvant CRT

20. Enhanced concentrations of I-FABP were observed during neoadjuvant CRT and showed to be
21. significantly higher after neoadjuvant CRT (36.1 pg/ml vs. 193.9 pg/ml; $p < 0.001$) (Table 2).
22. Remarkably, these elevated concentrations could not be related in univariate analysis to the
23. degree of pathological response or complications after neoadjuvant CRT or surgery.
24. Ang-1 concentrations between sT1 and sT3 were not significantly different (3.4 ng/ml vs.
25. 3.9 ng/ml; $p = 0.338$) (Table 2, Figure 2). Nevertheless, a low concentration of Ang-1 after

26.

27.

28. **Table 2.** Paired sample analysis in cytokine concentrations on different time points (mean)

29.

	sT1 (N = 26)	sT3 (N = 26)	p-value	sT3 (N = 27)	sT6 (N = 27)	p-value	sT6 (N = 24)	sT9 (N = 24)	p-value
30. Ang-1 (ng/ml)	3.4	3.9	0.338	4.1	4.5	0.455	4.2	4.5	0.532
31. I-FABP (pg/ml)	36.1	193.9	0.000	212.7	56.3	0.000	50.5	35.4	0.494
32. IL-1 β (pg/ml)	14.5	13.9	0.702	15.6	14.3	0.700	29.8	25.9	0.032
33. IL-6 (pg/ml)	20.3	15.5	0.687	23.5	489.4	0.000	377.7	204.8	0.018
34. IL-8 (pg/ml)	7.7	12.0	0.055	12.6	6.7	0.355	11.3	9.6	0.560
35. IL-10 (pg/ml)	32.8	46.0	0.581	50.6	62.2	0.009	62.8	38.5	0.022
36. Procalcitonin (pg/ml)	4.7	4.4	0.983	4.3	104.9	0.000	106.2	10.3	0.000
37. PAF (ug/ml)	4.8	5.3	0.046	5.3	4.7	0.024	4.6	5.2	0.013
38. TNF- α (pg/ml)	62.8	58.6	0.989	62.9	66.8	0.442	83.8	51.4	0.001

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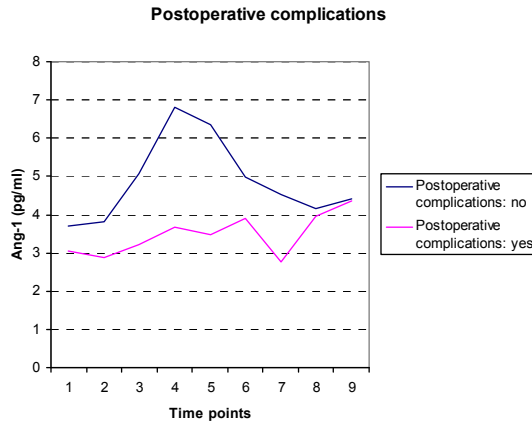


Figure 2. Ang-1 concentrations (mean) related to postoperative complications throughout different phases of the treatment

neoadjuvant CRT (sT3) was associated with more severe postoperative complications in multivariate logistic regression analysis (odds ratio (OR): 0.382; 95% confidence interval (CI): 0.193-0.758; $p = 0.006$).

Concentrations of PAF were significantly elevated at the end of neoadjuvant CRT (4.8 ug/ml vs. 5.3 ug/ml; $p = 0.046$) (Table 2). A sustained relatively high PAF concentration at the start and after neoadjuvant CRT was in multivariate ordinal regression analysis associated with major pathological response (OR: 0.202; 95% CI: 0.064-0.636; $p = 0.006$ and OR: 0.434; 95% CI: 0.241-0.782; $p = 0.015$ respectively) (Figure 3). When analyzing

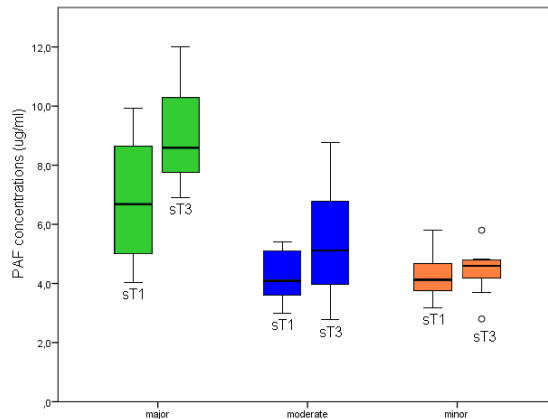


Figure 3. PAF sT1 and sT3 concentrations (ug/ml) related to major, moderate and minor pathological response

1. each degree of pathological response, only PAF concentrations after neoadjuvant CRT in
 2. patients with major pathological response were significantly elevated (mean sT1: 7.3ug/
 3. ml vs. sT3: 9.1 ug/ml; $p = 0.001$).
 4. Although IL-1 β concentrations decreased during neoadjuvant CRT, none of the IL concen-
 5. trations (1 β , 6, 8, or 10), nor TNF- α or procalcitonin were statistically different between
 6. sT1 and sT3 or associated neither with the degree of tumor response nor with postop-
 7. erative complications (Table 2). None of the examined cytokines were associated with
 8. complications during neoadjuvant CRT.

9.

10. 2. Cytokine concentrations during surgery

11. The surgical insult was responsible for large variations in most of these cytokines. Signifi-
 12. cantly elevated concentrations after surgical resection (sT3 vs. sT6) were observed for IL-
 13. 6, IL-10, and procalcitonin. In assessing the effect of two and lung ventilation on cytokine
 14. concentrations, differences between sT4 and sT5 were examined and only IL-6 turned out
 15. to be significantly different (mean: 87.79 and 347.90 respectively, $p = 0.021$). Concentra-
 16. tions of PAF and I-FABP were significantly decreased after surgical resection (Table 2). Of
 17. these cytokines, only Ang-1 was in multivariate logistic regression analysis (sT4 and sT5)
 18. related to postoperative complications (OR: 0.687; 95%CI: 0.486-0.970; $p = 0.033$ and OR:
 19. 0.678; 95%CI: 0.468-0.983; $p = 0.040$ respectively).

20.

21. 3. Cytokine concentrations in the postoperative period

22. Many of the deviating concentrations after surgical resection returned to normal in the
 23. first postoperative week. Concentrations of IL-1 β , IL-6, IL-10, procalcitonin, and TNF- α
 24. decreased significantly between sT6 and sT9. Concentrations of PAF were rising in this
 25. postoperative period (Table 2). In univariate analysis, concentrations of Ang-1 on sT7
 26. ($p = 0.014$), IL-6 on sT8 ($p = 0.008$) and sT9 ($p = 0.011$), and TNF- α on sT8 ($p = 0.040$) were
 27. associated with postoperative complications. However, in the multivariate logistic regres-
 28. sion analysis, only Ang-1 was significantly associated with postoperative complications
 29. (OR; 0.514; 95%CI: 0.281-0.941; $p = 0.031$).

30.

31.

32. **DISCUSSION**

33.

34. Neoadjuvant CRT is a crucial component in the curative treatment of EC patients. It has
 35. been demonstrated to improve both disease free and overall survival considerably after
 36. radical transthoracic esophagectomy¹. However, both are accompanied by extensive
 37. tissue damage and stress related severe immunological response with activation of sev-
 38. eral cytokines and regulation of tumor receptor expression leading to either inhibition

1. or stimulation of several growth factors and cell regulatory proteins^{9,10,14}. A number of
2. cytokines stimulate cell growth, including IL-1 β and IL-6, while others induce or enhance
3. toxicity during treatment (IL-6 and TNF- α), which triggers a cascade of inflamma-
4. tory pathways^{6,8,9,19}. The clinical relevance of cytokine activation and its correlation with
5. pathological response and complications caused by either CRT or subsequent surgery in
6. a multimodal treatment is not clear yet. Based on these concerns, we aimed to provide
7. prognostic value for a number of cytokines throughout different presupposed time points
8. in the treatment of EC patients.

9. Systemic effects of both chemotherapy and radiotherapy induce pro-inflammatory re-
10. sponses through IL-1 β , IL-6, IL-8, and TNF- α within hours after exposure^{9,20,21,19}. However,
11. in the present data we could not demonstrate differences in concentrations in none of
12. these cytokines. In fact, we observed significantly elevated concentrations of I-FABP and
13. PAF after CRT. Measurement of I-FABP seemed to be related to chemotherapy-induced
14. gastrointestinal (GI) mucositis, as was described by Derikx et al.²². They observed a
15. rapid increase of I-FABP early after damage of the mucosal cell integrity. The increased
16. concentrations of I-FABP that we observed, apparently originated from the damaged GI-
17. tract, but could not be related to complications caused by CRT. The rapid decrease in the
18. postoperative phase, even might suggest that the esophagus was the source of elevated
19. I-FABP concentrations.

20. Besides significantly increased concentrations of PAF after neoadjuvant CRT, high PAF con-
21. centrations before and after CRT were associated with major pathological response. This
22. may have clinical consequences, since these patients may not benefit from subsequent sur-
23. gery, while curative intended esophagectomy in patients with insufficient or no response
24. may be moved forward. Through binding to PAF receptor (PAF-R), PAF has been shown to
25. activate several pathways such as nuclear factor-kappa B (NF- κ B)^{10,23}. PAF-R can augment
26. chemotherapy-induced effects through NF- κ B dependent process, which is accompanied
27. with the release of cytokines¹⁰. Furthermore, PAF is produced by various tissues and cell
28. types and in response to different stimuli, including oxidative stress^{23,24}. Both chemo- and
29. radiotherapy are potent pro-oxidative stressors and during tumors growth, many cells die
30. by apoptosis or necrosis which is accompanied by oxidation of membrane phospholipids.
31. These apoptotic cells express PAF-like molecules²³⁻²⁵. *Sakhi et al.* concluded that elevated
32. levels of antioxidant biomarkers before radiotherapy and increased oxidative stress dur-
33. ing radiotherapy may improve survival²⁶. In the current study, we observed elevated PAF
34. concentrations after CRT among all three groups (major, moderate and minor response),
35. but only the major response group showed a significant difference. One of the possible
36. explanations could be the release of PAF expressed by the massive amount of apoptotic
37. tumor cells, while the initial response may be explained by NF- κ B dependent process.
38. However, we did not see an accompanying release of cytokines. Nevertheless, PAF con-

1. concentrations could be of great importance and its association with pathological response
2. needs to be confirmed in different cohorts before conducting with clinical consequences.
3. In contrast to I-FABP and PAF, concentrations of Ang-1 could not be related to CRT
4. administration, but were related to postoperative complications in different phases of
5. the treatment. Angiopoietin (1 and 2) is a growth factor that specifically binds to the
6. endothelial receptor tyrosine kinase Tie-2. Ang-1 mediated Tie2 signaling will lead to the
7. maintenance of cellular integrity and quiescence of the endothelial barrier by covering
8. the vessel with periendothelial cells whereas Ang-2 mediated Tie2 signaling will lead to
9. the removal of these cells²⁷⁻²⁹. Decreased concentrations of Ang-1 are related to infectious
10. complications^{27, 28, 30}. Although Ang-1 concentrations were not significantly different be-
11. tween start and end of neoadjuvant CRT, extensive apoptosis of vascular endothelial cells
12. affects endothelial function, including promotion of vessel maturation through angiogen-
13. esis³¹. Ang-1 in the current study might be negatively associated with the inflammatory
14. response to surgery, which results in increased vascular permeability and inflammation.
15. This might lead to early identifications of patients with a severe systemic inflammatory
16. distress syndrome.
17. Cytokine alterations after transthoracic esophagectomy have been extensively described
18. and investigated^{22, 32, 33}. Surgical stress and the necessity of OLV is responsible for a mas-
19. sive release of pro-inflammatory cytokines and a depressed host immune response by
20. T helper type 1 (Th1) and 2 (Th2) cells^{14,15}. In the current study, we observed increased
21. IL-6 concentrations between conventional two-lung ventilation and OLV, but since surgery
22. was continued over time, we were not able to determine the real effect of OLV alone.
23. Despite protective ventilation strategy, OLV is associated with operative hypoxemia due to
24. shunting of blood via the non-ventilated lung as well as surgery-induced compression³⁴.
25. Hypoxemia causes a release of pro-inflammatory cytokines, which might result in the
26. development of postoperative acute respiratory distress syndrome³⁵. Further reduction
27. of pro-inflammatory response and hypoxemia during surgical resection might be achieved
28. by applying high frequency jet ventilation, which has been demonstrated as a safe and
29. adequate ventilation technique during esophagectomy³⁶.
30. Limited data is available about the influence of neoadjuvant CRT on cytokine production
31. peri- and postoperatively^{21, 37}. In rectal cancer patients a detrimental effect of preoperative
32. CRT on postoperative cytokine release was demonstrated with depressed concentrations
33. of IL-6 and TNF- α compared to patients without preoperative CRT²⁰. In general, neoadju-
34. vant therapy is assumed to reduce Th1 and Th2 cytokine production leading to prolonged
35. T cell imbalance that extends beyond the time of surgery²¹.
36. There are limitations in this study, since we included a relatively small number of patients.
37. For this reason, coefficients in ordinal regression analysis may not be fully accurate and
38. moreover, we did not correct our data for multiple testing. The results of this study should

1. therefore be interpreted as a pilot, whereby deduced hypotheses need to be confirmed
2. in a large cohort.
- 3.
4. In conclusion, cytokine concentrations in particular PAF and Ang-1, in patients treated
5. with neoadjuvant CRT followed by esophagectomy for EC seems to have prognostic value
6. on the degree of pathological response (PAF) and occurrence of postoperative complica-
7. tions (Ang-1). Concentrations of I-FABP were increased considerably after neoadjuvant
8. CRT indicating to early GI damage. More research is necessary before these cytokines can
9. be considered as potentially useful prognostic markers.

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1. Summarizing discussion and future perspectives

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1. Important improvements have been achieved in the past decades in staging and multi-
2. modality treatment of esophageal cancer (EC) patients¹. Nevertheless, curative treatment
3. for patients with EC remains challenging. Surgical resection, often preceded by neoad-
4. juvant chemoradiotherapy (CRT), is still the mainstay of treatment with curative intent,
5. but is also associated with considerable postoperative morbidity (40-60%) and mortality
6. (3-5%)^{2,3}. Many patients are over 60 years of age and presenting with associated co-
7. morbidity, which has an important impact on treatment decision-making. Several patients
8. and tumor-related factors determine treatment outcome, but there are unfortunately to
9. date no objective measurements available for an adequate risk-assessment of EC patients.
10.
11. The aim of this thesis was to identify different risk-factors for perioperative morbidity
12. and mortality during different phases in the standard treatment of esophageal cancer
13. patients, which could provide us an additional tool for a better selection of patients to
14. different curative intended treatment options.
15.
16. **Chapter 2** describes the influence of age on postoperative outcome after an extended
17. transthoracic esophagectomy with two-field lymphadenectomy. Elderly patients, defined
18. as ≥ 70 years of age, were compared to younger patients for comorbidity, postoperative
19. course, recurrent disease and survival. We concluded that age alone is not a sufficient
20. prognostic indicator for short- and long-term outcome after esophagectomy. Despite a
21. twofold increased risk of in-hospital mortality in elderly patients, we could not observe
22. significant differences. And although overall complications were statistically comparable,
23. cardiac complications such as arrhythmia, and pulmonary complications, especially at-
24. electasis and respiratory insufficiency occurred more frequently in elderly patients. The
25. presence of comorbidity was the strongest prognostic factor for the development of
26. postoperative complications in this cohort. Moreover, long-term survival and recurrence
27. rates were not related to the supposed disadvantage of elderly patients.
28. Both life expectancy and the incidence of EC are rising. Therefore, already in the near
29. future, clinicians will be increasingly confronted with elderly patients with EC⁴. Denying
30. surgery based on age alone seems not reasonable, but reticence is required in those
31. with frailty due to co-morbidity, in particular based on cardiopulmonary dysfunction. In
32. a review from 2013, authors concluded that elderly patients were at increased risk of
33. pulmonary and cardiac complications, and perioperative mortality after esophagectomy⁵.
34. Important improvements can be achieved in appropriate staging and selection of patients
35. using optimal preoperative cardiopulmonary preparation. Severe pulmonary problems can
36. be avoided by preoperative intensive muscle training and adequate epidural anesthesia.
37. Furthermore, different surgical approaches have been applied to reduce morbidity and
38. mortality without diminishing the oncologic outcome. Currently, minimal invasive sur-

1. gery is propagated as the surgical method to reduce perioperative risk in these high-risk
2. surgical patients, but large-scale randomized controlled trials are needed to confirm this
3. assumption⁶.
4.
5. Since there is no adequate risk-prediction model in selecting patients for surgical resec-
6. tion, we attempted in **Chapter 3** to find the currently most accurate risk-prediction model
7. for postoperative morbidity and mortality after esophagectomy. Therefore, five of the
8. most frequently used risk-prediction models including P-POSSUM and O-POSSUM modifi-
9. cations, Charlson Comorbidity Index (CCI) and its Age Adjusted Charlson Score (ACCI) and
10. the standard American Society of Anesthesiologists (ASA) classification, were evaluated.
11. Although each of these risk-prediction models showed some relation between postopera-
12. tive outcome and risk-score, we recommended O-POSSUM as individual risk stratification
13. since it assessed the condition of the patient and the risk of surgery most accurately.
14. For comparison between different cohorts, P-POSSUM was the most powerful predictor
15. since it underestimated mortality by only one patient. For further applicability of clinical
16. practice, we subdivided the O-POSSUM score in a low, intermediate and high-risk group.
17. Despite these efforts, O-POSSUM is not generally used by clinicians, probably because of
18. a lack of publicity. Instead, the most popular model of risk-assessment in daily practice is
19. the ASA classification that excels in simplicity.
20. With multimodality treatment and a predominantly elderly population with considerable
21. comorbidities, many factors could be associated with a complicated postoperative course.
22. Therefore, identification of high-risk surgical patients remains difficult. With generally used
23. ASA classification, we still have to deal with inter-observer dependent risk-assessment.
24. With a more reliable score that realistically assess the magnitude of the therapy, we might
25. even improve informed consent. Further research should be focused on already existing
26. risk-adjusted models instead of developing new. In our opinion it is preferable to divide
27. patients in risk-groups to improve informed consent and preoperative workup.
28.
29. The incorporation of neoadjuvant CRT in the multimodality treatment of EC patients has
30. dramatically increased in recent years. This is particularly due to the additional value of
31. the Dutch national CROSS trial in which a significant survival benefit of 13% at 5 years
32. after neoadjuvant CRT was demonstrated¹. Although reported adverse events during neo-
33. adjuvant CRT were reported to be acceptable, other studies described an increased risk
34. for thromboembolic toxicity as well as increased risk for postoperative complications⁷⁻¹⁰.
35. **Chapter 4** describes the incidence and impact of preoperative and postoperative throm-
36. boembolic events (TEE) in EC patients. Patients with neoadjuvant CRT were matched
37. with patients who were treated with surgery alone. In accordance to our hypothesis,
38. neoadjuvant CRT was identified as an independent prognostic factor for developing TEE's

1. in the preoperative phase, especially in those with a previous history of TEE. Postopera-
2. tively we could not demonstrate any differences in the incidence of TEE's between both
3. groups. Although the majority of preoperative TEE's were idiopathic and diagnosed during
4. a second re-staging CT-scan, we recommend secondary prophylaxis during neoadjuvant
5. CRT in patients with a previous history of TEE. We base this recommendation mainly on a
6. guideline published in 2007 of the American Society of Clinical Oncology¹¹. However, pro-
7. spective studies are needed to further define the use and safety of prophylactic therapy
8. during platinum-based CRT in EC patients.

9. Other than the risk for a medical emergency, preoperative TEE's will inevitably interact
10. with the postoperative course since anesthesiologists are more reluctant to administer
11. epidural analgesia under anticoagulation. Adequate postoperative analgesia is important
12. after esophagectomy, because postoperative pain compromises pulmonary function,
13. coughing, and mobilization. Adequate epidural analgesia is associated with a reduced risk
14. for pulmonary complications¹². Appropriate prevention is necessary to avoid anticoagula-
15. tory therapy resulting in the use of other strategies than epidural analgesia. Nevertheless,
16. despite of a significantly longer delay until surgery in patients with preoperative TEE's, we
17. were not able to demonstrate any effect on the postoperative course.

18. Chemoradiotherapy prior for a radical esophagectomy might be associated with an
19. increased risk for cardiopulmonary toxicity¹³⁻¹⁵. We evaluated in **Chapter 5** the effect of
20. neoadjuvant CRT on postoperative morbidity and mortality in a matched cohort after
21. esophagectomy. In multivariate analysis, neoadjuvant CRT was significantly associated
22. with an increased risk for pneumonia and arrhythmia. Overall complications were com-
23. parable between both groups, which was in accordance to the CROSS trial¹. In literature,
24. conflicting data have been reported about the impact of neoadjuvant CRT on postopera-
25. tive morbidity and mortality. However, the radiation exposure of heart and lungs during
26. CRT is quite substantial and correlations between lower doses of radiotherapy are related
27. to minimize the irradiation of the lungs¹³. Moreover, radiation to the pericardium might
28. lead to an increased risk for pericardial effusion, which could be reflected in postoperative
29. cardiac complications¹⁶. Therefore, further research should be focused on reduction of
30. the amount of radiation on these organs, without compromising the beneficial effects of
31. CRT. New and promising radiation techniques, such as proton beam therapy, could reduce
32. cardiopulmonary toxicity.

33.

34. Hospital volume is associated with improved short- and long-term outcomes in EC pa-
35. tients¹⁷. We hypothesized in a report (not included in this thesis) that surgeon-volume
36. in a high-volume center is an additional independent prognostic factor for postoperative
37. outcome after esophagectomy. In this report, we included two high-volume centers in the
38. Netherlands and after multivariate analyses; surgeon volume was the only independent

1. prognostic factor for the development of anastomotic leakage. Since we aimed to include
2. a great part of the northern located centers in the Netherlands, further research will be
3. carried out to determine the effect of surgeon volume in a large multicenter trial.
4. The effect of open transthoracic esophageal resection on early postoperative peripheral
5. blood values and their association with postoperative morbidity and mortality was evalu-
6. ated in **Chapter 6**. A group of 210 consecutive EC patients underwent a radical transthoracic
7. esophagectomy with curative intent. Standard peripheral blood values were acquired on
8. three different time points with a maximum to 48 hours after resection. After multivariate
9. analyses and ROC analysis, early deranged blood values of lactate dehydrogenase (LDH),
10. creatinine, and C-reactive protein (CRP) were related to infectious complications after
11. esophagectomy. Since major complications frequently interact with multiple pathophysi-
12. ological mechanisms, complications of various etiologies were associated with different
13. deranged peripheral blood values. This underscores the non-specificity of these measure-
14. ments and the difficulty for a correct interpretation. Further research should be focused
15. on more specific measurements to identify or predict postoperative complications in an
16. early phase. Moreover, the pathophysiological mechanisms leading to a more aberrant
17. postoperative course in patients is still not well understood. A better understanding and
18. awareness might lead clinicians to start interventions earlier.
19.
20. In **Chapter 7** we evaluated nine cytokines that reflect different (patho)physiological re-
21. sponses to better understand the innate immunological response throughout different
22. phases in the multimodal treatment of EC patients. In this hypothesis-generating study,
23. we included 35 patients and performed multivariate analyses to assess the degree of
24. pathological response after CRT and complications caused by either CRT or subsequent
25. surgery to identify prognostic value for these cytokines. Concentrations of intestinal fatty
26. acid binding protein (I-FABP) were considerably increased after neoadjuvant CRT indicat-
27. ing gastrointestinal damage, since I-FABP is released in the case of a damaged integrity
28. of mucosal cells¹⁸. Remarkably, I-FABP levels were far lower after surgery. High concentra-
29. tions of platelet activating factor (PAF) before and after neoadjuvant CRT were related
30. to major pathological response. Immunological pathways might also be responsible for
31. augmentation of chemotherapy-induced effects of PAF through a nuclear factor-kappa B
32. (NF- κ B) dependent process¹⁹. Furthermore, apoptotic cells and oxidative stress can induce
33. PAF and both radiotherapy and chemotherapy are known as potent oxidative stressors²⁰.
34. Finally we identified angiotensin 1 (Ang-1) throughout different time points as an indi-
35. cator of postoperative complications. Ang-1 is involved in the maintenance of cellular
36. integrity and quiescence of the endothelial barrier of vascular cells²¹. A decreased Ang-1
37. concentration perioperatively could reflect an increased inflammatory response, which
38. might result in vascular permeability²². Therefore, research should be focused on reduc-

1. tion of release of pro-inflammatory cytokines during surgical procedure. High frequency
2. jet ventilation (HFJV) might contribute to a reduction of pro-inflammatory response, since
3. this ventilation technique prevents patients from shunting of the non-ventilated lung and
4. is accompanied by low tidal volumes. Moreover, HFJV has been demonstrated as a safe
5. and adequate ventilation technique during esophagectomy²³. Since we evaluated these
6. cytokine concentrations in a relatively small group of EC patients, large prospective trials
7. are needed to confirm our hypotheses.

8.

9. In conclusion, with this thesis we aimed to contribute to the knowledge of several treat-
10. ment related risk-factors in reducing perioperative morbidity and mortality in the stan-
11. dard curative treatment of esophageal cancer patients. Esophageal resection combined
12. with neoadjuvant CRT should be initially considered in all medical fit and oncologically
13. suitable patients. However, based on the outcomes of this thesis, clinicians should be
14. aware of a complicated course due to side effects of CRT and patient and tumor-related
15. characteristics. Individualizing treatment strategy remains an important target to improve
16. quality of life and postoperative outcome.

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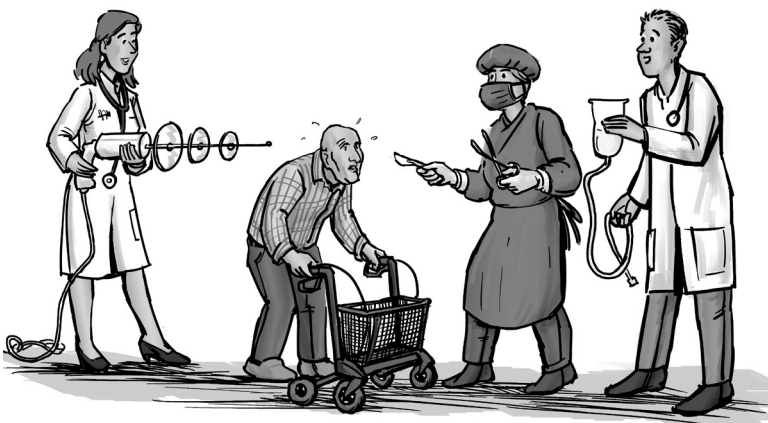
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Nederlandse samenvatting

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1. In het afgelopen decennium zijn belangrijke verbeteringen bereikt in de curatieve mul-
2. timodale behandeling van patiënten met een slokdarmcarcinoom¹. Vele patiënten met
3. een slokdarmcarcinoom zijn ouder dan 65 jaar en hebben een of meerdere bijkomende
4. aandoeningen (co-morbiditeit). Een curatieve behandeling van het oesofaguscarcinoom
5. blijft daarom in vele gevallen uitdagend. Een chirurgische resectie van de slokdarm,
6. vaak voorafgaand door neoadjuvante chemoradiotherapie (CRT), blijft de belangrijkste
7. behandelmodaliteit, maar gaat vaak gepaard met een aanzienlijk risico op postoperatieve
8. morbiditeit (40-60%) en mortaliteit (3-5%)^{2,3}. Tot op heden is het helaas onduidelijk welke
9. risicofactoren bijdragen aan een gecompliceerd perioperatief beloop.
- 10.
11. Het doel van dit proefschrift was om verschillende risicofactoren te identificeren die
12. voorspellend zijn voor perioperatieve morbiditeit en mortaliteit gedurende verschillende
13. fasen in de behandeling van patiënten met een slokdarmcarcinoom.
- 14.
15. In **Hoofdstuk 2** beschrijven we de invloed van leeftijd op de postoperatieve uitkomst na
16. een transthoracale slokdarmresectie. Oudere patiënten (gedefinieerd als 70 jaar en ouder)
17. werden vergeleken met jongere patiënten met betrekking tot comorbiditeit, postoperatief
18. beloop, optreden van recidieven en de lange termijn overleving. We concludeerden in dit
19. onderzoek dat leeftijd geen onafhankelijke voorspellende factor is voor korte -en lange
20. termijn uitkomst na een slokdarmresectie. Patiënten met een of meerdere comorbiditeiten
21. hadden het hoogste risico op postoperatieve complicaties. Ondanks het ontbreken van een
22. significant verschil, was het percentage oudere patiënten die in het ziekenhuis overleed ten
23. gevolge van de operatie ruim twee keer zo hoog. Het totaal aantal postoperatieve compli-
24. caties tussen beide groepen was vergelijkbaar, maar cardiale complicaties (in het bijzonder
25. hartritmestoornissen) en pulmonale complicaties (vooral atelectase en respiratoire insuffi-
26. ciëntie) kwamen vaker voor in oudere patiënten. Er was geen significant verschil in de lange
27. termijn overleving en het aantal recidieven in oudere patiënten vergeleken met jongere pa-
28. tiënten. Gezien het feit dat de levensverwachting en de incidentie van slokdarmcarcinomen
29. stijgt, zullen klinici vaker geconfronteerd worden met oudere patiënten⁴. Selecteren van
30. patiënten voor een slokdarmresectie alleen gebaseerd op de leeftijd lijkt niet redelijk, maar
31. terughoudendheid is vereist bij patiënten met comorbiditeit. Belangrijke verbeteringen zijn
32. mogelijk in een adequate selectie en optimale preoperatieve cardiopulmonale voorberei-
33. ding⁵. Bovendien zou minimaal invasieve chirurgie kunnen bijdragen aan een verminderde
34. perioperatief risico op morbiditeit en mortaliteit in risicovolle chirurgische patiënten⁶.
35. Grootschalige gerandomiseerde studies zijn nodig om deze veronderstelling te bevestigen.
- 36.
37. Tot op heden bestaat er geen goed model in het selecteren van chirurgische patiënten;
38. het doel in **Hoofdstuk 3** was om vijf veelgebruikte risicomodellen, waaronder P-POSSUM,

1. O-POSSUM, Charlson Comorbiditeit Index (CCI), de op leeftijd aangepaste Charlson
2. Score (ACCI) en de American Society of Anesthesiologists (ASA) classificatie, te evalueren.
3. Ondanks dat alle modellen in meer of mindere mate een redelijke voorspelling deden
4. van het postoperatieve risico, concludeerden we dat O-POSSUM het meest nauwkeurige
5. model was voor de individuele risico-inschatting. Voor de vergelijking tussen verschillende
6. cohorten, bleek P-POSSUM de meest nauwkeurige voorspeller te zijn, omdat dit model
7. de totale sterfte met slechts één patiënt onderschatte in ons cohort. Ter verbetering van
8. de klinische toepasbaarheid, hebben we de O-POSSUM score onderverdeeld in een laag,
9. gemiddeld en hoog risicogroep. Desondanks wordt de O-POSSUM score nog niet in de
10. dagelijkse praktijk gebruikt, mogelijk door een gebrek aan publiciteit. In plaats daarvan
11. wordt de ASA classificatie frequent gebruikt, die uitblinkt in eenvoud.
12. Met de huidige multimodale behandeling kunnen meerdere factoren van invloed zijn op
13. een gecompliceerd postoperatieve beloop. De identificatie van een risicovolle chirurgische
14. patiënt blijft daarom moeilijk. Aangezien momenteel de ASA classificatie frequent gebruikt
15. wordt, is de risico-inschatting onderhevig aan subjectieve waarnemingen. Daarnaast kan
16. een eenduidige risicoanalyse die een realistisch beeld geeft van de omvang van de behan-
17. deling ook bijdragen aan een verbeterde *informed consent*. Verder onderzoek zou gericht
18. moeten zijn op al bestaande risicoanalyse modellen. Naar onze mening zouden patiënten
19. ingedeeld moeten worden in risico-groepen waarmee *informed consent* en preoperatieve
20. voorbereiding verbeterd kunnen worden.
- 21.
22. De invloed van neoadjuvante CRT in de multimodale behandeling van patiënten met een
23. slokdarmcarcinoom is in de afgelopen jaren spectaculair toegenomen. Voor een deel is
24. dit toe te schrijven aan een groot nationaal onderzoek (CROSS trial) waarbij de auteurs
25. een significant overlevingsvoordeel van 13% hebben aangetoond na vijf jaar¹. Ondanks
26. dat de gerapporteerde bijwerkingen in dit onderzoek door CRT aanvaardbaar waren, heb-
27. ben verschillende andere studies een verhoogd risico op trombo-embolische toxiciteit
28. evenals een verhoogd risico op postoperatieve complicaties beschreven⁷⁻¹⁰. **Hoofdstuk**
29. **4** beschrijft de incidentie van pre -en postoperatieve trombo-embolische processen in
30. patiënten met een slokdarmcarcinoom. In dit onderzoek werden patiënten met neoadju-
31. vante CRT gematcht met patiënten die alleen een slokdarmresectie hadden ondergaan. In
32. overeenstemming met onze hypothese, werd neoadjuvante CRT geïdentificeerd als een
33. onafhankelijke prognostische factor voor de ontwikkeling van trombo-embolische proces-
34. sen in de preoperatieve fase en vooral bij patiënten met een belaste voorgeschiedenis
35. voor trombo-embolische processen. De postoperatieve incidentie van trombo-embolische
36. processen tussen beide groepen was gelijk. Ondanks dat de meerderheid van de preope-
37. ratieve trombo-embolische processen zonder klinische klachten gepaard gingen en bij
38. toeval gediagnosticeerd werden tijdens een tweede re-stagerende CT scan, raadden we in

1. dit onderzoek secundaire profylaxe aan tijdens neoadjuvante CRT bij patiënten met een
2. belaste voorgeschiedenis. Deze aanbeveling werd vooral gebaseerd op een richtlijn uit
3. 2007 van de American Society of Clinical Oncology¹¹. Prospectieve onderzoeken zijn nodig
4. om het gebruik en de veiligheid van profylactische therapie gedurende neoadjuvante CRT
5. te evalueren.
6. Preoperatieve trombo-embolische processen kunnen, behalve het risico op een medische
7. noodsituatie, ook invloed hebben op het postoperatieve beloop, aangezien anesthesisten
8. terughoudend zijn om epidurale analgesie toe te passen onder bepaalde vormen van an-
9. tistolling. Postoperatieve pijnstilling is van groot belang na een slokdarmresectie, omdat
10. postoperatieve pijn gepaard kan gaan met een verminderde longfunctie, pijn bij hoesten,
11. en een afnemende mobilisatie. Een goed werkende epidurale pijnstilling is geassocieerd
12. met een verminderd risico op pulmonale complicaties¹². Adequate trombo-embolische
13. preventie is dus noodzakelijk om te voorkomen dat er een ander beleid dan epidurale
14. analgesie wordt gevoerd. We konden echter geen verschil aantonen in het postoperatieve
15. beloop bij patiënten met een preoperatief trombo-embolische proces.
- 16.
17. Chemoradiotherapie voorafgaand aan een slokdarmresectie wordt verondersteld gepaard
18. te gaan met een verhoogd risico op cardiopulmonale toxiciteit¹³⁻¹⁵. In **Hoofdstuk 5** hebben
19. we het effect van neoadjuvante CRT op postoperatieve morbiditeit en mortaliteit in een
20. gematchte groep na een slokdarmresectie geëvalueerd. Na multivariate analyse bleek
21. neoadjuvante CRT significant geassocieerd met een verhoogd risico op de ontwikkeling
22. van longontstekingen en hartritmestoornissen. Het totaal aantal complicaties was verge-
23. lijkbaar in beide groepen, in overeenstemming met het CROSS onderzoek¹. De afgelopen
24. jaren zijn tegenstrijdige resultaten gerapporteerd over de invloed van neoadjuvante
25. CRT op postoperatieve morbiditeit en mortaliteit. De stralingsdosis op cardiopulmonale
26. organen tijdens neoadjuvante CRT is echter substantieel. Er zijn onderzoeken die een cor-
27. relatie tussen een lagere stralingsdosis en een vermindering van de pulmonale belasting
28. laten zien¹³. Bovendien zou bestraling van het pericard leiden tot een verhoogd risico op
29. pericardvocht, zich mogelijk uitend in postoperatieve cardiale complicaties¹⁶. Vervolgon-
30. derzoek zou zich dan ook moeten richten op bestralingsmethoden, die leiden tot minder
31. schadelijke bijwerking van de straling op deze organen, zonder afbreuk te doen aan de
32. gunstige effecten van CRT. Veel belovende stralingstechnieken zoals protontherapie,
33. kunnen cardiopulmonale toxiciteit verminderen.
- 34.
35. Ziekenhuis volume wordt geassocieerd met verbeterde korte en lange termijn uitkomsten
36. in patiënten met een slokdarmcarcinoom¹⁷. In een verslag (niet opgenomen in dit proef-
37. schrift) hebben we verondersteld dat het aantal uitgevoerde operaties door een chirurg
38. in een hoog-volume ziekenhuis een onafhankelijke prognostische factor is voor de post-

1. operatieve uitkomst na een slokdarmresectie. In dit verslag hebben we twee hoog-volume
2. ziekenhuizen in Nederland geïnccludeerd en na multivariate analyses, bleek het aantal
3. uitgevoerde operaties door een chirurg de enige onafhankelijke prognostische factor te
4. zijn voor een naadlekkage. Ons doel is echter om een groot deel van de noordelijk gelegen
5. centra in Nederland te includeren, vervolg onderzoek zal hier dan ook op gericht zijn.
6.
7. Het effect van een slokdarmresectie op vroege postoperatieve labwaarden en de associ-
8. atie met postoperatieve morbiditeit en mortaliteit werd geëvalueerd in **Hoofdstuk 6**. Een
9. groep van 210 opeenvolgende slokdarmpatiënten onderging een radicale transthoracale
10. resectie. Standaard afgenomen labwaarden werden op drie verschillende tijdstippen ge-
11. includeerd met maximum tot 48 uur na de operatie. Multivariate analyses en ROC analyse
12. toonden prognostische waarde voor lactaat dehydrogenase (LDH), creatinine en C-reactief
13. proteïne (CRP) voor het ontstaan van infectieuze complicaties na een slokdarmresectie.
14. Ernstige complicaties integreren met meerdere pathofysiologische mechanismen, die zich
15. uiten middels verschillende afwijkende labwaarden. Dit bevestigt het niet-specifieke ka-
16. rakter van deze waarden en de daaraan gerelateerde lastige interpretatie. In dit onderzoek
17. attenderen we klinici er op zich bewust te zijn van een mogelijk gecompliceerd postope-
18. ratieve beloop en een zo nodig vroege interventie indien deze waarden afwijkend blijken
19. te zijn. Verder onderzoek moet gericht zijn op meer specifieke markers om postoperatieve
20. complicaties in een vroeg stadium te identificeren. Bovendien zijn de pathofysiologische
21. mechanismen die leiden tot een gecompliceerd postoperatief beloop nog steeds niet
22. goed duidelijk. Een verbeterde kennis zou kunnen leiden tot vroegtijdige interventies.
23. In **Hoofdstuk 7** hebben we negen cytokines geëvalueerd met verschillende (patho)
24. fysiologische mechanismen om meer inzicht te verschaffen in de immunologische reactie
25. gedurende verschillende fasen in de multimodale behandeling van slokdarmpatiënten.
26. In deze hypothese genererende studie hebben we 35 patiënten geïnccludeerd. Om de
27. prognostische waarde te bepalen van deze cytokines met betrekking tot de pathologische
28. respons na CRT en de complicaties veroorzaakt door CRT of de daaropvolgende opera-
29. tie, hebben we multivariate analyses uitgevoerd. Concentraties van intestinal fatty acid
30. binding protein (I-FABP) namen na neoadjuvante CRT aanzienlijk toe, duidend op aan
31. de behandeling gerelateerde toxische gastrointestinale beschadiging, aangezien I-FABP
32. vrijkomt bij een beschadigde integriteit van mucosale cellen¹⁸. Na chirurgie namen de
33. concentraties I-FABP juist weer sterk af. Hoge concentraties van platelet activating fac-
34. tor (PAF) voor en na neoadjuvante CRT waren gecorreleerd aan pathologische respons.
35. Mogelijk is dit effect gerelateerd aan toegenomen chemotherapie-geïnduceerde effecten
36. van PAF door activering van immunologische pathways¹⁹. Bovendien komt PAF vrij bij de
37. apoptose van tumor cellen en tijdens oxidatieve stress en zowel radiotherapie als che-
38. motherapie zijn krachtige oxidatieve stressoren²⁰. Ten slotte bleek angiopoietin 1 (Ang-1)

1. een prognostische marker voor postoperatieve complicaties gedurende verschillende
2. fasen in de multimodale behandeling. Ang-1 is betrokken in het handhaven van de cel-
3. lulaire integriteit en endotheliale barrière van vasculaire cellen²¹. Een verlaagde Ang-1
4. concentratie perioperatief, gerelateerd aan een verhoogde ontstekingsreactie, kan leiden
5. tot verhoogde vasculaire permeabiliteit²². Verder onderzoek zou gericht moeten zijn
6. op vermindering van de afgifte van pro-inflammatoire cytokines tijdens de chirurgische
7. procedure. Hoog frequente jet ventilatie (HFJV) kan wellicht een bijdrage leveren aan een
8. vermindering van deze respons. Deze ventilatietechniek voorkomt dat patiënten shunten
9. over de niet-geventileerde long en gaat tevens gepaard met lage teugvolumes. Bovendien
10. is aangetoond dat HFJV een veilige ventilatietechniek is tijdens een slokdarmresectie²³.
11. Bovenstaande hypothesen zijn gebaseerd op een relatief kleine groep patiënten, grote
12. prospectieve studies zijn dan ook nodig om gegeneerde hypothesen te bevestigen.
- 13.
14. In conclusie, met dit proefschrift hebben we beoogd meer inzicht te geven in de mogelijke
15. risicofactoren die betrokken zijn in de relatieve hoge perioperatieve morbiditeit en mor-
16. taliteit bij in opzet curatieve behandeling van patiënten met een slokdarmcarcinoom. Een
17. curatieve behandeling, bestaande uit een slokdarmresectie gecombineerd met neoadju-
18. vante CRT, zal bij elke medisch fitte en op oncologische basis geselecteerde patiënt over-
19. wogen worden. De uitkomsten van dit proefschrift zullen er toe leiden dat klinici zich meer
20. bewust zijn van welke behandeling-, patiënt-, en tumor-gebonden factoren betrokken zijn
21. bij een mogelijk gecompliceerd beloop. Individualiseren van het behandelprotocol blijft
22. een belangrijke doelstelling om de kwaliteit van leven en het postoperatieve resultaat te
23. verbeteren.
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Dankwoord

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1. Curriculum Vitae

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4.

5.

6. Dirk Bosch werd geboren op 24 juli 1983, te Emmerich (Duitsland). Hij groeide op in een
7. warm gezin als middelste zoon van Jaap en Yvonne en als broer van Eric en Marc. In
8. 1993 verhuisde het gezin naar Nederland, alwaar zij in Diepenveen kwamen te wonen.
9. In 2002 behaalde Dirk zijn VWO diploma met het profiel Economie & Maatschappij. Na
10. zijn eindexamen ging Dirk rechten studeren aan de Rijksuniversiteit Groningen. In dit jaar
11. kwam hij tot de ontdekking dat dit niet de juiste studie voor hem was, waarna hij het
12. roer radicaal omgooide. In een korte tijd behaalde Dirk alsnog het beoogde VWO diploma
13. Natuur & Gezondheid aan het Luzac College te Arnhem. In 2005 startte Dirk met de studie
14. geneeskunde, waar hij volledig op zijn plek bleek te zijn.

15.

16. Zijn affiniteit met wetenschappelijk onderzoek kwam al vroeg naar voren. Zijn aandacht en
17. interesse ging hierbij uit naar de behandeling van patiënten met een slokdarmcarcinoom.
18. In zijn derde studiejaar startte hij een proefproject vanuit de Junior Scientific Masterclass
19. (JSM) bij de afdeling Chirurgische Oncologie. Daarna volgde op dezelfde afdeling een we-
20. tenschappelijke stage en zo werd de basis gelegd voor een MD/PhD traject. In 2010 startte
21. hij onder leiding van prof. dr. J.Th.M. Plukker (Chirurgische Oncologie) en prof. dr. M.M.R.F.
22. Struys (Anesthesiologie) met zijn MD/PhD traject naar perioperatieve risicofactoren voor
23. postoperatieve complicaties in patiënten met een slokdarmcarcinoom.

24.

25. In 2011 behaalde Dirk zijn artsenbul en ging hij als arts-assistent met veel toewijding
26. aan het werk op de Chirurgische Intensive Care in het UMCG. Daar kon hij zijn kennis en
27. vaardigheden verder uitbreiden en bleek hij interesse te hebben in hemodynamische en
28. pulmonale problematiek. Sinds januari 2014 is Dirk in opleiding tot Anesthesioloog in het
29. UMCG.

30.

31. In zijn vrije tijd mag hij graag zeilen of (zeil)bootjes opknappen, echter sinds hij de trotse
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33.

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