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The role of neoadjuvant chemotherapy in ovarian cancer patients with extensive tumor burden

To the editor: I read with great interest the article by Menczer et al. [1] on the outcome prediction before neoadjuvant chemotherapy (NAC) in ovarian cancer. In the study, the authors indicated that progression free survival (PFS) of ovarian cancer patients who underwent NAC was not different between marked improvement group and no/some improvement group. The median PFS of the two groups were 7.9 and 7.2 months. Of course, as the authors addressed, the small size of this study may not provide enough evidence to draw any meaningful conclusion. However, as a hypothesis-developing study, this study raised several important hypotheses that should be considered in the future studies on the role of NAC in ovarian cancer.

First, this study suggested no meaningful correlation between the response to NAC and clinical outcome, i.e., PFS, after interval debulking. The short PFS in this study may not be surprising because they gave NAC to the selected high-risk patients by criteria suggested by Nelson et al. [2], i.e., extensive upper abdominal disease and/or extraperitoneal disease. As the authors did not observe any difference of PFS between good vs. poor responders, this result may be interpreted as a challenge to the role of NAC in patients with extensive tumor burden. Although the authors did not compare the rate of successful cytoreduction between good and poor responders, it is obvious that surgical cytoreduction would be easier in good responders to NAC. This may imply that enhanced feasibility of cytoreduction provided by NAC may have no role in these setting, especially in terms of prognosis. This interesting observation should be confirmed in further studies.

In addition, it should be also noted that CA-125 decreased more than 50% in all patients in the study. Thus, it is possible that all patients may be similarly benefited by NAC in terms of surgical resectability. If this is the case, the cytoreduction outcome between good and poor responders may not be dramatically different in this study. Personally, I experienced that more than 50% CA-125 reduction is sufficient to increase feasibility of cytoreduction in patients with extensive tumor burden. Therefore, I would like to indicate that the cutoff dividing 'no/some improvement' and 'marked improvement' group may be arbitrary. If the extent of chemoresponse to NAC was regarded as a continuous variable in this study, this study would have been much more informative.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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In reply: We thank Dr. Sokbom Kang for his interest in our investigation and his kind remarks. Obviously patients selected for neoadjuvant chemotherapy (NAC) are a selected unfavorable group of ovarian cancer patients. The advantage of this approach as we have mentioned in our paper include an increased rate of optimal residual disease, less extensive surgery, reduced blood loss, lower morbidity, shortened hospital stay and improved quality of life. In spite of these advantages, NAC has not been shown to be superior with regard to outcome over up front surgery. It has only been shown not to be inferior to up front surgery [1]. The high rate of optimal cytoreduction in the total group (<0.5 cm in 86.5%) precluded a meaningful comparison between the rate of successful cytoreduction between good and poor responders, in our limited number of patients. Indeed as the Dr. Sokbom Kang noted "all patients may be similarly benefited by NAC in terms of surgical respectability".

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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