Failure of the International Prognostic Index to prognosticate outcome in primary gastric DLBC lymphoma

We read with interest the original article published in the *Annals of Oncology* by Binn et al. [1], addressing the role of surgery plus chemotherapy in the management of diffuse large B-cell gastric lymphoma. We would like to make a correction in this regard. The authors stated that their results support the prognostic value of the International Prognostic Index (IPI) in predicting survival outcome in localized gastric lymphoma, and in the next sentence they indicate that these results are in agreement with ours, published in 1999, in one of the largest published series about this disease [2]. In fact, according to our paper, the IPI failed to classify patients into prognostically meaningful risk strata. A modified prognostic index was developed and proved to be of more prognostic significance. However, we recommended that prospective validation of the proposed model be attempted. It might be of interest if the authors can re-examine their data according to our proposed model.

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We have read the article on the management of gastric lymphomas with interest [1]. The authors compared the survival of 44 patients from the Groupe d’Étude des Lymphomes de l’Adulte (GELA) who had been treated without surgery and 40 included in the protocol of the Groupe d’Étude des Lymphomes Digestifs (GELD) who had undergone surgical resection followed by chemotherapy. All the patients analyzed for survival were reported as having a low International Prognostic Index (IPI 0–1). We think that results from this study must be evaluated cautiously for the following reasons.

First, lactate dehydrogenase (LDH), one of the main elements of IPI score calculation, was found to be higher in 28% of GELA patients compared with 2.4% in the GELD group. The exact timing of LDH determination in the GELD group in reference to surgery was not reported. Serum LDH levels, hence the IPI score, may change depending on whether it was determined before or after surgery, since removal of tumor bulk would certainly decrease LDH level. On the other hand, if it was tested immediately following surgery, it may be elevated. Thus, IPI scores prior to surgery are more informative.

Secondly, the authors defined the point of randomization as the start time for overall and event-free survival. The word ‘randomization’ probably only applies to those patients from GELA where patients had been randomized to LNH-87 and LNH-93 studies, since there is no actual randomization for the current study. In other words, the starting point for survival in GELD patients was not clearly defined.

Thirdly, response criteria were not clearly defined for GELD patients. The authors stated that all patients had achieved complete response, 95% with complete resection of the tumor and an additional 5% following chemotherapy. It is debatable whether complete resection could be an appropriate substitute for complete response according to the criteria defined by Cheson et al. [2]. Moreover, response to chemotherapy is an innate good prognostic feature of the tumor itself. In the article by Binn et al., persistence of radiological abnormalities at sites of previous bulky disease were considered as complete response if tumoral reduction was >75% [1]. However, it must be classified as ‘complete response/unconfirmed’ according to the criteria of Cheson et al. [2].

Fourthly, neither the chemotherapeutic nor the surgical strategy was homogeneous in the study population. Treatment was more aggressive (chemotherapy with or without transplantation) in the GELA group.

In the Discussion, the authors emphasize that their results conflict with several studies suggesting that complete or incomplete surgical resection is a favorable prognostic factor for survival. Unfortunately, some of the prior studies that contradict the present work also belong to the same authors [3, 4]. Indeed much remains to be learned regarding the biology and clinical course of gastric lymphomas. Some investigators are trying to modify the IPI so that it correlates better with the course of gastric lymphomas [5, 6], while others are working on molecular prognostic factors, such as DNA content and proliferative activity in this entity [7, 8]. Hopefully, all these studies will provide new insight into the management of gastric diffuse large B-cell lymphomas.

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M. Binn, A. Ruskon

between the last three groups. The results of our study, which
diate, high-risk), but that there was not any significant difference
better prognosis than the other groups (low-intermediate, interme-
drew that in their population, including patients with extended
predict overall survival rate in gastric large B-cell lymphoma. Ann Oncol 2003; 14:

I also read with interest the comments by Abali and Barista. I
agree that timing of LDH determination is important. It was deter-
between the level of LDH in the GELA patients and the GELD
patients were included in two trials comparing several regimens.
our aim was not to determine the better chemotherapy
Chemotherapy in the GELA group was not homogeneous as
However, our aim was not to determine the better chemotherapy
but to compare two strategies: surgery versus chemotherapy.
Authors from the GELD group previously published results show-
the absence of curative surgery. Pathological examination of
staging does appear as a well adapted mean in evaluating
response.

Chemotherapy in the GELA group was not homogeneous as
patients were included in two trials comparing several regimens.
our aim was not to determine the better chemotherapy
but to compare two strategies: surgery versus chemotherapy.
Authors from the GELD group previously published results show-
the efficiency of surgery [4, 5]. The results of the present study
confirmed their findings and showed that in patients with similar
inclusion criteria, chemotherapy provided comparable survival to
surgery. Therefore, we concluded that gastrectomy is probably
not mandatory in low-risk patients with localized gastric DLBC
lymphomas.

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