We read with interest the review written by Randi et al. [1]. We found that the authors failed to describe comprehensively all the biliary tract cancer (BTC) entities. Recent evidence indicates that the term BTC includes cholangiocarcinoma, ampullary carcinoma and carcinoma arising from the epithelial lining of the gall-bladder and bile ducts (intrahepatic, perihilar and distal biliary tree cancers). We agree with Randi et al. about the information regarding the extrahepatic cholangiocarcinoma, but excluding the intrahepatic and the perihilar cholangiocarcinoma, they missed important information about their epidemiology and the differences regarding the disease course, responsiveness to chemotherapy and molecular profiles. Specifically, He et al. evaluated and compared the biological characteristics and sensitivity to chemotherapy and radiotherapy of intrahepatic and extrahepatic cholangiocarcinoma cells in vitro. He et al. demonstrated that they are different in shape, doubling time, chromosome karyotype, tumor marker level and chemosensitivity; in fact, intrahepatic cholangiocarcinoma cells were less sensitive to cisplatin and paclitaxel and not sensitive to the other four chemotherapeutic drugs tested. On the contrary, extrahepatic cholangiocarcinoma cells were highly sensitive only to cisplatin but not sensitive to the other five drugs tested. Moreover, the authors showed that they both have low radiosensitivity. So He et al. concluded that intrahepatic and extrahepatic cholangiocarcinoma have peculiar growth characteristics and consequently, also prognosis and treatment should be differentiated [2]. Moreover, intrahepatic and extrahepatic cholangiocarcinoma have different epidemiological features. Recent data show that the incidence and mortality rates of intrahepatic cholangiocarcinoma have been increasing. On the contrary, the incidence of extrahepatic cholangiocarcinoma is constant and mortality rates have been decreasing. Even if the mortality for BTC is decreasing because of the utilization of cholecystectomy for lithiasis, high mortality rates are reported in some countries, such as India, China and South America [3]. The Japanese Society of Biliary Surgery has organized a registry project and established a classification of BTC. It has established guidelines for the treatment of cancer of the biliary tract based on the extent of involvement at each site, considering three anatomical regions: the biliary duct, gall-bladder and papilla of Vater. A total of 3518 cases of BTC were registered from 1998 to 2002. These cases were analyzed with regard to patient survival [4]. Recently, Furuse et al. reported the guidelines for chemotherapy of biliary tract and ampullary carcinoma. In the guidelines, he stated that clinical trials of chemotherapy had been conducted in patients with BTC in general due to the small number of cases, even though he underlined that clinical trials should be conducted considering the individual diseases separately, because treatment strategy, sensitivity to chemotherapy, genetics and prognosis differ extensively from disease to disease. In fact, these different behaviors correspond to different survival rates among the sites of BTCs [5]. Although these findings should be confirmed in larger studies, we indicate the inclusion of perihilar and intrahepatic cholangiocarcinoma in the BTCs. Future clinical trials should be carried out separating these entities to find the right therapeutic approach.

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references


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