STORY OF THE WEEK

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No Survival Advantage With Prophylactic Surgery for Stage IV Small Intestinal NETs

JAMA Oncology

TAKE-HOME MESSAGE

- This cohort study evaluated outcomes in 363 asymptomatic patients with stage IV small intestinal neuroendocrine tumors and distant metastases.
- No difference was found in overall survival between the 161 patients who underwent prophylactic surgery within 6 months of the diagnosis and the 202 patients who were treated nonsurgically or with delayed surgery (median, 7.9 vs 7.6 years, respectively). Nor was there a difference in cancer-specific survival (median, 7.7 vs 7.6 years, respectively).

– Jeffrey Wiisanen, MD

Abstract

This abstract is available on the publisher's site.

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IMPORTANCE

Primary tumor resection and mesenteric lymph node dissection in asymptomatic patients with stage IV small intestinal neuroendocrine tumors (SI-NETs) are controversial.

OBJECTIVE

To determine the association of locoregional surgery (LRS) performed at diagnosis with outcomes in patients with asymptomatic SI-NETs and distant metastases.

DESIGN, SETTING, AND PARTICIPANTS

This cohort study included asymptomatic patients with stage IV SI-NETs diagnosed from January 1, 1985, through December 31, 2015, and identified using the prospective database of SI-NETs from Uppsala University Hospital, Uppsala, Sweden. Patients included were treated at a tertiary referral center and followed up until May 31, 2016, with data from the Swedish National Patient Register. The 363 patients with stage IV SI-NETs without abdominal symptoms were divided between those who underwent prophylactic up-front surgery within 6 months from diagnosis combined with oncologic treatment (hereafter referred to as LRS group [n=161]) and those who underwent nonsurgical treatment or delayed surgery as needed combined with oncologic treatment (hereafer referred to as delayed LRS group [n=202]).

EXPOSURES

Prophylactic up-front surgery within 6 months from diagnosis combined with oncologic treatment vs nonsurgical treatment or delayed surgery as needed combined with oncologic treatment.

MAIN OUTCOMES AND MEASURES

Overall survival (OS), length of hospital stay (LOS), postoperative morbidity and mortality, and reoperation rates measured from baseline. Propensity score matching was performed between the 2 groups.

RESULTS

The 363 patients included 173 women (47.7%) and 190 men (52.3%), with a mean (SD) age at diagnosis of 62.4 (11.1) years. Two isonumerical groups with 91 patients in each resulted after propensity score matching. The LRS and delayed LRS groups were comparable in median OS (7.9 years [range, 5.1-10.7 years] vs 7.6 years [range, 5.8-9.5 years]; hazard ratio [HR], 0.98; 95% CI, 0.70-1.37; log-rank P=.93) and cancer-specific survival (7.7 years [range, 4.5-10.8 years] vs 7.6 years [range, 5.6-9.7 years]; HR, 0.99; 95% CI, 0.71-1.40; log-rank P=.99). No difference was found in 30-day mortality (0 patients in both matched groups) or postoperative morbidity (2 [2.2%] vs 1 [1.1%]; P>.99), median LOS (73 days [range, 2-270 days] vs 76 days [range, 0-339 days]; P=.64) or LOS due to local tumor-related symptoms (7.0 days [range, 0-90 days] vs 11.5 days [range, 0-69 days]; P=.81), or incisional hernia repairs (4 patients [4.4%] in both groups; P>.99). Patients in the LRS group underwent more reoperative procedures (13 [14.3%]) compared with those in the delayed LRS group (3 [3.3%]) owing to intestinal obstruction (P<.001).

CONCLUSIONS AND RELEVANCE

Prophylactic up-front LRS conferred no survival advantage in asymptomatic patients with stage IV SI-NETs. Delayed surgery as needed was comparable in all examined outcomes and was associated with fewer reoperations for intestinal obstruction. The value of a priori LRS in the presence of distant metastases is challenged and needs to be elucidated in a randomized clinical study.

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