Predictive factors for survival of patients with inoperable malignant distal biliary strictures: a practical management guideline

F Prat, O Chapat, B Ducot, T Ponchon, J Fritsch, A D Choury, G Pelletier, C Buffet

Abstract
Background—Stenting is the treatment of choice for inoperable malignant strictures of the common bile duct. Criteria for the choice of stents (plastic versus metallic) remain controversial because predicting survival is difficult.

Aims—To define prognostic factors in order to improve the cost effectiveness of endoscopic palliation.

Patients—One hundred and one patients were included in a prospective trial. Seven prognostic variables for survival were analysed (age, sex, bilirubinaemia, weight loss, presence of liver metastases, and tumour histology and size). All patients were followed until death or at least one year after inclusion. By the end of the study, 81 (80.2%) patients had died.

Results—In univariate analysis, the variables associated with survival were weight loss (p<0.05) and tumour size (p<0.01). By multivariate analysis, tumour size was the only independent prognostic factor (p<0.05). A threshold of 30 mm at diagnosis distinguished two survival profiles: the median survival of patients with a tumour greater than 30 mm was 3.2 months, whereas it was 6.6 months for patients with a tumour less than 30 mm (p<0.001).

Conclusions—A practical strategy could be based on tumour size at diagnosis: a metal stent should be systematically chosen for patients with an inoperable tumour smaller than 30 mm, while larger tumours are efficiently palliated by a plastic stent.

(Gut 1998;42:76–80)

Keywords: stents; pancreatic cancer; endoscopic retrograde cholangiopancreatography; prognostic factors; biliary tract cancer; palliative treatment

Methods and patients
The present study is derived from a prospective randomised trial aimed at comparing three methods of endoscopic drainage for inoperable malignant strictures of the common bile duct. The results of this trial have been reported elsewhere.

Criteria for inclusion were: existence of jaundice secondary to a distal malignant common bile duct stricture, without previous attempts at biliary drainage; referral to one of the two participant centres (Bicêtre Hospital or Edouard Herriot Hospital) for endoscopic palliation of jaundice; performance status of 0 (asymptomatic), 1 (symptomatic, fully ambulatory), or 2 (symptomatic, in bed less than 50% of day) after the Eastern Cooperative Oncology Group (ECOG) classification and ASA grade 1 or 2; or a decision that the patient was unfit for surgery on the basis of tumour extension (estimated by clinical factors; biliary tract cancer; palliative treatment.
Survival of patients with operable malignant distal biliary strictures

Figure 1 Global survival curve.

Figure 2 Survival curves for small and large tumours.

### Table 1 Patient characteristics

<table>
<thead>
<tr>
<th>Variable studied</th>
<th>Mean (SD) age (y)</th>
<th>Age range (y)</th>
<th>Sex (M/F)</th>
<th>Percentage weight loss</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Diagnosis (%)</th>
<th>Tumour size in mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of patients</td>
<td>101</td>
<td>73.2 (12.5)</td>
<td>39–95</td>
<td>49/52</td>
<td>9.1 (6.9)</td>
<td>0–27</td>
<td>Cancer of the pancreatic head</td>
<td>65 (64.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cholangiocarcinoma</td>
<td>21 (20.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ampullary cancer</td>
<td>3 (3.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Metastatic lymph nodes</td>
<td>12 (11.9)</td>
</tr>
<tr>
<td>Mean (SD) bilirubinaemia before stent</td>
<td>248.7 (163.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(normal &lt;17 µmol/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2 Prognostic significance for survival of commonly available criteria at the time of diagnosis (log rank test and Cox model)

<table>
<thead>
<tr>
<th>Variable studied</th>
<th>Relative risk</th>
<th>95% CI</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Univariate analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Bilirubinaemia</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Liver metastases</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Percentage weight loss</td>
<td>NA</td>
<td>NA</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Sex</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Tumour size</td>
<td>NA</td>
<td>NA</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Type of primary tumour</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Multivariate analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Tumour size &lt;30 mm</td>
<td>1.4–4.3</td>
<td>p&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>Tumour size ≥30 mm</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ECOG 2 or less. The seven items were the patient’s age, sex, and weight loss, the tumour size and histological type, the presence or absence of distant metastases (to the liver), and total serum bilirubin the day before stenting. Percentage weight loss was calculated by the formula: \( \frac{\text{weight on inclusion/usual weight}}{\text{usual weight}} \). Tumour size was defined as the largest diameter when a mass was visible on transcutaneous ultrasound or computed tomography scan (the images available at the time of endoscopic retrograde cholangiopancreatography (ERCP) were usually from the peripheral hospital referring the patient), and as the total length of the stricture on retrograde cholangiography when no mass was identifiable. In patients with a visible mass, it was checked that mass diameter and stricture length on ERCP were correctly correlated. Histology was classified as pancreatic head carcinoma, cholangiocarcinoma, ampullary carcinoma, and metastatic lymph nodes; it was obtained from guided needle biopsies, biliary brush cytology and biopsies, or from knowledge of the primary tumour. When no histological sample was available, morphological criteria such as a double stricture of the common bile and pancreatic ducts for a pancreatic head carcinoma, were accepted.

Randomisation was done in blocks of six patients each stratified for both sex and investigation centre. The three randomisation groups were mixed for the prognostic study because their global survivals were not different. Furthermore, the comparability of the three groups for the different patient variables was tested. In a second step, univariate and multivariate analyses of the different factors were undertaken. Finally, the prognostic factors were tested in the study population.

Examination, chest x ray, transcutaneous abdominal ultrasonography and/or computed tomography scan, and endoscopic ultrasonography in some cases), or age. Exclusion criteria were: the patient’s residence located abroad or more than 150 km (100 miles) from the endoscopy centre; an extension of the stricture to the main biliary confluence (hilum) or the existence of obstructive duodenal invasion; a suspected benign biliary stricture; or the patient’s refusal to participate after receiving information about the trial. The study was approved by the ethics committee of the Lyon Civil Hospitals, and patients were included after written informed consent was obtained.

At inclusion, patient characteristics were noted on a specific form and then entered onto a database. Patients were followed prospectively by monthly mailings and telephone calls to the referring centres and general practitioners. Follow up was conducted until the patient’s death or for at least one year after inclusion. The global survival was defined as the timespan between initial stenting and death.

Of the patient data, seven criteria were considered for the prognostic study, with regard to the following criteria: previously reported or studied in the literature as potentially related to survival of patients with pancreaticobiliary cancers; and usual availability of data in the common set of clinical, biological, and morphological investigations. Data such as a thorough assessment of nutritional status were therefore not considered; neither was the performance status, since all the patients were classified as...
Figure 3 Algorithm for patient management.
low late morbidity for those with the longest survival (which is the case with bypass surgery, but not with plastic stents).13–16 Metallic stents appear to meet both end points, with a low probability of symptomatic dysfunction even in long term survivors.17 In the few patients who develop stent obstruction, endoprostheses intubation with a plastic stent remains possible, and in the even fewer patients who develop duodenal obstruction (3% in our series), a simple gastrojejunal anastomosis is not precluded. However, the cost of metallic stents is roughly 15–20-fold higher than that of polyethylene stents, and is not likely to be drastically reduced, due to high manufacturing costs. A cost effective management policy therefore would be to use plastic stents in patients with a short life expectancy (less than six months, according to our data), and metal stents in other patients (expected to survive at least six months).

This study has shown that an assessment of biliopancreatic tumour size is a sufficient predictor of survival. In the univariate analysis, tumour size and weight loss were found to be predictive of survival. In patients with a cancer of the head of the pancreas, 80–90% present with significant weight loss on diagnosis.18 This factor is inconsistently recognised as prognostic.19 The weight is not an accurate reflection of the cancer patient’s nutritional status, because of the usual expansion of extracellular fluids and oedema.20 A more accurate evaluation of nutritional status might improve the assessment of prognosis, such as has been shown by Falconer et al with albuminemia.21 Performance status was not tested as a prognostic variable, as all the patients had been selected at inclusion for having a fair performance status. A low performance status is, however, associated with poor prognosis. Several studies omitted to consider the presence of distant metastases as a potential prognostic factor. However, in contrast to our results, van den Bosch et al,19 as well as Pereira-Lima et al in a retrospective study,22 have shown that the presence of distant metastases remained a significant predictive factor of poor survival even in a multivariate analysis. However, our patients were referred for palliative treatment because they were considered inoperable; the group had a larger (and therefore statistically less discriminant) percentage of metastatic patients (28%) than in surgical series. In our multivariate analysis, tumour diameter was the only independent prognostic factor. Other factors clearly related to survival (such as presence of liver metastases, weight loss, and histology) are indeed linked to tumour size. The size factor has been identified in previous studies.23–27 However, these studies presented conflicting results probably because they included either operable patients (those with relatively small tumours) or inoperable patients (generally with larger tumours).

We suggest that endoscopic drainage devices should be selected using an algorithm based on tumour size (fig 3): in a patient presenting for the first time with inoperable malignant jaundice and a tumour smaller than 30 mm in diameter, the expected median survival is 6.6 months; a metal stent is therefore recommended. On the other hand, patients presenting with a tumour larger than 30 mm have an expected median survival of 3.2 months, justifying the use of a plastic stent. If this decision algorithm had been used in our series, 7% of the patients would have unnecessarily received a metal stent, because of their unexpectedly short survival (table 3). Whatever the method for calculating the costs per patient, this is much less than the excess cost induced by a systematic use of metal stents in every patient (two thirds of whom do not exceed six months in survival). On the other hand, 13% with large tumours at the time of diagnosis finally survived more than six months. In such cases, the prognosis may be corrected when more follow up is available, and the plastic stent can be exchanged, either prophylactically or after a symptomatic dysfunction, for a metal stent. This approach would be easy to apply and we believe warrants a prospective controlled study.

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