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.

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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.11

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) classification12 and ASA grade 1 or 22; or a decision that the patient was unfit for surgery on the basis of tumour extension (estimated by clinical

Approximately 10–20% of patients with malignant obstruction of the common bile duct are nowadays operated on with the intention of complete resection and cure. Half of these patients will undergo resection, and the others some form of palliative bypass surgery.2,3 Ninety per cent of patients with malignant obstructive jaundice may therefore benefit only from palliative treatment. Among these patients, some will survive only a few weeks, most will die within six months, but some others may survive in a fairly good condition for one or even several years.9 Until recently, two kinds of therapeutic options were offered to such patients: a surgical bypass or an endoprosthesis, generally made of polyethylene. The percutaneous insertion of plastic endoprostheses has been shown to generate excess morbidity1 due to a 12 French gauge access through the liver; however, even with the use of thinner catheters (7 French) and self expanding stents, the transhepatic route remains more invasive than the endoscopic route, and should not be the primary option for common bile duct obstruction, although it can be recommended for the palliation of hilar strictures.

Several studies have shown the advantages of endoscopic stenting over surgical bypass, although “long term survivors” could clearly benefit from palliative surgery by precluding the need for stent exchanges necessitated by stent clogging.4–7 The recent introduction of self expanding metal stents, whose patency has been shown to be longer than that of plastic stents, may affect the decision: endoscopic stenting could be the option of choice for all patients unlikely to undergo curative resection.4−6 However, economic issues must be considered, and metallic stents, due to their high cost, should probably be reserved for those patients whom they might really benefit.9 Prediction of survival therefore becomes a critical issue, but reliable predictive factors are still lacking. Because life expectancy can be an essential determinant in a patient’s management, we tried in this study to identify prognostic indicators and to suggest a simple management guideline.

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Figure 1 Global survival curve.

Table 1 Patient characteristics

<table>
<thead>
<tr>
<th>Variable studied</th>
<th>Relative risk</th>
<th>95% CI</th>
<th>p Value</th>
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<tbody>
<tr>
<td>Age</td>
<td>NA</td>
<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td>Bilirubinemia</td>
<td>NA</td>
<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td>Liver metastases</td>
<td>NA</td>
<td>NA</td>
<td>NS</td>
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<tr>
<td>Percentage weight loss</td>
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<td>NA</td>
<td>p&lt;0.05</td>
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<tr>
<td>Sex</td>
<td>NA</td>
<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td>Tumour size</td>
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<td>NA</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Type of primary tumour</td>
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<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td>Multivariate analysis</td>
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<tr>
<td>Weight loss</td>
<td>NA</td>
<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td>Tumour size &lt;30 mm</td>
<td>1</td>
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<td>NA</td>
</tr>
<tr>
<td>Tumour size ≥30 mm</td>
<td>2.5</td>
<td>1.4-4.3</td>
<td>p&lt;0.01</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: l−(weight on inclusion/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.11 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.

Figure 2 Survival curves for small and large tumours.
Statistical significance was determined using the χ² test for qualitative data, and one way analysis of variance and non-parametric tests for quantitative data. Survival times were compared by the log rank test. Survival curves are presented using the actuarial method. The influence of a number of simultaneous variables on survival was estimated with the Cox proportional hazard model. Results are expressed as mean (SD).

Results
One hundred and five patients were included in the study. Follow up was not available in four patients, three of whom had failed endoprosthesis insertion, and one did not comply with the stent exchanges required. Data from these four patients were therefore not included in the analysis. The patient characteristics of the three groups were similar (table 1). Histological confirmation of malignancy was obtained in 65% of cases. In all other cases, the patient’s history was typical of biliary or pancreatic cancer. Tumour size was obtained from computed tomography or ultrasound scans in 68 patients and from ERCP alone in 33. Four patients were lost at follow up: three had moved from France to another country, and one had been followed in another centre from which no information could be obtained. Three patients underwent surgery during follow up for symptoms of gastric outlet obstruction: one had a gastroenteric bypass 155 days after inclusion and two others had a choledocho-duodenoanastomosis and gastrojejunal anastomosis 22 and 365 days, respectively, after insertion. Another patient underwent a hepatico-jejunostomy 384 days after inclusion for stent dysfunction.

Biliary drainage was successful in 97.4% of cases. Procedure related morbidity and mortality were 11.9% and 3.9%, respectively, with no difference between groups; there were six cases of biliary sepsis, two cases of pancreatitis, one bleeding sphincterotomy, and one case of transitory renal failure. Two patients died within eight days of primary stent insertion from biliary sepsis and two others from upper digestive haemorrhage, in which the causative role of endoscopic procedures was suspected, but not proved.

The mean follow up after inclusion was 166 (131) days. By the end of the study, 81 patients (80.2%) had died. The global median survival was 143 days (4.7 months). Figure 1 presents the global survival curve; 37.6% of the patients survived less than three months, 30.7% three to six months, and 31.7% more than six months.

In the univariate analysis, only two of the seven items tested were found to be significantly associated with survival: percentage weight loss and tumour size. In the multivariate analysis, tumour size was the only independent predictor of survival (table 2). The study population was split into two samples, depending on tumour size, and survival was compared between these samples by the log rank test. Using this method, a threshold of 30 mm in size was determined as the best survival discriminator (fig 2): the median survival was 6.6 months for patients with a tumour smaller than 30 mm and 3.2 months for patients with a larger tumour (p<0.001).

When applied to the 101 patients included, 19 (18.8%) would have been correctly classified as surviving more than six months, 62 (61.4%) correctly classified as surviving six months or less, and 20 (19.8%) would have been wrongly classified (table 3).

Discussion
In our randomised trial, we have shown that self expanding metal stents significantly increased the symptom free survival compared with plastic stents. However, a cost effectiveness analysis had shown that this improvement was really beneficial only for the subgroup of patients surviving more than six months (32% in this study). Predictive factors of survival therefore remained to be determined.

The restoration of efficient biliary drainage has been shown to be useful not only for the relief of jaundice and pruritus, but also to improve the general quality of life, by increasing appetite and reducing indigestion. In inoperable patients, this objective is all the more important since treatment is purely palliative, aimed at reducing symptoms of discomfort and improving patients’ well being for their remaining lifetime. In patients with malignant jaundice, the ideal palliative treatment is therefore a drainage method with a low procedure related morbidity (which is the case with endoscopic stents, as compared with transhepatic stents and bypass surgery), and a
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...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 can 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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