Proton Beam Therapy with High-Dose Irradiation for Superficial and Advanced Esophageal Carcinomas

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ABSTRACT

Purpose: With the aim of improving the results of treatment for esophageal carcinoma, we have investigated the efficacy and toxicity associated with the use of a 250-MeV proton beam for radical radiation therapy in esophageal carcinoma.

Experimental Design: Thirty patients with esophageal carcinoma (superficial, n = 13; advanced, n = 17) had been treated with proton beam therapy alone or with photon therapy followed by proton beam therapy in combination with photon and proton beams. In proton beam therapy, one fraction dose was 1.8–2.0 Gy for photon and 2.5–3.7 Gy (mean, 3.1 Gy) for proton beam. In proton beam therapy alone, one fraction dose was 3.1–3.6 Gy (mean, 3.2 Gy). Overall mean total doses of the irradiation were 77.7 Gy in superficial carcinoma and 80.7 Gy in advanced carcinoma, respectively.

Results: Mean overall actuarial survival in patients with superficial and advanced carcinomas was 60.1 and 38.6 months, respectively. The local recurrence and disease-specific survival rates for patients with superficial carcinoma were 0 and 100% at 5 years, and 0 and 87.5% at 10 years, respectively; the same rates for the patients with advanced carcinoma were 56.6 and 49.0% at 5 years, 78.3 and 38.1% at 10 years, respectively. Radiation-induced esophageal ulcer without injury of adjacent organs occurred in 20 (66.7%) of 30 treated patients.

Conclusions: Better local control and 5- and 10-year disease-specific survival rates were achieved by a higher dose of irradiation with well-defined proton fields in superficial and advanced esophageal carcinomas.

INTRODUCTION

In the treatment of advanced esophageal carcinoma, conventional X-ray (photon) radiotherapy alone has been reported to have a 5-year survival rate with disappointing results of only 6–10% (1–7). Such unfavorable results of the treatment may be caused by the inclusion of patients who have large tumor with stricture, regional lymph node metastasis, or poor medical condition in the case of indication for radiotherapy. Another critical reason may be the delivery of inadequate doses to the primary tumor and/or poor targeting technique. Thus, radiotherapy alone has resulted in frequent local failure, local recurrence, and distant metastasis. Recently, however, the radiation has been combined with chemotherapy as primary treatment to achieve successful results (4–7). These studies produced a significant survival advantage for patients with localized esophageal cancer who received chemoradiotherapy, although the 3- and 5-year survival rates were still low.

On the other hand, esophageal cancer characteristically presents late in the course of disease because of the relatively asymptomatic interval from the onset of disease to diagnosis. However, the detection rate of superficial esophageal cancer has gradually increased in Japan, mainly because of the availability of Lugol dye endoscopy (8). Accordingly, the effectiveness of definitive radiation therapy in superficial esophageal carcinoma has extensively been studied by Japanese study groups (9, 10). Excellent local control and survival rates have been reported.

To further improve the results of treatment in patients with esophageal carcinoma, IBT has been proposed as a “boost” to the primary tumor, allowing potentially increasing tumor control and relative sparing of the surrounding normal tissues (11–14). In applying a similar concept, high-energy (250 MeV) proton beams have been introduced for esophageal carcinoma in our Institute (15, 16). Proton beams have a distinct physical advantage over photons. The beams produce little side scatter and stop abruptly at any prescribed depth. The pattern of energy deposition is characterized by the Bragg peak, wherein the dose is minimal on entry and reaches a maximum at the stopping region, which is planned to occur in the target volume (17). Proton beams can be shaped to deliver homogeneous radiation doses to irregular three-dimensional volumes such as those required for esophageal carcinoma. This makes it possible to deliver high doses of tumor irradiation to the target volume while simultaneously reducing the amount of photons reaching normal esophageal or adjacent normal tissues. We have administered substantially high radiation doses (>70 Gy) with a fraction size larger than 2.5 Gy. The importance of proton beam therapy to improve local disease control and survival for patients with esophageal carcinoma has been suggested in the previously
reported early analysis of the study (15, 16). A similar clinical approach using proton beams has been applied to five patients with esophageal carcinoma in another institution (18).

This study was undertaken to further assess the efficacy and toxicity of proton beam therapy and the first long-term survival beyond 5 years in superficial and advanced carcinomas. We describe how proton beam therapy, with a high dose of irradiation delivered by a well-defined proton field, results in excellent local control and survival.

**MATERIALS AND METHODS**

**Patients.** From October 1985 to June 1994, 36 patients with esophageal cancer were registered to receive proton beam irradiation at the Tsukuba University Hospital. In this clinical trial, patients were selected for the following reasons: refused surgery, advanced age, medical inoperability, and technical unresectability. Patients were considered ineligible if they had a disease metastasis to distant sites, such as lung or liver; if they had a second primary malignancy simultaneously; if they had undergone previous external irradiation; if they were incapable of self-care; or if informed consent could not be fully obtained. Thirty of 36 patients entered in the analysis were treated with a curative intent for their primary tumors and were followed up until death. The clinical characteristics of these 30 patients (26 male and 4 female) are shown in Tables 1 and 2. Patients’ ages ranged from 45 to 95 years with a mean of 70.2 ± 2.2 (mean ± SE) years. Thirteen patients (mean age, 71.0 years; range, 45–86 years; Table 1) had superficial carcinoma; the other 17 patients (mean age, 70.0 years; range, 50–95 years; Table 2) had advanced carcinoma. Superficial (cancerous invasion was limited to the mucosa or submucosa) and advanced (cancerous invasion reached or penetrated to proper muscle or adventitia) esophageal carcinoma have been defined by the guidelines for clinical and pathological studies on carcinoma of the esophagus (19). Histological assessments, made from biopsy specimens taken from the esophageal lesions, showed that 29 patients had squamous cell carcinoma and one patient (case 7) had tubular adenocarcinoma. Tumor was located in the upper third in 3 patients (10.0%), the middle third of the thoracic esophagus in 19 (63.3%), and in the abdominal esophagus in 1 (3.3%). The esophageal tumor length had been determined from the barium swallow studies and endoscopic findings, taking the longest of the two available determinations. The mean length of the superficial carcinoma was 2.3 cm (range, 1.5–3.0 cm), and of the advanced carcinoma was 6.4 cm (range, 3.0–15.0 cm). The depth of cancerous invasion of the esophageal wall (T1 to T3) had been evaluated by X-ray and endoscopic examinations according to the guidelines for clinical and pathological studies on carcinoma of the esophagus (19) and for radiotherapy in the treatment of esophageal carcinoma (20). Extension of the tumor to adjacent structures (T4) and the presence of regional lymph node metastasis had been assessed by CT images. Taken together with these findings, clinical staging had been defined by Union International Contre Cancer (UICC)-tumor-node-metastasis (TNM) classification of esophageal carcinoma (21). The clinical staging of all of the patients for the retrospective analysis was finally reevaluated and was confirmed. As a result, 12 of 13 patients with superficial carcinoma revealed stage I, and most (94.1%) of 17 patients with advanced carcinoma were identified as stage III.

**Radiation Therapy.** Proton beam therapy was given at the Proton Medical Research Center of the University of Tsukuba, with a 250-MeV-proton-beam generator by the booster synchrotron of the National Institute for High Energy Physics in Tsukuba City. For precise localization and identifi-
accelerator or a shortage of machine time (27–30 weeks/year; 3–3.5 h/day), as described previously (15, 16). Thus, proton beam therapy had been given either alone or in combination with photons. In photon therapy, five-times-a-week treatment was delivered using 10-MV X rays. Consequently, two patients with superficial carcinoma and four patients with advanced carcinoma had been treated with proton beam alone to the primary lesion. The other 11 patients with superficial carcinoma and 13 patients with advanced carcinoma had been treated with combined photon and proton beam irradiation. In the combination therapy, the patients initially received photon radiation, followed by irradiation with proton beam. Initial AP-PA portals for photon therapy were extended at least 3 cm above and below the primary tumor, with at least a 2-cm lateral margin. The treatment field included the supraclavicular fossae if the tumor originated above the level of the carina. When mediastinal nodal disease was suspected, the suspected nodes were included with an additional 1–2-cm margin. The daily fraction size ranged from 1.8 to 2.0 Gy in photon therapy, and from 2.5 to 3.7 Gy in proton therapy. The daily fraction size of the proton beam could be increased, because the proton beam has the advantage of producing a homogeneous dose distribution with a well-defined field to deeply seated tumors. Practical doses of photon and/or proton in individual patients with superficial and advanced carcinomas are summarized in Table 1 and 2, respectively. Mean total dose of irradiation for 30 esophageal cancer patients was 79.4 Gy. All of the patients were able to complete the planned irradiation without interruption; even if most patients were irradiated with substantially higher doses compared with those traditionally used (1–7). None of the patients received chemotherapy for tumor during the clinical trial; this allowed us

cation of the irradiation field, radiopaque markers (iridium chips of 0.5 mm in diameter and 3.0 mm in length) were implanted at the proximal and distal edges of the primary tumor using an endoscopic technique. As shown in Fig. 1, proton radiation was delivered through an anterior approach. The exact method for proton beam irradiation has been described previously in detail (15–17, 22). Briefly, set-up accuracy was noted immediately using a real-time field verification system, and the patient positioning was corrected accordingly. Respiration-gated irradiation was made if the respiration-induced movement of the esophagus had exceeded 5 mm in the cranial-caudal direction. Finally, the design of a beam-shaping compensator (bolus) and isodose distributions were presented on the CT image of the representative patient with advanced esophageal carcinoma (Fig. 1). The method had insured accurate localization of the proton beam with respect to the tumor volume in this study. Thus, the target volume had been determined by setting margins around the tumor boundary as small as practical. Namely, the treatment field for proton beam included the primary tumor, with at least a 2-cm lateral margin. The daily fraction size ranged from 1.8 to 2.0 Gy in photon therapy, and from 2.5 to 3.7 Gy in proton therapy. The daily fraction size of the proton beam could be increased, because the proton beam has the advantage of producing a homogeneous dose distribution with a well-defined field to deeply seated tumors. Practical doses of photon and/or proton in individual patients with superficial and advanced carcinomas are summarized in Table 1 and 2, respectively. Mean total dose of irradiation for 30 esophageal cancer patients was 79.4 Gy. All of the patients were able to complete the planned irradiation without interruption; even if most patients were irradiated with substantially higher doses compared with those traditionally used (1–7). None of the patients received chemotherapy for tumor during the clinical trial; this allowed us

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Age/ Sex</th>
<th>Site (cm)</th>
<th>Stage</th>
<th>X-ray</th>
<th>Proton/ Total</th>
<th>Local response</th>
<th>Local recurrence</th>
<th>Survival (mo)</th>
<th>Ulcer</th>
<th>Stricture</th>
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<tr>
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<td>Im</td>
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<td>2.50</td>
<td>75.0</td>
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</tbody>
</table>

*1 Fr, fraction dose; Im, midthoracic esophagus; Ei, lower thoracic esophagus; Ea, abdominal esophagus; Iu, upper thoracic esophagus.

*2 Values in parentheses represent onset of local recurrence (months).

| Table 2 Patient characteristics, dose of irradiation, efficacy, and toxicity in advanced esophageal carcinoma |
to precisely evaluate the efficacy and toxicity of proton beam therapy with high-dose of irradiation.

Follow-Up. After completion of the radiation therapy, barium swallow studies and endoscopic examinations were carried out at regular intervals, and the clinical radiation effect was evaluated according to the criteria for evaluating the therapeutic effect in the guidelines (19, 20). Briefly, local control was defined as a lack of either clinical or pathological evidence of tumor recurrence in the esophagus. Indeed, the onset of local recurrence was determined by the disease relapse confirmed by regular endoscopic and/or X-ray examinations. The duration of follow-up ranged from 5 to 132 months (median, 47.8 months). Eleven of 30 treated patients were followed up for more than 60 months, and 3 of the 11 patients were followed up for over 10 years. The survival time was judged on September 30, 2002.

Statistical Analysis. Overall survival, disease-specific survival, and local recurrence rates were calculated from the first date of external irradiation. Probability of disease-specific survival and local recurrence rates for patients with superficial and advanced esophageal carcinomas was calculated by using the Kaplan-Meier method (23). The statistical differences in local recurrence and survival curves during the entire follow-up period were evaluated by the log-rank test, and a P of <0.05 was regarded as significant. The statistical analysis was performed with StatView software (SAS Institute Inc., Cary, NC).

RESULTS

Table 1 shows the summary of irradiation doses of practical photon and proton beam, and results of their therapy in each patient with superficial esophageal carcinoma. Two patients were treated with proton beam alone with total dose of 79 Gy and 75 Gy in 25 and 24 fractions, respectively. The other 11 cases were initially treated with X rays with doses of 16.2–50.4 Gy (mean, 39.0 Gy) in 9–28 fractions, followed by proton irradiation with doses of 30.0–52.9 Gy (mean, 39.5 Gy) in 10–20 fractions (mean, 12.9 fractions), thus total combined doses were 69.1–86.5 Gy (mean, 77.8 Gy). The one-fraction dose of proton beam was 2.5–3.7 Gy (mean, 3.1 Gy). Overall mean total doses of the irradiation were 77.7 Gy in 13 patients with superficial esophageal carcinoma.

Cancerous lesions of all 13 patients with superficial carcinoma completely disappeared by the end of the proton beam therapy, and a CR was obtained in all cases (100%). CR criteria used in the study have been defined by the Japanese Society of Esophageal Disease (19). Briefly, all measurable, evaluated primary tumor lesions disappear at the end of the treatment, and no new lesions appear for at least four weeks. In all 13 cases of superficial carcinoma, there was no local recurrence throughout the long-term follow-up. One patient (case 12), however, relapsed with a small cancerous lesion outside of the upper part of the radiation field in the esophagus at 6 months after the treatment. Salvage surgery was carried out, and the patient is now alive and well. Regional lymph node metastasis (right perithecéal lymph node) occurred in one patient (case 5) 20 months after the treatment without local recurrence in the esophagus. The lymph node swelling involved in cancer was outside the area of the radiation field. He died of pleural dissemination of esophageal carcinoma. At autopsy, any local recurrent cancerous lesion could not histologically be observed in the esophageal mucosa. Eleven of 13 patients died of intercurrent diseases, as shown in Table 1. Mean overall actuarial survival for patients with superficial carcinoma was 60.1 months.

Table 2 shows the summary of practical irradiation doses of photon and proton beam, and the results of this therapy in each patient with advanced esophageal carcinoma. Four patients were treated with proton beam alone with a total dose of 75.5–89.5 Gy (mean, 84.1 Gy) in 25–29 fractions (mean, 27.5 fractions). The other 13 cases were treated with X rays with doses of 30.6–51.6 Gy (mean, 43.9 Gy) in 17–26 fractions, followed by proton beam with doses of 25.0–54.5 Gy (mean, 35.8 Gy) in 9–16 fractions (mean, 11.9 fractions); thus, total combined doses were 70.8–89.5 Gy (mean, 79.7 Gy). The one-fraction dose of proton beam was 2.5–3.7 Gy (mean, 3.1 Gy). Overall mean total doses of irradiation were 80.7 Gy in 17 patients with advanced esophageal carcinoma.

CR was obtained in 16 (94.1%) of 17 patients with advanced carcinoma; local failure occurred in one patient (5.9%; case 17). Among 16 patients who have had local control, local recurrence had been observed in 8 patients. The recurrent time from the end of the proton beam therapy was different in each case, ranging from 8 to 75 months. The mean time to recurrent progression of treated local control region was 28 months. The cumulative monthly incidental curves of local recurrence have been plotted in Fig. 2. The 5-year local-recurrence rates for patients with superficial carcinoma, advanced carcinoma, and for whole populations were 0, 56.6, and 28.9%, respectively; the 10-year rates were 0, 78.3, and 40.7%, respectively. The local recurrence rate in patients with advanced carcinoma was significantly higher than those with superficial carcinoma (P < 0.0001). Concerning the pattern of local recurrence, four of eight patients showed recurrence in the middle of the tumor site treated with high-dose irradiation, but the other 4 patients (cases 19, 27, 28, and 29) revealed marginal recurrence in the field of proton beam therapy. The marginal recurrent lesion could be
observed in the superior (cases 19 and 29) and inferior (cases 27 and 28) margins in the field of the irradiated tumor.

Six of eight patients with local recurrence were considered to have suffered disease-specific death. One patient (case 19) showed local recurrence (0-IIc type carcinoma) in the posterior wall at the oral margin of the treated tumor at 44 months after radiotherapy, as previously described in detail (16). After receiving salvage surgery, he had maintained his health, but died of hepatoma at 132 months after the irradiation. Only one patient (case 24) is still alive, and he has survived for more than 10 years without tumor recurrence. Mean overall actuarial survival for patients with advanced carcinoma was 38.6 months, but 9 of 17 patients with advanced carcinoma died of intercurrent diseases, as shown in Table 2. The disease-specific survival curves for superficial carcinoma are plotted in Fig. 3. The survival rate at 5 years for patients with superficial carcinoma, advanced carcinoma, and for whole populations was 100, 49.0, and 67.1%, respectively; the 10-year survival rates were 87.5, 38.1, and 61.0%, respectively. The disease-specific survival rate in patients with superficial carcinoma was significantly higher than in those with advanced carcinoma (P < 0.02).

Acute toxicity including mucositis was minimal, followed by complete healing in 1–1.5 months. Severe late injury, esophageal ulceration, was documented in 9 (69.2%) of 13 and 11 (64.7%) of 17 patients with superficial and advanced carcinoma, respectively (Tables 1 and 2). Additional detailed findings about radiation-induced ulceration were summarized in Table 3. Onset of ulcer was variable in each case, ranging from 3 to 11 months (mean, 5.6 months) in the field of proton beam after the radiation therapy. Eleven (55%) of 20 ulcer patients were eventually healed by appropriate conservative management, such as liquid or soft food and/or i.v. hyperalimentation. Resolving time required for healed state was ranged from 0.5 to 8 months (mean, 4.4 months). Although 6 of completely healed 11 patients had been cured without any clinical sequelae, the other 5 patients had developed esophageal stricture with clinical symptoms, dysphagia. To easily swallow a food, two (cases 2 and 26) of the patients with fibrotic stricture were further treated with endoscopic balloon-dilated method. There was no case that required surgery to manage the stricture. In 7 (cases 4, 10, 13, 16, 21, 22, and 29) of 20 patients with ulceration, a healed state could not be confirmed, because the shorter survival of these patients did not allow enough observation time to evaluate the healing process of ulceration. Treatment-induced esophageal bleeding was observed in two patients (cases 8 and 15). However, there was no life-threatening esophageal perforation or fistula. The spinal cord, heart, and lung, which are the dose-limiting organs at risk, did not reveal any symptomatic late complications.

**DISCUSSION**

The present study clearly demonstrates that the proton beam therapy with high-dose irradiation for superficial and advanced esophageal carcinomas has improved local control and 5- and 10-year disease-specific survival rates. These indicate that the therapy for esophageal carcinoma has potential advantages over external conventional photons. The magnitude of the advantage is an improved control of local tumors, resulting in diminishing local failure and recurrence, and lengthening survival.

In studies of superficial carcinoma treated with definitive radiation, total dose ranged from 60 to 70 Gy (mean, 65.5 Gy; Refs. 9, 10). Favorable therapeutic results have been obtained with disease-specific 5-year survival rate of 62–71%. These results reflect the fact that appropriate radiotherapy is generally more effective against tumors with a small tumor volume. In our study, proton beam therapy showed no local recurrence and 100% 5-year disease-specific survival in patients with superficial carcinoma, strongly suggesting the more improved local control and long-term survival rates. In Japan, the 5-year survival rate in patients with surgically treated superficial esophageal carcinoma has been shown to be more than 60 to 90% (24, 25). The treatment outcome in our study is approximately equal to the result of surgery. Thus, proton beam therapy with the high dose of radiation presented here for superficial carcinoma might be used as an alternative to surgery.

In conventional radiation therapy alone for advanced esoph-
Table 3 Summary of radiation-induced ulceration

<table>
<thead>
<tr>
<th>Ulcer, no. of cases</th>
<th>Mean time required, mo &lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incidence</td>
</tr>
<tr>
<td>Superficial carcinoma (13 cases)</td>
<td>9</td>
</tr>
<tr>
<td>Advanced carcinoma (17 cases)</td>
<td>11</td>
</tr>
<tr>
<td>Total (30 cases)</td>
<td>20</td>
</tr>
</tbody>
</table>

<sup>a</sup> Values in parentheses represent numbers of patient with esophageal stricture.
<sup>b</sup> Values in parentheses represent range of time required (months).

Proton Beam Therapy for Esophageal Carcinoma

The beneficial effect of the proton beam irradiation is attributable to the capability of delivering homogeneous dose distribution with well-defined fields to deeply seated irregular large tumor masses with deep invasion. In addition, the biological effectiveness of irradiation would be greater than that of the physical dose actually given, when large daily radiation doses (>2.5 Gy) for the therapy were administered at the tumor site. These factors may also have contributed to the favorable results obtained at Tsukuba.

The 5- and 10-year survival rates with treatment by surgery in esophageal cancer with a length 5–7 cm were shown to be 21.9% and 17.9%, respectively, and were 22.4% and 17.8% for class T3-cancer, respectively, in a study of Iizuka et al. (27). In particular, the 5- and 10-year survival rates of patients with stage III were 17.2% and 13.8%, respectively (27). Thus, the treatment outcome of proton beam therapy in advanced carcinoma presented here is comparable with that of surgery, although the number of patients treated with proton beam is small. These findings are distinctly different from those of patients with advanced carcinoma treated by high-dose-rate IBT (13, 14). It is reasonable to conclude that proton beam therapy with high-dose of irradiation provides an effective treatment modality even in patients with advanced esophageal carcinoma.

An improvement in local control in the study could certainly lead to improved survival rates. To improve local control and survival rate, a radiation dose to primary tumor should be increased, as has been described by Suit and Westgate (26). However, the increased irradiation dose in proton beam therapy simultaneously caused higher incidence of esophageal ulcer or bleeding, as compared with that of conventional radiation therapy. The higher complication rates might also be related to the large fraction size (>2.5 Gy) of irradiation. Similar severe late complications of the esophagus, such as ulceration or fistula have been reported in high-dose-rate IBT after external irradiation (11–14). Whereas, there seems to be no definite correlation between delivered dosage for the present treatment and the incidence of ulcer formation, because mean external total dose, mean total proton dose, and mean one fraction size of proton beam in 20 patients with esophageal ulceration was 79.7, 46.6, and 3.11 Gy, respectively, but those in 10 patients without late complication were also similar values, showing 78.9, 45.1, and 3.01 Gy, respectively. Thus, high-dose of irradiation plus unknown individual factors might contribute to the incidental formation of esophageal ulcer. The unknown individual factors include how meals are consumed: the type of food (soft or solid); the amount (light or heavy); and the timing (when and how often).

We would like to emphasize that local failure and recur-
REFERENCES
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