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LETTER TO THE EDITOR

Response to Reader's Queries

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Dear Sir,

We thank our reader for showing interest in our case report and raising pertinent questions. We are in agreement with the reader that multidisciplinary approach is the key to the management of gastrointestinal stromal tumor (GIST) as the evidence-based guidelines continue to expand. Further, the decision to offer adjuvant or neoadjuvant targeted therapy (not chemotherapy) for GIST should be done in a multidisciplinary setting. The reader's questions have been answered below point by point.

1. Did initial surgery for the primary tumor achieve an R0 resection margin?

The patient underwent a prereferral R0 resection of a c-KIT-positive gastric GIST at an outside facility. While the histopathologic features of the primary tumor are that of low to intermediate risk, the pattern of disease recurrence in this case is unusual. The patient did not receive adjuvant imatinib (not chemotherapy) at the outside hospital, as this preceded the recently published American College of Surgeon Oncology Group trial (Z9001). Beyond this point, we cannot offer any definitive reasons for this decision.

With regard to extent of diagnostic workup for this locally advanced unresectable recurrent GIST, this was initially detected on cross-sectional imaging (computed tomography (CT) scan). An upper GI endoscopy with EUS capabilities was performed which showed normal-appearing stomach with postsurgical changes. It also showed no intramural lesion but showed a large mass abutting the antrum of the stomach with two satellite lesions inferior to the left hemiliver. Typical appearance on the CT scan and no intramural involvement strongly suggested a recurrence; thus, no biopsy was obtained. Given that the primary tumor was c-KIT positive as are most recurrent GISTs, our multidisciplinary decision was to offer neoadjuvant imatinib therapy for this locally advanced unresectable GIST. Further, the patient underwent a positron emission tomography (PET) scan before initiation of imatinib, which confirmed the presence of a large, highly PET-avid recurrent tumor and satellite nodules. A repeat PET scan done shortly after initiation of imatinib showed considerable decrease in the size and FDG uptake of the masses. These features are quite typical of GIST and, together with the early radiological (PET) response to imatinib, indicate that the masses did indeed represent GIST and further that the tumor remained kit positive at that time. While the possibilities of a c-KIT-negative recurrent GIST or newly developed primary mutations exist, the early and continued radiographic response is strongly suggestive of a c-KIT-positive recurrent GIST.

2. Our reader states that the benefit of using tyrosine kinase inhibitors in the neoadjuvant setting should be balanced against the probability of the tumors developing secondary resistance to imatinib. We are in agreement that this treatment analogy should be considered in the setting of a resectable recurrent GIST. However, and as we discussed in our case, the patient presented with radiographic features of locally advanced unresectable GIST and it was imperative to use neoadjuvant imatinib.

Again, we thank our reader for his interest in this case.

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