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EVALUATION OF THE TREATMENT OUTCOMES OF PREOPERATIVE CONCURRENT CHEMORADIOTHERAPY FOR PATIENTS WITH STAGE II, III ESOPHAGEAL CANCER AT 175 MILITARY HOSPITAL

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ABSTRACT

Objectives: To describe some clinical and paraclinical characteristics and evaluate the treatment outcomes of preoperative concurrent chemoradiotherapy for patients with stage II, III esophageal cancer (EC) at 175 Military Hospital.

Subjects and methods: A descriptive retrospective combined prospective study on 36 patients with stage II, III esophageal cancer who received preoperative concurrent chemoradiotherapy with the weekly Paclitaxel/Carboplatin regimen (Paclitaxel 50 mg/m², Carboplatin AUC 2) combined with radiotherapy of 41.4 Gy/23 Fx, followed by surgery 4–8 weeks later, from January 2021 to April 2026.

Results: The mean age was 60.67 ± 7.79 years; 97.2% were male; 97.2% of patients had a history of smoking and/or alcohol use. Dysphagia was observed in 100% of patients, mostly grade 2 (58.3%); all patients reported weight loss. Pathology was squamous cell carcinoma in 100% of cases; the mean tumor length was 5.52 ± 1.18 cm; 88.9% were T3 and 11.1% T4; stage III accounted for 83.3%. After chemoradiotherapy, the symptomatic response rate was 91.7%, and the response rate according to RECIST 1.1 was 88.9% (complete response 13.9%, partial response 75.0%). 63.9% of patients underwent surgery, with an R0 resection rate of 95.7%; the pathologic complete response (pCR) rate was 39.1%. The median disease-free survival (DFS) was 24 months, and the median overall survival (OS) was 47 months. Overall survival (OS) at 12, 24, and 36 months was 96.8%, 93.2%, and 69.9%, respectively; disease-free survival (DFS) at 12, 24, and 36 months was 79.2%, 48.4%, and 36.3%, respectively. The surgical group had a median OS of 51 months and median DFS of 38 months, markedly longer than the non-surgical group (OS 31 months, DFS 17 months). Toxicity was mostly grade 1–2: esophagitis 94.4%, dermatitis 86.1%, pneumonitis 69.4%, leukopenia 50.0% (only 2.8% grade 3); no grade 4 toxicity was observed.

Conclusion: Preoperative concurrent chemoradiotherapy with the weekly Paclitaxel/Carboplatin regimen combined with radiotherapy of 41.4 Gy/23 Fx is an effective and well-tolerated treatment for patients with stage II, III esophageal cancer at 175 Military Hospital.

Keywords: *Esophageal cancer, preoperative concurrent chemoradiotherapy*

1. INTRODUCTION

Esophageal cancer (EC) is one of the malignancies with a poor prognosis, ranking 11th in incidence and 7th in mortality among all cancers worldwide[1]. According to GLOBOCAN 2022, in Vietnam, EC ranks 12th among the most common cancers, with approximately 3,686 new cases and 3,470 deaths each year; more than 95% of patients have squamous cell carcinoma (SCC)[1]. The treatment of cancer in general, and esophageal cancer in particular, is multimodal, combining surgery, radiotherapy, chemotherapy, and immunotherapy, among other methods. For patients with locoregionally advanced disease (stage II, III), surgery alone yields limited results, with a high recurrence rate and a 5-year survival rate of only 25–35%; therefore, preoperative concurrent chemoradiotherapy (nCRT) combined with surgery has become the mainstream approach and the gold standard of treatment[2,3]. This approach not only helps downstage the tumor and increase the rate of radical resection but also eradicates micrometastatic cells, thereby significantly improving overall survival and disease-free survival compared with surgery alone[4,5]. In Vietnam, studies on the efficacy of preoperative concurrent chemoradiotherapy combined with surgery for locoregionally advanced esophageal cancer have shown encouraging initial results[7,8,9,10]. However, data on long-term survival outcomes and toxicity of this regimen remain limited. At 175 Military Hospital, preoperative concurrent chemoradiotherapy for EC has been implemented in recent years, but outcomes have not yet been published. Therefore, in order to contribute to the body of research on preoperative concurrent chemoradiotherapy for resectable esophageal cancer—aiming to improve survival, enhance patients' quality of life, and continuously improve outcomes in EC treatment—we conducted this study with two objectives: (1) To describe some clinical and paraclinical characteristics of patients with stage II, III esophageal cancer; (2) To evaluate the treatment efficacy of preoperative concurrent chemoradiotherapy in the study population.

2. SUBJECTS AND METHODS

2.1. Study subjects

A total of 36 patients with a confirmed diagnosis of stage II, III esophageal cancer received preoperative concurrent chemoradiotherapy with the Paclitaxel–Carboplatin regimen at 175 Military Hospital from January 2021 to April 2026.

Inclusion criteria:

- Age 18–75 years, performance status (PS) 0–1.

- Patients with esophageal cancer confirmed by histopathology, stage II, III, resectable according to the 8th edition AJCC classification (2017).

- First-line treatment with chemotherapy and radiotherapy.

- Adequate liver, kidney, and bone marrow function, with no severe medical conditions contraindicating chemoradiotherapy and surgery.

- Patients consented to participate in the study.

Exclusion criteria:

- Patients > 75 years or < 18 years of age, PS ≥ 2.

- Cervical esophageal cancer, esophageal cancer with unresectable lymph node involvement, or esophageal cancer with distant metastasis.

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- History of another malignancy within the past 5 years.

- Pregnant or breastfeeding women.

- Patients who have previously received chemoradiotherapy, or who have advanced chronic diseases (severe heart failure, grade III–IV renal failure, Child-Pugh B or C cirrhosis, etc.).

2.2. Research methods

- Study design: A descriptive retrospective combined prospective study.

- Sample size: Convenience sampling (all eligible patients during the study period).

- Treatment regimen: Paclitaxel 50 mg/m² + Carboplatin AUC 2 administered intravenously weekly × 5 weeks, combined with concurrent radiotherapy at a total dose of 41.4 Gy/23 Fx. At 4–8 weeks after completion of chemoradiotherapy, treatment response was evaluated and indications for esophagectomy were considered.

- Study variables:

+ Clinical and paraclinical characteristics: age, sex, medical history, symptoms, tumor location, tumor size, tumor morphology, histopathology, and disease stage.

+ Evaluation of treatment response 4–8 weeks after chemoradiotherapy: clinical symptomatic response and CT response according to RECIST 1.1 criteria.

+ Postoperative evaluation: proportion of patients who underwent surgery, resection margin status, and pathologic response.

+ Follow-up of overall survival (OS) and disease-free survival (DFS) using the Kaplan–Meier method.

+ Toxicity assessment according to CTCAE v5.0.

- Data analysis: SPSS 22.0 software was used; proportions were compared using the χ^2 test or Fisher's exact test, with $p < 0.05$ considered statistically significant.

3. RESULTS

3.1. Clinical and paraclinical characteristics

Table 1. Clinical and paraclinical characteristics (n = 36)

Characteristic	n=36
Age:	
$\bar{X} \pm SD$	60.67 ± 7.79
<60	11 (30.6%)
60-70	22 (61.1%)
>70	3 (8.3%)
Sex:	
Male	35 (97.2%)
Female	1 (2.8%)
Tumor location:	
Upper 1/3	0
Middle 1/3	9 (25%)
Lower 1/3	16 (44.4%)
Upper-Middle 1/3	4 (11.1%)
Middle-Lower 1/3	7 (19.4%)
Tumor stage:	
T1	0
T2	0
T3	32 (88.9%)
T4	4 (11.1%)
History:	
None	1 (2.8%)
Smoking	10 (27.8%)
Alcohol	6 (16.7%)
Smoking + Alcohol	19 (52.8%)
Nodal stage: N0	6 (16.7%)
N1	17 (47.2%)
N2	13 (36.1%)
N3	0

Characteristic	n=36
Dysphagia: Grade 0	0 (0%)
Grade 1	2 (5.6%)
Grade 2	21 (58.3%)
Grade 3	13 (36.1%)
Grade 4	0 (0%)
Disease stage:	
II	6 (16.7%)
III	30 (83.3%)
Weight loss:	
None	0 (0%)
<5%	26 (72.2%)
5-10%	10 (27.8%)
>10%	0 (0%)
Histopathology:	
Squamous cell carcinoma (SCC)	36 (100%)
Tumor morphology:	
Fungating	
Ulcerative	
Fungating + Ulcerative	
Fungating + Infiltrative	
Fungating + Ulcerative + Infiltrative	
Mean tumor length: X ± SD	5.52±1.18cm

Comment:

- Mean age was 60.67 ± 7.79 years; the ≥ 60-year-old group accounted for the majority (69.4%); males accounted for 97.2%; 97.2% of patients had a history of smoking and/or alcohol use.

- 100% of patients had dysphagia (predominantly Grade 2, accounting for 58.3%) and 100% of patients had weight loss. 100% of patients had squamous cell carcinoma on histopathology. The tumor was most commonly located in the lower 1/3 (44.4%); mean tumor length was 5.52 ± 1.18 cm. 88.9% of patients were stage T3, 11.1% were T4; stage III accounted for 83.3%.

3.2. Treatment outcomes

3.2.1. Response after concurrent chemoradiotherapy

Table 2. Functional symptom response after treatment

Functional response	n = 36	%
Symptom-free	4	11,1
Improved	29	80,6
Unchanged	1	2,8
Worsened	2	5,6

Comments: The functional response rate after treatment was 91.7% (33/36), of which 11.1% became symptom-free and 80.6% improved; only 5.6% of patients showed clinical worsening.

Table 3. Response according to RECIST 1.1 criteria

Response on CT scan	n = 36	%
Complete response (CR)	5	13,9
Partial response (PR)	27	75,0
Stable disease (SD)	1	2,8
Progressive disease (PD)	3	8,3

Comments: 88.9% of patients responded to treatment (CR + PR), with CR at 13.9% and PR at 75.0%; 8.3% of patients had progressive disease after chemoradiotherapy.

3.2.2. Postoperative outcomes

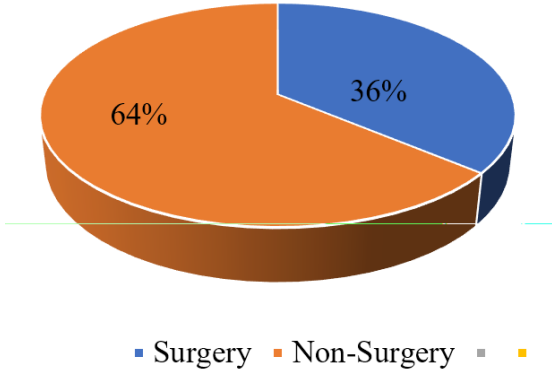

Chart 1. Proportion of patients undergoing surgery

Table 4. Reasons for not undergoing surgery after chemoradiotherapy (n = 13)

Reason for non-surgery	n (13)	%
Progressive disease (PD) after chemoradiotherapy	3	23.1
Unfit for surgery – performance status decline from severe malnutrition	1	7.7
Declined surgery – complete response (CR) on RECIST 1.1	3	23.1
Declined surgery – fear of postoperative complications	6	46.1

Comments: After chemoradiotherapy, 23/36 patients (63.9%) underwent esophagectomy. The remaining 13 patients (36.1%) did not undergo surgery for the following reasons: 3 patients due to progressive disease (PD) on RECIST 1.1; 1 patient was unfit for surgery despite disease control, due to performance status decline from severe malnutrition; and 9 patients due to patient/family refusal of surgery, of whom 3 had achieved complete response (CR) on imaging and 6 declined because of concerns about postoperative complications.

Table 5. Assessment of resection margins after surgery

Resection margin	n = 23	%
R0	22	95,7
R1	0	0
R2	0	0
Rx	1	4,3

Comments: The R0 resection rate was 95.7%; there were no cases with gross residual tumor (R2) or microscopic residual tumor (R1).

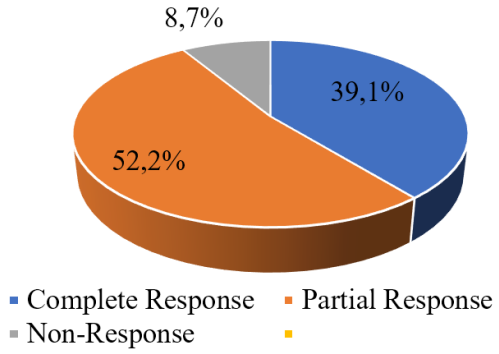

Chart 2. Pathological response of both tumor and lymph nodes after surgery

Comments: The pathological complete response rate of both tumor and lymph nodes (pCR) was 39.1%; the overall response rate was 91.3%.

3.2.3. Disease-free survival (DFS) and overall survival (OS)

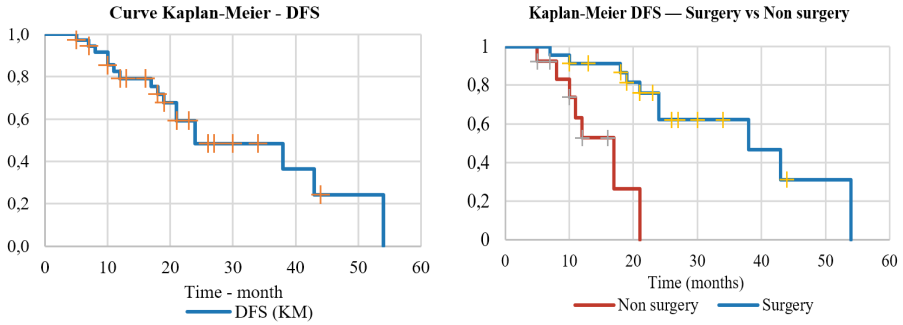

Chart 3. Kaplan-Meier graph for disease-free survival (DFS)

Comments: The median disease-free survival (DFS) was 24 months. The disease-free survival rates at 12, 24, and 36 months were 79.2%, 48.4%, and 36.3%, respectively.

In subgroup analysis, the median DFS was 38 months in the surgery group and 17 months in the non-surgery group.

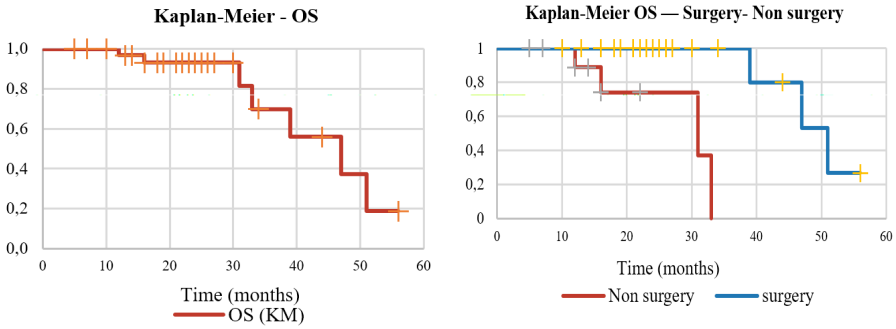

Chart 4. Kaplan-Meier graph for overall survival (OS)

Table 6. Treatment response and overall survival outcomes (n=36)

Outcome	Data
Median follow-up time (min-max)	23.06 months (21.5-56)
Median overall survival (95% confidence interval)	47 months
1-year overall survival rate	96.8%
2-year overall survival rate	93.2%
3-year overall survival rate	69.9%

Comments: Median follow-up time was 23.06 months (minimum 21.5 months; maximum 56 months). Median overall survival was 47 months. The OS rates at 12, 24, and 36 months were 96.8%, 93.2%, and 69.9%, respectively.

In subgroup analysis, the median OS was 51 months in the surgery group and 31 months in the non-surgery group.

3.2.4. Toxicity

Table 7. Adverse events according to CTCAE v5.0

Adverse event	Grade 0		Grade 1		Grade 2		Grade 3-4	
	n	%	n	%	n	%	n	%
Decreased Hb	25	69.4	8	22.2	3	8.3	0	0
Decreased WBC	18	50	13	36.1	4	11.1	1	2.8
Decreased neutrophils	21	58.3	12	33.3	3	8.3	0	0
Decreased platelets	32	88.9	4	11.1	0	0	0	0
Elevated liver enzymes	31	86.1	5	13.9	0	0	0	0
Elevated creatinine	36	100	0	0	0	0	0	0
Nausea	23	63.9	11	30.6	2	5.6	0	0
Vomiting	26	72.2	10	27.8	0	0	0	0
Diarrhea	35	97.2	1	2.8	0	0	0	0
Alopecia	34	94.4	2	5.6	0	0	0	0
Peripheral neuropathy	32	88.9	4	11.1	0	0	0	0
Esophagitis	2	5.6	28	77.8	6	16.7	0	0
Dermatitis	5	13.9	31	86.1	0	0	0	0
Pneumonitis	11	30.6	25	69.4	0	0	0	0
Mediastinal fistula	35	97.2	1	2.8	0	0	0	0

Comments: Adverse events were predominantly Grade 1–2. The main hematologic toxicity was leukopenia (50.0%); only 1 patient (2.8%) experienced Grade 3 leukopenia. The most common radiation toxicities were esophagitis (94.4%), dermatitis (86.1%), and pneumonitis (69.4%). One patient developed a mediastinal fistula after treatment. No Grade 4 toxicities were observed.

3.2.5. Factors associated with pCR response

Table 8. Factors associated with pCR response

Factor	Subgroup	n	Complete response (pCR)	Partial response	No response	p-value
Age	< 60	8 (100%)	2 (25%)	6 (75%)	0	0.487
	60 - 70	13 (100%)	6 (46.2)	5 (38.5)	2 (15.3)	
	> 70	2 (100%)	1 (50%)	1 (50%)	0	
History	Tobacco	6 (100%)	2 (33.3%)	3 (50%0	1 (16.7%)	0.909
	Alcohol	3 (100)	1 (33.3%)	2 (66.7%)	0	
	Tobacco + Alcohol	14 (100%)	6 (42.9%	7 (50%)	1 (7.1%)	
Dysphagia	Grade 1	1 (100%)	1 (100%0	0	0	0.215
	Grade 2	15 (100%)	7 (46.7%)	6 (40%)	2 (13.3%)	
	Grade 3	7 (100%)	1 (14.3%)	6 (85.7%)	0	
Weight loss	< 5%	20 (100%0	9 (45%)	9 (45%)	2 (10%)	0.206
	5 - 10%	3 (100%)	0	3 (100%)	0	
Tumor location	Middle third	7 (100%)	4 (57.1%)	3 (42.9%)	0	0.767
	Lower third	10 (100%)	3 (30%)	6 (60%)	1 (10%)	
	Upper–middle third	2 (100%)	1 (50%)	1 (50%)	0	
	Middle–lower third	4 (100%)	1 (25%)	2 (50%)	1 (25%)	
Tumor size	< 1/2 circumference	6 (100%)	2 (33.3%)	4 (66.7%)	0	0.341
	1/2 – 3/4 circumference	12 (100%)	6 (50%0	4 (33.3%)	2 (16.7%)	
	> 3/4 circumference	5 (100%)	1 (20%)	4 (80%)	0	
Tumor morphology	Fungating	9 (100%)	2 (22.2%)	7 (77.8%)	0	0.235
	Ulcerative	4 (100%)	1 (25%)	3 (75%)	0	
	Fungating–ulcerative	8 (100%)	4 (50%)	2 (25%)	2 (25%)	
	Fungating–infiltrative	1 (100%)	1 (100%)	0	0	
	Fungating, ulcerative, infiltrative	1 (100%)	1 (100%)	0	0	

Factor	Subgroup	n	Complete response (pCR)	Partial response	No response	p-value
T stage	T3	22 (100%)	9 (40.9%)	12 (54.5%)	1 (4.6%)	0.004
	T4	1 (100%)	0	0	1	
N stage	N0	2 (100%)	1 (50%)	1 (50%)	0	0.990
	N1	11 (100%)	4 (36.4%)	6 (54.5%)	1 (9,1%)	
	N2	10 (100%)	4 (40%)	5 (50%)	1 (10%)	

Univariate analysis of the 23 surgically treated patients showed: age (p = 0.487), history (p = 0.909), degree of dysphagia (p = 0.215), weight loss (p = 0.206), tumor location (p = 0.767), tumor size (p = 0.341), tumor morphology (p = 0.235), and N stage (p = 0.990) were not significantly associated with pCR response. When analyzing the degree of pathological regression, T stage showed a statistically significant difference (p = 0.004).

4. DISCUSSION

Among 36 patients with stage II, III esophageal cancer who received neoadjuvant concurrent chemoradiotherapy at Military Hospital 175, the mean age was 60.67 ± 7.79 years, with the ≥ 60-year group accounting for the majority (69.4%). This outcome is comparable to the study by Hong Yang, with a mean age of 60 years[4], and slightly higher than the study by Nguyen Thi Ha (55 ± 8 years)[9]. A shift in disease onset toward older age groups has also been reported in recent analyses of the global esophageal cancer burden, reflecting population aging[2]. Males accounted for 97.2%, similar to domestic studies by Nguyen Xuan Hoa (99.2%)[11] and Pham Quang Anh (97.1%)[8]. The proportion of patients with a history of tobacco smoking and/or alcohol consumption reached 97.2%, consistent with worldwide studies confirming that tobacco and alcohol are the two main risk factors for esophageal cancer — particularly squamous cell carcinoma[2]. This also explains why the proportion of squamous cell carcinoma in our study reached 100%, similar to the studies by Nguyen Thi Ha [9], Nguyen Thi Nhu An [7], and markedly higher than that of P. van Hagen (23%) [16], owing to differing epidemiological characteristics in Western countries where adenocarcinoma predominates [1].

Dysphagia was present in 100% of patients, predominantly Grade 2 (58.3%) and Grade 3 (36.1%); 100% of patients experienced weight loss. This reflects the typical presentation of stage II–III esophageal cancer, in which large tumors obstruct the esophageal lumen. The mean tumor length was 5.52 ± 1.18 cm, larger than in the study by P. van Hagen (4 cm) [16], and consistent with the characteristics of Vietnamese patients, who are often diagnosed late.

The majority of patients were at stage III (83.3%), with T3 accounting for 88.9%; comparable to the study by Tran Van Tien (stage III accounting for 84.1%) [14] and Hong Yang (83.9%) [5]. The distribution of tumor location was concentrated in the lower third (44.4%) and the middle third (25.0%) — the two locations suitable for curative esophagectomy under current guidelines [6].

4.2. Treatment efficacy

After chemoradiotherapy, the functional response rate reached 91.7% — a clinically very meaningful figure for patients, as dysphagia is a symptom that directly affects quality of life. The response rate per RECIST 1.1 reached 88.9%,

with a complete response (CR) rate of 13.9% and a partial response (PR) rate of 75.0%; only 8.3% of patients showed progression on CT. The CR rate was lower than that reported by Nguyen Thi Nhu An (37.5%)[7], Nguyen Thi Ha (22.7%)[9], and Tran Van Tien (25.7%)[10]; this may be explained by the fact that, after chemoradiotherapy, post-radiation fibrosis and inflammatory lesions make accurate imaging assessment difficult and dependent on the subjective experience of the radiologist.

After concurrent chemoradiotherapy, 23/36 patients underwent surgery (63.9%). This rate is lower than that of P. van Hagen (94%)[12] and Hong Yang (82.6%)[5], mainly because some patients had poor performance status, disease progression after chemoradiotherapy, or patient/family refusal of surgery. This is a common issue at treatment centers in Vietnam, reflecting the gap between clinical practice at tertiary referral hospitals and selective trial conditions, and indicating the need for careful pre-treatment counseling as well as strategies to optimize patient performance during the interval between chemoradiotherapy and surgery.

Notably, 3 of the 9 patients who declined surgery had achieved a complete radiological response, illustrating a recognized clinical dilemma in the "watch-and-wait" strategy for esophageal squamous cell carcinoma. However, given the known discordance between radiological CR and pathological CR — only 39.1% of our surgical cohort achieved pCR despite an 88.9% RECIST response rate (radiological CR: 13.9%) — close endoscopic and imaging surveillance is essential in patients who decline surgery after apparent complete response, to avoid missing residual or recurrent disease.

Among the 23 patients who underwent surgery, the R0 resection rate reached 95.7% — comparable to the studies by Pham Quang Anh (100%)[8], Hong Yang (98.4%)[5], and P. van Hagen (92%)[12]. The pCR rate in our study reached 39.1%, comparable to the studies by Nguyen Thi Ha (43.2%) [9] and Hong Yang (43.2%) [5], lower than the squamous cell carcinoma subgroup of P. van Hagen (49%) but markedly higher than P. van Hagen's overall pCR across both histological subgroups (29%) [4,12]. This outcome further confirms that the weekly Paclitaxel/Carboplatin regimen combined with radiotherapy 41.4 Gy/23 Fx is effective for esophageal squamous cell carcinoma — the subgroup that predominates in Vietnamese patients.

With a median follow-up of 23.06 months, the median overall survival (OS) was 47 months. The estimated overall survival rates at 12, 24, and 36 months were 96.8%, 93.2%, and 69.9% — favorable outcomes for a stage II, III esophageal cancer population. When compared with major international studies, our outcomes show notable similarity: the 10-year long-term update of the CROSS trial (median OS 49.4 months, 5-year OS rate 47%, 10-year 38%) [4] and the NEOCRTEC5010 trial (median OS 100.1 months, 3-year OS rate 69.1%) [5]. Nevertheless, in our study the median follow-up has only reached 23.06 months, so long-term survival outcomes (≥ 5 years) cannot yet be fully assessed; longer follow-up is needed to fully evaluate the long-term efficacy of the regimen at Military Hospital 175.

The median disease-free survival (DFS) was 24 months, with DFS rates at 12, 24, and 36 months of 79.2%, 48.4%, and 36.3%, respectively. This outcome confirms the major role of the nCRT regimen in improving survival prognosis. The 1-year DFS rate of nearly 80% indicates that the regimen provides good response and effective local and systemic disease control in the early period. However, the drop in DFS from the first year (79.2%) to the second year (48.4%) reflects the complex biological characteristics of esophageal cancer: recurrence or distant metastasis events typically cluster in the 12- to 24-month period after treatment — similar to domestic and international studies [4,5]. Analysis

from the NEOCRTEC5010 trial also emphasizes that the post-operative recurrence rate is high and the majority occurs within the first 2 years, with a 5-year survival rate in the recurrence group of only 17.8% compared with 89.2% in the non-recurrence group [13]. This is the practical basis for the recommendation of adjuvant nivolumab after surgery in patients who did not achieve pCR per the CheckMate 577 study, with the final update at ASCO 2025 continuing to confirm sustained DFS benefit and a trend toward improved OS [14]. Notably in our study, the group of patients who underwent surgery after chemoradiotherapy had a median OS of 51 months and a median DFS of 38 months, markedly longer than the non-surgical group (31 and 17 months), once again confirming the role of curative surgery after neoadjuvant chemoradiotherapy in improving treatment outcomes, especially when R0 and pCR are achieved. This superiority reaffirms the current gold standard: neoadjuvant chemoradiotherapy aimed at downstaging and increasing the R0 resection rate, with curative surgery being the key to providing the best chance of long-term survival.

4.3. Toxicity and factors associated with pCR response

Regarding toxicity, adverse events were mainly Grade 1–2 and related to the irradiated area: esophagitis 94.4%, dermatitis 86.1%, pneumonitis 69.4%. Hematologic toxicity included leukopenia 50.0% (only 2.8% Grade 3) and neutropenia 41.7%; no patient experienced Grade 4 toxicity or had to discontinue treatment because of toxicity. The mediastinal fistula rate was 2.8% (1/36) — within acceptable limits for the regimen. This toxicity profile is comparable to the report by Cloos-v. Balen M. et al. (2021) on 145 patients, with a ≥ Grade 3 acute toxicity rate of 25.5% 15, indicating that the Paclitaxel/Carboplatin + 41.4 Gy/23 Fx regimen is well tolerated and can be widely applied at units capable of delivering concurrent chemoradiotherapy.

Analysis of clinical and paraclinical factors associated with pCR response showed that no factor reached statistical significance in the binary pCR/non-pCR analysis ($p > 0.05$), possibly due to the limited sample size for analysis ($n = 23$). However, there was a trend toward better response in the group with earlier T stage, with a statistically significant difference ($p = 0.004$); nevertheless, as the T4 group in the surgical set included only 1 case, this outcome needs to be confirmed in a larger sample size.

5. CONCLUSION

From a study of 36 patients with stage II, III esophageal cancer who received neoadjuvant concurrent chemoradiotherapy with the weekly Paclitaxel/Carboplatin regimen combined with 41.4 Gy/23 Fx radiotherapy at Military Hospital 175, we draw the following conclusions:

1. Clinical and paraclinical characteristics: Mean age 60.67 ± 7.79 years; males accounted for 97.2%; 97.2% of patients had a history of smoking and/or alcohol consumption. 100% of patients had dysphagia (predominantly Grade 2) and 100% had weight loss. Histology was squamous cell carcinoma (100%); mean tumor length 5.52 ± 1.18 cm; T3 accounted for 88.9%, stage III for 83.3%.

2. Treatment efficacy: The functional response rate after chemoradiotherapy reached 91.7%; the response rate per RECIST 1.1 reached 88.9% (CR 13.9%, PR 75.0%). 63.9% of patients underwent surgery, with an R0 rate of 95.7% and a pCR rate of 39.1%. The median disease-free survival (DFS) was 24 months and the median overall survival (OS) was 47 months. Overall survival (OS) at 12, 24, and 36 months was 96.8%, 93.2%, and 69.9%, respectively; disease-free survival (DFS) at the same time points was 79.2%, 48.4%, and 36.3%, respectively. The surgical group had markedly longer median OS and DFS than the non-surgical group (51 vs. 31 months and 38 vs. 17 months). Toxicity was predominantly Grade 1–2, with no Grade 4 toxicity observed.

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