The ROYAL MARSDEN
NHS Foundation Trust

ICR The Institute of Cancer Research

Case Presentation: Gastroesophageal junctional adenocarcinoma

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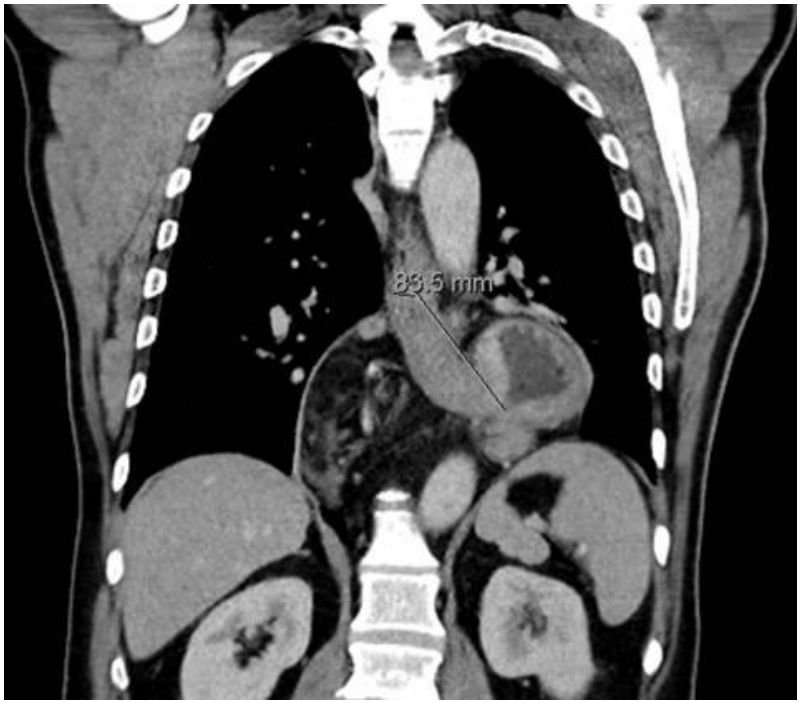
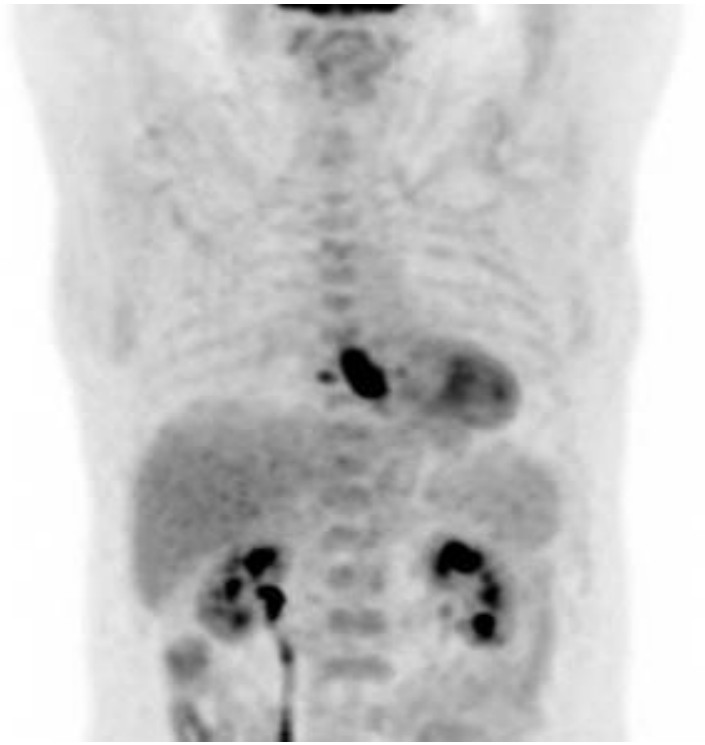
The ROYAL MARSDEN Cancer Charity

Case presentation – GEJ cancer

- 54 year old man presents with epigastric discomfort, dysphagia for 3 months and 5kg weight loss
- Endoscopy demonstrates bulky lesion at GEJ
- Biopsy consistent with moderately differentiated adenocarcinoma. HER-2 negative.
- Past medical history; smoker, hypertension
- ECOG PS = 1

Case presentation – GEJ cancer





- Bulky gastroesophageal junctional tumour
- T4N2 (possible left diaphragmatic crus invasion)

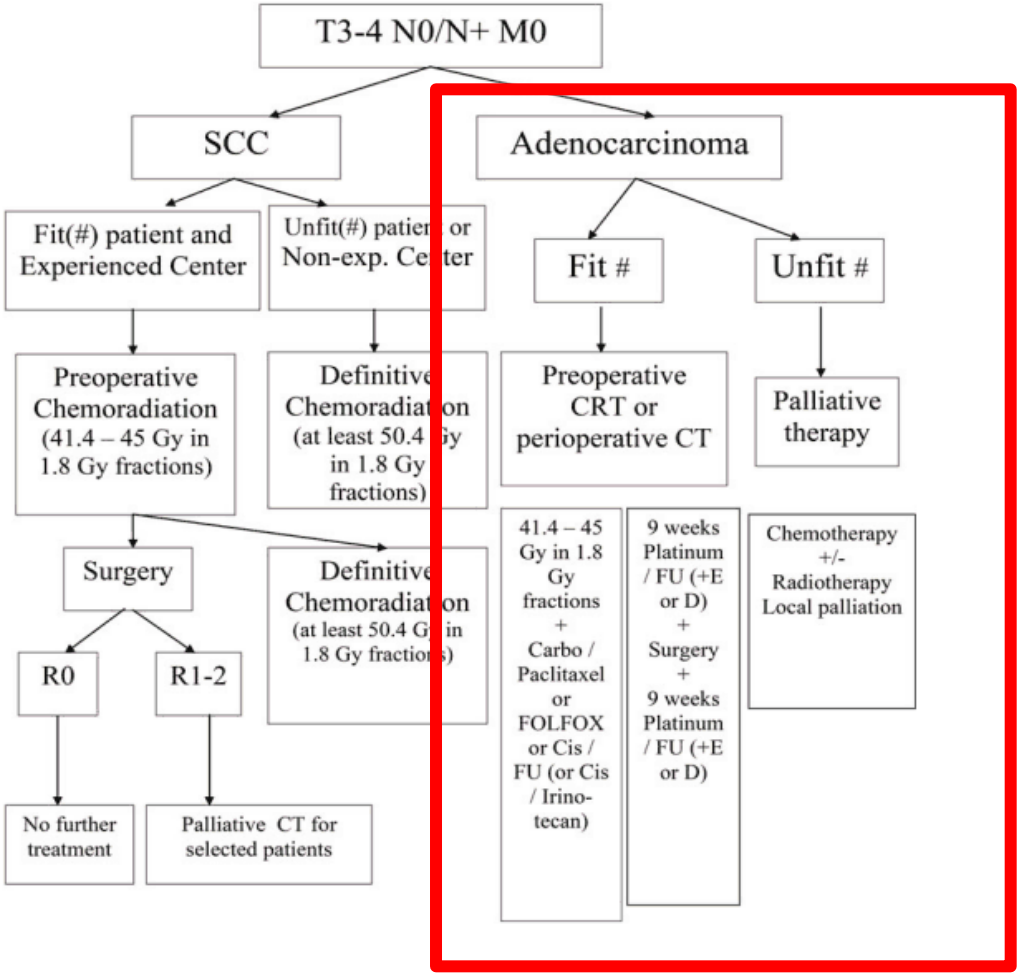
What did we do next?

- Surgery alone.
- Neoadjuvant chemoradiotherapy followed by surgery (CROSS)
- Peri-operative chemotherapy followed by surgery (MAGIC/FFCD)
- Surgery followed by chemoradiotherapy (INT 0116).
- Surgery followed by chemotherapy (CLASSIC).

What did we do next?

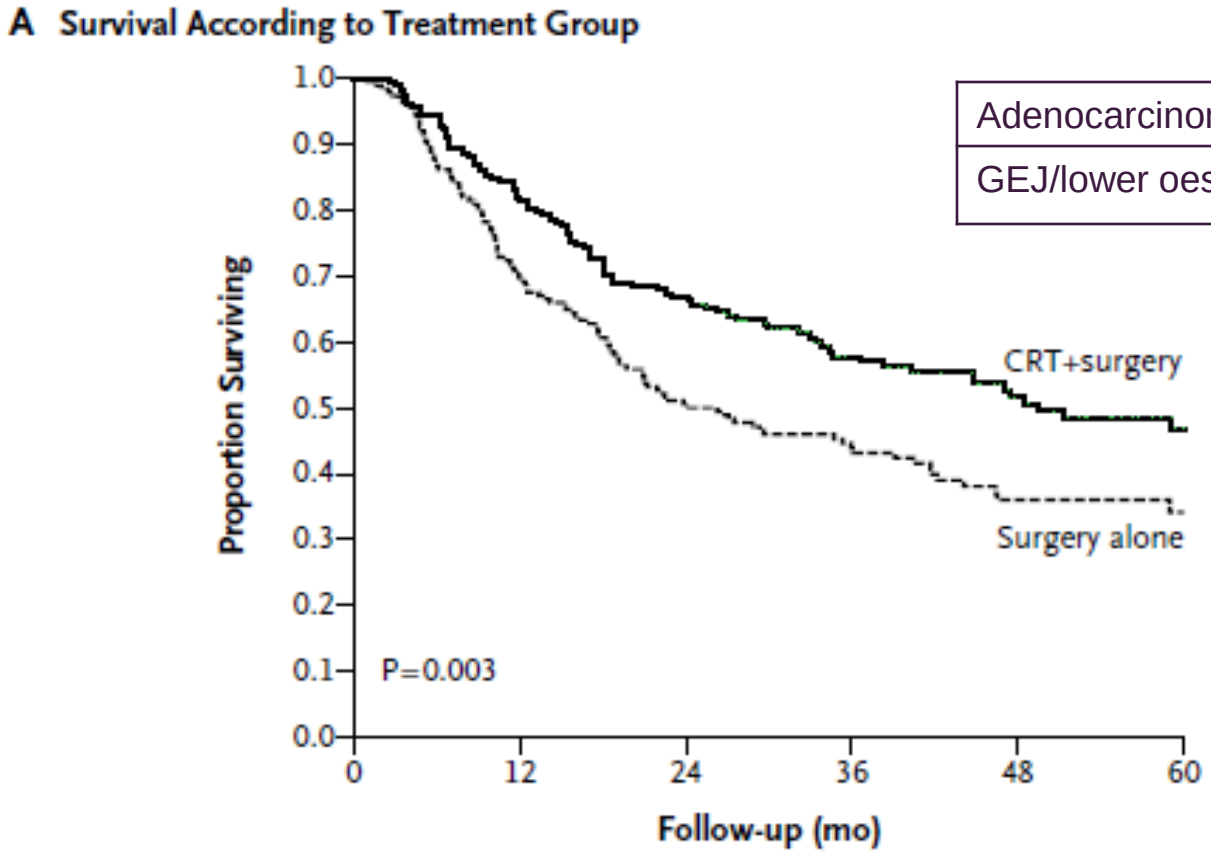
- Surgery alone. No, survival ~ 20% surgery alone
- Neoadjuvant chemoradiotherapy followed by surgery (CROSS)
- Peri-operative chemotherapy followed by surgery (MAGIC/FFCD)
- Surgery followed by chemoradiotherapy (INT 0116). No, aim is R0 resection
- Surgery followed by chemotherapy (CLASSIC). No, different patient population

ESMO Guidelines – Locally advanced GEJ cancer



Ann Oncol 2013; 24 (Suppl 6): vi51-vi56.

Should we consider pre-operative chemoradiotherapy for this patient? CROSS



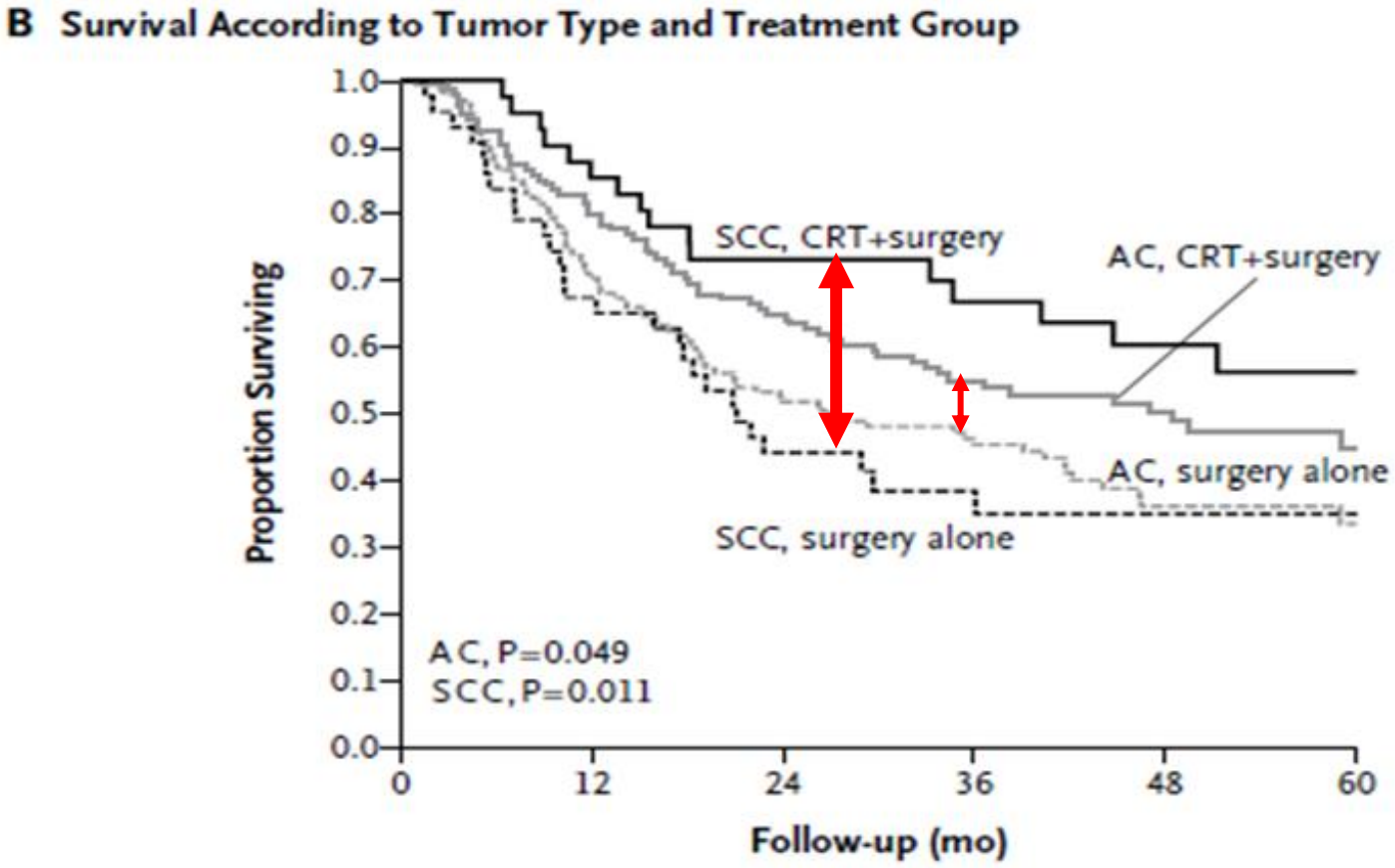
Adenocarcinoma	75%
GEJ/lower oesophageal	~80%

Survival benefit for pre-operative CRT overall

Median OS was 49.4 months with CRT+ surgery vs 24 months for surgery alone (p = 0.003) ⇒ **This is an effective treatment option**

Van Hagen et al, NEJM 366(22): 2074-2084

Should we consider pre-operative chemoradiotherapy for this patient? CROSS

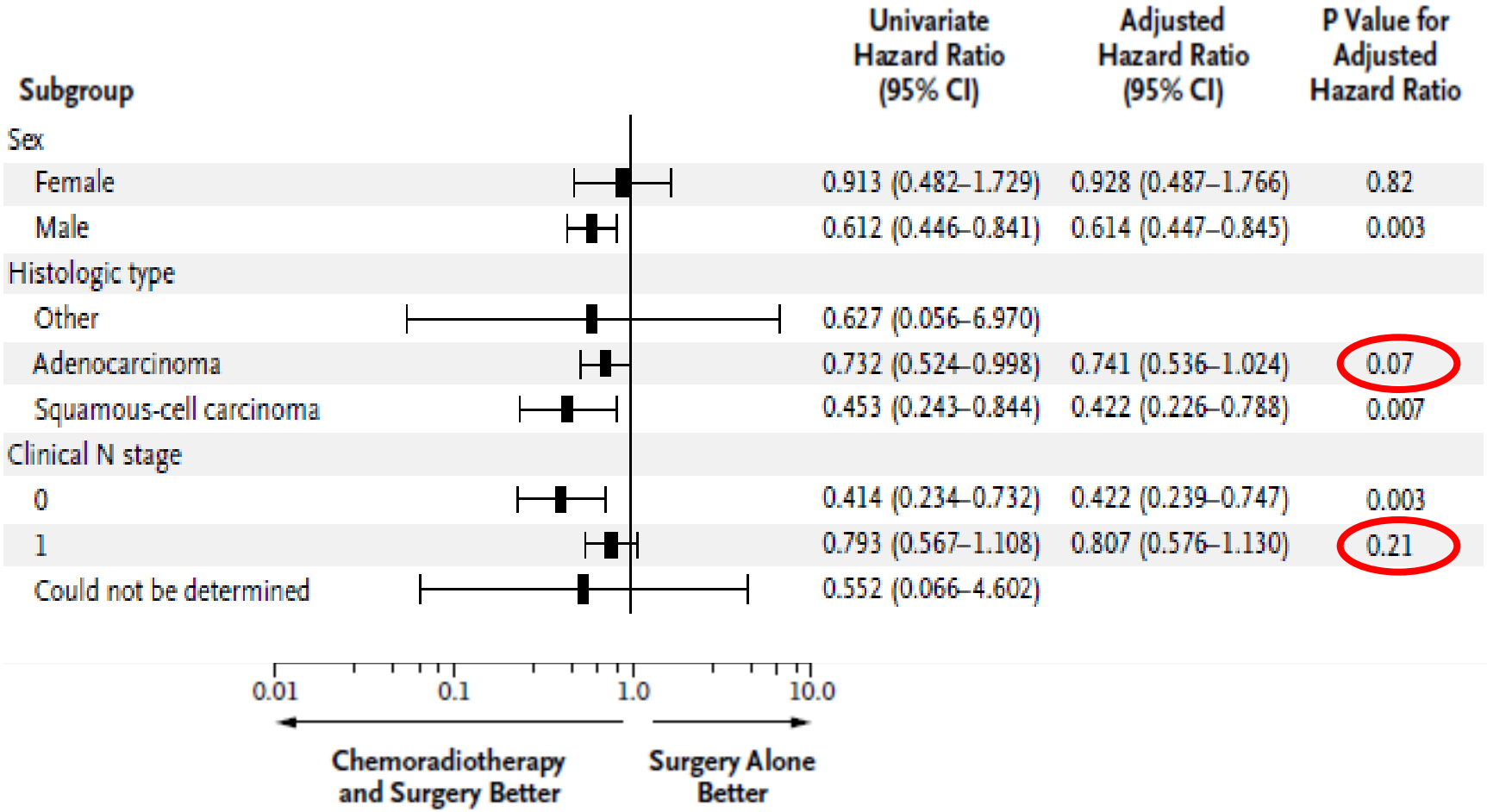


⇒ **However, the survival benefit is greater in SCC**

Van Hagen et al, NEJM 366(22): 2074-2084

Should we consider pre-operative chemoradiotherapy for this patient? CROSS

Which patients benefit most from neoadjuvant CRT ?

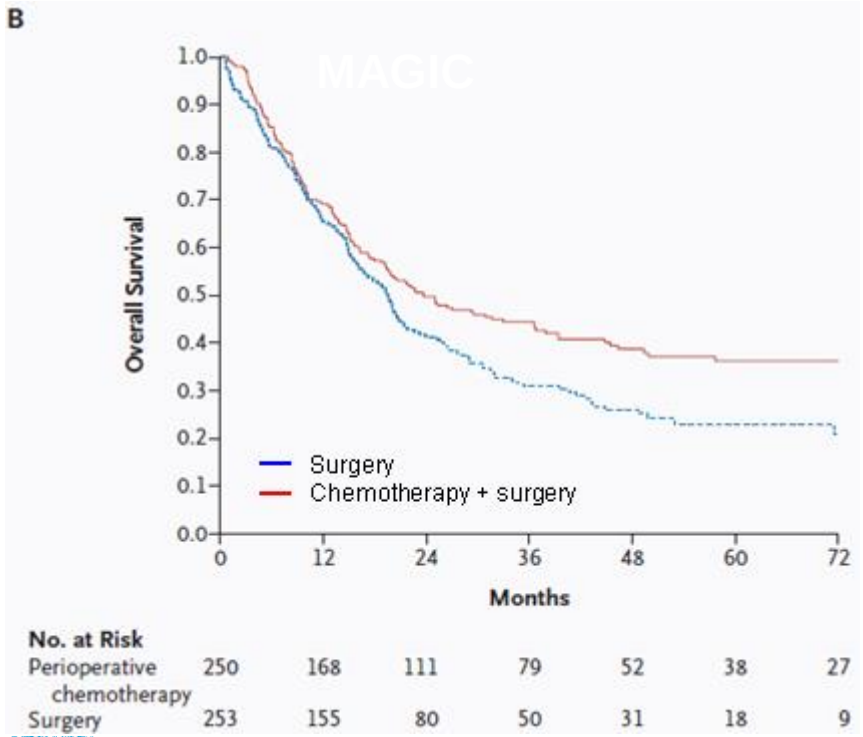


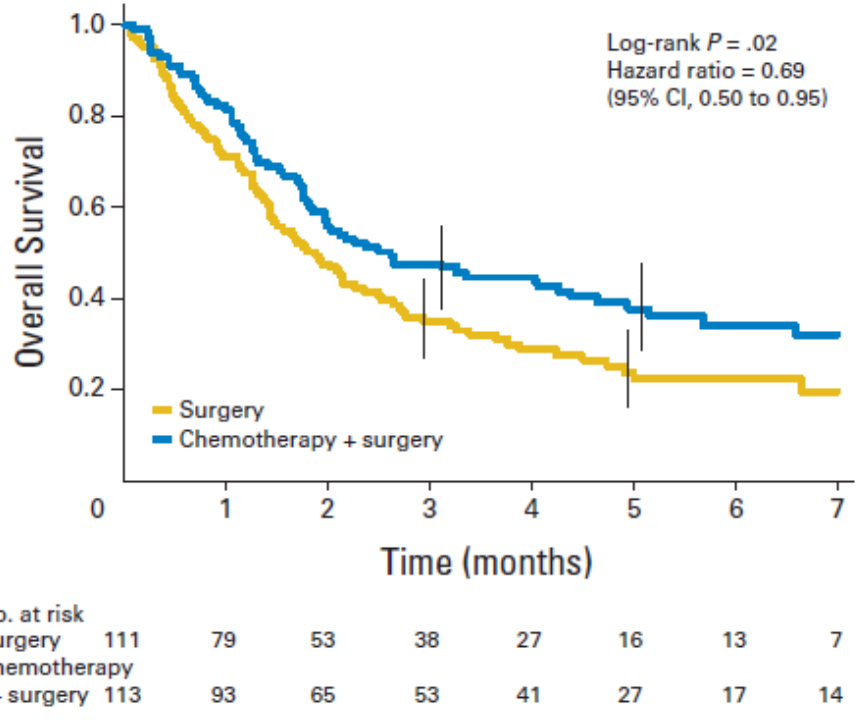
Subgroup	Univariate Hazard Ratio (95% CI)	Adjusted Hazard Ratio (95% CI)	P Value for Adjusted Hazard Ratio
Sex			
Female	0.913 (0.482–1.729)	0.928 (0.487–1.766)	0.82
Male	0.612 (0.446–0.841)	0.614 (0.447–0.845)	0.003
Histologic type			
Other	0.627 (0.056–6.970)		
Adenocarcinoma	0.732 (0.524–0.998)	0.741 (0.536–1.024)	0.07
Squamous-cell carcinoma	0.453 (0.243–0.844)	0.422 (0.226–0.788)	0.007
Clinical N stage			
0	0.414 (0.234–0.732)	0.422 (0.239–0.747)	0.003
1	0.793 (0.567–1.108)	0.807 (0.576–1.130)	0.21
Could not be determined	0.552 (0.066–4.602)		

Van Hagen et al, NEJM 366(22): 2074-2084

Should we consider peri-operative chemotherapy for this patient? MAGIC & FFCD

- MAGIC & FFCD trials recruited >700 patients in total established peri-operative chemotherapy as an standard in OG cancer
- Improves OS / PFS & decreases risk of death by 25%

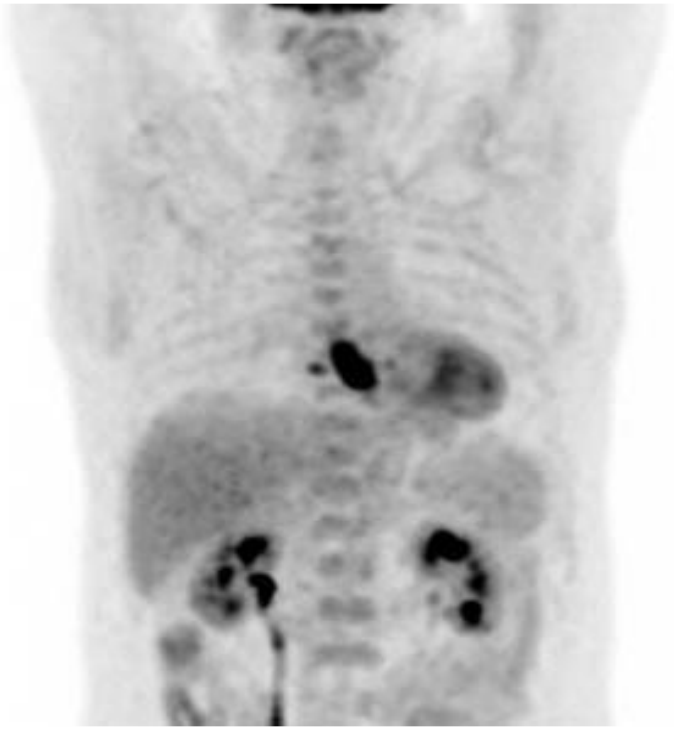


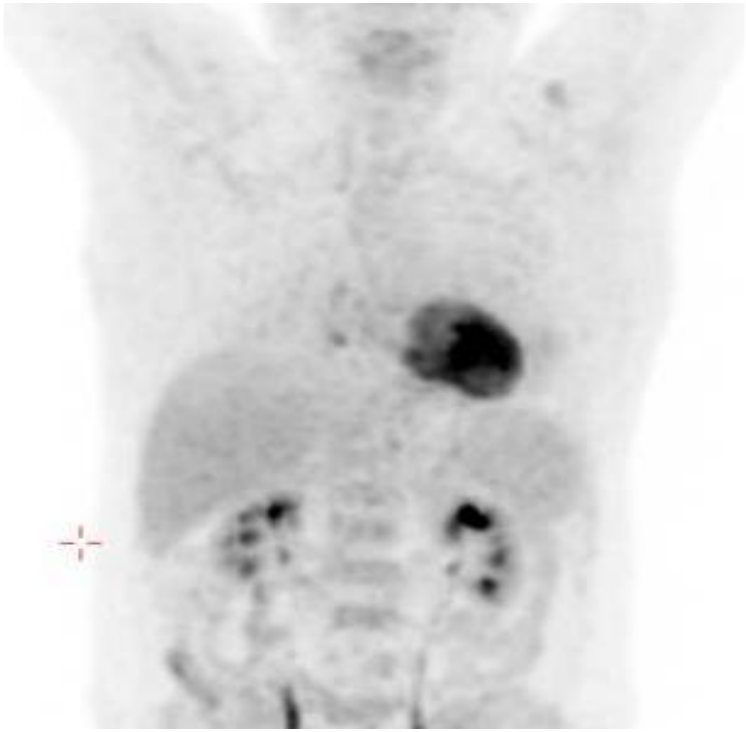


Cunningham et al, NEJM 355(1): 11-20. Ychou et al, JCO, 29(13): 1715-1721

Case presentation

- Following MDT discussion patient received peri-operative ECX chemotherapy





Following 3 cycles of ECX

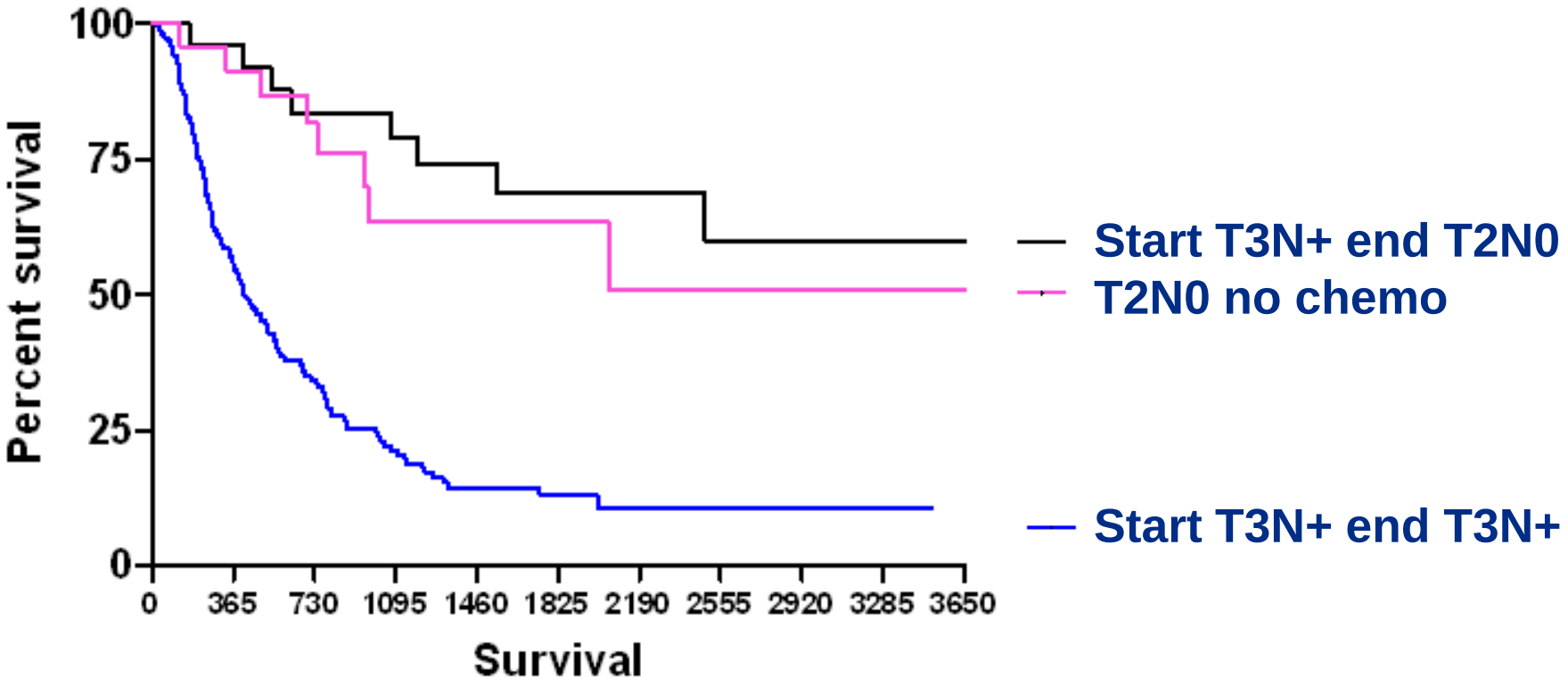
Case presentation

- The patient proceeded to oesophago-gastrectomy
- Histology reveals a T2N0 (0/26 LN) tumour with negative margins

What does this mean for the patient?

Survival is determined by tumour stage after neoadjuvant chemotherapy

- 665 consecutive resections at RMH and GSTT 2000-2010
- Comparison of pre-operative radiological stage to post-operative pathological stage



Slide courtesy of Mr W Allum (Royal Marsden) and Prof R Mason and Mr A Davies (Guys and St Thomas')

Summary

- 54 year old male
- Bulky gastroesophageal junction adenocarcinoma
- No metastatic disease
- Good PS

- MDT discussion
- Peri-operative chemotherapy with ECX
- Good metabolic response on PET pre-operatively
- Evidence of downstaging at surgery

Issues for discussion

1. Optimal perioperative therapy for GEJ tumours (neo-adjuvant CRT (CROSS) vs perioperative chemotherapy (MAGIC) vs others).

2. Which patients derive the most benefit from neoadjuvant chemoradiotherapy or peri-oprative chemotherapy?

3. Is there a role for PET directed therapy?

4. What should we do if there is no response to pre-operative chemotherapy?

THANK YOU….

QUESTIONS?