MADRID 2017 ESMO congress

ESMO Clinical Practice Guidelines

Resectable locally advanced oesophagogastric cancer

Clinical Case Presentation

Elizabeth Smyth

Royal Marsden Hospital and Institute of Cancer Research

Sutton, UK

DISCLOSURES

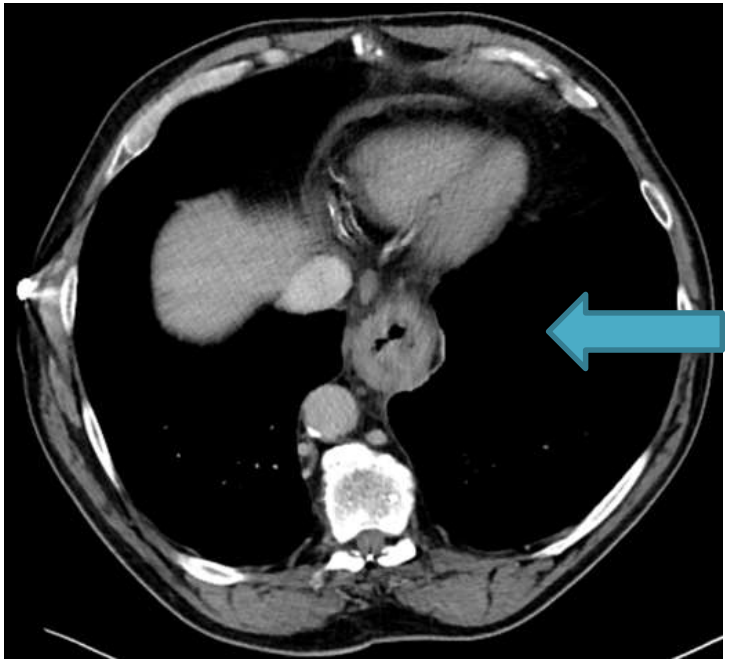
Honoraria for advisory role to Bristol-Meier Squibb, Five Prime Therapeutics and Gritstone Oncology

Patient history

- **Presentation:** 69 year-old male with 3 month history of progressive dysphagia and 7 kg weight loss, BMI 31, no history of reflux
- **Medical history**: Hypertension and past smoker (20 pack year history), good general health, ECOG PS=1
- **Gastroscopy:** circumferential tumour in lower oesophagus extending into upper part of gastroesophageal junction (Siewert I)
- **Histology**: moderately differentiated adenocarcinoma, HER2 positive

BMI, body mass index; ECOG, Eastern Cooperative Oncology Group; HER2, human epidermal growth factor receptor 2

Staging investigations: CT



- CT demonstrates:
  - Type I gastroesophageal junctional cancer
  - Possible infiltration of left pleura
  - Lymph nodes in peri-oesophageal tissue
- CT staging: cT4N2M0

CT, computed tomography; TNM, tumour, node and metastasis

Investigations

Q1. Which investigations are recommended prior to making a treatment decision?

1. Laparoscopy
2. Endoscopic ultrasound (EUS)
3. PET
4. All of the above

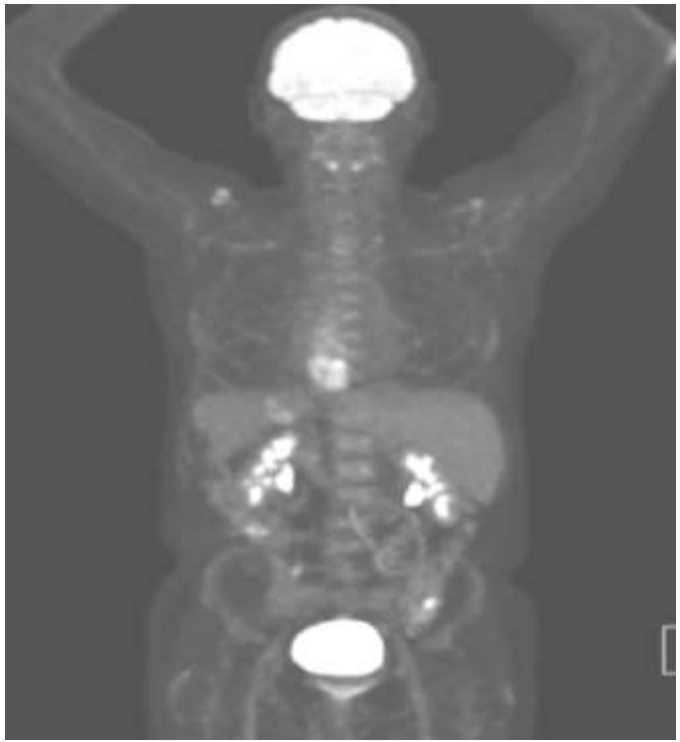
(one answer)

Investigations

Q1. Which investigations are recommended prior to making a treatment decision?

1. Laparoscopy *(optional, if tumour infiltrates the cardia)*
2. Endoscopic ultrasound *(advisable)*
3. PET *(if available, will detect metastases in up to 15%)*
4. All of the above ✓

Staging investigations



- PET demonstrates
  - 6cm thickening of the oesophagus
  - No evidence of metastatic disease
- EUS – cT4aN2

EUS, endoscopic ultrasound; PET, positron-emission tomography; TN, tumour, node

Treatment

Q2. What is the current recommended treatment approach?

1. Surgery alone
2. Surgery then adjuvant chemotherapy or chemoradiotherapy
3. Perioperative chemotherapy
4. Perioperative chemotherapy + trastuzumab
5. Neoadjuvant chemoradiotherapy
6. Definitive chemoradiotherapy
7. Either perioperative chemotherapy or neoadjuvant chemoradiotherapy

(one answer)

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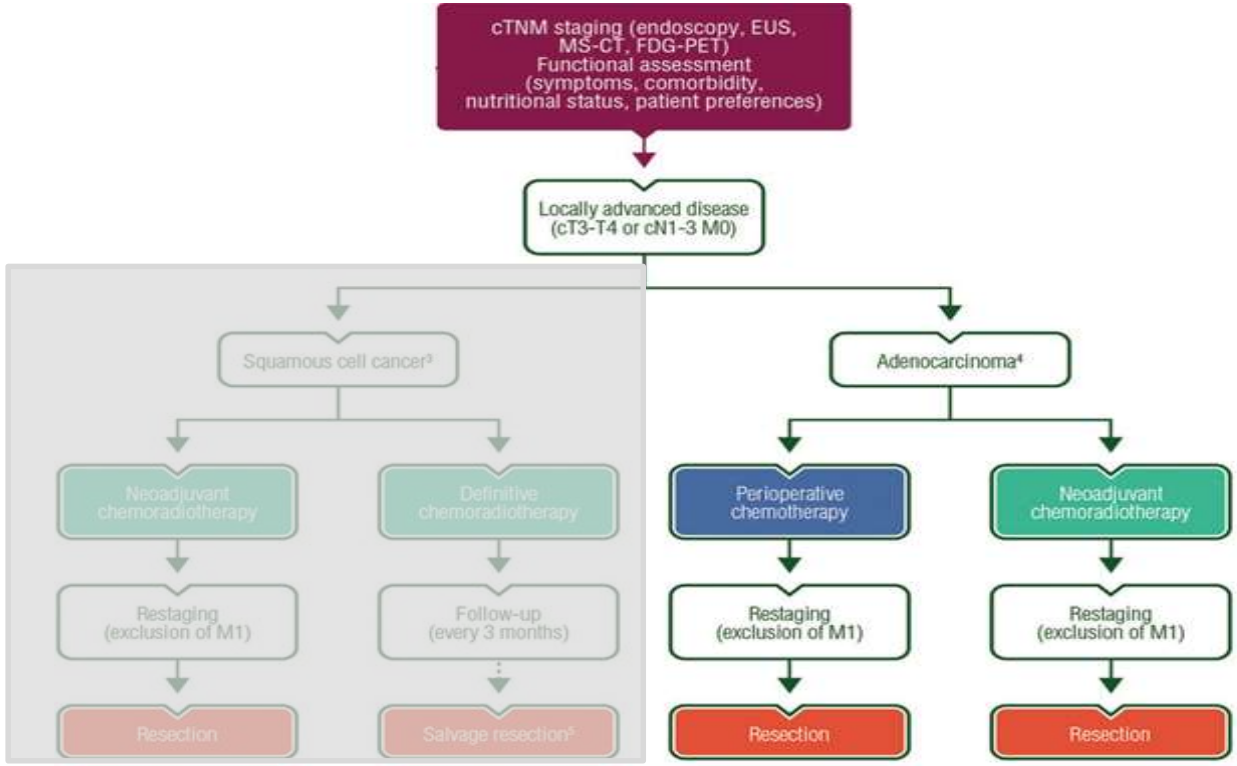
Treatment

Q2. What is the current recommended treatment approach?

1. Surgery alone
2. Surgery then adjuvant chemotherapy or chemoradiotherapy
3. Perioperative chemotherapy plus surgery
4. Perioperative chemotherapy + trastuzumab
5. Neoadjuvant chemoradiotherapy (CRT) then surgery
6. Definitive chemoradiotherapy
7. Either perioperative chemotherapy or neoadjuvant chemoradiotherapy ✓

ESMO Guidelines



EUS, endoscopic ultrasound; FDG-PET, fluorodeoxy glucose-positron-emission tomography; MS-CT, multiple-slice helical computed tomography; TNM, tumour, node and metastasis

ESMO Guidelines

Neoadjuvant chemoradiotherapy and perioperative chemotherapy are both validated treatment options for gastroesophageal adenocarcinoma

Neoadjuvant CRT (CROSS)	• 5 year OS in CROSS (ADC+SCC) was 47% versus 33% (CRT versus surgery arms) • Updated median OS for adenocarcinoma patients in CROSS was 43.2 months (24·9–61·4) versus 27·1 months (13·0-41·2) in the surgery alone arm (Shapiro 2015)
Perioperative chemotherapy (FLOT/FFCD/MAGIC)	• 5 year survival in MAGIC was 36% versus 23% (chemotherapy versus surgery arms); in FLOT4 predicted 5 years OS for FLOT arm was 45% (Al-Batran, ASCO 2017) • Median overall survival for patients treated with perioperative FLOT was 50 months (38-na)

ADC, adenocarcinoma; CRT, chemoradiotherapy; OS, overall survival; SCC, squamous cell carcinoma

Key recommendations

- MDT discussion is mandatory
  - Upfront interdisciplinary planning of treatment
  - Consideration of performance status, co-morbidities
  - Correct nutritional status; jejunostomy is preferred to stent

- Surgery
  - High volume centre

MDT, multidisciplinary team

Treatment

- Treated with 3 cycles of ECX chemotherapy
- One episode of febrile neutropenia
- Post treatment CT: response, tumour now T3
- Lymph nodes reduced in size: staging cT3N2M0
- Surgical margin felt not at risk

CT, chemotherapy; ECX, epirubicin, cisplatin and capecitabine; TNM, tumour, node and metastasis

Treatment

Q3. What is the current recommended treatment approach?

1. Another three cycles of pre-operative ECX?
2. Switch to preoperative FLOT chemotherapy?
3. Switch to pre-operative chemoradiation?
4. Proceed with radical transthoracic Ivor-Lewis-oesophago-gastrectomy?
5. Watch-and-wait, re-assessment after three months?

(one answer)

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Treatment

Q3. What is the current recommended treatment approach?

1. Another three cycles of pre-operative ECX?
2. Switch to preoperative FLOT chemotherapy?
3. Switch to pre-operative chemoradiation?
4. Proceed with radical transthoracic Ivor-Lewis-oesophago-gastrectomy? ✓
5. Watch-and-wait, re-assessment after three months?

Treatment

- MDT decision was proceed to surgery
- Ivor Lewis oesophagogastrectomy performed
  - Good recovery post-operatively, weight stabilised
- Pathology showed UICC/AJCC
  - T3 tumour, 2/26 lymph nodes positive
  - R0 resection (negative margins)
  - Tumour regression: Mandard grade 3

AJCC, American Joint Committee on Cancer; MDT, multidisciplinary team; UICC, Union for International Cancer Control

Post-operative treatment

Q4. What is the recommended treatment now?

1. No further treatment
2. Continue same chemotherapy as pre-operatively
3. Switch chemotherapy
4. Adjuvant chemoradiotherapy

(one answer)

Post-operative treatment

Q4. What is the recommended treatment now?

1. No further treatment
2. Continue same chemotherapy as pre-operatively *(if patient is fit for this)* ✓
3. Switch chemotherapy
4. Adjuvant chemoradiotherapy