Neo-adjuvant/Adjuvant treatment in gastric cancer: What is optimal approach in 2017? Case based discussions

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Disclosure

• Advisory Board: Sanofi Oncology, Eli-Lilly, Bristol Meyers Squibb, MSD, Bayer, Roche, Five Prime Therapeutics

• Research funding: Janssen-Cilag, Sanofi Oncology, Merck-Serono, Novartis

• Honorarium: Taiho, Pfizer, Amgen, Eli-Lilly
Case history

- 75 years old female
- Mar 2017 presented with 4/52 history of worsening dysphagia; feeling food stuck in upper chest; able to tolerate soft diet
- Weight loss 1 stone (6.35kg) in last 4 weeks
- ECOG PS = 1
- PMH: bilateral cataract operations; eczema
- Medication: Betamethasone cream
- SH: Lives alone independently, widowed; ex-smoker stopped 9 years ago; drinks 21 units of alcohol per week
Case history

- OGD tumour seen between 33-35cm occupying 25% of circumference with no obstruction
- Histology → moderately to poorly differentiated adenocarcinoma, intestinal type, HER2 negative
- CT → T2N1M0 type II OGJ adenocarcinoma confirmed on EUS
- PET/CT → M0
- Laparoscopy → no peritoneal metastases
Staging CT and PET T2N1M0
What treatment would you recommend?

1) Surgery alone
2) Surgery followed by adjuvant chemotherapy
3) Neoadjuvant chemoradiation followed by surgery
4) Pre- and post-operative chemotherapy
5) Surgery followed by adjuvant chemoradiation
6) Neoadjuvant chemotherapy followed by surgery
7) Others
Multimodality treatment of OGJ/ gastric adenocarcinoma

Pre-operative

- Pre-operative chemoradiation
  - Surgery

- Pre-operative chemotherapy
  - Surgery

- Pre-operative chemotherapy
  - Post-operative chemotherapy

Post-operative

- Surgery
  - Post-operative chemotherapy
  - Post-operative Chemoradiation

- Surgery
  - Post-operative chemotherapy

- Surgery
Multimodality treatment of OGJ/ gastric adenocarcinoma

Pre-operative

Post-operative

Surgery

Post-operative chemotherapy
Adjuvant therapy in gastric cancer

**ACTS-GC**
- n=529
- S-1
- Observation
- n=530

**CLASSIC**
- n=520
- CAPOX
- Observation
- n=515

**Survival Analysis**
- **HR**: 0.66; 95% CI: 0.51-0.85
- p=0.0015

---

ITACA-S

Overall survival

HR: 0.98; 95% CI: 0.82-1.18; p=0.865

5-yr OS: 51% for sequential arm
50.6% for 5FU/LV arm

n= 538
5-FU/LV × 9 cycles

R

n= 562
FOLFIRI × 4 cycles
Docetaxel/ cisplatin × 2 cycles

Bajetta et al Ann Oncol 2014
Multimodality treatment of OGJ/ gastric adenocarcinoma

Pre-operative

Post-operative

Surgery

Post-operative chemoradiation
Post-operative chemoradiation in resected OGJ/gastric cancer

Intergroup 0116

CALGB 80101

1.0

ECF

5FU

P = .0046

1Smalley et al J Clin Oncol 2012; 2Fuchs et al ASCO 2011
CRITICS survival outcome

Patients with stage Ib-IVa adenocarcinoma of OGJ and stomach

Overall survival

Post op CRT
RT 45Gy in 25#
Cisplatin weekly
Capecitabine daily

Verheij et al ASCO 2016
Multimodality treatment of OGJ/ gastric adenocarcinoma

Pre-operative

- Pre-operative chemoradiation

- Surgery

Post-operative
CROSS Pre-op CRT

Patients with carcinoma of oesophagus and OGJ
24% OGJ tumours
75% adeno

n=178
Paclitaxel/carboplatin + RT
Surgery

n=188
Surgery

Shapiro et al Lancet Oncol 2015
Multimodality treatment of OGJ/ gastric adenocarcinoma

Pre-operative

- Pre-operative chemotherapy
  - Surgery
  - Post-operative chemotherapy

Post-operative
Peri-operative chemotherapy

**MAGIC**

HR = 0.75; 95% CI: 0.60–0.93
p = 0.009

CSC = peri-operative ECF; S = surgery alone

**FNLCC ACCORD 07-FFCD 9703 trial**

Log-rank p=0.02
HR = 0.69
(95% CI, 0.50 to 0.95)

Case history

- 75 year old female
- PS=1
- T2N1M0 type II OGJ cancer
- Discussed at the MDT meeting
- Peri-operative chemotherapy to be offered
Which peri-operative chemotherapy would you recommend?

1) ECF/ECX
2) CF/CX
3) FLOT
The Royal Marsden ST03 trial design

- Primary endpoint: OS
- Target recruitment: 1,100 patients (80% power to detect 10% increase in 5-year survival from 40% to 50%)

ECX = epirubicin, cisplatin, capecitabine

Cunningham et al. Lancet Oncology 2017
STO3 survival

- **508 deaths** (248 ECX, 260 ECX+B) have been observed
  - Median follow-up is 33 months in both arms

<table>
<thead>
<tr>
<th>Overall survival</th>
<th>ECX</th>
<th>33.97 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ECX+B</td>
<td>34.46 months</td>
</tr>
<tr>
<td>Hazard Ratio</td>
<td>1.09</td>
<td>(95% CI 0.91 to 1.29)</td>
</tr>
<tr>
<td>Log-rank p-value</td>
<td>0.36</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-year overall survival (95% CI)</th>
<th>ECX</th>
<th>50.3% (45.5% to 54.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECX+B</td>
<td>48.1% (43.2% to 52.7%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary outcomes</th>
<th>PFS</th>
<th>HR=1.05 p=0.56</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DFS</td>
<td>HR=1.04 p=0.62</td>
</tr>
</tbody>
</table>

Cunningham et al Lancet Oncology 2017
Survival vs. MAGIC

Overall survival in ST03 compared with chemotherapy plus surgery (CSC) arm in MAGIC

3 year survival (95% CI)

<table>
<thead>
<tr>
<th></th>
<th>ST03 ECX</th>
<th>ST03 ECX+B</th>
<th>MAGIC CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>48.9% (43.6% to 53.8%)</td>
<td>47.6% (42.3% to 52.7%)</td>
<td>44.4% (38.0% to 50.7%)</td>
</tr>
</tbody>
</table>

Cunningham et al ECC 2015
Primary endpoint Phase II (n=300): rate of complete pathological remission (pCR)
Primary endpoint for phase III (n=714): OS, HR 0.76, power 80%, two sided p<0.05

ECC/F = epirubicin, cisplatin, capecitabine/ 5-FU every 3 weeks
FLOT = Docetaxel, oxaliplatin, 5-FU every 2 weeks

Al-Batran et al Lancet Oncol 2016; ASCO 2017
### FLOT4: Progression-Free Survival

**Survival Probability**

<table>
<thead>
<tr>
<th>Progression-free survival (months)</th>
<th>ECF/ECX</th>
<th>FLOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Logrank**

- Censored: Logrank p=0.0036

**HR**

- 0.75 [0.62-0.91]

- p=0.004 (log rank)

**PFS rate**

<table>
<thead>
<tr>
<th></th>
<th>ECF/ECX</th>
<th>FLOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2y</td>
<td>43%</td>
<td>53%</td>
</tr>
<tr>
<td>3y</td>
<td>37%</td>
<td>46%</td>
</tr>
<tr>
<td>5y*</td>
<td>31%</td>
<td>41%</td>
</tr>
</tbody>
</table>

*projected PFS rates

**Arm (as randomized) | ECF/ECX | FLOT**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ECF/ECX</td>
<td>300</td>
<td>215</td>
</tr>
<tr>
<td></td>
<td>145</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>FLOT</td>
<td>356</td>
<td>241</td>
</tr>
<tr>
<td></td>
<td>175</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>66</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**mPFS**

- 18 months [15-22]
- 30 months [21-41]

Al-Batran et al ASCO 2017
FLOT4: Overall Survival

<table>
<thead>
<tr>
<th></th>
<th>ECF/ECX</th>
<th>FLOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>mOS</td>
<td>35 months [27-46]</td>
<td>50 months [38-na]</td>
</tr>
<tr>
<td>HR</td>
<td>0.77 [0.63 - 0.94]</td>
<td>p=0.012 (log rank)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS rate*</th>
<th>ECF/ECX</th>
<th>FLOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2y</td>
<td>59%</td>
<td>68%</td>
</tr>
<tr>
<td>3y</td>
<td>48%</td>
<td>57%</td>
</tr>
<tr>
<td>5y</td>
<td>36%</td>
<td>45%</td>
</tr>
</tbody>
</table>

*projected OS rates

Al-Batran et al ASCO 2017
# Chemo Related Toxicity

<table>
<thead>
<tr>
<th>Grade 3-4 &gt;5%</th>
<th>ECF/ECX (N=354)</th>
<th>FLOT (N=354)</th>
<th>P-value (Chi-Square)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>13 (4%)</td>
<td>34 (10%)</td>
<td>0.002</td>
</tr>
<tr>
<td>Vomiting</td>
<td>27 (8%)</td>
<td>7 (2%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nausea</td>
<td>55 (16%)</td>
<td>26 (7%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Fatigue</td>
<td>38 (11%)</td>
<td>25 (7%)</td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td>30 (9%)</td>
<td>63 (18%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>75 (21%)</td>
<td>94 (27%)</td>
<td></td>
</tr>
<tr>
<td>Neutropenia</td>
<td>139 (39%)</td>
<td>181 (51%)</td>
<td>0.002</td>
</tr>
<tr>
<td>Sensory</td>
<td>7 (2%)</td>
<td>24 (7%)</td>
<td>0.002</td>
</tr>
<tr>
<td>Thromboembolic</td>
<td>22 (6%)</td>
<td>9 (3%)</td>
<td>0.03</td>
</tr>
<tr>
<td>Anemia</td>
<td>20 (6%)</td>
<td>9 (3%)</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Al-Batran et al ASCO 2017
Can we predict better who is going to benefit from which (neo)adjuvant therapy?
MUNICON

T3 or T4 adenocarcinoma of type 1 and 2 OGJ
Received Cisplatin/5-FU ± paclitaxel
Oxaliplatin instead of cisplatin if GFR <60ml/kg/min

Metabolic responders
n=54

Chemotherapy for 12 weeks

PET Day 0
Chemotherapy
Platinum/5-FU± Paclitaxel

PET Day 14

Metabolic non-responders
n=56

Surgery

Metabolic response defined as:
↓ of ≥35% tumour glucose SUV
Primary endpoint: median overall survival

Lordick et al Lancet Oncology 2007
Event-free and overall survival

Event free survival

Overall survival

Lordick et al Lancet Oncology 2007
MUNICON II

T3 or T4 adenocarcinoma of type 1 and 2 OGJ
Received Cisplatin/5-FU ± paclitaxel
Oxaliplatin instead of cisplatin if GFR <60ml/kg/min

PET Day 0
Chemotherapy Platinum/5-FU ± Paclitaxel

PET Day 14
Chemotherapy for 12 weeks
ChemoRT C or F + 32Gy in 20#

Chemotherapy for 12 weeks → Surgery

Metabolic responders
n=33

Metabolic non-responders
n=23

Metabolic response defined as:
↓ of ≥35% tumour glucose SUV
Primary endpoint: R0 resection rate

Time to progression and overall survival

Time to progression

Overall survival

Australisan AGITG DOCTOR randomised trial

T2 or more, T1N+ or poorly differentiated adenocarcinoma of oesophagus/ OGJ (type 1 and II)
Received Pre-operative Cisplatin/5-FU

Metabolic responders
n=45

Metabolic responders defined as:
↓ of ≥35% tumour glucose SUV

Primary endpoint: major histological response (<10% residual viable primary tumour) to the neoadjuvant therapy regimen

Continue CF

Surgery

PET Day 0
Chemotherapy Cisplatin/5-FU

PET Day 15

Metabolic non-responders
n=77

DCF
n=31

DCF/RT
45Gy in 25#

n=35

Surgery

Barbour et al ESMO 2016
## Australisan AGITG DOCTOR randomised trial

<table>
<thead>
<tr>
<th>Metabolic responder (↓FDG uptake &gt;35%)</th>
<th>Metabolic non-responder (↓FDG uptake ≤35%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>DCF</td>
</tr>
<tr>
<td>45</td>
<td>31</td>
</tr>
</tbody>
</table>

### Primary endpoint

**Major histopathological response**

- **<10% residual tumour**
  - Metabolic responder: 3/45 (7%)
  - Metabolic non-responder: 6/31 (19%)
  - Overall: 22/35 (63%)

- **10-50% residual tumour**
  - Metabolic responder: 11%
  - Metabolic non-responder: 21%
  - Overall: 21%

- **>50% residual tumour**
  - Metabolic responder: 82%
  - Metabolic non-responder: 58%
  - Overall: 12%

- **R0 resection**
  - Metabolic responder: 69%
  - Metabolic non-responder: 64%
  - Overall: 94%

Barbour et al ESMO 2016
**CALGB 80803 Trial Schema**

**T3/4 or N+ Esophageal/GEJ Adenoca PET Scan pre-treatment**

- **Induction Chemo:** modified FOLFOX6 days 1,15, 29
- **PET Scan day 36-42**
- **PET responders:** ≥ 35% decrease in SUV: continue initial chemo + concurrent RT (50.4 Gy in 28 fx)
- **PET non-responders:** < 35% decrease in SUV: cross-over to alternative chemo + concurrent RT (50.4 Gy in 28 fx)

**Surgical resection 6 weeks post-RT**

**Companion Studies**
- Quality of life
- Molecular markers of response

Goodman et al ASCO GI 2017
pCR Rates

**Induction**
- mFOLFOX n=129
  - **PET Responder**
    - 73/129 (57%)
    - **Concurrent FOLFOX**
    - **Evaluable**
    - pCR: 24/64 (37.5%)
  - **PET Non-Responder**
    - 39/129 (30%)
    - **Concurrent Carbo/Taxol**
    - **Evaluable**
    - pCR: 7/37 (19.0%)

**Induction**
- Carbo/Taxol n=128
  - **PET Responder**
    - 64/128 (50%)
    - **Concurrent Carbo/Taxol**
    - **Evaluable**
    - pCR: 7/56 (12.5%)
  - **PET Non-Responder**
    - 49/128 (38%)
    - **Concurrent FOLFOX**
    - **Evaluable**
    - pCR: 7/41* (17.0%)

*One ypT0N1 excluded

**Efficacy criteria met for both induction arms**

Goodman et al ASCO GI 2017
THE ROYAL MARSDEN

Oncogenes
- Amplification – FISH/CISH
- Overexpression - IHC

Tumour suppressor genes
- Deletions – FISH
- Downregulation - IHC

Microdissection
- aCGH
- Expression profiling
- miRNA assays
- Methylation assays

Patient tumour sample

Tissue Microarray (TMA)

Oncogenes
- Amplification – FISH/CISH
- Overexpression - IHC

Tumour suppressor genes
- Deletions – FISH
- Downregulation - IHC
ECF/X vs. FLOT
Genomic subtype for gastric cancer

171 gene set identified 2 intrinsic subtypes:
Genomic intestinal (G-INT)
Genomic diffuse (G-DIF)

Tan et al Gastroenterology 2011
Differential effect to chemotherapy according to intrinsic subtype of gastric cancer

<table>
<thead>
<tr>
<th>Treatment</th>
<th>G-INT (deaths/n)</th>
<th>G-DIF (deaths/n)</th>
<th>HR (95% CI), P value (G-INT: HR = 1.0)</th>
<th>P value for interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjuvant 5-FU–based treatment</td>
<td>20/45 (44%)</td>
<td>29/38 (76%)</td>
<td>2.71 (1.52–4.85), P = .001</td>
<td>.002</td>
</tr>
<tr>
<td>Surgery alone</td>
<td>49/136 (36%)</td>
<td>48/86 (56%)</td>
<td>1.37 (0.92–2.05), P = .12</td>
<td></td>
</tr>
</tbody>
</table>

HR (95% CI), P value (5-FU–based therapy, HR = 1)

1.68 (0.98–2.88), P = .06
0.90 (0.56–1.45), P = .67

Tan et al Gastroenterology 2011
Microarray-based tumour molecular profiling to direct choice of platinum compounds: proof-of-concept phase II study

Median turnaround time = 7 (IQR 5-9) working days

G1: oxaliplatin-sensitive
G2: cisplatin-sensitive
G3: status unclear or gene expression not available

Yong et al GI ASCO 2017
Microarray-based tumour molecular profiling to direct choice of platinum compounds: proof-of-concept phase II study

<table>
<thead>
<tr>
<th></th>
<th>G1 (Intestinal)</th>
<th>G2 (Diffuse)</th>
<th>G3 (Unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOX</td>
<td>30</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>SP</td>
<td>13</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PR</td>
<td>13 (44.8%)</td>
<td>1 (8.3%)</td>
<td>4 (26.7%)</td>
</tr>
<tr>
<td>SD</td>
<td>10 (34.5%)</td>
<td>10 (83.4%)</td>
<td>9 (60.0%)</td>
</tr>
<tr>
<td>PD</td>
<td>6 (20.7%)</td>
<td>1 (8.3%)</td>
<td>2 (13.3%)</td>
</tr>
<tr>
<td>NA</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

G1: oxaliplatin-sensitive
G2: cisplatin-sensitive
G3: status unclear or gene expression not available

Yong et al GI ASCO 2017
Can treatment be tailored according to TCGA subtype?

EBV 9%  
MSI 22%  
GS 20%  
CIN 50%

Can treatment be tailored according to TCGA subtype?

Can treatment be tailored according to TCGA subtype?

EBV-infected/MSI gastric cancer

PD-L1 expression

Interferon-γ gene set enrichment

TI: tumour-infiltrating
IM: invasive margin

120/1318 (9.1%) EBV-associated in resected gastric cancer specimens*

Derks et al Oncotarget 2016; *Kim et al ASCO 2017
20/303 (6.7%) had MSI-H tumours

Smyth et al JAMA Oncol 2017
Overall survival by microsatellite status - CLASSIC

A. Among patients treated with surgery alone, those with microsatellite instability-high tumors had significantly better disease-free survival, compared to those with microsatellite-stable tumors (log-rank: p = 0.0149). B. Among those who received adjuvant chemotherapy, disease-free survival did not differ significantly with respect to the microsatellite instability status (log-rank: p = 0.1132). C. Among patients with microsatellite-stable disease, adjuvant chemotherapy provided a disease-free survival benefit over surgery alone (log-rank: p = 0.0025). D. However, among patients with microsatellite instability-high gastric cancer, disease-free survival did not differ significantly between those treated with adjuvant chemotherapy and those who underwent surgery alone (log-rank: p = 0.7858).

36/592 (6.1%) had MSI-H tumours

Kim et al ASCO 2017
Peri-operative immunotherapy

Pre-operative

Pre-operative chemoradiation

Surgery

Post-operative nivolumab

Post-operative

CHECKMATE 577

n=760

**Screening**

- Age ≥18 years
- Stage II/III carcinoma of the E/GEJ
- Completed pre-operative CRT followed by surgery
- Residual pathologic disease following complete resection

**Treatment**

Randomized

- Nivolumab
- Placebo

Post-treatment follow-up

THE ROYAL MARSDEN
Peri-operative immunotherapy

Pre-operative

- Pre-operative Chemo + PEMBRO
  - Surgery
  - Post-operative chemo + PEMBRO

Post-operative
Peri-operative immunotherapy

Pre-operative

Patients with resectable adenocarcinoma of OGJ and stomach

KEYNOTE 589

n=800

CX x3 → Surgery → CX x3

CX x3 + pembrolizumab → Surgery

CX x3 + pembrolizumab → Pembro q3w x ~1 year
The Cancer Genome Atlas oesophageal cancer

<table>
<thead>
<tr>
<th>Location</th>
<th>ESCC (164)</th>
<th>UC (165)</th>
<th>GEJ (165)</th>
<th>Indeterminate</th>
<th>Stomach (359)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophagus</td>
<td>90</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEJ</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundus/body</td>
<td>47</td>
<td>6</td>
<td>60</td>
<td>141</td>
<td></td>
</tr>
<tr>
<td>Antrum/pylorus</td>
<td>141</td>
<td>60</td>
<td>71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>Total (559)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIN</td>
<td>288</td>
</tr>
<tr>
<td>GS</td>
<td>71</td>
</tr>
<tr>
<td>MSI</td>
<td>78</td>
</tr>
<tr>
<td>EBV</td>
<td>30</td>
</tr>
</tbody>
</table>

The Cancer Genome Atlas Research Network; Nature 2017
Case history

- 75 year old female
- PS=1
- T2N1M0 type II OGJ cancer
- Discussed at the MDT meeting
- Peri-operative chemotherapy to be offered
- When returned to my clinic, she could not remember anything that I said
- GP recently referred to her local memory clinic
What treatment would you recommend?

1) Palliative care alone
2) Surgery alone
3) Surgery followed by adjuvant chemotherapy
4) Neoadjuvant chemoradiation followed by surgery
5) Pre- and post-operative chemotherapy
6) Surgery followed by adjuvant chemoradiation
7) Neoadjuvant chemotherapy followed by surgery
What treatment would you recommend?

1) Palliative care alone – 8%
2) Surgery alone – 42%
3) Surgery followed by adjuvant chemotherapy – 25%
4) Neoadjuvant chemoradiation followed by surgery – 0%
5) Pre- and post-operative chemotherapy – 8%
6) Surgery followed by adjuvant chemoradiation – 8%
7) Neoadjuvant chemotherapy followed by surgery – 8%
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