“Case discussion on gastric cancer based on ESMO guidelines”

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The Clinical Practice Guidelines (CPGs)

Number of ESMO CPGs:

- In Annals of Oncology
- On the ESMO website
- On the OncologyPRO website

Average downloads per manuscript during the 1st 6 months post-publication
Among the Top Ten most highly cited articles in Annals of Oncology:

#2: ESMO Consensus Guidelines for management of patients with colon and rectal cancer. A personalized approach to clinical decision making

#3: Metastatic non-small-cell lung cancer (NSCLC): ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up

#4: Renal cell carcinoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up

#8: Locally recurrent or metastatic breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up
Breast cancer
- Primary breast cancer

Lung cancer
- Malignant pleural mesothelioma *
- Thymic epithelial tumours NEW

Gastrointestinal cancers
- Cancer of the pancreas

Haematological malignancies
- Chronic lymphocytic leukaemia
- Philadelphia chromosome-negative chronic myeloproliferative neoplasms *NEW
- Hairy cell leukaemia *NEW
- Peripheral T-cell lymphomas NEW
- Diffuse large B-cell lymphoma (DLBCL)

Genitourinary cancers
- Cancer of the prostate *

Melanoma
- Cutaneous melanoma

Cancers of unknown primary site
- Cancers of unknown primary site

Supportive and palliative care
- Management of oral and gastrointestinal mucosal injury *
- Central venous access in oncology NEW
- Treatment of dyspnoea in advanced cancer patients NEW
Recent/coming soon consensus publications:

- ESMO Consensus Conference: Locally-advanced stage III non-small-cell lung cancer (NSCLC) - Published online 20 April 2015
- ESMO-ESGO-ESTRO consensus conference on endometrial cancer: diagnosis, treatment and follow-up – Submitted for publication July 2015
- ESMO consensus guidelines for the management of patients with metastatic colorectal cancer – accepted for publication

Recent consensus conferences:
- ESMO Consensus Conference on Malignant Lymphoma “Common open issues involving multiple mature lymphoid disorders” – June 2015
POCKET GUIDELINES

2011 – 1 pocket guideline (Lung Cancer)

2012 - 6 pocket guidelines:

2013 – 7 pocket guidelines:

2014 – 9 pocket guidelines:
POCKET GUIDELINES

2015

2015 updated/new titles:
- Breast Cancer
- Lung Cancer
- Urogenital Cancer
- Upper GI Cancers
- Lower GI Cancers
- Gynaecological Malignancies
- Lymphomas
- Melanoma

2014 titles still valid:
- Supportive Care
- Bone Health
MOBILE APPS

All of the latest pocket guidelines are now available on the ESMO Cancer Guides app, available for iOS and Android.

The app also includes the ESMO Guides for Patients in several languages.

New for 2015: try out the ESMO Interactive Guidelines app

- Lung & Chest Tumours: available now
- Upper GI cancers: available now
- Lower GI cancers: coming soon
- Urogenital cancer: coming soon
GUIDES FOR PATIENTS

in collaboration with the Anticancer Fund

Guides for Patients based on ESMO Clinical Practice Guidelines, prepared in a format your patients can easily understand

The main goal of the project is to constantly help patients and their relatives to better understand the nature of different types of cancer and appreciate the best available treatment choices.

Patient guides are available in different languages (English, Dutch, French, Spanish). Other languages are available for some titles (Romanian, Polish, Portuguese)

Download from www.esmo.org or www.anticancerfund.org

Online: AML, bladder cancer, breast cancer, cervical cancer, CML, colorectal cancer, endometrial cancer, follicular lymphoma, head & neck cancer, liver cancer, melanoma, non-small-cell lung cancer, oesophageal cancer, ovarian cancer, pancreatic cancer, prostate cancer, and stomach cancer

Coming soon: Soft tissue sarcoma, Glioma, Bone sarcoma, Multiple myeloma

- Pick up copies at the ESMO Booth and in the Patient Advocates area!
MANAGEMENT ON LOCALIZED GASTRIC CANCER

72 year old female PS1

No relevant previous comorbidities

Unspecific epigastric discomfort

Significant asthenia and weight loss for 3 months

Occasional vomiting and fullness after eating small amounts of food.

DIAGNOSTIC TESTS: Gastroscopy
MANAGEMENT ON LOCALIZED GASTRIC CANCER

GASTROSCOPY:
Ulcerated and infiltrating lesion of 5 cm in the corpus/antrum of the stomach

Multiple biopsies were done.

Poorly differentiates adenocarcinoma of intestinal type

Staging procedures were ordered
MANAGEMENT ON LOCALIZED GASTRIC CANCER

CT Scan
Chest: No lung or mediastinal mets
Abdominal-pelvic: No liver or peritoneal mets.
Thickening of the whole gastric wall without invasion of any surrounding local structures.
Multiple perigastric lymph nodes, but no extraperigastric and paraortic nodes

An endoscopic ultrasonography and a laparoscopy were not considered

cT3cN+M0
Classical approach to localised gastric cancer

- Surgical resection
- Pathology assessment and estimation of risk
- Treatment based upon classical TNM stage
- Postoperative chemotherapy of doubtful *versus* no value
- Postoperative chemoradiation
Currently recommended approach to localised gastric cancer

- Clinical assessment and staging
- Multidisciplinary team discussion
- Preoperative treatment in all patients with clinical stage II and III
- Surgical resection after chemotherapy
- Pathology assessment and estimation of risk
- Postoperative chemotherapy if tolerated
- Participation in trials
Treatment for localised gastric cancer: What is standard of care?

■ Algorithm for the management of gastric cancer

Gastric cancer (adenocarcinoma)

Operable Stage T1N0
- Consider endoscopic/limited resection
  - Preoperative chemotherapy
  - Surgery
  - Post-operative chemotherapy

Operable Stage >T1N0
- Preferred pathway
  - Surgery
  - Adjuvant chemoradiation
  - Adjuvant chemotherapy

MANAGEMENT ON LOCALIZED GASTRIC CANCER

Three courses of preoperative CT with CAPE-OX were given With good tolerance

A D2 surgical resection with partial gastrectomy was performed. No liver or peritoneal mets were detected.

The pathology report indicated poorly differentiated adenocarcinoma of intestinal subtype invading till the muscular layer, but not beyond. One involved out of 16 lymph nodes in the perigastric fat. None of the 12 LN in the extraperigastric regions were involved with tumor

ypT2 ypN1/38 M0
MANAGEMENT ON LOCALIZED GASTRIC CANCER

Three courses of prosterative CT with CAPE-OX were planned after surgery.

Due to surgical relates morbidities no postoperative chemotherapy could be administered.

The patient is doing well with no evidence of relapsing disease 48 months after surgical resection.
Gastric Cancer Clinical Cases

Dr Ian Chau
Consultant Medical Oncologist
The Royal Marsden Hospital
London & Surrey
Case history 1

- 73 years old male
- Jan 14 presented with epigastric pain and weight loss of 5 pounds
- OGD showed ulcer in lesser curve between 42 and 46cm
- Biopsy showed moderately differentiated intestinal type adenocarcinoma HER2 negative
- Previously fit and healthy Still coaching for the London Irish Rugby Club
- PS=1
Staging CT T3N1
Case history 1 (cont’d)

- CT → T3N1 gastric antral tumour
- Feb 14 PET/CT ⊕ T3N0M0
Case history 1 (cont’d)

- CT → T3N1 gastric antral tumour
- Feb 14 PET/CT → T3N0M0
- Feb 14 Laparoscopy → tumour starting at level of OGJ involving cardia and extending along lesser curvature to the incisura
- Surgical Plan: extended total gastrectomy
What treatment would you recommend?

1) Surgery alone
2) Surgery followed by adjuvant chemotherapy
3) Surgery followed by adjuvant chemoradiation
4) Peri-operative chemotherapy
5) Neoadjuvant chemotherapy followed by surgery
6) Neoadjuvant chemoradiation followed by surgery
7) Others
Case history 1 (cont’d)

- Feb-Apr 2014 Received pre-operative ECX × 3 cycles
- 14 Jun 2014 Laparoscopic total gastrectomy
- Histology: ypT3N3 (18/33 lymph nodes) involved R0 resection; resection specimen showed tumour to be HER2 positive
What treatment would you recommend?

1) No further treatment
2) Continue ECX
3) Give chemoradiation
4) Change to paclitaxel
5) Change to paclitaxel + ramucirumab
6) Change to cisplatin/capecitabine plus trastuzumab
Case history 1 (cont’d)

- Discharged Day 9 post-operative, but persistent nausea and vomiting
- Continuing weight loss and nausea for 3 months post-op
- Unable to receive any post-operative adjuvant therapy
- Jan 2015 Surveillance CT scan
- Patient’s PS was 1 and nausea had completely settled.
The Royal Marsden

CT and PET/CT showed solitary liver metastases

Speaker’s own contribution
Case history 2

- 55 years old male
- Presented shortness of breath, lethargy, anaemia with 6kg weight loss
- OGD showed 6cm ulcer in gastric fundus
- Biopsy showed poorly differentiated intestinal type adenocarcinoma; HER2 -ve
- Local GP; 19 years old daughter died from ALL at Royal Marsden Hospital 4 years ago.
Pre-treatment

T4N1M1 with retroperitoneal lymphadenopathy
Treatment for advanced gastric cancer: What is standard of care? ESMO guidelines

Inoperable or metastatic

Surgery

Re-assess

Palliative chemotherapy

HER-2 negative
Platinum+ fluorpyrimidine-based doublet or triplet regimen

HER-2 positive
Trastuzumab + CF/CX

Best supportive care if unfit for treatment

Consider clinical trials of novel agents

2nd line chemo
Clinical trials if adequate PS

Case history 2 (cont’d)

• CT → T4N1M1 gastric adenocarcinoma with coeliac axis, retroperitoneal lymphadenopathy

• Commenced on ECX
Case history 2 (cont’d)

- CT → T4N1M1 gastric adenocarcinoma with coeliac axis, retroperitoneal lymphadenopathy
- Commenced on ECX
- ECX 4 cycles with PD in primary tumour, malignant lymphadenopathy plus new peritoneal deposits
- PS = 1
What treatment would you recommend?

1) Weekly paclitaxel
2) Best supportive care
3) Paclitaxel + ramucirumab
4) Irinotecan
5) Ramucirumab monotherapy
6) Docetaxel
7) Others
Would you enrol him into a clinical trial with immunotherapy (PD1/PDL-1 antibody)?

1) Yes
2) No
Case history 3

- 45 years old male
- June 2010 Diagnosed with metastatic adenocarcinoma OGJ with widespread lymphadenopathy
- July 2010 Started on E-Carbo-X (another institution)
- August 2010-January 2011 EOX × 7 cycles with complete (metabolic) response
- October 2013 Recurrence on OGJ primary, but no distant metastases
- Repeat biopsy → HER2 positive
- October 2013-January 2014 Folfiri/Trastuzumab x6 cycles
- January-March 2014 Folfiri/Trastuzumab cycles 7 and 8 (treatment interrupted because of cardiac arrest).
Case history 3 (cont’d)

• April-May 2014 Carboplatin/Raltitrexed/Trastuzumab (GI bleed).

• Chemoradiation to primary, 54Gy in 30 fractions (concomitant Raltitrexed/Carboplatin), completed 05.08.2014.

• October 2014: Reassessment endoscopy showed regression in oesophageal tumour within radiation field but some progression of a proximal tumour which appears to be separate and outside radiation field

• Chemoradiation to encompass oesophageal disease 25-28cm plus bilateral supraclavicular fossae 54Gy/30# with concomitant Raltitrexed/Carboplatin completed December 2014
Case history 3 (cont’d)

• June 2015 Repeat OGD showed residual adenocarcinoma
• CT and PET scans showed retroperitoneal lymphadenopathy and lung metastases
• Performance status: 0
What treatment would you recommend?

1) Weekly paclitaxel
2) Best supportive care
3) Paclitaxel + ramucirumab
4) Irinotecan
5) Ramucirumab monotherapy
6) Docetaxel
7) Others
Case history 3 (cont’d)

• June 2015 Repeat OGD showed residual adenocarcinoma
• CT and PET scans showed retroperitoneal lymphadenopathy and lung metastases
• Performance status: 0
• 6 cycles of Paclitaxel plus ramucirumab with good partial response
• Patient wanted a treatment break
Case history 3 (cont’d)

• April 2016 small volume lung metastases progression on surveillance CT
• Performance status: 0
What treatment would you recommend?

1) Watch and Wait
2) Rechallenge with paclitaxel + ramucirumab
3) Irinotecan
4) Ramucirumab monotherapy
5) Docetaxel