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ESMO Preceptorship Programme

Gastric cancer – Barcelona, Spain – 30-31 August 2019

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Challenges in the perioperative treatment of gastric cancer

DISCLOSURE OF INTEREST

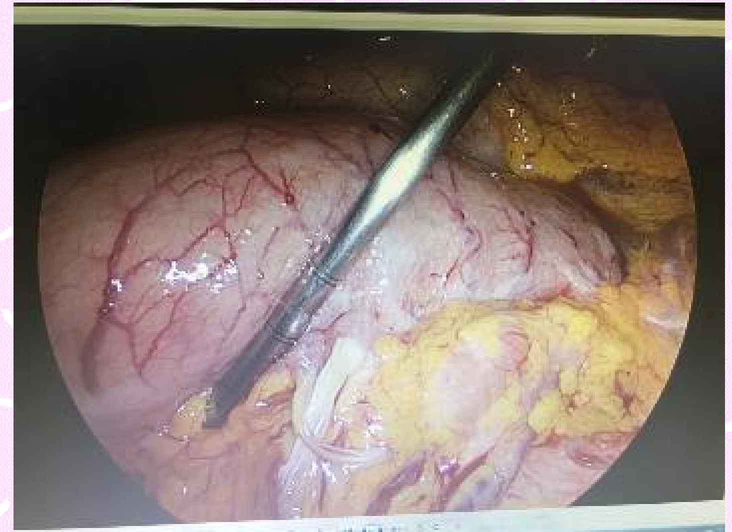
- No conflict of interest

Presentation – Feb 2019

- **66 y/o woman;** early satiety with a sense of abdominal burden; weight loss 2 kg (51 -> 49 kg); eats only liquidish food.
- No co-morbidities, no family history; no drug intake
- **Physical examination**: ECOG 0-1; outer mucosa – pale; RS/CVS – NAD; Abdomen – retro umbilical solid lesion ≈ 8/9 cm, not attached to the abdominal wall; Limbs - peripheral edema; no signs of DVT.
- **Upper endoscopy**: in the distal gastric antrum on the bigger curve – large tumor lesion, contact bleeding and obstruction of pylorus – biopsy; no EUS available.
- **Histology**: G3 **mucinous** tubular adenocarcinoma; **ICH**: PAS (+), HER2 negative
- **Lab**: Hg 92, MCV 81.7fl, MCH 28.9pg, total protein 59.07g/l, Albumin 32.85g/l, serum iron 4.0µmol/l ,CEA 6.6 U/ml. The rest – within ref. ranges.

Staging

- **Abdominal ultrasound:** no suspicious lesions in the liver
- **Whole body CT**: no distant spread; the stomach wall – the entire wall is up to 15mm; no infiltration in the surrounding structures; no enlarged or pathologically changed LN
- **PET/CT:** diffuse thickening of the stomach wall with increased metabolic activity mostly in antrum – SUV max 5.9; no metabolically active lymph nodes; no distant spread.
- **cT3 cN0 (+?) cM0**



- **Diagnostic laparoscopy** – no hepatic lesions, no evidence of disease in peritoneum; peritoneal cytology from 4 abdominal quadrants (-) neg., extirpation of 1 perigastric lymph node – final pathology G2 adenocarcinoma with infiltration of the nodal capsule;
- **G3 cT3 cN+ cM0**

Management: Neoadjuvant therapy

- **FLOT** q2w + **G-CSF:** Docetaxel, Oxaliplatin, Folinic acid and 5-fluorouracil (CTCAE: HFS grade II)
- **BSC:** Vit B12, Folinic acid, i.v. iron, human albumin; Erythropoetin
- **Clinically**: improvement, ↓ satiety, lesion hardly palpable, eats solid food.
- **CT post 3 cycles** (18 Mar – 17 Apr 19) - RECIST 1.1 SD
- **Lab:** Hgb 101, Albumin

How long should NACT be given?

Management: surgery

➢ **09 May 2019:** Laparoscopic subtotal gastrectomy (1st in Bulgaria) with D2 LND, - gastro-jejunal anastomosis a. m. Roux-en-Y. Cholecystectomy.

- **During surgery:** ≈ 400 ml yellowish ascites; ↓↓tumor volume
- **Pathology:** ascites **(+)** pos. (adenocarcinoma); G3 adenocarcinoma with infiltration of the entire gastric wall, penetrating the serosa in some areas; LV+ and perineural invasion, direct invasion in the small omentum. Massive fibrosis with islets of tumor cells (<20%). Resection margins - **islets of tumor cells**. 9+/54 dissected LN and in some of them - fibrosis (post-treatment response!?); HER2 negative
- **Assessment of tumor response**: PR to NACT – grade 2 by Becker. No possibility for re-OP.
- Stage: ypT4a ypN3 pM1 (per) Postop ChT: **FLOT**

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Questions:

1. Suboptimal staging in mucinous histology
2. Assessment of response to NACT: PR or PD?
3. Duration of NACT
4. Prognosis
5. Role for post-OP radiotherapy?
6. Post-OP ChT – FLOT + G-CSF?
7. Q3w vs q2w?

Post-OP management

- Pt was understaged initially – ascites during OP not considered as PD. PR to NACT (80% ↓ of cellularity, massive fibrosis) cT4 cN3 cM1 (per)
- Postop ChT: **FLOT + G-CSF q3w**
- **If tolerance ok – 4-6 cycles (4 months)**
- **Follow-up:** clinical examination, US (ascites?), CT
- No role for PET/CT; poor prognosis!!!

Thank you for your attention!