Guías SEOM 2015 / ESMO 2016: mensajes claves

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Oesophageal cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up

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doi:10.1093/annonc/mdw329
The multidisciplinary management of gastro-oesophageal junction tumours

European Society of Digestive Oncology (ESDO): Expert discussion and report from the 16th ESMO World Congress on Gastrointestinal Cancer, Barcelona

Digestive and Liver Disease 48 (2016) 1283–1289

Evidence-based attitudes and guidelines are not easy to elaborate since most of the trials and studies reported mixed cases of oesophageal adenocarcinoma and squamous cell tumours, oesophageal and GOJ cancers and gastric cancers [4–6].
Gastric cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up†

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Seom guidelines for the treatment of gastric cancer 2015

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References:
doi:10.1093/annonc/mdw350

Clin Transl Oncol (2015) 17:996–1004
DOI 10.1007/s12094-015-1456-y
Grades of recommendation

A  Strong evidence for efficacy with a substantial clinical benefit, strongly recommended
B  Strong or moderate evidence for efficacy but with a limited clinical benefit, generally recommended
C  Insufficient evidence for efficacy or benefit does not outweigh the risk or the disadvantages (adverse events, costs, ...), optional
D  Moderate evidence against efficacy or for adverse outcome, generally not recommended
E  Strong evidence against efficacy or for adverse outcome, never recommended
incidence and epidemiology

(1) cardia gastric cancer (CGC) arising in the area of the stomach adjoining the esophageal–gastric junction [5], and (2) non-CGC (NCGC) arising from more distal regions of the stomach.
diagnosis and pathology

Gastroscopy and biopsy of suspicious lesions are the basis for definitive diagnosis. Histology is reported according to World Health Organization criteria [21] and Lauren classification (intestinal and diffuse). Immunohistochemistry (IHC) determines HER2 overexpression in advanced disease, according to GC-specific criteria [22], to decide trastuzumab treatment.
staging and risk assessment

Recommendation: Initial staging and risk assessment should include physical examination, blood count and differential, liver and renal function tests, endoscopy and contrast-enhanced computed tomography (CT) scan of the thorax, abdomen ± pelvis (Table 1) [V, A]. Laparoscopy is recommended for patients with resectable gastric cancer [III, B]. Multidisciplinary treatment planning before any treatment is mandatory [IV, C].
Staging is performed according to the 2010 AJCC TNM classification, 7th edition (Table 1) [4]. Four major groups are considered for clinical management purposes (Table 2).
Multidisciplinary treatment planning before any treatment decision is mandatory. The core membership of the multidisciplinary team should include surgeons, medical and radiation oncologists, radiologists and pathologists, with other members as available [IV, C].
management of local/locoregional disease

**Recommendation:** Endoscopic resection is appropriate for selected very early tumours [III, B]. For stage IB–III gastric cancer, radical gastrectomy is indicated and perioperative therapy is recommended for these patients [I, A]. Medically fit patients should undergo D2 resections in high-volume surgical centres [I, B].
management of local/locoregional disease

Surgery

Early GC (T1a) may be amenable to endoscopic resection if it is well differentiated, <2 cm, confined to the mucosa, and non-ulcerated. Intestinal Lauren histology and no alternative. T1A GC not meeting criteria for endoscopic treatment will require less extensive surgery than IB-III tumors and lymph node dissection can be limited to peri-gastric and local nodes (Table 3).
The current UICC/AJCC TNM (seventh edition) classification recommends excision of a minimum of 15 lymph nodes to allow reliable staging. In Asian countries, experience from observational and randomised trials demonstrates that D2 dissection leads to superior outcomes compared with D1 resection [II, B].
management of local/locoregional disease

Surgery

There is uniform consensus that lymphadenectomy must include at least 15 lymph nodes. Gastrectomy with D2 lymph node dissection is a recommended procedure (2B), but should be performed by experienced surgeons in high-volume centers. Routine pancreatectomy and splenectomy are no longer recommended with D2 lymph node dissection.
management of local/locoregional disease

Surgery

When predicting lymph node involvement, those with negative nodes should be operated laparoscopically, whereas those with predicted positive nodes would require open surgery.
management of local/locoregional disease  perioperative chemotherapy

These results have led to the adoption of perioperative CT as a standard approach for medically fit patients with resectable locally advanced (cT2 or higher, any N) distal esophageal, esophagogastric junction, or gastric tumors [IA] throughout most of European countries and other parts of the world.
management of local/locoregional disease  
perioperative chemotherapy

(as ECX: epirubicin, cisplatin, capecitabine, in preference to ECF) [IV, C]. Also, other platinum/fluoropyrimidine doublets or triplets may be considered; in particular, oxaliplatin may replace cisplatin [as EOX (epirubicin, oxaliplatin, capecitabine)]; it is non-inferior to ECX in the metastatic setting).
management of local/locoregional disease  
perioperative chemotherapy

Recommended treatment duration is 2–3 months.

There is no current evidence to support the use of perioperative trastuzumab therapy or any other biologically targeted drug, including anti-angiogenic compounds.
management of local/locoregional disease  neoadjuvant chemotherapy

Preoperative combined CRT is now the preferred approach for localized EGJ and gastric cardia cancers (IB). However, it is still an experimental procedure in potentially resectable non-cardia gastric adenocarcinomas (2B).
Recommendation: For patients with ≥Stage IB gastric cancer who have undergone surgery without administration of preoperative chemotherapy (e.g. due to understaging before the initial decision for upfront surgery), postoperative chemoradiotherapy (CRT) or adjuvant chemotherapy is recommended [I, A]. For patients having undergone preoperative chemotherapy, the addition of postoperative radiotherapy (RT) has no added benefit.
management of local/locoregional disease  adjuvant treatment

*Chemoradiation*  In patients with resected gastric or GEJ adenocarcinoma stages IB–IV (M0), the INT-0116 trial reported better OS (HR 1.35; $p = 0.005$) and DFS (HR 1.52; $p < 0.001$) with the MacDonald regimen (5FU/LV plus radiotherapy) versus surgery alone [39] (IB).
Chemotherapy  The benefit of adjuvant CT has also been reported. An absolute increment of 6 % in OS (HR 0.82; \( p < 0.001 \)) and a better DFS (HR 0.82; \( p < 0.001 \)) were published in a large, individual patient-level meta-analysis of adjuvant 5FU-based chemotherapy versus surgery alone in resected GC [41] [I,A]. However, the preferred combination chemotherapy could not be determined.
management of advanced/metastatic disease

first-line treatment

Recommendation: Doublet or triplet platinum/fluoropyrimididine combinations are recommended for fit patients with advanced gastric cancer [I, A].
management of advanced/metastatic disease

first-line treatment

In general, resection of the primary tumour is not recommended in the palliative setting; however, a small number of patients with
management of advanced/metastatic disease

(first-line treatment)

(BSC), have demonstrated that CT increases median overall survival and improves the quality of life of patients with advanced gastric cancer [I,A].
Management of advanced/metastatic disease

First-line treatment

Cisplatin-based chemotherapy
Chemotherapy with docetaxel
Oxaliplatin-based chemotherapy
Oral fluoropyrimidines
Irinotecan combinations
management of advanced/metastatic disease
elderly first-line treatment

In addition, a meta-analysis of three phase III trials comparing patients ≥70 years with younger patients demonstrated no differences in response rates or OS between the two patient groups [II, B]
management of advanced/metastatic disease

second-line treatment

IRINOTECAN
PACLITAXEL
DOCETAXEL
RAMUCIRUMAB
PACLITAXEL + RAMUCIRUMAB
management of advanced/metastatic disease

second-line treatment

Alternatively, in patients with disease progression >3 months following first-line chemotherapy, it may be appropriate to consider a rechallenge with the same drug combination as an additional treatment option [IV, C] [79]. In patients with symptomatic, locally
personalised medicine and targeted therapy

**Recommendation:** Trastuzumab is recommended in conjunction with platinum and fluoropyrimidine-based chemotherapy for patients with HER2-positive advanced gastric cancer [I, A].

*Trastuzumab* [IB]
specific situations

metastasectomy

Until further evidence is presented, both gastrectomy and metastasectomy should be considered experimental for patients with gastric cancer.

Gastrectomía: I, A
Metastasectomy: V, C
specific situations

peritoneal metastases

Currently, this approach cannot be recommended outside the context of clinical research.

HIPEC: Asia (I, A)
Francia (IV, C)
follow-up, long-term implications and survivorship

*Follow-up* In the setting of operable gastric cancer, a regular follow-up may allow treatment of symptoms and early detection of recurrence, though there is no evidence that it improves survival outcomes [III, B].
MUCHAS GRACIAS