Upper GI Cancers: an overview

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Disclosures (1)

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Disclosures (2)

Amsterdam UMC
Universitair Medische Centra

Disclosures (2)

Upper gastrointestinal cancer

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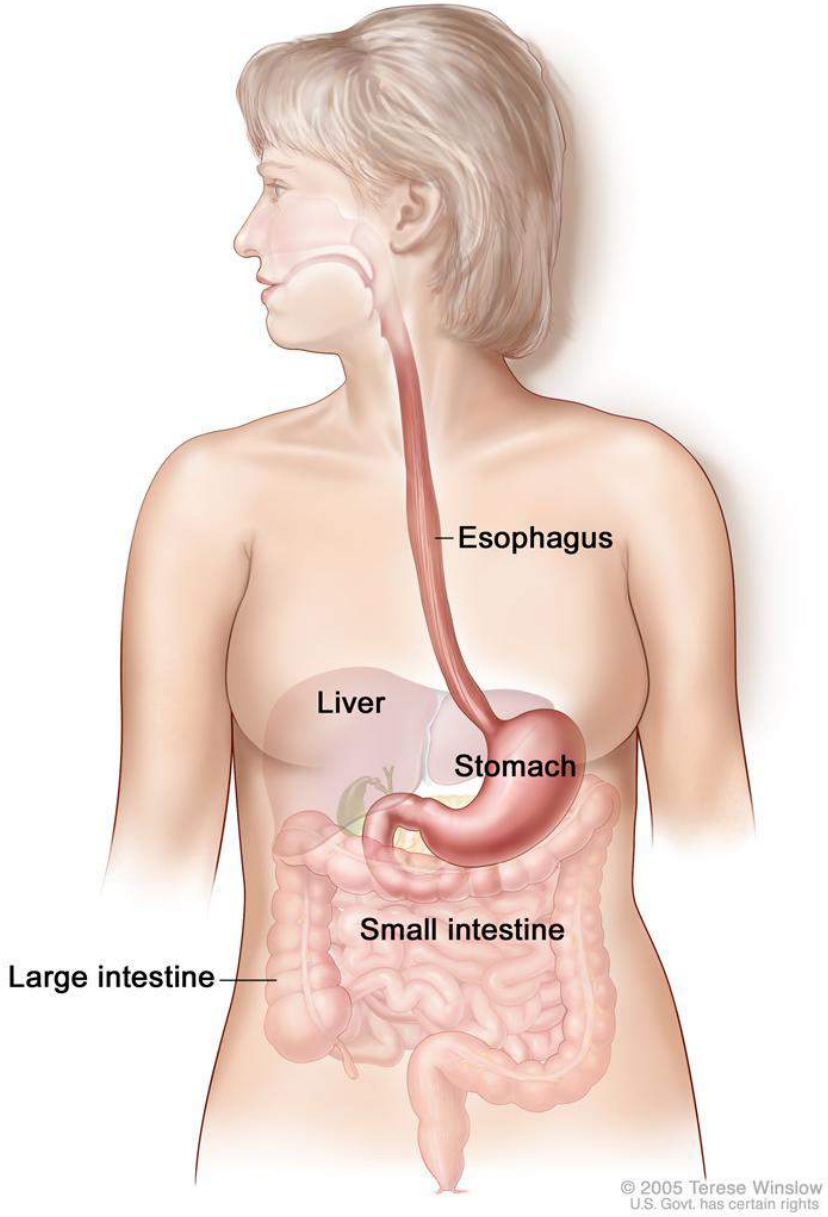
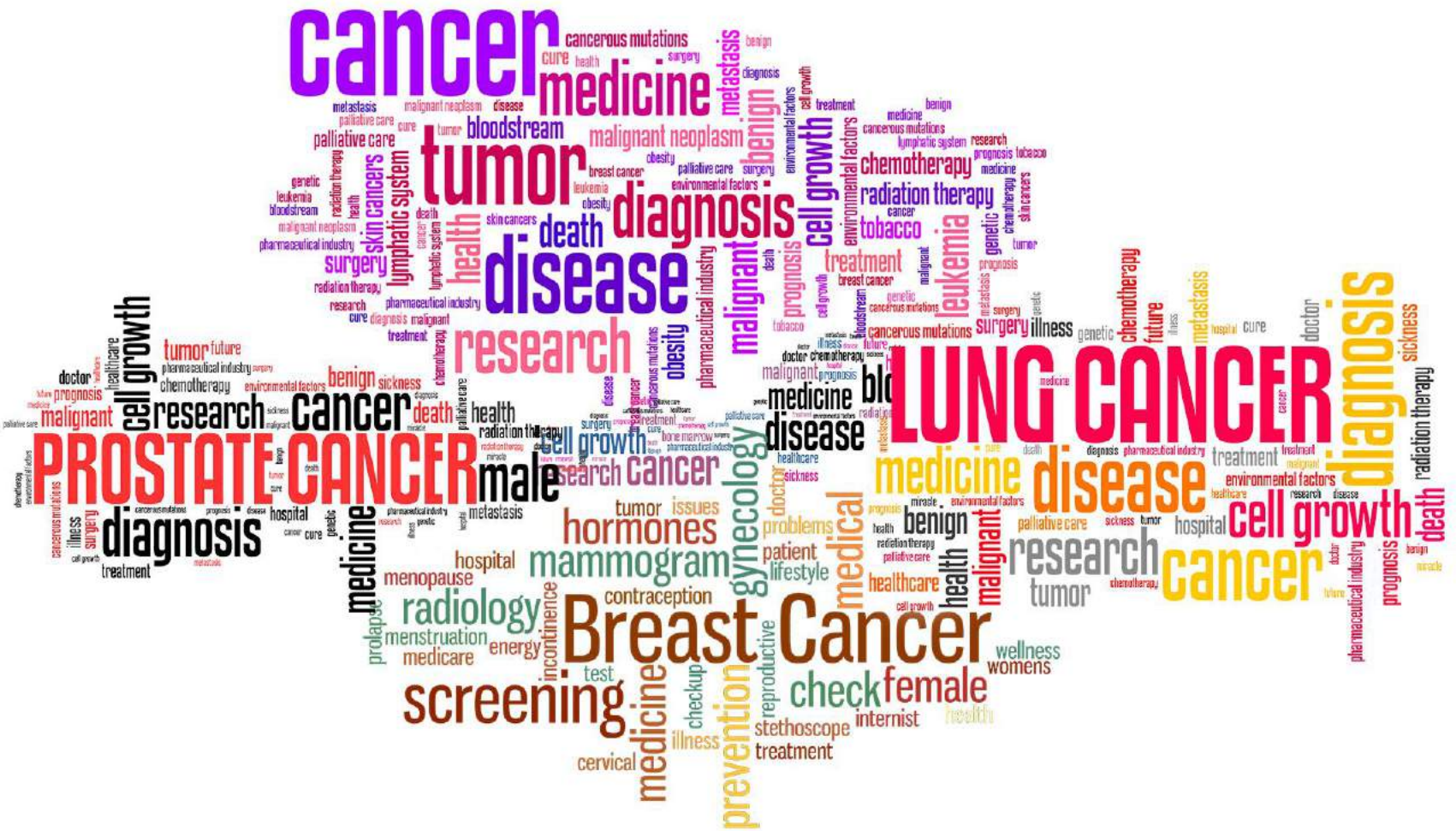


Why upper gastrointestinal cancer?



Lynn Matrisian, ASCO 2016

Belongs to the most deadliest cancers

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Cancers with a Five-year Survival Rate Below 50%

	2016 Est. Cases	2016 Est. Deaths	Five-Year Relative Survival Rate
Pancreas	**53,070**	**41,780**	**8%**
Lung	**224,390**	**158,080**	**18%**
Liver & intrahepatic bile duct	**39,230**	**27,170**	**18%**
Esophagus	**16,910**	**15,690**	**20%**
Stomach	**26,370**	**10,730**	**30%**
Brain & other nervous system	**23,770**	**16,050**	**35%**
Ovary	**22,280**	**14,240**	**46%**
Myeloma	**30,330**	**12,650**	**49%**
Leukemia	60,140	24,400	62%
Colon & rectum	134,490	49,190	66%
Non-Hodgkin lymphoma	72,580	20,150	72%
Kidney & renal pelvis	62,700	14,240	74%
Urinary bladder	76,960	16,390	79%
Uterine corpus	60,050	10,470	83%
Breast	249,260	40,890	91%
Melanoma of the skin	76,380	10,130	93%
Prostate	180,890	26,120	99%

8 of the Deadliest Cancers

(aka Recalcitrant Cancers)

4 of 8 are upper GI

Lynn Matrisian, ASCO 2016

Belongs to the most deadliest cancers

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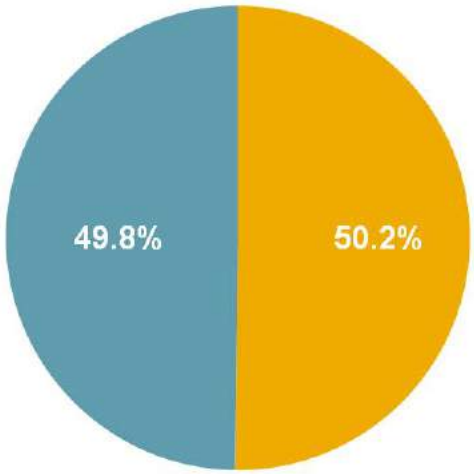
Deadliest Cancers Make Up

50% of all Cancer Deaths



2016 Est. Cancer Deaths

8 deadliest site-specific cancers combined

296,390

All other cancers combined

299,300

Lynn Matrisian, ASCO 2016

Aims

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Improve survival!

Maintain quality of life!

Treatment of resectable esophageal/gastric cancer

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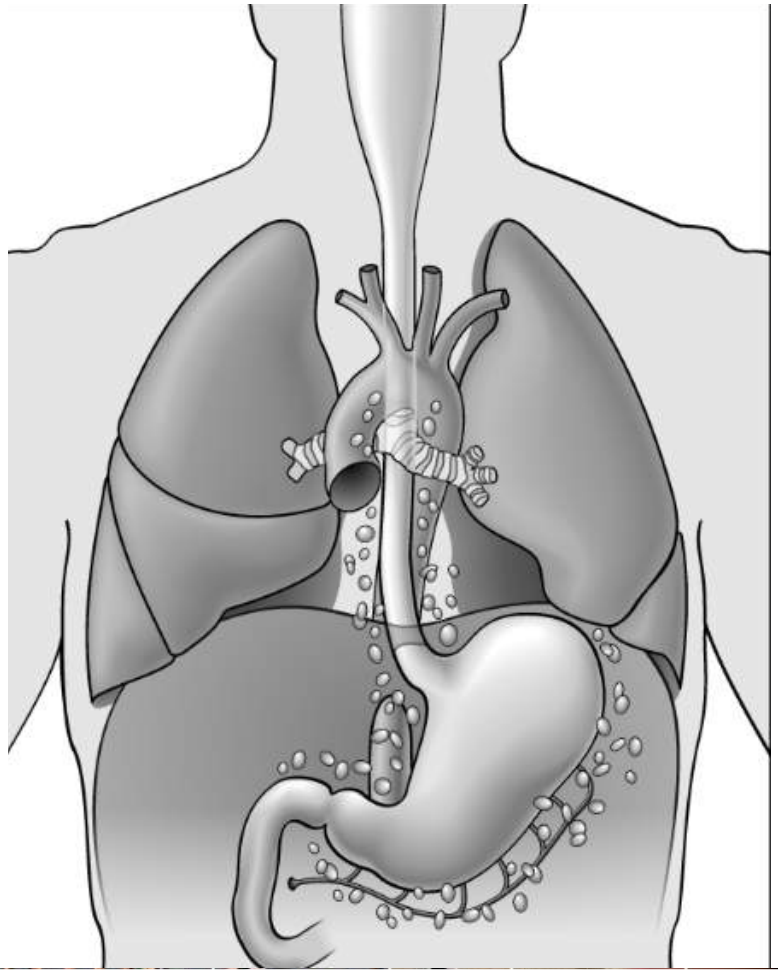

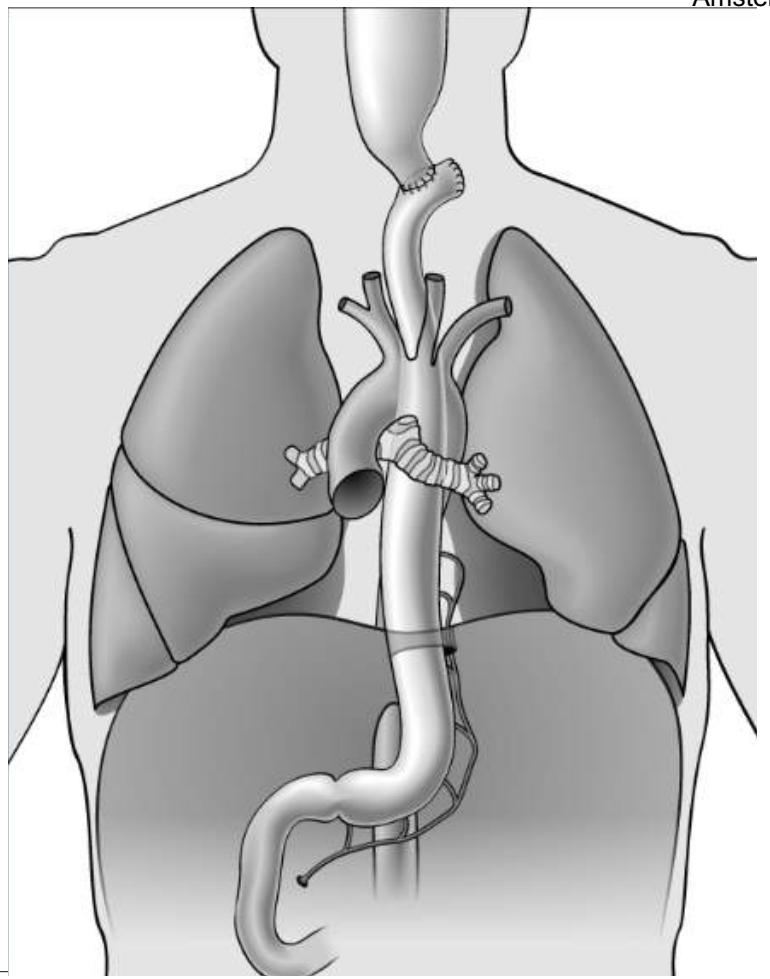

Courtesy dr. S. Gisbertz, upper GI surgeon

Resection esophageal cancer

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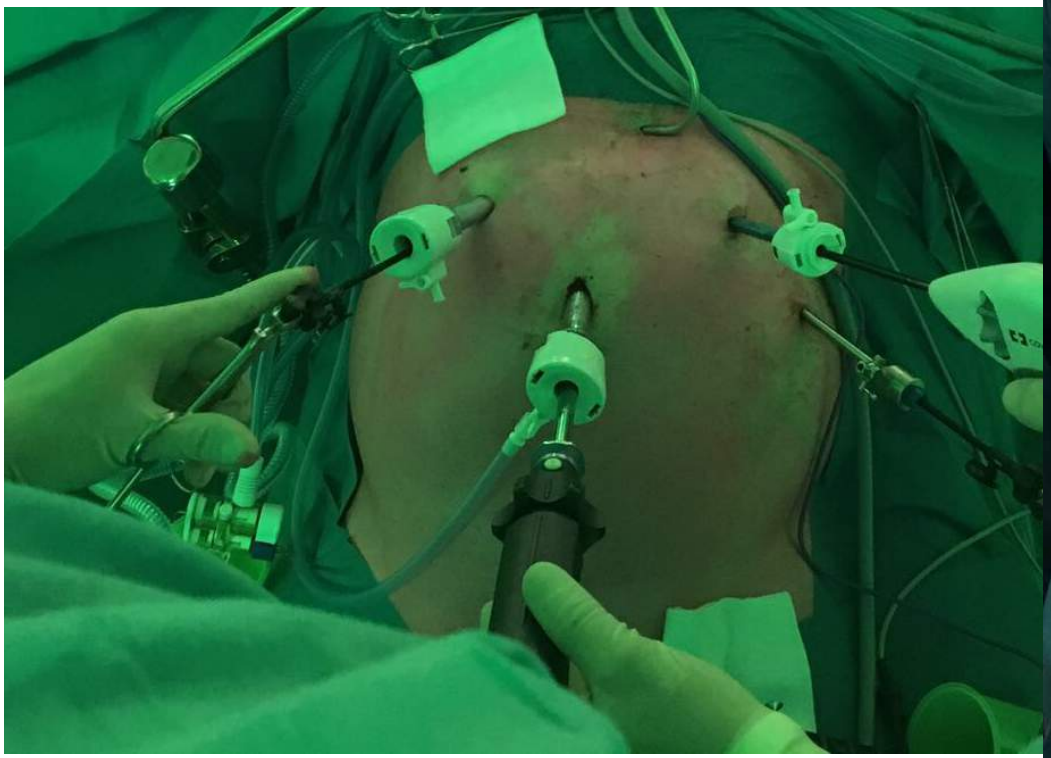

Courtesy dr. S. Gisbertz, upper GI surgeon

Lymph nodes

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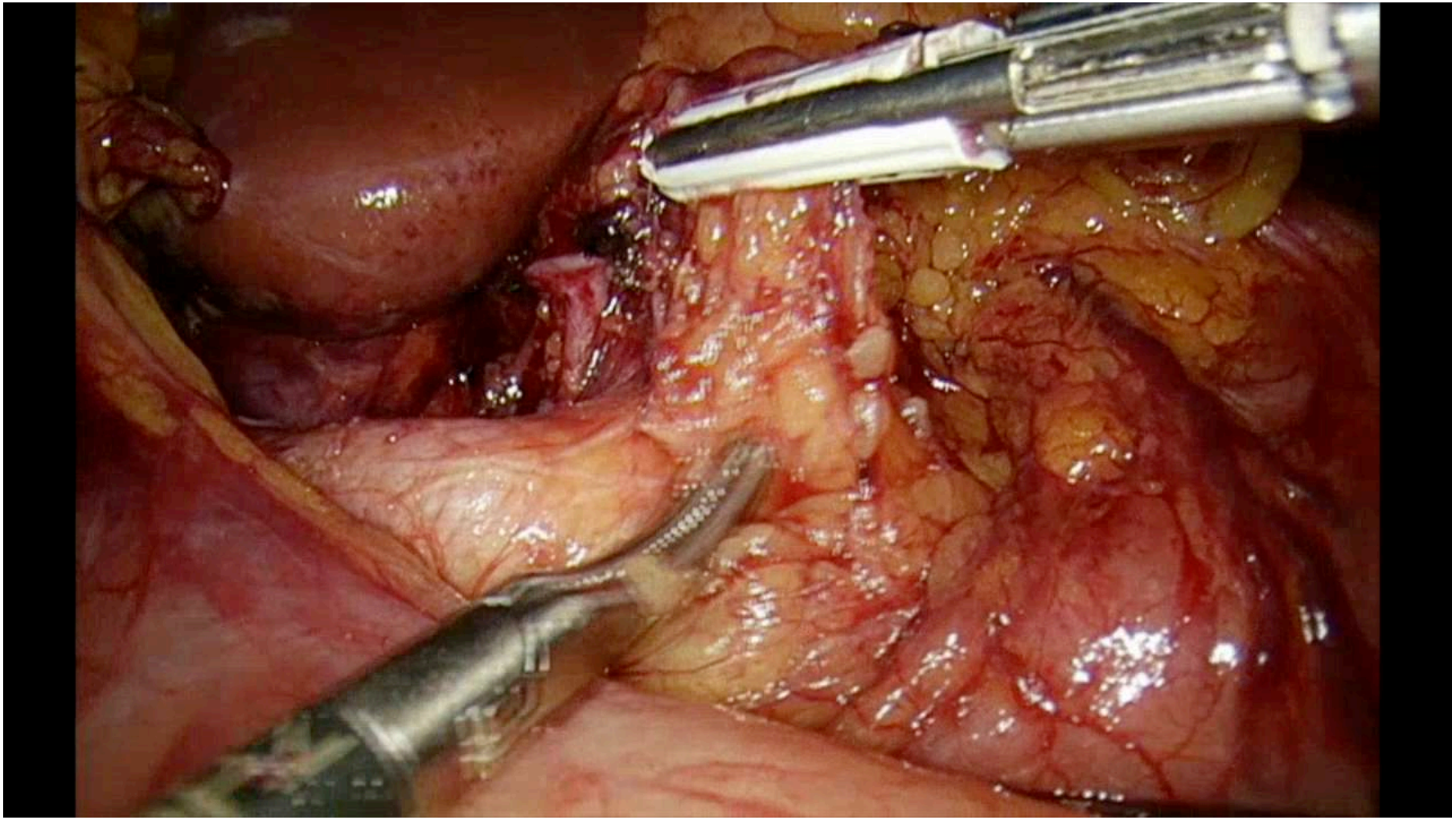

Courtesy dr. S. Gisbertz, upper GI surgeon

Creation of a gastric tube

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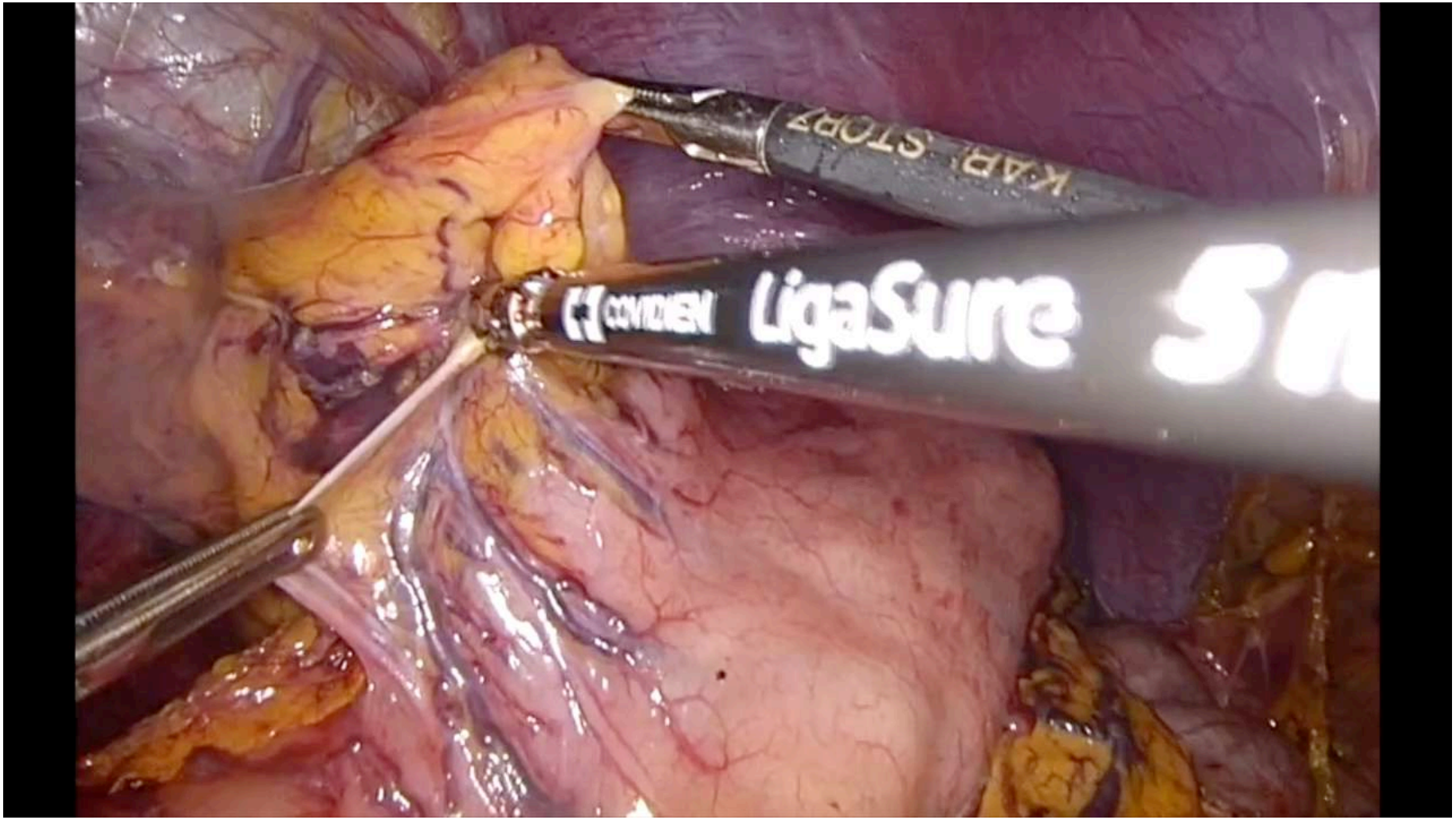

Courtesy dr. S. Gisbertz, upper GI surgeon

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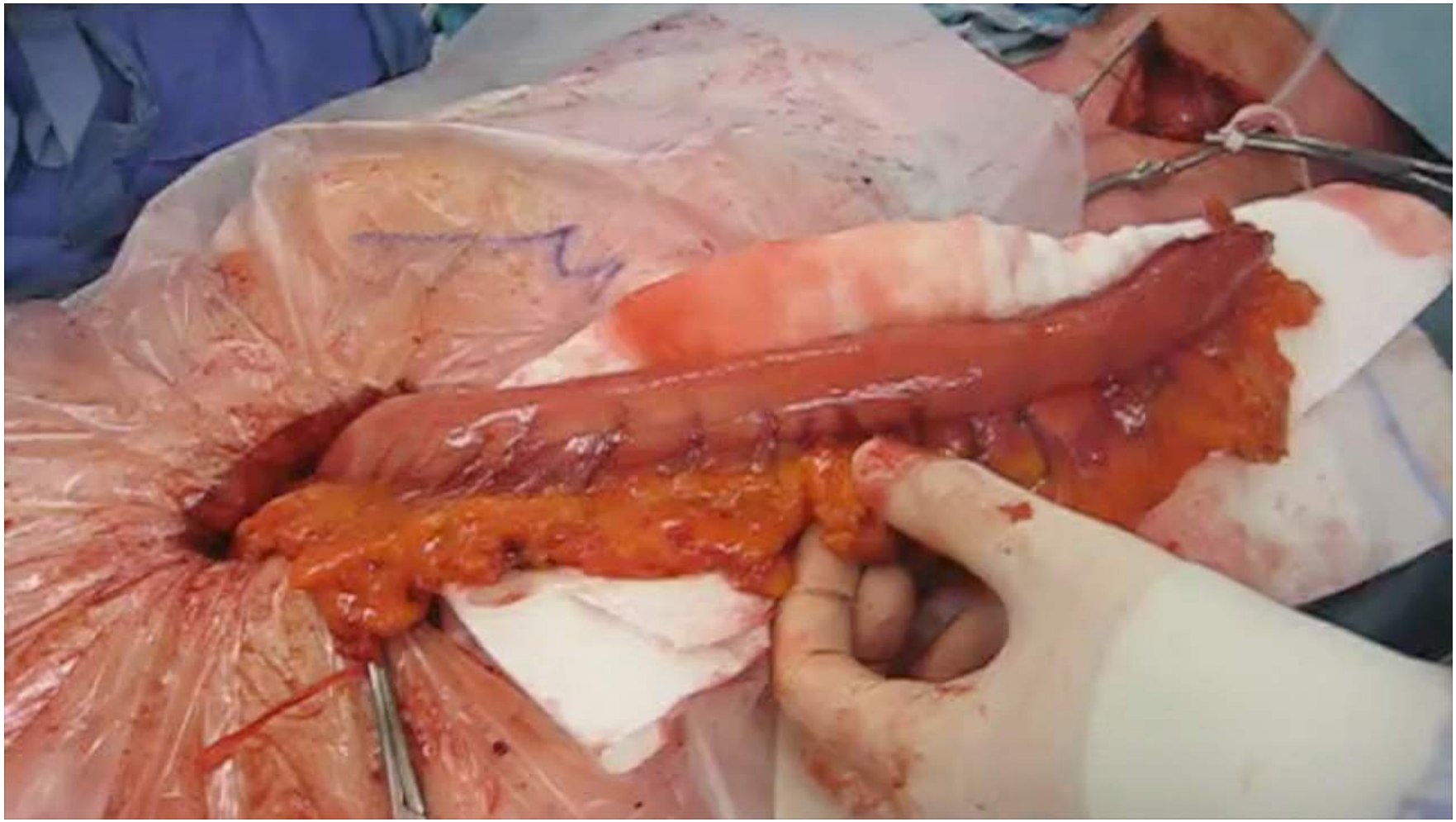

Courtesy dr. S. Gisbertz, upper GI surgeon

Resection of gastric cancer

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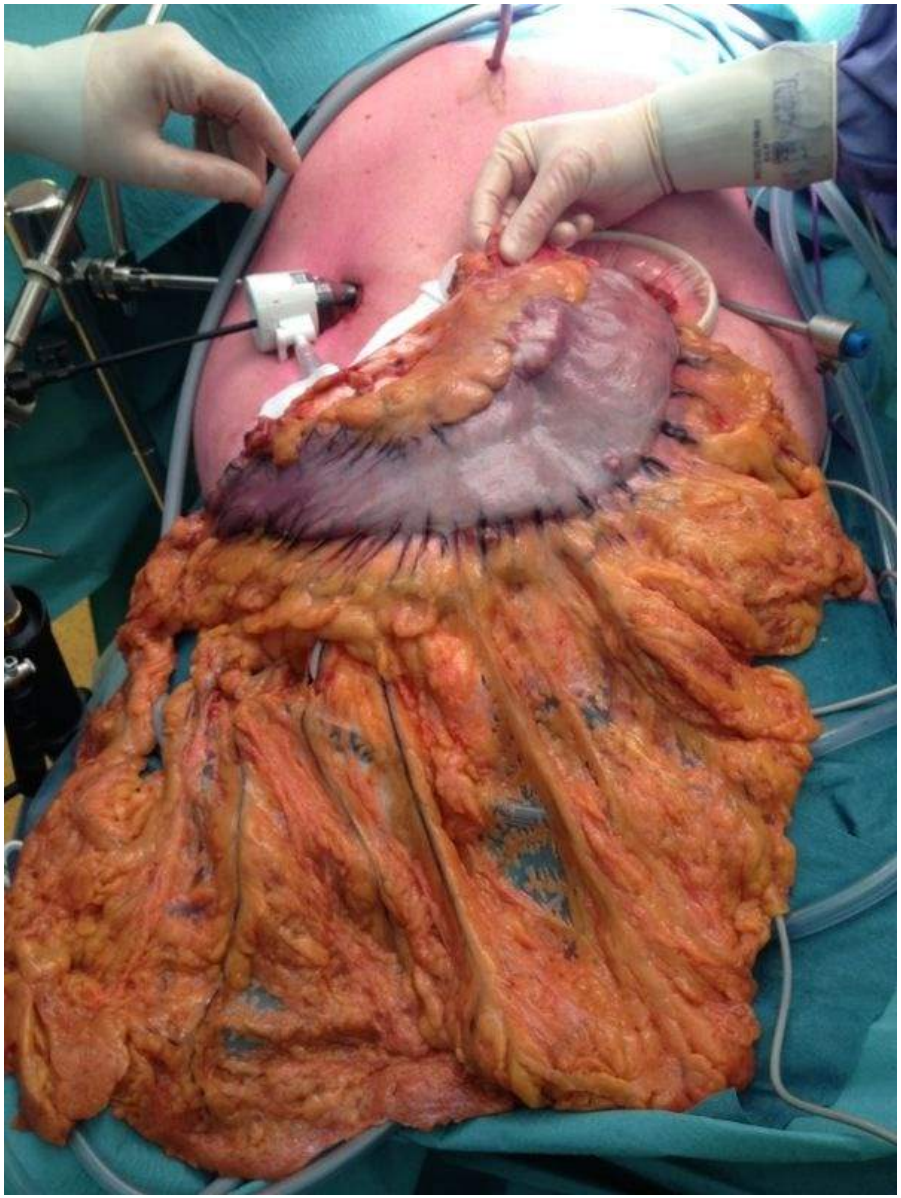

Courtesy dr. S. Gisbertz, upper GI surgeon

Need for centralization of care

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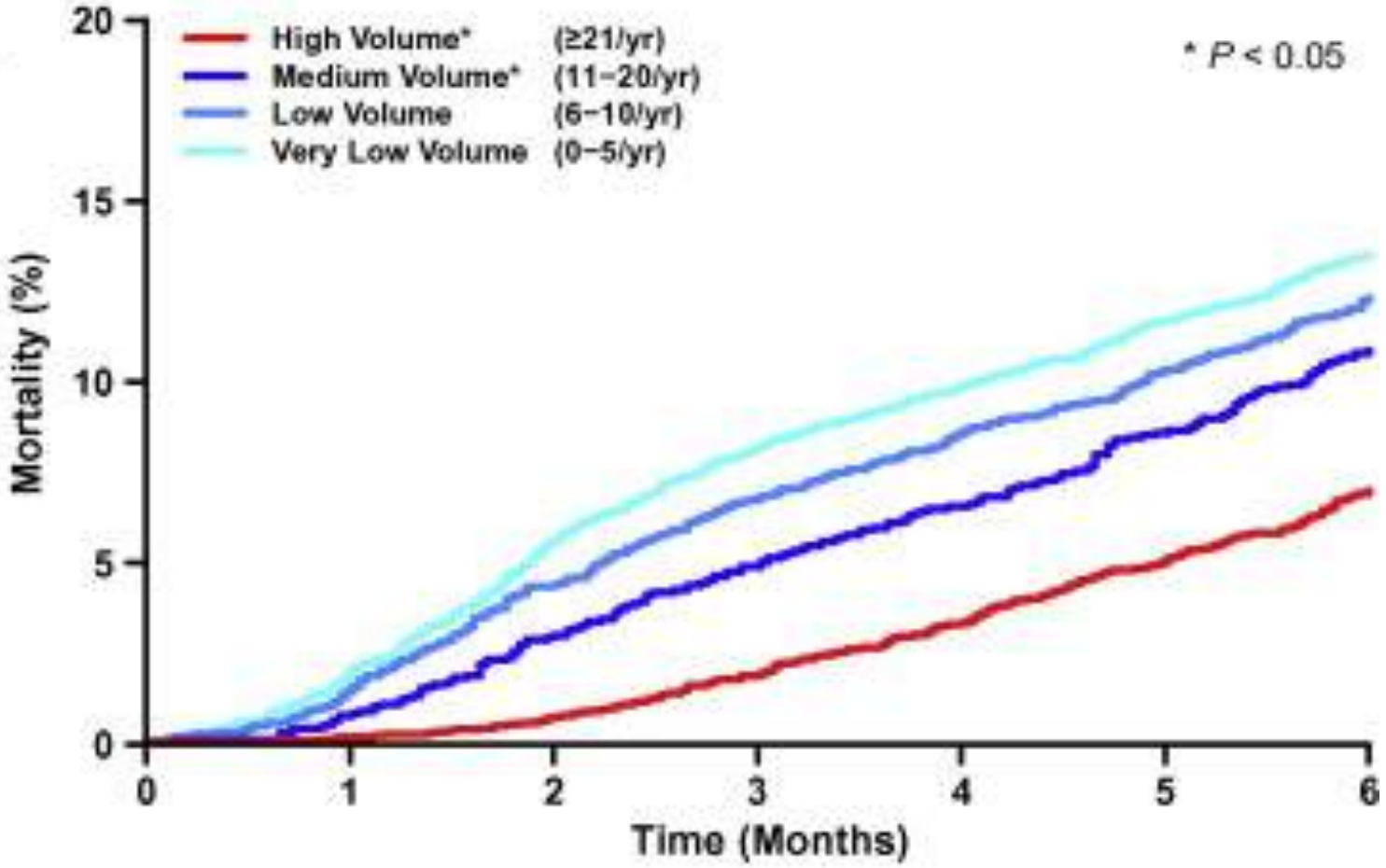

Dikken, Eur J Cancer 2012

Need for centralization of care – also in the palliative setting!

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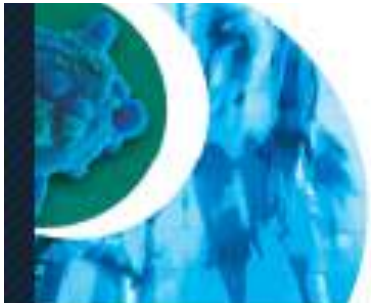

EJC
EUROPEAN JOURNAL OF CANCER

Volume-outcome relation in palliative systemic treatment of metastatic oesophagogastric cancer

Haj Mohammad N, Bernards N, van Putten M, Lemmens VEPP, van Oijen MGH, **van Laarhoven** HWM.

Eur J Cancer 2017

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Needed: multimodality treatment!

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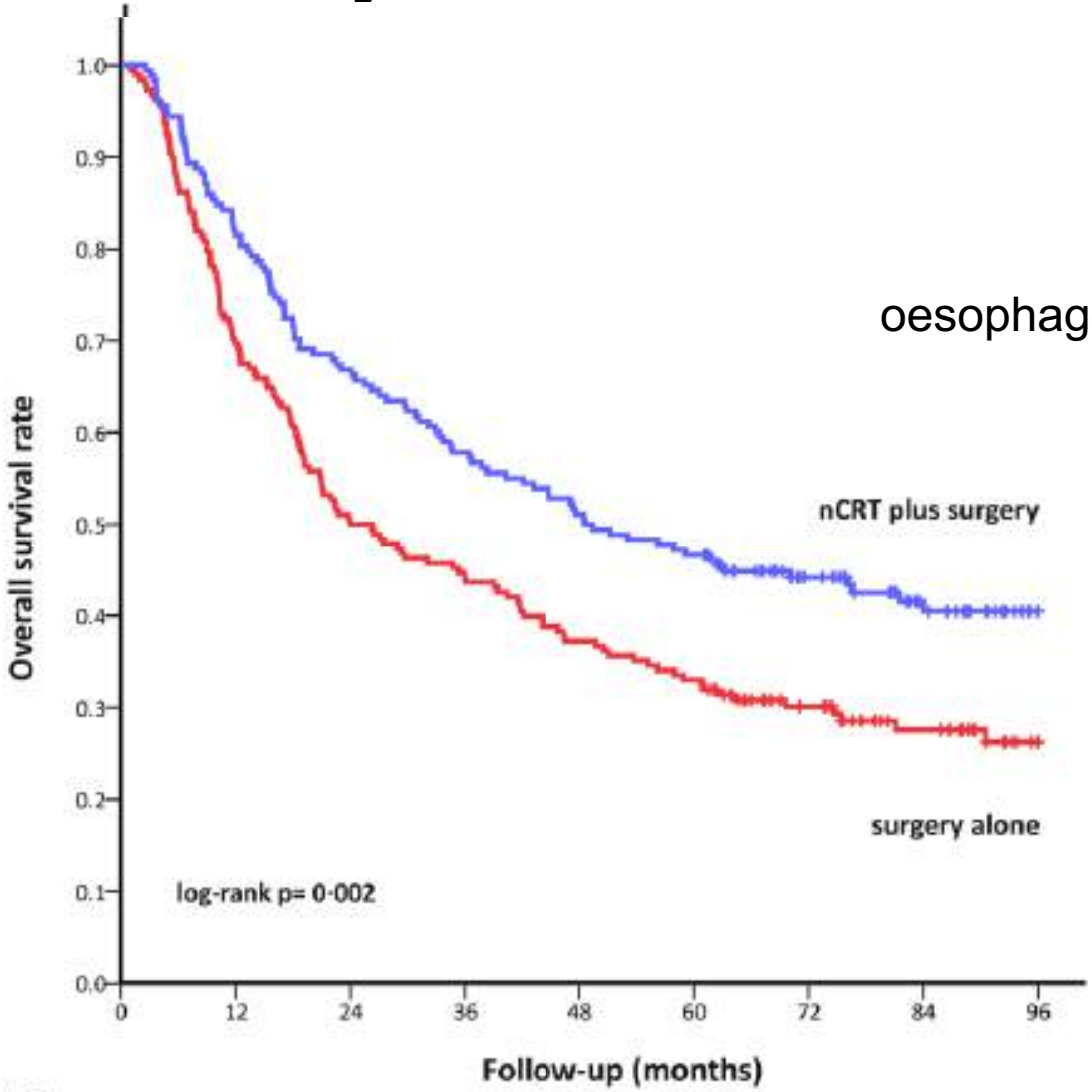
oesophageal cancer



Patients at risk									
nCRT plus surgery	178	145	119	103	91	83	59	40	22
Surgery alone	188	131	94	83	70	62	42	28	14
Total	366	276	213	186	161	145	101	68	36

Shapiro Lancet Oncol 2015

Needed: multimodality treatment!

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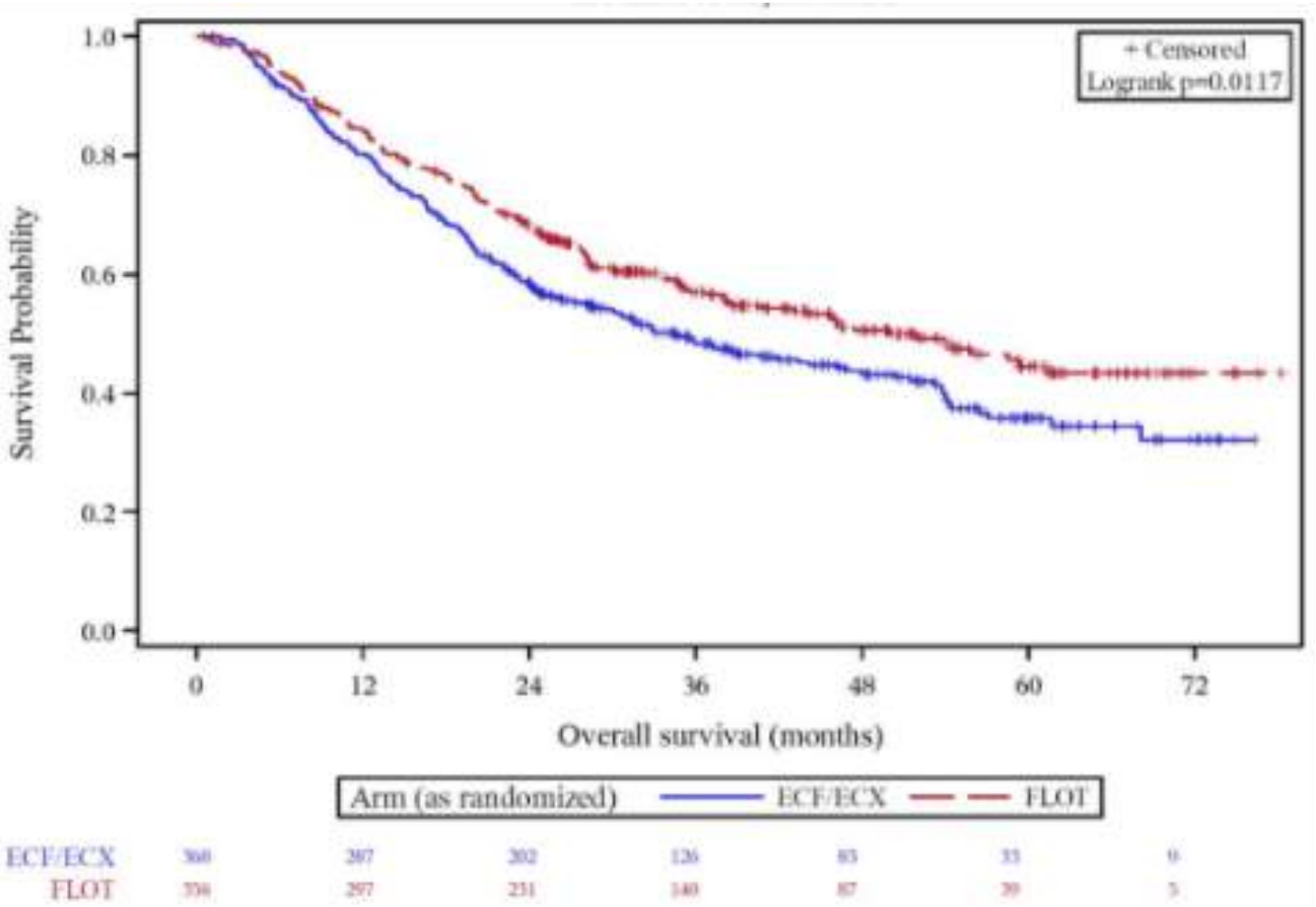
gastric cancer



Al Batran ASCO 2018

Needed: research!

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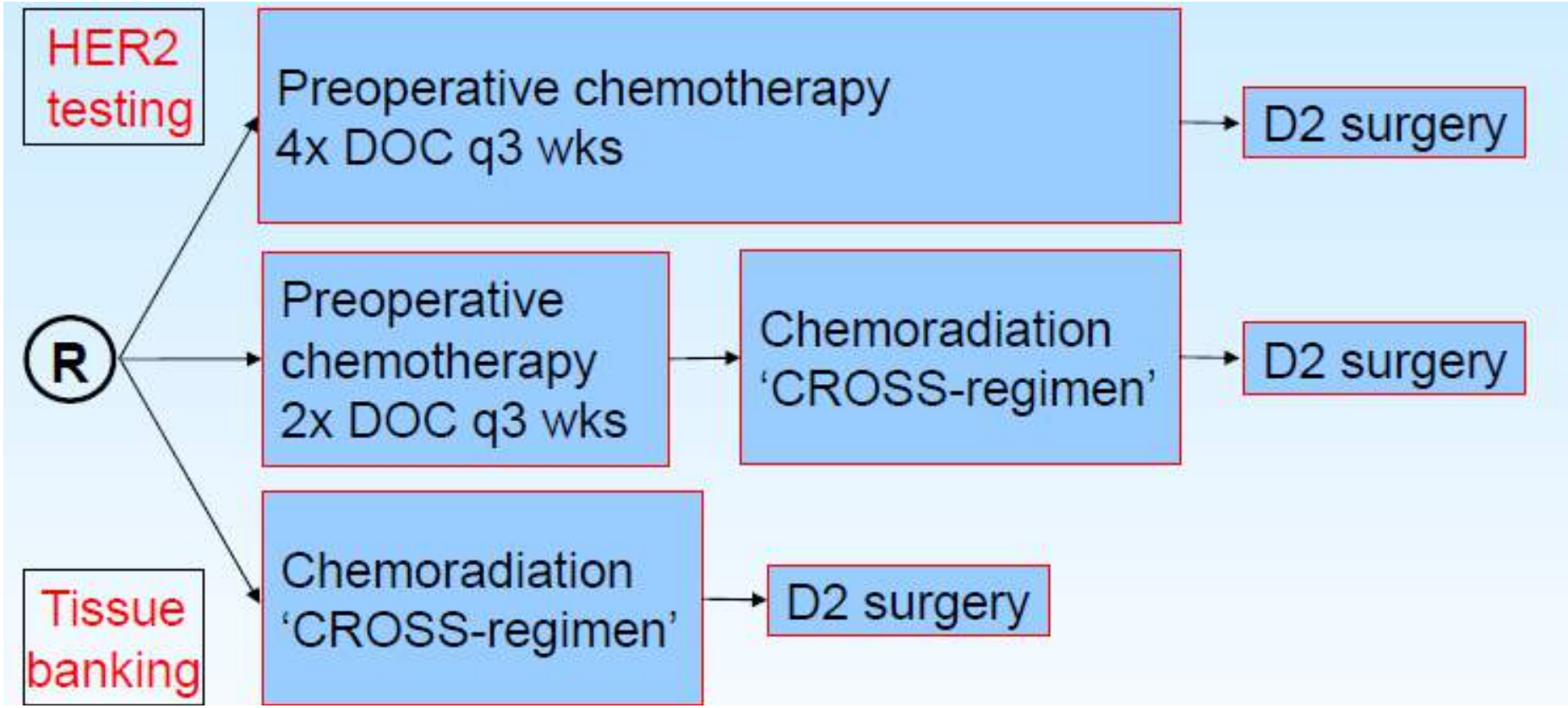

CRITICS-2 study design

Needed: research!

PDL-1 targ**e**ting in **r**esectable oesophageal cancer: a phase IB and **fe**asibility study of Atezolizumab and **c**hemoradia**t**ion: A single arm feasibility study

Wk 1 Day 1	Wk 2 Day 8	Wk 3 Day 15	Wk 4 Day 22	Wk 5 Day 29	Wk 6 Day 36	Wk 7 Day 43	Wk 8 Day 50	Wk 9 Day 57	Wk 10 Day 64	Wk 11 Day 71	Wk 12 Day 78	Wk 13 Day 85	Wk 14 Day
T C RT A	T C RT	T C RT	T C RT A	T C RT		A			A			A	S

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UMC Utrecht

PERFECT study design

Immunotherapy

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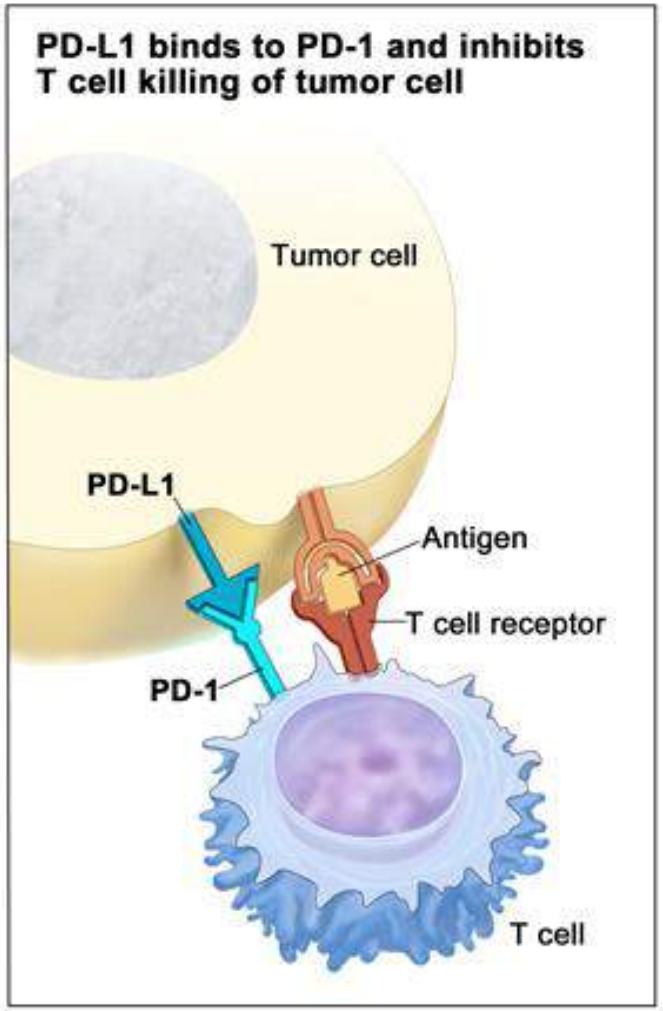

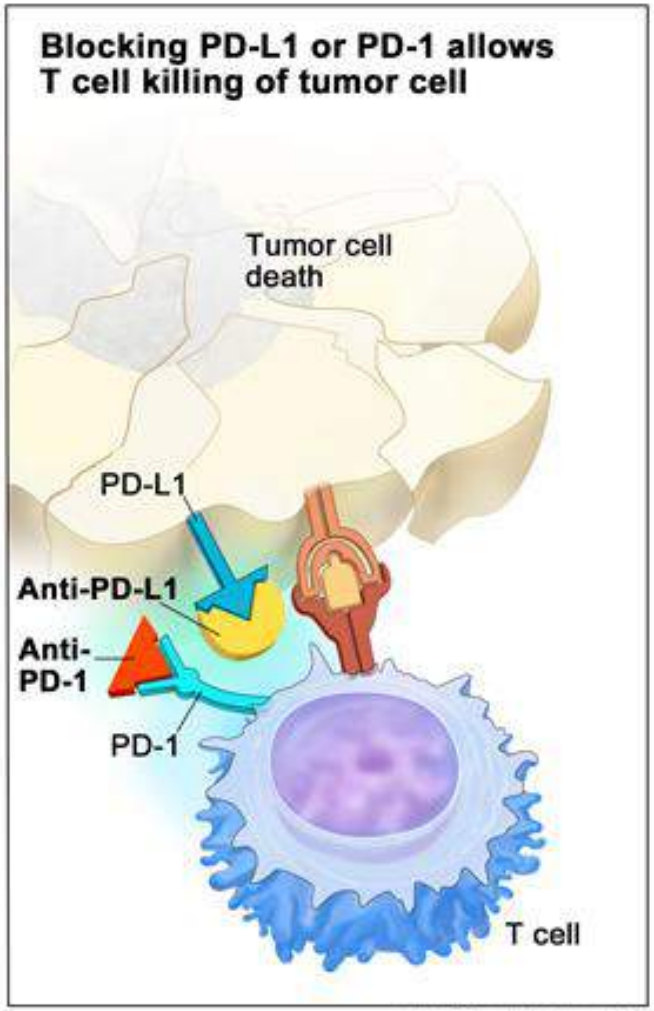

Immunotherapy works (a bit)

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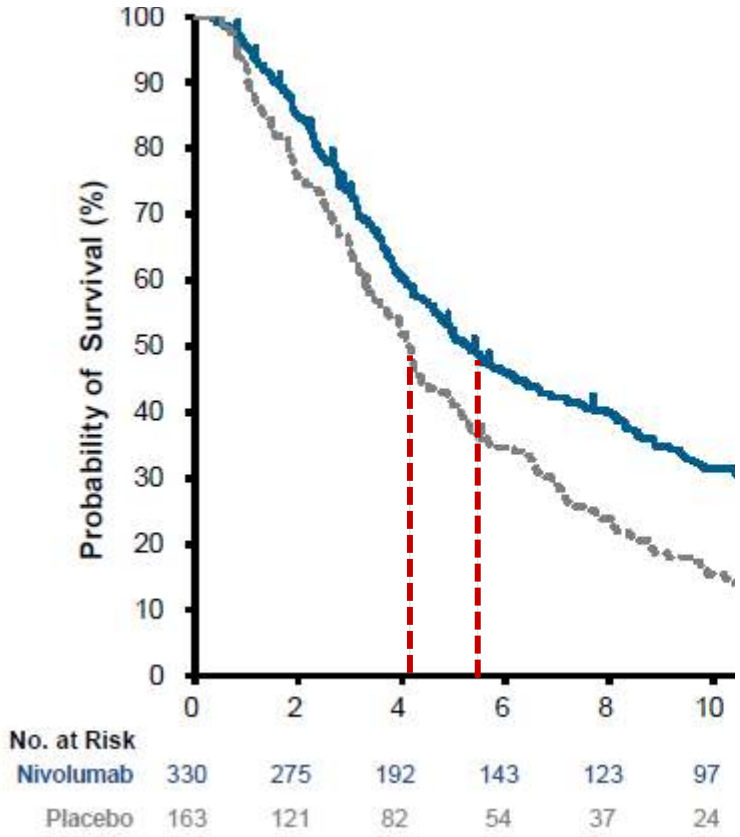

Median follow-up[a]: 15.7 months (range, 12.1–27.2)	
Median OS, months (95% CI)	
Nivolumab (N = 330)	5.3 (4.6–6.4)
Placebo (N = 163)	4.1 (3.4–4.9)
Hazard ratio, 0.62 (95% CI, 0.50–0.76) *P* < 0.0001	

Boku ESMO 2017

Immunotherapy works (a bit)

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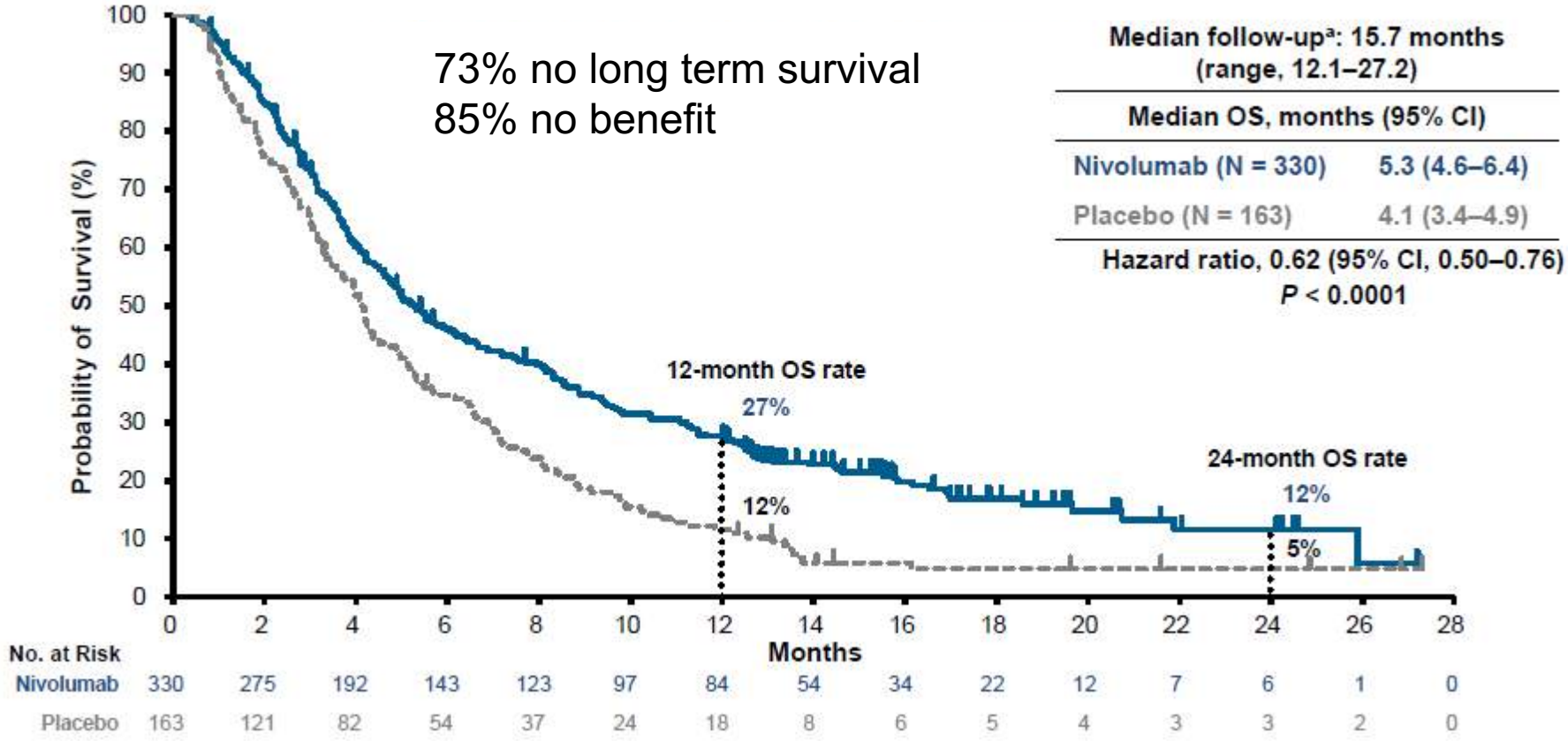

Boku ESMO 2017

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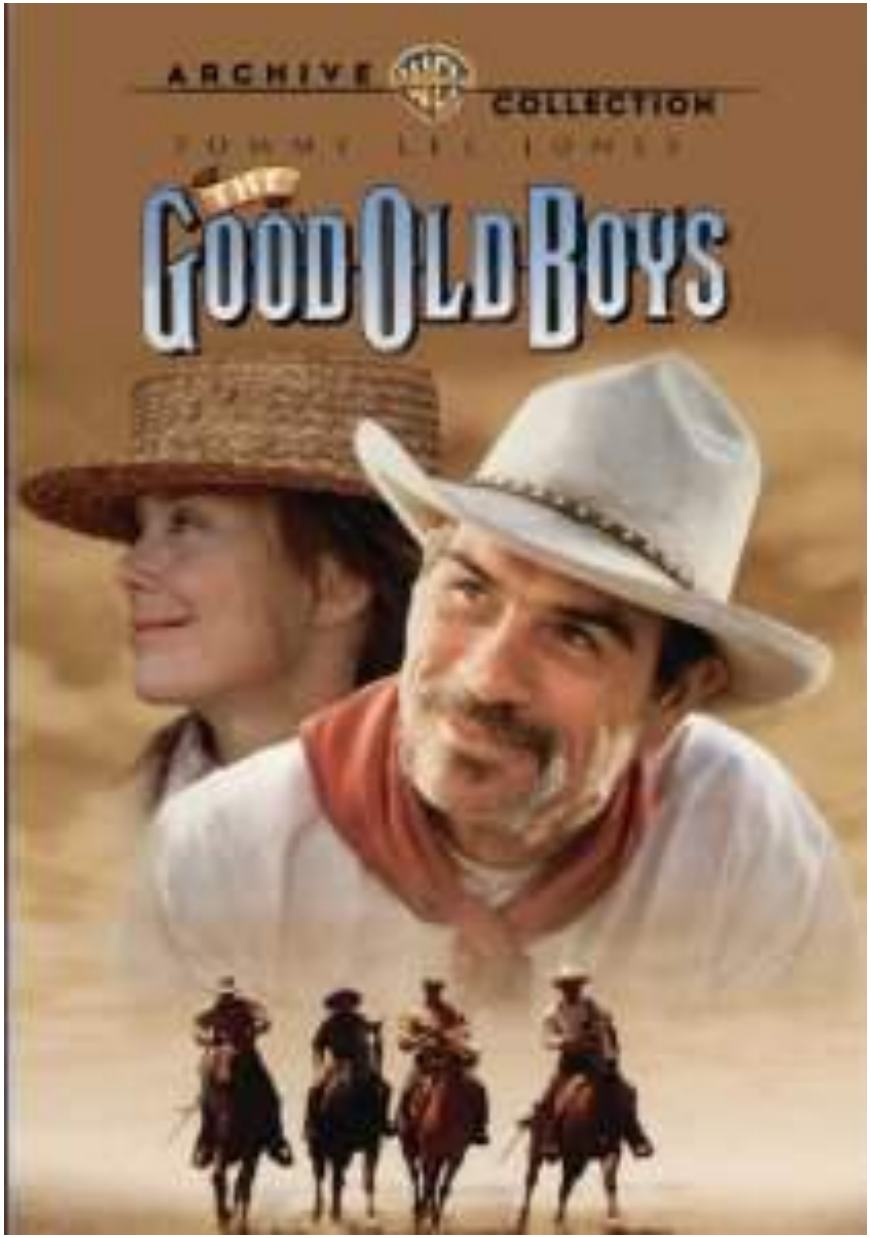
Targeted therapy

Chemotherapy



Targeted therapy

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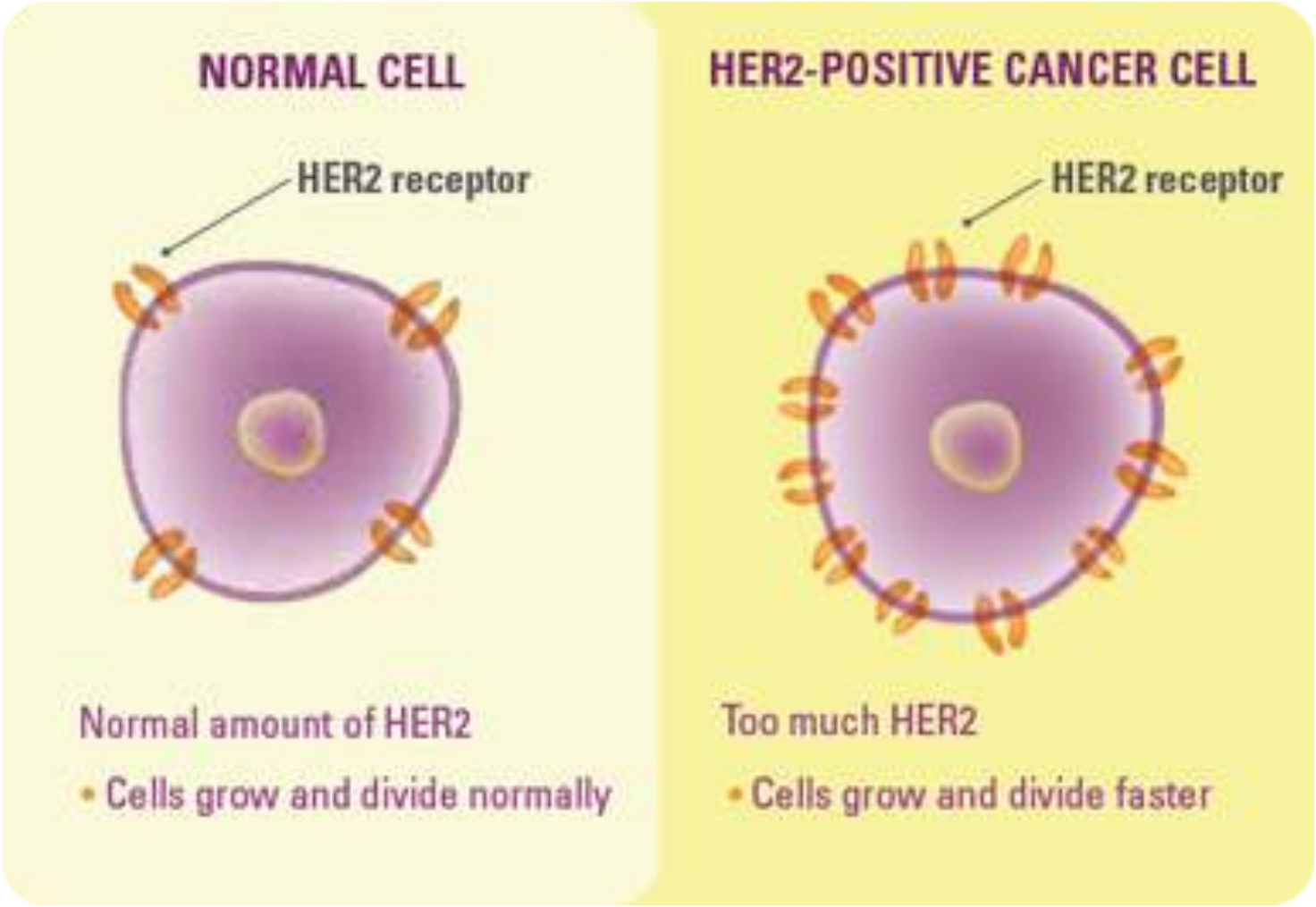

HER2 targeted therapy

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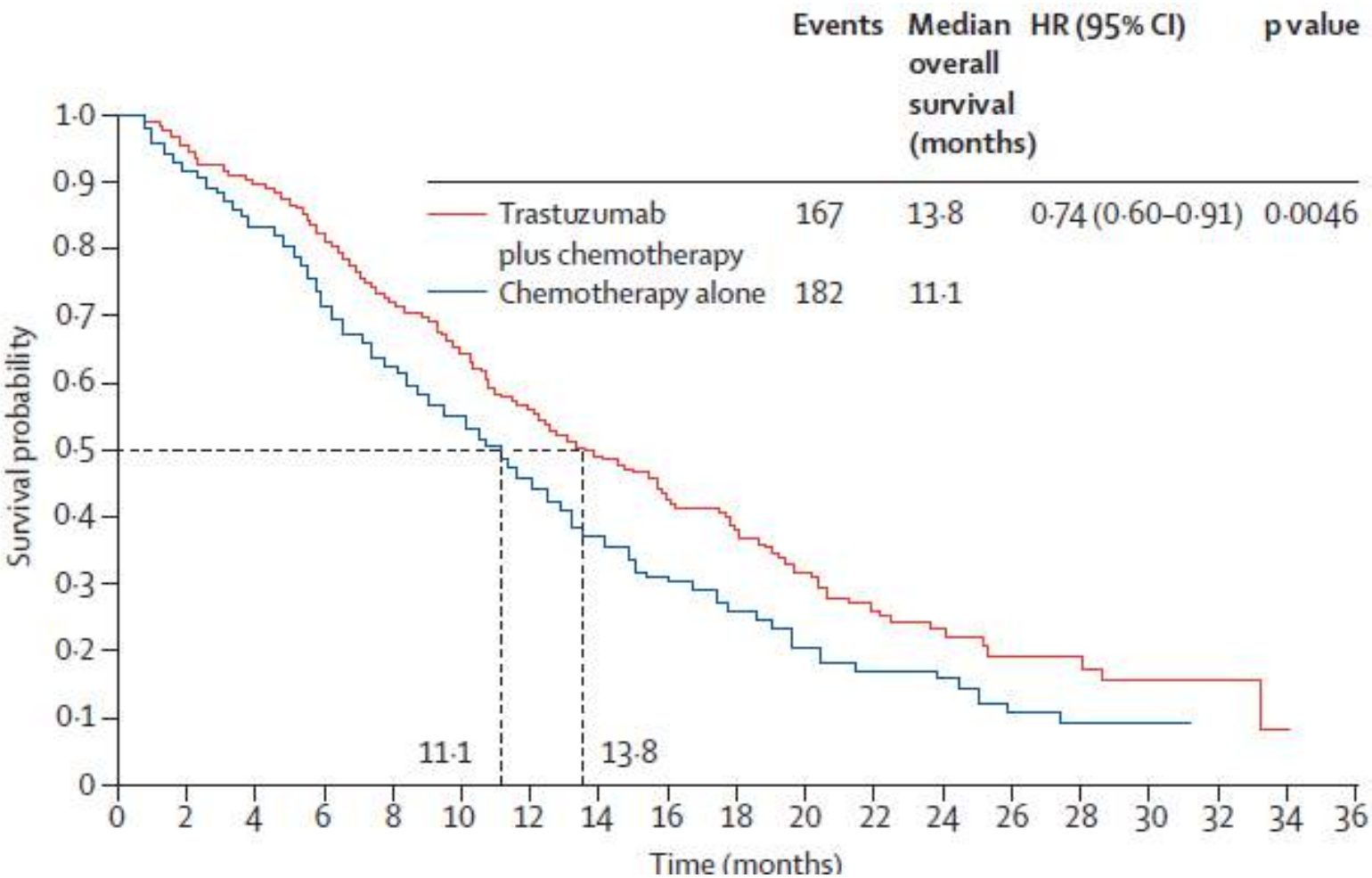

Bang, Lancet 2010, 376 (9742): 687

Resistance develops …

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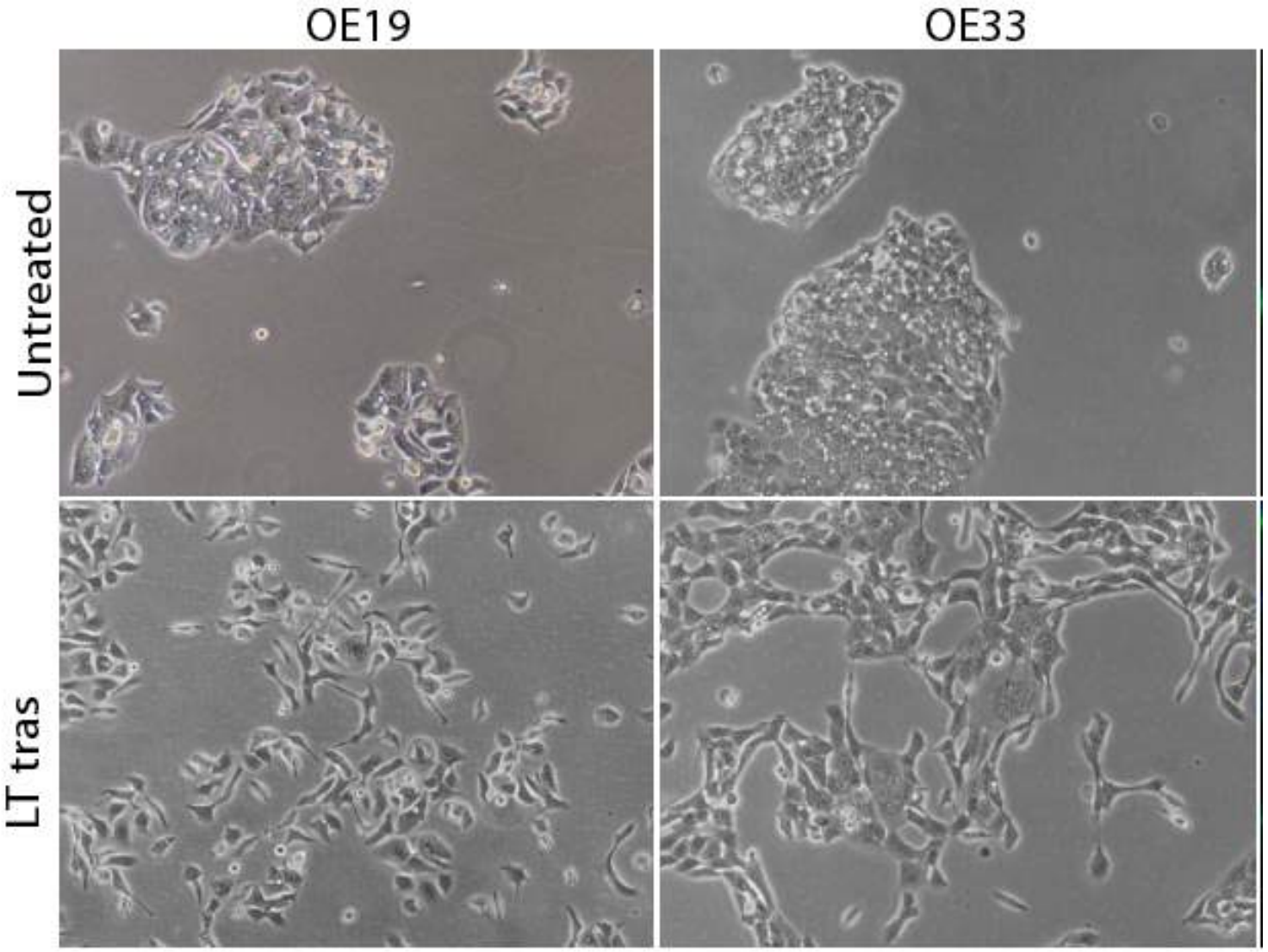

Ebbing , Oncotarget 2016

Chemotherapy

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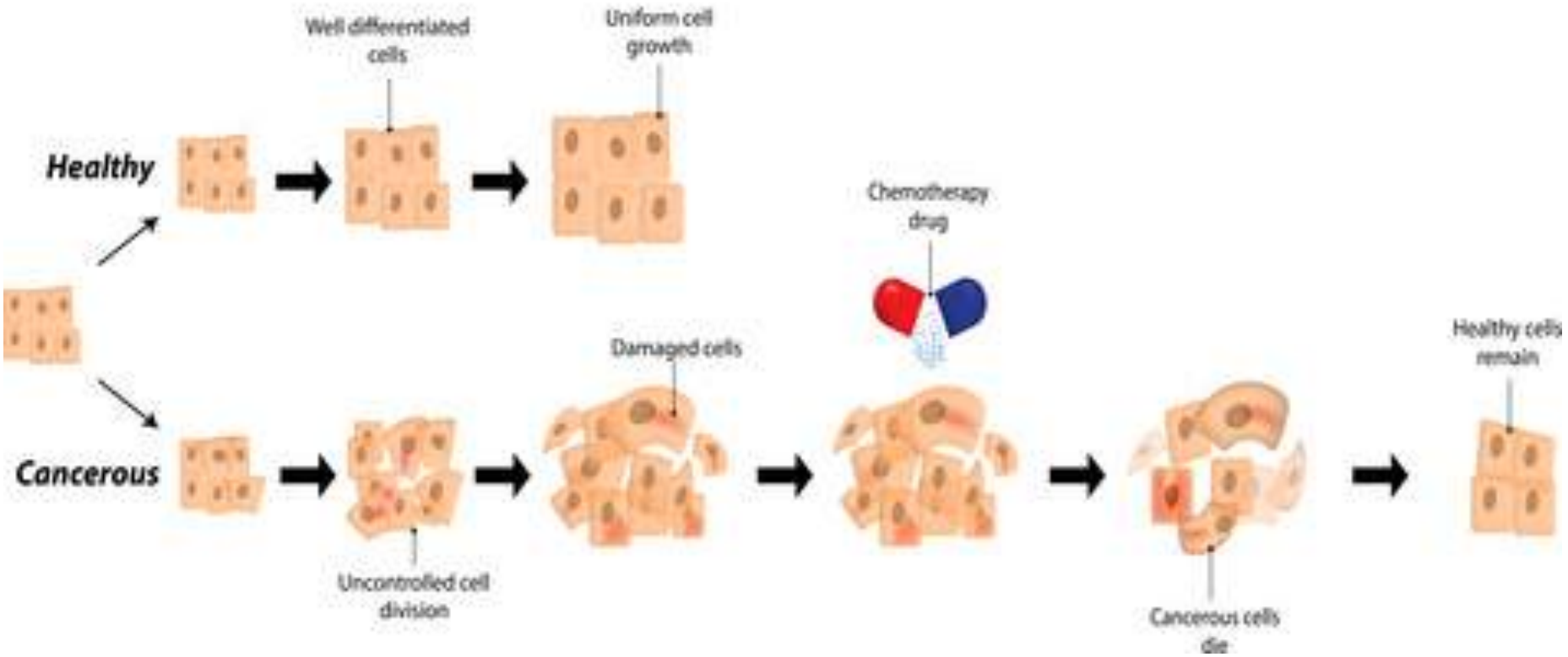


EVIDENCE
EVIDENCE

Volume 108, Issue 10
October 2016

Amsterdam UMC

The Efficacy and Safety of First-line Chemotherapy in Advanced Esophagogastric Cancer: A Network Meta-analysis FREE

Emil ter Veer, Nadia Haj Mohammad, Gert van Valkenhoef, Lok Lam Ngai, Rosa M. A. Mali, Maarten C. Anderegg, Martijn G. H. van Oijen, Hanneke W. M. van Laarhoven

JNCI: Journal of the National Cancer Institute, Volume 108, Issue 10, 1 October 2016, djw166, https://doi.org/10.1093/jnci/djw166

Published: 30 August 2016 **Article history** ▾

Ter Veer JNCI 2016

Network meta-analysis

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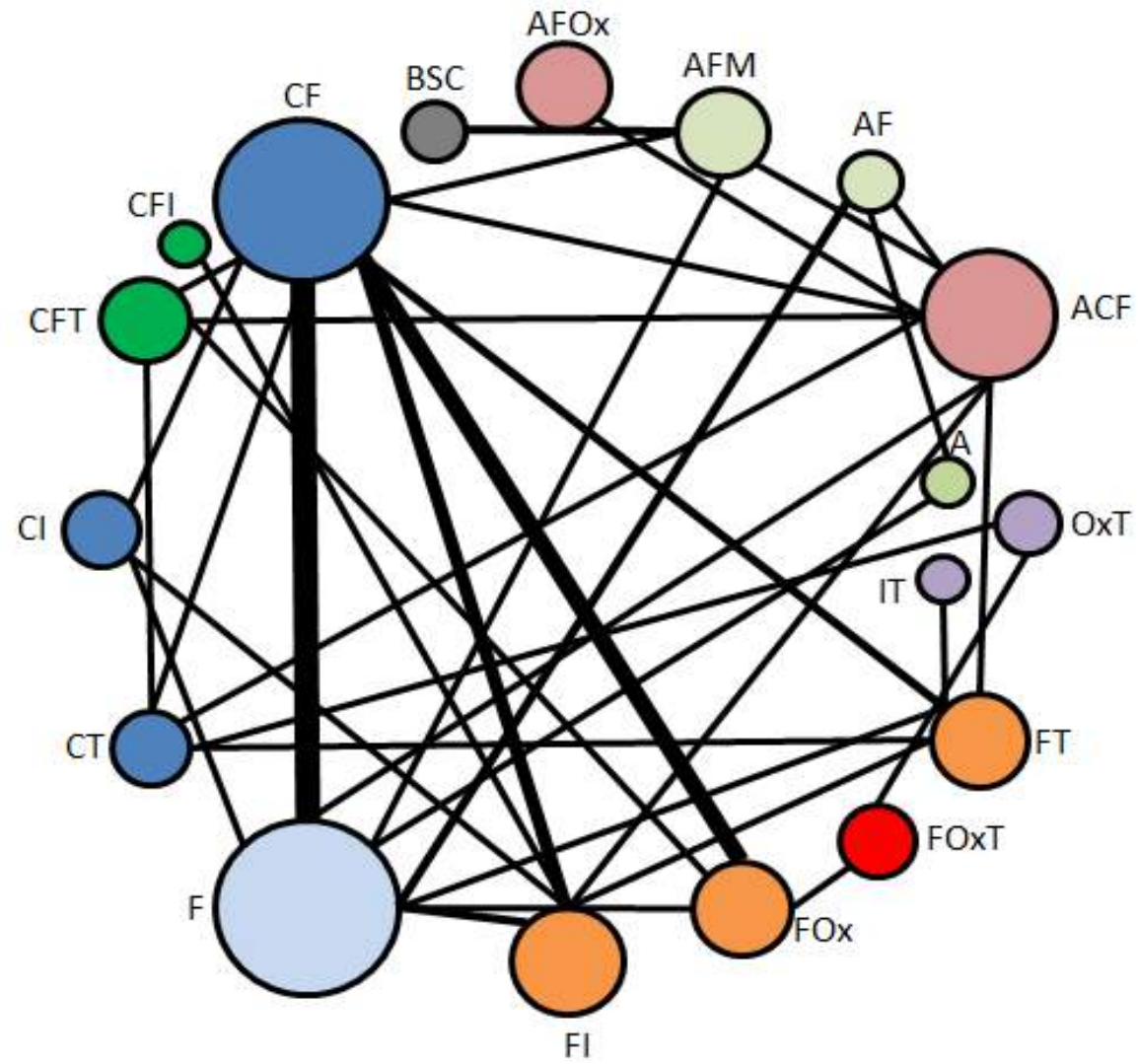

Ter Veer JNCI 2016

All regimens compared to supportive care

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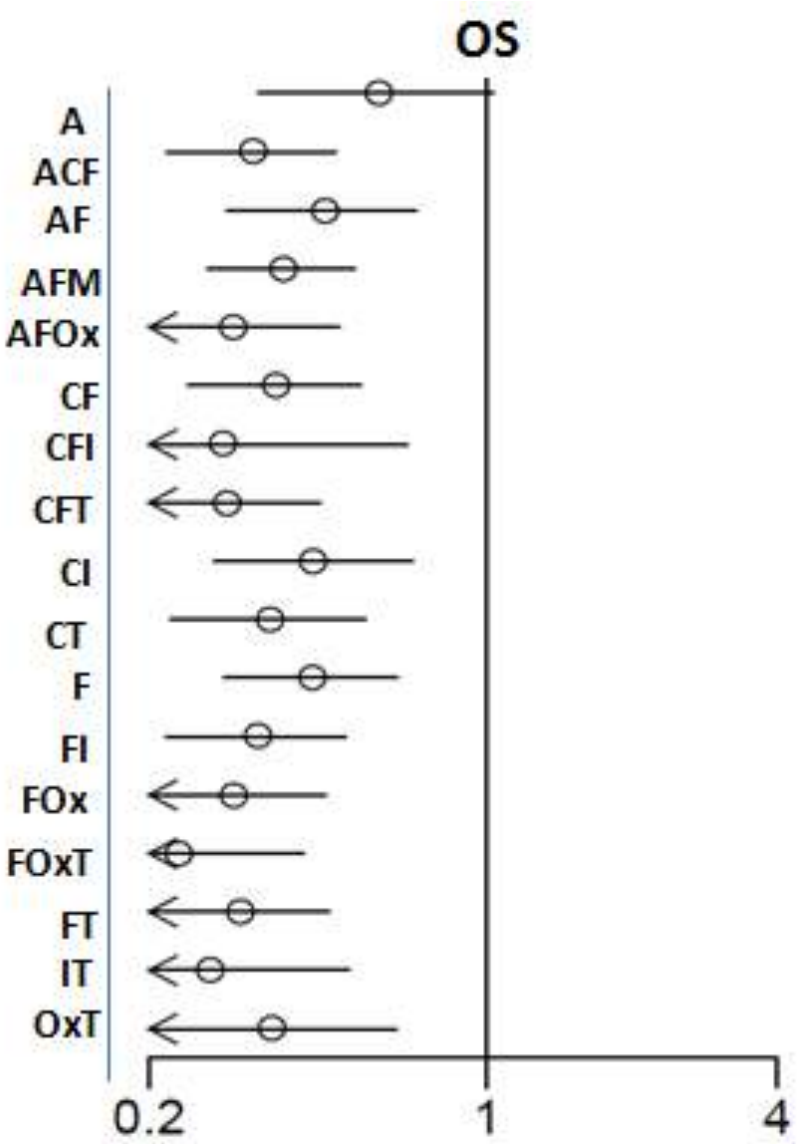

Ter Veer JNCI 2016

All regimens compared to monotherapy

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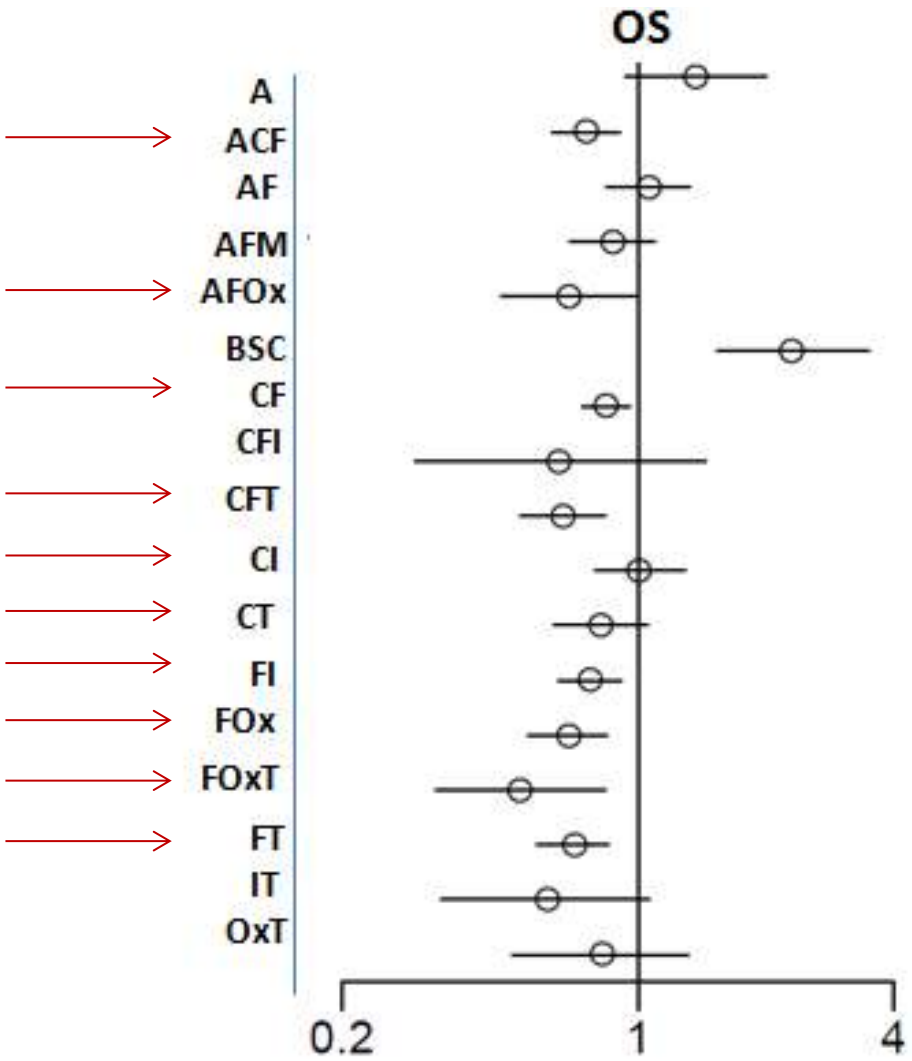

Ter Veer JNCI 2016

No benefit of anthracycline triplets over F-doublets

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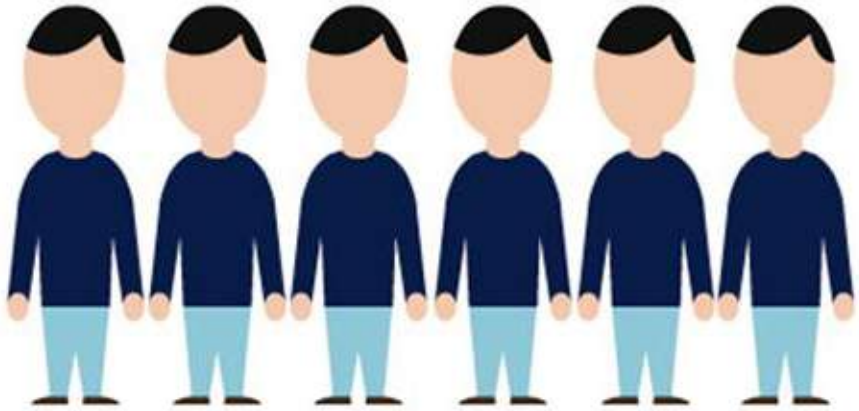
FI	1.18 (0.78–1.78) 1.05 (0.81–1.40)	– 1.08 (0.81–1.48)	1.01 (0.83–1.23) 1.08 (0.85–1.40)	– 1.17 (0.76–1.86)
1.01 (0.66–1.56) 0.92 (0.73–1.14)	**FT**	– 1.03 (0.75–1.40)	1.09 (0.72–1.64) 1.03 (0.79–1.34)	– 1.13 (0.70–1.76)
– 0.89 (0.69–1.13)	– 0.97 (0.75–1.26)	**FOx**	– 1.00 (0.74–1.36)	– 1.09 (0.67–1.75)
1.01 (0.83–1.24) 0.98 (0.79–1.20)	0.81 (0.52–1.26) 1.06 (0.85–1.35)	– 1.10 (0.86–1.42)	**ACF**	1.09 (0.95–1.24) 1.09 (0.75–1.58)
– 0.89 (0.61–1.30)	– 0.97 (0.66–1.45)	– 1.00 (0.67–1.51)	0.91 (0.79–1.04) 0.91 (0.66–1.25)	**AFOx**

Ter Veer JNCI 2016

Controlled setting



Real world

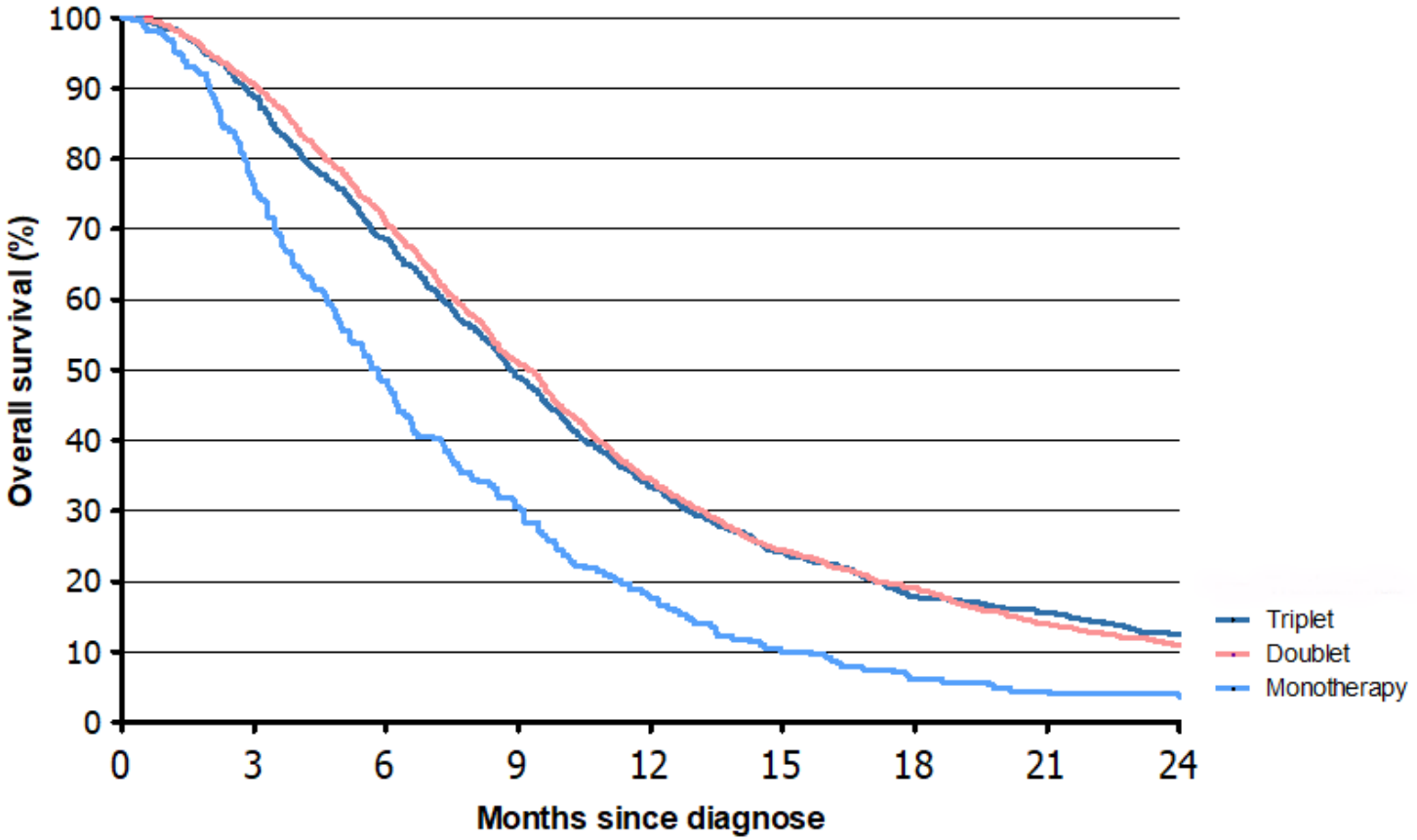
POCOP

DUCG
Dutch Upper GI Cancer Group

Prospective **O**bservational **C**ohort **S**tudy of
Oesophageal-gastric cancer **P**atients

W. Dijksterhuis, EGCC 2018

Real world data from the Dutch Cancer Registry



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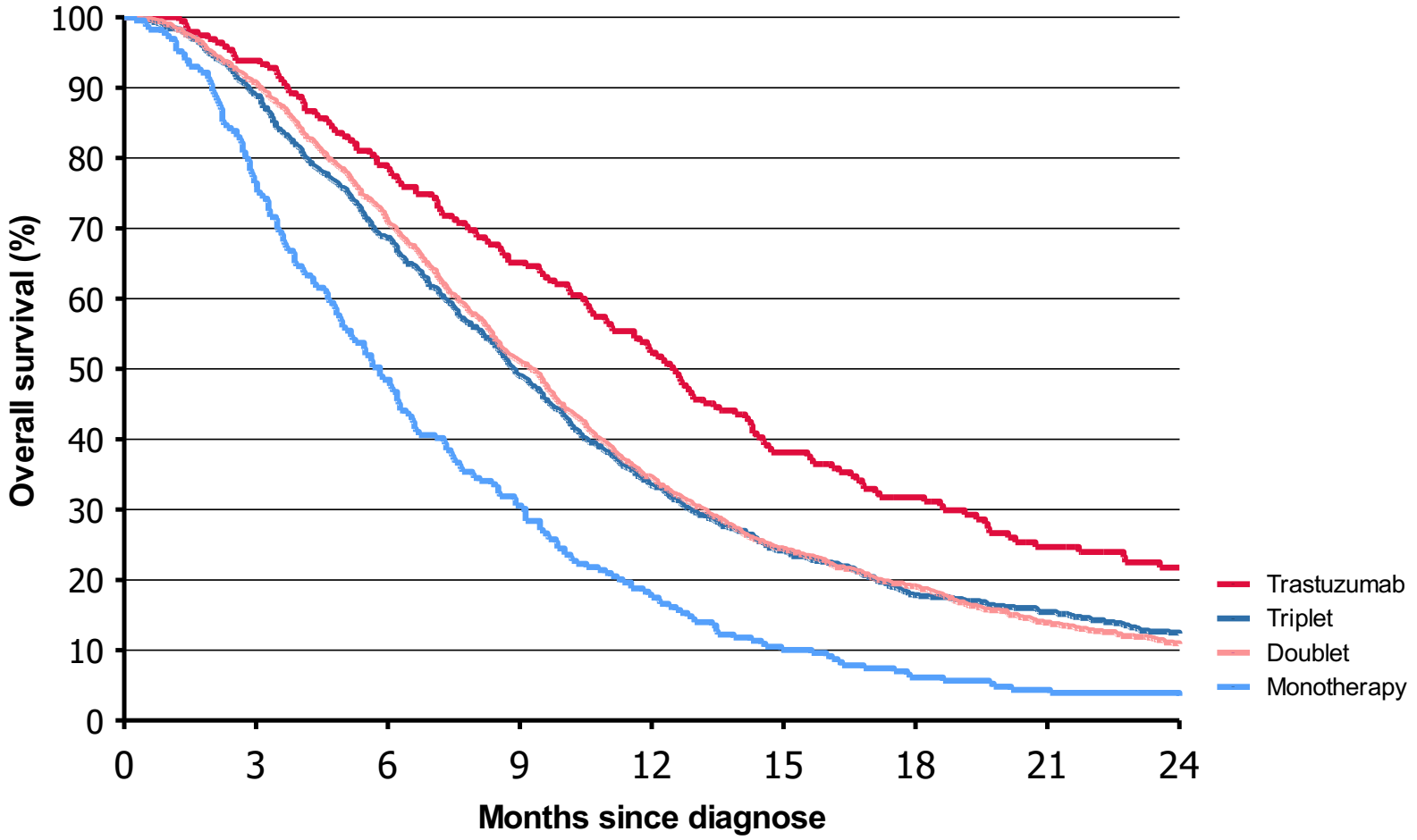


W. Dijksterhuis, EGCC 2018

Time for prognostic/predictive models?

DUCG
Dutch Upper GI Cancer Group

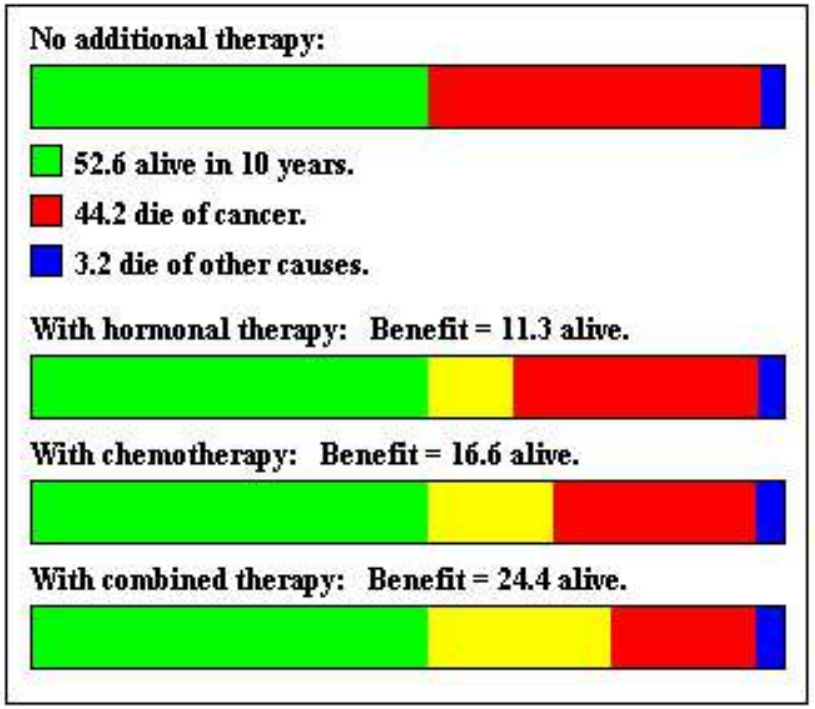
Adjuvant! for Breast Cancer (Version 8.0)

Patient Information

Age:	51
Comorbidity:	Minor Problems
ER Status:	Positive
Tumor Grade:	Grade 3
Tumor Size:	2.1 - 3.0 cm
Positive Nodes:	1 - 3
Calculate For:	Mortality
10 Year Risk:	45 Prognostic

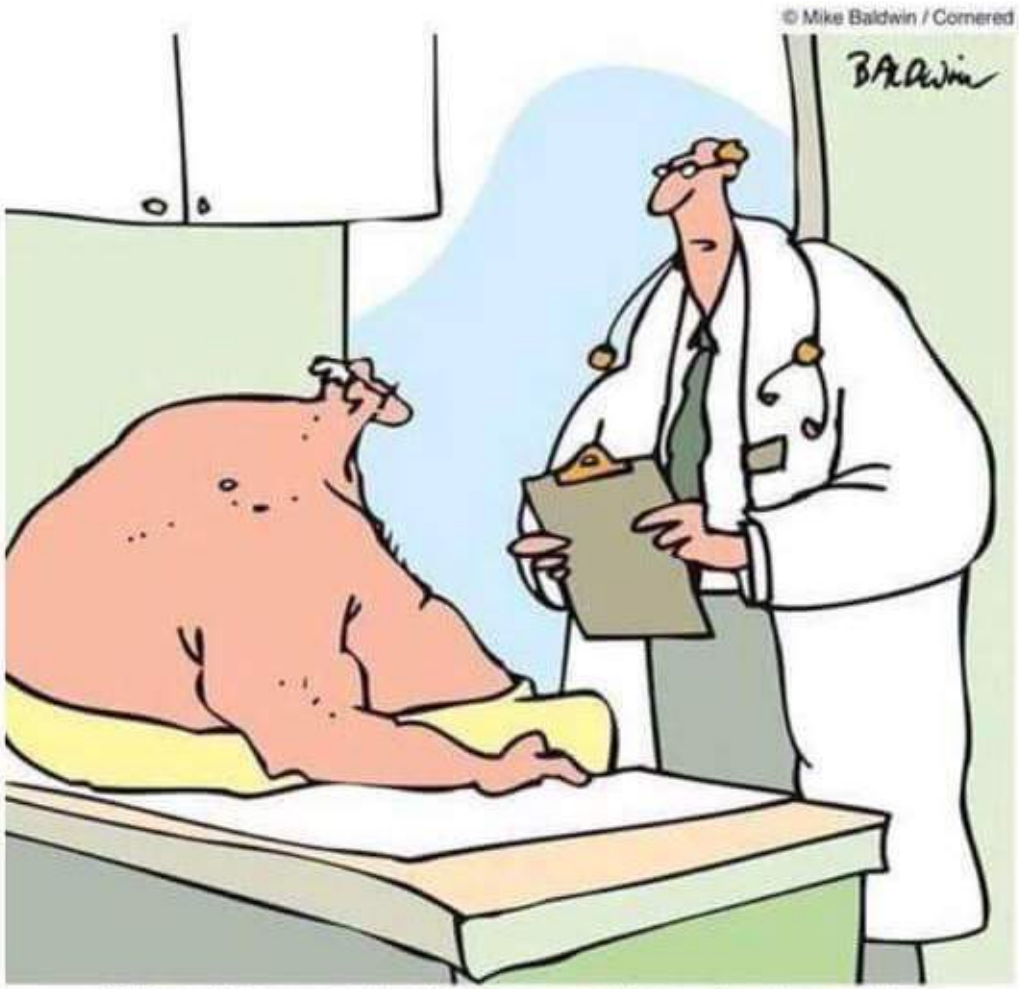
Adjuvant Therapy Effectiveness

Horm:	Tam for 2-3 yrs then AI for 2-3 yrs
Chemo:	3rd Generation Regimens



Webinterface to allow for shared decision making: SOURCE

H. van den Boorn ASCO 2018



"You've got six months, but with aggressive treatment we can help make that seem much longer."

Improved efficacy is correlated with improved QOL

Study	Treatment Groups	Efficacy Versus QoL
Glimelius 1997[13]	ELF + BSC BSC	Improved efficacy and improved QoL for ELF
Webb 1997[8]	FAMTX ECF	Improved efficacy and improved QoL for ECF
Tebbutt 2002[10]	PVI 5-FU PVI 5-FU + MMC	Equal efficacy and equal QoL
Ross 2002[9]	ECF MCF	Equal efficacy but worse QoL for MCF
Ajani 2007[11]	CF DCF	Improved efficacy and improved QoL for DCF
Cunningham 2008[19]	ECF EOF ECX EOX	Equal efficacy and equal QoL for the 3 comparator groups vs ECF
Dank 2008[12]	IF CF	Equal efficacy and equal QoL

Al Batran Cancer 2010

POCOP

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Prospective **O**bservational **C**ohort **S**tudy of
Oesophageal-gastric cancer **P**atients

PROMs

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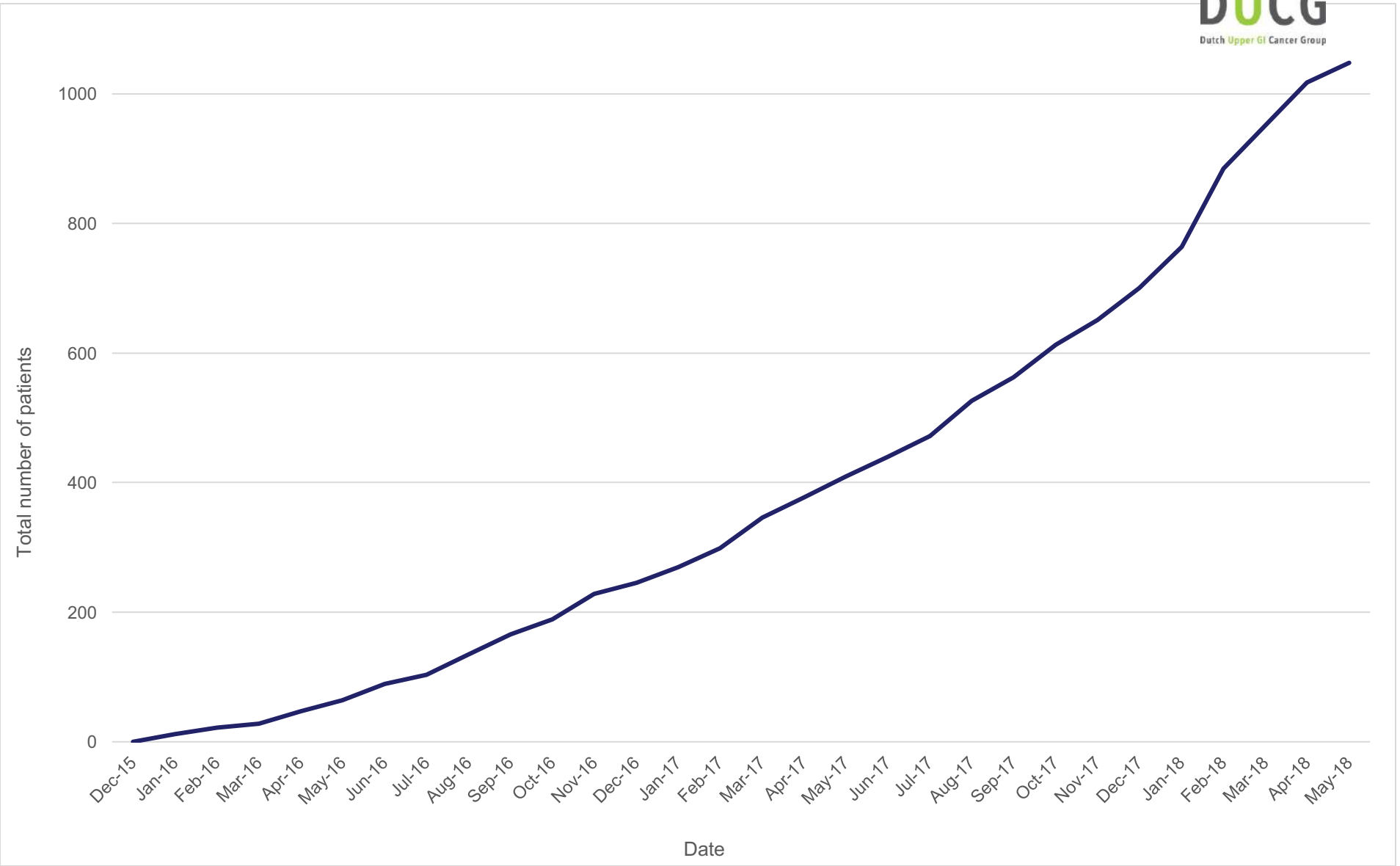
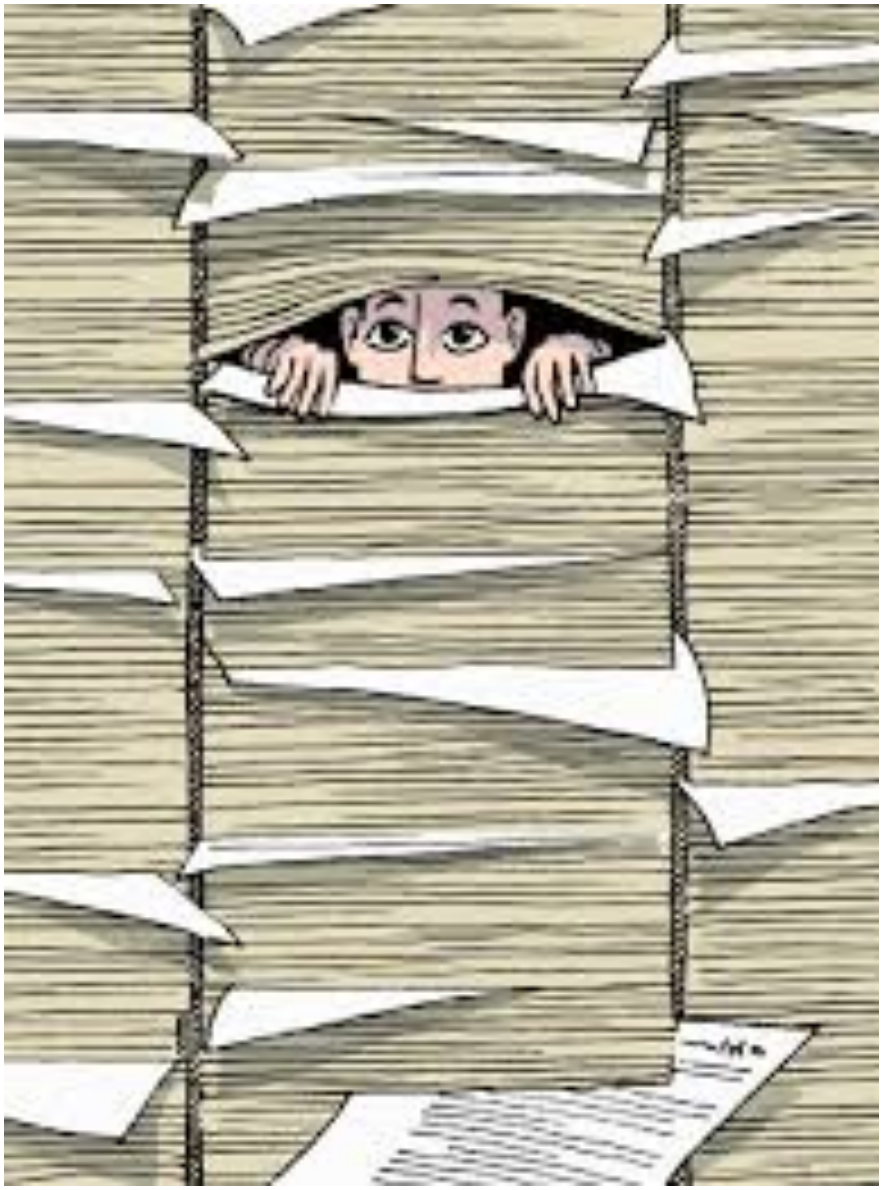
PROMs inclusion

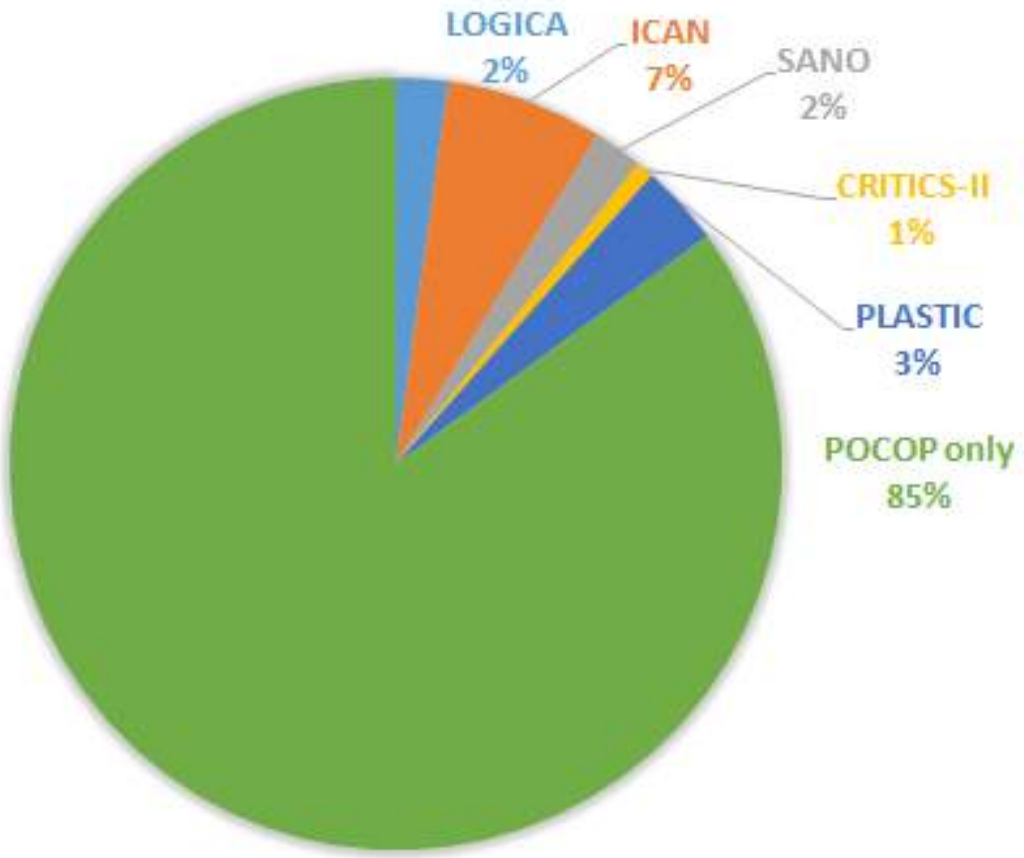




Clinical trials and prospective studies including POCOP-PROMs

- ICAN
- LOGICA
- CRITICS-II
- SANO

- PLASTIC
- eQuipe
- Centralisation study



Courtesy JJ van Kleef

Effect of systematically collecting PROs

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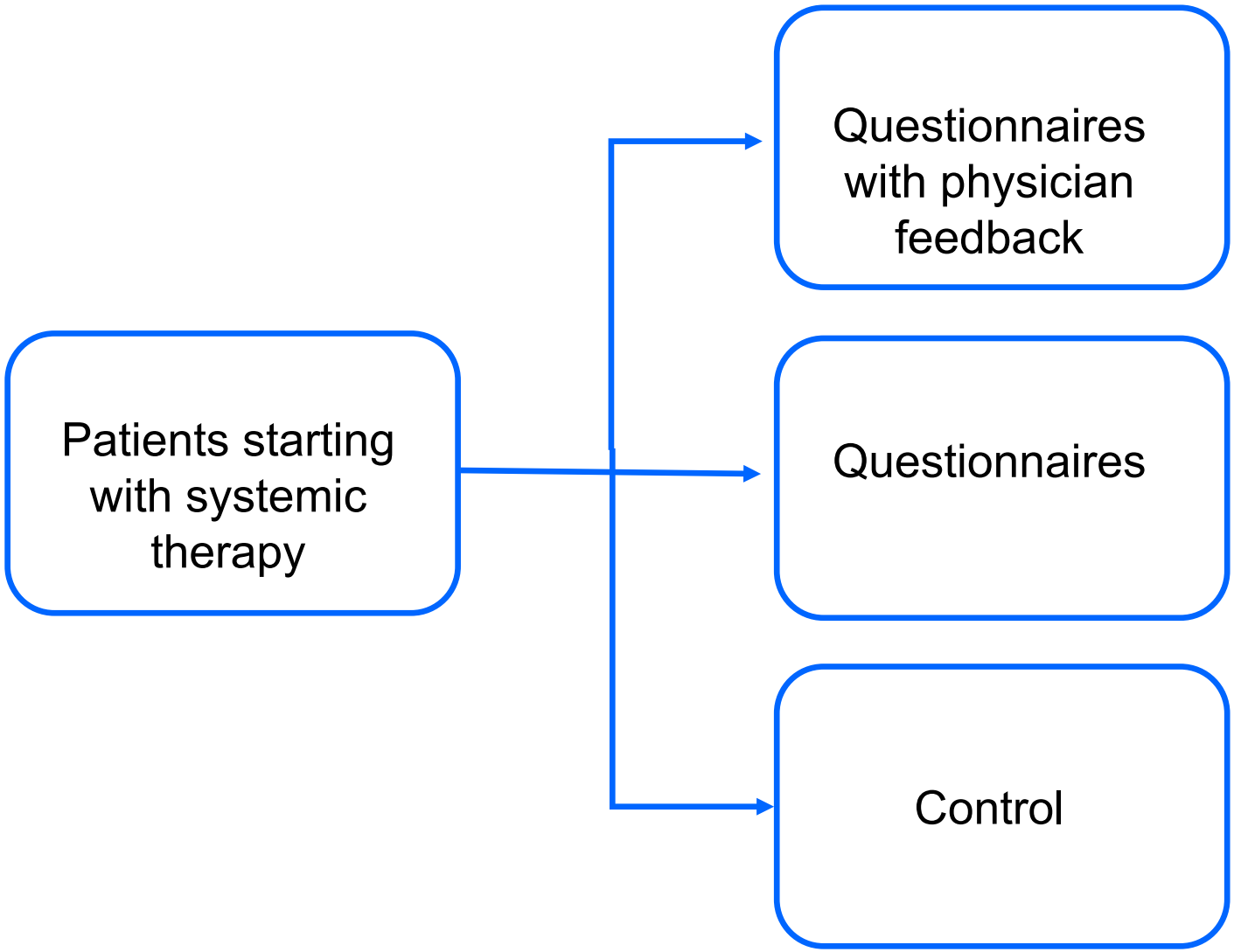
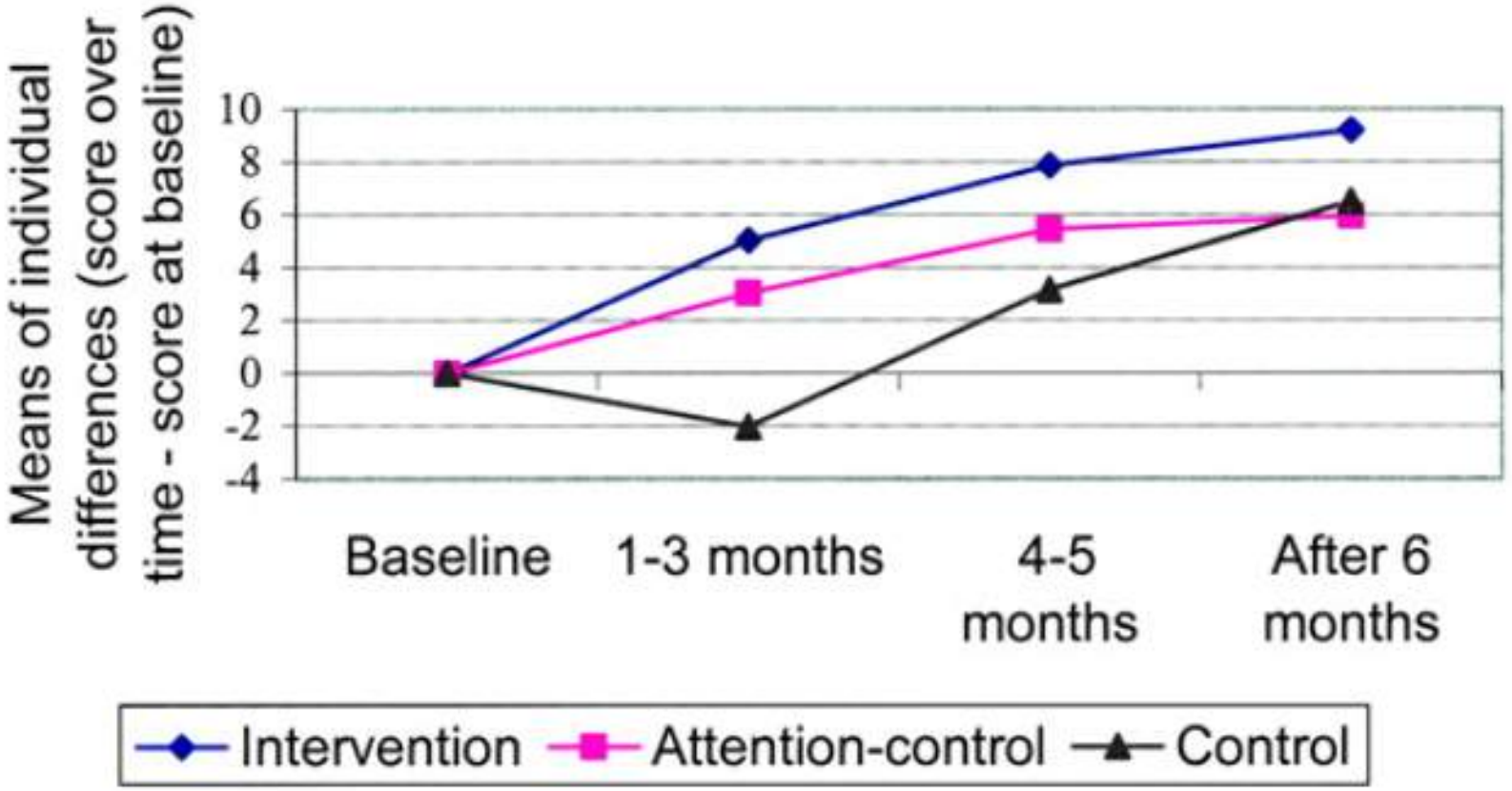


Velikova, JCO 2004

Systematically collecting PROs improves QOL



Velikova, JCO 2004

POCOP

Nederlandse Federatie van Kankerpatiënten organisaties

Conclusion

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To improve survival and quality of life of esophagogastric cancer, we need:

1. A multidisciplinary approach, including the patient perspective

2. Prospective studies

3. Real world data

Acknowledgments


Jessy Joy van Kleef


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Ans van Driel


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Amsterdam UMC