patients receive either another 3 courses of ECC chemotherapy or CRT. Currently, over 400 patients have been entered in the study. In conclusion, there is no evidence that CRT can replace D2 dissection. More importantly, it seems that CRT will have its best effect after optimal surgery.

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PG 9.04 SPEAKER ABSTRACT

Oesophagogastric cancer: A case for perioperative chemotherapy

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Although the global incidence of gastric adenocarcinoma is declining in western countries, the incidence of gastroesophageal junction (GEJ) tumors has risen faster than other GI adenocarcinoma over the last quarter century [1].

For resectable desease, the use of adjuvant chemotherapy has been disappointing and has never been adopted as a standard of care. In 2001, Macdonald reported a positive phase III trial for a post operative radiochemotherapy regimen, but associated to a high digestive toxicity and a low quality of surgical procedures.

After several phase II trials of Neoadjuvant chemotherapy, the results of a large phase III study (MAGIC) were published in 2006 [2]. Five hundred and three patients with resectable stomach (74%), lower oesophagus or GEJ adenocarcinoma were randomized between surgery alone and perioperative chemotherapy using ECF regimen. A significant improvement of TN stage and R0 resection was obtained in the chemotherapy group and resulted in a better Progression Free Survival (HR 0.66) and a better 5 year overall Survival (36%versus 23%). The surgical mortality was not affected by pre-operative chemotherapy but only 55% of operated patients could initiate post-operative chemotherapy.

More recently, a French trial published in 2011 [3] confirms these results using another chemotherapy regimen with 5-Fu (800 mg/m^2/day day 1−4 in CI) and Cisplatin (100 mg/m^2 day 1 or 2) every 4 weeks. Two hundred and twenty four patients were randomized between surgery alone (n = 111) and perioperative chemotherapy (n = 113). At the opposite of the MAGIC trial, a majority of patients (75%) had a tumor located to lower oesophagus or GEJ.

No significant difference was obtained in pathological T or N staging but the neoadjuvant chemotherapy improved the R0 resection rate (84% versus 74%). The post operative fatal complications were similar in the two groups and only 50% of the patients could receive at least one cycle of postoperative chemotherapy.

The 5-year Disease Free Survival and Overall Survival were significantly improved in the chemotherapy arm, respectively 34% vs 19% and 38% vs 24%.

These two randomized trials support the use of peri-operative chemotherapy as a standard of care for resectable Oesophagogastric adenocarcinoma.

Some questions are still pending for the chemotherapy regimen: the role of Epirubicin, the possibility to replace Cisplatin by Oxaliplatin and intravenous 5FU by Capecitabine, the place of Taxanes.

Other questions have to be adressed in future trials: the early selection of good candidates to neoadjuvant chemotherapy (PET, Biomarkers, . . .), the place of Biologic drugs (Trastuzumab in HER-2 positive tumors, c-met inhibitors, . . .) or the role of pre-operative radiotherapy.

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Friday, 23 March, 16:00−17:30

Session VIII. Gastric Cancer

PG 10.01 SPEAKER ABSTRACT

Predicting the response to neoadjuvant chemotherapy I (Who profits from neoadjuvant chemotherapy)

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Despite a decline in the overall incidence, gastric adenocarcinoma remains the second most common cause of cancer death worldwide and thus a significant global health problem. Even in early-stage locoregional confined disease the 5-year survival rarely exceeds 25−35%. Randomized trials have demonstrated a benefit from neoadjuvant and perioperative chemotherapy. However the optimal approach in individual patients is not clear and remains controversial. A consistent finding is that patients who have a histopathological response to neoadjuvant therapy are more likely to receive a survival benefit. These clinical data provide a strong argument for the urgent development of methods to predict histopathological response to neoadjuvant therapies for gastric adenocarcinomas. Published data demonstrate that clinino-pathological features (tumour histology and location), imaging through metabolic response by FDG-PET and tissue/molecular biomarkers may have all a predictive value for neoadjuvant therapies. However it is still uncertain from published data whether or not they will be useful for clinical decision making in individual patients. Existing candidate biomarkers need to be properly qualified and validated and novel biomarkers are required and an optimal approach should involve the combination and integration of clinical, imaging, pathological and molecular biomarkers.

PG 10.02 SPEAKER ABSTRACT

Predicting the response to neoadjuvant chemotherapy II (Ability of pretherapeutic parameters to predict response and prognosis early in patients with locally advanced gastric cancer)

S. Lorenzen. *NCT Nationales Centrum für Tumorerkrankungen, UNI-Klinikum Heidelberg, Heidelberg, Germany*

Introduction: Response to neoadjuvant chemotherapy is an independent prognostic factor in locally advanced gastric cancer. However, no prospectively tested pretherapeutic parameters predicting response and/or survival in gastric cancer are available in clinical routine.

Patients and Methods: We evaluated the prognostic significance of various clinicopathologic parameters in 410 patients who were treated with neoadjuvant chemotherapy followed by gastrectomy. Clinical and histopathological response evaluation was performed using standardized criteria. A prognostic score was created on the basis of the variables identified in the multivariate analysis.

Results: Three pretherapeutic parameters were identified as positive predictive factors for response and prognosis: tumor localization in the middle third of the stomach ($p = 0.001$), well differentiated tumors ($p = 0.001$) and intestinal tumor type according to Laurén's classification ($p = 0.03$). A prognostic index was constructed, dividing the patients into three risk groups: low (n = 73), intermediate (n = 274) and poor (n = 63). The three groups had significantly different clinical ($p = 0.007$) and histopathological response rates ($p = 0.001$) and survival times, with a median survival time that was not reached in the low risk group, 39.2 months in the intermediate risk group and 20.5 months in the poor risk group. The corresponding 5 year survival rates were 65.3%, 41.2%, and 21.2% ($p < 0.001$), respectively.

Conclusion: A simple scoring system based on three clinicopathologic parameters, accurately predicts response and prognosis in neoadjuvant treated gastric cancer. This system provides additional useful information that could be applied to select gastric cancer patients pretherapeutically for different treatment approaches. However, prospective testing of the score in an independent patient cohort is warranted.

PG 10.03 SPEAKER ABSTRACT

Lessons from the GASTRIC metaanalysis of adjuvant treatment

P. Rougier. *Digestive Oncology, Hopital Ambroise Paré, Boulogne Billancourt, France*

Background: Despite potentially curative resection of stomach cancer, 50−90% of patients die of disease relapse. Numerous encouraging phase II and phase III trials compared surgery alone to adjuvant chemotherapy, but definitive evidence is lacking. These trials generally used the overall survival at 5 years as the primary endpoint leading to long and costly trials. Our group has