GASTRO-HEP News

By Samantha Alleman

The 2016 Gastrointestinal Cancers Symposium was held January 21-23 in San Francisco, California. Below is a selection of highlights from the meeting. For a full list of abstracts, visit http://meetinglibrary.asco.org.

Surgery Vs Endoscopic Submucosal Dissection for Patients With Early Gastric Cancer

Clinical outcomes of surgery and endoscopic submucosal dissection for patients with early gastric cancer are similar, but late complication rates are significantly lower with endoscopic submucosal dissection, according to a retrospective study.

Dr Ki-Nam Shim and colleagues compared data of 59 early gastric cancers in 57 patients treated with surgery with data of 79 early gastric cancers in 76 patients treated with endoscopic submucosal dissection between 2005 and 2015. Early gastric cancers outside of the mucosal layer were not included. Along with demographic and pathologic data, the authors also evaluated complication and 5-year overall survival rates.

Mean follow-up periods were 31.5 months (5-96 months) and 68.4 months (1-139 months) for patients in the endoscopic submucosal dissection and surgery groups, respectively (P<.001). One patient (1.9%) in the endoscopic submucosal dissection group had metachronous tumors, whereas no patient in the surgery group had metastasis or recurring tumors. The 5-year overall survival rates of endoscopic submucosal dissection and surgery were similar (91.2% vs 87.4%, respectively; P=.490 by log-rank test), as were early complication rates within 3 months of either procedure (P=.501). However, endoscopic submucosal dissection was superior to surgery regarding late complication rates (P=.002).

Neoadjuvant Sorafenib in Patients With Resectable Hepatocellular Carcinoma

Neoadjuvant sorafenib (Nexavar, Bayer) has a favorable safety and toxicity profile and yields significant activity in patients with resectable hepatocellular carcinoma, according to an open-label, multicenter, phase 2 study. The study assessed biologic, pathologic, and radiologic changes in tumor.

Dr Mohamed Bouattour and colleagues enrolled 30 patients to receive preoperative administration of sorafenib 400 mg twice daily for 4 weeks to be followed by surgery. Of the 30 patients enrolled, 28 were evaluable for safety. Owing to early limiting toxicities, 3 patients were unsuitable to receive the medication; 25 patients were evaluable for the primary endpoints (antitumor activity and histologic changes on paired tumor samples and plasma biomarkers between baseline and following sorafenib). Secondary endpoints included safety, R0 surgery, and postsurgical complications.

Median tumor size at baseline was 37 mm, and 21 patients (84%) had a single lesion. Median duration and dosing of sorafenib were 28 days and 793 mg/day, respectively. In general, preoperative sorafenib had a favorable safety profile; all 28 patients showed stable disease, according to Response Evaluation Criteria in Solid Tumors (RECIST). Of the 19 patients evaluated based on Choi criteria and modified RECIST, 10 (53%) and 6 (32%), respectively, showed objective responses. No patient eligible for evaluation experienced an unexpected complication after undergoing liver resection, and 22 patients (88%) achieved R0 tumor resection. Intratumor necrosis was detected in 17 surgical specimens; in 24% of these cases, the necrosis covered at least 50% of the specimen. Analysis of blood biomarkers revealed a postsorafenib treatment trend of elevated angiogenesis biomarkers (VEGF-A, VEGF-C, and P1GF).

Endoscopic Stenting for the Management of Leaks Following Minimally Invasive Esophagectomy

Postesophagectomy anastomotic leaks can be effectively managed by endoscopic stent placement. Leaks that occur after minimally invasive esophagectomy (MIE) constitute a small yet significant morbidity in MIE, and optimal management following this procedure is not well defined.

Following institutional review board approval, Dr Brenda Ernst and colleagues reviewed the records of 148 patients who underwent MIE from November 2006 to February 2015 at Mayo Clinic Arizona and who underwent endoscopic management of anastomotic leaks. Of the 148 MIE procedures, 136 (91.8%) were thoracic anastomoses and 12 (8.1%) were cervical anastomoses.

Clinically significant anastomotic leaks were detected in 13 (8.8%) patients at a median of 6.1 days; 11 (8%) had undergone thoracic anastomosis and 2 (16%) had undergone cervical anastomosis. Ten patients underwent video-assisted thoracoscopic surgery with pleural space irrigation and chest tube replacement for treatment of their anastomotic leaks, while 11 patients underwent stent deployment at the surgical connection. Fistulas and leaks were placed in the fully covered portion of the stent, with the remaining portion placed in the esophageal remnant. After a mean of 54 days, the stents were removed. Two patients required stent-in-stent placement due to overgrowth into the stent body. Stenting was successful in sealing all leaks.