MANAGEMENT OF LOCALLY ADVANCED GASTROESOPHAGEAL CANCERS

Dr. Joleen Hubbard
- GI Medical Oncology

Dr. Alex Stark
- Surgical Oncology

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The individual is responsible for determining whether this activity meets the requirements for acceptable continuing education for their discipline. In addition, you may be required to provide proof of attendance to the board upon request such as certificate, handout, agenda, etc. You should claim only those hours actually spent in the educational program. To obtain continuing education credit, you must complete the evaluation.

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Dr. Joleen Hubbard, MD, DOES have relevant financial relationships to disclose with ineligible companies that have existed WITHIN THE LAST 24 MONTHS, even if it has now ended, as it relates to presenting the content of this activity.

Prior: Advisory Board – Bayer, BeOne, Incyte, Amgen, Taiho, Astra Zeneca

Prior: Research Funding to Institution - Exact Sciences, Biontech, C4 Therapeutics

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OBJECTIVES

At the completion of this activity, the participants should better be able to:

1. Discuss risk factors for gastroesophageal cancers
2. Describe the appropriate diagnostic procedures to assess locally advanced gastroesophageal cancers
3. Discuss the management strategies of gastroesophageal cancers
4. Describe expected patient outcomes associated with different treatment options available for locally advanced GE junction/gastric adenocarcinomas

Continuing education credit will be awarded upon completion of the Microsoft Form survey evaluation; your response to the survey also attests to your attendance at this educational activity. A QR code and link will be displayed at the end of the presentation.

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GASTROESOPHAGEAL CANCERS

Overview

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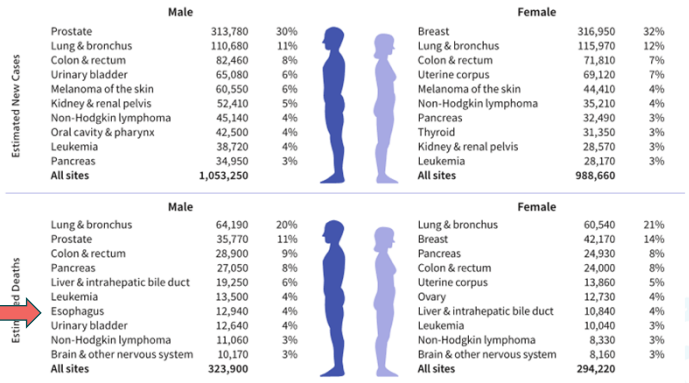
GASTROESOPHAGEAL PREVALENCE IN THE UNITED STATES: 2025

52,370 gastroesophageal cancer diagnoses in the US leading to approximately **27,030** deaths

Esophagus: 22,070 new cases, 16,250 deaths

Stomach: 30,300 new cases, 10,780 deaths

7th most common cause of cancer death among males



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Cancer Statistics. Siegel 2025

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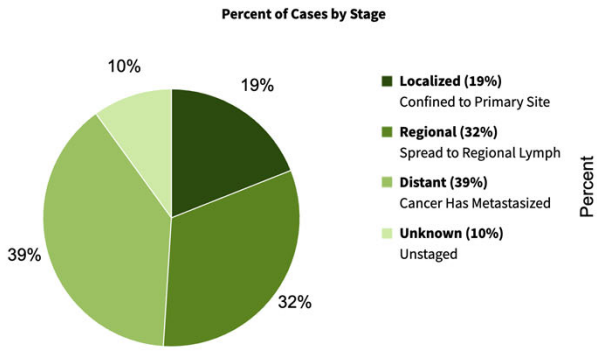
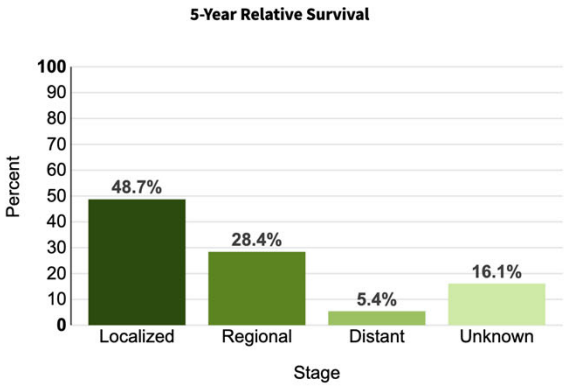
ESOPHAGEAL CANCER STAGE AND SURVIVAL





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https://seer.cancer.gov/

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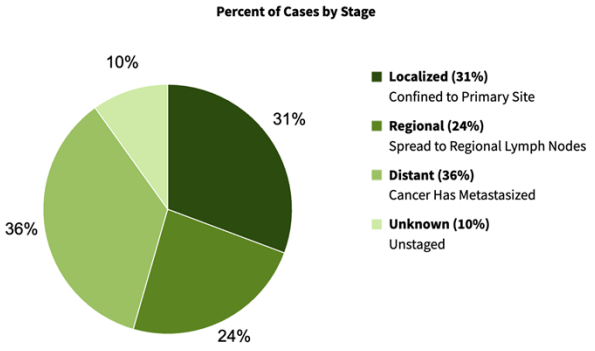
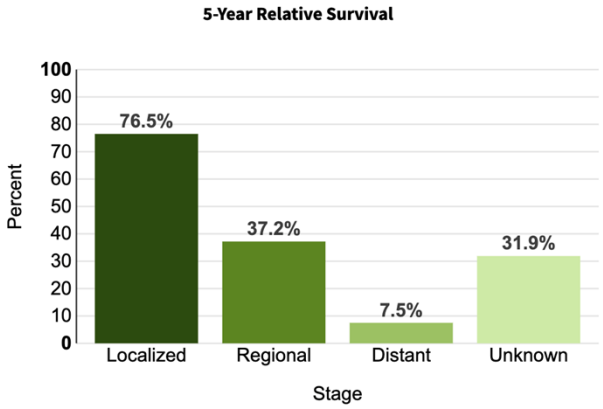
GASTRIC CANCER STAGE AND SURVIVAL





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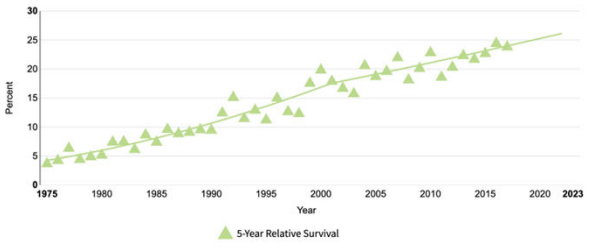
GASTROESOPHAGEAL CANCERS: SURVIVAL TRENDS

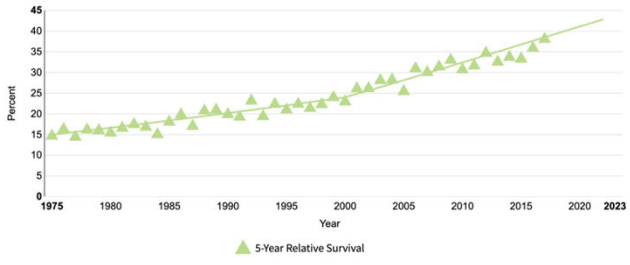
Esophageal cancer

5-year relative survival: 21.9%



Gastric cancer

5-year relative survival: 37.9%



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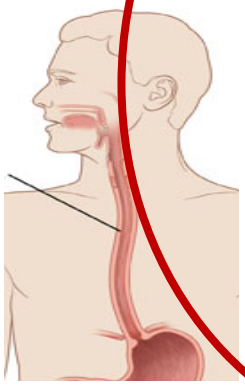
ESOPHAGEAL CARCINOMA - 2 SUBTYPES

Squamous cell carcinoma

- Upper 1/3 of Esophagus
- Decreasing incidence in the US
  - Smoking, alcohol
  - Corosive injury
  - HPV
  - Achalasia
  - Diet
    - High intake red meats, fats, processed foods



Adenocarinoma

- Lower 2/3 of Esophagus
- Increasing incidence in the US
  - GERD (Barrett's)
  - Smoking, alcohol
  - Obesity
  - Diet
    - High intake red meats, fats, processed foods

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CASE 1

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CASE 1: 49F

- Presented to Urgent Care with 4 days of abdominal pain and black tarry stools. The pain has been intermittent over the past 6 months, located in the epigastric area and radiates to her back.
  - She had a CT scan 1 month prior which showed a distended gall bladder and possible hiatal hernia
  - Took omeprazole x 2 weeks with slight improvement but then discontinued it
- Pertinent exam findings:
  - Tachycardia
  - Abdominal tenderness RUQ and epigastric area
- Laboratory studies:
  - Hgb 14.0 (prev 14.5), normal chem7
- Management:
  - GI cocktail with minimal improvement
  - ER recommended, but pt was uninsured
  - Stool H. Pylori Antigen, FOBT
  - Referral to gastroenterology who recommended EGD

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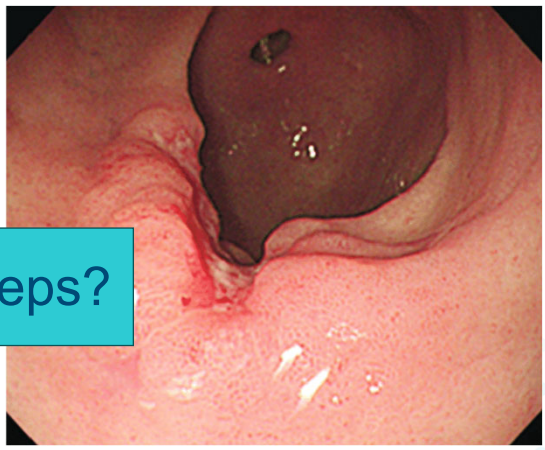
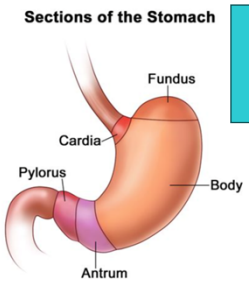
CASE 1: 49F WITH ABDOMINAL PAIN AND MELENA

- EGD:
  - 3 x 4 cm area of nodular, ulcerated, erythematous tissue in the antrum with several small ulcerated areas within the lesion
  - Biopsy: poorly differentiated adenocarcinoma, diffuse type
    - H. pylori negative
    - DNA mismatch repair enzymes intact





Next Steps?

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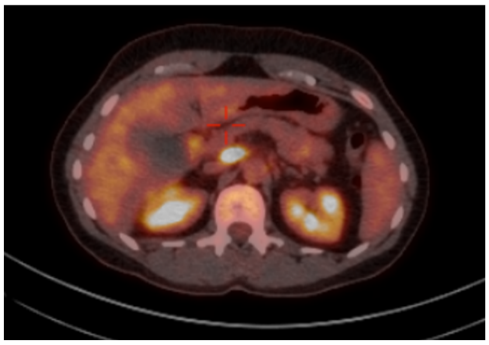
CASE 1: 49F WITH ADENOCARCINOMA OF THE GASTRIC ANTRUM

- Work up
  - CT CAP: asymmetric thickening along anterior wall of gastric antrum, no evidence for metastatic disease
  - PET scan: uptake in in the gastric antrum, intensely avid precaval/portacaval lymph nodes, less avid porta hepatis, right cardiophrenic angle are indeterminate



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  - Endoscopic ultrasound:
    - Mass found in the body/antrum of the stomach
    - 2 malignant appearing lymph nodes in the aortocaval region, biopsied
    - Porta hepatis region nodes appeared endoscopically, biopsied
    - Staged T3 N1 by sonographic appearance

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  - Endoscopic ultrasound:
    - Mass found in the body/antrum of the stomach
    - 2 malignant appearing lymph nodes in the aortocaval region, biopsied – negative for malignancy
    - Porta hepatis region nodes appeared endoscopically, biopsied - negative for malignancy
    - Staged T3 N1 by sonographic appearance
  - Diagnostic laparoscopy: no evidence of carcinomatosis
    - Peritoneal washings negative for malignancy

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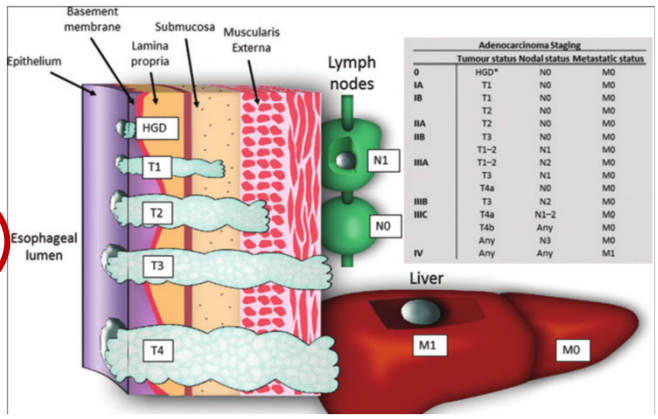
GASTROESOPHAGEAL ADENOCARCINOMA – MANAGEMENT BY STAGE

Stage Ia - Limited to the mucosa (T1, T1a) may be managed with endoscopic mucosal resection

Stage Ib - Penetrated into the submucosa (T1b) no lymph nodes → surgical resection

Stage II-III - Invades muscularis propria (≥T2) OR any lymph node positive disease → multimodality management with chemotherapy &/or radiation and surgery

Stage IV – Distant metastasis → systemic therapy



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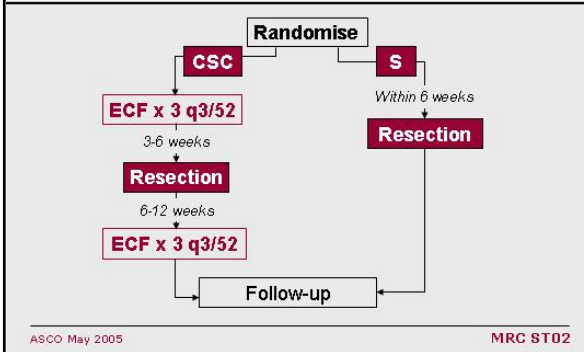
MAGIC TRIAL

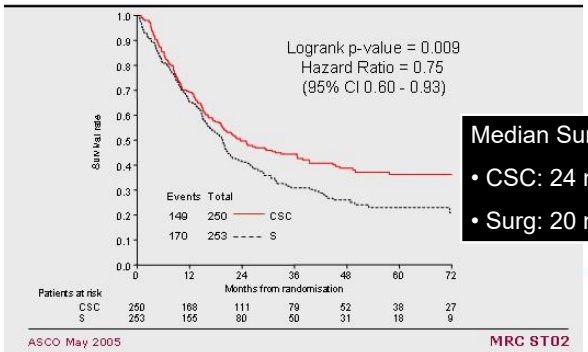
≥ Stage II Esophagus, GE junction, gastric **adenocarcinoma**

Perioperative chemotherapy with epirubicin, cisplatin and 5-fluorouracil (5-FU) versus surgery alone

Design



Survival



Median Survival
- CSC: 24 months
- Surg: 20 months

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Cunningham NEJM 2006

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