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GASTROINTESTINAL NEWS

Newsletter di aggiornamento sui tumori gastrointestinali

GASTROINTESTINAL NEWS nel 2007 si presenta rinnovato sia nella veste che nel contenuto. Nato per iniziativa del comitato scientifico e coordinato da Intermedia, mantiene la pubblicazione quindicinale e continua ad occuparsi di cancro gastrointestinale. Le news non verranno più tradotte in italiano, ma pubblicate in lingua inglese e, una volta al mese, verrà proposto un commento su un particolare articolo, preparato da un componente del comitato scientifico.

NEWS DALLA RICERCA

Gemcitabine Plus Capecitabine Compared With Gemcitabine Alone in Advanced Pancreatic Cancer: A Randomized, Multicenter, Phase III Trial of the Swiss Group for Clinical Cancer Research and the Central European Cooperative Oncology Group - Journal of Clinical Oncology 2007; Volume 25, Number 16, June 1: Pages 2212 - 2217 (abstract)

Therapeutic strategies in oesophageal carcinoma: role of surgery and other modalities - Lancet Oncology 2007; Volume 8, Number 6, Jun: Pages 545 - 553 (abstract)

Priorities in Colorectal Cancer Research: Recommendations From the Gastrointestinal Scientific Leadership Council of the Coalition of Cancer Cooperative Groups - Journal of Clinical Oncology 2007; Volume 25, Number 16, June 1: Pages 2313 - 2321 (abstract)

Favorable indications for hepatectomy in patients with liver metastasis from gastric cancer - Journal of Surgical Oncology 2007; Volume 95, Issue 7, 1 June: Pages 534 - 539 (abstract)

Cryosurgery for resectable and unresectable hepatic metastases from colorectal cancer - European Journal of Surgical Oncology 2007; Volume 33, Issue 5, June: Pages 590 - 596 (abstract)

Assessing quality of life in patients with colorectal cancer: An update of the EORTC quality of life questionnaire - European Journal of Cancer 2007; Volume 43, Issue 10, July: Pages 1564-1573 (abstract)

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I TUMORI NEUROENDOCRINI DEL PANCREAS (info)

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NEWS DALLA RICERCA

Gemcitabine Plus Capecitabine Compared With Gemcitabine Alone in Advanced Pancreatic Cancer: A Randomized, Multicenter, Phase III Trial of the Swiss Group for Clinical Cancer Research and the Central European Cooperative Oncology Group

Richard Herrmann, György Bodoky, Thomas Ruhstaller, Bengt Glimelius, Emilio Bajetta, Johannes Schüller, Piercarlo Saletti, Jean Bauer, Arie Figer, Bernhard Pestalozzi, Claus-Henning Köhne, Walter Mingrone, Salomon M. Stemmer, Karin Tàmas, Gabriela V. Kornek, Dieter Koeberle, Susanne Cina, Jürg Bernhard, Daniel Dietrich, Werner Scheithauer

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Journal of Clinical Oncology 2007; Volume 25, Number 16, June 1: Pages 2212 - 2217

Purpose: This phase III trial compared the efficacy and safety of gemcitabine (Gem) plus capecitabine (GemCap) versus single-agent Gem in advanced/metastatic pancreatic cancer.

Patients and Methods: Patients were randomly assigned to receive GemCap (oral capecitabine 650 mg/m^2 twice daily on days 1 to 14 plus Gem 1,000 mg/m^2 by 30-minute infusion on days 1 and 8 every 3 weeks) or Gem (1,000 mg/m^2 by 30-minute infusion weekly for 7 weeks, followed by a 1-week break, and then weekly for 3 weeks every 4 weeks). Patients were stratified according to center, Karnofsky performance score (KPS), presence of pain, and disease extent.

Results: A total of 319 patients were enrolled between June 2001 and June 2004. Median overall survival (OS) time, the primary end point, was 8.4 and 7.2 months in the GemCap and Gem arms, respectively (P = 0.234). Post hoc analysis in patients with good KPS (score of 90 to 100) showed a significant prolongation of median OS time in the GemCap arm compared with the Gem arm (10.1 *v* 7.4 months, respectively; P = 0.014). The overall frequency of grade 3 or 4 adverse events was similar in each arm. Neutropenia was the most frequent grade 3 or 4 adverse event in both arms.

Conclusion: GemCap failed to improve OS at a statistically significant level compared with standard Gem treatment. The safety of GemCap and Gem was similar. In the subgroup of patients with good performance status, median OS was improved significantly. GemCap is a practical regimen that may be considered as an alternative to single-agent Gem for the treatment of advanced/metastatic pancreatic cancer patients with a good performance status.

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Therapeutic strategies in oesophageal carcinoma: role of surgery and other modalities

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Lancet Oncology 2007; Volume 8, Number 6, Jun: Pages 545 - 553

Traditionally, surgery is considered the best treatment for oesophageal cancer in terms of locoregional control and long-term survival. However, survival 5 years after surgery alone is about 25%, and, therefore, a multidisciplinary approach that includes surgery, radiotherapy, and chemotherapy, alone or in combination, could prove necessary. The role of each of these treatments in the management of oesophageal cancer is under intensive research to define optimum therapeutic strategies. In this report we provide an update on treatment strategies for resectable oesophageal cancers on the basis of recent published work. Results of the latest randomised trials allow us to propose the following guidelines: surgery is the standard treatment, to be used alone for stages I and IIa, or possibly with neoadjuvant chemotherapy or chemoradiotherapy for stage IIb disease. For locally advanced cancers (stage III), neoadjuvant chemotherapy or chemoradiotherapy followed by surgery is appropriate for adenocarcinomas. Chemoradiotherapy alone should only be considered in patients with squamous-cell carcinomas who show a morphological response to chemoradiotherapy, and produces a similar overall survival to chemoradiotherapy followed by surgery, but with less post-treatment morbidity. Although the addition of surgery to chemotherapy or chemoradiotherapy could result in improved local control and survival, surgery should be done in experienced hospitals where operative mortality and morbidity are low. Moreover, surgery should be kept in mind as salvage treatment in patients with no morphological response or persistent tumour after definitive chemoradiotherapy.

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Priorities in Colorectal Cancer Research: Recommendations From the Gastrointestinal Scientific Leadership Council of the Coalition of Cancer Cooperative Groups

Peter J. O'Dwyer, S. Gail Eckhardt, Daniel G. Haller, Joel Tepper, Dennis Ahnen, Stanley Hamilton, Al B. Benson, III, Mace Rothenberg, Nicholas Petrelli, Heinz-Joseph Lenz, Robert Diasio, Raymond DuBois, Daniel Sargent, Jeff Sloan, C. Daniel Johnson, Robert L. Comis, Michael J. O'Connell

Coalition of Cancer Cooperative Groups; University of Pennsylvania, Abramson Cancer Center, Philadelphia; Allegheny Cancer Center, Pittsburgh, PA; University of Colorado Health Sciences Center, Denver, CO; Mayo Clinic; Mayo Clinic Comprehensive Cancer Center, Rochester, MN; University of California, San Francisco; University of Southern California Norris Cancer Center, Los Angeles, CA; Vanderbilt-Ingram Cancer Center, Nashville, TN; University of North Carolina, Chapel Hill, NC; Mayo Clinic Scottsdale, Scottsdale, AZ; The University of Texas M.D. Anderson Cancer Center, Houston, TX; Helen F. Graham Cancer Center, Newark, DE; University of Chicago, Chicago, IL; and the Princess Margaret Hospital, Toronto, Canada

Journal of Clinical Oncology 2007; Volume 25, Number 16, June 1: Pages 2313 - 2321

Emerging technologies have greatly expanded our ability to detect, characterize, and treat colorectal cancer. The Coalition of Cancer Cooperative Groups convened a multidisciplinary panel, the Scientific Leadership Council in GI cancer, to discuss and advise on the priorities and opportunities to advance current and future approaches into the clinical arena to impact most rapidly the morbidity and mortality from this disease. The Council's recommendations for research priorities are the result of engagement of community and academic oncologists, patient advocacy groups, and other stakeholders including the pharmaceutical industry and governmental agencies. We detail some key prospects for investigation in the areas of colon cancer detection, prevention, and surgical and medical management. Many are in early or definitive clinical trials, and a focus on rapid accrual is urged. The implementation of biology-directed laboratory investigations, both in association with ongoing clinical trials and as a separate developmental strategy for targeted therapies, is supported as the route to individualized therapy.

The Council held its initial meeting in Philadelphia, PA, on December 13-14, 2004. A follow-up Scientific Dialogue with representatives of oncology-focused pharmaceutical companies and the patient advocacy community was held in Dana Point, CA, on April 14-15, 2005.

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Favorable indications for hepatectomy in patients with liver metastasis from gastric cancer

Yoshihiro Sakamoto, MD [1], Takeshi Sano, MD [2], Kazuaki Shimada, MD [1], Minoru Esaki, MD [1], Makoto Saka, MD [2], Takeo Fukagawa, MD [2], Hitoshi Katai, MD [2], Tomoo Kosuge, MD [1], Mitsuru Sasako, MD [2]

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Journal of Surgical Oncology 2007; Volume 95, Issue 7, 1 June: Pages 534 - 539

Background The prognosis of patients with liver metastasis from gastric cancer (LMGC) is dismal. The purpose of this study was to review our recent outcomes of hepatectomy for LMGC and to determine the suitable candidates for surgery.

Study Design The outcomes of 37 patients with LMGC who underwent hepatectomy between 1990 and 2005 were assessed. No extrahepatic distant metastasis and feasibility of macroscopic curative resection were requisite indications for surgery. The prognostic values of clinicopathological factors were assessed by univariate and multivariate analyses.

Results There was no in-hospital mortality. The median survival time and overall 5-year survival rate after hepatectomy of the patients with LMGC were 31 months and 11%, respectively. Intrahepatic recurrence following hepatectomy was found in 23 patients (62%). Variables independently associated with poor survival were bilobar metastasis ($P = 0.002$, CI = 1.9 - 16.3) and a maximum tumor diameter of $\geq$ 4 cm ($P = 0.006$, CI = 1.4 - 7.7). The depth of the primary tumor and the timing of metastasis were not associated with survival.

Conclusions Surgical resection for LMGC may be indicated in patients with unilobar metastasis and/or tumors less than 4 cm in diameter. Synchronous metastasis is not a contraindication for hepatectomy.

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Cryosurgery for resectable and unresectable hepatic metastases from colorectal cancer

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European Journal of Surgical Oncology 2007; Volume 33, Issue 5, June: Pages 590 - 596

Aims Hepatic cryosurgery is useful for patients with hepatic metastases from colorectal cancer confined to the liver but considered unresectables because of the number and location of lesions. While encouraging results were reported following cryosurgery for unresectable liver metastases we considered particularly valuable to examine the safety and effectiveness of cryosurgery in patients with resectable and unresectable metastases from colorectal cancer.
Methods Between January 1997 and September 2005, 53 patients with liver metastases from colorectal cancer underwent hepatic cryosurgery at our institution. Hepatic metastases were resectable in 31 (58.5%) patients and unresectable in 22 (41.5%).
Results A total of 136 liver metastases were treated in 53 patients. The size of treated lesions ranged from 0.5 to 10 cm (mean 2.7). There were 2 postoperative deaths (3.8%) from massive bleeding and from cryoshock. The overall morbidity rate was 66%. The median follow-up was 24.8 months. The overall survival rate at 12 months was 86.1%, at 48 months it was 27%. No significant difference was found between survival rates in patients with resectable or unresectable metastases. Among 31 patients with resectable liver metastases 7 (22.6%) patients developed recurrence at the site of cryosurgery.
Conclusion Survival rates were comparables between patients with resectable and unresectable metastases but a high complication rate and a substantial rate of local recurrence following cryosurgery should caution against its use to treat resectable disease.

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Assessing quality of life in patients with colorectal cancer: An update of the EORTC quality of life questionnaire

S. Gujral[a], T. Conroy[b], C. Fleissner[c], O. Sezer[c], P.M. King[a], K.N.L. Avery[d], P. Sylvester[a], M. Koller[e], M.A.G. Sprangers[f], J.M. Blazeby[a, d, g, h,] and on behalf of the European Organisation for Research and Treatment of Cancer Quality of Life Group

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European Journal of Cancer 2007; Volume 43, Issue 10, July: Pages 1564 - 1573

Abstract The European Organisation for Research and Treatment of Cancer (EORTC) has a portfolio of questionnaire modules to supplement the QLQ-C30 to assess patient reported outcomes in cancer clinical trials. This study updated the module for colorectal cancer. A review of the literature identified 20 articles that used the EORTC colorectal module. Eight papers did not report data from scales addressing sexual function and 8 added additional scales to assess ano-rectal function. Interviews with patients (n = 79) and professionals (n = 11) informed item selection, reduction and modification. A new 29 item module was devised and further patient interviews (n = 120) examined its format and content validity. Patients found the new module acceptable with relevant content. The new module, the EORTC QLQ-CR29, is hypothesised as containing 6 scales and 11 single items. An international study examining its clinical and psychometric validity will be performed.

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APPUNTAMENTI

I TUMORI NEUROENDOCRINI DEL PANCREAS
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