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Scientific Symposium
New Trends in Upper GI

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ANALYSIS OF FUNCTIONAL OUTCOMES POST GASTRECTOMY AND OESOPHAGECTOMY

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Background: Advances in gastric and oesophageal cancer management have led to improved survivorship. Factors affecting quality of life in long-term survivors are now coming to the attention of caregivers. The causes are multifactorial and include structural changes in upper gastrointestinal tract, abnormal gastrointestinal motility, altered pH, bacterial overgrowth, and insufficient bile salt or pancreatic enzyme production. The objective of this study was to analyse the extent of this problem in a gastric and oesophageal cancer population.
Materials and methods: A prospectively maintained database identified 174 patients who underwent gastrectomy for gastric cancer and 146 patients who underwent oesophagectomy for oesophageal cancer from 2006-2014. A retrospective analysis was performed to assess those referred to gastroenterology with functional symptoms. Investigations performed and subsequent results were analysed.
Results: 45/174 (26%) of patients had significant functional symptoms post gastrectomy and 33/146 (22.6%) of patients had similar problems post oesophagectomy requiring referral to gastroenterology. Concerning symptoms included weight loss, diarrhoea, nausea, and abdominal pain. 27/45 (60%) of gastrectomy patients had undergone a total gastrectomy. 32/33 (97%) of oesophagectomy patients had undergone an Ivor Lewis oesophagectomy. The most common diagnosis was small intestine bacterial overgrowth (SIBO) 40/45 (89%) gastrectomy patients were found to have SIBO, diagnosed on methane breath test or duodenal aspirate. 26/33 (79%) oesophagectomy patients were diagnosed with SIBO. Organisms isolated included E. Coli, Enterococcus, Klebsiella, Streptococcus, Clostridium and Candida. 8/45 (18%) post gastrectomy and 5/33 (15%) post oesophagectomy had bile salt malabsorption diagnosed on SeHCAT scan. 5/45 (11%) post gastrectomy and 3/33 (9%) post oesophagectomy had pancreatic insufficiency on faecal elastase testing.
Conclusions: Improved survival rates post upper gastrointestinal surgery have identified that survivors can develop functional problems months to years after surgery. The most common diagnosis is SIBO. As this is easily treated with antibiotics we would advocate early recognition and investigation of functional symptoms to avoid weight loss and distressing symptoms in this population.
Conflict of interest: No conflict of interest.

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CHEMOTHERAPY VERSUS CHEMORADIOTHERAPY AFTER SURGERY AND PREOPERATIVE CHEMOTHERAPY FOR RESECTABLE GASTRIC CANCER: PER PROTOCOL ANALYSIS OF THE CRITICS TRIAL

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Background: The American Intergroup 0116 study (Macdonald et al; NEJM; 2001) and the British MAGIC trial (Cunningham et al; NEJM; 2006) changed clinical practice for resectable gastric cancer. It was shown that overall survival after surgery improved with postoperative chemoradiotherapy and perioperative chemotherapy, respectively. Intention-to-treat analysis of the data in the CRITICS trial (chemotherapy versus chemoradiotherapy after surgery and preoperative chemotherapy for resectable gastric cancer; Lancet Oncology; 2018) did not show a survival difference between the two treatment arms. Due to comorbidity, the aging society, treatment related toxicity and major surgery, compliance is a problem in clinical studies. A per protocol analysis was performed acknowledging the limitations of such analysis.
Material and methods: The CRITICS trial was an open label phase 3 trial in which 788 patients with stage Ib– IVa resectable gastric or oesophagogastric adenocarcinoma were included. Patients from the Netherlands, Sweden, and Denmark were randomly assigned to perioperative chemotherapy or preoperative chemotherapy with postoperative chemoradiotherapy. For this analysis, only outcomes of patients who actually started postoperative treatment were analyzed. Since the two treatment arms are not inherently balanced in such per protocol analysis, landmark analysis (adjusting for baseline, preoperative chemotherapy, surgery and pathology variables) and Inverse Probability Weighted (IPW) analysis were used to estimate and compare overall and event-free survival.
Results: Median follow-up duration is 6.2 years.

	Randomization	Pre-operative CT	Surgery	Post-operative CT	Post-operative CRT	Completed treatment
CT	393 (100%)	334 (85%)	310 (79%)	**233 (59%)**		180 (46%)
CRT	395 (100%)	318 (81%)	326 (83%)		**245 (62%)**	197 (50%)

CT = chemotherapy; CRT = chemoradiotherapy

Conclusion: Actual results of the per protocol analysis as well as updated results of the intention-to-treat analysis will be presented.
Conflict of interest: No conflict of interest.

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LAPAROSCOPY-ASSISTED VERSUS OPEN D2 DISTAL GASTRECTOMY FOR ADVANCED GASTRIC CANCER: FIVE YEAR OVERALL SURVIVAL AND MORBIDITY RESULTS FROM A RANDOMIZED PHASE II MULTICENTER CLINICAL TRIAL (COACT 1001).

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Background: For advanced gastric cancer (AGC), D2 gastrectomy is the standard treatment. However, a laparoscopic D2 gastrectomy(LG) is technically challenging surgery. Our previous report of COACT 1001 study, which is randomized phase II study to evaluate the feasibility of LG compared with open surgery(OG) for AGC, showing primary endpoint of non-compliance of lymph node dissection and three-year disease-free survival supported role of LG for AGC. Herein we report five-year overall and disease-free survival outcome of the study.
Methods: Patients with cT2-T4a and cN0-2 (AJCC 7thstaging system) distal gastric cancer were randomly but not blindingly assigned to LG or OG groups. Patients were followed up for recurrence and survival for 5 years.
Results: Between Jun 2010 and Oct 2011, 204 patients were enrolled and underwent either LADG (n = 105) or ODG (n = 99). Of those, 196 patients (100 in LADG and 96 in ODG) were included in the intention-to-treat analysis. There were no significant differences in the five- year overall survival between LG and OG groups (85.1% vs 84.1%, respectively; p = 0.749). In the subgroup analysis, five-year overall survival was not different in between the groups according to the clinical stage (stage I: 95.7 % vs 95.5 %; p = 0.988, stage II: 96.1 % vs 84.6 %; p = 0.057, stage III: 48.3 % vs 74.1 %; p = 0.156) and pathological stage (stage I: 97.5 % vs 94.4 %; p = 0.512, stage II: 100 % vs 90.8 %; p = 0.099, stage III: 48.7 % vs 72.7 %; p = 0.151, stage IV: 100 % vs 0 %; p = 0.18). Five-year disease-free survival also was not significantly different between two groups (74.5 % vs 78.7 %, respectively; p = 0.604). The trend of overall and disease-free survival was favorable for LG in stage II but OG in stage III.
Conclusions: LG was feasible for AGC based on the five-year overall and disease-free survival rate. Further research should be done in large scale for stage III gastric cancer.
Conflict of interest: No conflict of interest.

Scientific Symposium
Innovations and Areas for Development in the Surgical Management of Melanoma

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RISK STRATIFICATION OF SENTINEL NODE POSITIVE MELANOMA PATIENTS DEFINES SURGICAL MANAGEMENT AND ADJUVANT THERAPY TREATMENT CONSIDERATIONS

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Background: In light of the evolving landscape of adjuvant therapy in melanoma and the recently confirmed absent survival benefit of completion lymph node dissection (CLND), it becomes important to explore possible consequences of omitting CLND, and whether it is possible to adequately stratify positive sentinel node (SN) patients solely based on information retrieved from the melanoma up to the sentinel lymph node biopsy (SLNB).
Methods: A retrospective cohort from nine European Organization for Research and Treatment of Cancer Melanoma Group centers was used. Patients were staged based on SLNB and CLND result according to the American Joint Committee on Cancer (AJCC) criteria and stratified by ulceration and SN tumour burden. These were incorporated in Cox regression models. Predictive ability was assessed using Harrell's concordance index (c-index) and the Akaike information criterion (AIC).
Results: In total, 1015 patients were eligible. CLND led to upstaging in N-category in 19% and in AJCC stage in 5-6%. The model incorporating only ulceration and SN tumour burden performed equally well as the model incorporating substages after CLND. The model incorporating substages based on SLNB had the lowest predictive ability. Stratifying by ulceration and SN tumour burden resulted in four positive SN groups from which low-, intermediate and high-risk prognostic classes could be derived.
Conclusions: Adequate stratification of positive SN patients was possible based on ulceration and SN tumour burden category. The identification of low-, intermediate- and high-risk patients could guide adjuvant therapy in clinical practice. Omitting CLND seems to have little consequences.
Conflict of interest other substantive relationships: A.C.J. van Akkooi is associated with consultancy for Amgen, Novartis, MSD-Merck and Merck-Pfizer grants from Amgen and Novartis travel/accommodations/meeting expenses from Amgen, Novartis, MSD-Merck and Merck-Pfizer. All not related to this work. P. Rutkowski is associated with board membership of MSD & Blueprint Medicine consultancy for BMS, MSD, Roche, Novartis & Amgen speakers bureaus for Pfizer, Novartis, Roche, MSD, BMS. All not related to this work. C. Robert is associated with consultancy for BMS, Roche, Amgen, Novartis and MSD. All not related to this work. U. Keilholz is associated with consultancy forGlycotope, AstraZeneca, Pfizer, MSD, Merck and BMS speakers bureau for AstraZeneca, BMS, Merck, MSD and Pfizer. All not related to this work. A.M.M. Eggermont is associated with consultancy for Actelion, Agenus, Bayer, BMS, Ellipses, GSK, HalioDX, Incyte, ISA pharmaceuticals, Merck/Serono, MSD, Nektar, Novartis, Pfizer, Sanofi. All not related to this work. All other authors declare no competing interests or funding.This abstract with corresponding manuscript have been recently published in the European Journal of Cancer (doi:10.1016/j.ejca.2018.02.022). The data have not been presented at an international congress.

Scientific Symposium
State of the art in Breast Reconstruction Surgery (SSM/ NSM/ Implants, Autologous, RT)

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PATIENT REPORTED OUTCOMES OF SATISFACTION WITH BILATERAL BREAST REDUCTION SURGERY FOR BREAST CANCER TREATMENT

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Background: Oncoplastic surgery for breast cancer has increased in popularity over the last few years, with the oncological safety confirmed in several studies. There is, however, limited published data on patient reported outcomes from this surgical approach. This study will look at patient reported outcomes on satisfaction following bilateral breast reduction surgery as part of breast cancer treatment.
Materials and Methods: The validated BREAST-Q breast reduction module was sent to all surviving patients who had had no documented cancer recurrence and had undergone bilateral breast reduction surgery as part of breast cancer treatment in Tayside between August 2013 and August 2017. Q-score was then used to analyse data and correlate this with patient and clinical information including age, specimen weights, BMI, diagnosis,

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