Welcome to Master Class for Oncologists

Los Angeles, CA
October 3, 2008

Session 1: 7:30 AM - 8:15 AM
Update on Esophagogastric Cancers
Speaker:
Peter C. Enzinger, MD
Dana-Farber Cancer Institute & Harvard Medical School

Presenter Disclosure Information

The following relationships exist related to this presentation:

• Dr. Enzinger has been a Consultant/Speaker for: Sanofi-Aventis, Roche, Genentech, and Imclone-BMS

Off Label/Investigational Discussion
Dr. Enzinger has been a Consultant/Speaker for: Sanofi-Aventis, Roche, Genentech, and Imclone-BMS

Example Section Page

Audience Response Question

Demographics of Esophageal Cancer
How has the incidence of esophageal ADC changed from 1979 to 2004 in white males (USA)?

1) -51%
2) about the same
3) +53%
4) +157%
5) +211%
6) +463%
7) Unsure

Incidence of Esophageal Cancer: 16,470 new cases and 14,280 deaths in 2008
Proposed Cascade of Pathologic Events in Gastric Adenocarcinoma

Helicobacter pylori → Salt → mutagens → B-carotene → higher pH → bacterial growth + nitrate → gastric mucoid acid → salt → N-nitroso chronic inflammation → reactive oxygen species → promotion → inhibition → adenoma → carcinoma

Adapted from Correa

1997 AJCC Classification of Gastric Carcinoma

AJCC 2002

T2a: a tumor that invades the muscularis propria
T2b: a tumor that invades into the subserosa

Gastric Cancer

Survival in 633 patients, according to 1997 TNM stage

Figure 3. Survival in 633 patients, according to TNM 1987 stage (A) and TNM 1997 stage (B).

Localized Esophageal Cancer

Does surgical volume have an impact on survival?

Esophagectomy and Hospital Mortality as Function of Hospital Volume

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Patients</th>
<th>Years Database</th>
<th>Low Volume</th>
<th>High Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past, 1998</td>
<td>1,366</td>
<td>1990-94 California</td>
<td>&lt; 30 resections/yr (16%)</td>
<td>&gt; 30 resections/yr (5%)</td>
</tr>
<tr>
<td>Saloner, 2000</td>
<td>---</td>
<td>1996-98 NC cancer centers vs. community hospitals</td>
<td>&lt; 5 Medicare readmissions (3%)</td>
<td>&lt; 5 Medicare readmissions (4%)</td>
</tr>
<tr>
<td>van Lanschot, 2000</td>
<td>1,798</td>
<td>1993-98 Dutch National Medical Registry</td>
<td>&lt; 10 Medicare readmissions (2%)</td>
<td>&gt; 10 Medicare readmissions (5%)</td>
</tr>
<tr>
<td>Veres, 2004</td>
<td>1,128</td>
<td>1984-97 Maryland</td>
<td>&lt; 2 Medicare readmissions (6%)</td>
<td>&gt; 2 Medicare readmissions (5%)</td>
</tr>
<tr>
<td>Kuo, 2001</td>
<td>1,792</td>
<td>1992-2000 Massachusetts</td>
<td>&lt; 5 Medicare readmissions (9%)</td>
<td>&gt; 5 Medicare readmissions (5%)</td>
</tr>
</tbody>
</table>

Esophagectomy: Surgeon/Hospital Volume and Mortality (USA)

Adjusted Operative Mortality (%) vs. Annual Hospital Volume

Surgeon Volume vs. Adjusted Operative Mortality (%)

Localized Esophageal Cancer

Does adjuvant chemotherapy improve surgery?

Neoadjuvant chemotherapy compared with surgery alone in localized esophageal cancer

FNLCC ACCORD 07-FFCD 9703 Trial: Schema

ACCORD 07: Surgical Results

ACCORD 07: Pathological Results

ACCORD 07: Overall Survival
Randomization
Balanced with minimization by institution, cN0 / cN1

Post-op CTx (standard arm A)
Pre-op CTx (test arm B)

Surgery
2 x FP

2 x FP

Surgery

FP: cisplatin + 5FU
5-FU 800mg/m² d1-5 ci
cisplatin 80mg/m² d1 div

Igaki H. Presented at: American Society of Clinical Oncology Annual Meeting; 2008; Abstract 4510.

JCOG 9907: Pre- vs. Post-operative cisplatin/5-FU for esophageal SCC

N= 330 pts

Unadjusted one-sided stratified logrank $P = 0.0444 > 0.0254$ (alpha)
Hazard ratio = 0.76 (94.91%CI: 0.56–1.04)

Unadjusted two-sided logrank $P = 0.013$
Hazard ratio by Cox model = 0.64 (95%CI: 0.45–0.91, p=0.014)

Progression-free survival (PFS) Overall survival (OS)

Post
Median PFS=2.0y
Pre
Median PFS=3.0y
Post
5yOS=38.4%
Pre
5yOS=60.1%

Does neo-adjuvant chemoradiation therapy improve surgery?

Localized Esophageal Cancer

Arm A Arm B

PLF I PLF II PLF III (3 weeks) Surgery

1 6 7 1314 17 20-21

PLF I PLF II 15 x 2 Gy in 3 weeks Surgery

Arm B PE (1 week)

PLF: Cisplatin 50mg/m² 1h, d 1-15.29. Leukovorin/5-FU 500mg/m² 2h / 2g/m² 24h, d1,8,15,22,29,36
PE: Cisplatin 50mg/m² 1h, d 2-4. Etoposide 80 mg/m², d 2-5


All-cause mortality estimates for neoadjuvant C/RT compared with surgery alone

POET: Post-op Mortality

<table>
<thead>
<tr>
<th></th>
<th>Arm A (n=52)</th>
<th>Arm B (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital mortality</td>
<td>2 (3.8%)</td>
<td>5 (10.2%)*</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Anastom. leakage</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Kardiac shock</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

* Fisher’s exact p = 0.26


POET: Overall Survival

<table>
<thead>
<tr>
<th></th>
<th>Arm A</th>
<th>Arm B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival (%)</td>
<td>47.4%</td>
<td>42.1%</td>
</tr>
<tr>
<td>HR Arm B vs. A</td>
<td>0.67 (0.41-1.07)</td>
<td></td>
</tr>
<tr>
<td>Median survival</td>
<td>21.1 mo</td>
<td>33.1 mo</td>
</tr>
<tr>
<td>Median follow-up</td>
<td>45.2 mo</td>
<td>46.2 mo</td>
</tr>
</tbody>
</table>


Localized Esophageal Cancer

Can surgery improve the outcome of chemoradiation?

Prospective Randomized Intergroup Study:

Radiation Therapy vs. Chemotherapy + Radiation Therapy for Localized SCC or ADC of the Esophagus

Schema

```
<table>
<thead>
<tr>
<th></th>
<th>R A N D O M I Z E</th>
</tr>
</thead>
<tbody>
<tr>
<td>tumor size</td>
<td>2 x Cisplatin (75 mg/m²) + 5-fluorouracil (1000 mg/m²/d CI x 4d) + radiation therapy (5000 cGy)</td>
</tr>
<tr>
<td>histology</td>
<td>radiation therapy (6400 cGy)</td>
</tr>
<tr>
<td>weight loss</td>
<td></td>
</tr>
</tbody>
</table>
```


Intergroup Study

French Phase III Trial

- 455 patients with localized esophageal cancer were given 2 courses of 5-FU/cisplatin plus radiation therapy
- 259/455 patients experienced a “partial response”, were considered operative candidates, and entered the randomized component of the trial

Chemoradiation Therapy With or Without Surgery:

### French Phase III Trial

<table>
<thead>
<tr>
<th>3-month mortality</th>
<th>Survival median</th>
<th>2-year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>19.3 months</td>
<td>40%</td>
</tr>
</tbody>
</table>

Partial Response (259 pts)

---

### German Phase III Trial (Schema)

Patients: (N = 177)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 cycles: 5-FU/LV + Cisplatin + Etoposide</td>
<td>9% 17.7 months 34%</td>
</tr>
<tr>
<td>Chemoradiaiton: Cisplatin + Etoposide + &gt; 60 Gy RT</td>
<td>Surgery</td>
</tr>
</tbody>
</table>

### German Phase III Trial (Results)

<table>
<thead>
<tr>
<th>Arm</th>
<th>Completed Treatment</th>
<th>Treatment Mortality</th>
<th>3-yr Local Recurrence</th>
<th>Median Survival</th>
<th>5-Year Survival</th>
<th>Induction Chemotherapy Responders</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>C/RT -&gt; S</td>
<td>62%</td>
<td>12.8%</td>
<td>41%</td>
<td>16 mo</td>
<td>31%</td>
</tr>
<tr>
<td>B</td>
<td>C/RT</td>
<td>85%</td>
<td>3.5% (p=0.03)</td>
<td>64%</td>
<td>15 mo</td>
<td>24% (p=0.02)</td>
</tr>
</tbody>
</table>

### C/RT +/- Surgery for Esophageal SCC

Median survival (N=172): Arm A (C/RT ->S) - 16.4 months Arm B (C/RT only) - 14.9 months

31.3% (p = 0.02)

### Conclusions from these data

Localized Esophageal

Pre-op cisplatin/5-FU chemotherapy offers a small survival advantage in distal esophageal and GE junction cancer.

Neoadjuvant cisplatin-based chemoradiation offers a greater survival advantage with better local control but with increased surgical morbidity.

Surgery may not be needed in patients who have a clinical response to chemoradiation.

### Localized Gastric Cancer

What can surgery accomplish?
What Is the Ideal Extent of Lymphadenectomy?

- **D0**: removes less than all relevant N1 nodes
- **D1**: requires the dissection of the N1 nodes (1-6)
- **D2**: includes the N1 and N2 nodes (7-11)
- **D3**: includes the N1, N2, and N3 nodes (12-15)
- **D4**: includes the N1, N2, N3, and N4 nodes (16)

*Nodes 2, 4 remain if distal subtotal gastrectomy*

Randomized Study of D1 and D2 Dissection for Gastric Cancer

- **711 patients undergoing curative resection of gastric cancer**

<table>
<thead>
<tr>
<th></th>
<th>Peri-Op Morbidity</th>
<th>Peri-Op Mortality</th>
<th>Median Hospital Stay (days)</th>
<th>5-Yr Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1 Dissection</td>
<td>25%</td>
<td>4%</td>
<td>14</td>
<td>45%</td>
</tr>
<tr>
<td>D2 Dissection</td>
<td>43%</td>
<td>10%</td>
<td>16</td>
<td>47%</td>
</tr>
</tbody>
</table>
What are proven strategies to enhance surgical resection?

Localized Gastric Cancer

Intergroup Protocol 0116

Adjuvant Therapy for Gastric Cancer

- Stratify:
  - depth of tumor penetration
  - number involved nodes
  - location of tumor
  - extent of surgery

- 5-FU/leucovorin x 1 + 4500 cGy radiation
- 5-FU/leucovorin x 2

- Observation

- Randomize

Chemoradiotherapy: 50%
Surgery Only: 41%
P = 0.005

3 years


Intergroup Protocol 0116

ECF x 3 q3/52
3-6 weeks
Resection

ECF x 3 q3/52
6-12 weeks

Follow-up

CSC

MAGIC Trial: Schema

503 Patients:
- 15% Lower Third
- 12% GE Junction

Patients at risk

Logrank p-value = 0.009
Hazard Ratio = 0.75
(95% CI 0.60 - 0.93)

MAGIC: Survival

- 50%
- 41%
- 36%
- 23%

Survival rate

Months from randomization

Patients at risk

CSC

MAGIC: Survival

Localized Gastroesophageal Junction Cancer

Audience Response Question

• What is suboptimal treatment for a 68yo male (PS 0, no sign co-morbidities) with T3N1M0 GEJ ADC?

1) Surgery alone
2) Chemotherapy → surgery → chemotherapy
3) Chemoradiation therapy → surgery
4) Surgery → chemotherapy → chemoradiation → chemotherapy
5) Unsure
Conclusions from these data

Localized Gastric:

Post-operative 5-FU-based chemoradiation therapy remains the standard of care for muscle-invasive or LN positive disease.

The MAGIC trial demonstrates that pre & post-operative ECF improves survival. It may be particularly beneficial for downstaging extensive local disease.

What are the active agents & combinations for this disease?

Advanced Esophagogastric Cancer: Older Single Agents

<table>
<thead>
<tr>
<th>Class</th>
<th>Agent</th>
<th>Mechanism Of Action</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimetabolite</td>
<td>S-Flourouracil</td>
<td>Inhibits thymidine synthase</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Methotrexate</td>
<td>Inhibits purine nucleotide and thymidine synthase</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Pentostatin</td>
<td>Inhibits thymidine synthase</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Gemcitabine</td>
<td>Inhibits ribonucleotide reductase</td>
<td>0%</td>
</tr>
<tr>
<td>Antibiotic</td>
<td>Mitomycin-C</td>
<td>Produces interstrand DNA cross-links</td>
<td>30%</td>
</tr>
<tr>
<td>Anthracycline</td>
<td>Doxorubicin</td>
<td>Intercalates into DNA and interacts with topoisomerase II</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Epirubicin</td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>Docetaxel</td>
<td></td>
<td>21%</td>
</tr>
<tr>
<td>Heavy Metal</td>
<td>Cisplatin</td>
<td>Produces intrastrand and interstrand DNA cross-links</td>
<td>9%</td>
</tr>
<tr>
<td>Topoisomerase Inhibitor</td>
<td>Eltoposide</td>
<td>Binds to and inhibits topoisomerase II</td>
<td>8%</td>
</tr>
</tbody>
</table>

Chemotherapy for Advanced Gastric Cancer: Important Randomized Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Regimen</th>
<th>n</th>
<th>Response (%)</th>
<th>DS (months)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wils et al. 1991</td>
<td>FAMTX</td>
<td>105</td>
<td>9</td>
<td>7.5</td>
<td>0.004</td>
</tr>
<tr>
<td>Chih et al. 2000</td>
<td>FAMTX</td>
<td>105</td>
<td>11</td>
<td>7.1</td>
<td>NS</td>
</tr>
<tr>
<td>Vanhoefer et al. 2000</td>
<td>ELF</td>
<td>133</td>
<td>12</td>
<td>6.7</td>
<td>NS</td>
</tr>
<tr>
<td>Webb et al. 1997</td>
<td>ECF</td>
<td>111</td>
<td>45</td>
<td>8.8</td>
<td>0.0009</td>
</tr>
<tr>
<td>Ross et al. 2002</td>
<td>ECF</td>
<td>289</td>
<td>42</td>
<td>9.4</td>
<td>NS</td>
</tr>
</tbody>
</table>

CDHP = 5-chloro-2,4-dihydroxypyridine; na = not available.

Advanced Esophagogastric Cancer: Newer Agents

<table>
<thead>
<tr>
<th>Class</th>
<th>Agent</th>
<th>MOA¹</th>
<th>Response²,³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimetabolite</td>
<td>Capcitabine</td>
<td>Reduces thymidine production and complements with uridine triphosphate for incorporation into RNA</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>S-1</td>
<td>Inhibits thymidine synthase and CDHP, and complements with uridine triphosphate for incorporation into RNA</td>
<td>26%</td>
</tr>
<tr>
<td>Heavy Metal</td>
<td>Oxaliplatin</td>
<td>Produces intra- and interstrand platinum-DNA cross-links</td>
<td>na</td>
</tr>
<tr>
<td>Taxane</td>
<td>Paclitaxel</td>
<td>Binds to and stabilizes tubulin inhibiting microtubule disassembly</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Docetaxel</td>
<td></td>
<td>21%</td>
</tr>
<tr>
<td>Topoisomerase Inhibitor</td>
<td>Irinotecan</td>
<td>Inhibits topoisomerase I</td>
<td>21%</td>
</tr>
</tbody>
</table>

Metastatic Esophagogastric Cancer

REAL-2: Schema

Previously untreated Patients with locally advanced or metastatic esophagogastric cancer

**2 x 2 design**

Stratified for:
- Centre (63 centres mainly UK, 2 Aus)
- Locally advanced versus metastatic
- PS 0/1 versus 2

**REAL-2: Survival (ITT)**

<table>
<thead>
<tr>
<th>Time since randomisation (years)</th>
<th>Probability of survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>5</td>
<td>96 (95% CI: 85-99)</td>
</tr>
<tr>
<td>10</td>
<td>92 (95% CI: 88-96)</td>
</tr>
<tr>
<td>15</td>
<td>80 (95% CI: 74-86)</td>
</tr>
<tr>
<td>20</td>
<td>61 (95% CI: 53-70)</td>
</tr>
<tr>
<td>25</td>
<td>38 (95% CI: 30-49)</td>
</tr>
<tr>
<td>30</td>
<td>20 (95% CI: 14-27)</td>
</tr>
</tbody>
</table>

**Primary endpoint:** Non-inferiority in PFS, HR < 1.4

**Secondary endpoints:** Response rate (RR), time to response (TTR), overall survival (OS), safety

**Capecitabine / Cisplatin vs. 5-FU / Cisplatin Schema**

**Previously untreated advanced gastric cancer**

<table>
<thead>
<tr>
<th>XP - Capecitabine 1000 mg/m² d1-14</th>
<th>0.96 (0.79-1.15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOF</td>
<td>0.92 (0.76-1.11)</td>
</tr>
<tr>
<td>EOX</td>
<td>0.80 (0.66-0.97)</td>
</tr>
</tbody>
</table>

**5-FU/LV vs. 5-FU/LV + oxaliplatin**

**Primary endpoint:** Superiority for TTP

**Secondary endpoints:** Response rate (RR), time to treatment failure (TTF), overall survival (OS), safety

**5-FU/LV + oxaliplatin vs. 5-FU/LV + cisplatin Schema**

**Previously untreated advanced gastric cancer**

<table>
<thead>
<tr>
<th>FLO - 5-FU 2000 mg/m² 24-hr CI</th>
<th>0.80 (95% CI: 0.63-1.04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leucovorin 200 mg/m²</td>
<td>85 mg/m² d1</td>
</tr>
<tr>
<td>Oxaliplatin 85 mg/m² d1</td>
<td></td>
</tr>
</tbody>
</table>

**5-FU/LV + oxaliplatin vs. 5-FU/LV + cisplatin Schema**

**Primary endpoint:** Superiority for TTP

**Secondary endpoints:** Response rate (RR), time to treatment failure (TTF), overall survival (OS), safety

**5-FU/LV vs. 5-FU/LV + oxaliplatin**

**Primary endpoint:** Superiority for TTP

**Secondary endpoints:** Response rate (RR), time to treatment failure (TTF), overall survival (OS), safety

**V 325: Phase III for Advanced Gastric Cancer**

**Stratification Factors:**
- Liver Involvement
- Prior Gastrectomy
- Measurable vs Evaluable Disease
- Weight Loss (>5%) in Prior 3 Months
- Centers

**Randomize**

- Docetaxel 75 mg/m² IV over 1 hr
- 5-FU 750 mg/m²/day by CIV over 5 days Days 1-5
- Cisplatin 100 mg/m² IV over 1-3 hrs both on Day 1 only
- Cycles repeated every 3 weeks
- Cycles repeated every 4 weeks

**Adequate hydration and anti-emetics required**

**Response assessment every 8 weeks independent of treatment schedule**


Grade 3-4 Hematologic Toxicity

<table>
<thead>
<tr>
<th></th>
<th>Number (%) of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TCF</td>
</tr>
<tr>
<td>Hematological abnormalities (Grade 3-4)</td>
<td></td>
</tr>
<tr>
<td>Neutropenia</td>
<td>02%</td>
</tr>
<tr>
<td>Anemia</td>
<td>18%</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>8%</td>
</tr>
<tr>
<td>Febrile neutropenia or neutropenic infection</td>
<td>39%</td>
</tr>
</tbody>
</table>

Without or with secondary prophylactic G-CSF

<table>
<thead>
<tr>
<th></th>
<th>Without</th>
<th>With</th>
<th>Without</th>
<th>With</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of evaluable patients</td>
<td>219</td>
<td>41</td>
<td>222</td>
<td>20</td>
</tr>
<tr>
<td>Febrile neutropenia or neutropenic infection</td>
<td>20%</td>
<td>15%</td>
<td>13%</td>
<td>15%</td>
</tr>
</tbody>
</table>

* % is calculated in evaluable patients
** Regardless of relationship

CPT-11/Cisplatin in Advanced Esophago-gastric Cancer Phase II Trials

<table>
<thead>
<tr>
<th>Author</th>
<th>Regimen</th>
<th>Cancer Type</th>
<th># Patients</th>
<th>Major Response Rate</th>
<th>G3-4 Diarrhea</th>
<th>G4 ANC</th>
<th>Median Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boku</td>
<td>2-weekly</td>
<td>Gastric</td>
<td>44</td>
<td>48%</td>
<td>20%</td>
<td>57%</td>
<td>9 mo.</td>
</tr>
<tr>
<td>Ilson</td>
<td>weekly</td>
<td>Esoph. GE jct.</td>
<td>35</td>
<td>57%</td>
<td>11%</td>
<td>9%</td>
<td>15 mo.</td>
</tr>
<tr>
<td>Ajani</td>
<td>weekly</td>
<td>GE jct.</td>
<td>38</td>
<td>58%</td>
<td>22%</td>
<td>15%</td>
<td>9 mo.</td>
</tr>
<tr>
<td>Ajani**</td>
<td>weekly</td>
<td>GE jct.</td>
<td>29</td>
<td>31%</td>
<td>13%</td>
<td>9%</td>
<td>5 mo.</td>
</tr>
<tr>
<td>Ilson</td>
<td>weekly</td>
<td>Esoph. GE jct.</td>
<td>10 naive 25 pret.</td>
<td>53%</td>
<td>3%</td>
<td>5.0 mo.</td>
<td>0.0 mo.</td>
</tr>
<tr>
<td>Ilson</td>
<td>weekly</td>
<td>Esoph. GE jct.</td>
<td>26</td>
<td>38%</td>
<td>18%</td>
<td>11%</td>
<td>NK</td>
</tr>
</tbody>
</table>

1. % includes

Audience Response Question

Metastatic Esophagogastric Cancer

The most active single agents are the 5-fluoropyrimidines, platinum analogues, taxanes, and irinotecan.

Combinations of fluoropyrimidine and platinum remain the standard of care.

Weekly irinotecan/cisplatin is most convenient. FOLFOX is best for hepatic or renal insufficiency.

Audience Response Question

Demographics of Esophageal Cancer

How has the incidence of esophageal ADC changed from 1979 → 2004 in white males (USA)?

1) -51%
2) about the same
3) +51%
4) +157%
5) +211%
6) +463%
7) Unsure
Audience Response Question

Metastatic Esophagogastric Cancer
What is not an acceptable treatment for a 72yo male (PS 0, no sign co-morbidities) with metastatic gastric ADC?

1) Cisplatin/5-fluorouracil
2) Docetaxel
3) Gemcitabine
4) ECF or EOX
5) DCF (docetaxel, cisplatin, 5-FU)
6) FOLFOX
7) Irinotecan/Cisplatin
8) Unsure

Questions & Answers

Thank you for attending Master Class for Oncologists