Eastern Canadian Gastrointestinal Cancer Consensus Conference 2016

MICHAEL VICKERS, MD MPH FRCPC
MEDICAL ONCOLOGIST, UOTTAWA, TOHCC

Montreal
Feb 5-7, 2016
Objectives

- Review EC5 consensus statements involving Colorectal Cancer, Pancreatic Cancer, and Hepatobiliary Cancer.

Colorectal Cancer

- **Is there a clinical benefit to follow-up of colorectal cancer patients that have undergone curative surgical resection?**

  - There is general consensus and evidence that some form of surveillance will provide survival benefit to those patients who are eligible for curative therapy at the time of recurrence. (Level I)
  
  - Current evidence suggests that it is cost-effective. (Level II-2)
  
  - Survivorship care can be provided by medical oncologists, radiation oncologist, surgeons, general practitioners, and/or nurse practitioners. (Level III)
  
  - One study has demonstrated that there is no difference in outcome between patients followed up by oncologists and general practitioners. (Level II-2)
  
  - Emerging literature suggests that alternative follow-up strategy may be appropriate. (Level III)
What is the recommended surveillance of stage II and III colorectal cancer patients that have completed treatment?

- We endorse surveillance based on local jurisdiction guidelines such as Cancer Care Ontario and the American Society of Clinical Oncology (ASCO).

- Individual scenarios need to be discussed between the patient and the physician regarding the elements of the surveillance program. (Level III)

- Positron emission tomography-computed tomography (PET-CT) is not recommended for routine surveillance. (Level III)
What are the key elements of a cancer survivorship program?

Ideally, all patients should be offered a comprehensive survivorship program that includes (Level III):
- Management of late treatment-related side effects;
- Psychosocial side effects; and
- Detection and management of late disease recurrence.

We endorse continued development and evaluation of the survivorship programs. (Level III)

What are the criteria for liver metastasectomy for metastatic colorectal cancer?

All cases should be discussed at multidisciplinary rounds which should include medical and radiation oncologists, hepatopancreatobiliary surgeons and colorectal surgeons. (Level III)

Non-curative-intent treatment for extrahepatic disease remains a contraindication to liver metastasectomy. (Level III)

All liver metastases should be resected and adequate future liver remnant function should be preserved irrespective of the number of lesions. (Level III)

R0 resection should be considered to be achievable in one or more operation(s)(Level III)

Ablative therapy in addition to resection may be used as an adjunct in selected patients where resection of all lesions cannot be achieved (Level III)

The definition of resectable liver metastasis continues to evolve (Level III)
What is the optimal sequence and timing of interventions?

- The timing and sequence of chemotherapy, radiation, surgery remains to be defined and should be determined in multidisciplinary rounds prior to initiation of treatment (Level III)

OLIGOMETASTASIS

What is the role of Stereotactic Body Radiation Therapy (SBRT) in the treatment of oligometastases?

- SBRT refers to high dose, high precision external beam radiotherapy.
- SBRT is an effective and well-tolerated form of ablation that is continuing to evolve as a local treatment modality in the management of oligometastatic disease. (Level II-3)
Pancreatic Cancer

- What is the optimal approach to borderline resectable pancreatic cancer?
  - A multidisciplinary team is crucial to improve outcomes (Level III)
  - Patients should be treated in a clinical trial setting where possible (Level III)
  - Surgery provides meaningful extension to survival, and should be provided at a high-volume centre (Level II-2)
  - Where possible, classify and manage disease according to prospectively established criteria: (Level III)
    - A priori classification of resectable, borderline resectable and locally advanced unresectable pancreatic cancer should be determined by a multidisciplinary team.
What is the role of chemotherapy or chemoradiation in patients with unresectable locally advanced pancreatic cancer (LAPC)?

- Unresectable LAPC is treated with palliative intent. (Level III)
- Chemotherapy is the only modality of treatment having evidence to improve OS (Level I)
- Use of chemoradiation after initial chemotherapy for locoregional control may be considered. (Level I and II-2)
- Best supportive care is a reasonable option for this population in patients with poor performance status through shared decision making between the patient and physician. (Level III)

Hepatobiliary Cancers
What is the role of SBRT in the treatment of hepatocellular carcinoma (HCC) and biliary tract cancers (BTCs)?

- Based on studies and case series, there appears to be a role for SBRT to treat Childs-Pugh A and selected B7 HCC patients in those patients that are not candidates for resection, transplant, or other locoregional and curative options. (Level II-1 and II-2)

- In patients who are not suitable for transarterial (chemo)embolisation or radiofrequency ablation, SBRT may be considered as a bridging therapy to liver transplant. (Level II-2)

- Concurrent radiation with systemic therapy is not recommended due to potential for increased toxicity and is still considered experimental. (Level II-1)

- The role of SBRT for BTCs is still considered experimental

- We encourage enrolment in a clinical trial(s) to better define the role of SBRT in HCC and BTCs. (Level II-1 and II-2)

- In patients who have untreated hepatitis B, referral for suppressive therapy of hepatitis B before radiation should be strongly considered. (Level II-2).

What is the role of transarterial chemoembolization in unresectable and non-transplantable Barcelona Clinic Liver Cancer intermediate-stage hepatocellular carcinoma?

- TACE is the standard of care for Barcelona Clinic Liver Cancer intermediate-stage hepatocellular carcinoma in patients deemed eligible at multidisciplinary rounds. (Level I)

- Bland embolization may be an alternative to TACE in patients who are not candidates for conventional TACE. (Level I)

- Drug-eluting beads TACE offers equivalent oncologic outcomes and may be better tolerated. (Level I)

- Other transarterial therapies such as transarterial radioembolization and transarterial ethanol ablation require further study. (Level II-1 and II-2)
What is the best way to prepare patients with gastrointestinal malignancies for anti-cancer treatment in terms of infectious complications?

- Systemic therapy given to patients with gastrointestinal malignancies can lead to immunosuppression and increase their risk of infections, thus a thorough infectious and vaccination history should be obtained. (Level II)

- This may require updating vaccinations and appropriate referral to infectious disease specialists. Specific vaccines, timing and sequence may be complex during cancer chemotherapy. (Level III)

- In patients starting anti-neoplastic therapy, Hepatitis B and C should be screened in at risk populations. (Level II-2)

- In patients with hepatitis B, suppressive therapy should be considered when treated with immunosuppressive therapy. (Level III)

- In patients at risk of tuberculosis, testing should be considered. (Level III)