

Pancreatic Cancer News from ESMO GI Congress: ‘Outcomes Are Improving’

BY ROBERT H. CARLSON

BARCELONA, Spain—At a meeting of primarily medical oncology presentations, a gastrointestinal surgeon had some positive news, and a message, for medical oncologists about treating pancreatic adenocarcinoma. “It should

ing here at the European Society for Medical Oncology World Congress on Gastrointestinal Cancer.

“And with increasing evidence on the surgical and perioperative aspects of pancreatic cancer therapy, the short-term and long-term outcomes of resectable

and borderline resectable pancreatic cancer are improving,” he said in a session on surgical resection for pancreatic cancer.

Most physicians still think pancreatic cancer cannot be cured and that patients die, but there are some patient groups that have much better survival rates than

others, he said. “Studies show that surgery can offer a cure rate of 20 to 30 percent with a median survival after surgery of between 10 and 40 months, which should be compared to what medical oncology can offer—between six and nine

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MARKUS BÜCHLER, MD, PHD, began his presentation with the standard conflict-of-interest statement, but with a wry twist: “I have no conflict of interest to disclose... because I am a surgeon.”

not be forgotten that the only cure for pancreatic cancer is offered by surgery,” said Markus Büchler, MD, PhD, Professor of Surgery and

“Studies show that surgery can offer a cure rate of 20 to 30 percent, with a median survival after surgery of between 10 and 40 months, which should be compared to what medical oncology can offer—between six and nine months.”

Surgeon-in-Chief at the University of Heidelberg and Director of the European Pancreas Center, speak-

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months,” he said, citing as an example the following review article for which he was senior author: *Hartwig W et al: Lancet Oncology 2013;14:e476-e485*.

Among the recent studies he cited in surgical treatment of pancreatic cancer to support his optimistic outlook were the following, for which he is also senior author:

- Research showing that the presence of one lymph node does not mean a worse outcome after surgery (*Oliver Strobel et al, in press*). “Patients with

N0 stage have the same outcome as patients with N1,” Büchler said, emphasizing, though, that at least 24 lymph nodes have to be sent to the pathology department to be able to determine stage.

- A single, local recurrence occurs in about 20 to 30 percent of patients after pancreatic cancer resection, and a purely local recurrence after pancreatic surgery is amenable to a second surgery in at least half of patients. “In patients

who had a local recurrence where we did a second operation, when the local recurrence was removable, the patients had a median 26 months of additional survival,” he said

(*Werner et al: Nature Reviews Clinical Oncology 2013;10:323-333*).

- Whether to do combined pancreatic resection with resection of one to three liver metastases is a very controversial issue, Büchler said, but the data show that pancreatic resections

with M1 disease can be performed with acceptable safety in highly selected patients (*Shrikhande et al: Annals of Surgical Oncology 2007;14:118-127*). “In our series published in 2007, these patients did better when we removed the liver metastases together with the primary tumor, but that was only in 29 patients. We have updated the series to 144 patients with M1 disease and clearly resectable primary tumor, and found that when we do the surgery these patients do better long term as against the patients who undergo chemotherapy. But it’s too early to conclude

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[definitively]—it is still an open issue for the future.”

• After neoadjuvant chemotherapy, about 30 percent of patients become resectable and have good outcomes. In adjuvant treatment, in the randomized controlled ESPAC-3 (European Study Group for Pancreatic Cancer) trial of 1,149 patients treated with adjuvant chemotherapy consisting of either fluorouracil plus folic acid or gemcitabine

following pancreatic cancer resection, there was no difference between the two regimens (*Neoptolemos et al: JAMA 2010;304:1073-1081*). “This was an important message, because you were believing that gemcitabine was better, but the answer is that gemcitabine is only more expensive—not better; 5FU has the same effect in adjuvant treatment,” Büchler said. And in an ESPAC-3 update among patients

with resected periampullary adenocarcinoma receiving either adjuvant chemotherapy or observation, the data clearly show a statistically significant survival benefit associated with adjuvant chemotherapy, he said (*Neoptolemos et al: JAMA 2012;308:147-156*).

• ESPAC-3 data are also suggesting that adjuvant chemotherapy need not be started so soon after surgery (*Valle et al: JCO*

2014;32: 504-512). A 2014 report concluded that completion of all six cycles of planned adjuvant chemotherapy was an independent prognostic factor after resection for pancreatic adenocarcinoma, rather than early initiation, and there seemed to be no difference in outcome if chemotherapy is delayed up to 12 weeks. “You were told to start chemotherapy within four weeks after surgery, but the answer now is that you can easily start with very good results up to 12

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For tappable links to all the studies cited here, read the article on our iPad edition.

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weeks," Büchler said. "This is good for the patients, because they can recover from the surgery."

- And according to research from ESPAC-3 on human equilibrative nucleoside transporter 1 (hENT1), levels of that biomarker in pancreatic adenocarcinoma may predict survival in patients who receive adjuvant gemcitabine after resection (*Greenhalf et al: JNCI 2014;106:djt347*).

Became a Surgeon Because...

In an online biography, Markus Büchler said he became a surgeon because his father, a physician, "hated surgeons," quoting his father as saying, "I put them in the hospital, where the surgeons kill them." He became a surgeon, Büchler said, to prove his father wrong.

He concluded his presentation at the ESMO meeting by noting that surgeons in the University of Heidelberg's Department of General, Visceral and Transplantation Surgery perform approximately 800 pancreatic resections per year, with an overall mortality rate of only 3.5 percent.

**ESPAC Trials
Continue Apace**

Results from ESPAC-4, a Phase III trial with more than 1,000 patients testing adjuvant gemcitabine versus gemcitabine-capecitabine, will be available later in 2014, Büchler said.

And the Phase III ESPAC-5 trial has started, with four study arms: pancreatic adenocarcinoma treated with surgery alone; treatment with either of two arms of neoadjuvant chemotherapy; and treatment with neoadjuvant chemoradiotherapy. ■

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