

# Clinical case:

## Management of oligometastatic gastric adenocarcinoma

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# Clinical case

50 years old male  
Currently working in an office

Smoker of 10 cigarettes/day  
No comorbidities, except from  
H.pylori eradication in 2020.

Familiar history: No relationship

## First sign/symptom

### September 2024

Consults at Emergency Department due to upper gastrointestinal bleeding and secondary anemia.

## Anamnesis

- Dyspepsia
- An episode of melena 1 month ago
- 10 kg weight loss in the last 6 months

# Clinical case

## Complementary tests

**Gastroscopy (Sept 2024):** Upper gastrointestinal bleeding secondary to an ulcerated lesion. Hemostasis achieved with Coagrasper.

**Pathology report:** negative for malignancy.

**CT scan (Sept 2024):** Ulcerated antropyloric mass with peritumoral lymphadenopathy.

**Gastroscopy (Oct 2024):** A large lesion at the incisura extending toward the antral region. Due to its size, advancement into the duodenum is not possible and lymph nodes cannot be adequately assessed. The lesion is solid, heterogeneous, highly vascularized, and ulcerated.

**Pathology report:** mesenchymal tumor.

**EUS (Oct 2024):** Pyloric stenosis due to extrinsic compression.

**Pathologic report (cytology):** Poorly cohesive carcinoma. **HER2 negative, pMMR, CLDN18.2 negative, PD-L1 CPS 0.**

# Clinical case

## Complementary tests

**Laparoscopy (Oct 2024):** Antral tumor involving the serosa with infiltration of the first portion of the duodenum. At the round ligament, 3 right-sided low-suspicion lesions were identified, and one was biopsied. Partial gastric transection was performed, along with gastrojejunostomy and jejunojejunostomy with Roux-en-Y reconstruction.

**Pathology report:** peritoneal biopsy positive for adenocarcinoma

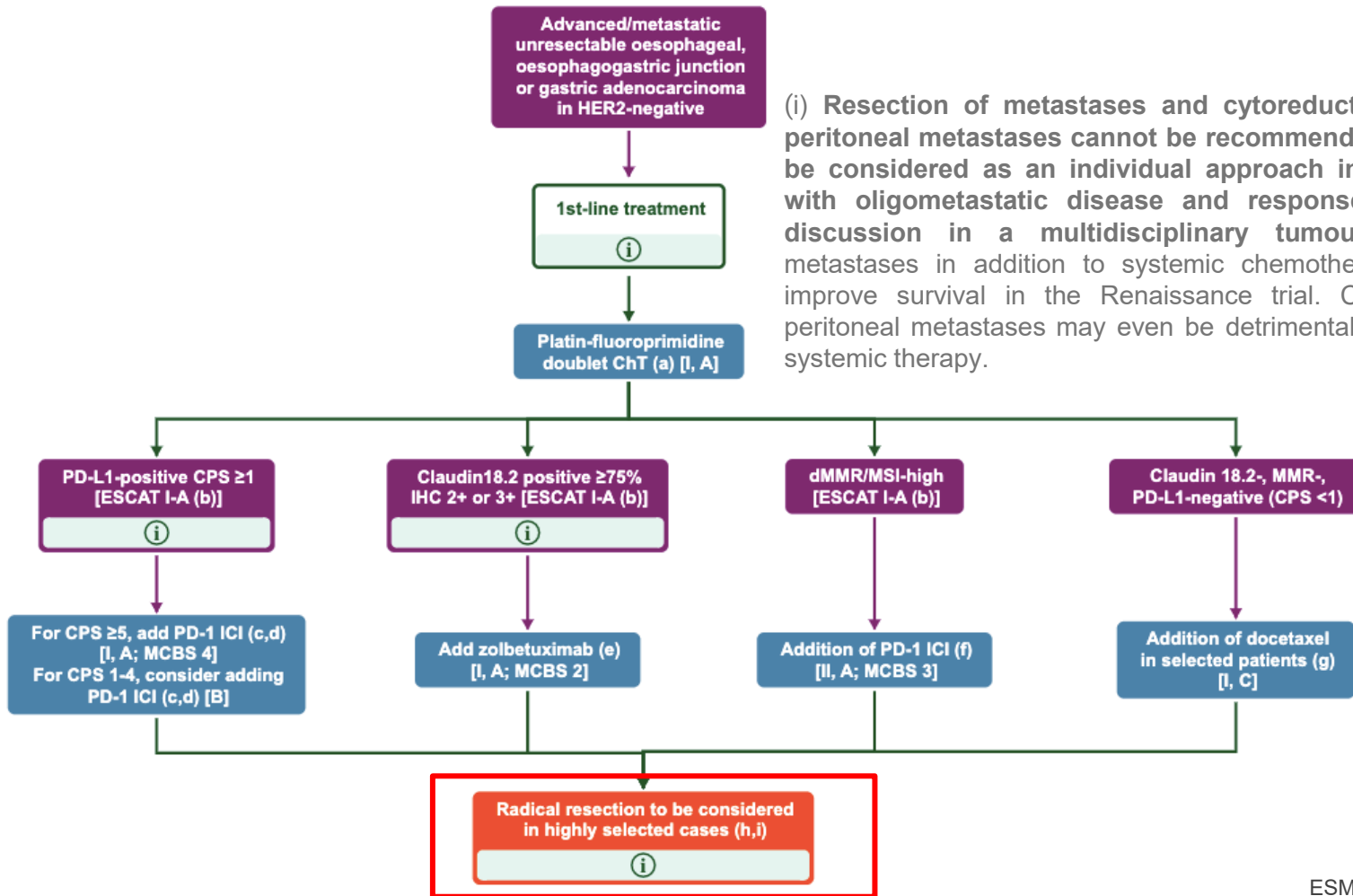
**Peritoneal lavage cytology:** Negative for malignant cells.

**CEA and CA 19-9 (Oct 2024):** Negative.

**DPYD (Oct 2024):** Normal metabolizer.

## DIAGNOSIS

50 years old previously healthy male diagnosed with antral **gastric neoplasm**, specifically a **poorly cohesive** carcinoma, **pMMR, CPS 0, HER2-negative, Claudin18.2-negative stage IV cT4b** (with infiltration of the first portion of the duodenum) **N+ M1** (peritoneal lesion). Due to gastric outlet obstruction with retention, a bypass procedure has been performed. ECOG 1.



(i) Resection of metastases and cytoreductive surgery in case of peritoneal metastases cannot be recommended in general, but might be considered as an individual approach in highly selected cases with oligometastatic disease and response to ChT after critical discussion in a multidisciplinary tumour board. Resection of metastases in addition to systemic chemotherapy was not shown to improve survival in the Renaissance trial. Cytoreductive surgery for peritoneal metastases may even be detrimental. The standard of care is systemic therapy.

# Multidisciplinary tumor board



**Bulky tumor** (would require gastrectomy ± pancreaticoduodenectomy due to duodenal infiltration)

**No** peritoneal carcinomatosis.  
**3 lesions** (round ligament)

Medical  
Oncologists  
Radiotherapy  
Oncologists  
Radiologists  
Surgeons  
Pathologists  
Nutritionists



*In your center, what would be your preferred initial approach for this patient?*

- A) Upfront surgery including CRS/HIPEC
- B) Systemic chemotherapy followed by reassessment
- C) Palliative/supportive approach

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Intensified 1st  
line therapy +  
Reassessment

**FLOT** x8 cycles (November 2024 – March 2025).  
Maximum radiological response: **partial response.**

# Reassessment

## Complementary tests

**Laparoscopy (February 2025):** Three lesions were identified. Peritoneal fluid was collected for repeat cytological analysis. Additional biopsies were obtained from peritoneal lesions in the right flank/right hypochondrium. PCI=6.

**Pathology report:** fibroadipose tissue without evidence of malignancy.

**Peritoneal lavage cytology:** Negative for malignant cells.

## Quiz

*After a good response to chemotherapy and negative peritoneal cytology, what would you do next?*

- A) Proceed to radical surgery
- B) Continue systemic therapy
- C) Switch to maintenance / less intensive treatment



# SURGERY

# Treatment

## Surgery

Fuenlabrada's Hospital (7<sup>th</sup> May 2025)

- Laparoscopic distal gastrectomy with subtotal

**FLOT** x4 cycles (June 2025 – August 2025).

## Results

Pathology report

•**Gastrectomy:**

Residual infiltrating adenocarcinoma

poorly  
Tumor  
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argins

•**Peritoneal lavage cytology:**

Positive for malignant cells.

# Follow-up

October 2025 (5 months after surgery)

**CT- scan:**

Indeterminate ascites, without lesions at the peritoneal level. No signs of tumor recurrence.

January 2026 (8 months after surgery)

**Current status:** progressive clinical deterioration. Abdominal pain, postprandial fullness and decreased bowel movements.

**Physical examination:** ECOG 2. Abdomen with ascitic features, firm, with nearly absent peristalsis

**Labs:** normal.

2nd Line Treatment: **Paclitaxel-Ramucirumab**

**TUMORAL PROGRESSION.  
PERITONEAL CARCINOMATOSIS.**

- Right **hydronephrosis** grade II and progressive tapering of the proximal ureter, showing diffuse mucosal enhancement and mild surrounding fat stranding, tumor infiltration cannot be excluded.
- Mildly distended small bowel loops
- Large-volume, multiloculated **ascites**, significantly increased compared to prior CT, predominantly in the lower abdomen.

Does the combination therapy consisting of *gastric resection with CRS/HIPEC* in patients with gastric cancer and limited peritoneal metastases and/or tumour-positive cytology result in an overall survival benefit compared to standard treatment consisting of *palliative systemic therapy*?

# Discussion

## Study design

- Phase III
- Two arms (1:1)

## Outcomes

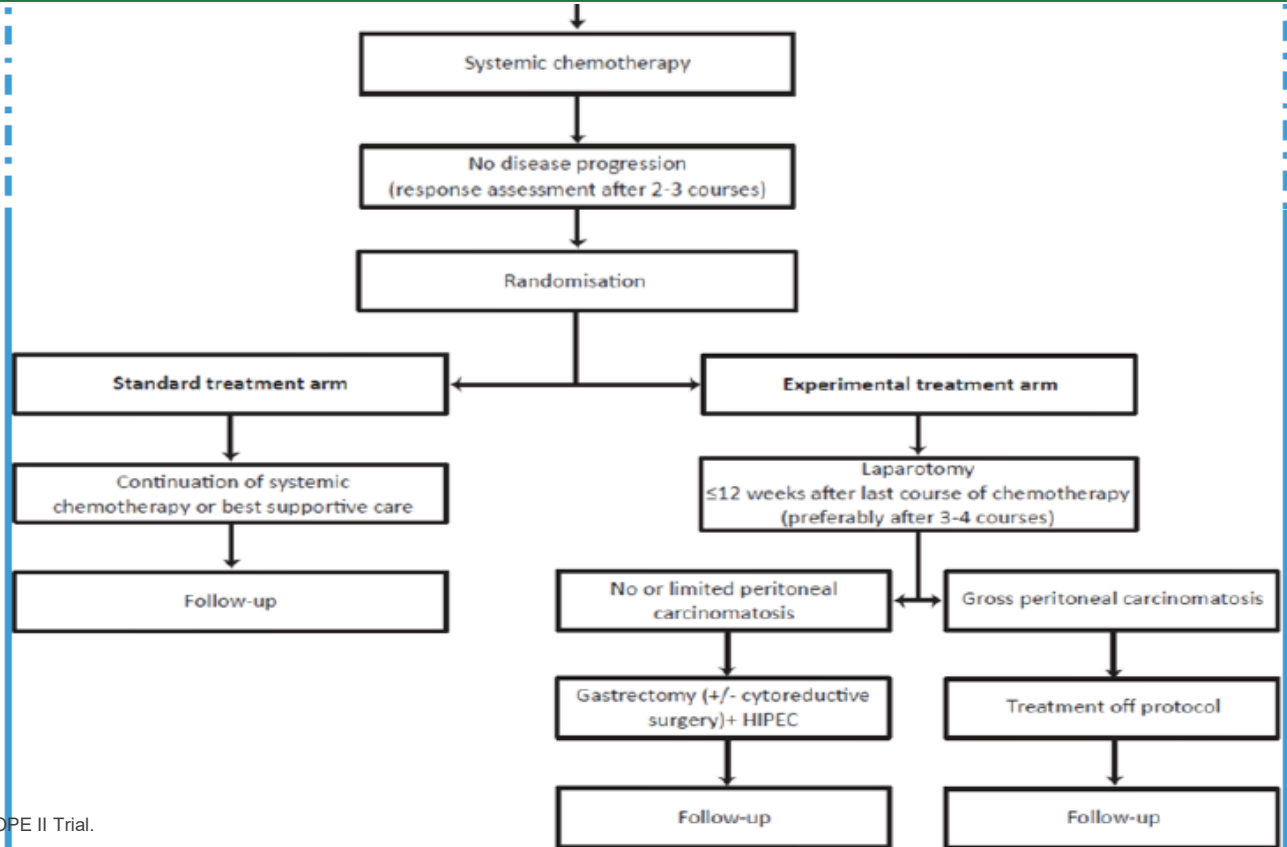
1st: OS  
2nd: Toxicity, quality of life, PFS, cost-effectiveness, pharmacokinetics

## Patient selection

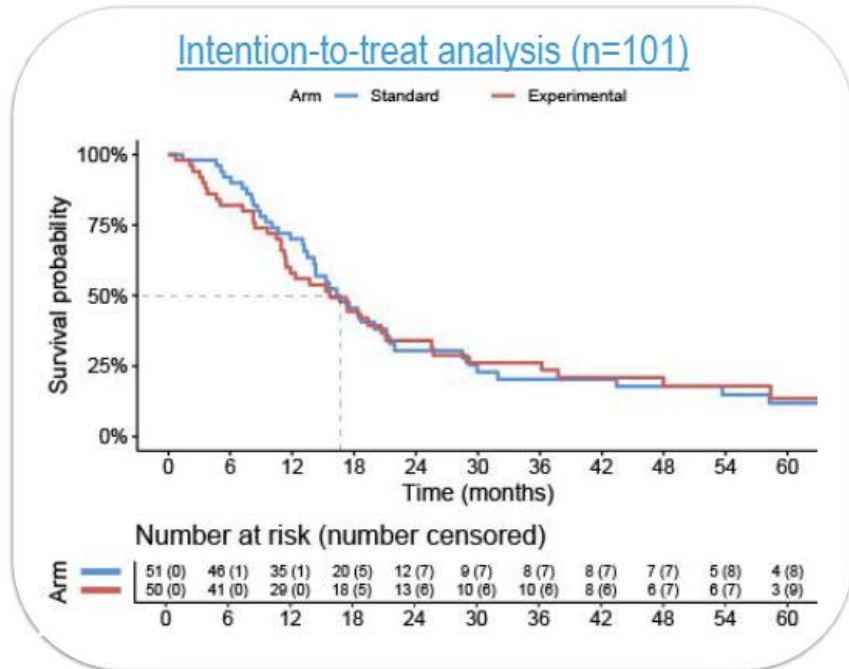
Resectable cT3-T4 gastric adenocarcinoma

+

Limited peritoneal metastases (PCI < 7) and/or tumour positive citology



# RESULTS: OVERALL SURVIVAL



Standard arm: 16.6 months mOS  
Experimental arm: 15.7 months mOS  
**HR: 1.1, p = 0.7**

## CONCLUSION

Gastrectomy and CRS/HIPEC **did not show survival benefit** in gastric cancer patients with limited peritoneal metastases and/or tumour positive cytology compared to systemic therapy alone.

## RESULTS: SAFETY

- 49 serious adverse events;  $p < 0.001$ 
  - 4 SAEs reported in the standard arm (n=3), *nausea (50%) most common*
  - 45 SAEs in the experimental arm (n=22), *ileus (17%) and anastomotic leakage (13%) most common*
- 3 treatment-related deaths (6%), all in the experimental arm

# Thank you for your attention

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