Masaryk Memorial Cancer Institute

ICI & AFROC

Oligometastatic Oesophageal Cancer Case report

Tomas Sokop, Radka Lordick Obermannová and GI MDT, MMCI

Department of Comprehensive Cancer Care, Masaryk Memorial Cancer Institute, Brno, Czech Republic

AFROC, Multidisciplinary Tumour Board, 5 September 2024

Background

52 years old male presented with **odynophagia, dysphagia and weight loss** in 8/2023 in the ENT ward, PS1(weight loss of 5-10kg from March 2023)

History:

- smoker (10-20 cig/day 30 years)
- alcohol use disorder cured at the age of 33 years
- lateral wall NSTEMI in 2021 (PCI + DES)
- diabetes mellitus type II (PAD) – non-compliant in treatment
- clinical depression on medication
- unemployed, divorced, living alone

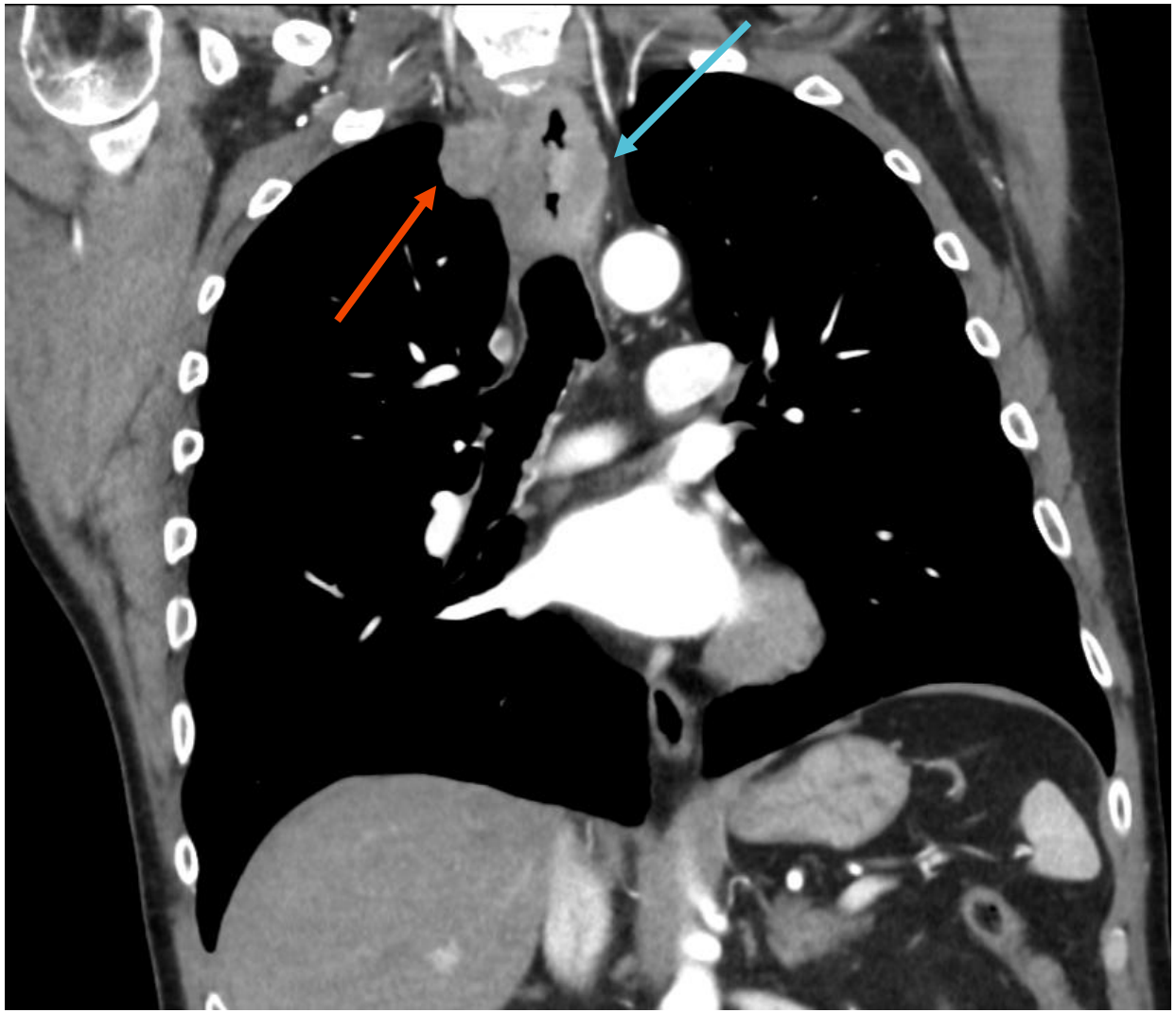
Initial diagnostics I

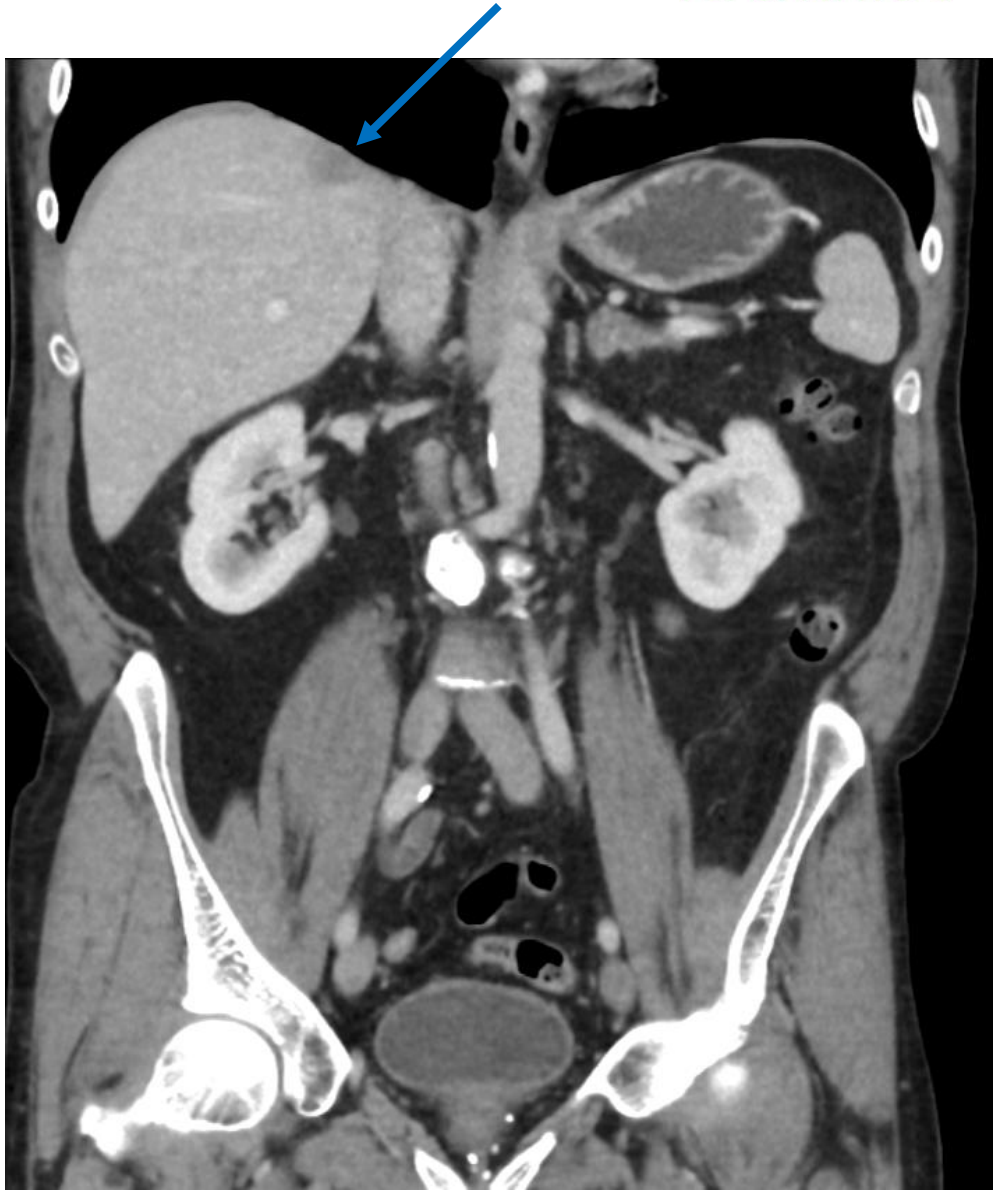
- **Oesophageal passage:** C7/Th1–Th4 - **6.5 cm long** intraluminal irregular formation, suspected from tumour

- **Rigid oesophagoscopy:** dorsal and right oesophageal wall infiltrated by relatively smooth **intraluminal tumour in 17-18 cm from incisors, obturating 2/3 of the lumen**, not possible to pass by endoscope; biopsy performed

- **Whole body CT scan:** thickening of the proximal oesophageal wall 10-12 cm in length, **contact with surrounding structures**, **2** enlarged **mediastinal LNs**, **2 bilobar liver lesions** suspected from metastases

  (secondary findings: prostate hyperplasia, susp. chronic pancreatitis)





Initial diagnostics II

- **Histology:** poorly differentiated squamous (eventually adeno-squamous) carcinoma of proximal oesophagus, PD-L1: TPS 0 %, CPS 10

Summary:
Squamous cell carcinoma of proximal oesophagus, G3
cT3 N1 (mediastinal) M1 (liver), stage IVB, dg. 8/2023

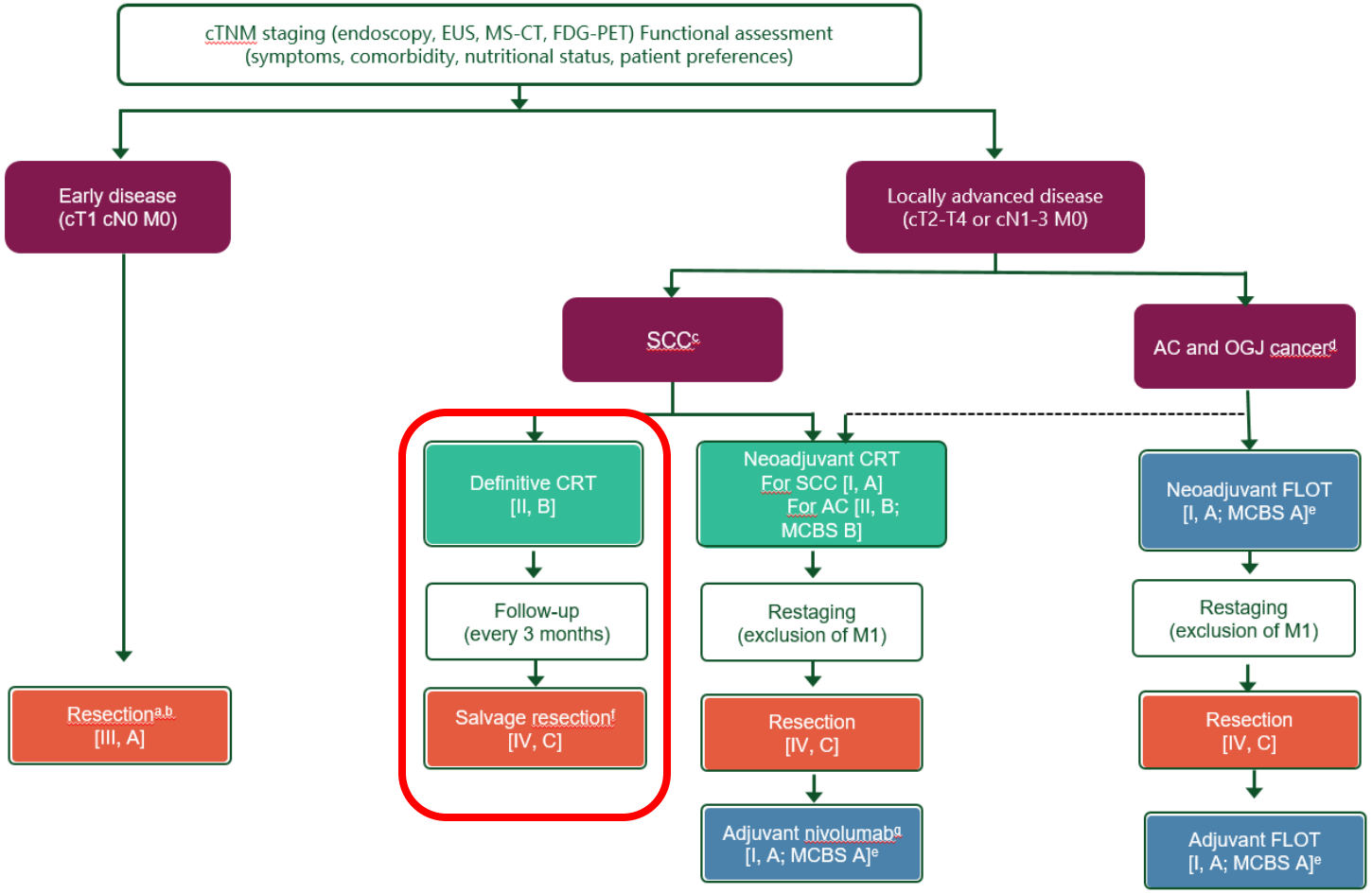
Initial procedures

- DPYD: heterozygous, UGT: fully active homozygous
- TPS 0, CPS 10
- Molecular tumor board (TSO 500): no targetable alteration
- Nutrition questionnaire: weight: 80kg, height: 180cm, BMI: more than 20 [0b], Appetite: 100-75% [0b], Weight loss: <10% / 6 months. <10% [1b], Dietary intake: < 1/2 servings, > 5 days, porridge [5b], Risk factors (other): mucosal tox,severe surgery,RT neck [1b] - risk: 7, Risk- nutritional support

MDT: locally advanced primary tumor, oligometastatic disease – **definitive concomitant chemoradiotherapy**, despite metastatic stage, in fit patient with symptoms to **gain rapid local control**.

CITSEQ trial

ESMO GUIDELINES



Lordick Obermannová et al. eUPDATE 2024: In progress

Treatment

Definitive chemoradiotherapy with FOLFOX versus fluorouracil and cisplatin in patients with oesophageal cancer (PRODIGE5/ACCORD17): final results of a randomised, phase 2/3 trial

Thierry Conroy, Marie-Pierre Galais, Jean-Luc Raoul, Olivier Bouché, Sophie Gourgou-Bourgade, Jean-Yves Douillard, Pierre-Luc Etienne, Valérie Boige, Isabelle Martel-Lafay, Pierre Michel, Carmen Llacer-Moscardo, Eric François, Gilles Créhange, Meher Ben Abdelghani, Beata Juzyna, Laurent Bedenne, Antoine Adenis, for the Fédération Francophone de Cancérologie Digestive and UNICANCER-GI Group

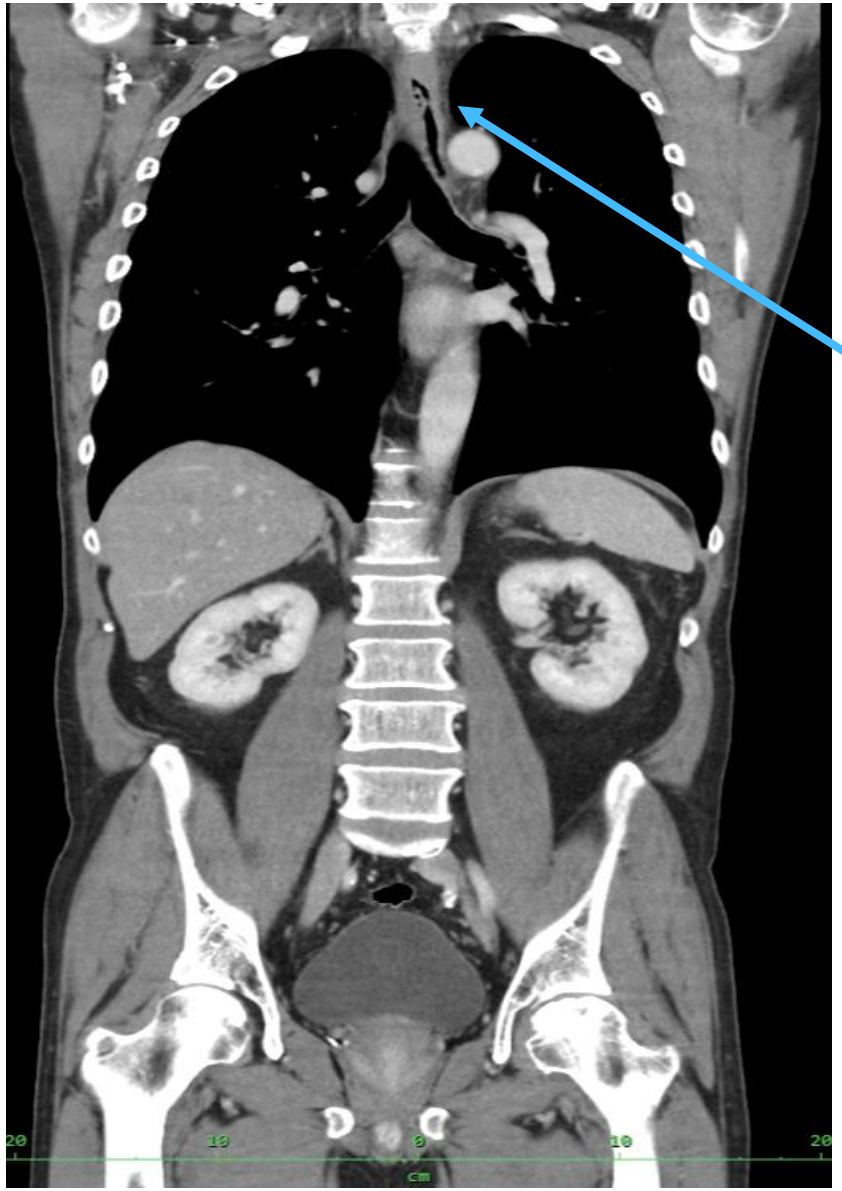
Plan: 6x FOLFOX, 2 concomitant with radiotherapy (50Gy in 25 fractions)

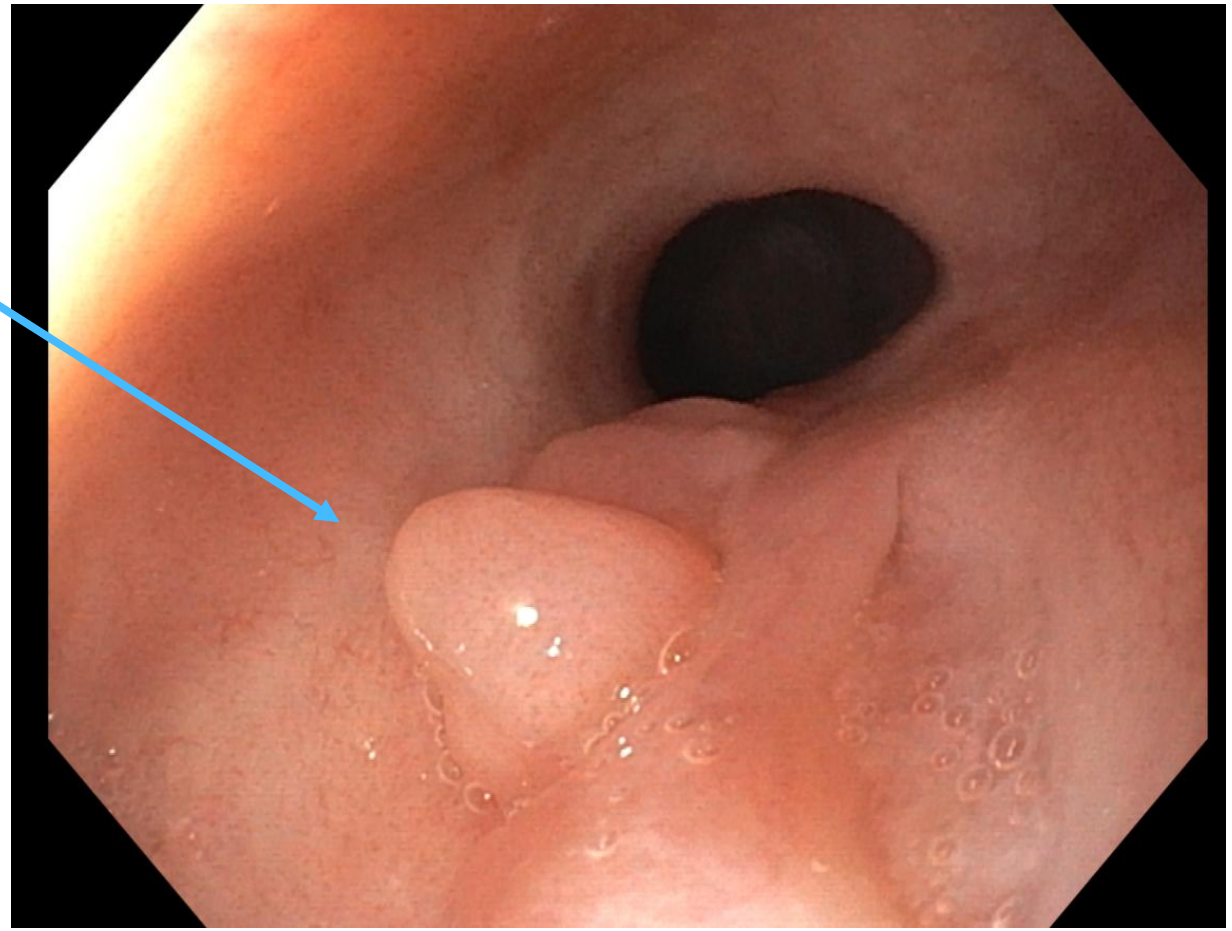
- mFOLFOX6 (50% 5-FU reduction in DPYD heterozygote) - 6 cycles
- RT 24 x 1,8 Gy (TD 43,2 Gy- mucositis G3)
- 9-11/2023 concomitant chemoradiotherapy
- AE: skin toxicity G3, mucositis G3, peripheral neurotoxicity G2, no hematological toxicity

Treatment effect assessment

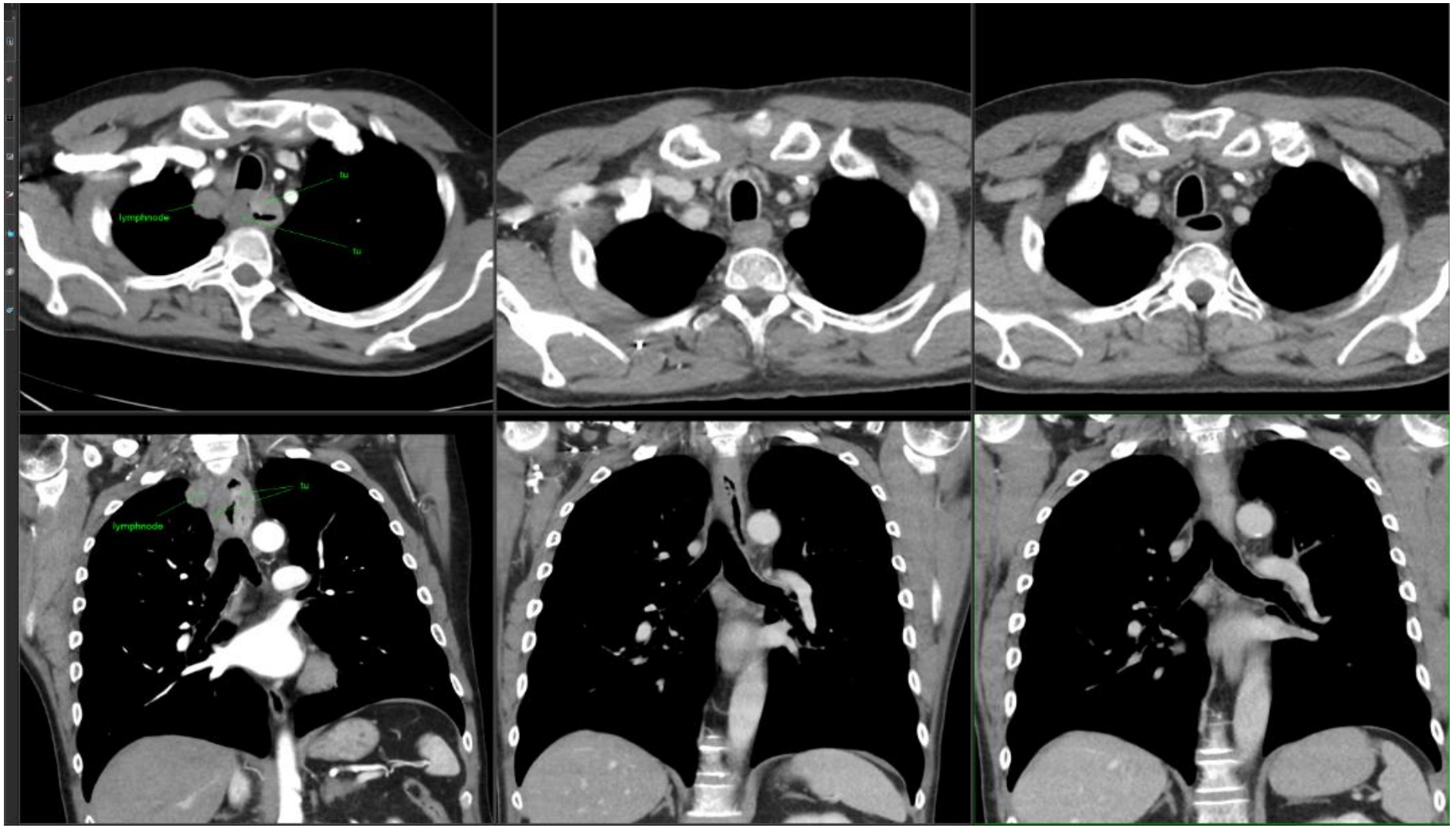
- **1/2024 CT scan** - significant infiltrate regression, slight proximal oesophageal wall thickening, pathological mediastinal LAP regression, liver lesions – significant volume regression, difficult to distinguish
- **3/2024 Gastroscopy** - prominent residual lesion of the proximal esophagus, unobstructed, no circulatory involvement, macroscopically stable lesion without haemorrhage or necrosis - **histologically physiological epithelium**
- **4/2021 CT** scan- **CR** (compared to the previous higher, it takes regression of the infiltration here, it is not distinguishable in CT. After RT changes subpleurally paramediastinal bilat. - Pathol. mediastinal nodules in persistent regression, regression of nodule size in dx. hilum.- The described lesions in S2 and S7/8 are not detectable today. New lesions are not present. Signs of chronic pancreatitis.)
- **9/2024-CT scan- CR**

= complete remission, lasts until 9/2024





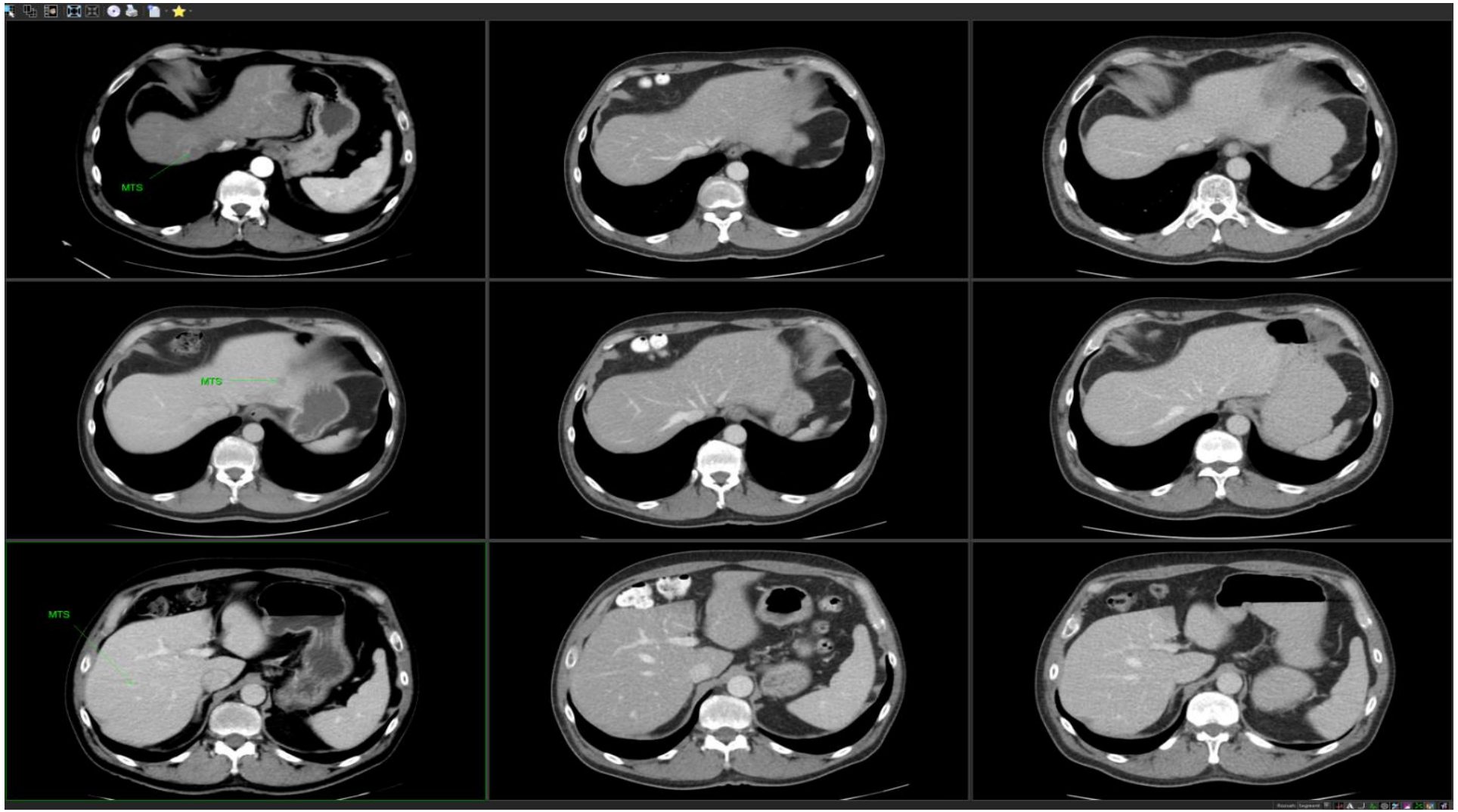
Dynamics of the disease on imaging



8/2023 1/2024 8/2024

Courtesy: Jan Křístek

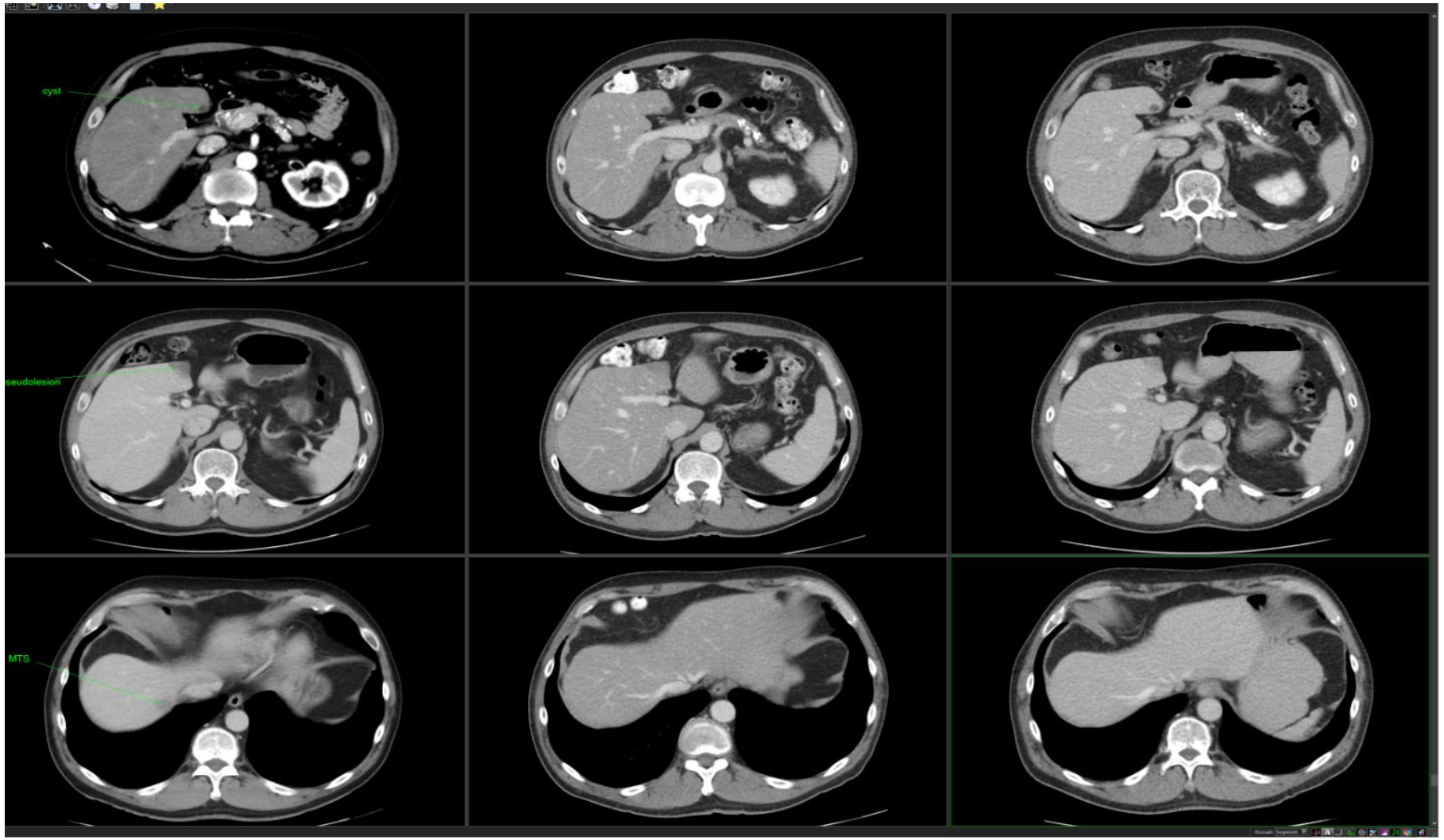
Dynamics of the disease on imaging



8/2023 1/2024 8/2024

Courtesy: Jan Křístek

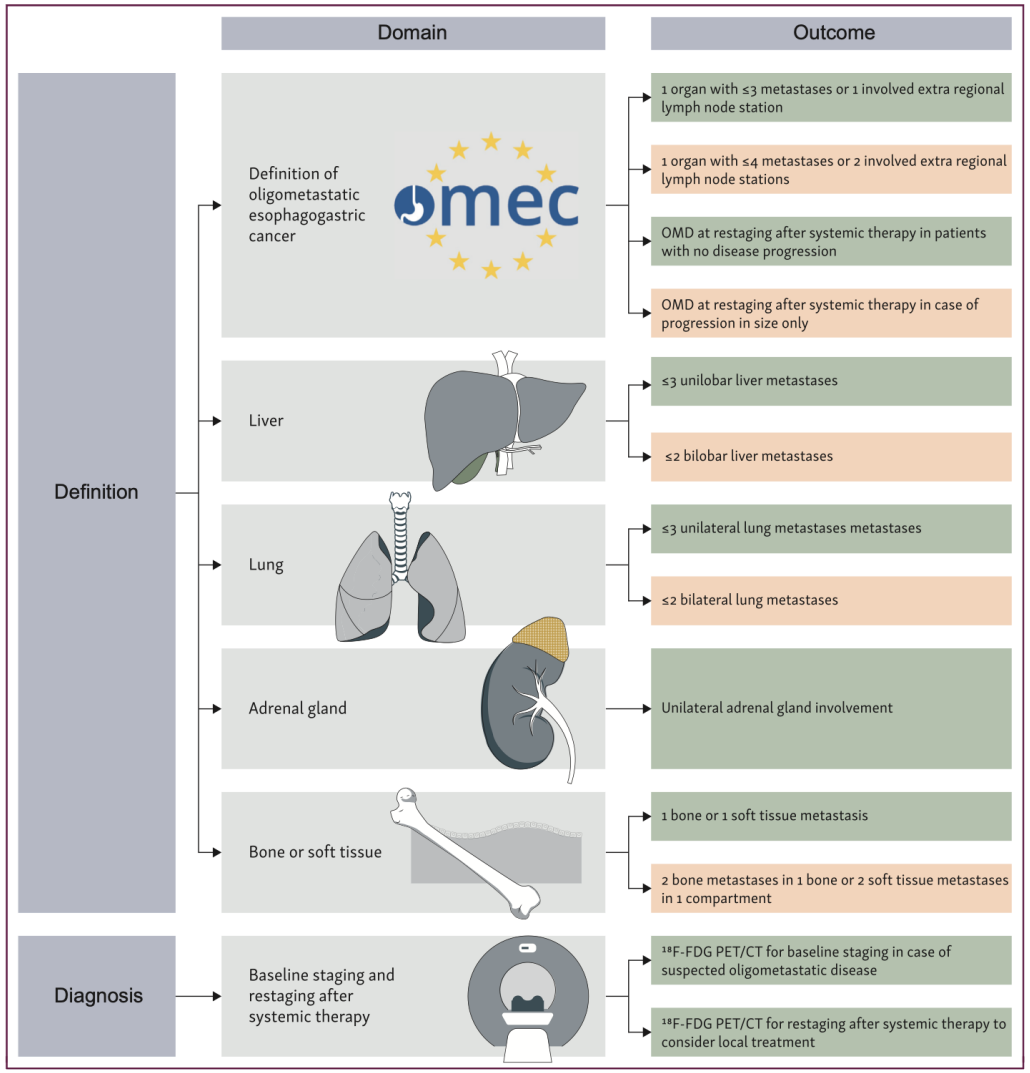
Dynamics of the disease on imaging



8/2023 1/2024 8/2024

Courtesy: Jan Křístek

Oligometastatic esophagogastric cancer – definition



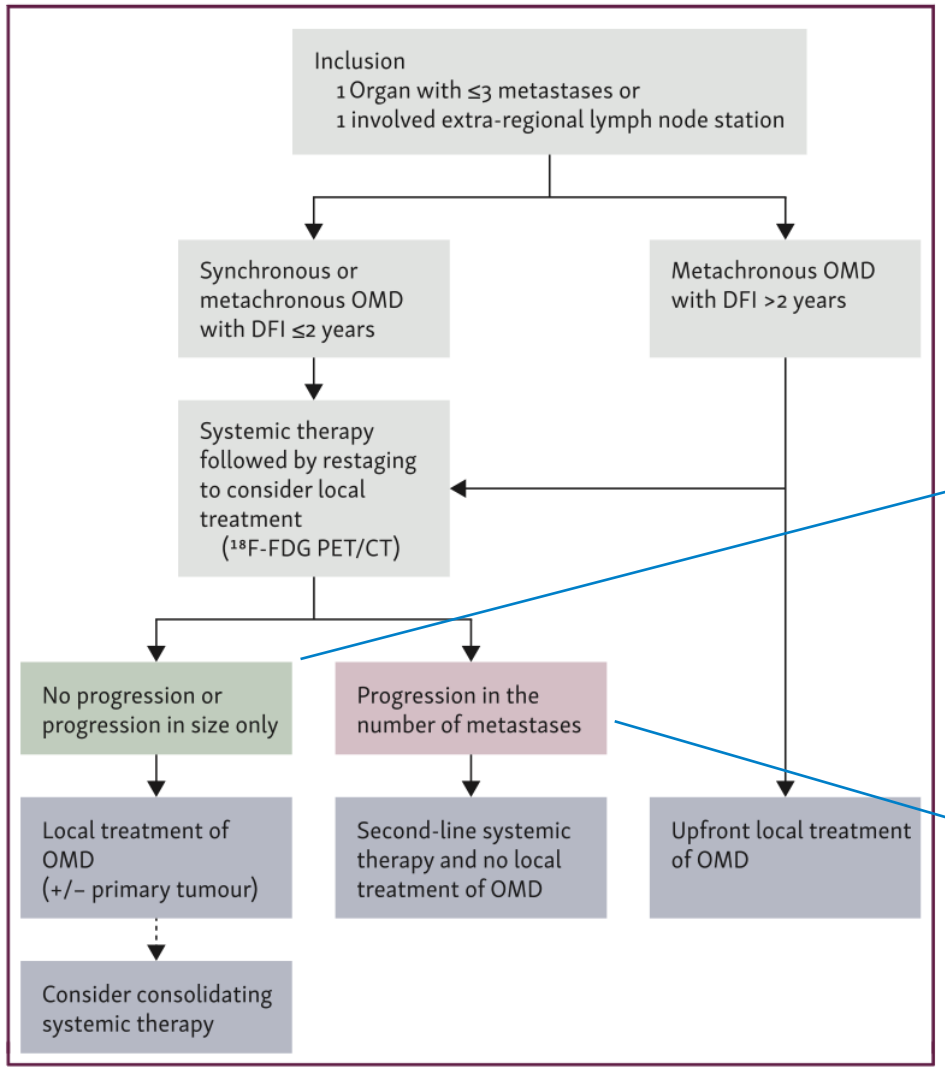
OLIGOMETASTATIC ESOPHAGOGASTRIC CANCER

Recommendations from a Delphi consensus study in Europe

Definition of oligometastatic disease	Diagnosis of oligometastatic disease	Treatment of oligometastatic disease
1 organ with ≤3 metastases or 1 involved extra-regional lymph node station	^{18}F-FDG PET/CT for baseline staging in case of suspected oligo-metastatic disease	Systemic therapy followed by restaging to consider local treatment
Consensus	Consensus	Consensus
Patients without progression...	^{18}F-FDG PET/CT for restaging after systemic therapy before considering local treatment	Upfront local treatment of metachronous oligometastases another option when disease-free interval >2 years
Consensus		
...or with progression in size only after systemic therapy		
Fair agreement	Consensus	Fair agreement
ESMO GASTROINTESTINAL ONCOLOGY	Kroese et al.	July 7, 2023

Kroese TE, Bronzwaer SFC, Van Hillegersberg R, Van Rossum PSN, … **Obermannová R**, Van Laarhoven HWM. Oligometastatic disease in esophagogastric cancer: an update of recommendations on definition, diagnosis, and treatment. *ESMO Gastrointestinal Oncology*. 2023;2:100009. doi:10.1016/j.esmogo.2023.08.008

Oligometastatic esophagogastric cancer II - treatment



Real practice implications:

When no progression: **watch and wait strategy**

When progression in size only: **local treatment**

1) SBRT
2) Surgical metastasectomy

followed by systemic treatment **+/-**

When progression in number of metastases: **systemic treatment +/- ICI**

1) FOLFOX reinduction +/- IO
2) Nivolumab monotherapy

Kroese TE, Bronzwaer SFC, Van Hillegersberg R, Van Rossum PSN, Van Laarhoven HWM. Oligometastatic disease in esophagogastric cancer: an update of recommendations on definition, diagnosis, and treatment. *ESMO Gastrointestinal Oncology*. 2023;2:100009. doi:10.1016/j.esmogo.2023.08.008

Obermannová R, Alsina M, Cervantes A, et al. Oesophageal cancer: ESMO Clinical Practice Guideline for diagnosis, treatment and follow-up. *Annals of Oncology*. 2022;33(10):992-1004. doi:10.1016/j.annonc.2022.07.003

Conclusions

- Oligometastatic disease is an intermediate biological and clinical stage between curable localized and incurable polymetastatic cancer
- Treatment effect and disease dynamics are important for further decisions
- Discussion at MDT at an expert center is crucial to the patient‘s outcome

Masaryk Memorial Cancer Institute

MUNI MED

Thank you for your attention!

Discussion

Žlutý kopec 7, 656 53 Brno
Czech Republic
www.mou.cz