Fakultät für Medizin

Dokumenttyp: journal article

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Titel des Beitrags:
Expert opinion on management of gastric and gastro-oesophageal junction adenocarcinoma on behalf of the European Organisation for Research and Treatment of Cancer (EORTC)-gastrointestinal cancer group.

Abstract:
A multidisciplinary approach is mandatory for patients with gastric cancer. Patients should be managed by an experienced team of physicians. The outcome of patients is related to the experience of the multidisciplinary team. Surgery is the cornerstone of the management of patients with resectable gastric cancer. The standard recommendations for resectable gastric adenocarcinoma are free-margin surgery with at least D1 resection combined to removal of a minimum of 15 lymph nodes. It has been shown that the outcome of patients with resectable gastric cancer can be improved by a strategy of perioperative (pre- and postoperative) chemotherapy or by postoperative chemoradiotherapy. The evidence comes from large randomised phase 3 studies. In the treatment of unresectable, locally advanced or metastatic gastric or gastro-oesophageal junction adenocarcinoma, no chemotherapy combination was accepted as the gold standard. Cisplatin/5-FU (CF) and ECF (epirubicin plus CF) regimens have been investigated widely in clinical studies and were until recently presented as the reference regimens.
Despite a relative chemosensitivity of gastric cancer, a low rate of complete response was obtained, the response duration was short and patients' outcomes remained poor. Recently, new options have been introduced in the management of advanced gastric cancer. It has been shown that capecitabine is at least as good as 5-FU and that oxaliplatin at least as good as cisplatin in these combinations. It has also been demonstrated that the addition of docetaxel to CF resulted in statistically significant improved efficacy endpoints (including patient's quality of life), but also in an increased toxicity. The DCF regimen (docetaxel, cisplatin and 5-FU) has become, therefore, a new active option in advanced gastric cancer in selected patients in good condition. Further randomised trials are therefore to be designed to further improve chemotherapy by modifying and optimising the chemotherapy regimens, and investigating novel treatment combinations. The addition of biological agents to the optimal chemotherapy regimen may achieve further improvements in efficacy.