SISTEMA SANITARIO REGIONALE

AZIENDA OSPEDALIERA
SAN CAMILLO FORLANINI

Roma, 02.12. diceembre 2019

Tumori Gastro Intestinali

Carlo Garufi
Direttore UOC Oncologia ,

cgarufi@scamilloforlanini.rm.it

Modulo dichiarazione conflitto di interessi

Tutti i rapporti finanziari intercorsi negli ultimi due anni devono essere dichiarati.

☐ Non ho rapporti (finanziari o di altro tipo) con le Aziende del farmaco

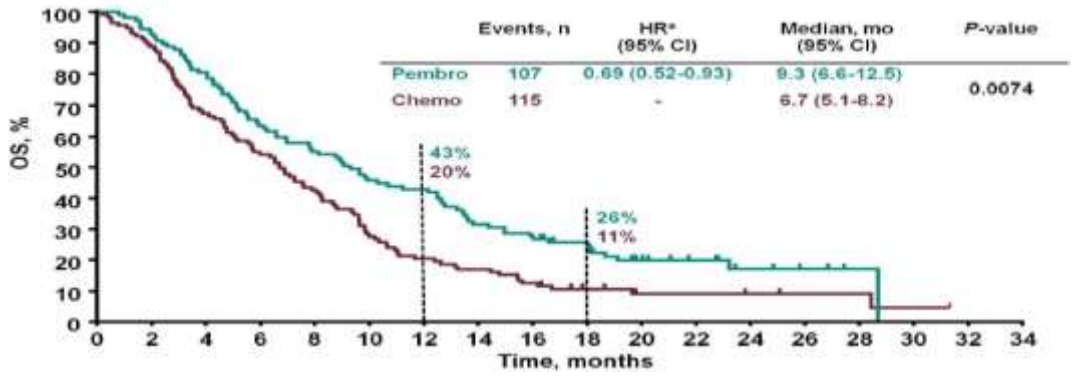
☒ Ho / ho avuto rapporti (finanziari o di altro tipo) con le Aziende del farmaco

Relationship	**Company/Organization**
Meeting sponsorship, Board	Merck, Servier
Board	MSD
Meeting Organization	ROCHE

Truly ″Practice Changing″ Studies

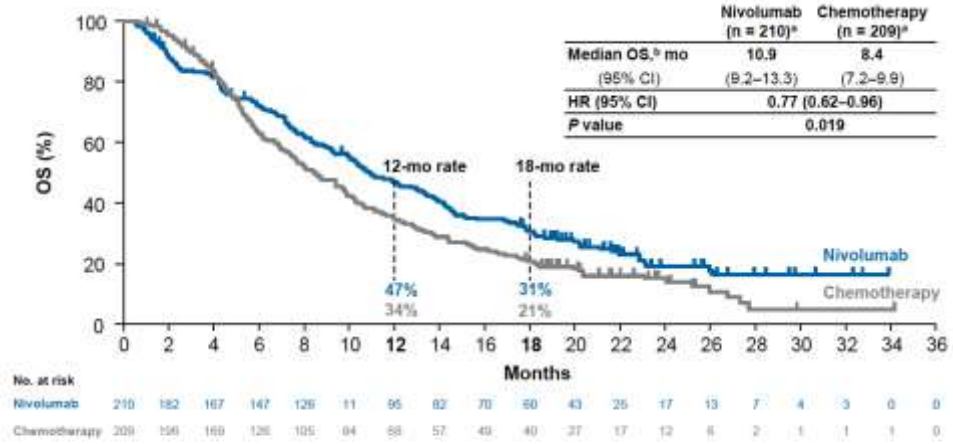
- Addressing unmet needs
- Study design that compare experimental arm to a ″ standard ″ practice
- Positive outcomes that are clinical meaningful
- Reproducive results
- ***Practices accessible to the comunity***

Esophageal Cancer 2nd line



Kojima et al ASCO GI 2019

PD-L1
CPS ≥10 subgroup
n= 222 (35%)
Overall survival



Cho et al, ESMO 2019

- Nivolumab provided superior OS, with a 23% reduction in the risk of death and a 2.5-month improvement in median OS, versus chemotherapy

*Intent-to-treat population; bMinimum follow-up: 17.6 months.
CI, confidence interval; mo, months

Treatment paradigm in advanced/ metastatic SCC oesophagus 2019

Inoperable/ metastatic/ recurrent SCC

Platinum + FP- based chmotherapy

Nivolumab

Pembrolizumab if PD-L1 CPS ≥10

Taxanes or irinotecan

CHECKMATE 648[1]

n=939

R

- Cisplatin + 5-FU
- Nivolumab + Cisplatin + 5-FU
- Nivolumab + ipilimumab

1° endpoint: OS and PFS in PD-L1 TPS ≥1

KEYNOTE 590[2]

n=700

R

- Cisplatin + 5-FU
- Cisplatin + 5-FU + pembrolizumab

1° endpoint: OS and PFS in PD-L1 CPS ≥10

THE ROYAL MARSDEN

[1]Ajani et al ASCO GI 2019 NCT03143153;
[2]Kato et al Future Oncol 2019 NCT03189719

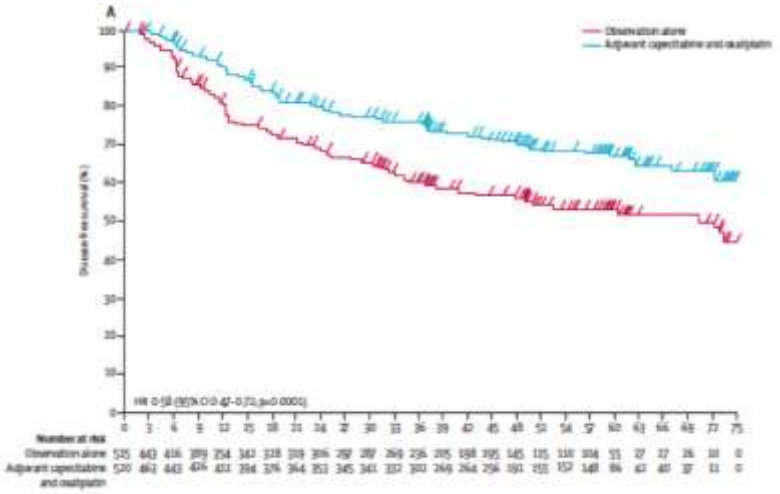
CLASSIC TRIAL

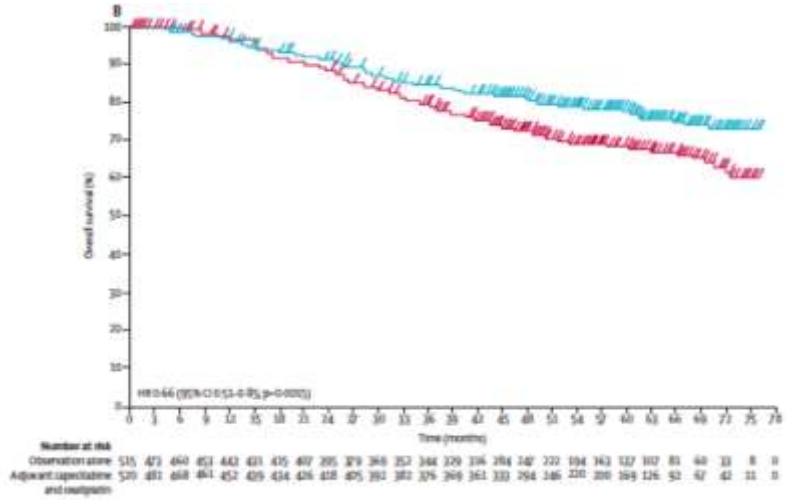
D2 resected, stage II-IIIB GC patients

R

Arm A: 8 cycles of XELOX

Arm B: Observation





5-yr OS improved by 9% (78% vs 69%) which corresponds to a NNT of 11.1

Noh SH, et al. Lancet Oncol 2014

Perioperative chemotherapy with fluorouracil plus leucovorin, oxaliplatin, and docetaxel versus fluorouracil or capecitabine plus cisplatin and epirubicin for locally advanced, resectable gastric or gastro-oesophageal junction adenocarcinoma (FLOT4): a randomised, phase 2/3 trial

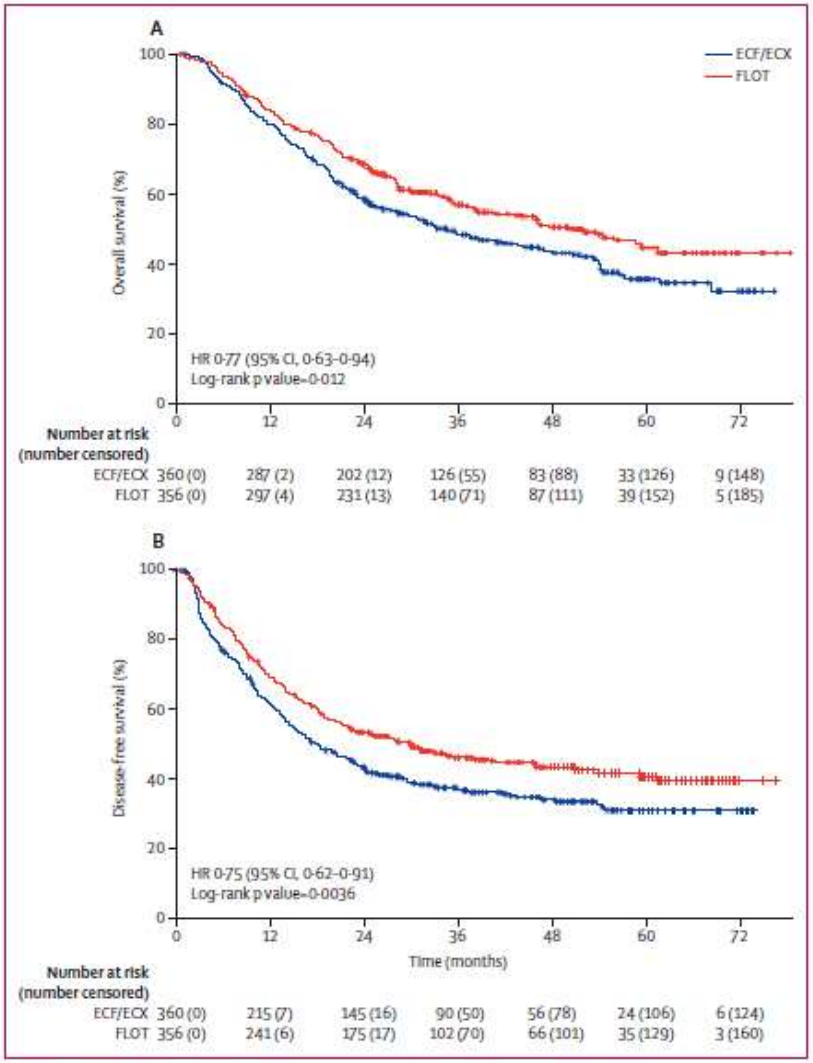
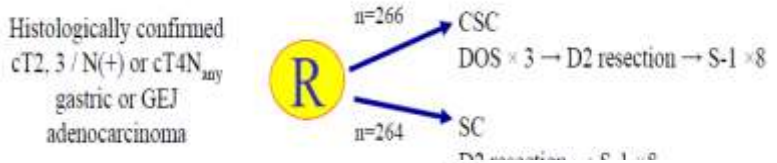


Figure 2: **Kaplan–Meier estimates of overall survival (A) and disease-free survival (B)**
(A) Overall survival in the intention-to-treat population in the ECF/ECX group versus the FLOT group. (B) Disease-free survival in the intention-to-treat population in the ECF/ECX group versus the FLOT group. (ECF/ECX=epirubicin and cisplatin plus either fluorouracil or capecitabine. FLOT=fluorouracil plus leucovorin, oxaliplatin and docetaxel. HR=hazard ratio. CI=confidence interval.

Lancet, 2019

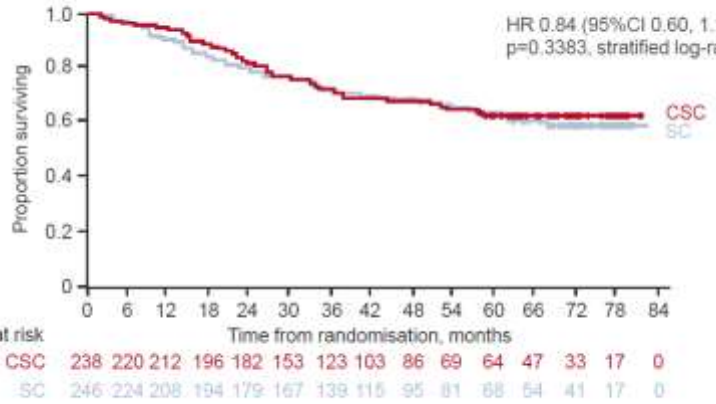
PRODIGY: Randomised phase III study in gastric and GEJ adenocarcinoma of peri-op vs. post-op chemotherapy



PFS

Kang Y-K, et al. Ann Oncol 2019;30(suppl):abstr LBA41

OS

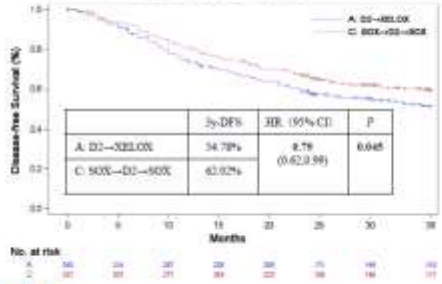


R0 resection	**214 (96.4)**	**211 (85.8)**

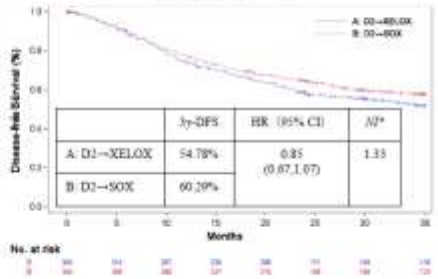
GASTRIC CANCER: WHICH STRATEGY IN OPERABLE DISEASE (In Asia)?

RESOLVE Primary comparisons

ARMs A vs. C



ARMs A vs. B



THE ROYAL MARSDEN

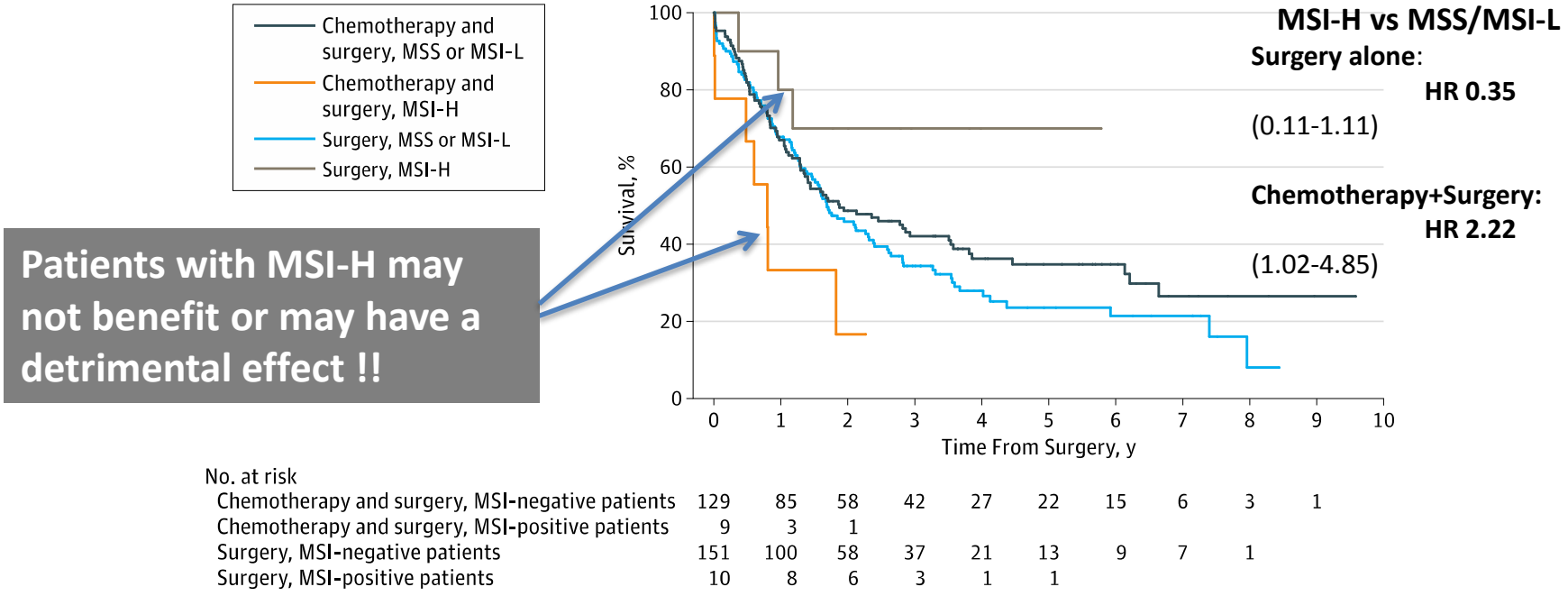
Ji et al ESMO 2019

JAMA Oncology | Original Investigation

Mismatch Repair Deficiency, Microsatellite Instability, and Survival

An Exploratory Analysis of the Medical Research Council Adjuvant Gastric Infusional Chemotherapy (MAGIC) Trial

Elizabeth C. Smyth, MB, BCh, MSc; Andrew Wotherspoon, MD; Clare Peckitt, MSc; David Gonzalez, PhD; Sanna Hullki-Wilson, BSc, MSc; Zakaria Eltahir, PhD; Matteo Fassan, MD, PhD; Massimo Rugge, MD, FACG; Nicola Valeri, MD, PhD; Alicia Okines, MD; Madeleine Hewish, MD, PhD; William Allum, MD; Sally Stenning, MSc; Matthew Nankivell, MSc; Ruth Langley, MD, PhD; David Cunningham, MD, FMedSci



Patients with MSI-H may not benefit or may have a detrimental effect !!

Smyth et al. JAMA Oncol 2017, 3:1197-1203

Courtesy of N. Tinari

MSI-GC-01: Individual patient data meta-analysis of microsatellite instability (MSI) and gastric cancer from four randomized clinical trials.
Pietrantonio et al, ASCO 2019

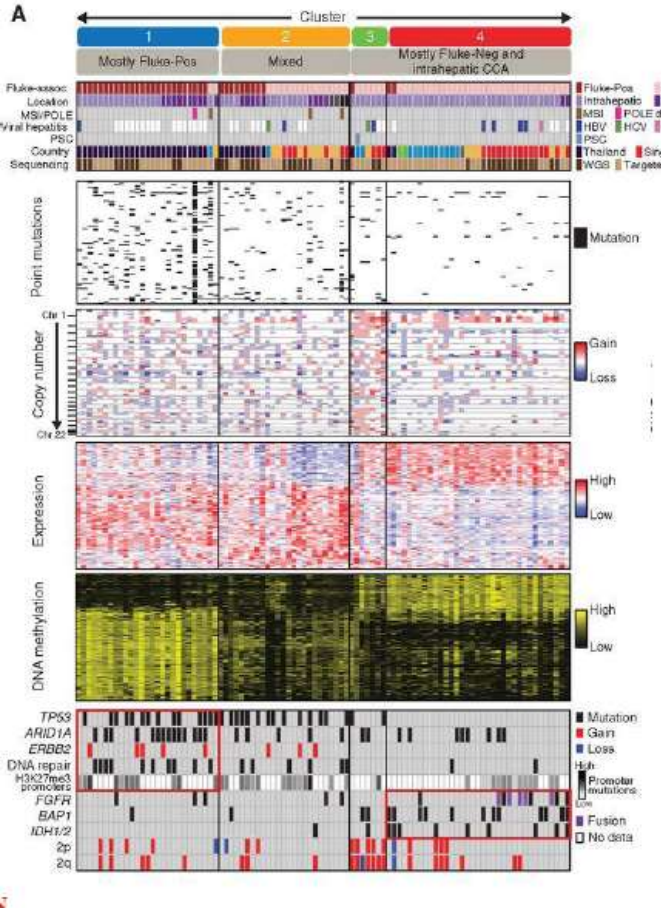
- Data from MAGIC, CLASSIC, ITACA-S, ARTIST (1552 patients)

Perioperative or adjuvant chemotherapy may not be helpful for pts with MSI-H GC
Immune checkpoint blockade should be prospectively investigated in this population.

	4 RCT			MAGIC + CLASSIC		
	5y-OS %	HR (95% CI)	Interaction test	5-y OS %	HR (95% CI)	Interaction test
MSS: Chemo vs surgery	62 vs 53	0.73 (0.61-0.86)		62 vs 53	0.71 (0.58-0.88)	
MSI: Chemo vs surgery	75 vs 83	1.49 (0.56-3.96)	0.141	63 vs 83	2.46 (0.84-7.2)	0.027

Courtesy of N. Tinari

Molecular Classification of Cholangiocarcinoma



Liver Flukes:

Clonorchis sinesis – China, Korea, Vietham

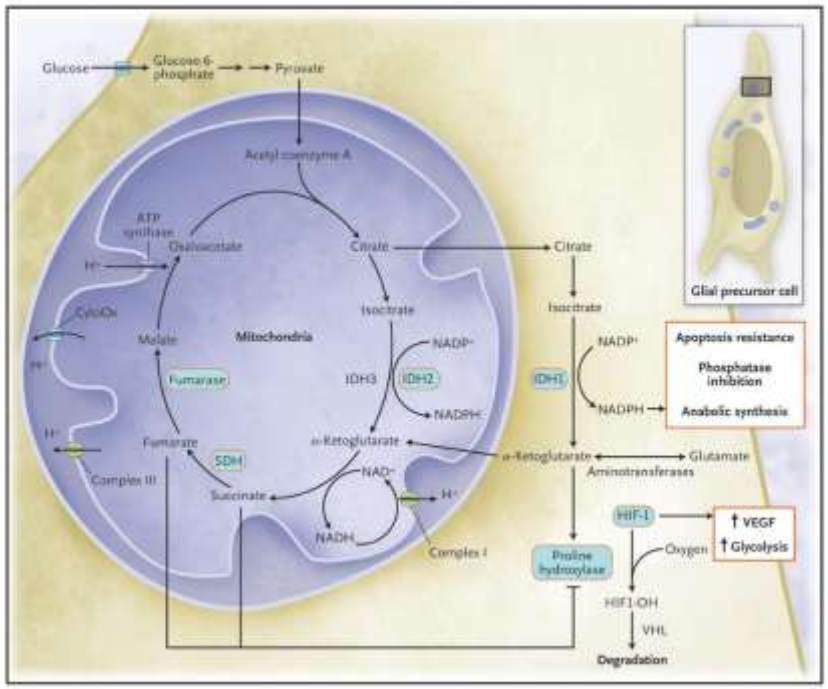
Opisthorchis viverrini: Thailand, Cambodia, Laos

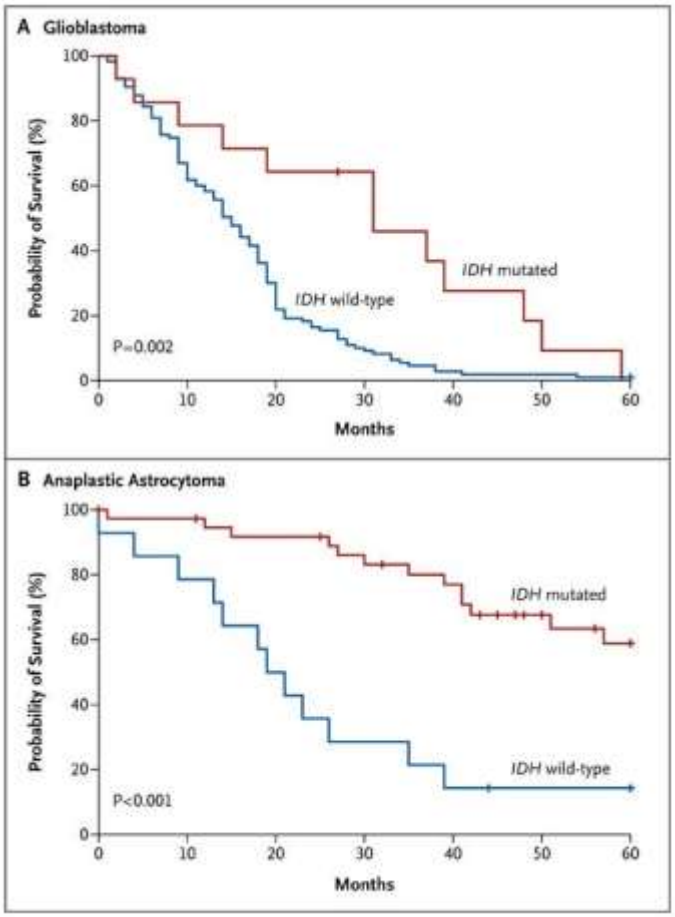
	Mostly fluke-positive	*Mixed*	*Mostly fluke-negative and intrahepatic CCA*	
Cluster	1	2	3	4
Genetic alterations	- Highest SNV burden - Enriched in *TP53*, *ARID1A*, *BRCA1/2* mutations - Enriched in H3K27me3-assoc. promoter mutations	Enriched in *TP53* mutations		- Enriched in *BAP1* and *IDH1/2* mutations - Enriched in *FGFR* alterations
Copy-number alterations	*ERBB2* amplification		Highest CNA burden 1p, 2p, 2q, 7p, 16p, 19q, 20q ↑	
Gene expression	*ERBB2* ↑ - *TET1* ↓ - *EZH2* ↑	*CTNNB1*, *WNT5B*, *AKT1* ↑	- Immune-related pathways ↑ - *PD1*, *PDL2*, and *BTLA*	*FGFR1* *FGFR2* *FGFR3* *FGFR4* ↑
Methylation phenotype	CpG island hypermethylated			CpG shore hypermethylated
Prognosis	Poorer prognosis			Better prognosis

Jusakul et al Cancer Discov 2017

Survival of Adult Patients with Malignant Gliomas with or without *IDH* Gene Mutations.

The Roles of IDH1, IDH2, Succinate Dehydrogenase, and Fumarase in Cellular Metabolism.





The NEW ENGLAND JOURNAL of MEDICINE

Yan H et al. N Engl J Med 2009;360:765-773.

FGF/FGFR signaling pathway plays a central role in multiple cellular processes

23 ligands (FGF1-23)

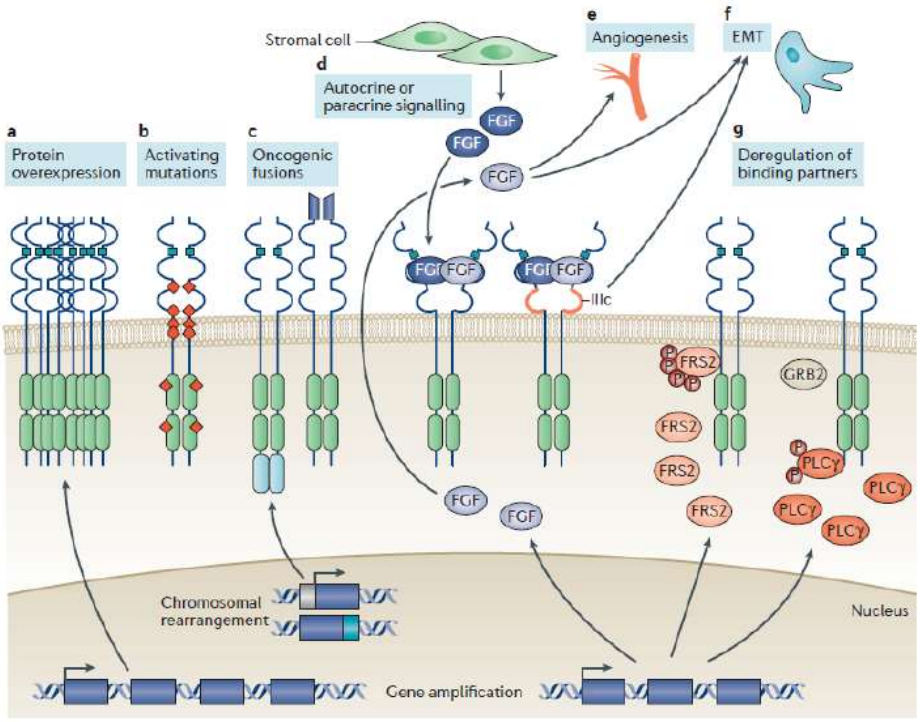
4 FGFR family members

- FGFR1, FGFR2, FGFR3, and FGFR4

FGFR signaling stimulates proliferation, cell migration, angiogenesis

Different FGFR alterations lead to constitutive signalling:

- Gene amplification
- Activating mutations
- Protein overexpression
- Fusions/rearrangements



Babina & Turner, Nature Rev Cancer 2017

Targeted therapy in molecularly-altered advanced cholangiocarcinoma

	Ivosidenib[1]	Infigratinib[2]	Pemigatinib[3]	Dabrafenib + Tremetinib[4]
N	124	71	107	35
Target	IDH	FGFR	FGFR	BRAF
ORR	2%	25.4%	35.5%	36%
DCR	53%	83.6%	82%	75%
mPFS	2.7 months	6.8 months	6.9 months	9.2 mmonths
mOS	10.8 months	12.5 months	21.1 months	11.7 months

[1]Abou-Alfa et al ESMO 2019; [2]Javle et al ESMO 2018
[3]Vogel et al ESMO 2019; [4]Wainberg et al ASCO GI 2019

Epatocarcinoma: ESMO clinical Practice Guidelines for diagnosis, treatment and Follow up

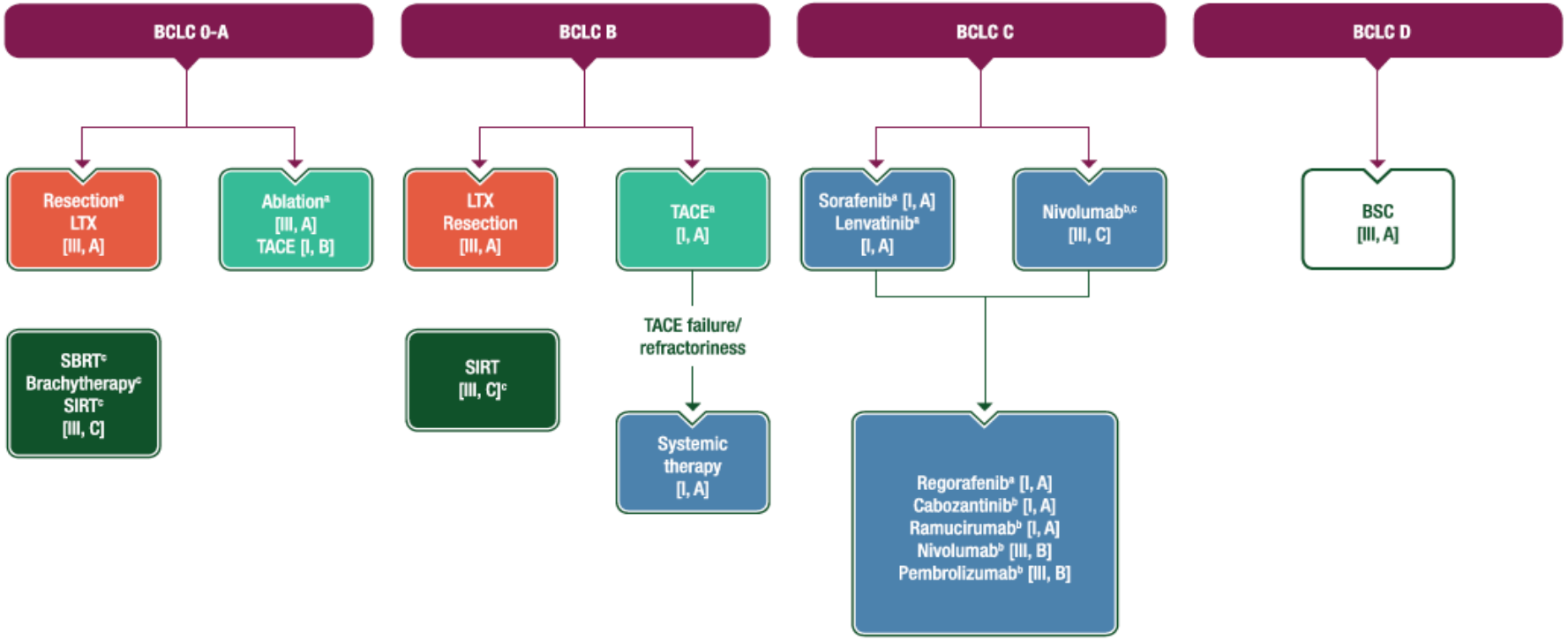


Figure 1. HCC treatment options depending on BCLC stage.
[a]See Table 4 for indication constraints based on tumour burden and liver function.
[b]Not EMA-approved as of August 2018.
BCLC, Barcelona Clinic Liver Cancer; BSC, best supportive care; EMA, European Medicines Agency; HCC, hepatocellular carcinoma; LTX, liver transplantation; SBRT, stereotactic body radiotherapy; SIRT, selective internal radiotherapy; TACE, transarterial chemoembolisation.

Vogel et al. 2018, Annals of Oncology

HCC

LBA38_PR: CheckMate 459: A randomized, multi-center phase 3 study of nivolumab (NIVO) vs sorafenib (SOR) as first-line (1L) treatment in patients (pts) with advanced hepatocellular carcinoma (aHCC) – Yau T, et al

Study objective

- To investigate the efficacy and safety of nivolumab compared with sorafenib as a 1L treatment for patients with advanced HCC

Key patient inclusion criteria

- Advanced HCC
- Ineligible for surgery and/or for loco-regional therapy or PD after surgery and/or loco-regional therapy
- Child-Pugh class A
- Systemic therapy naive
- ECOG PS 0–1

(n=743)

R 1:1

Nivolumab 240 mg iv q2w (n=371) → PD/ toxicity

Sorafenib 400 mg po bid (n=372) → PD/ toxicity

Stratification

- Aetiology (HCV vs. non-HCV)
- Vascular invasion and/or extrahepatic spread (present vs. absent)
- Geography (Asia vs. non-Asia)

PRIMARY ENDPOINT

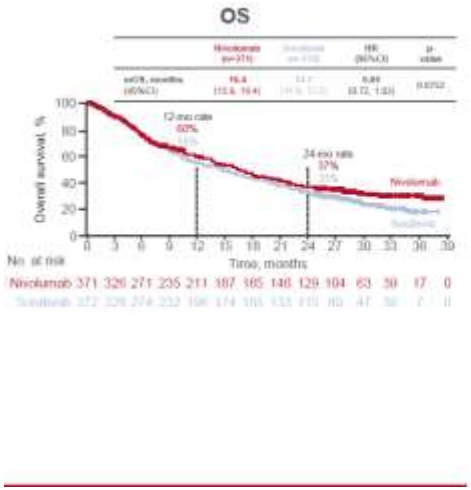
- OS

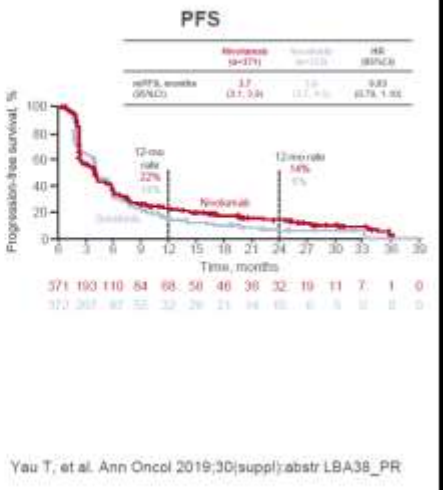
SECONDARY ENDPOINTS

- ORR, PFS, efficacy by PD-L1 status, safety

Yau T, et al. Ann Oncol 2019;30(suppl):abstr LBA38_PR

Key results





Yau T, et al. Ann Oncol 2019;30(suppl):abstr LBA38_PR

In patients with advanced HCC, 1L nivolumab did not provide a significant improvement in OS compared with sorafenib although had a manageable safety profile

LBA39: Randomised efficacy and safety results for atezolizumab (Atezo) + bevacizumab (Bev) in patients (pts) with previously untreated, unresectable hepatocellular carcinoma (HCC) – Lee M, et al

Study objective

- To investigate the efficacy and safety of atezolizumab + bevacizumab as a 1L treatment in patients with unresectable HCC

Key patient inclusion criteria

- Advanced HCC
- Child-Pugh up to class B7 for Arm A and class A for Arm F
- Systemic therapy naïve
- ECOG PS 0–1

(n=743)

Arm A: 1L HCC
Atezolizumab 1200 mg + bevacizumab 15 mg/kg iv q3w → PD/ toxicity

Arm F: 1L HCC → R 1:1
- Atezolizumab 1200 mg + bevacizumab 15 mg/kg iv q3w
- Atezolizumab 1200 mg iv q3w → PD/ toxicity

Stratification
- AFP level (<400 vs. ≥400 ng/mL)
- Macrovascular invasion and/or extrahepatic spread (present vs. absent)
- Geography (Asia excluding Japan vs. rest of world)

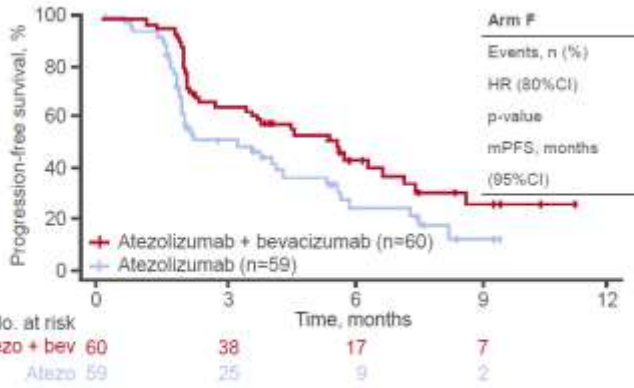
PRIMARY ENDPOINTS
- Arm A: ORR (RECIST v1.1)
- Arm F: PFS (RECIST v1.1)

SECONDARY ENDPOINTS
- OS; safety

Lee M, et al. Ann Oncol 2019;30(suppl):abstr LBA39

Key results

PFS



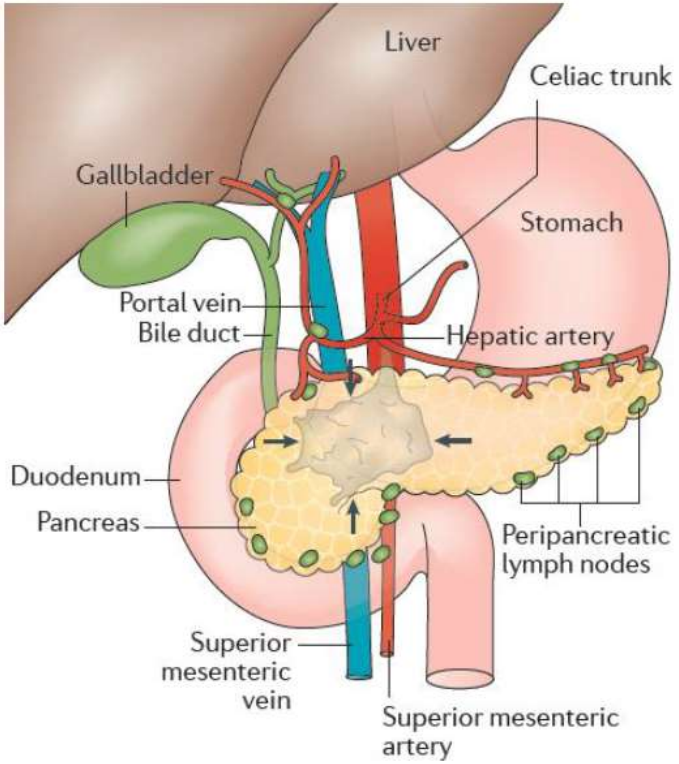
Arm F	Atezo + Bev (n=60)	Atezo (n=59)
Events, n (%)	35 (58)	39 (66)
HR (80%CI)	0.55 (0.40, 0.74)	
p-value	0.0108	
mPFS, months	5.6	3.4
(95%CI)	(3.6, 7.4)	(1.9, 5.2)

Lee M, et al. Ann Oncol 2019;30(suppl):abstr LBA39

NEOLAP – combination chemotherapy in LAPC

What do we know in PC ?

- Pancreatic cancer (PC) is projected to become the second leading cause of cancer-related death world-wide by 2030
  - 4 mill GI cancer - 338,000 PC
- The clinical landscape of pancreatic cancer is currently divided into four subgroups
  - Resectable PC
  - Borderline resectable PC
  - **Locally advanced PC (combination chemotherapy)**
  - Metastatic PC



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Rahib et al. Cancer Res 2014; Siegel et al, CA Cancer J Clin 2018; Ducreux et al, Sem Oncol 2019; NCCN v3 2019

Criteri TC per definizione

BLPC e LAPC

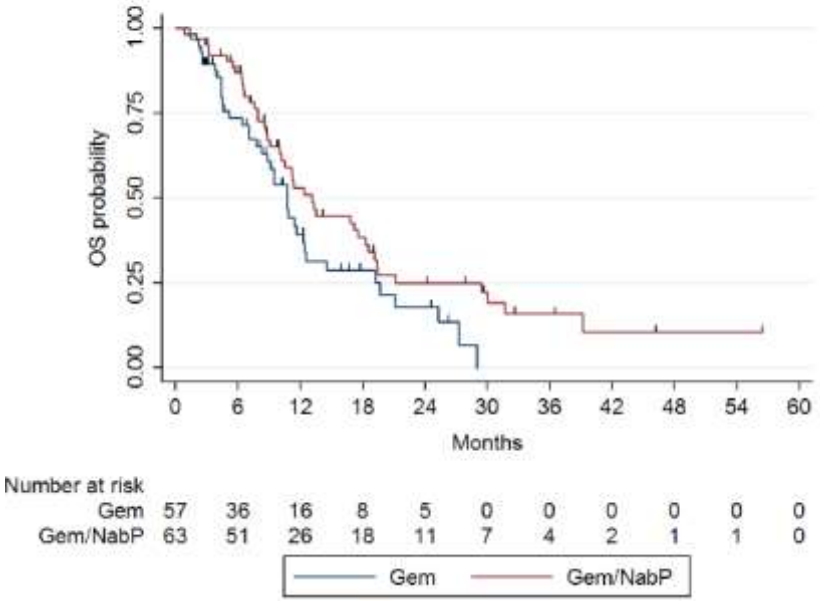
Table 1. Comparison of CT-based criteria distinguishing resectable, borderline resectable, and locally advanced disease

		MD Anderson [8, 15]	AHPBA/SSAT/SSO [19]	NCCN (Version 2.2016) [22]	Alliance [23]
Celiac	Resectable	No involvement	No involvement	No arterial tumor contact	No involvement
	Borderline	No involvement	No involvement	Solid tumor[b] contact ≤180°, *or* >180° without involvement of the aorta and with intact and uninvolved gastroduodenal artery[a] (body/tail only)	Tumor-vessel interface <180°
	Locally Advanced	Any involvement	Any involvement	>180° solid tumor contact (any portion of pancreas), or any degree of solid tumor contact with aortic involvement (body/tail only)	Tumor-vessel interface ≥180°
SMA	Resectable	No involvement	No involvement	No arterial tumor contact	No involvement
	Borderline	Abutment ≤180°	Abutment ≤180°	Solid tumor contact ≤180°	Tumor-vessel interface <180°
	Locally Advanced	>180° involvement	>180° involvement	>180° solid tumor contact (any portion of pancreas), or any solid tumor contact with the first jejunal branch off SMA (head/uncinate only)	Tumor-vessel interface ≥180°
CHA	Resectable	No involvement	No involvement	No arterial tumor contact	No involvement
	Borderline	Short segment abutment <180° or encasement ≥180° amenable to reconstruction	Short segment abutment <180° or encasement ≥180° amenable to reconstruction	Solid tumor contact without extension to celiac axis or hepatic bifurcation, allowing for safe/complete reconstruction	Any degree of reconstructible involvement
	Locally Advanced	Involvement not amenable to reconstruction	Involvement not amenable to reconstruction	Any solid tumor contact with extension to celiac axis or hepatic bifurcation	Nonreconstructible involvement
SMV/PV	Resectable	Any involvement without occlusion	No involvement	No tumor contact with the SMV/PV or ≤180° contact without vein contour irregularity	Tumor-vessel interface <180°, no occlusion
	Borderline	Short segment occlusion only, with patent vein above and below the occlusion amenable to surgical reconstruction	Abutment, encasement, and/or occlusion amenable to surgical reconstruction (any involvement)	Solid tumor contact with the SMV/PV of >180°, contact of ≤180° with contour irregularity of the vein, or thrombosis of the vein but with suitable vessel proximal and distal to the site allowing for safe and complete reconstruction	Tumor-vessel interface ≥180° and/or occlusion amenable to surgical reconstruction
	Locally Advanced	Non-reconstructible occlusion	Any non-reconstructible involvement or major venous thrombosis extending for several cm	Unreconstructible SMV/PV due to tumor involvement or occlusion (tumor or bland thrombus) *Head/uncinate only:* Contact with most proximal draining jejunal branch into SMV	Any non-reconstructible involvement

Gilbert JW et al, Ann Oncol 2017; 28: 2067-2076

GAP and NEOLAP in locally advanced pancreatic cancer

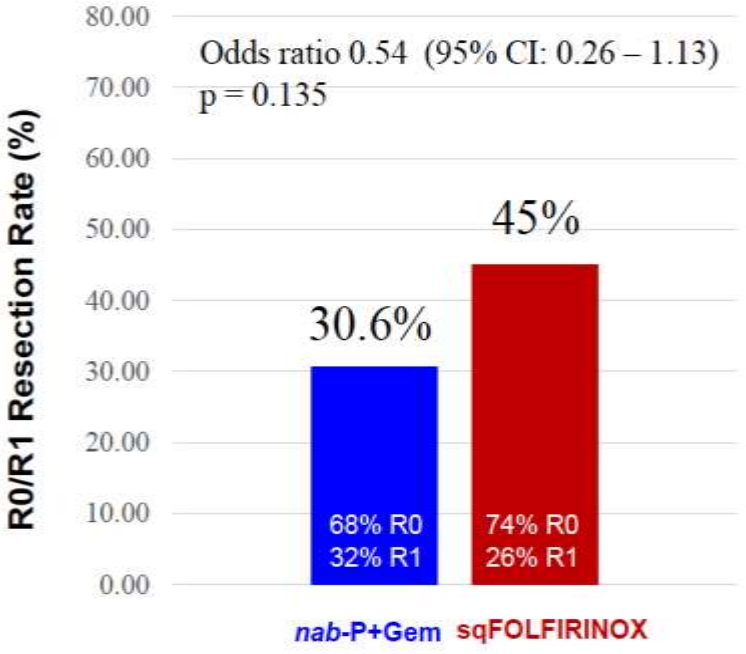
GAP[1]



Arm	Events	Median	95%CI
Gem	39	10.7 months	8.3 – 12.4
Gem/NabP	43	13.1 months	10.0 – 18.3

HR 0.65; 90%CI 0.44-0.94, one-tailed p=0.03

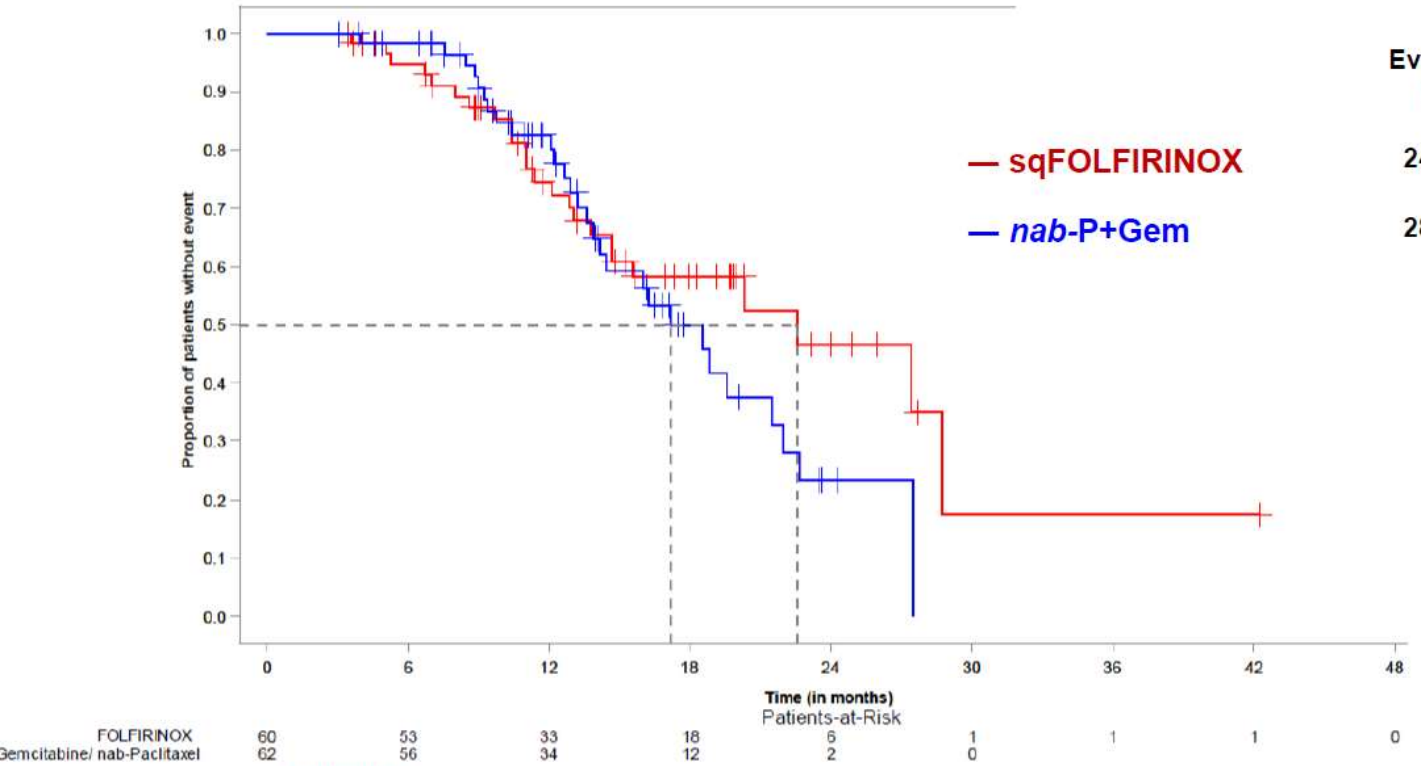
NEOLAP[2]



[1]Cascinu et al ESMO 2019:
[2]Kunzmann et al ESMO 2019

GAP and NEOLAP in locally advanced

OVERALL SURVIVAL



	Events/ N	Median (months)	95% CI
sqFOLFIRINOX	24/60	22.5	14.7 – 28.7
nab-P+Gem	28/62	17.2	14.2 – 21.9

HR 0.73 (95% CI: 0.42 – 1.28)
***p* (log-rank) = 0.268**

Median follow-up: 13.8 months

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***p* = Log-rank test (2-sided, alpha=0.05)**

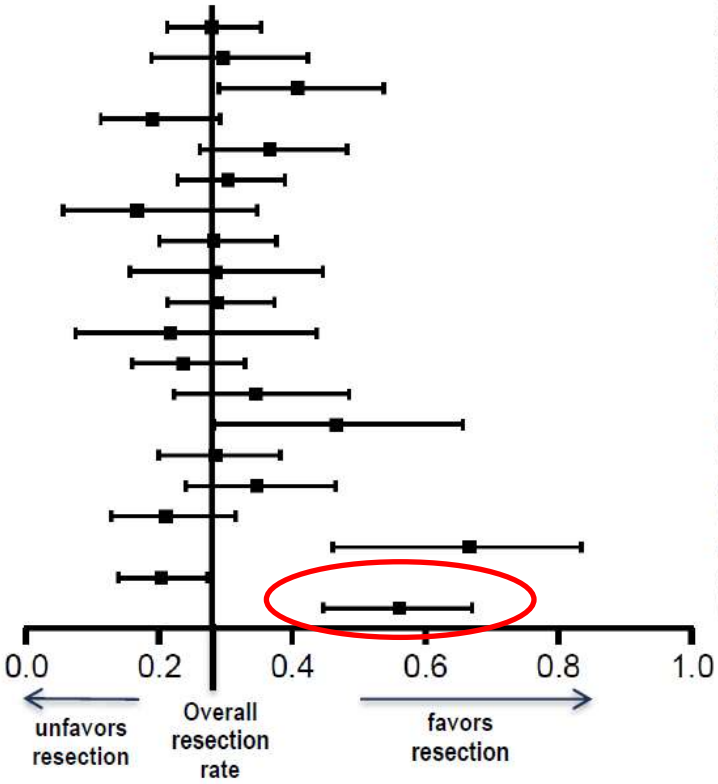
assessed by local MDT

[1]Casolla et al ESMO 2019.
[2]Kunzmann et al ESMO 2019

SUBGROUP ANALYSIS FOR RESECTION (ITT-POPULATION)

AIO

Subgroup	No. events/Patients	Rate [CI 95%]	*p*-value (multivariate)
Overall	46/165	0.279 (0.212-0.354)	
Gem/nab-Pac	19/64	0.297 (0.189-0.424)	0.261
FOLFIRINOX	27/66	0.409 (0.290-0-537)	
Male	16/84	0.191 (0.113-0.291)	0.0034
Female	29/79	0.367 (0.261-0.483)	
≤70 years	41/135	0.304 (0.228-0.389)	0.085
>70 years	5/30	0.167 (0.056-0.347)	
ECOG 0	31/110	0.282 (0.200-0.376)	0.804
ECOG 1	12/42	0.286 (0.157-0.446)	
NLR ≤5	38/132	0.288 (0.212-0.373)	0.337
NLR >5	5/23	0.217 (0.075-0.437)	
CA 19-9 <500 U/mL	25/106	0.236 (0.159-0.328)	0.243
CA 19-9 >500 U/mL	19/55	0.346 (0.222-0.486)	
CA 19-9 >90% decr.	14/30	0.467 (0.283-0.657)	0.294
CA 19-9 <90% decr.	29/102	0.284 (0.199-0.382)	
Tumor size ≤median	26/75	0.347 (0.240-0.465)	0.064
Tumor size >median	17/81	0.210 (0.127-0.315)	
PR yes	18/27	0.667 (0.460-0.835)	0.0002
PR no	28/138	0.203 (0.139-0.280)	
Expl. laparotomy	46/82	0.561 (0.447-0.670)	



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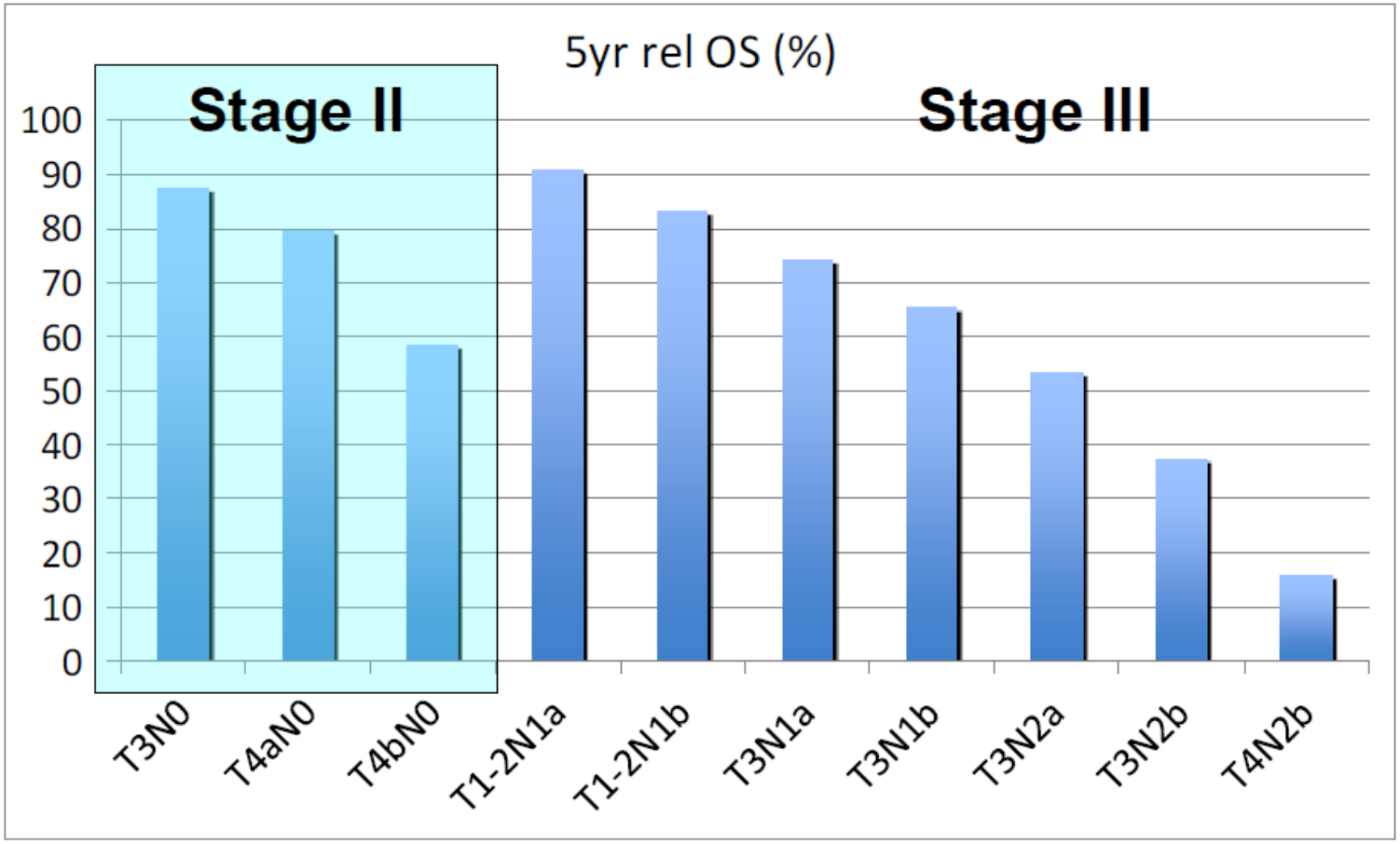
Stage II AJCC v7



Gunderson et al, JCO 2009

Clinical Prognostic Factors for Stage II Colon Cancer

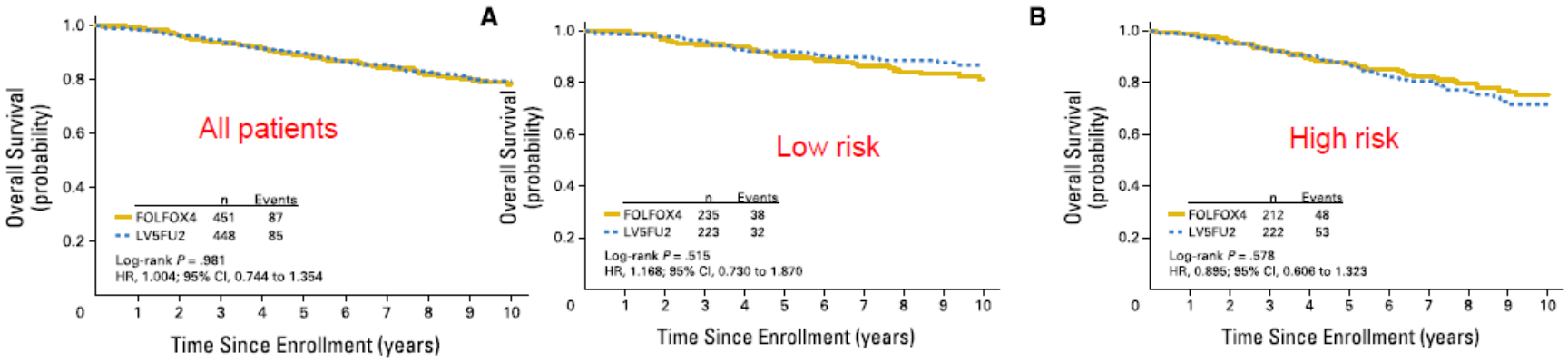
Definition of High Risk Stage II Disease

- T4
- Poorly differentiated
- Invasion (vascular/lymphatic/perineural)
- Inadequate nodal harvest (<10 SCOT, <12 TOSCA, HORG, ACHIEVE)
- Obstruction
- Perforation

Although no consensus exists on the definition of high-risk stage II colon cancer, the European Society for Medical Oncology and American Society of Clinical Oncology guidelines include T4 lesions, perforation, and number of analyzed lymph nodes fewer than 10 or 12 as high-risk characteristics.

Tournigant et al. JCO 2015

Updated MOSAIK Data Low Risk & High Risk Stage II FOLFOX vs. FU/LV



		5 y DFS		6y OS	
	N Pat	HR	P-value	HR	P-value
high risk	569	0.72 0.51-1.01	.062	0.91 0.66-.97	.648
low risk	330	1.36 0.76-2.45	1.01	1.36 0.67-2.5	.399

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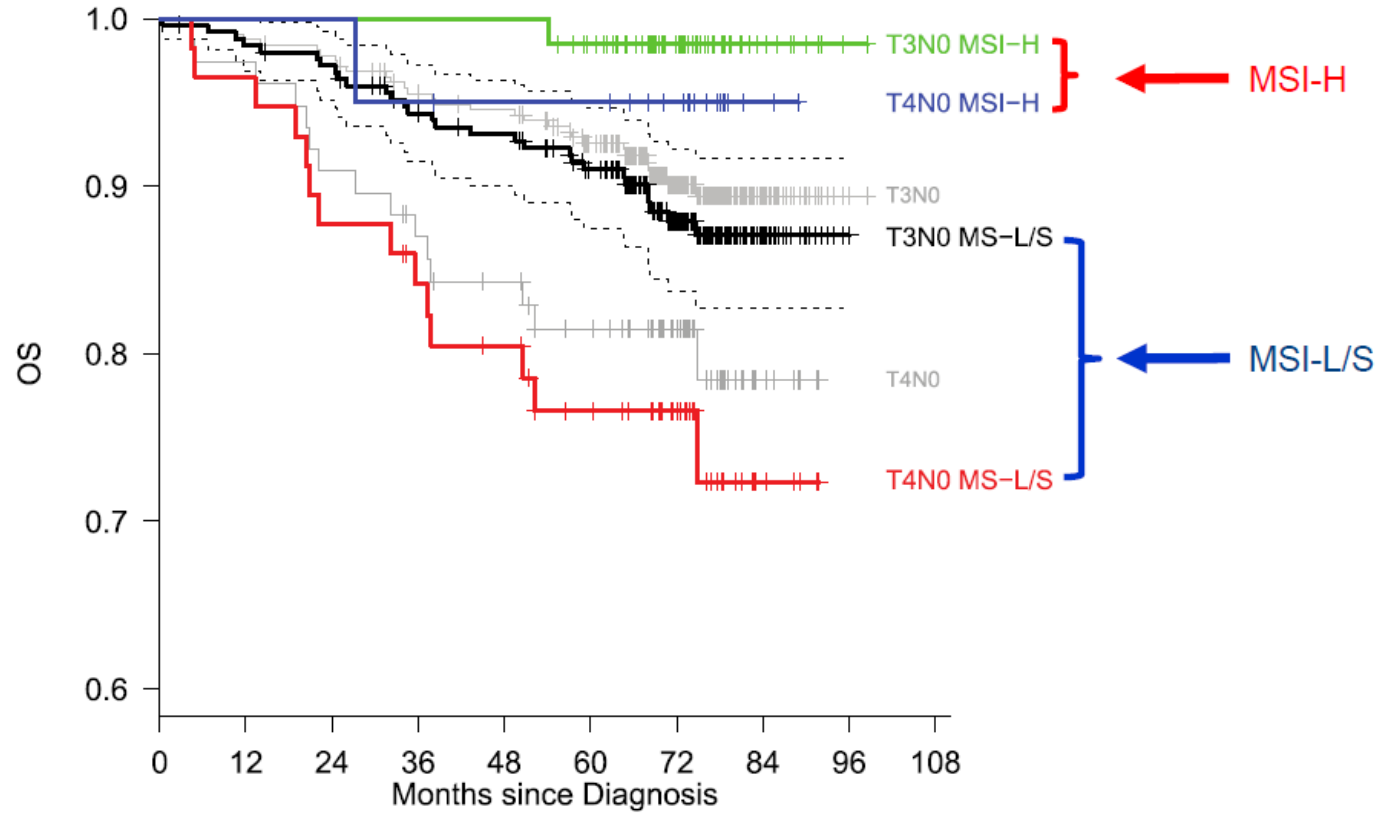
Tournigant et al. JCO 2015

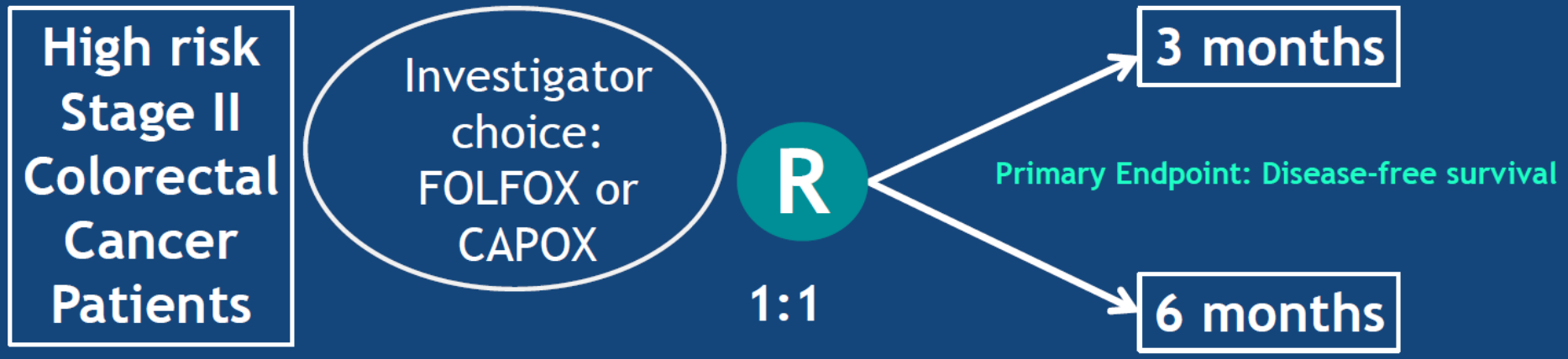
Integrated Analysis of Molecular and Clinial Prognostic Factors in Stage II Colon Cancer



At risk:								Number of events	
T3N0 MS−L/S	251	246	242	230	225	209	138	31	29
T3N0 MSI−H	66	66	66	66	66	61	35	9	1
T4N0 MS−L/S	57	55	50	46	43	37	26	5	14
T4N0 MSI−H	20	20	20	19	18	18	14	2	1

Roth AD, et al. J Natl Cancer Inst. 2012 Nov 7;104(21):1635-46

Study Schema To evaluate the ***non-inferiority*** of 3m vs 6m



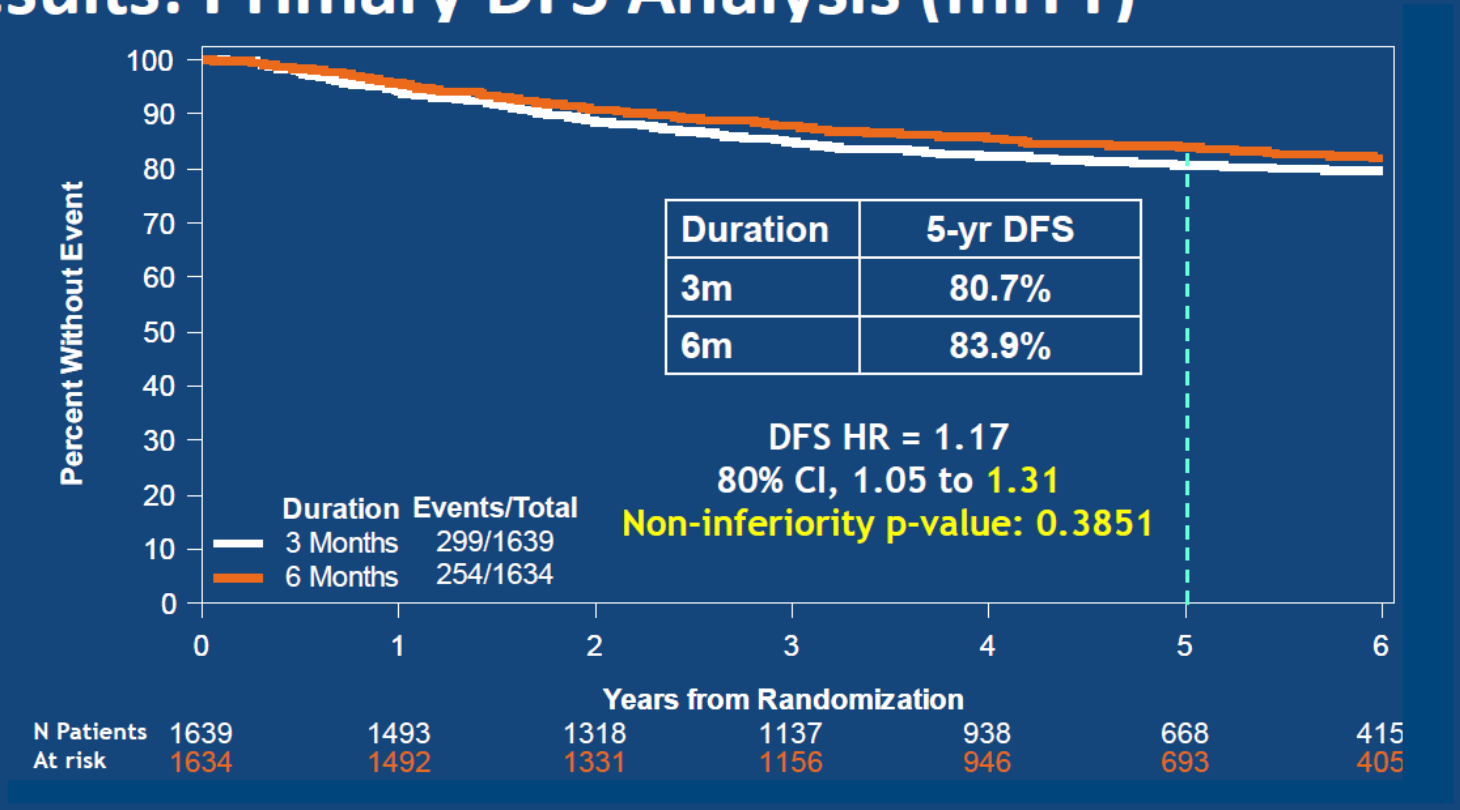
Prospective analysis of ***four*** concurrently conducted phase III randomized trials

IDEA Trials Summary (High Risk Stage II)

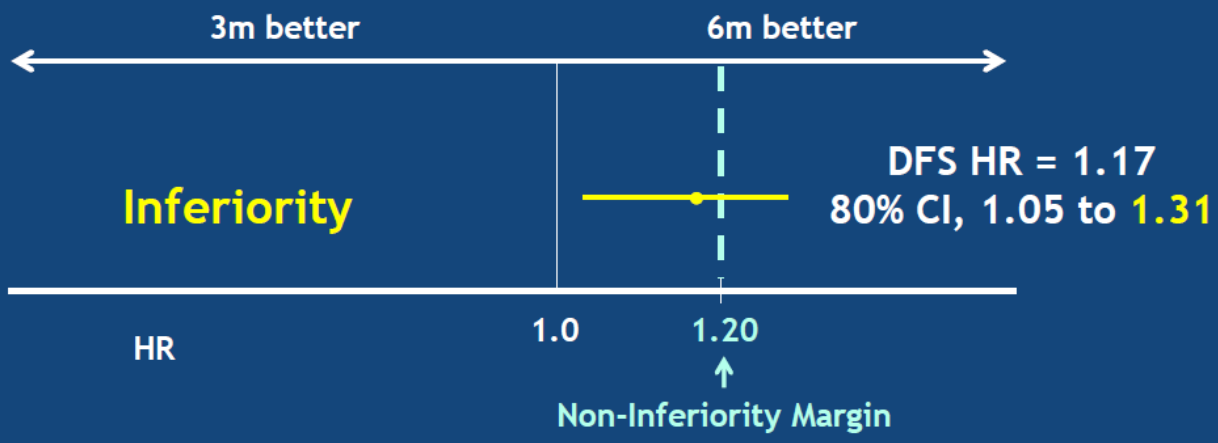
Trial	Regimen(s)	HR stage II Colorectal Cancer Patients	Enrolling Country
TOSCA	CAPOX or FOLFOX4	1268	Italy
SCOT	CAPOX or mFOLFOX6	1078*	UK, Denmark, Spain, Australia, Sweden
HORG	CAPOX or FOLFOX4	413	Greece
ACHIEVE2	CAPOX or mFOLFOX6	514	Japan

*Included 130 rectal patients

Results: Primary DFS Analysis (mITT)

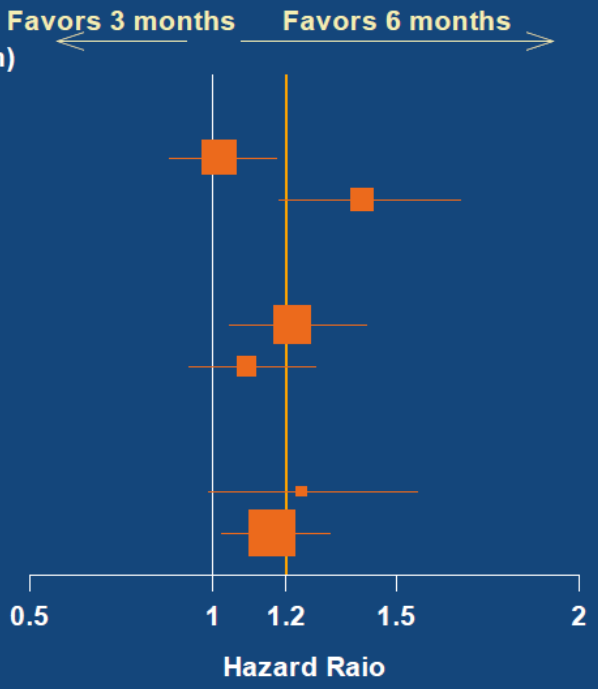


Results: Primary DFS Analysis:Statistical Conclusions



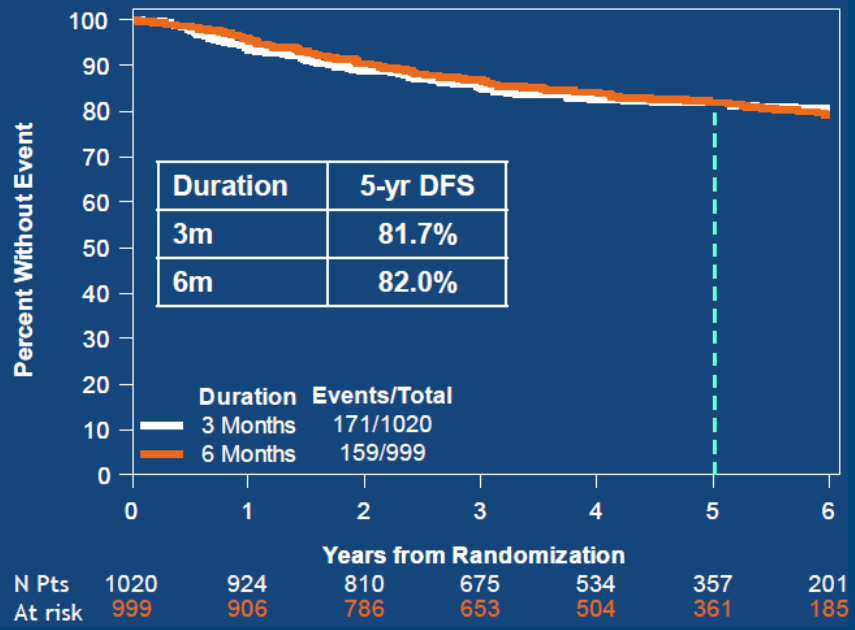
Results: DFS Comparison by Regimen and risk

	Patients 3 month arm	Patients 6 month arm	HR (3m/6m)	Interaction P-value Raw	Interaction P-value Adjusted for multiple comparisons
Regimen					
CAPOX	1006	979	1.018	0.07	0.20
FOLFOX	615	622	1.408		
T stage					
T1-3	1091	1094	1.217	0.53	0.78
T4	544	538	1.094		
Inadequate Nodal Harvest					
Yes	311	304	1.242	0.78	0.78
No	1308	1307	1.162		

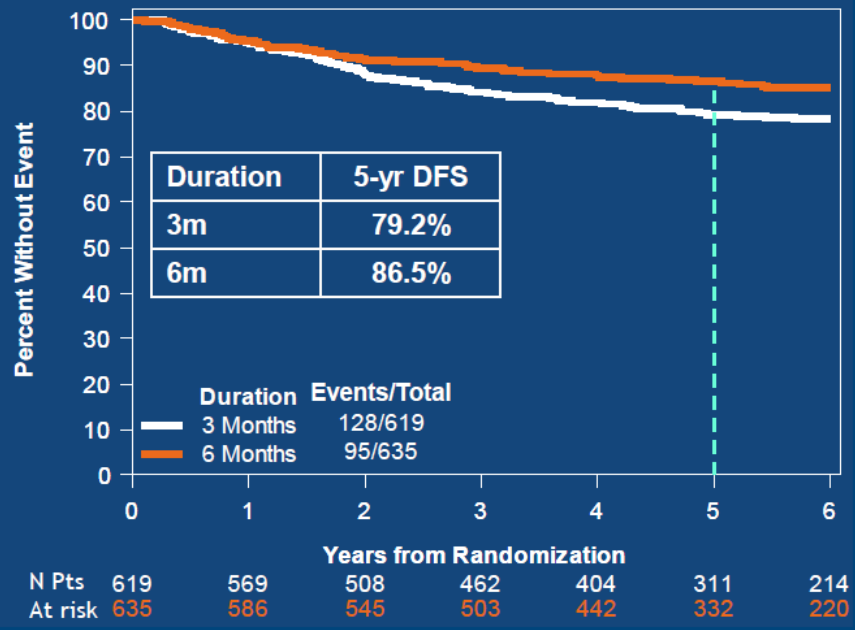


Results: DFS Comparison by Regimen

CAPOX



FOLFOX

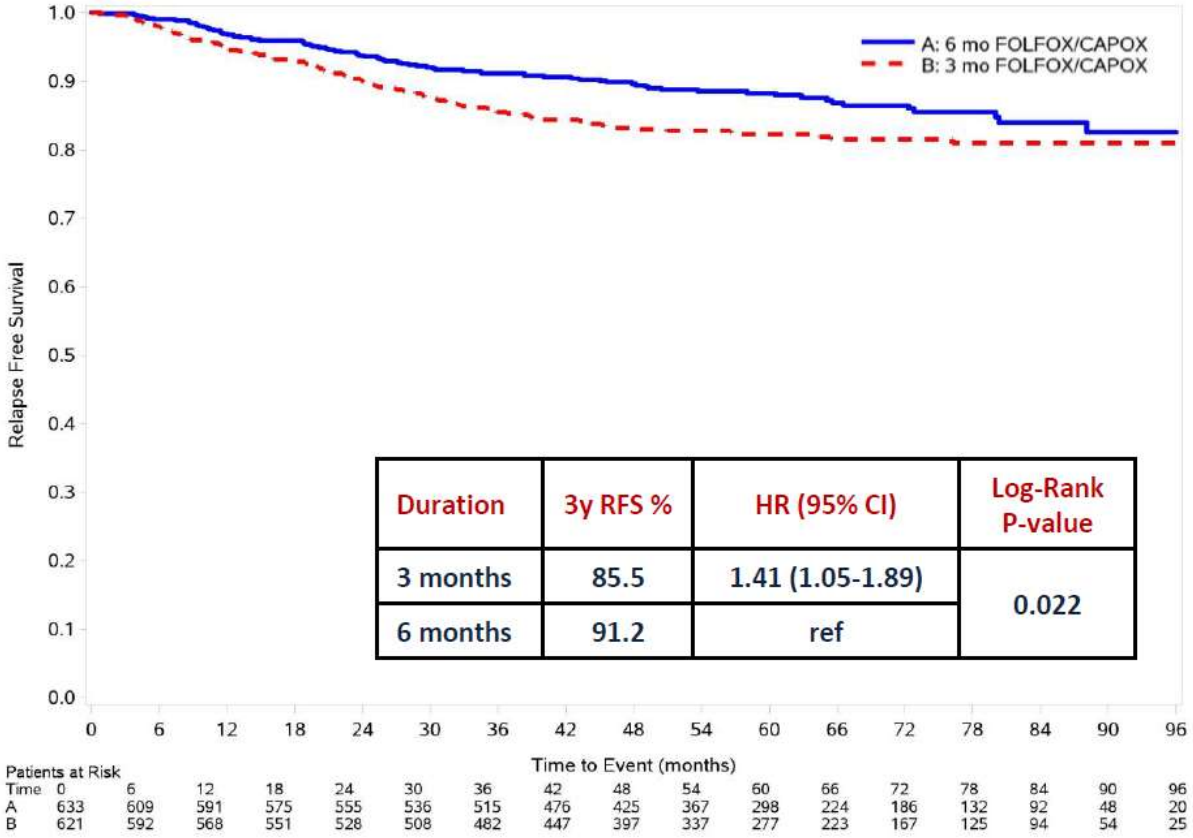


Conclusions

- Overall non-inferiority was not shown for 3 months
- 3 months treatment results in significantly less toxicity
- Similar regimen effect as in stage III disease
  - **Strongly suggests non-inferiority for 3 months CAPOX**
  - **Strongly suggests inferiority for 3 months FOLFOX**

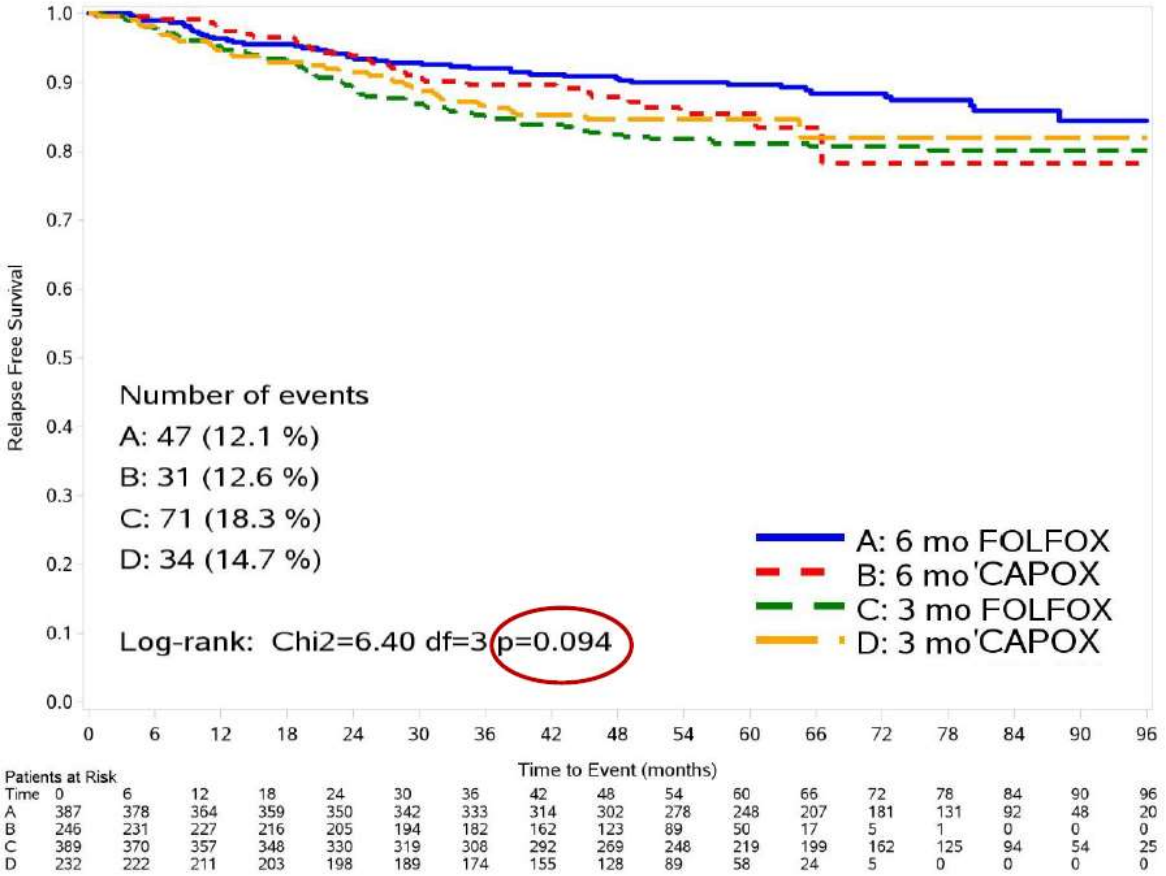
SUPERIORITY OF 6 MONTHS FOLFOX (Garufi)

Relapse-Free Survival



Duration	3y RFS %	HR (95% CI)	Log-Rank P-value
3 months	85.5	1.41 (1.05-1.89)	0.022
6 months	91.2	ref	

RFS by treatment duration and regimen



HIGH-RISK

T4
<12 lymph nodes
perforation/obstruction
tumour grade 3,
in the absence of MSI:
6 months fluoropyrimidine

VS

VERY HIGH-RISK

MSS and T4 or more than one validated risk factor,
consider addition of oxaliplatin:
3 months of CAPOX
6 months of FOLFOX

Conclusione di Sara Lonardi

LIQUID BIOPSY

LBA30_PR: Analysis of circulating tumor DNA (ctDNA) from patients enrolled in the IDEA-FRANCE phase III trial: prognostic and predictive val for adjuvant treatment duration – Taieb J, et al

Study objective

- To investigate whether ctDNA can be used as a prognostic or predictive marker for determining intensity and duration of adjuvant treatment

Key patient inclusion criteria
- Stage III colon cancer
- Data from the IDEA France cohort study

(n=2010)

R 1:1

T1-3 N1
3-month chemotherapy
mFOLFOX or CAPOX
→ PD

T4 and/or N2
6-month chemotherapy
mFOLFOX or CAPOX
→ PD

Stratification
- Centre, T stage, N stage, ECOG PS, age

PRIMARY ENDPOINT
- DFS

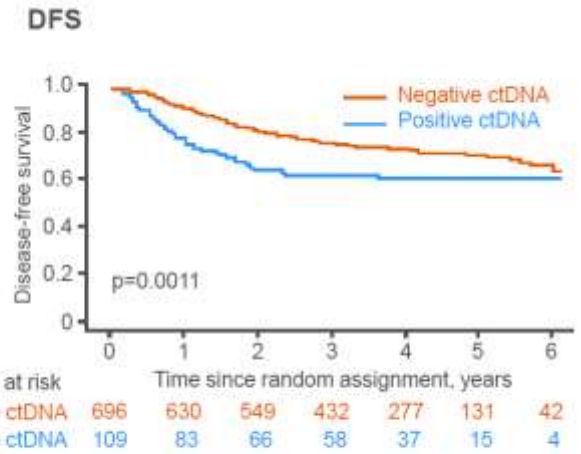
SECONDARY ENDPOINT
- Safety

*Digital pathology is used to quantify the densities of CD3+ and cytotoxic CD8+ T cells in core tumour and invasive margin and converted to predefined cut-offs and grouped as either low, intermediate or high or as low or intermediate + high or as a continuous score

Taieb J, et al. Ann Oncol 2019;30(suppl):abstr LBA30_PR

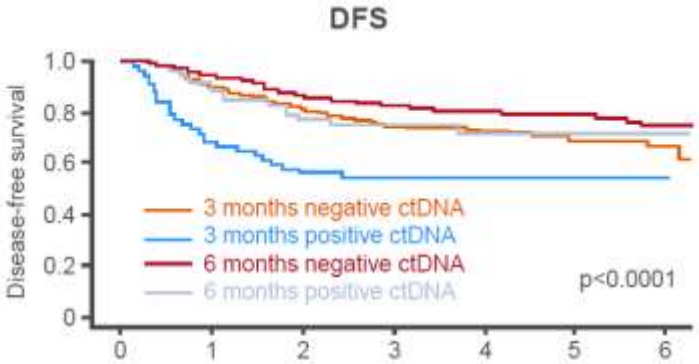
	DFS rate, %	95%CI
Negative ctDNA	82.39	79.32, 85.05
Positive ctDNA	64.12	54.19, 72.44

Positive vs. negative
HR 1.85 (95%CI 1.31, 2.61); p<0.001



No. at risk							
Negative ctDNA	696	630	549	432	277	131	42
Positive ctDNA	109	83	66	58	37	15	4

Taieb J, et al. Ann Oncol 2019;30(suppl):abstr LBA30_PR



No. at risk							
3-mo negative ctDNA	346	309	269	204	134	60	19
3-mo positive ctDNA	56	37	30	27	18	4	1
6-mo negative ctDNA	350	321	280	228	143	71	23
6-mo positive ctDNA	53	46	36	31	19	11	3

ESMO 2019 – GI Cancers

- **Esophagus**: established IO 2nd line
- **Gastric**: confirmed perioperative approach
- **HCC**: still unmet need (Sorafenib, Lenvatinib, Nivolumab)
- **Intrahepatic Colangio**: molecular testing possible (IDH1, FGFR, BRAF and MSI)
- **Pancreatic**: LAPC doublet standard, triplet possible
- **Colon**: new triplet for BRAF patients; Stage II still Fluoropirymidines. Liquid Biopsy: very near ….