Symposium VI

Adjuvant (Postoperative/Neoadjuvant) Chemotherapy in GB Cancer

Chonnam National University Medicsl School, Chonnam National University Hwasun Hospital

Ik-Joo Chung

Complete surgical resection still remains the only curative measure for GB cancer. However, recurrence is common, if it happens, it is considered to be fatal. Some auxiliary treatments, such as neoadjuvant or adjuvant chemotherapy and radiation therapy, have been introduced to enhance survival of patients with GB cancer. However, there is no established regimen for such measures. In addition, indications for adjuvant chemoradiation therapy have not yet been determined. The benefit of adjuvant RT or chemoradiotherapy after a complete margin-negative resection of GBC has not been tested in randomized controlled trials. However, impressions of a survival advantage have been reported in many retrospective reports in which either radiation alone or chemoradiotherapy (generally with a concomitant fluoropyrimidine) was administered. A survival benefit from adjuvant chemotherapy is suggested by a single randomized Japanese trial comparing surgery alone versus two postoperative courses of 5-FU and mitomycin (1). The optimal regimen has not been established, and questions remain as to the best way to integrate radiotherapy with chemotherapy. Despite the paucity of high quality evidence, guidelines from the National Comprehensive Cancer Network (NCCN) suggest that fluoropyrimidine-based chemotherapy and radiation therapy be "considered" after resection for all except T1N0 GB cancer (2). Guidelines from the European Society of Medical Oncology (ESMO) also suggest consideration of postoperative chemoradiotherapy after complete surgical resection (3). Guidelines for patients with margin-positive resections are covered elsewhere. I suggest adjuvant fluoropyrimidine-based chemoradiotherapy for patients with completely resected GB cancer ≥T2. In addition, I suggest at least four months of systemic chemotherapy in addition to chemoradiotherapy, if the patient can tolerate it. While some clinicians use gemcitabine with or without cisplatin, most use a fluoropyrimidine alone. The optimal way to integrate chemoradiotherapy and chemotherapy is uncertain. Some clinicians start with chemotherapy first in patients with node-positive disease, based on the rationale that this approach will avoid needless RT for patients who are destined to develop early distant metastases.

Treatment of unresectable locally advanced gallbladder cancers usually consists of various palliative strategies which provide only a modest survival benefit. The clinical outcome for unresectable advanced gallbladder cancers with preoperative chemoradiation in terms of feasibility, safety, and survival is encouraging in recent study (4). This treatment strategy has a curative potential for the otherwise fatal disease.

References

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