The SIC-GIRCG 2013 Consensus Conference on Gastric Cancer

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- Giovanni De Manzoni, Gian Luca Baiocchi, Massimo Framarini, Maurizio De Giuli, Domenico D'Ugo, Alberto Marchet, Donato Nitti, Daniele Marrelli, Paolo Morgagni, Andrea Rinnovati, Riccardo Rosati, Franco Roviello, Rosaldo Allieta, Stefano Berti, Umberto Bracale, Patrizio Capelli, Angelo Cavicchi, Natale Di Martino, Annibale Donini, Angelo Filippini, Gianfranco Francioni, Marco Frascio, Alfredo Garofalo, Stefano Maria Giulini, Giovanni Battista Grassi, Paolo Innocenti, Antonio Martino, Gualtiero Mazzocconi, Lorenzo Mazzola, Severino Montemurro, Nicola Palasciano, Gianni Pantuso, Heinrich Pernthaler, Roberto Petri, Diego Piazza, Rosario Sacco, Giovanni Sgroi, Carlo Staudacher, Michele Testa, Carlo Vallicelli ,Nereo Vettoretto, Costantino Zingaretti, Lorenzo Capussotti, Mario Morino, Giorgio Maria Verdecchia

[1]1st Department of General Surgery, Borgo Trento Hospital, University of Verona, P.le Stefani, 1, 37121, Verona, Italy, giovanni.demanzoni@univr.it.

Abstract

The topic chosen by the Board of the Italian Society of Surgery for the 2013 annual Consensus Conference was gastric cancer. With this purpose, under the direction of 2 chairmen, 36 experts nominated by the Regional Societies of Surgery and by the Italian Research Group for Gastric Cancer (GIRCG) participated in an experts consensus exercise, preceded by a questionnaire and mainly held by telematic vote, in accordance with the rules of the Delphi method. The results of this Consensus Conference, presented to the 115th National Congress of the Italian Society of Surgery, and approved in plenary session, are reported in the present paper.

Keywords

Gastric cancerSurgeryChemotherapyStagingEndoscopyLaparoscopy

Introduction

Gastric cancer is one of the most common cancers in the world [1]. Unlike other tumors of the gastrointestinal tract, there have been in recent years limited progresses in

chemotherapy and radiotherapy, thus surgery remains the mainstay of therapy. In daily clinical practice, the surgeon plays a central role in the multidisciplinary team managing gastric cancer patients in all the steps, from the preoperative phase (staging and therapeutic strategy decision) up to the follow-up.

From an historical perspective, Italian surgeons were among the first in the West, in the latter half of the last century, to acknowledge the indications of Eastern Centers; owing to the high incidence of this tumor in their Countries, in the period 1970–1980 the Japanese surgeons in particular have developed an aggressive surgical approach based on extended (D2) and superextended (D3) lymphadenectomy [2], while the intervention more frequently performed in Europe and in USA provided for a limited lymphadenectomy (D1). This gave rise to a scientific conflict, which rested on an impressive difference in terms of long-term survival, such as to achieve an overall 5-year survival of around 75 % in Japan [3] and 25 % in Europe [4]. In this context a number of Italian surgeons, just by acknowledging these clear differences, and consequently by accepting the modus operandi of Japanese colleagues, started in the 1980s concentrating their efforts on which other ways we differed from them (essentially, a more meticulous and aggressive surgery in terms of nodal clearance). By this way, the Italian surgery has made a fundamental contribution in the worldwide spreading of Japanese therapy and results, and has become in the 1990s and early 2000 an undisputed scientific and clinical landmark in the treatment of gastric cancer in the West [5, 6].

However, while in the 1990s the goal was to demonstrate that an extended and superextended lymphadenectomy could be performed even in our Countries with postoperative morbi-mortality compatible with the terms of the “good clinical practice”, actually the imperative is to standardize the therapeutic process even in those areas—as such as surgery—characterized by individual variability related to the skill, the dexterity, the experience and the number of procedures.

On the basis of these considerations, in 2012 the Board of the Italian Society of Surgery (SIC) has decided to devote the 2013 annual Consensus Conference to gastric cancer, and the Italian Research Group for Gastric Cancer (GIRCG) was invited to take active part in the organization and conduct this Consensus Conference. The GIRCG is participated from long time, in a multidisciplinary way, by a number of clinicians having specific expertise in the field of gastric cancer diagnosis, care and research. The aim of the GIRCG was to obtain results similar to those reported by Eastern Centers in terms of recurrence rate and survival; most of the members of GIRCG passed some times of their initial

formation in the Tokyo National Cancer Center. In the last 10 years GIRCG published 28 papers in high-impact journals [7–10] and an international book [11], organized 12 workshop and 1 post-university masterclass, which is actually at its third edition; in 2009, during Kracovia 8th International Gastric Cancer Congress, GIRCG obtained the commitment of organizing the 10th International Gastric Cancer Congress in June 2013 in Verona.

Methods

In December 2012, Professor Giovanni De Manzoni and Dr. Giorgio Maria Verdecchia were commissioned by the Italian Society of Surgery for organizing the 2013 Consensus Conference on Gastric Cancer. By January, 2013, a Scientific Secretary has been appointed and a road map has been established. In the Consensus Conference logo, along with the symbol of 115th SIC National Congress to be held in Turin in October 2013 (a climber who ascends the Mole Antonelliana and the motto "every limit is a challenge"), the coat of arms of SIC, GIRCG and IGCA was placed (Fig. 1). First of all, a questionnaire covering all the fields of surgical management of gastric cancer was developed and sent to all the directors of a Surgical Department in Italy, with the aim to underline the critical points for which a clear consensus was already not widespread. The results of this questionnaire would be the object of another publication. At the same time, a number of experts were designed by 13 Italian Regional Societies of Surgery (two experts for every Society) and by the GIRCG board. Overall, 36 experts finally accepted to take part in this web-based Consensus Conference. By September 2013, all the experts answered the questionnaire; in the meantime, the scientific secretary drafted nine statements, whose arguments included in a complete way all diagnostic and therapeutic steps of clinical management of gastric cancer patients, as per direct or partial competence of the surgeon. In detail, statement titles were: staging, endoscopic treatment, neoadjuvant therapy, extent of gastric resection, lymphadenectomy, associated resections, palliative therapy, mini-invasive surgery, follow-up. The Delphi method was adopted [12]: all the participating experts received the first version of the statements for their judgments, and subsequently a summary of the revisions made by other experts, as well as the reasons everyone provided for his judgments; in no case was the single expert opinion sent to the other participants enabling them to identify the expert itself. The scientific secretary played the role of "facilitator". Overall, three rounds of statements revision were allowed by the facilitator (28/9/2013, 3/10/2013 and 7/10/2013). Definitive vote for approval was done on October 9th, 2013. At this point some nine experts were chosen by the Scientific secretary and by the presidents for final linguistic revision and public presentation of the nine statements, which was scheduled during the 115th National SIC Congress. During the general assembly, after statements presentation, all the people attending the meeting were allowed to officially undersign the Consensus Conference results. The final version of the statements was signed indeed by more than 150 Italian surgeons ("Appendix"), in their official version, which is the following.

Fig. 1
The logo of the SIC-GIRCG Consensus Conference on Gastric Cancer

Statements

Statement 1

Staging

The preoperative staging of gastric cancer should include contrast-enhanced thoraco-abdominal CT scan. Endo-US may improve diagnostic accuracy on T and N stage, but it is formally indicated in the selection of patients for endoscopic therapy. Staging laparoscopy is recommended in cases deemed to be at risk of peritoneal carcinomatosis not visible or doubtful at CT scan. The cytological examination of peritoneal lavage, although limited by a low sensitivity, is a useful completion of the final pathologic staging.

Statement 2

Endoscopic treatment

If endo-US is suggestive for intramucosal EGC (cT1aN0) and if tumor is <2 cm, not ulcerated, Lauren intestinal histotype, endoscopic treatment can be considered. Endoscopic therapy is curative only if the tumor is removed in one piece and if histological examination confirms infiltration limited to the mucosa, well differentiation, absence of lateral and deep resection margins infiltration and absence of lymphovascular invasion.

Statement 3

Neoadjuvant therapy

In cT3-4 and/or N+ gastric cancer, M0 and without esophago-gastric junction infiltration, the choice between primary surgery and neoadjuvant chemotherapy should be discussed in a multidisciplinary setting. For advanced gastric cancer with infiltration of the esophago-gastric junction, the utility of neoadjuvant chemo or chemo–radiotherapy followed by surgery is demonstrated. In linitis plastica, first-line chemotherapy should preferably be performed.

Statement 4

Extent of gastric resection

The proximal margin should be assessed in fresh specimens, and it is adequate when >2 cm in T1, 3 cm in T2-4 for intestinal-type cancer with non-infiltrative appearance, and 5 cm in all the other cases; however, if preoperative staging is not clearly nullifying the T and the histotype, proximal margin is always appropriate if larger than 5 cm. In all the cases in which it is possible to obtain a proximal margin free from tumor as specified above, subtotal gastrectomy is preferable to total gastrectomy.

Statement 5

Lymphadenectomy

In curative gastrectomies, lymph node dissection should be the standard D2 (D1 (stations 1–7) + 8a (common hepatic artery), 9 (celiac), 11p (proximal splenic artery), 11d (distal splenic artery, only in total gastrectomy) and 12a (anterior hepato-duodenal ligament) both for early gastric cancer and advanced gastric cancer. The D2-plus lymphadenectomy

(posterior hepato-duodenal ligament, pancreatic and periaortic nodes) is still a subject of research.

Statement 6

Associated resections

Splenectomy (or, where technically possible, radical excision of the splenic hilum lymph nodes through the Jinnai maneuver) should be reserved to cases of advanced gastric cancer of the upper part of the stomach along the greater curvature, in which the malignancy is suspected to be T4 or there are suspected nodes at splenic hilum. The removal of the distal pancreas is foreseen only in case of direct infiltration of the pancreatic capsule by the tumor. In the case of D2 lymphadenectomy in course of total gastrectomy, it is not necessary to perform splenectomy.

Statement 7

Palliative therapy

In presence of hematogenous metastasis or peritoneal carcinomatosis, palliative gastrectomy should be reserved for symptomatic cases. In selected cases of single or limited liver metastases, not requiring major hepatectomy, hepatic resection can be considered; in selected cases of peritoneal carcinomatosis limited to a few nodules in the supramesocolic space, peritonectomy and possible intraperitoneal chemo hyperthermia can be considered; both these treatment have, however, mainly palliative intent and should be discussed in multidisciplinary setting for associated palliative perioperative chemotherapy.

Statement 8

Mini-invasive surgery

Radical gastrectomy in EGC can be performed with laparoscopic approach (standard or robotic), anyway respecting the above parameters of correct surgical oncology. The use of the laparoscopic approach in advanced malignancy not protruding to the serosa (cT2, cT3)

is still under evaluation. There are currently no data that allow to consider safe the laparoscopic approach to tumors protruding to the serosa.

Statement 9

Follow-up

After radical gastrectomy, the patient should be followed by regular oncologic follow-up for at least 5 years.

Conclusions

The above reported statements represent the result of a Consensus Conference of Italian experts and comprehensively cover the clinical management of patients with gastric cancer, from staging to follow-up. They can be a useful tool to address the surgeon in managing patients with gastric cancer. According to the principles set out in these statements, surgeons comply with the best, internationally accepted, actual standard of care.

Appendix

The statements reported in this Consensus Conference were undersigned by the following peoples (further signatures are accepted at consensus.sic.cancrogastrico@gmail.com): *Baiano Giovanni (Formia), Marino Elisabetta (Perugia), Donini Annibale (Perugia), Graziosi Luigina (Perugia), Azzini Carlo (Cremona), Tresoldi Marco Mario (Monza), Martinotti Mario (Cremona), Mazzocconi Gualtiero (Roma), Mazzola Lorenzo (Lanciano), Gallo Gaetano (Catanzaro), Sema Giuseppe (Catanzaro), Sacco Rosario (Catanzaro), Carnevali Giorgio (Legnano), Grignani Fabrizio (Lainate), Galleano Raffaele (Savona), Solerio Dino (Chivasso), Bedin Natalino (Vittorio Veneto), Spinelli Andrea (Torino), Caccetta Massimiliano (Rivoli), Masciandaro Antonio (Collegno), Moscato Rosa (Torino), Galeano Antonio (Messina), Salvador Renato (Padova), Santi Stefano (Pisa), Mammoliti Francesco (Pisa), Vita Simone (Roma), Trignano Mario (Sassari), Pierpaolo Mariani (Seriate), Ricci Francesco (Rovereto), Garulli Gianluca (Riccione-Rimini), Guglielmi Alfredo (Verona), Cardona Rosario (Catanzaro), Tonin Dino (Pordenone), Antonelli Bruno (Sorrento), Cloro Luigi (Rossano Scalo), Papandrea Matteo (Catanzaro), Ruffolo Cesare*

(Treviso), Massani Marco (Treviso), Scalercio Vittorio (Terni), Bonatti Luca (Torino), Cestino Luca (Torino), Dardano Giovanni (Lavagna), Curbo Pietro (Moncalieri), Beltramo Massimo (Carate Brianza), Rampulla Valentina (Messina), Moraldi Aldo (Roma), Serinelli Francesco (Torchiarolo), Ansaloni Luca (Bergamo), Liuraghi Lorenzo (Varese), Pantuso Gianni (Palermo), Berselli Mattia (Varese), Cocozza Eugenio (Varese), Aloesio Roberto (Torino), Pacilio Carlo Alberto (Bologna), D'agostino Giuseppe (Novara), Monaco Giuseppe (Enna), Serocco Dario (Benevento), Citarella Antonio (Caserta), Carola Maria (Caserta), Vallicelli Carlo (Bologna), Palatucci Valeria (Salerno), Grassi Giovanni Battista (Roma), Piroli Silvia (Roma), Trapani Renza (Torino), Pannozzo Caterina (Latina),Federico Gheza (Brescia), Arru Luca (Luxembourg), Garofalo Alfredo (Roma), Allieta Rosaldo (Aosta), Tomasoni Matteo (Brescia), Gallo Vittorio (Verona), Zaccaroni Alberto (Forlì), Cicetti Moreno (Pesaro), Rigamonti Marco (Trento), Pisano Graziano (Crema), Rosato Lodovico (Ivrea), De Palma Maurizio (Napoli), Di Martino Natale (Napoli), Marcello Daniele (Ferrara), Pellegrino Luca (Cuneo), Soncini Stefania (Torino), Ferrara Antonio (Alcano), Sciponi Loreto (Avezzano), Deidda Simona (Cagliari), Agus Marina (Cagliari), Bellora Paolo (Torino), Catalini Giambattista (Camerino), Minciotti Edoardo (Gubbio), Butera Federico (Torino), Szichta Nenad (Torino), Pernthaler Heinrich (Merano), Buonanno Gennaro Maurizio (Benevento), Pulica Coriolano (Mantova), Frascio Marco (Genova), Motterlini Enrico (Romano di Lombardia), Zingale Francesca (Padova), Gerunda Giorgio (Modena), Di Calamo Enrico (Palmanova), Lucchesi Giovanni (Torino), Martino Antonio (Napoli), Bentivegna Filippo (Militello), Di Maria Carmelo Antonio Salvatore (Palagonia), Mandalà Vincenzo (Palermo), Cordovana Andrea (Milano), Panciroli Claudio (Reggio Emilia), Rotondo Roberto (Carpi), Urciuoli Giuliano (Potenza), Guarino Gerardo (Potenza), Sgroi Giovanni (Treviglio), De Nobili Umberto (Brescia), Tonelli Francesco (Firenze), Busi Giordano(Asola), Totaro Luigi (Brescia), Maria ChiaraVailati (Brescia). Ferraris Carlo (Torino), Orsini Vincenzo (Catanzaro), Comparetto Leonardo (Palermo), Allaix Marco Ettrore (Torino), Framarini Massimo (Forlì), Orsenigo Elena (Milano), Rinnovati Andrea (Arezzo), Morgagni Paolo (Forlì), Ministrini Silvia (Brescia), Zanotti Daniela (Brescia).

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