Management of neuroendocrine tumours, advanced and metastatic pancreatic cancer, and metastatic colorectal cancer

REPORT FROM THE 16TH ANNUAL EASTERN CANADIAN COLORECTAL CANCER CONSENSUS CONFERENCE (EC5), MONTREAL, QUEBEC, OCTOBER 23-25, 2014

Dr Elena Tsvetkova, MD, FRCPc
The Ottawa Hospital Cancer Centre

Participants
Dr. Tim Asmis, Medical Oncologist, The Ottawa Hospital Cancer Centre, Ottawa
Dr. Nathalie Aucoin, Medical Oncologist, Cité de la Santé de Laval, Laval
Dr. Jim Biagi, Medical Oncologist, Queen’s University, Kingston
Dr. Stephanie Brulé, Medical Oncologist, University of Ottawa, Ottawa
Dr. Ronald Burkes, Medical Oncologist, University Health Network Princess Margaret Hospital, Toronto
Dr. Bruce Colwell, Medical Oncologist, Dalhousie University, Halifax
Dr. Christine Cripps, Medical Oncologist, University of Ottawa, Ottawa
Dr. Richard Daffern, Medical Oncologist, St. Mary’s Hospital, Montreal
Dr. Mark Dorreen, Medical Oncologist, Dalhousie University, Halifax
Dr. Scot Dowden, Radiation Oncologist, Tom Baker Cancer Centre, Calgary
Dr. Catherine Dubé, Gastroenterologist, The Ottawa Hospital, Ottawa
Dr. Conrad Falkson, Radiation Oncologist, Queen’s University, Kingston
Dr. Rakesh Goel, Medical Oncologist, The Ottawa Hospital, Ottawa
Dr. Fawaz Halwani, Pathologist, Eastern Ontario Regional Laboratory Association
Dr. Nazik Hammad, Medical Oncologist, Queen’s University, Kingston
Dr. Marion L’Espérance, Surgeon, Centre de Santé et de Services sociaux de Sept-Îles, Sept-Îles
Dr. Christine Margarine, Pathologist, The Ottawa Hospital, Ottawa
Dr. Jean Maroun, Medical Oncologist, The Ottawa Hospital Cancer Centre, Ottawa
Dr. Nathalie Michaud, Surgeon, Centre de Santé et de Services sociaux de Sept-Îles, Sept-Îles
Dr. Malcolm Moore, Medical Oncologist, University Health Network Princess Margaret Hospital, Toronto
Dr. Marie-Hélène Nepveu, Gastroenterologist, Hôpital Générale de LaSalle, LaSalle
Dr. Nadege Perrin, Surgeon, Centre de Santé et de Services sociaux de Sept-Îles, Sept-Îles
Dr. Benoît Samson, Medical Oncologist, Montérégie Cancer Centre, Charles-LeMoyne Hospital, Longueuil
Dr. Berry Scott, Medical Oncologist, Sunnybrook Odette Cancer Centre, Toronto
Dr. Lucas Sideris, Surgeon, Maisonneuve-Rosemont Hospital, Université de Montréal, Montreal
Dr. Shelly Sud, Medical Oncologist, The Ottawa Hospital Cancer Centre, Ottawa
Dr. Mustapha Tehfe, Medical Oncologist, Centre Hospitalier de l’Université de Montréal, Montreal
Dr. Michael Thirlwell, Medical Oncologist, McGill University Health Centre, Montreal
Dr. Elena Tsvetkova, Medical Oncologist, The Ottawa Hospital Cancer Centre
Dr. Michael Vickers, Medical Oncologist, University of Ottawa, Ottawa

CONSENSUS
Canadian practice guidelines

NEUROENDOCRINE TUMOUR (NET)

Diagnosis
To ensure consistency in diagnosis, use of the World Health Organization (WHO) 2010 NET classification is recommended. Core biopsy should be obtained if safe and feasible; pathologic report should include Ki 67 index as independent predicting factor, mitotic rate, and grade. For diagnostic and monitoring purposes, baseline bloodwork with chromogranin A level, 24-hour urine 5-hydroxyindoleacetic acid (5-HIAA), baseline computed tomography (CT) and octreotide scan are advised. In patients with carcinoid symptoms, baseline echocardiogram should be obtained. Metaiodobenzylguanidine (MIBG) scan may be considered in selected patients.

Systemic therapy
There are data to support regular somatostatin analogue (SSA) injections for unresectable/metastatic progressive well-differentiated gastroenteropancreatic (GEP) NET. Recent data support treatment with sunitinib or everolimus in metastatic/unresectable pancreatic NET (PNET). The optimal sequencing of sunitinib and everolimus in reference to other treatment modalities has not been established. To date, there is a lack of evidence to recommend sunitinib...
CONSENSUS

or everolimus in the treatment of gastrointestinal NET. In well-differentiated metastatic PNET, streptozocin-based or capecitabine/temozolomide combination chemotherapy is a viable option. If appropriate, referral to a clinical trial may be considered. For poorly differentiated neuroendocrine carcinomas, platinum-based chemotherapy is recommended.

Surgical resection
Patients with metastatic disease should be managed by a multidisciplinary team. Resection of the primary tumour and/or metastases should be considered. Locoregional therapy, such as hepatic intraarterial embolization, chemoembolization, or radiofrequency ablation (RFA), could be an option if resection is not feasible. For small-bowel NET or primary tumours more than 2 cm in size, surgical resection with lymphadenectomy is advised. In potentially resectable disease, surgery may include lymphadenectomy/peritoneal stripping/liver resection.

LOCALLY ADVANCED PANCREATIC CANCER (LAPC)

Systemic therapy
A primary modality in the treatment of LAPC is systemic therapy. Based on expert opinion, multiple therapeutic regimens, such as gemcitabine, gemcitabine/nab-paclitaxel combination, or combination of 5-fluorouracil, leucovorin, irinotecan and oxaliplatin (FOLFIRINOX), may be considered. In case of borderline resectable disease, patients should be discussed at multidisciplinary tumour boards and/or referred to clinical trials.

Radiation therapy
Recent trials failed to support the superiority of chemoradiation over chemotherapy alone. However, chemoradiation may be considered in selected patients after discussion with the multidisciplinary team or in a clinical trial setting.

Metastatic pancreatic cancer
In patients with good performance status (PS), FOLFIRINOX or combination therapy with gemcitabine/nab-paclitaxel as first-line treatment is recommended. FOLFIRINOX dose modification and supportive care should be determined at the discretion of the treating physician. In patients with borderline PS, discussion of single-agent gemcitabine or best supportive care (BSC) may be appropriate. Trial participation is encouraged for selected patients. Current data support use of second-line chemotherapy in the management of metastatic pancreatic cancer. In patients with genetic predisposition, consideration of individualized treatment is recommended.

COLORECTAL CANCER (CRC)

General population screening
For asymptomatic patients aged 50 to 74, population-based CRC screening with fecal occult blood test (FOBT), fecal immunochemical test (FIT), or flexible sigmoidoscopy is recommended. There is no evidence of mortality benefit with colonoscopy-based screening vs these methods. Furthermore, there are issues of test quality in this setting. Colonoscopy remains the preferred followup test for positive FOBT and FIT screening, and should be completed within 8 weeks.

Increased-risk population screening
Collection of a full and appropriate family history is recommended in all patients to identify possible hereditary cancer syndromes/genetic predisposition to CRC. Patients with positive family history should be referred for genetic evaluation. The Consensus Conference endorses the US Multi-Society Task Force on CRC guidelines for screening and management of hereditary nonpolyposis colorectal cancer (HNPPC).

Metastatic colorectal cancer management
Based on the largest randomized controlled trial (RCT) to date, doublet of 5-fluorouracil (5FU)-based chemotherapy with bevacizumab remains a preferred first-line palliative treatment for metastatic CRC. Data support use of 5FU-based chemotherapy with EGFR inhibitor for unresectable metastatic CRC in the first-line setting in patients with known RAS wild-type status. Intermittent strategies of delivering systemic treatment for metastatic CRC do not result in a clinically significant reduction in overall survival (OS) compared with a continuous strategy, and should be a part of an informed discussion of treatment options with patients.

COMMENTARY

The EC5 2014 meeting produced fruitful discussion on locally advanced and metastatic pancreatic cancer. This resulted in a statement to consider newer approved chemotherapy combinations and to treat patients in the second-line setting if appropriate. Once again, the group emphasized the importance of a multidisciplinary approach in treating patients with NET and encouraged trial referral when appropriate. The group also discussed and prepared recommendations on the complex areas of screening and management of metastatic CRC. It is hoped that this consensus will be helpful in establishing and assuring adequate and comparable patient care across the country.

A full report on the meeting will be published in Current Oncology in 2015.