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ABSTRACTS

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Oral Presentations

OP-01

HIGH PREOPERATIVE FIBRINOGEN IS CLOSELY LINKED WITH CHEMOTHERAPY AND ADVANCED DISEASE IN PATIENTS WITH COLORECTAL CANCER

Tarık Akar[1]

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Background: There is still lack of a preoperative simple, reliable and non-invasive blood marker predicting the stage of the disease (luminal or extraluminal) and the need for chemotherapy at the time of diagnosis in patients with colorectal cancer (CRC).

Aim: To investigate any relationship between the preoperative fibrinogen level and CRC disease stage as well as the receipt of chemotherapy before surgery.

Method: A total 297 CRC patients undergoing surgical resection for any reason (curative or palliative) enrolled in this study. The serum fibrinogen level was calculated in the preoperative period. The need for chemotherapy was assessed by two different expert oncologists. Comparisons were made between the fibrinogen level with disease stage as well as the chemotherapy.

Results: The mean fibrinogen level was 455±128,5 mg/dL with high level in 77,4% of all CRC patients. The level of fibrinogen in both Duke's C and D significantly were higher than Duke's B (p<0,001). High preoperative fibrinogen level had a 27.9-fold increase the risk of receiving chemotherapy (Hazard Ratio:27.9, P<0.0001, 12.8-60.4; 95% C.I). The majority of CRC patients receiving chemotherapy (94,4%) had both high fibrinogen and carcinoembryonic antigen (CEA) levels.

Conclusion: High preoperative fibrinogen is closely associated with receipt of chemotherapy and advanced disease in patients with CRC. Notable, this association is more prominent when fibrinogen and CEA are both high.

Learning Point: Despite the improvements in the field of understanding of tumor growth, development and metastasis pathways in recent years, there is still a lack of a simple, non-invasive and reliable method that accurately measured to disease stage and the need for chemotherapy. Our study revealed some new information to clinicians and a patient who has a new CRC diagnosis at the time of diagnosis. If a patient with CRC has high preoperative fibrinogen and CEA, this patient has most probably advanced disease (extraluminal) and will high probably receipt chemotherapy.

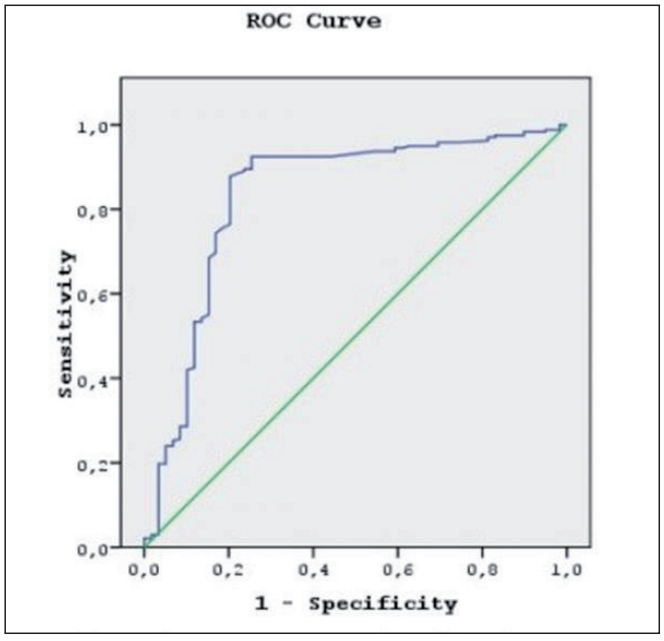

Figure 1.

Table 1.

Patients	297
Sex	
Male	160(53.8%)
Female	137(46.1%)
Age(year)	61.9±13.1(24-92)
>50	244(82.2%)
<50	53(17.8%)
Fibrinogen level	455±128,5(164-900)
High	230(77.4%)
Normal	67(22.6%)
CEA	67.4± 239.8(0.6-2242)
Normal	152(51.2%)
High	145(48.8%)
Anemia	
None(>13 gr/dl)	71(2.9%)
Hb(10-13 gr/dl)	133(44.8%)
Hb(<10 gr/dl)	93(31.3%)
Gall Bladder	
Exist with no stone	248(83.5%)
Exist with stone	30(10.1%)
Cholecystectomy	19(6.4%)
Adjuvant Chemotherapy	
Yes	238(80.1%)
No	59(19.9%)
Colorectal Tumors features	
Age groups	
20-29	6(2%)
30-39	77(2.4%)
40-49	44(14.8%)
50-59	60(20.2%)
60-69	83(27.9%)
70-79	77(25.9%)
80-89	19(6.4%)
>90	1(0.3%)
Location	
Rectum	136(45.8%)
Sigmoid colon	63(21.2%)
Descending colon	33(11.1%)
Transvers colon	9(3%)
Ascending colon and cecum	56(18.9%)
Simple location	
Left Colon	232(78,1%)
Right Colon	65(21,9%)
Cell types	
Adenocarcinoma	280(94.3%)
Mucinous adenocarcinoma	14(4.7%)
Signet ring cell carcinoma	3(1%)
Differentiation	
Well differentiated	163(54.9%)
Moderate differentiated	113(38%)
Poor differantiated	21(7.1%)
Tumor Stages	
(To Modified Duke's classification of Astler and Coller)	
B1	18(6.1%)
B2	84(28.3%)
B3	4(1.3%)
C1	26(8.8%)
C2	94(31.6%)
D	71(23.9%)
Simple Dukes's Stage	
B	106(35.7%)
C	120(40.4%)
D	71(23.9%)

OP-02

A SIX-YEAR SINGLE CENTER EXPERIENCE IN THE MANAGEMENT OF GALLBLADDER CANCER

Fatih Yıldız[1], Emrah Eraslan[1], Ferit Aslan[2], Gülnihal Tufan[1], Berna Öksüzoğlu[1]

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Introduction: Gall bladder cancer (GBC) is an uncommon but highly fatal malignancy. It ranks sixth among all gastrointestinal system cancers, but it is the most frequent tumour of all the biliary tract. The majority are found incidentally in patients undergoing exploration for cholelithiasis. The poor prognosis is thought to be related to the advanced stage at the time of diagnosis (1-5). In this report, we planned to evaluate the clinical characteristics, treatment options and survival of gall bladder cancer patients of our clinics.

Methods: A retrospective analysis of patients referred to Medical Oncology Clinics of Ankara Oncology Training and Research Hospital with the diagnosis of GBC between January 2011 and October 2017 was performed. Patients were selected from our center registry and demographics, clinical stage (early stage, locally advanced or distant metastases) surgical management (cholecystectomy or extended cholecystectomy), pathology, adjuvant and/or palliative therapy, second-line and third-line treatment choices and the date of death or last follow-up were recorded.

Results: Fifty patients were included of whom 41 (82%) were female. Median age was 61 years (range 36–85). Except 2 patient (1 patient with adenosquamous histology and 1 patient with signet ring cell carcinoma) all patients were reported to be adenocarcinoma (96%). Gallstones were present in about 70% of the patients. Twenty patients (40,0%) were staged as AJCC stage IV. All of locally and locally advanced stage patient (n:30) were treated surgically and extended resection was performed in 20 of them (40 %). Of those who underwent surgery, 11 patient (22 %) received both adjuvant chemoradiation and systemic chemotherapy, 4 patient (%8) radiotherapy alone and 4 patient (%8) chemotherapy alone. Eleven patient (22%) with early stage cancer did not receive any adjuvant treatment. Seven patients (14%) had second-line and only two patients (4%) had the third-line chemotherapy. Median disease-free survival (DFS) for the early stage was 8,6 months and for the locally advanced stage was 10,0 months (p:0,83). Median overall survival (OS) for the all cohort was 16.4 months (9.4 -23.4), for the early stage (stage I-II, n:17) was 38,9 months, for the locally advanced (stage III, n:13) was 30.6 months (19.3-41.9) and for the metastatic subpopulation (stage IV, n:20) 9,4 months (3.9 -14,9). For the patients who underwent extended resection (n:19) median OS was 53,2 months and for the patients who underwent cholecystectomy (n:11) was 30,62 months (p:0,42)

Conclusions: Gall bladder cancer is an uncommon but highly fatal carcinoma. Our results confirm the published literature and support better survival with extended resection and adjuvant chemoradiotherapy or chemotherapy.

OP-03

THE ROLE OF DYNAMIC SERUM THIOL-DISULPHIDE HOMEOSTASIS IN METASTATIC GASTRIC CANCER

Burak Bilgin[1], Mehmet Ali Nahit Şendur[1], Mutlu Hızal[1], Muhammed Bülent Akıncı[1], Didem Şener Dede[1], Samet Yaman[2], Salim Neşelioğlu[3], Nuriye Özdemir[1], Özcan Erel[3], Bülent Yalçın[1]

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Background: Gastric cancer (GC) is a one of the common cancer in the world. Many factors including oxidative stress are implicated in the pathogenesis of GC. Plasma thiol-disulphide reflect total antioxidant capacity in the body and dynamic thiol-disulphide homeostasis plays an important role cell signal mechanisms, apoptosis, transcription factors, antioxidant protection, and detoxification. We aimed to determine the association between thiol-disulphide homeostasis and GC.

Methods: Patients (pts) with advanced GC matched with same aged and sex healthy control cases were enrolled to study. Serum samples for thiol-disulphide test were obtained at the time of diagnosis. Thiol-disulphide homeostasis tests were measured by the automated spectrophotometric method. Cut off value for native thiol (NT)/disulphide ratio that reflect thiol-disulphide homeostasis was accepted as 0.04 by using ROC curve analyses.Kaplan–Meier survival analysis was carried out for DFS and overall survival OS.

Results: A total of 30 new diagnosed GC pts and 30 aged-sex matched control cases were enrolled to the study. Median age of the pts was 63 (min-max; 27 – 90). Rate of male and female pts were 66.4% and 33.3%, respectively. Fifty three percent of the pts had visceral metastasis. Total thiol (TT) and NT levels of pts were significantly lower than control arm. Disulphide level tend to lower in pts than control arm but not statistical significant. Disulphide/ NT rate was similar between 2 arms. Level of NT, TT, disulphide and disulphide/ NT rate were shown in table 1. There was no thiol-disulphide difference between visceral and non-visceral metastatic pts. After median 15 month follow up, median overall survival (OS) was 7.8 months. When stratified by NT/disulphide rate, there was nearly significant OS difference between <0.04 and ≥ 0.04 arms (mOS; ≥0.04: 6.4 months vs. <0.04: 8.8 months, p = 0.08).

Conclusions: We found that thiol-disulphide levels were lower than control arm but thiol-disulphide homeostasis were continue to maintain. These results may occur as a consequence of rapid cell proliferation. The higher disulphide/NT rate that reflects to oxidative status may predict worst prognosis. In our knowledge, this is the first trial that evaluate association with dynamic thiol/dysulphide homeostasis and GC.

Table 1. Thiol - Disulphide level of the pts and control cases

Parameters	*Patient, Median (min-max)*	*Control, Median (min-max)*	*p*
Native Thiol	374 (209 - 473)	435 (364 - 493)	0.001
Disulphide	15.5 (3 – 30)	19.3 (5.8 – 33)	0.091
Total Thiol	409 (246 – 507)	469 (403 – 532	<0,001
Disulphide / Native Thiol Rate	0.12	0.08	0.9

OP-04

EFFECT OF MUSCLE MASS ON TOXICITY IN PATIENTS WITH COLON CANCER TREATED WITH CAPECITABINE

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Introduction: The loss of skeletal muscle mass (sarcopenia) have been associated with poor outcomes in different malignancy types and increased toxicity with varying chemotherapies. Capecitabine is a water soluble pro-drug of 5-Fluorouracil which has a muscle dependent pharmacokinetic. Therefore, sarcopenia might be closely associated with increased plasma levels and attenuated toxicity. The aim of this study was to evaluate the probable association of capecitabine toxicity with sarcopenia.

Methods: In fifty-seven biopsy proven colon carcinoma patients for whom scans were available and appropriate for analysis were chosen and chemotherapy toxicity data were extracted from patient records data were recorded in a database. Nurse recorded height and weight measurements were collected. Computed tomography which were done for initial diagnosis and staging were used for analysis. Two consecutive transverse CT images from the third lumbar vertebrae (L3) and forth lumbar vertebrae were extracted, analysed by ImageJ program and mean of SMA measurements of L3 and L4 were calculated. Sarcopenia was defined as Skeletal Muscle Index (SMI=SMA/height2). An SMI of 41 or less was considered sarcopenic based on previously derived optimal stratification statistics relating SMI.

Results: Fifthy-seven patients with a median age of 65 (27-84) were included into study. Of patient whose images were available, 42.1% were women and 57.9% was men. At the diagnosis, sarcopenia was present in 57.9% of patients. The percentage of sarcopenia in women and in men were 17.5% and 40.4% which was statistically significant (p=0.03). In women, hand foot syndrome was found to be associated with sarcopenia and in men (p=0.04); mucositis (p=0.03) and hand foot syndrome (p=0.04) were associated with sarcopenia. More patients with sarcopenia were dose adjusted when compared to non-sarcopenic patients during chemotherapy cycles although the difference was not statistically significant.

Conclusion: Decreased muscle mass was associated with increased risk of toxicity of capecitabine especially as skin toxicity and mucositis. Dose limitations were more frequently observed in sarcopenic patients. Nutritional status is important in terms of providing proper and effective but less toxic treatments.

OP-05

THE COMPARISION OF LEFT- VERSUS RIGHT- SIDED COLON CANCER

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Background: Increasing evidence suggests that tumor response to primary treatment and survival according to the primary tumor localization (right-sided vs left-sided) in patients with metastatic colorectal cancer (mCRC) appears to be different. The aim of this study is to compare the results of the patients with left vs right colon cancer treated with chemotherapy (CT) regimen containing either anti- Epidermal Growth Factor Receptor (EGFR) or anti-Vascular Endotelial Growth Fator Receptor (VEGFR).

Patients and Methods: A retrospective analysis of 155 patients with mCRC was performed in this study. We analyzed the treatment and survival outcomes regarding the tumor localization of patients with mCRC who were treated with anti-EGFR + CT (oxaliplatine- or irinotecan-based) or anti-VEGFR + CT in the first line setting. Kaplan Meier and Cox-regression analysis were used to determine the prognostic factors affecting survival.

Results: Of the 155 patients, 44 (39.6%) had right-sided 111 (61.4%) had left-sided primary tumor. No statistically significant difference was observed in RAS status (mutant or wild) in right- vs left-sided mCRC (P = 0.47). The rates of partial response, stable disease and progression of patients treated with bevacizumab + CT in left- vs right-sided tumor were 62.5%, 23.6%, and 13.9% vs 51.9%, 11.1%, and 37%, respectively, indicating a favorable overall response rates for bevacizumab (P = 0.02). The *Overall Survival (OS)* was not statistically significant between right- vs left-sided tumors, yet there was a *trend toward* improved *OS* in patients with left-sided tumor treated with bevacizumab + CT compared to that of patients treated with cetuximab + CT (26.8 vs 21.4 months, P = 0.07). Patients with left-sided tumor tend to have better OS than those with right-sided tumors in univariate analysis; however, multivariate analysis showed that metastasectomy (P = 0.001, HR; 4.05, 95% CI; 1.752-9.393) and first-line treatment with bevacizumab (P = 0.007, HR: 1.88, 95% CI 1.191-2.973) were the factors associated with OS. In 95 patients with wild-type tumor treated with either bevacizumab or cetuximab containing regimen, no significant difference in OS was observed, irrespective of tumor localization; however, there was a trend toward better OS for bevacizumab arm (25.7 vs 21.1 months, respectively P = 0.06)

Discussion: RAS mutation status has been shown to be an important factor in the use of targeted therapy. Additionally, it has been indicated that the patients with left-sided tumors have better OS compared to those with right-sided tumors. While previous studies have suggested that tumor localization might affect the treatment outcomes of patients with mCRC, the effect we observed in this study appears to be far lower than we expected. As the limited quality and number of patients included in this study might change the results, these findings should be further determined by more prospective, randomized controlled studies.

OP-07

FIRST LINE FOLFIRINOX VERSUS GEMCITABINE FOR PANCREATIC CANCER: A SINGLE INSTITUTION RETROSPECTIVE REVIEW

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Background: Metastatic pancreatic cancer (mPC) is a highly lethal malignancy which has one of the worst treatment outcome. FOLFIRINOX (Oxaliplatin 65 mg/m^2 IV on day 1, Irinotecan 135 mg/m^2 IV on day 1, Fluorouracil (FU) 2400 mg/m^2 IV infusion over 46h on day 1, every 2 weeks) is an intense but a proven treatment approach with survival benefit for mPC. We aimed to report our experience and comparison with historical gemcitabine monotherapy (1000 mg/m^2 on day 1, 8 every 3 weeks) with FOLFIRINOX .

Methods: A retrospective analysis of patients referred to Medical Oncology Clinics of Ankara Oncology Research and Training Hospital with the diagnosis of inoperable locally advanced or metastatic pancreatic cancer and treated with FOLFIRINOX or gemcitabine from March 2013 to October 2017 was performed.

Results: Thirty seven patients were included in each group. The median ages were 52,7 years (range: 32-68) and 65,2 years (range: 47-81) for FOLFIRINOX and gemcitabine, respectively (p<0,001). All but one patiens had ECOG performance status of 0 or 1 in FOLFIRINOX group. In contrast, ten patiens had ECOG performance status of 2 in gemcitabine group (p=0,007). All patients receieved at least one cycle of chemotherapy; the mean numbers of cycles were 7,57 (1-30) and 3,76 (1-9) for FOLFIRINOX and gemcitabine, respectively. Only 8 patients (21.6%) had completed the whole planned 12 cycles of FOLFIRINOX and 11 patients had completed the whole planned 6 cycles of gemcitabine. Patients were evaluated for response 7 (18,9%) and 6 (16,2%) had partial remission 13 (35,1%) and and 7 (18,2%) stable disease with FOLFIRINOX and gemcitabine, respectively. The median PFS was 9,2 vs 3,8 months (p=0,014) and OS was 9,8 vs 5,9 months (p=0,046) for FOLFIRINOX and gemcitabine, respectively. FOLFIRINOX regimen was more toxic than gemcitabine regimen. The incidence of all grade neutropenia, neuropathy and emesis were more prominent in FOLFIRINOX group.

Conclusion: FOLFIRINOX is a difficult regimen for both patients and physicians with toxicity but with a survival benefit. Only one fifth of patients could complete the planned cycles in this study. Therefore, FOLFIRINOX chemotherapy compliance is a great challenge for both physicians and patients Survival benefit is evident in this real life experience but patient selection bias of this retrospective study should be considered.

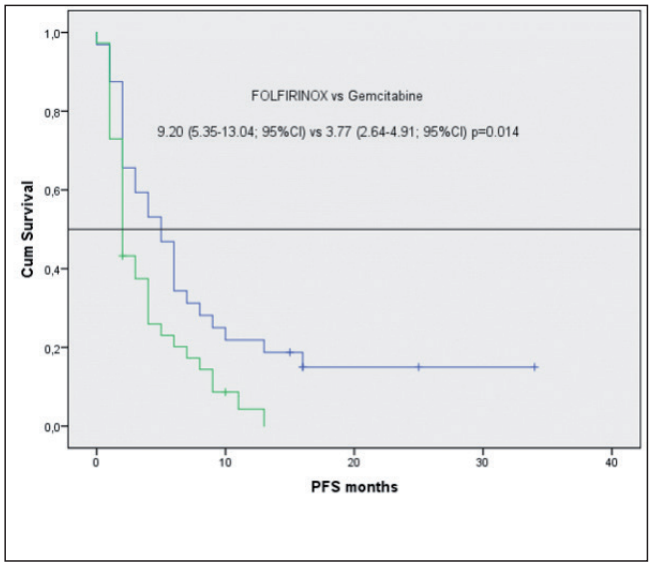

Figure 1.

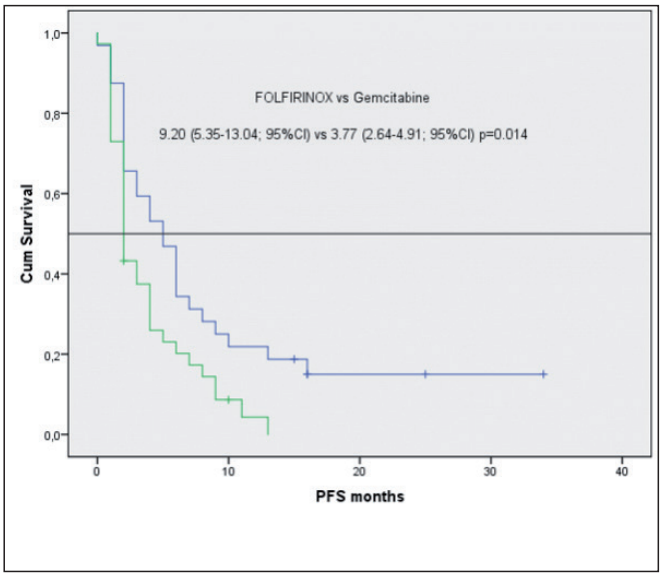

Figure 2.

Table 1. Main characteristics

	FOLFIRINOX	*GEMCITABINE*	*P*
Age, years	52,7 (32-68)	65,2 (47-81)	<0.001
Gender (male/female)	29 (78.4%)/8 (21.6%)	24 (64.9%)/13 (35.1%)	0.197
ECOG PS (0-1)	36 (97.3%)	28 (75.7%)	0.007
Without co-morbidity	24 (64.9%)	15 (40.5%)	0.079
Cigarette	22 (59.5%)	13 (35.1%)	0.074
Alcohol	7 (18.9%)	3 (8.1%)	0.204
Ratio of locally advanced	8 (21.6%)	6 (16.2%)	0.553
No of cycles	7.57 (1-30)	3.76 (1-9)	
Ratio of second line	12 (32.4%)	7 (18.9%)	0.001
No of dose reduction	10 [24% (10-30)]	6 [17% (10-20)]	0.259

Table 2. Side Effects

	All Side Effects			*Grade 3-4 Side effects*	
	FOLFIRINOX (n=34)	*GEMCITABINE (n=37)*	*P*	*FOLFIRINOX (n=34)*	*GEMCITABINE (n=37)*
Neutropenia	17 (50%)	9 (24%)	0.025	8 (23%)	4 (11%)
Neutropenic Fever				3 (9%)	0
Anemia	21 (62%)	16 (43%)	0.119	1 (3%)	1 (2%)
Trombocytopenia	3 (9%)	3 (8%)	0.914	0	1 (2%)
Neuropathy	5 (15%)	0	0.016	1 (3%)	0
Emesis	17 (50%)	7 (19%)	0.006	1 (3%)	0
Diarrhea	6 (18%)	5 (13%)	0.631	2 (6%)	1 (2%)
Fatigue	23 (68%)	23 (62%)	0.629	6 (18%)	5 (13%)
Nephrotoxicity	1 (3%)	4 (11%)	0.195	1 (3%)	0

OP-08

EVALUATION OF DYNAMIC SERUM THIOL-DISULPHIDE HOMEOSTASIS IN COLORECTAL CANCER

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Introduction: Colorectal cancer (CRC) is one of the most common cancer in the world. The relationship between oxidative stress and cancer pathogenesis was found in recent years. Dynamic thiol-disulphide homeostasis plays an important role in cell signal mechanisms, apoptosis, transcription factors, antioxidant protection, and detoxification. We aimed to this study, evaluated to the role of dynamic Thiol-Dysulphide homeostasis in CRC by using a new method.

Methods: The patients (pts) who diagnosed with CRC between 2015 and 2017 were retrospectively analysed. Serum samples for thiol-disulphide test were obtained at the time of diagnosis. Thiol-disulphide homeostasis tests were measured by the automated spectrophotometric method as described by Erel and Neselioglu.

Results: Eighty-eight pts with CRC and 110 control cases were enrolled to the study. Median ages of pts were 60.5 years and 64.8% of pts were male and 35.2% were female. There is no demographical difference between arms. Percent of the left sided tumor were 74.8 and right-sided were 25.9%. Stage 1, 2, 3 and 4 diseases were 11.5%, 27.6%, 39.1% and 21.8% respectively. Native thiol (NT), disulphide and total thiol (TT) levels of pts were significantly lower than the control arm. Disulphide/NT ratio did not significantly differ between pts and control arm (p=0.149). The level of NT, TT, disulphide and Dysulphide/NT ratio were shown in table 1. There was no correlation between thiol-disulphide level and tumor marker. TT and NT levels were not differed according to tumor localisation whereas disulphide level was significantly higher in left-sided tumor than right-sided (p=0.007). There was also no significant difference between thiol-disulphide levels and tumor stage. After 17 months follow up, median overall survival and disease-free survival data were not reached.

Conclusion: Despite TT, NT and disulphide levels were lower than control arms, the balance of thiol/disulphide was maintained. NT, TT and disulphide level may decrease as a consequence of the rapid cell proliferation and associated with CRC pathogenesis. In our knowledge, this is the first trial that evaluates relationship with dynamic thiol/disulphide homeostasis and CRC according to tumor stage and localisation. However, these finding should be validated and evolved with further investigation.

Table 1. Level of the Thiol and Dysulphide in Patient and Control Arm

	Patient Median (min-max)	*Control Median (min-max)*	*p*
Native Thiol	402 (245 - 533)	424 (262-606)	0.003
Disulphide	18.7 (1.6 - 34.65)	21 (8.4 – 38.4)	0.011
Total Thiol	437 (303 – 577)	464 (286 – 631)	0.001
Disulphide / Native Thiol	0.047 (0.01 – 0.12)	0.05 (0.02 – 0.1)	0.149

OP-09

IS SARCOPENIA A PROGNOSTIC FACTOR FOR PANCREATIC CANCER PATIENTS

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Introduction: Sarcopenia is defined as low skeletal muscle mass (kg/m^2, two standard deviation below the young reference group) concomitantly with loss of muscle function. Cancer cachexia is defined as a multifactorial condition closely with sarcopenia which affects almost 80% of pancreatic cancer patients. The relationship between loss of body weight over time and poor cancer outcomes has been known for a long time however data regarding quantitative measurements of sarcopenia is lacking. The aim of this study was to assess the prevalence and consequence of sarcopenia on survival in patients with pancreatic adenocarcinoma.

Methods: In fifty-one biopsy proven pancreatic ductal adenocarcinoma patients for whom scans were available and appropriate for analysis were chosen and data were recorded in a database. Nurse recorded height and weight measurements were collected. Computed tomography which were done for initial diagnosis and staging were used for analysis. Two consecutive transverse CT images from the third lumbar vertebrae (L3) and forth lumbar vertebrae were extracted, analysed by ImageJ program and mean of SMA measurements of L3 and L4 were calculated. Sarcopenia was defined as Skeletal Muscle Index (SMI=SMA/height2. An SMI of 41 or less was considered sarcopenic based on previously derived optimal stratification statistics relating SMI.

Results: Fifty-one patients with a median age of 60 (33-75) were included into study. Of patient whose images were available, 32.6% were women and 67.4% was men, 95.3% were staged as IV and only two patients were stage III. At the diagnosis, 30.2% of patients were in their normal weight however 77.5% of patients were overweighted and obese. Besides, in 79% of patients there was at least 10% of their weight loss at the diagnosis. Sarcopenia was present in 41.9% of patients. The percentage of sarcopenia in women and in men were 57.1% and 34.5%. There was no significant difference in the rate of sarcopenia between different genders. The percentage of sarcopenia in overweight patients were 21.4%. Median overall survival was 8.2 months. There was no statistically significant difference in survival between sarcopenic and non-sarcopenic patients (p=0.4) nor between obese and normal weight patients. However, although not significant statistically, patients who lost weight before the diagnosis lived shorter than the patients did not lose weight (8.2months vs. 12.3 months).

Conclusion: Definitive association between sarcopenia, sarcopenic obesity and survival cannot be drawn from the results however weight loss may be a bad prognostic factor for pancreatic cancer which may have an association with sarcopenia.

OP-10

WHAT IS THE OPTIMAL COMBINATION TREATMENT SEQUENCE IN OPERABLE ESOPHAGUS CANCER

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Background: In non-metastatic esophagus squamous cell tumors, the prognosis is poor despite curative local treatment. The parameter which has the strongest effect on local treatment modality is tumor localization. In upper esophagus tumors, current standard treatment is chemoradiotherapy(KRT) while in middle and lower esophagus tumors, single local treatment vs. combined local treatment is debated. In our study, we aimed to find an answer to chemoradiotherapy in the neoadjuvant or adjuvant setting in addition to surgical treatment in squamous cell carcinoma of the middle and lower esophagus.

Methods: Between 2005 and 2016, 43 patients who received combination therapy with non-metastatic mid-lower esophageal squamous cell carcinoma were evaluated as retrospectively. Patients were staged using computer tomography +/- PET CT or EUS. Adenocarcinoma hıstology, only radiotherapy as local treatment, and only surgical procedures were excluded from the study. Patients were staged as local and local advanced disease according to baseline radiology results. T4 tumor or lymph node positive were locally advanced disease, non-T4 and lymph node negative were local diseases. Neoadjuvant KRT vs. adjuvant KRT were evaluated comparatively.

Results: The total number of patients was 43. The proportion of patients who underwent neoadjuvant chemoradiotherapy was 58.1% (n = 25) and the ratio of postoperative adjuvant chemoradiotherapy was 41.9%(n = 18). The median age was 52.3 (+/- 1.72) in the neoadjuvant group and 47.1 (+/- 2.06) in the adjuvant group (p = 0.061). Gender, smoking and alcohol use, comorbidities, tumor grade, tumor location were similar between the two groups(p>0.05). Patıents clınıcal stagıng at the tıme of dıagnosıs, the local advanced disease rate was 72% (n = 18) in the neoadjuvant chemoradiotherapy arm and 33% (n = 6) in the adjuvant chemoradiotherapy arm. Pathologic complete response (stage 0) was found in 64% (n: 16),stage 2 was in 24% (n: 10) and stage 3 was 12% (n: 3) in neoadjuvant chemoradiotherapy arm. Directly to the surgery without neoadjuvant chemoradiotherapy 11% (n: 2) patients were stage 1, 17% (n: 3) patients were stage 2 and 72% were stage 3. There was no statistically significant difference between groups in terms of disease-free survival(p = 0.92) and overall survival (p = 0.302).

Conclusion: Combination therapies are currently being used in addition to single local treatments for squamous cell esophageal cancer. Studies on optimal treatment sequence in combination therapy are continuing. Although the higher rate of lymph node positive or T4 tumor in the neoadjuvant chemoradıotherapy arm, there was no statistically significant difference in disease-free survival and overall survival in neoadjuvant chemoradiotherapy and adjuvant chemoradiotherapy group.

OP-11

THE EFFECTS OF SERUM MMP2, MMP7, MMP9, TIMP1, VEGF, IL-6 AND IL-8 LEVELS ON CLINICAL STAGE AND PROGNOSIS IN CRC PATIENTS

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CRC is a type of cancer with a high mortality risk. Serum matrix metalloproteinases 2, 7, 9 (MMP 2, MMP 7, MMP 9), tissue matrix metalloproteinase inhibitor 1 (TIMP1), interleukin 6, interleukin 8 and vascular endothelial growth factor (VEGF) are involved in different stages of carcinogenesis. The aim of our study is to evaluate the relationship between serum MMP2, MMP7, MMP9, TIMP1, IL-6, IL-8 and VEGF levels and laboratory parameters and survival in CRC patients at different stages. Also to determine the relation with factors affecting prognosis.

23 male and 13 female chemotherapy naive patients were included in the study. The median age of the patients was 65.4 ± 12.5 years. 20 metastatic patients were classified as "metastatic" and other 16 patients as "non-metastatic". In the metastatic group, VEGF level tended to be more significant than non-metastatic group. (p = 0.089). IL-8, CEA and CA19-9 were significantly higher in the metastatic group than in the non-metastatic group (p = 0.039, p = 0.001, p = 0.007, respectively).

VEGF, IL-6 and IL-8, CEA and CA19-9 were higher in patients with progression than those without progression (p = 0.008; p = 0.011; p = 0.033; p = 0.006; p = 0.017, respectively).

There was a significant positive correlation between MMP 2 and IL-8 (p = 0.02), while there was a tend to be a significant positive correlation with leukocyte value increase (p = 0.08). There was a tend to be a significant negative correlation between MMP 2 and TIMP 1 (p = 0.06). There was a significant positive correlation between MMP7 and MMP2 (p = 0.02), IL-8 (p = 0.004) and VEGF (p = 0.0001) but there was a tend to be a significant negative correlation between MMP7 and IL-6 (p=0.06). There was a negative correlation between MMP7 and TIMP1 and it was close to significant difference (p = 0.06). There was a significant positive correlation between MMP9 and VEGF (p = 0.032), but close to negatively correlated with platelet and LDH (p = 0.08 and p = 0.058, respectively).

There was a tend to a significant negative correlation between TIMP1 and IL-8 (p = 0.08). There was a significant positive correlation between IL-6 level and neutrophil and VEGF (p = 0.035 and p = 0.0001, respectively), while there was a tend to a significant positive correlation between leukocyte levels (p = 0.051).

Increased IL-6 was inversely proportional with significantly decreased PFS (p = 0.033), there was a close significant decrease in OS rate (p = 0.051). Similarly, increased IL-8 was inversely proportional with significantly decreased PFS (p = 0.028), there was a close significant decrease in overall survival (p = 0.051). Increased VEGF were also significantly associated with PFS reduction (p = 0.058).

VEGF tended to be significantly higher in patients with liver metastases than in patients without liver metastases (p = 0.083). CEA and IL-8 were higher in patients with liver metastases than in patients without liver metastases (p = 0.004, p = 0.023, respectively).

OP-12

INVESTIGATING CATALASE AND CARBONIC ANHYDRASE ENZYME ACTIVITIES AND TRACE ELEMENTS LEVELS IN HEPATIC CARCINOMA

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Introduction: Hepatic carcinoma is one of common cancers, which leads to the death of 650,000 people per year worldwide. Previous studies have found that carbonic anhydrase (CA) izozymes are commonly expressed in malignant tumor cells in which they promote tumor growth by contributing to intracellular alkalization and extracellular acidification. However, it is noteworthy that these results are controversial. Also previous study have shown alteration some trace element levels and the weakening of the antioxidant defence system might play a role in the etiopathogenesis of the disease. The aim of this study to the determine activity levels of erythrocyte catalase and carbonic anhydrase enzymes and serum trace elements, heavy metals levels in patients with primary and metastatic hepatic cancer.

Metods: 40 patients with primary and metastatic hepatic cancer and 29 healthy volunteers included in this study. Trace elements and heavy metals (Pb, Cd, Mn, Cu, Mg, Zn, Fe and Co) were determine in serum samples of all study subjects with Atomic Absorption Spectrophotometer (AAS: UNICAM- 929 Spectrophotometer, Unicam Ltd., York Street, Cam- bridge, UK). Erythrocyte samples were prepared to measure catalase and carbonic anhydrase (CA II) enzyme activities.

Results: Patients and control group were similar in terms of age and gender. The patients in the cancer group were between 45-65 years old. There were 32 males and 8 females in the patient group. The individual in control group were between 48-65 years old. There were 23 males and 6 females in the control group. There were 14 patients had primary liver cancer and 26 patients had metastatic liver cancer in patient group. Biochemical parameters for the study group are shown in table 1. Carbonic anhydrase II level were higher in patients with primary and metastatic hepatic cancer in comparison with that of control subjects. Catalase (CAT) levels were lower in the primary and metastatic hepatic cancer groups than in the control group. Also serum iron (Fe), cobalt (Co), cadmium (Cd) and lead (Pb) levels were higher in primary and metastatic liver cancer groups than in control group. On the other hand serum magnesium (Mg), man- ganese (Mn), Zinc (Zn) and Copper (Cu) levels were lower in patient groups than control group.

Discussion and Conclusion: The present results indicate CA(II) levels higher in hepatic carcinoma and therefore might be a useful diagnostic biomarker for hepatic cancer. Also together with weakening of the antioxidant defense system, alteration some serum trace element levels may play a important role in the etiopathogenesis of hepatic cancers.

Table 1. Biochemical parameters of study group

	Primary (n = 14)	*Metastatic (n=26)*	*Control (n = 29)*
CA II (EU/gHb)	0.452±0.0368a*	1.161±0.0401A	0.111±0.00806
CAT (EU/gHb)	16.094±1.774b*	13.599±0.516B	61.480±0.210
Fe (µg/dl)	0.917 ± 0.182c*	0.49 ± 0.0311 C	0.0871 ± 0.009
Mg (µg/dl)	11.711 ± 0.567d *	6.044 ± 0.114 D	23.877 ± 0.418
Mn (µg/dl)	0.047 ± 0.003e *	0.0642 ± 0.00454 E	0.253 ± 0.012
Zn (µg/dl)	0.917 ± 0.083 f*	0.0455 ± 0.0102 F	2.243 ± 0.0339
Cu (µg/dl)	0.953 ± 0.068 g*	2.348 ± 0.032 G	3.231 ± 0.0487
Co (µg/dl)	0.024 ± 0.004 h*	0.211 ± 0.0112 H	0.00571 ± 0.000317
Cd (µg/dl)	0.004 ± 0.00072 k*	0.0619 ± 0.00496 K	0.00056 ± 0.00004
Pb (µg/dl)	0.273 ± 0.035 m*	0.937 ± 0.020 M	0.0587 ± 0.018

OP-13

LONG TERM PROGNOSTIC PATERNS OF NEUROENDOCRINE TUMORS: SINGLE CENTER DATA REGISTRY RESULTS

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Introduction: Well differentiated neuroendocrine tumors are not a homogenous disease group rather they display a spectrum of aggressiveness. While some clinical and pathological features and prognostic factors of neuroendocrine tumors are unique to the site, other characteristics are shared. Besides, due to rarity of this kind of tumors it is difficult to conduct clinical trials with long term follow-up. Data registries might have important impact on treatment guidelines and prognosis of patients. Here, we present the long term follow-up results of neuroendocrine tumor patients of different site of origin.

Method: Between 01. 2012 and 10. 2018, all of the patients who were carrying tumors in neuroendocrine histology with well differentiated characteristics (Low-intermediate grade, less than 20 mitoses per high power field and < 20% Ki-67 index) were retreaved from medical oncology recordings.

Results: In six years period, a total of 76 patients data were registered to a database. Regardless of site of origin, all patients who fullfills the pre-defined histological criteria were included. The most common diagnostic primary sites were mid-gut (31.1%), pancreas (25.7%), unknown primary with liver metastasis (17.6) and lung (13.5%). Median age of diagnosis was 54 (18-74). There were no gender differences. Patient characteristics were outlined in Table 1. In 11.8% (9 cases), there were carcinoid symptoms at the time of diagnosis and 79.7% of cases were having any other symptom. Regarding the diagnostic and surveillance techniques, it was available to make a somatostatin receptor imaging in 60.7% of patients and in 64.6% of patients somatostatin uptake were observed. In 5 patients, radionuclide therapy was applied. Somatostatin receptor antagonist were not recommended for 50% of patients. In rest 50% of the NET cases, 30.6% of them received SSRA in first line; 15.3% in second line and 4.2 in forth line. Octreotide was the choice of treatment in 61.1% of patients and lanreotide was used in 38.9%. In 16.9% of cases, chemotherapy was needed to alleviate disease symptoms. Treatment details were summarized in Table 2. In the global data registry median 30 months follow-up time was recorded (1-198 months). For intend-to treat population (n=51), median follow-up time was 46 months (10-198). At the end follow-up of 43 patients were appropiate for prognostic analyses. Median time to first progression was calculated as 25 months (3-137). Six patients were recorded as exitus and cancer specific mortality was recorded in only three of cases.

Conclusion: This database reveals relevant information regarding epidemiology, current clinical practices and prognosis of NETs in a single center, providing valuable insights that may contribute to understand regional disparities in the incidence, patterns of care and survival. More studies on the commonality and heterogeneity of GEP-NETs are warranted to improve diagnosis efficiencies and treatment outcomes.

Table 1: Patient Characteristics	
Characteristic	
Age, mean (range), yr	54 (18–74)
	No. (%)*
Male sex	38 (50)
Stage at diagnosis	
Localized	257 (48)
Regional	104 (20)
Metastatic	163 (32)
Missing/unknown	6 (1)
Carcinoid syndrome at presentation	9 (11,8)
Any Symptom at Presentation	62 (79.7)
Anatomic distribution	
Midgut	23 (31.1)
Hindgut	4 (5.4)
Lung	10 (13.5)
Pancreatic	19 (25.7)
unknown primary with liver metastasis	13 (17.6)

Table 2: Treatment Characteristics		
Characteristic (n=76)		**No. (%)***
Surgery		
Yes		42 (55.3)
No		34 (44.7)
Radioisotope therapy		
Yes		5 (6.6)
No		67 (88.2)
No data		4 (5.2)
Chemotherapy Choices		
Fluorouracil+streptozocin		3 (3.9)
Capecitabine+temozolomid		2 (3.9)
Single agent temozolomid		3 (2.6)
SSRA Choices		
Octreotide		22 (61.1)
Lanreotide		14 (38.9)
Thyrosine Kinase Inhibitors		
Sunitinib		
First line	6 (7.9)	
Second line	0 (0)	
Everolimus	1 (1.3)	

OP-14

EVALUATION OF DISEASE PERCEPTION IN ONCOLOGICAL PATIENTS WITH GASTROINTESTINAL SYSTEM MALIGNANCIES

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Introduction: Disease perception is a concept that directly affects the experiences, disease course, beliefs, values, coping mechanisms and psychopathologies of patients during disease periods (1). It is also a perception of the meaning and importance of a disease that threatens the health of the individual (2). Each patient forms own "disease presentation model". According to this model, individuals form schemes of disease and life-threatening conditions according to the information from concrete and abstract sources. These are the own thoughts of patients about the symptoms, duration and outcomes of their disease. This model determines whether patients can control their disease, or their beliefs about the efficiency of the treatment to control their symptoms, or whether they will cope with the treatment. Previous studies suggested that disease perception affects the care and treatment of the patients. Disease perception affects coping, adherence to treatment, continuity for oncological treatment, and rehospitalization (2-5).

Aim: The aim of this study is to evaluate the effect of disease perception in cases with gastrointestinal oncological disorder.

Method: This is a comparative, descriptive study. Twenty patients with gastrointestinal system disease that followed-up at the oncology department of a private hospital were included. Data were collected by patient demographic form, comorbidity index, and "Disease Perception Scale" . Chi-square, Kruskall-Wallis and Mann-Whitney U tests were used for the analyses.

Results: Age of the patients were between 19 to 77, male to female ratio was similar, 30% had colon cancer, 95% were taking chemotherapy, 60% were operated, 60% had metastases, 45% were prayed for distraction. Most important cause of the disease was expressed as stress by the participants. Women perceived more symptoms (p=0.005), had higher emotional expression scores, and had higher risk factor scores than men. There were positive associations between disease perceptions in patients with oral treatment (p=0.005), and between disease causes and diseases of patients (p=0.021).

Conclusion: According to our results, interventions for specific worries of patients should be planned and effects of these interventions should be monitored, as well as other parameters that affect disease perception and risk factors.

Poster Presentations

PP-01

APOCYNIN TUMBLED DOXORUBICIN-INDUCED HCT116 CELLS IN APOPTOSIS BY INHIBITING THE EXPRESSION OF P53, XIAP AND BCL-X1

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Background: Colorectal cancer is one of the most resistant cancers to many chemotherapeutic compounds. The mechanism of escape involves colon cancer cell death pathways. The efficacy of the anti cancer drug doxorubicin (Dox) is limited by the dose dependent mortality. Apocynin (Apo), is a methoxy-substituted catechol from *Picrorhiza kurroa* roots. This study examined the sensitizing effect of Apo in Dox treatment human colon cancer carcinoma HCT-116 cells.

Methods: HCT-116 cells were cultured in the presence of Dox (0.5, 1 μM) and /or Apo (1 mM) for 48 h. The viability was assayed by MTT assay. Cells cycle distribution of propidium iodide (PI) stained HCT-116 cells was analyzed by Flow cytometer. Apoptosis was assessed by fluorescein isothiocyanate (FITC)-conjugated annexin V and PI staining of floating and attached cells by flow cytomettry within 1 H. Western blot analysis was performed using β-actine, BCL-xl, p53, XIAP primary antibodies (Santa Cruz).

Results: Our results showed that Dox induced a dose dependent cytotoxicity (IC_{50} 2.32 ± 0.93 μM), and a cell cycle arrest in G2/M phase. Apo combined to Dox reduced the viability $IC_{50}$by 34.4%, but prevented cell cycle arrest. Apo alone had no impact on p53 expression, but down regulated the anti apoptotic proteins XIAP and BCL-xl. This effect persisted in the presence of Dox, and was correlated to increased number of apoptotic HCT-116 cells

Conclusion: Apo could deflect the HCT-116 cells blocked by Dox in G2 / M phase towards the apoptotic pathway through subtle modulatory events that are yet to be decrypted. Thus addition of Apo would be useful in cell sensitization to lower concentrations of Dox, limiting the dose dependent mortality.

PP-02

A NEW SCORING METHOD IN HEPATOCELLULAR CARCINOMA: IS THERE A RELATION BETWEEN "AGRESIVENESS INDEX " AND SURVIVAL?

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Objective: Both hepatic and tumoral factors are important in the prognosis of hepatocellular carcinoma (HCC). Recently, a HCC aggressiveness index was developed that includes the maximum tumor diameter (MTD), the number of tumor nodules, portal venous thrombosis (PVT), and serum alphafetoprotein (AFP) levels (Table 1). These 4 parameters have been suggested to be associated with survival. We planned a study to investigate the association of HCC aggressiveness index with survival in our HCC patients.

Materials and Methods: 113 HCC patients (98 males, 15 females, mean age 63.4 years) were included in our study who were able to access data to be used in the calculation of HCC aggressiveness index. The HCC aggressiveness index including the maximum tumor diameter (MTD), number of tumor nodules, portal venous thrombosis (PVT) and serum alphafetoprotein (AFP) level were calculated for all of our cases (Table 1). The time between the date on which patients received HCC diagnosis and the time of death was calculated and recorded as the survival time. Patients' Child Turcot Pugh (CTP) and MELD scores were calculated. The relationship between HCC aggressiveness index and survival was assessed by cox regression analysis.

Results: The mean age of the patients during diagnosis was 62.7 ± 9.7 for male patients and 66.51 ± 12.4 years for female patients. The HCC aggressiveness index averaged 6.5 ± 1.9 points in males and 5.6 ± 1.4 points in females. There was no significant difference between the two sexes in terms of this index. There was a significant correlation between the age of diagnosis and HCC aggressiveness index ($p < 0.05$). The overall survival time was 351.08 days. In cox regression analysis performed with CTP and MELD, a significant correlation was found between HSK aggressiveness index and survival. ($P < 0.05$). (Figure 1)

Conclusion: Considering the HCC aggressiveness index, including the important parameters about the patient and the tumour, it is advisable to be a predictor of prognosis as a practical calculation system for HCC. More studies are needed in this regard.

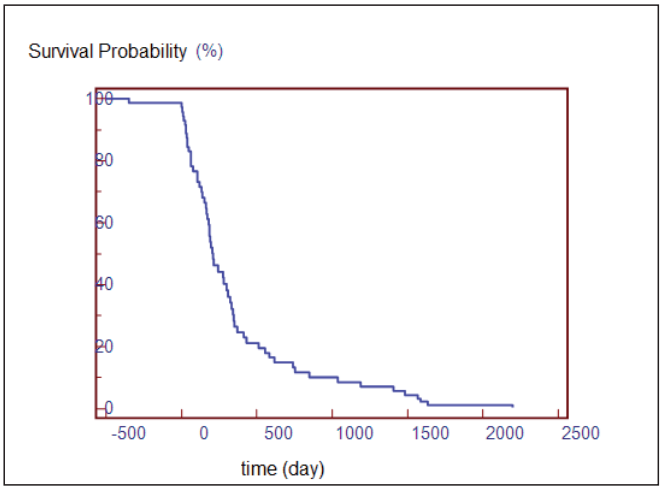

Figure 1.

Table 1.

	score 1	score 2	score 3
Maximum Tumour Diameter(cm)	<4.5	4.5 - 9.6	>9.6
Serum AFP Level (ng / mL)	<100	100 - 1000	>1000
Portal Vein Thrombosis	absent	-	exist
Number of Tumour Nodules	<=3	-	>3

PP-03

CATECHIN MODERATES PROINFLAMMATORY CYTOKINES, NITROSATIVE STRESS AND 5-FLUROURACIL INDUCED EXPERIMENTAL MUCOSITIS

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This study investigated the curative effect of catechin a polyphenolic antioxidant in experimental gastrointestinal mucositis induced in mice by 5-Fluorouracil (5FU), an anti metabolite chemo drug indicated in various adenocarcinoma.

Mice were injected intraperitoneally by 5-FU (75 mg/kg bw) alone (5-FU group), or followed after 18 h by a gavage with catechin (Ctc, 25 mg/kg; Ctc group). Control and Ctc groups received saline or Ctc, respectively. The next day, mice were sacrificed. Blood samples, colons and intestines were recovered and analyzed.

Our main results showed that Ctc improved the features of 5-FU-induced acute systemic and mucosal inflammation by attenuating inflammatory cells influx, CRP, NF-kB, IL-6, TNF-a and myeloperoxidase (MPO) levels. Ctc improved the highly altered mucosa architecture, mucus depletion and kystization of glands. It collapsed mucosal arginase, esterase and MPO activities, and the levels of nitric oxide (NO) and malondialdehyde (MDA, a byproduct of lipid peroxides) related to inflammatory cells infiltrate, and restored moderately catalase (CAT) activity and reduced glutathione (GSH) level.

All together, the results highlighted the efficacy of catechin in modulating seric a pro inflammatory cytokines and mucosal nitro-oxidative stress which could be beneficial in moderating the gastrointestinal side effects of the 5-FU chemo drug.

PP-04

WHAT IS THE RISK OF MALIGNANCY AT NORMAL APPEARING MUCOSA IN LEFT-SIDE ULCERATIVE COLITIS?

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Background: Colorectal malignancy risk is increased in ulcerative colitis patients. The risk is parallel with the extent of diseased colon and the duration. Proliferating cell nuclear antigen (PCNA) and Ki67 activities are known as immunohistochemical markers in proliferating cells. We designed a study to evaluate the differences between normal appearing mucosa and diseased areas in left-side ulcerative colitis patients; in terms of displasia development.

Methods: Totally 20 consecutive patients enrolled in the study whose surveillance biopsies performed in our clinics with the diagnosis of left-side ulcerative colitis. After obtaining informed consent from each patient, a colonoscopy performed and colonic biopsies were taken from the every 10 cms distances from caecum to anal verge. Then, the experienced pathologist investigated the samples according to the presence of inflammation and dysplasia, by means of PCNA (proliferating cell nuclear antigen) and ki67 activities.

Results: For all patients it is observed that the more distal involvement showed the more increased disease activity; macroscopically and microscopically. 12/20 patients showed inflammation in the proximal colonic mucosa samples. No difference found between the proximal and distal samples in terms of Ki67 activities (19.3±29.9 versus 23.4±29.09, p= 0.323). Also, there was no difference between the proximal and distal samples in terms of PCNA. (39.25±25.922 versus 46.25±27.62, p=0.332).

Conclusion: The activity of Ki67 and PCNA found to be similar in normal appearing mucosa and the affected mucosa of patients with distal ulcerative colitis, independent of disease activity. These results showed that, normal appearing mucosa affected by disease histopathologically, and has a proliferation potential similar that of the diseased segment, as well.

PP-05

MULTIMODALITY TREATMENT FOR PERITONEAL MESOTHELIOMA IN TURKEY: A SINGLE CENTER EXPERIENCE

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Introduction: Peritoneal mesothelioma (PM) is a rare pertioneal neoplasm. Cytoreductive surgery and hypertermic intraperitoneal chemotherapy (CRS+HIPEC) is the suggested treatment approach for PM. Systemic treatment has not been shown to improve PM patients' survival. Here, we present our multimodality treatment experience for PM in a single center.

Aim - Method: Between January 2009 and April 2017, thirty-one patients were included to the study. Clinico-pathologic characteristics and treatment outcome of patients were analysed by patients medical records, retrospectively.

Results: A *total of 31 patients* (58% *female, n=18*) with a *median age* of *55.6 years were* evaluated. Sixteen patients (51.6%) underwent surgery, in which 11 patients (35.5%) had CRS+HIPEC. HIPEC was performed with open technique, with a 42°C intraabdominal temperature in 60min duration. Cisplatin (80mg/m^2/l) with mitomycin (12mg/m^2/l) were performed intraperitoneally. In early postoperative period, 3 patients died from sepsis. These patients were diabetic and their preoperative CA125 levels were above 1000 U/ml. Six patients (19.4%) received adjuvant chemotherapy and one patient received neoadjuvant chemotherapy. In the all group, statistically significant OS difference was only achieved in patients treated with adjuvant therapy. Mean OS was 62,5 months (34–90,9 months) in the adjuvant therapy group and 21 months (11,7-31,6 months) in the non-adjuvant therapy group (p=0.03, Fig 1a).

As a first-line systemic chemotherapy, 18 patients (58.1%) treated with cisplatin plus pemetrexed, 4 patients (%12.9) received carboplatin plus pemetrexed. Single agent gemcitabine and gemcitabine with cisplatin were administered in each of 2 patients. Mean PFS and OS of patients that received first line therapy were 6 months (3,2-8,7 months) and 11,3 months (5,3-17,3 months), respectively. Second-line chemotherapies were gemcitabine (n=3), cisplatin plus pemetrexed (n=1) and pemetrexed (n=1). Patients who received second line chemotherapy achieved numerically longer mean OS (50,8 months (18,8-82,7 months) vs 21,6 months (9,9-33,4 months) (p=0.123, Fig.1b).

Conclusion: Our results showed that adjuvant chemotherapy improves OS for patients with PM who underwent CRS+HIPEC. However, multimodality treatment should be carefully evaluated in patients with PM who had diabetes mellitus and pre-op CA125 levels above 1000 IU/ml.

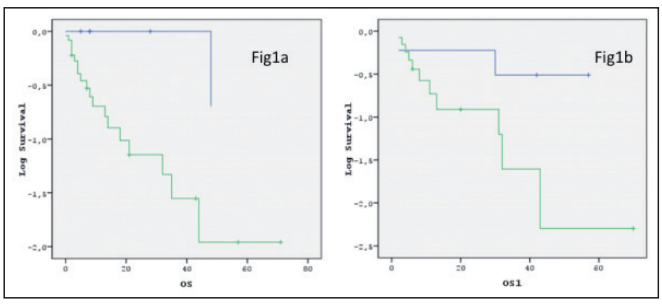

Figure 1.

PP-06

PROGNOSTIC FACTORS FOR PATIENTS WITH ESOPHAGEAL CANCER FOLLOWING RADIOTHERAPY

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Aim: To evaluate long-term outcomes and prognostic factors for esophageal carcinoma treated with radiotherapy (RT) or chemo-radiotherapy (CRT) at the Department of Radiation Oncology, Eskisehir Osmangazi University Hospital between 2006-2017.

Patients and Methods: Forty-eight patients with non-metastatic and pathologically confirmed squamous cell carcinoma (SCC) or adenocarcinoma (AC) who received RT, with or without chemotherapy (CT) and surgery were enrolled in the study. RT was delivered in daily fractions of 1.8 Gy to a total dose of median 50,4 Gy (range: 45-70,2). In univariate analyses, the Kaplan–Meier method was applied to estimate overall survival (OS) and PFS for various group partitions. The categorical variables between groups were compared using Pearson's Chi square test. For all tests, a P-value of <0.05 was considered statistically significant.

Results: There were 48 patients, with a median age of 57 years. Table-1 summarized the patient and tumor characteristics .There were 10 (20,8%) patients receiving adjuvant radiotherapy, 38 (79,2%) patients receiving definitive or neoadjuvant RT. Thirty-two patients (66,7%) received CRT. The median follow-up from the end of RT was 18 (range: 2-106) months. Eighteen of 38 (47%) patients with neoadjuvant or definitive RT had complete response. Fourteen of the cases with complete response received CRT. During follow-up, distant metastases developed in 13 patients. The most common metastatic site was the lung. Univariate analyses showed that female gender and surgical treatment improved OS (p= 0,027 and p =0,044). OS for women was 89± 11 months and for males it was 56 ± 11 months. OS was 81± 12 in cases undergoing surgery, and 57 ±10 months in cases without surgery. T stage (chi-square test =6,83 and p=0,001) were associated with complete response.

Discussion: In accordance with our results, several other studies have shown that advanced T stage is a strong indicator for a poor prognosis (1-2). With a median OS of 18 months, our results are well in line, as the cohort included 47,9% of patients with T4 stage. Preoperative CRT followed by surgery is the most common approach for patients with resectable esophageal cancer.In this study, the addition of curative surgery increased overall survival.

Conclusion: Advanced T stage is a strong indicator for a poor prognosis. We know that adding surgery to CRT reduces locoregional recurrence. In this study, the addition of curative surgery to CRT increased overall survival.

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Table 1. Patient and Tumor Characteristics

Age(y):	57(43-80)
Sex (n): Female / Male	21(43,8%) / 37(56,2%)
KPS (n): ≥80 / <80	22(45,8%) / 26(54,2%)
T Stage (n): T2 / T3 / T4	1(2,1%) / 24(50%) / 23(47,9%)
N Stage(n): N+ / N-	14(29,2%) / 34(70,8%)
Histopathology(n): SCC / AC	42(%87,5) / 6(10,4%)
Tumor Site(n): Upper / Middle / Lower	15(31,3%) / 10(20,8%) / 23(47,9%)

PP-07

A RARE HORMONE POSITIVE TUMOR DETECTED IN PREGNANCY: AGGRESIVE ANGIOMYXOMA

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Background: Aggressive angiomyxoma(AA), is a very rare gynecologic tumor. As a slow-growing mesenchymal neoplasm, AA tends to locally infiltrate and recur. AA presents a strong female predominance, with a female-to-male ratio of approximately 6:1, and often arises from the female pelvis-perineum region. Most of these tumors Show estrogen and progesterone receptor positive and likely to be hormone dependent.

Case: A 22-year-old female patient was 8 weeks pregnant while a cystic lesion was detected in the perirectal area 200x100 mm. In the control, the fetus was found to have no heartbeat and the pregnancy terminated. The mass in the perirectal area was totally excised. Pathology result was aggressive angiomyxoma. Immunohistochemistry results desmin, estrogen, and progesterone receptor, SMA and EMA were positively detected. The patient was admitted to our clinic with a delay of 3 months due to post-operative wound infection. Local recurrence was detected in pelvic MR at 3 months postoperatively. The recurrence mass was unresectable and started GnRH analog for neoadjuvant purposes. Follow-up surgery was planned to the response status.

Conclusion: Surgery is the first choice of the treatment for both of the primary and recurrent cases, aiming to remove the tumors completely on the premise that the genital anatomy and the functions of the pelvic organs weren't impaired seriously. GnRH analogs can inject for adjuvant or neoadjuvant treatment. The present case confirms that AA is locally aggressive and notorious for local recurrence.

PP-08

BREAST CANCER METASTASIS TO RECTUM

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Introduction: Gastrointestinal, especially rectal metastasis in breast cancer is uncommon. Here we presented a case with breast cancer metastased to the rectum.

Case: A 60-year-old female complained from a 6-month history of change in bowel habits and rectal pain. She had a history of breast cancer 15 years ago. She was performed right modified mastectomy and axillary lymph dissection. She was administered 6 course of chemotherapy and then she was given 5 years of tamoxifen. She was in remission on her last control examination 9 months ago. For her complaints she applied to gastroenterologist and colonoscopy was performed. Colonoscopy showed a lesion in the distal rectum causing luminal narrowing (Fig. 1). Biopsy was done and the result was non-diagnostic. Although pathology was not consistent with malignancy, the initial clinical impression was that of primary rectal carcinoma. Furthermore the staging CT scan of the thorax and abdomen was performed which revealed a 4 cm segment of diffuse wall thickening in the rectum. Then biopsy was repeated and the pathology revealed that it was malign epithelial carcinoma. Immunohistochemical stains showed the tumor cells were positive for cytokeratin 7, GATA-3, estrogen receptor (ER), and progesterone receptor (PR). Otherwise it was negative for CEA, cytokeratin 20, CDX-2, and C-erb B2. FDG-PET was performed and it showed that

there were multiple skeletal metastasis and rectal involvement (Fig. 2). The patient was planned to undergo palliative radiotherapy and to start hormonal therapy with letrozole.

Conclusion: Altered bowel habits or other abdominal symptoms should suggest for potential metastasis to the rectum in a patient with a history of breast cancer. Histopathological and immunohistochemical examination of rectal biopsies is crucial for diagnosis.

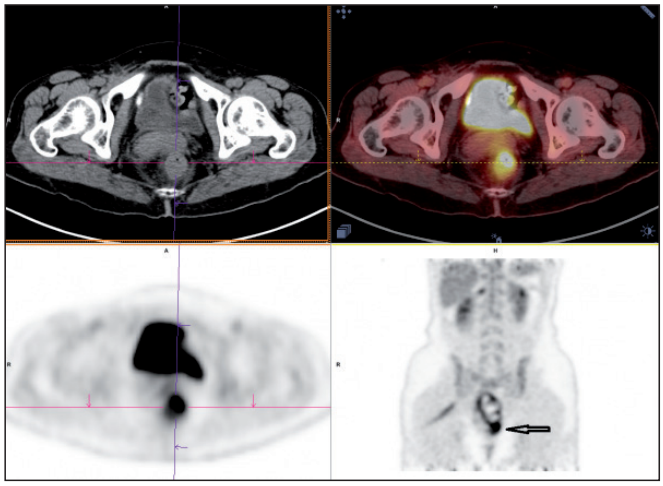

Figure 1.

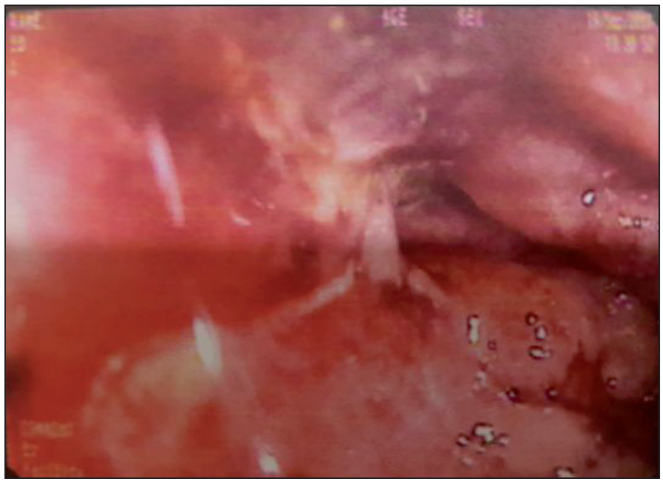

Figure 2.

PP-09

FOLFIRINOX FOR ADVANCED PANCREATIC CANCER: SINGLE CENTER RETROSPECTIVE STUDY

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Metastatic pancreatic cancer (mpc) is one of the most aggressive and is the 4th leading cause ofcancer related death worldwide [1]. Most of patients presenting of pancreatic carcinoma have locally advanced, or metastatic disease at diagnosis[2]

Numerous randomized trials conducted since the 1990s have attempted to build on single-agent therapy, with litle improvements in survival. Given poor prognosis and limited effective treatment options, there is a significant unmet medical need for an improved treatment regimen.The accord 11/0402 phase ii/iii clinical trial, conducted by the prodige group of the Fédération Nationale des Centres de Lutte Contre le Cancer, generated results that provide support for folfirinoxchemotherapy [5-fluorouracil (5fu), leucovorin, irinotecan, oxaliplatin] as first-line treatment in mpcpatients[8]. A substantial impact of folfirinox was demonstrated with respect to the trial's primary endpoint of os and secondary endpoints of progression-free survival (pfs) and quality of life (qol). Median os was 11.1 months in patients treated with folfirinox, compared with 6.8 months in patients treated with gemcitabine monotherapy ($p < 0.0001$)[8].

Methods: We reviewed all patients with LAPC or MPC treated with FOLFIRINOX in our institution between January 2014 and December 2016. All of patients received FOLFIRINOX as first-line treatment for metastatic or locally advanced disease. 9 patients with LAPC and MPC were treated with FOLFIRINOX. All patients were treated with at least 6 cycle of FOLFIRINOX.

Median age of patients initiating treatment was 64 years (range 28–76), 4 male 5 female patients.

Results and conclusion: All patients received 6 cycles of FOLFİRİNOX as a first line of treatment. 2 patients had stable disease after 6 cycles ,others had partial remission according to RECIST criteria. None of the patients had grade 3-4 toxicities.

Based on the outcomes of this study, FOLFIRINOX shows relatively high response rates and a promising with acceptable toxicity rates. limitations of this study is its retrospective design, which may lead to selection bias. A second limitation is the small number of patients.

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Table 1. Demographics and baseline characteristics of patients

Patients Caracteristics	
Median age at diagnosis in years	64 (38-69)
Sex Male	4
Female	5
ECOG PS 0	1
ECOG PS 1	3
ECOG PS 2	5
Bilirubin at start of treatment < 1.5 UNL	5
Bilirubin at start of treatment > 1.5 UNL	4
Location Proximal	8
Location Distal	1

PP-10

RESPONSE WITH PANITUMUMAB IN CETUXIMAB RESISTANCE: A CASE REPORT

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Anti-Egfr (cetuximab-panitumumab) treatment provides with the advantage of chemotherapy-assisted survival, in patients with metastatic colorectal cancer with wild-type histomorphology. Presence of cross-resistance after treatment with anti-EGFR is not fully known. We described pan-RAS wild type patient who responded with panitumumab combination progressing after cetuximab combination therapy.

NH, 71 y, women, had been diagnosed with multipl hepatic and pulmonary metastases caused by primary recto-sigmoidal can-

cer. Molecular examinations revealed pan-Ras and B-Raf wild type histo-morphology.After oxaliplatin / irinotecan 5-FU-leucovirin-cetuximab/bevacizumab combination therapy for 42 monts, she received regarofenib for four months and raltitrexed for 3 months The patient was treated with panitumumab-irinotecan-5-fu-leucovirin for 6 months with objective response. Finally she had progression in pulmonary metastases and was died at the end 5 years from diagnosis of metastatic colorectal cancer.

Existing studies have demonstrated that among colorectal cancer patients with wild-type KRAS, harboring mutations of BRAF, PIK3CA, NRAS, or PTEN-null may demonstrate resistance to anti-EGFR-targeted therapy, and biomarkers detection can provide better-personalized treatment for mCRC patients.

Panitumumab response can be observed when cetuximab resistance develops with some mutations. For example; an established mutation in the EGFR ectodomain S492R imparts resistance to cetuximab,yet strikingly remains responsive to panitumumab.

In this case despite of cetuximab resistance was developped, the patient had responded panitumumab combination therapy for six months.

PP-11

RESULTS OF POSTOPERATIVE ADJUVAN CHEMORADIOTHERAP IN GASTRIC CANCER: SINGLE CENTER EXPERIENCE

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Introduction: Despite the increased resectability rates of gastric cancer in recent years, the 5-year survival rates range from 8% to 26% with surgery alone.postoperative radiochemotherapy has been shown to provide the survival advantage of in high-risk operated gastric cancer patients. In this study, our patients with gastric cancer receiving adjuvant chemoradiotherapy after surgery were evaluated retrospectively.

Methods: Forty patients who underwent adjuvant chemoradiotherapy at the Adnan Menderes University oncology clinic between January 2012-2017 were retrospectively studied.Postoperative adjuvant chemoradiotherapy was recommended to patients with T3-T4 tumor , lymph node metastasis, surgical margin positive or inadequate resection . Patients received 2 cycles of ECF(epirubicin 30 mg / m 2, cisplatin 50 mg / m 2, 5 fluorouracil (5-FU) 1000 mg / m 2, and folinic acid 200 mg / m 2) or FU FA followed by radiotherapy and then 2 more cycles ECF.

Results: 31 of the patients were male (77.5%), 9 were female (22.5%). The median age was 61 (38-79) years. Histopathologic examination revealed adenocarcinoma morphology in all patients and ring cell carcinoma in 12 patients (30%) as subtype. When the differentiation grades were evaluated, 7 patients had good differentiation (17.5%), 15 patients had moderate differentiation (37.5%) and 17 patients had poor differentiation (42.5%) and one patient's tumor differentiation data could not be reached.Thirteen patients (32.5%) had proximal tumors, 27 of them had corpus and distal location. Thirty-one patients had subtotal (52.4%) and 19 patients (47.5%) gastrectomy. According to tumor stage, 1 patient was T1 (2.7%), 13 patients were T2 (35.1%), 19 patients were T3 (51.4%) and 4 patients were T4 (10.8%). 77.4% of the patients were node positive. When the chemotherapy regimens they received were evaluated, 36 patients received ECF (90%), 3 patients received cisplatin + 5 FU (7.5%) and 1 patient received FU-FA regimen (2.5%). 67.5% of the patients received external radiotherapy. Distant organ metastasis developed in local recurrences (10%) and in 13 patients (32.5%) in 4 patients with median follow-up of 15 months (5-60 months). 13 of the patients received second line chemotherapy. During the follow-up period, 11 of the patients were lost. Survival-related parameters were tumor stage and number of metastatic lymph nodes. Two-year total survival was 67%

Discussion: Adjuvant chemoradiotherapy is a standard treatment in patients with high gastric adenocarcinoma. The results are consistent with the literature

PP-12

A VERY RARE TUMOR OF GALLBLADDER: SCHWANNOMA

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Background: Schwannomas occurring in the gallbladder are extremely rare. Preoperative diagnosis of gallbladder schwannomas appears to be very difficult because they are normally asymptomatic and are often found incidentally. Gallbladder schwannoma, a benign tumor derived from the Schwann's cells in the gallbladder wall. We report such an extremely rare case of schwannoma of the gallbladder, which was treated by laparoscopic cholecystectomy under the diagnosis of cholecystolithiasis.

Case: A 67-year-old man, presented with recurrent episodes of right hypochondralgia for many years, admitted to surgery department of our hospital under the diagnosis of cholecystolithiasis. Ultrasonography showed high echoic lesions in the gallbladder. A laparoscopic cholecystectomy was performed. The gross specimen showed a 1 mm-sized, well-circumscribed, localized mass, which was surrounded by a fibrous capsule. Microscopic examination revealed that the tumor mainly consisted of spindle-shaped cells; neither atypical cells nor signs of malignancy were found. Immunohistochemical staining showed a strong positive S-100 protein reaction, whereas c-kit and Desmin were negative. The final diagnosis of gallbladder schwannoma was made. The patient was followed up postoperatively.

Conclusion: Schwannomas of the gallbladder can be successfully treated surgically. The treatment of choice is cholecystectomy due to the diagnostic uncertainty before surgery, even with an extensive application of various imaging modalities. Generally detected incidentally patient who has operated any cause.

PP-13

A CASE REPORT OF PRIMARY LUNG CANCER AND RECTAL CANCER METASTASIS COEXISTENCE IN LUNG METASTASECTOMY

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Introduction: Primary lung cancer and rectal cancer metastasis coexistence in lung metastasectomy in local-advanced rectum cancer patients are rare in the literature. We aimed to present our case in this context.

Findings: A 63-year-old male patient who admitted because of hematochezia underwent rectoscopy and a rectal mass was detected from the 10th cm to the 16th cm. PET-CT was performed for staging. PET-CT showed pathologic FDG uptake only in the rectal mass. Then the neo-adjuvant chemoradiotherapy was started on the patient. After chemoradiotherapy, 2 cycles of chemotherapy were given on the FOLFOX6 protocol, and then a low anterior resection and lymph node dissection was performed on April 28, 2015. Moderate

differentiation adenocarcinoma, ypT3N0Mx, TRG 3/5 (according to Mandard), 1 reactive lymph node found on the pathological examination. Post-op adjuvant chemotherapy was administered 5 more times in the FOLFOX6 protocol. Adjuvant chemotherapy was completed and patient was obtained for untreated follow-up. In the thorax CT taken at the 16th month of untreated follow-up, two nodules were observed in the lower lobe of the right lung. One was in the posterobasal segment and the other one was in the superior segment which were 10.5*8.5 mm and 8 mm respectively. The patient with a 45-year smoking history in his background was referred to the thoracic surgery for the sample. On May 11, 2017, wedge resection was performed for the nodule which was located on the posterobasal segment and right lower lobe superior segmentectomy was performed for the other nodule by thoracic surgeon. In the pathology report, the nodule extracted by wedge resection was interpreted as colon adenocarcinoma metastasis, whereas the nodule extracted by superior segmentectomy was reported as primary lung adenocarcinoma.

Conclusion: The possibility of second primary cancer should always be kept in mind in patients with rectal cancer. It should be considered that the newly developed lung nodules in patients with the history of intense cigarette smoking, as well as our case, may belong to primary lung cancer before they are interpreted as rectal cancer metastasis. These patients should be referred to surgical units for sampling at appropriate cases.

PP-14

STEVENS-JOHNSON SYNDROME INDUCED BY REGORAFENIB USE IN A PATIENT WITH METASTATIC COLORECTAL CANCER

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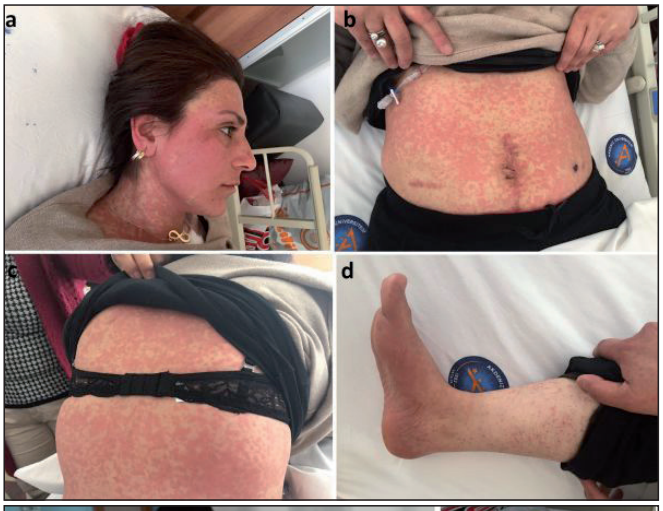
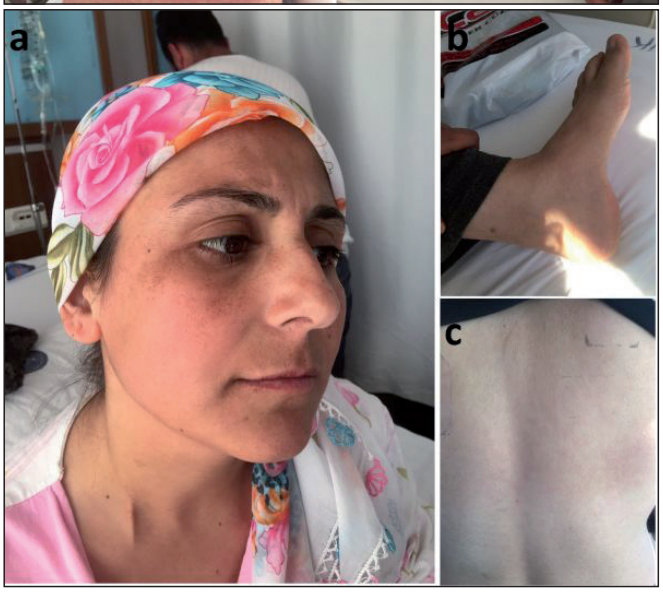
Introduction: Colorectal cancer is the second most common cause of cancer-related deaths and 25% of patients are diagnosed with metastatic disease. Regorafenib was demonstrated to prolong PFS and OS in patients with metastatic colorectal cancer. Stevens-Johnson syndrome (SJS) is a type IV hypersensitivity reaction, which may have a mortal clinical course. Many different drugs may cause SJS, and regorafenib was rarely reported as a cause. To our knowledge, this is the first case reported from Turkey.

Case report: A 33-year-old female patient was operated on March 2014 for a rectosigmoid tumor. She had a pT4aN2bM0 tumor and received adjuvant XELOX. Adjuvant radiotherapy was not administered. Between 2015 and 2017, as a RAS mutant patient with recurrent metastatic disease, she was treated with FOLFIRI+bevacizumab and FOLFOX+bevacizumab. Regorafenib was started as a third-line treatment for the patient with stage IV colorectal cancer. On the 12th day of treatment, she developed periorbital edema and erythematous plaques developed covering the whole body. Oral mucosal lesions with crusting and macular lesions about 1 centimeters were seen on lower limbs (Figure 1). Bullous areas occasionally developed on the described lesions. Regorafenib was stopped. Biopsies were taken from peribullous areas was compatible with erythema multiforme, whereas perilesional areas were negative with immunofluorescence examination. Methylprednisolone was administered (1 mg/kg intravenously for 5 days) and was tapered over in 15 days. On the 4th day of treatment, all lesions significantly regressed (Figure 2). Patient opted out of further treatment and was followed up with palliative support. She died due to tumor burden in June 2017.

Discussion: Fluoropyrimidine, oxaliplatin and irinotecan are the basis of cytotoxic treatment in metastatic colorectal cancer. However, molecular targeting therapies prolong survival. Regorafenib is a multikinase inhibitor that inhibits growth factors associated with tumor microcirculation and mutant oncogenic kinases KIT, RET and BRAF, which are key players in the oncogenic pathway. CORRECT and CONCUR phase III trials have shown regorafenib has PFS and OS benefit in patients with metastatic colorectal cancer. Most common side effects are fatigue, loss of appetite, hand-foot syndrome, diarrhea and hypertension. SJS is a type IV hypersensitivity reaction, which may have a mortal clinical course, presents as mucocutaneous blistering and sloughing. Although its has an incidence of 1 to 2 cases per million, mortality rate is very high when it progresses to toxic epidermal necrolysis. Many different drugs may cause SJS, such as antibiotics, NSAIDs and anticonvulsants. Clinicians should keep in mind that SJS may develop in patients treated with regorafenib, this rarely seen but highly mortal condition should be closely followed-up at the beginning of symptoms.





PP-15

A RARE CASE OF HEPATOCELLULAR CARCINOMA WITH 5 YEAR SURVIVAL.

Burcu Çakar[1], Serkan Yıldırım[1], Cengiz Yılmaz[1], Sevgi Topcu[1], Rüchan Uslu[1], Bülent Karabulut[1]

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Background: Hepatocellular cancer (HCC) is primary tumor of the liver that usually develops in the setting of chronic liver disease. Most patients presented to clinics in inoperable state and the prognosis is generally poor despite local ablative treatment modalities and

systemic chemotherapy options. Here, we represent a hepatocellular carcinoma patient with 63 months overall survival.

Method: 67 years old man was diagnosed as HCC after an abdominal ultrasonography for checkup. The patient had a right lobe liver resection in Feb.2011.The pathology revealed a tumor with 8.7 cm diameter with solid and trabecular pattern. As there was no evidence of disease, the patient started his follow-up controls in our oncology clinic. Hepatit markers were negative, he had no liver disease in his medical history. In 6 months, two new lesions appeared in the liver which was evaluated as inoperable by surgeons. Serum alpha fetoprotein level was normal. Transarterial chemoembolization(TACE) was applied in 2 sessions and afterwards sorafenib 800 mg/day was started. The only adverse events was grade 2 oedema during sorafenib. After 16 months on treatment, one liver lesion showed progression which was not suitable for TACE. In 25 months, the liver metastasis showed a marked increase and the treatment switched to regorafenib.

Result: The patient had tolerated the drug well without any grade 3-4 events and is still on treatment with stable disease with 63 months survival.

Conclusion: Although different treatment modalities in HCC, 5- year survival rate is approximately 10% for these patients. Reintroducing the systemic treatments in early phase of local ablative treatments may result with better outcomes in these patients. In our case, we could reach 5.2 year survival with standart treatment methods.

PP-16

A RARE CASE OF PERITONEAL METASTASIS FROM HEPATOCELLÜLER CARCINOMA

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İntrodiction: Hepatocellular carcinoma (HCC) is an aggressive tumor that often occurs in the setting of chronic liver disease and cirrhosis. There are many treatment options in HCC, including liver transplantation. Liver transplantation provides the best chance of cure for patients with HCC and liver cirrhosis. Despite liver transplantation, disease recurrence occurs in 10-60% of patients.

Case Presentation: A 63-year-old man was admitted to our hospital for treatment of HCC and its peritoneal metastasis.He had a history of liver transplantation for HCC which occurs in the setting of cirrhosis due to HBV seven years ago. At that time, a percutaneous tumor biopsy was performed, and the pathological diagnosis was hepatocellular carcinoma. Immunsupresive and anti-viral drugs were used after liver tranasplantation. He had no symptoms, and on physical examination, a tumor was not palpable at the 7 year after tranasplatation.But contrast-enhanced computed tomography (CT) showed a 45 mm diamatter soft tissue which is born of peritoneum. This lesion was extracapsular localized and near the segment 8 of liver. The soft tissue lesion was evaluated as recurrence and surgically excised; and the pathological diagnosis was well differentiated hepatocellular carcinoma. The patient is followed without treatment for 3 months because there is no residue after resection,

Discussion: Distant metastasis from HCC is relatively rare. Lung, lymph node, bone, and adrenal are frequently the organs of metastasis. Peritoneal recurrences of HCC are uncommon (2%). The causes of peritoneal metastasis are a history of tumor biopsy or local therapy and spontaneous hemorrhage of HCC. In this case, the cause of peritoneal metastasis was considered the history of tumor biopsy.

PP-17

A CASE OF CARCINOID SYNDROME CONTROLLED BY HIGH DOSE OCTREOTIDE

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Introduction: Carcinoid syndrome is often seen in patients with metastatic disease or patients whose tumor secretes amines directly to the systemic circulation from the primary tumor site without undergoing enterohepatic circulation. Patients with carcinoid syndrome often have flushing, diarrhea and abdominal pain, but less frequently with telangiectasia, bronchospasm and heart valve disease and rarely pellagra. Somatostatin analogs are used effectively in the treatment of patients with carcinoid syndrome.

Case: In July 2014, a 59-year-old male patient is admitted to the emergency department with a complaint of epigastric pain and diarrhea. After symptomatic treatment is directed to the outpatient clinic. It was learned from the patient's past medical history that he had an operation in 2009 due to lung carcinoid tumor. Physical examination findings are facial redness, incision on the left side of the back, 2/6 murmur in the mesocardiac focus, no breath sounds on the left side, increased intestinal voices and palpable liver edge below the right costal margin. In abdominal MRI, multiple metastatic lesions in the liver and 2 cm mass in the left adrenal were shown. Endoscopy was performed, no tumor was detected. On colonoscopy, polypoid lesions were excised. Hyperplastic polyp and tubulovillous adenoma were found. PET/CT showed no evidence of hypermetabolic involvement in the liver, 18 mm diameter nodular lesion in the left adrenal gland and calcification lesion area in the prostate gland had slightly hypermetabolic. In the blood tests CgA> 500 ng / ml and CEA: 23,68 ng / ml were high; ACTH and PSA were normal. A high level of 5-HIAA was detected in the 24-hour urine. The liver biopsy was reported as grade II neuroendocrine tumor metastasis according to the 2010 WHO classification. Two cycles of cisplatin and etoposide were administered. In November 2014, response was evaluated by PET/CT. Apart from a significant increase in the left adrenal gland, stable disease was detected. The treatment was continued for 3 cycles with weekly carboplatin and paclitaxel plus octreotide LAR 20 mg monthly. Post-treatment PET/CT evaluation was stable disease so patient was followed with monthly octreotide LAR 30 mg. In October 2016 he applied with diarrhea like water 3-5 times a day, distention, gas and flushing complaints. CgA>500 ng/ml (diluted: 9852 ng / ml) was revealed. After getting approval from the authority off-label useage of monthly 60 mg octreotide was started.

Conclusion: In carcinoid syndrome, long-acting form of octreotide or lanreotide is used in order of 20-30 mg or 120 mg monthly doses. Another somatostatin analogue, pasireotide, has been studied in carcinoid syndrome, but the indication is currently absent. If symptoms can not be controlled in carcinoid syndrome, high dose octreotide (40-60 mg) can be used monthly or telotristat etiprate which inhibits tryptophan hydroxylase, may be added to somatostatin analogues.

PP-18

A COMPLETE RADIOLOGIC RESPONSE WITH FOLFOX PLUS PANITIMUMAB IN YOUNG LIVER METASTATIC RECTUM CANCER

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Background: Colorectal cancer (CRC) is one of the most common malignancies worldwide and continues to be one of the leading causes of cancer-related death globally. The liver is the most common site of metastasis from CRC. The majority of patients with liver metastases from primary CRC have the non-resectable disease.The combination chemotherapy with anti-EGFR or anti-VEGF agents has become the standard first-line treatment for patients with metastatic colorectal cancer. We report a case of the patient with a complete response to treatment with FOLFOX and Panitumumab in a patient with metastatic rectum cancer.

Case: A 38-year-old man was referred to our hospital because of rectal bleeding. Abdominal computed tomography(CT) and colonoscopy revealed rectum cancer with multiple liver metastases. Biopsy result was adenocarcinoma. K-RAS and N-RAS result was wild type. The patient received six courses of FOLFOX plus Panitimumab, and CT showed a nearly complete response of the liver metastases and there was radiologic and endoscopic complete response in the rectum. Surgery planned for two residual lesions in the liver.

Conclusion: The combination chemotherapy with anti-EGFR or anti-VEGF agents has become the standard first-line treatment for patients with metastatic colorectal cancer. Surgical resection should be considered for patients with initially unresectable rectum cancer with liver metastases if systemic chemotherapy is effective.

PP-19

METACHRONOUS ESOPHAGUS NEUROENDOCRINE CARCINOMA AND LIP SQUAMOUS CARCINOMA: A RARE CASE

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Introduction: Neuroendocrine tumors (NET) are a heterogeneous group of intense neuroendocrine secretory granules. It is often gastroenteropancreatic and pulmonary origin, but rarely may also originate from esophagus. We report a metachronous esophagus NET patient who was in follow-up period because of lip squamous cancer.

Case: A 72-year-old female patient was admitted to medical oncology clinic with complaints of dysphagia and weight loss in 2016 April. In past medical history patient was diagnosed with early stage non-keratinized squamous cell carcinoma due to mass in lower lip in 2013 September. Esophagogastroscopy was performed. A ulceroinfiltran mass was revealed in size of 20 to 25 mm in the middle of the esophagus. Biopsy was proven the esophageal neuroendocrine carcinoma. In biochemical examination 5-hydroxyindole acetic acid in 24-hour urine and serum chromogranin A levels were revealed high. Conglomerate lymph nodes at the level of esophagogastric junction were detected in abdominal MRI. In the case, cisplatin - etoposide chemotherapy was started with monthly lanreotide. After three cycles of chemotherapy, control abdominal MR was normal. The patient refused to take 3 more cycles of chemotherapy, but continued monthly lanreotide injections. In July 2017 patient came with complaint of dyspnea. Total collapse in the left lower lobe due to a malignant mass in size of 5 × 3.5 cm in the subcarinal area and pleural effusion was detected in thorax CT. The bronchoscopic biopsy showed small cell lung cancer so cisplatin etoposide chemotherapy restarted. After one cycle of chemotherapy patient was improved clinically.

Conclusion: In our case, developing dysphagia might be thought of metastases of the primary head and neck tumor when conglomerate para-esophageal lymph nodes were seen in abdominal imaging. If endoscopy was not performed metacron tumor could be missed. Two or more primary tumors are rarely detected in the same case, but careful attention should be paid to the synchronous tumors at the beginning or metachronous tumors in the posttreatment follow-up. Neuroendocrine tumors can transform into small cell carcinomas. In the case of rapid progression biopsy must be considered and chemotherapy should be started at the earliest stage. Especially in case of clinical suspicion, diagnostic sampling should be done even if metastasis is reported by imaging methods in highly vascular organs such as lungs and liver.

PP-20

LEPTOMENINGEAL METASTASIS: AN UNUSUAL METASTAS OF RECTUM CANCER

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Background: Leptomeningeal carcinomatosis (LMC) is defined as seeding of the meninges and the subarachnoid space by malignant cells. Gastrointestinal cancers are responsible for 4% to 14% of cases of LMC. Colorectal carcinoma (CRC) spreading to the leptomeninges is even a rarer occurrence.

Case: A 51-year-old man was diagnosed with local advance adenocarcinoma of the rectum. Chemoradiotherapy was recommended by the multidisciplinary team. After chemoradiotherapy, he underwent an uncomplicated low anterior resection. The postop stage was T3N2M0. He received adjuvant chemotherapy after surgery. Local recurrence was occurrence one year after surgery. Then was operated for relapse. One year after local recurrence liver metastasis was an occurrence. He received two line chemotherapy in the metastatic setting(FOLFİRİ and FOLFOX plus Panitumumab). After 3 months FOLFOX plus Panitumumab treatment, he complained double vision. Cranial MR was normal. Based on the cytological detection of tumor cells in the cerebrospinal fluid, a leptomeningeal carcinomatosis was diagnosed, despite normal findings on MRI. Then intrathecal chemotherapy with methotrexate was performed. The patient died 3 months after diagnosis.

Conclusion: Most patients with this type of cancer have a poor prognosis. Its clinical manifestation is highly variable, presenting as radicular pain with or without neurological deficits, as well as with headaches and hallucinatory irritation symptoms or visual problems. Treatment of Leptomeningeal carcinomatosis is radiotherapy, intrathecal and systemic chemotherapy. Despite treatment prognosis poor.

PP-21

ORAL CAVITY METASTASIS OF COLON CANCER: A RARE CASE PRESENTATION

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Introduction: Colorectal cancer is the most common gastrointestinal cancer worldwide. It is the third most common cancer and the fourth leading cause of cancer-related death. 5-year overall survival is mostly depends on stage of disease. While overall survival rate is 90% for localized disease, it decreases below 15% for stage 4 disease. Also metastasis site is effective on survival. In cases with lung only metastasis overall survival is better than liver only metastasis, but cases with peritoneal metastasis have the worst prognosis. In the literature oral cavity metastasis of colon cancer is rarely reported. Here we want to present a case with oral cavity metastasis occurred while having treatment for metastatic colon cancer.

Case report: A 54-year-old, ECOG performance status 1, male patient had a transurethral prostatectomy on September 2015 in an outer center for a prostatic mass lesion. The pathology was reported as prostatic adenocarcinoma. Computerized tomography of abdomen revealed metastatic lesions in the liver. The biopsy of the mass lesion observed in colonoscopic evaluation in November 2015 is reported as adenocarcinoma. We performed a thorax-abdomen computerized tomography for staging of the patient and established multiple metastases of the lungs and liver. Because the evaluation of KRAS, NRAS, and BRAF mutations will take a long time, we initiated irinotecan, calcium folinate, 5-FU, and bevacizumab for the first line treatment of the patient. A colostomy operation was performed because of colon perforation occurred after 15 days receiving the third chemotherapy. After the operation mutation analysis was reported to be wild type for KRAS, NRAS, and BRAF. Bevacizumab was removed and cetuximab was added to the treatment of the patient. After ten days from the fifth administration of this regimen, due to deep vein thrombosis of left forearm, bemiparin was initiated. Partial response was achieved at the end of sixth cycle, and the treatment was prolonged for three cycles. Stable disease was observed after third cycle, and another three cycles was planned. The patient preferred oral treatment and we switched to capecitabine, irinotecan and cetuximab. After third cycle a swelling was occurred at the left cheek of the patient. Ear nose throat professionals obtained a punch biopsy from the mass lesion in the mouth of the patient. The pathology was reported as colon carcinoma metastasis. After this report, oxaliplatin, calcium folinate, 5-FU, and bevacizumab regimen was initiated. The follow up of the patient who received third cycle of this regimen is ongoing.

Conclusion: Metachronous metastasis of colorectal cancer to oral cavity is a very rare situation with a poor prognosis. A biopsy should always be considered for accurate diagnosis. These cases usually are not candidates for surgery and surgery may be considered for only palliation. Although chemotherapy is administered in these cases, overall survival is not longer than 8 months.

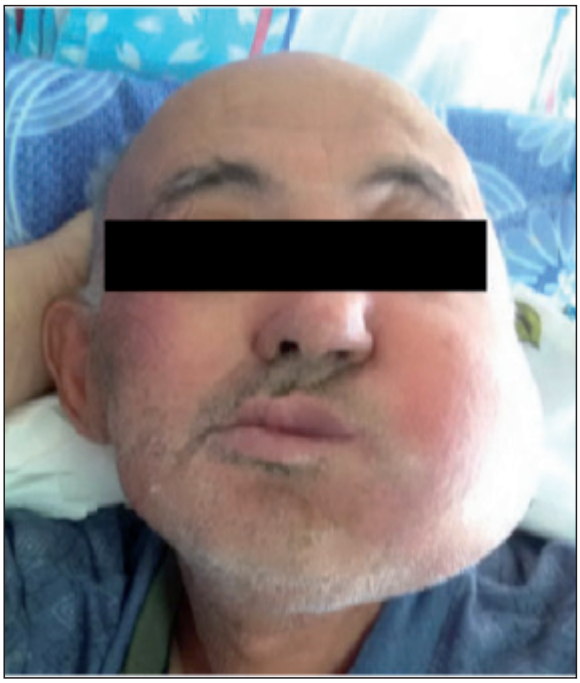

Figure 1.

PP-22

TREATMENT WITH FOLFIRI PLUS PANITUMUMAB IN A METASTATIC COLON CANCER AND RENAL FAILUER PATIENT UNDERGOING HEMODIALYSIS

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Aim: It is still unclear how patients will conquer and what side effects will be encountered during the use of these targeted therapies in patients undergoing hemodialysis with chronic renal failure.

Case: A 46-year-old female hemodialysis program due to post-renal chronic renal failure.The patient underwent low anterior resection due to sigmoid colon adenocarcinoma 10 years ago.T3N2M0 was diagnosed and received 6 cycles of adjuvant FOLFOX chemotherapy. 6 months ago went to the doctor because of abdominal and back pain. In the PET CT detected 8 cm mass (SUV Max 7.57) in the left kidney location and konglomere lymph nodes (SUV max 9.2) starting at the level of the renal hilus and ending at the level of the 5th lumbar vertebra. Mass biopsy of the left kidney location was reported as RAS wild type colon adenocarcinoma metastasis. İleostomy was opened due to ileus assessed in the general surgery department and the case was considered as inoperable. The patient was evaluated by the urology clinic and bilateral nephrostomy was performed. The patient assessed in medical oncology clinic metastatic colon adenocarcinoma RAS wild type, ongoing hemodialysis 3 days a week due to chronic renal failure. There was height 155 cm, weight 45 kg, body surface area 1.40 m2, ECOG performance status 2, Hb; 10mg/dl, PLT; 379, WBC; 6.5, urea; 144, creatinine; 5.41 creatinine clearance; 9.33 ml/min, sodium; 135mg/dl , potassium; 4.5mg/dl, CEA: 278, liver function tests were within normal limits. As the first series of chemotherapy FOLFİRİ ([irinotecan 180 mg/m2 intravenously (IV) over 120 minutes, folinic acid 400 mg/m2 over 120 minutes, followed by 5-FU 400 mg/m2 IV bolus, then 2,600 mg/m2 IV infusion, over 48 hours) 20% dose reduction plus panitumumab (full dose 6mg/kg) was started every 14 days. The patients is ongoing hemodialysis three days a week (Monday, Wednesday, Friday) and chemotherapy was administered on Thursdays. That is, the patient was given

chemotherapy 24 hours after hemodialysis and hemodialysis again chemotherapy after 24 hours. 6 cycles FOLFİRİ plus panitumumab chemotherapy was completed without additional dose reduction and without any grade 3-4 side effects. No side effects were observed except grade 2 anemia and grade 1 rash during chemotherapy. Partial radiological response was obtained after 3 cycles. the patient's CEA level 278 dropped to 28. The objective clinical response of the patient was obtained and the patients ECOG performance status was 1 and patients weight gain from 45 kg to 50 kg. After 6 cycles FOLFİRİ plus panitumumab chemotherapy, the partial response still persists. The patient's chemotherapy is still ongoing as there is no progression and no toxicity develops.

Discussion: In a patient with RAS wild type metastatic colon cancer and hemodialysis due to chronic renal failure at the same time, FOLFIRI plus panitumumab chemotherapy was safely used, effective and well tolerated without any obvious toxicity.

PP-23

EFFECTIVE APPLICATION OF MULTIMODALITY TREATMENT METHODS YIELD IN LONG TERM SURVIVAL: A CASE REPORT

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Introduction: The treatment of rectal cancer has changed over the last two decades as far as surgery, radiotherapy and chemotehrapy are concerned. Effective surgery, neoadjuvant radiotherapy in early stages and modern cytotoxic chemotherapies, implementation of biological agents and local paliative approaches in limited metastasis improved survival rates. Here, we present a metastatic rectal cancer patients who is effectively treated with multimodality approach and living for more than 10 years.

Case Report: A thirty-nine years old female patient was admitted to general surgery clinic with symptom of hematochesia. Colonoscopic biopsy revealed adenocarcinoma and low anterior resection was done at June 2008. She was diagnosed with a T3N0MO rectal adenocarcinoma and referred to our clinic. Concomitant chemoradiotherapy was applied and adjuvant chemotherapy with FUFA was applied between August 2008 and February 2009. Fifteen months later, an oligometastatic lesion was detected in right lung, metastesectomy was offered to the patient however she refused to get surgery. Sterotactic radiotherapy was not a readily available option fort hat time, hence, 6 cycles of FOLFOX was applied with partial response. Afterwards, progression was detected on that lesion. Mutational analyses revealed ras wild type rectal carcinoma and FOLFIRI+ Cetuximab was applied between August 2008 and February 2013; very good partial response was achieved and metastesectomy was done. On the follow-up period, sixteen months later, new metastatic lesions in liver and perirenal area was detected. On third line. FOLFOX application (November 2014-January 2015) was the choice of treatment which lead to partial response, RF ablation was done to liver and perirenal lesions. RFA yielded in more response in perirenal lesion, surgically it is resected, and postoperatively radiotherapy was applied to operation area. She was lost to follow-up for 12 months and when she admitted again she was diagnosed with multiple lung metastasis, perirenal mass and liver lesions. Between february 2016 and may 2016 FOLFOX rechallange with Bevacizumab was given, maintenance treatment with FUFA+ bevacizumab was applied for 12 cycles until progression. At march 2017, progression has occurred and regorafenib was started. She is still on regorafenib treatment with stabil disease.

Conclusion: Effective and timely use of local ablative therapies, proper applications of biological agents may have promising results that change an acute process into a chronic disease and have yield in improved survival rates.