Hacettepe Üniversitesi
Kanser Enstitüsü

8 th INTERNATIONAL GASTROINTESTINAL CANCER CONFERENCE

7 - 9 December 2018
Swiss Hotel, Istanbul - Turkey

ABSTRACTS

www.igicc2018.org

SCIENTIFIC SECRETARIAT

Prof. Dr. Şuayib Yalçın
Hacettepe University Institute of Oncology Department of Medical Oncology
E-mail : syalcin@hacettepe.edu.tr

ORGANIZATION SECRETARIAT

Serenas Tourism Congress Organization and Hotel Management Co.
Turan Gunes Bulvari 5. Cadde No:13, 06550 Cankaya – Ankara / Turkey
Phone : +90 312 440 50 11
Fax : +90 312 441 45 62
E-mail : info@igicc2018.org

Dear Colleagues,

It is my great pleasure to invite you to attend the 8th International Gastrointestinal Cancers Conference (IGICC 2018) to be held 7– 9 December 2018 in Istanbul. This international gastrointestinal scientific event is endorsed by international societies such as UICC.

Our conference will include all gastrointestinal, hepatobiliary, pancreatic malignancies as well as NETs, GISTs and gastrointestinal lymphomas and issues related to the care of patients with gastrointestinal cancer. The delegates will gain a greater understanding of current clinical practices in gastrointestinal malignancies with lectures by high profile international speakers, presentations of cutting-edge research and clinical practice, clinical case discussions, seminars and a wide range of submitted papers. IGICC will create opportunities for participants to present and share experiences, explore new directions and debate topics with international experts.

Considering the success of the first seven conferences 8.IGICC will be again an indispensable opportunity for education and update of the treatment of gastrointestinal cancers, providing a clear overview for treatment, with the focus on individualized, multidisciplinary approach with the participation of broad range of experts.

I cordially invite you to participate in this meeting by attending and submitting your scientific work as an abstract to be considered for presentation in IGICC 2018.

We are looking forward to welcoming you to Istanbul.

Prof. Dr. Suayib Yalcin

INTERNATIONAL FACULTY (In Alphabetical Order)

Dan ADERKA, *(Israel)*
Ilias ATHANASIADIS, *(Greece)*
Shouki BAZARBASHI, *(Saudi Arabia)*
Ioannis BOUKOVINAS, *(Greece)*
Ivana BLAZIC, *(Serbia)*
Axel GROTHEY, *(USA)*
Meinolf KARTHAUS, *(Germany)*
Jamal KHADER, *(Jordan)*
Ruzica MAKSIMOVİC, *(Serbia)*
Aung NAING, *(USA)*
Marina NIKITOVIC, *(Serbia)*
Demetris PAPAMICHAEL, *(Cyprus)*
Marc PEETERS, *(Belgium)*
Philip Agop PHILIP, *(USA)*
Ofer PURIM, *(Israel)*
Ali SHEMSEEDINE, *(Lebanon)*

NATIONAL SCIENTIFIC FACULTY (In Alphabetical Order)

Hüseyin ABALI, *(Turkey)*
Osman ABBASOGLU, *(Turkey)*
Cigdem AFSAR, *(Turkey)*
Hakan AKBULUT, *(Turkey)*
Devrim AKINCI, *(Turkey)*
Okan AKHAN, *(Turkey)*
Tulay AKMAN TUZEL, *(Turkey)*
Mehmet ALAKAVUKLAR, *(Turkey)*
Necati ALKIS, *(Turkey)*
Cagatay ARSLAN, *(Turkey)*
Mehmet ARTAC, *(Turkey)*
Ozlem ATA, *(Turkey)*
Fazil AYDIN, *(Turkey)*
Faruk AYKAN, *(Turkey)*
Salim BASOL TEKIN, *(Turkey)*
Cemil BILIR, *(Turkey)*
Erdal Birol BOSTANCI, *(Turkey)*
Hakan Sat BOZCUK, *(Turkey)*
Evin BUYUKUNAL, *(Turkey)*
Meltem CAGLAR TUNCALI, *(Turkey)*
Ebru CILBIR, *(Turkey)*
Timucin CIL, *(Turkey)*
Fuat DEMIRELLI, *(Turkey)*
Murat DINCER, *(Turkey)*
Omer DIZDAR, *(Turkey)*
Erkan DOGAN, *(Turkey)*
Hilmi EGE, *(Turkey)*
Tamer ELKIRAN, *(Turkey)*
Hüseyin ENGIN, *(Turkey)*
Sibel CETIN ERDAMAR, *(Turkey)*
Dilek ERDEM, *(Turkey)*
Burcak ERKOL, *(Turkey)*
Durmuş ETIZ, *(Turkey)*
Turkkan EVRENSEL, *(Turkey)*
Ethem GECIM, *(Turkey)*
Cengiz GEMICI, *(Turkey)*
Erdem GOKER, *(Turkey)*
Güzin GONULLU DEMIRAG, *(Turkey)*
Meltem HALIL, *(Turkey)*
Hakan HARPUTLUOGLU, *(Turkey)*
Pervin HURMUZ, *(Turkey)*
Abdurrahman ISIKDOGAN, *(Turkey)*
Mahmut ILHAN, *(Turkey)*
Ozkan KANAT, *(Turkey)*
Bülent KARABULUT, *(Turkey)*
Nuri KARADURMUS, *(Turkey)*
Halil KAVGACI, *(Turkey)*
Umut KEFELI, *(Turkey)*
Ozge Durdu KESKIN, *(Turkey)*
Saadettin KILICKAP, *(Turkey)*
Murat KOCER, *(Turkey)*
Seref KOMURCU, *(Turkey)*
Sahin LACIN, *(Turkey)*
Erdinc NAYIR, *(Turkey)*
Bülent ORHAN, *(Turkey)*
Berna OKSUZOGLU, *(Turkey)*
Feyyaz OZDEMIR, *(Turkey)*
Mustafa OZDOGAN, *(Turkey)*
Ahmet OZET, *(Turkey)*
Hale Başak OZKOK, *(Turkey)*
İbrahim PETEKKAYA, *(Turkey)*
Mehmet Ali Nahit SENDUR, *(Turkey)*
Coşkun TECIMER, *(Turkey)*
Serdar TURHAL, *(Turkey)*
Hande TURNA, *(Turkey)*
Faruk ZORLU, *(Turkey)*
Ferah YILDIZ, *(Turkey)*

ABSTRACT REVIEW COMMITTEE

Philip Agop PHILIP, *(USA)*
Tülay Akman TUZEL, *(Turkey)*
Mehmet ARTAC, *(Turkey)*
Özlem ATA, *(Turkey)*
Nilüfer AVCI, *(Turkey)*
Faruk AYKAN, *(Turkey)*
Shouki BAZARBASHI, *(Saudi Arabia)*
Ebru CILBIR, *(Turkey)*
Timuçin CIL, *(Turkey)*
Faysal DANE, *(Turkey)*
Ömer DIZDAR, *(Turkey)*
Özge Durdu KESKIN, *(Turkey)*
Tamer ELKIRAN, *(Turkey)*
Hüseyin ENGIN, *(Turkey)*
Özlem ER, *(Turkey)*
Pervin HURMUZ, *(Turkey)*
Özkan KANAT, *(Turkey)*
Bülent KARABULUT, *(Turkey)*
Jamal KHADER, *(Jordan)*
Saadettin KILICKAP, *(Turkey)*
Aung NAING, *(USA)*
Bülent ORHAN, *(Turkey)*
Başak OYAN ULUC, *(Turkey)*
Berna OKSUZOGLU, *(Turkey)*
Feyyaz OZDEMIR, *(Turkey)*
Demetris PAPAMICHAEL, *(Cyprus)*
Mehmet Ali Nahit SENDUR, *(Turkey)*
Ali SHEMSEDDIN, *(Lebanon)*
Isil SOMALI, *(Turkey)*
Hande TURNA, *(Turkey)*
Şuayib YALCIN, *(Turkey)*
Ozan YAZICI, *(Turkey)*
Ferah YILDIZ, *(Turkey)*
Özcan YILDIZ, *(Turkey)*
Faruk ZORLU, *(Turkey)*

Presentations

IDENTIFYING AND MANAGEMENT OF PULMONARY TOXICITY

Ali Alkan, MD

Mugla Sitki Kocman University Training Research Hospital, Medical Oncology, Muğla, Turkey

In our clinical practice, while treating patients we try to minimize the side effects of our treatment. However, we inevitably encounter numerous toxicities associated with our treatment strategies. In the treatment of gastrointestinal cancer, it's the same like other cancers. The lungs are vital organs and although they are rare, we encounter pulmonary toxicity while treating GI cancers.

The lungs process the entire cardiac output. So, they are exposed to iatrogenic damage. %10-20 of patients treated with antineoplastic agents are prone to any degree of pulmonary toxicity. In addition, acute respiratory failure related with drugs were most commonly associated with cytotoxic drugs (53%). Some of the pulmonary toxicities (PT)s are potentially predictable. Those drugs usually have a cumulative dosage. However, many of the PTs are idiosyncratic and unpredictable.

The underlying mechanisms of PTS are;

- Direct injury to pneumocytes or the alveolar capillary endothelium
- The systemic release of cytokines that can cause endothelial dysfunction, capillary leak syndrome and noncardiogenic pulmonary edema
- Oxidative injury from free oxygen radicals
- Damage to epidermal growth factor receptors expressed on type II pneumocytes which are responsible for alveolar wall repair
- Immune attack which is observed in immunotherapy drugs

There are some defined syndromes associated with cytotoxic drug regimens. Such as; Acute bronchoconstriction, infusion reactions, alveolar hemorrhage, eosinophilic pneumonia, hypersensitivity pneumonitis, interstitial pneumonitis, radiation recall, non-cardiogenic pulmonary edema, capillary leak syndrome, acute lung injury and pulmonary veno-occlusive disease. There are numerous cytotoxic and immunotherapy drugs which have been associated with these syndromes. However, in gastrointestinal cancer treatment, well defined pneumotoxic drugs are platinum drugs, taxanes, bevacizumab, gemcitabine, irinotecan, sorafenib, trastuzumab and immunotherapy drugs.

General approach to pulmonary toxicity is same for all drugs. Clinical suspicion is the most important part of clinical approach. In mild cases, patients usually present with non-productive cough, mild fever and dyspnea. Generally physical examination is normal. But bibasillar crackles and wheezing can be detected. For differential diagnosis laboratory work up including complete blood count, acute phase reactants, renal and hepatic function tests should be done. For exclusion of cardiac pathologies, ecg, echocardiography should be done. Bronchoscopy can show increased cellular count. Pulmonary function tests are useful for evaluation of the severity of pulmonary damage. Radiology is an important part of diagnostic work- up. In CT scans ground glass opacities, consolidation, interlobular septal thickening and centrilobular nodules can be detected.

In the treatment of pulmonary toxicities, there is no evidence-based recommendations All the strategies are empirical. Discontinuation of the drug is the best effective treatment strategy. However, the risks, benefits and availability of alternative treatments should be considered. Glucocorticoids are usually important in the treatment. The decision to initiate glucocorticoid therapy depends on the severity and rapidity of worsening of pulmonary impairment. However, the evidence is generally observational, there are no randomized trials. There is no standard dosage recommendation, usually 1 mg/kg, daily methylprednisolone recommended.

Rechallenging patient with the same drug should be decided on a case by case basis. It should be based upon the individual agent, the severity of the reaction and the availability of alternative therapies. There is some strategies for screening, such as asking about dyspnea, auscultation for crackles, serial chest radiographs, serial pulmonary function tests. The strategies are not specific. There are no randomized trials and there are no specific recommendations.

While treating gastrointestinal cancer patients, we should be cautious about toxicities. Suspicion about toxicity is the most important part of the approach. In addition, we should ask symptoms and evaluate the patients if necessary.

MANAGEMENT OF CANCER PAIN

Sahin Lacin, MD

Diyarbakır Gazi Yasargil Training and Research Hospital, Diyarbakır, Turkey

Cancer pain management is one of the most important part of cancer patients treatment. The incidence of the cancer pain is prominently prevalent in patients with cancer. The prevalance of moderate to severe pain is around 40% to 50% and very severe pain experienced by 40% to 50% of cancer patients, also 80% of terminal stage cancer experience moderate to severe pain[1, 2]. Cancer patients pain due to many diffent causes like direct tumour invasion of local tissues, visceral obstructions, nerve compression and plexus invasion, ischaemia, inflammation, chemotherapy induced neuropathy, paraneoplastic neuropathy and arthropathy, post-surgical pain and radionecrosis. The cancer pain types are divited to two groups which are nociceptive(pain signals from nerve endings) and neuropathic(damage to nerve fibres). Pain management in cancer patients requires an individualized treatment and multimodal plan of treatments which must incorporate with pharmacological, interventional, rehabilitation, and behavioral approaches. There are many different suggested pain assessment tools and treatment guides, and the most common guides that oncologists use in their daily practice are ESMO and NCCN guidelines[3, 4]. These guidelines recommend to assess cancer pain in different ways which include werbal, numerical etc. After difinition of cancer pain severity, patients are treated by appropriate drugs according to World Health Organization (WHO) analgesic ladder [5]. Analgesic ladder recommendation based on a sequential three-step suggest giving analgesics at regular intervals “by the clock”, to prescribe according to pain intensity as evaluated by a scale of intensity of pain, and dosing of pain medication be adapted to the individual. Adjuvant analgesics suggested by the analgesic ladder to combine to cancer pain treatment which refer to a small number of drugs that were marketed for indications other than pain but were found to be potentially useful as analgesics in patients receiving opioid therapy [6]. NSAIDs and acetaminophen are generally used with adjuvant analgesic for mild cancer pain, however, opioids constitute main treatment agents for moderate or sever cancer pain [7-12]. Clinicians should be aware and it is important to monitor and reassess the long-term use of NSAIDs because of their significant toxicity which include nephrotoxicity, hepatotoxicity, gastrointestinal bleeding, platelet dysfunction and renal failure) and some of them may increase the risk of thrombotic cardiovascular adverse reactions[13]. There are many different way for opioid administration such as oral, transdermal, spinal delivery, buccal, sublingual, intra-nasal, epidural and intrathecal[14-16]. Therefore, opioids can be used for pain in cancer patients with different and difficult conditions. On the other hand , opiods have different toxixity patern that include sedation, drowsiness, constipation, nausea, vomiting, respiratory depression, cognitive disturbances, tolerance and opioid-induced hyperalgesia, hypogonadotrophic hypogonadism and also opioid-induced androgen deficiency [17]. Also physical modalities such as bath, walking supports, therapeutic and conditioning exercise, energy conservation, massage and acupuncture may help relive cancer pain. Finally, as mentioned above, proper cancer pain management is one of the most important parts of cancer treatment that can positively affect the life and disease course of cancer patients. Therefore, patients should be treated with appropriate agents until pain can be tolerated.

References

1. Portenoy, R.K., Treatment of cancer pain. Lancet, 2011. 377(9784): p. 2236-47.
2. Haumann, J., E.B.A. Joosten, and M. Everdingen, Pain prevalence in cancer patients: status quo or opportunities for improvement? Curr Opin Support Palliat Care, 2017. 11(2): p. 99-104.
3. Robert A. Swarm, M., Judith A. Paice, PhD, , NCCN Guidelines Version 1.2018 Panel Members Adult Cancer Pain. NCCN, 2018. Version 1.2018(Adult Cancer Pain).
4. Fallon, M., et al., Management of cancer pain in adult patients: ESMO Clinical Practice Guidelines. Ann Oncol, 2018. 29(Supplement_4): p. iv166-iv191.
5. Organization, W.H., Cancer pain relief: with a guide to opioid availability. 1996: World Health Organization.
6. Wooldridge, J.E., C.M. Anderson, and M.C. Perry, Corticosteroids in advanced cancer. Oncology (Williston Park), 2001. 15(2): p. 225-34; discussion 234-6.
7. Tielemans, M.M., et al., Identification of NSAID users at risk for gastrointestinal complications: a systematic review of current guidelines and consensus agreements. Drug Saf, 2010. 33(6): p. 443-53.
8. Stockler, M., et al., Acetaminophen (paracetamol) improves pain and well-being in people with advanced cancer already receiving a strong opioid regimen: a randomized, double-blind, placebo-controlled cross-over trial. J Clin Oncol, 2004. 22(16): p. 3389-94.
9. Beakley, B.D., A.M. Kaye, and A.D. Kaye, Tramadol, Pharmacology, Side Effects, and Serotonin Syndrome: A Review. Pain Physician, 2015. 18(4): p. 395-400.

10. Raptis, E., et al., Pregabalin vs. opioids for the treatment of neuropathic cancer pain: a prospective, head-to-head, randomized, open-label study. Pain Pract, 2014. 14(1): p. 32-42.
11. Kane, C.M., et al., Opioids combined with antidepressants or antiepileptic drugs for cancer pain: Systematic review and meta-analysis. Palliat Med, 2018. 32(1): p. 276-286.
12. Wiffen, P.J., S. Derry, and R.A. Moore, Tramadol with or without paracetamol (acetaminophen) for cancer pain. Cochrane Database Syst Rev, 2017. 5: p. CD012508.
13. Food, U. and D. Administration, FDA strengthens warnings that non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs) can cause heart attacks or strokes [Communication]. 2015 http://www. fda. gov/Drugs. DrugSafety/ucm451800. htm (accessed 16 Sep 2015).
14. Zheng, S., et al., Evaluation of intrathecal drug delivery system for intractable pain in advanced malignancies: A prospective cohort study. Medicine (Baltimore), 2017. 96(11): p. e6354.
15. Zeppetella, G., et al., A network meta-analysis of the efficacy of opioid analgesics for the management of breakthrough cancer pain episodes. J Pain Symptom Manage, 2014. 47(4): p. 772-785 e5.
16. Stevens, R.A. and S.M. Ghazi, Routes of opioid analgesic therapy in the management of cancer pain. Cancer Control, 2000. 7(2): p. 132-41.
17. Rodriguez, R.F., et al., Incidence of weak opioids adverse events in the management of cancer pain: a double-blind comparative trial. J Palliat Med, 2007. 10(1): p. 56-60.

Oral Presentations

OP-001

SURGICAL APPROACH, POSTOPERATIVE PATHOLOGY AND THE ROUTE TO CHEMO FOR STAGE 3 COLON CANCER: ONE CENTER EXPERIENCE

Serkan Değirmencioğlu[1]

[1]Pamukkale University Hospital Medical Oncology Department

Aim: Colorectal cancer is the third mortal cancer all around the world. Surgical resection is the backbone of therapy for early and local advanced stages. Despite of modern surgical techniques 5 year progression free survival rate is still 49% for stage III cancer. Adjuvant chemotherapy, used for high risk stage II and stage III patients, gains survival benefit and reduces the mortality rate. We aimed to evaluate the surgical procedures, number of excised lymph nodes, histologic differantiations and the operation to chemotherapy interval in our clinic.

Material – Method: Two hundred and thirty stage III colon cancer patients who treated with adjuvant chemotherapy between years 2011 and 2017, were retrospectivally analysed. Inclusion criterias were being stage III colon cancer and treating with CAPOX or FOLFOX regimens. The analyses were carried out using SPSS v21 and $p<0.05$ was accepted as significant. Descriptive studies were analyzed using chi-square test and Mann-Whitney U-test depending on group numbers.

Results: Surgical technique had no effect on prognosis ($p=0.466$). There was a statistically significant correlation between histologic differantiation and clinical progression ($p=0.001$). Prolongation of operation to chemotherapy duration was statistically increased the progression rate ($p=0.03$). The number of total resected lymph nodes had no effect on progression ($p=0.158$). However increased number of metastatic lymph nodes had a significant impact on progression ($p=0.0001$) (Table-1 and 2) .

Discussion: Colon cancer treatment guidelines offer minimum 12 lymph node resection. Our patients' dissected number of total lymph nodes were satisified for this condition. Negative impact of increased metastatic lymph nodes and poor histologic differantiation on prognosis was compatible with literature. Prolongation of operation to chemotherapy duration was statistically increased the progression rate. For this reason all treatment guidelines offer to start chemotherapy 6-8 weeks after operation.

Conclusion: This is the first study evaluating operation techniques, histopathologic findings and operation to chemotherapy interval on stage III Turkish colon cancer patients. However it must be enpowered with multisentric attendance for establishing a national database.

Keywords: Colon cancer, stage III, metastatic lymph node, operation type, chemotherapy interval

Table 1. The impact of operation type and histologic differantiation on progression calculated by Chi-square test * $p < 0.05$ is statistically significant.

		No progression	*Progression*	*Total*	*p*
Operation type	Elective	130 (88.4%)	71 (85.5%)	201 (87.4%)	
	Urgent	17 (11.6%)	12 (14.5%)	29 (12.6%)	0.446
	Good	10 (%7)	6 (6.8%)	16 (7%)	
Histologic Differantiation	Moderate	60 (%41.8)	18 (20.7%)	78 (33.9%)	0.001
	Poor	73 (%51.2)	63 (72.5%)	136 (59.1%)	

Table 2. The impact of operation to chemotherapy interval, total resected lymph nodes and metastatic lymph nodes on progression calculated by Mann-Whitney U test * $p < 0.05$ is statistically significant

	Progression	*Mean ± Std. Dev.*	*Med (min - max)*	*p*
Operation to chemo interval (day)	No (n=143)	44.57 ± 23.51	42 (13 - 229)	0.03
	Yes (n=87)	48.8 ± 21.53	46 (15 - 188)	
Total resected lymph nodes (n)	No (n=143)	14.79 ± 5.94	14 (1 - 33)	0.158
	Yes (n=87)	15.85 ± 5.7	15 (4 - 31)	
Metastatic lymph nodes (n)	No (n=143)	2.5 ± 3	1 (0 - 28)	0.0001
	Yes (n=87)	3.3 ± 2.88	2 (1 - 18)	

OP-002

CLINICAL SIGNIFICANCE OF SERUM IGF-1 AND IGFBP-3 IN PATIENTS WITH ESOPHAGEAL CARCINOMA.

Murat Sarı[1], Muhammet Zübeyr Üçüncü[2]

[1]Istanbul University, Istanbul Medical Faculty, Department Of Medical Oncology

[2]Istanbul Gelişim University, Institute Of Health Sciences, Department Of General Surgery

Objective: Esophageal carcinoma (EC) is a common cancer of the gastrointestinal (GI) tract and about 300.000 people worldwide die from it annually. It constitutes 1.5 – 2 % of all cancers and 5 - 7% of all GI cancers. In this type of cancer, early diagnosis, early treatment and close follow-up can reduce mortality. However, for early diagnosis, reliable markers are needed which can be used in early diagnosis. The aim of this study was to investigate the role of insülin - like growth factor binding protein-3 (IGFBP-3) and insulin- like growth factor-1 (IGF-1) for the diagnosis of esophageal tumor.

Material and Method: Thirty-nine patients with histopathologically confirmed diagnosis of EC and forty-nine age- and sex-matched healthy controls were included in our study at Istanbul University Institute of Oncology. Serum IGF-1 and IGFBP-3 levels were determined using enzyme-linked immunosorbent assay (ELISA).

Results: The study group consisted of 49 control subjects and 39 patients. The mean age of the patients was 57.58 ± 11.54 years. Nineteen patients were male (48,7%). Serum IGF-1 and IGFBP-3 levels were significantly lower in the patient group than those in the control group ($p<0.001$). The median survival was 11months (95% CI= 8.3-13,6). 1-year survival rate was 46.2 % and 3-year survival rate was 25.1 %. Recurrence was observed in 22 patients. There was no significant difference between the IGF values and the IGFBP3 values in patients with recurrence. At the end of the median 11-month follow-up (1-85) period, 82% (n=32) of the patients died. There was no significant difference between IGF-1 and IGFBP3 between T, N and pathological stages of the disease.

Conclusion: In our study, we showed that serum IGF-1 and IGFBP-3 levels could be used for early diagnosis of EC. In order to reach a clear opinion, it was concluded that larger series should be made.

Keywords: Esophageal carcinoma, serum, IGF-1, IGFBP-3

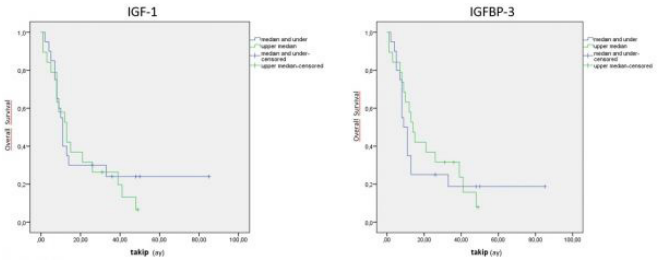


Table 1. Comparison between patient and control groups.

	Control	*Patients*	*p value*
Number (n)	49	39	
Age (mean, year)	48,10±16,84	57,59±11,54	0.004
IGF- 1	165,73±59,19	123,32±59,27	0.001
IGFBP-3	4,57±1,32	3,35±1,31	0.001

Table 2. Results of comparisons between the IGF-1 and IGFBP-3 levels assays and disease characteristics.

	IGF-1	*p value*	*IGFBP-3*	*p value*
Stage 1	113,50±6,36	0,784	4,50±1,74	0,620
Stage 2	107,77±50,28		3,10±1,08	
Stage 3	133,86±50,24		3,39±1,35	
Stage 4	123,32±59,27		3,26±1,39	
Adenocancer	99,24±17,71	0,337	3,01±1,27	0,538
Squamous cell cancer	126,86±62,50		3,40±1,33	
Poor	132,92±56,86	0,562	3,59±1,32	0,38
Moderate	119,17±69,43		2,99 ±1,34	
Good	102,02±22,47		3,63±1,18	

OP-003

THE PROGNOSTIC VALUE OF INFLAMMATION-BASED SCORES FOR HEPATOCELLULAR CARCINOMA

İrem Bilgetekin[1], Berna Öksüzoğlu[1], Umut Demirci[1]

[1]Depatment Of Medical Oncology;dr.a.y.oncology Education And Research Hospital;university Of Health Sciences;yenimahalle;ankara;turkey

Introduction: Hepatocellular carcinoma (HCC) has a poor prognosis. Recently, inflammation-based scores (IBS) have been associated with cancer spesific survival. In this study, we aimed to examine the impact of IBS on the prognosis of HCC.

Materials and Methods: Between January 2011-April 2018, a total of 125 patients with intermediate and advanced stage HCC were evaluated, retrospectively. Clinicopathologic characteristics and IBS (neutrophil/lymphocyte ratio-NLR, prognostic nutritional index-PNI, aspartate aminotransferase/platelet count ratio-APRI) were recorded. Univariate and multivariate analyses were performed.

Results: Median age is 64 years (22-85), 105 males (%84). Etiologies were HBV (n=74), ethanol use (n=20), HCV (n=9), and non-alcoholic steatohepatitis (n=8). Local treatment options yielded a median OS of 24.8 months (95% CI: 12.8-36.8) in intermediate stage HCC. Patients with initial ECOG performance status (PS) ≥2 (n=49-39.2%) were followed with best supportive care (BSC). Median OS of patients followed with BSC was 6.9 months (95% CI:0.6-8.7). After failure of primary treatments, further options (n=30) were as follows: Sorafenib (n=26), capecitabine (n=1) and adriamycin (n=3). Median PFS for sorafenib is 11.6 months (95% CI: 0.1-25.2) in this group. On the other hand, median PFS of sorafenib in first line treatment (n=17) is 7.7 months (95% CI: 6.9-8.4).Initial ECOG PS, Child Pugh score, tumor size, portal vein thrombosis were found to be significantly associated with OS in univariate analyses. Initial tumor size (>5 cm), older age (>65 years), ECOG PS 2-3, applicability of local treatment options, higher APRI and higher NLR index were found as statistically significant independent prognostic factors for OS in multivariate analysis (Table 1).

Discussion: In the current study, higher APRI index and higher NLR are significantly associated with poor OS. Besides; PS, larger tumor size and older age are found as independent prognostic factors for OS. There is a continuing need for predictive and prognostic indexes for better patient and treatment modality selection.

Keywords: Aspartate aminotransferase/platelet count ratio index, ECOG Performance status, Hepatocellular carcinoma, Prognosis

OP-004

GASTROINTESTINAL SYSTEM CANCERS AFTER RENAL TRANSPLANTATION: SINGLE CENTER EXPERIENCE

Derya Kıvrak Salim[1], Hasan Şenol Coşkun[2], Sema Sezgin Göksu[2]

[1]Sbü Antalya Education And Research Hospital, Medical Oncology Department

[2]Akdeniz University Hospital,medical Oncology Department

Introduction: Renal transplantation improves survival with successful immunosuppressive agents in end-stage renal disease patients . Solid cancer development risk has increased in renal transplant patients higher than expected in age-matched normal population. Immunosuppression duration is determinant for the cancer development. Solid organ cancers in renal transplant patients show poor outcome with median OS of <4 months. The aim of this study is to describe survivals and risk factors which may affect survivals in post renal transplant gastrointestinal system cancers.

Material and Methods: This retrospective study was conducted at single medical oncology center Akdeniz University Hospital, Antalya. Inclusion criteria were as follows: renal transplanted patients aged 18 years or older; histology or cytological confirmed gastrointestinal system malignancy. 10 patients who had diagnosis of gastrointestinal system cancers after renal transplantation between May 2007 and May 2017 were included into the study. Overall survival (OS) was the primary endpoint of the study. Secondary end points were as follows: progression free survival (PFS), to describe factors affecting OS and PFS.

Results: Baseline characteristic of 10 patients are outlined in table1. Median age was 56.5 years (range 37-69). All patients were diagnosed with stage IV disease. Liver metastases were seen in 6 patients and lung metastases were seen in 5 patients. Median gastrointestinal system cancer development time from transplantation was 68 months (range 18-161). 6 patients had induction immunsuppresive therapy at transplantation (3 patients had ATG and 3 patients had Basiliximab). Most patients (90%) had tacrolimus+ mycophenolate mofetil (MMF) or cyclosporine+ MMF as maintenance immunsuppressive therapy. Six patients received hemodialysis, 2 patients received peritoneal dialysis before transplantation and 2 patients had preemptive transplantation. Median dialysis duration was 50 months (range 1-133). After malignancy development 2 patients rejected renal greft. Median treatment duration for malignancy was 4.5 months (range 1-11

months) with a median of 4 cycles of chemotherapy. Seven of donors were living related, 2 were living un-related and 1 was deceased donor. Median OS was 10 months [95%CI 0-30.1],median PFS was 7 months [95%CI 1.6-12.4] (Figure 1 & 2).

Discussion: Survivals in renal transplant patients are too short to see treatment advantages but too vulnerable for the adverse effects. In the literature median overall survival for the gastric cancers is about 4-10 months; for pancreas cancers 4-9 months; for hepatocelular cancers 10 months and for colorectal cancers 20 months with the metastatic therapeutic options. This study of gastrointestinal system cancers in renal transplanted patients showed poorer survival outcomes (mOS 10 months and mPFS 7 months) to treatments and shorter treatment durations when compared with the literature.

Keywords: gastrointestinal system cancers, renal transplatation, survival

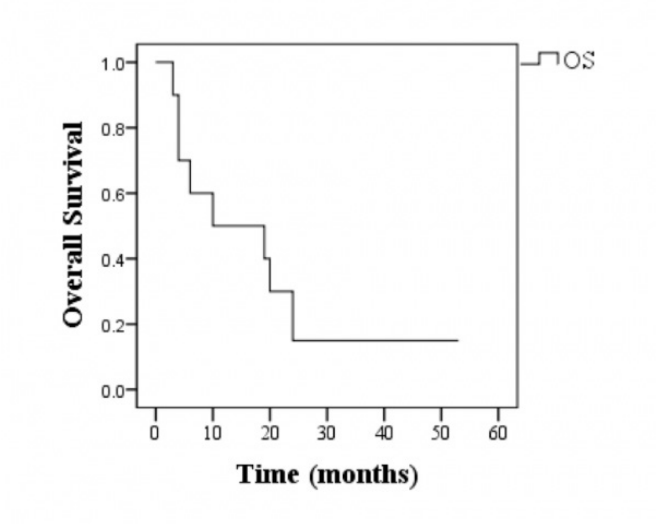


Figure 1. OS

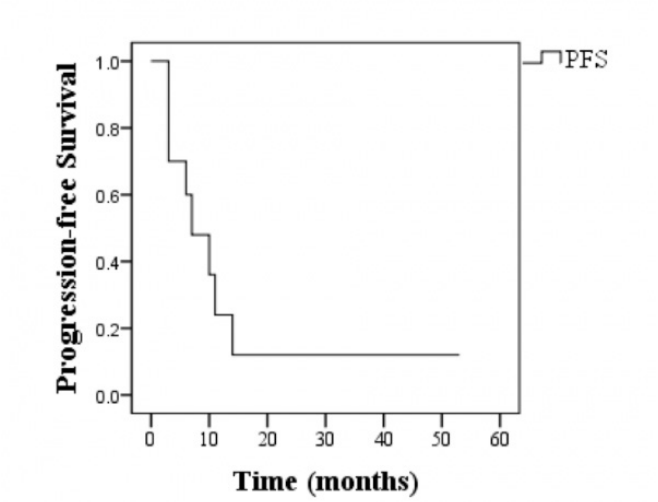


Figure 2. PFS

Table 1. Demographical and clinical features (n:10)

Age , years, median (range)	56.5 (37-69)
Gender , female-to-male, n(%)	3(30)/7(70)
Primary Tumor n(%)	
Colorectal Cancer (CRC)	5(12.8)
HCC	2(5.1)
Pancreas	1(2.6)
Stomach	2(5.1)
ECOG PS, n(%)	
< 2	8(80)
≥2	2(20)
Primary tumor resection, n(%)	
Yes	5(50)
No	5(50)
Primary tumor size (cm), median (range)	3.5(0-6)
Immunosuppression time, median (range)	69 (19-131)
Renal Failure Etiology, n(%)	
Iatrogenic	1(10)
Hypertensive nephropathy	4(40)
Diabetic nephropathy	3(30)
Glomerulonephritis	1(10)
Nephrolithiasis	1(10)
HLA mismatch number, n(%)	
0-3 mismatch	5(50)
4-6 mismatch	5(50)
Blood Group, n(%)	
A+	5(55.6)
B+	1(11.1)
0+	3(33.3)
OS, median (95%CI)	10(0-30.1)
PFS, median (95%CI)	7(1.6-12.4)

OP-005

IS FOLFIRINOX MORE EFFECTIVE IN METASTATIK PANCREATIC CANCER WHO HAS SURGERY FOR PRIMARY LESION ?

Serkan Yıldırım[1], Cengiz Yılmaz[1], Sevgi Topçu[1], Pınar Gürsoy[1], Burcu Çakar[1], Ulus Ali Şanlı[1], Bülent Karabulut[1]

[1]Ege University Hospital Medical Oncology Department

Introduction: FOLFIRINOX is standart first line therapy for fit patients in metastatic pancreatik cancer.İn the adjuvant setting effectiveness of FOLFIRINOX is proven in a preliminary report presented at the 2018 annual ASCO meeting. Based on this information it can be hypotezied taht FOLIFIRNOX treatment is more effective in metastatic pancreatic cancer patients who had surgery for primary and then metastasied. We did this retrospective study based on this hypotesis. The aim of the study is to compare FOLFIRINOX treatment in metastatic pancreatic cancer patients who had surgery for primary lesion (then metastasized) and who had de novo metastatic disease.

Material metod: This is a retrospective study performed in single center: Ege University Hospital in İzmir-Turkey. it. Data were collected from 2013-2017. İnclusion criteria encompassed: ≥18 years old, pathologically comfirmed pancreatic adenocarsinoma who has metastasized, ECOG performance status 0-1, received FOLFIRINOX for first line treatment. Primary outcome of this retrospective study is progression free survival according

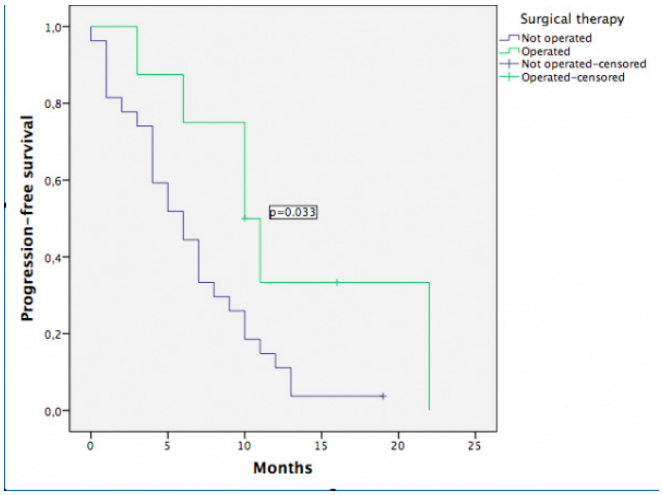
to patients who have surgery or not. Second outcome is overall survival.

Results: 35 patients were enrolled between 2013-2017. All patients were metastatic and received first line FOLIFIRNOX. 8 patients had surgery and then metastasized, 27 patients were de novo metastatic. Surgery and then metastasized groups progression free survival was median 10 mounths . De novo metastatic groups progression free survival was median 6 mounths. Surgery and then metastasized groups progression free survival was stastically meaningfull longer than de novo metastatic group(p:0.033). Secondary end point was overall survival. Surgery and then metastasized groups overall survival was 20 mounths. De novo metastatic groups overall survival was 7 mounths. Surgery and then metastasized groups overall survival was statistically significant longer than de novo metastatatic group(p:0.020).

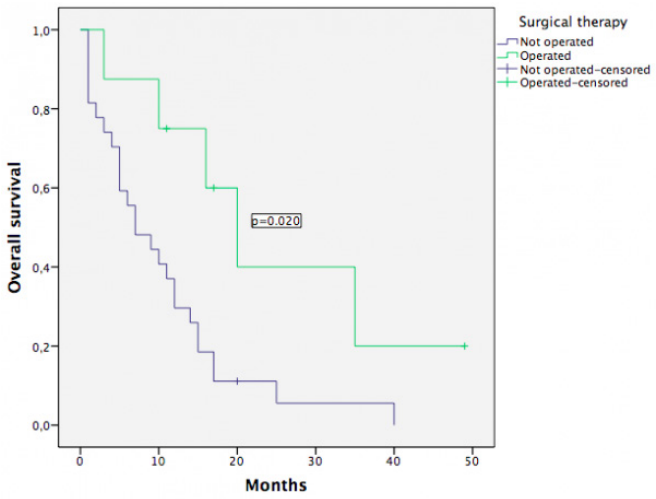
Discussion: In our study we diveded metastatic panceratic cancer patients who recevied first line FOLFIRINOX in to two groups. first group of patients who had sergery before after the metastasis devoleped, second de novo metastatic patients. We compared these two groups. in progression free survival(primary end point) and overall survival(secondary end point) we achieved statisticallay meaningfull results in favor of first group. looking at results of our work, patients who had surgery and then metastatised group FOLFIRINOX treatment has better outcomes. İn the light of these results surgery for primary lesion may be considered in selected metastatic pancreatic cancer patients.

Conclusion: According to the results of our study, we can obtain two results. first- metastatic patients who has surgery before benefits more form FOLFIRINOX treatment than who has de novo metastatic disease. Second- in selected patients who have de novo metastatic disease may have cytoreductive surgical resection for longer survival.

Keywords: metastatic pancreatic cancer, folfirinox, de novo metastatic, surfery and then metastasized



Progression free survival



Overall survival

OP-006

EVALUATION OF EPCAM AND VCAM-1 LEVELS IN PATIENTS WITH COLORECTAL CANCER

Hüseyin Engin[1], Elif Kahraman Güner[1]

[1]*Bülent Ecevit University Department Of Medical Oncology*

Introduction: Cellular adhesion molecules (CAM) may be good indicators for diagnosis and prognosis in some malignant tumors including colorectal cancer. In this study we aimed to determine serum VCAM-1 (Vascular Cell Adhesion Molecule-1) and EPCAM (Epidermal Cell Adhesion Molecule) levels in patients with colorectal cancer and evaluate the relationship with colorectal cancer. These two parameters have never been studied in colorectal cancer thus far.

Patients and Methods: Sixty-four patients with newly diagnosed colorectal cancer who had no previous chemotherapy or radiotherapy treatment and 64 healthy individuals were included in the study. Serum EPCAM and VCAM-1 levels were investigated in relation to colorectal cancer stage, differentiation grade, presence of lymphovascular and perineural invasion, lymph node involvement and metastasis. Statistical analysis was performed using the SPSS 19.00 program.

Results: The groups were compared of serum VCAM-1 and EPCAM level; the serum VCAM-1 level in the patient group was significantly higher than the control group (p=0.001). When classified according to the differentiation degree, the difference in serum EPCAM and VCAM-1 levels in the patient group was not statistically significant. When patients with colorectal cancer are evaluated for cancer stage, presence of lymphovascular and perineural invasion, lymph node involvement and metastasis status, the difference was significant in EPCAM levels (p=0.001, p=0.008, p=0.003, p=0.004, p=0.001 respectively). There was no correlation between these parameters and VCAM-1 levels.

Conclusions: EPCAM and VCAM-1 are important adhesion molecules that play a role in carcinogenesis and metastasis process. In this study, EPCAM levels were found to be associated with prognostic factors; but there was no diagnostic benefit when compared to the healthy group. VCAM-1 level was not found to be associated with prognostic factors even though it was higher than control group. In order to further clarify the role of cell adhesion molecules in colorectal cancer, more studies are needed.

Keywords: Colorectal Cancer, EPCAM, VCAM1

OP-007

EFFICACY OF THE SECOND-LINE TREATMENT IN METASTATIC PANCREAS CANCER

Mehmet Ali Nahit Sendur[1], Burak Bilgin[1], Ebru Karcı Güner[2], Mutlu Hizal[1], Yakup Ergün[3], Ece Esin[4], Elif Berna Köksoy[2], Ahmet Sezer[5], Muhammed Bülent Akıncı[1], Nuriye Özdemir[3], Berna Öksüzoğlu[4], Bülent Yalçın[1], Güngör Utkan[2], Yüksel Ürün[2]

[1]Ankara Yildirim Beyazit University, School Of Medicine, Department Of Medical Oncology
[2]Ankara University, School Of Medicine, Department Of Medical Oncology
[3]University Of Medical Sciences, Ankara Numune Education And Research Hospital, Department Of Medical Oncology
[4]University Of Medical Sciences, Dr. Abdurrahman Yurtaslan Ankara Oncology Hospital , Department Of Medical Oncology
[5]Baskent University, School Of Medicine, Department Of Medical Oncology

Introduction: Pancreas cancer is the fourth most common cancer in both men and women. Median overall survival is less than 30 months in early pancreas cancer which is treated as surgery. In addition, median overall survival is less than 12 months in metastatic pancreas cancer and only very few of patients can received second-line treatment. In this multicentre study, we aimed that evaluated to efficacy of second-line treatment in metastatic pancreas cancer.

Material and Methods: Totally, 161 patients who received second-line treatment were enrolled to study. Demographic, clinic and pathological features of the patients were recorded as retrospectively. All statistical procedures were performed with SPSS 20 (SPSS Inc, Chicago, Illinois). A *P* value < 0.05 was considered to statistically significant. A 5% type-1 error level was used to infer statistical significant.

Results: Thirty-one percent of patients were female and 61.8 % of patient were male. Median age of the patients were 59 (30 – 79). The most common tumor localisation was head of pancreas (56%) and second and third common localisations were corpus (26%) and body (18%), respectively. Before second-line treatment, the rate of ECOG 0, 1, 2 and 3 of patients were 26.1%, 39.8%, 28.6% and 5.6%, respectively. Eleven patients (6.8%) received gemcitabine, 10 patients (6.2%) received gemcitabine and cisplatine combination, 6 patients received FOLFIRI, 81 patients (50.3%) received oxaliplatine based chemotherapy, 20 patients received capacitabine and 3 patients (1.9%) received nab-paclitaxel as second-line treatment. There was no different between efficacy of treatment regimes. Median overall survival with second-line treatment was 4 months and median overall survival from diagnosis was 11 months.

Discussion: there was no standard treatment in metastatic pancreas cancer. In previous trials, median OS was between 3 and 6 months. In our study, median OS was compatible with previous trial and also we found that efficacy of the treatment was similar between treatment regimes.

Keywords: Pancreas cancer, metastatic, secondline, oxapilatine

OP-008

THE EFFECT OF EXTRALEVATOR ABDOMINOPERINAL RESECTION ON LOCAL CONTROL IN LOWER RECTUM CANCER PATIENTS

Bülent Aksel[1], Mahmut Onur Kültüroğlu[1]

[1]A.Y. Ankara Oncology Research And Training Hospital

Introduction: Abdominoperineal Resection (APR) is stil lthe gold standard intervention in the surgical treatment of rectum adenocarcinoma within the first 4 cm from the anal werge. Local recurrence rates after APR is higher in comparison with tumors that can be treated with anterior or lower anterior resection of the rectum. For the elimination of this situation,Extralevator Abdominoperineal Resection (ELAPR) was defined in which the resection boundaries were extended laterally to the levator muscle. Neoadjuvant chemoradiotherapy (NAKRT) is an other treatment modality that contributes to local control. Long-term results of ELAPR should be known in patients treated with NACRT.

Patients and Methods: We retrospectively evaluated 70 patients treated in our clinic between 2013-2016 and underwent NACRT and APR or ELAPR surgery because of T3NX or TXN(+) rectum adenocarcinoma. In APR operations, abdominal and perineal surgery were performed in lithotomy position. Whereas in ELAPR operations, perineal surgery was performed in prone and abdominal surgery in lithotomy position. In ELAPR operations, dissection was continued in the lateral of the levator ani muscle and the mesorectum was removed in a cylindrical manner.

Results: 32 patients were female and 38 were male. APR was applied to 34 patients and ELAPR to 36 patients. Three patients had complete response after neoadjuvant treatment. There were no differencein the distribution of the patientsin groups with respect to age, gender, BMI, grade, lymphovascular and perineural invasion. While the proximal surgical margin was negative in all patients, radial surgical margins were positive in 2 patients in the APR group and 1 patient in the ELAPR group. While the mean number of lymph nodes removed in the APR group was 11.2 ± 4.8, it was 12 ± 5.7 in the ELAPR group (p=0.2). According to Kaplan-Meier analysis, 2-year local recurrence rates were 7.4% (95% C.I. 0.5-4.9) in the APR group and 9.2% (95% C.I. 0.8-5.2) in the ELAPR group (p: 0.4).

Discussion and Conclusion: The contribution of ELAPR to local control was not shown in patients with rectal adenocarcinoma treated with NACRT. Sufficient evidence has not yet been established for this operation with high local wound morbidity to be accepted as standard intervension. For this purpose, multicenter prospective randomized studies with longer follow-up are needed.

Keywords: abdominoperineal resection, local control, rectum carcinoma

OP-009

THE ROLE OF THE PRETREATMENT INFLAMMATORY INDEXES IN THE SURVIVAL OF HEPATOCELLULAR CARCINOMA TREATED WITH SORAFENIB

Havva Yeşil Çınkır[1]

[1]Gaziantep University Faculty Of Medicine

Introduction: Inflammation has been reported to play an important role in cancer progression. The neutrophil to lymphocyte ratio (NLR) and the platelet to lymphocyte ratio (PLR) are used as a basic parameter of systemic inflamation in some tumors. The aim of this study was to examine the association between the pretreatment NLR and PLR, progression-free survival (PFS) and overall survival (OS) in hepatocellular carcinoma patients treated with sorafenib.

Method: A retrospective review of 65 patients with hepatocellular carcinoma who were treated with sorafenib between February 2012 and December 2017. NLR was defined as the absolute neutrophil count diveded by the absolute lymphocyte count; PLR was defined as the absolute platelet count diveded by the absolute lymphocyte count. Cut off value determined according to median values. The patients were further dived into the two groups as NLR $\leq$ 4 and NLR > 4; PLR $\leq$ 157 and PLR > 157. OS and PFS were assessed using the Kaplan-Meier method.

Result: The median age was 62 years (range,29 to 83 years). 12 to 65 patients were female (18,5 %) and 53 were male (81,5 %). The etiology was consist of 58,5% hepatitis B, 10,8% hepatitis C, 18% cryptogenic. Median PFS was 18 (95 % confidence interval (Ci) 13-22) weeks in those with NLR $\leq$4 and 12 (95 % Ci 3-20) weeks in NLR > 4 (p:0,46); 18 (95 % confidence interval (Ci) 13-22) weeks in those with PLR $\leq$157 and 8 (95 % Ci 0-16) weeks in PLR > 157 (p:0,024) . Median OS was 32(95 % Ci 19-44) weeks in those with NLR $\leq$4 and 22 (95 % Ci 7-36) weeks in NLR > 4 (p:0,187); 33 (95 % Ci 24-41) weeks in those with PLR $\leq$157 and 19 (95 % Ci 3-34) weeks in PLR >157 (p:0,188). In table 1 the results was showned.

Discussion and conclusion: Patients with increased pre-treatment NLR and PLR showed poorer PFS and OS than patients with HCC who were treated with sorafenib without increased NLR and PLR. We concluded that the NLR and PLR might serve as a useful biomarker for these patients. The limitation of the study was that the number of patients was low, so there was no statistical significance despite the numerical difference. Further large prospective studies should be carried out to confirm whether NLR and PLR have predictive value.

Keywords: hepatocellular carcinoma, sorafenib

Table 1. Patients demographics and survival results

Variables	*Number*	*p Value*
Median Age	62 (29-83)years	
Gender Female / Male	12 (18,5 %) / 53 (81,5 %)	
Etiology Hepatitis B /Hepatitis C/Cryptogenic	58,5%/10,8%/18%	
OS NLR >4 /NLR <4 PLR >157/PLR < 157	22/32 19/33	0,187 / 0,188
PFS NLR >4/NLR <4/ PLR >157/PLR < 157	12/18 8/18	0,46 / 0,024

OP-010

SKELETAL MUSCLE AREA CHANGES IN ANTI-EGFR COMBINED CHEMOTHERAPY REGIMENS IN RAS WILD METASTATIC COLORECTAL CANCER.

Osman Köstek[1], Hosna Eslame[1], Nazım Can Demircan[1], Serdar Solak[2]

[1]Trakya University, Department Of Medical Oncology
[2]Trakya University, Department Of Radiology

Introduction: Various intracellular signaling pathways are related to the regulation of skeletal muscle protein degradation. It is known that one of the EGFR signaling transduction pathway, phosphatidylinositol 3-kinase/Akt signaling cascade normally plays role in protein synthesis. Currently, there is no data about anti-EGFR therapies are associated with skeletal muscle degradation. Our aim is to compare cetuximab and panitumumab therapies in combination with FOLFOX or FOLFIRI in the aspect of skeletal muscle area change in the first or second line of RAS wild mCRC patients.

Material and methods: This study is a retrospective descriptive study. To assess the skeletal muscle area change during therapy, only 40 patients were analyzed due to the presence of baseline and follow-up CT images in our hospital. Baseline and follow-up CT studies of the patients were performed. CT images which were performed at the diagnosis and follow up during treatment period before progression was used for analysis. To measure the cross-sectional areas of SMA, L3 was set as a landmark, and muscles were identified based on their anatomic features, and the structure of those specific muscles was quantified based on pre-established thresholds of skeletal muscle tissue. Cross-sectional areas (cm^2) of muscle tissues were computed for each image.

Results: A total of 40 patients (28 patients in cetuximab arm and 12 patients in panitumumab) were treated at the first or second-line setting. First-line treatment regimens consisted of FOLFOX-Cetuximab (5 patients), FOLFIRI-Cetuximab (7 patients), FOLFOX-Panitumumab (1 patient) and FOLFIRI-Panitumumab (5 patients) (p=0.66). Second-line treatment regimens were FOLFOX-Cetuximab (5 patients), FOLFIRI-Cetuximab (11 patients), FOLFOX-Panitumumab (none) and FOLFIRI-Panitumumab (6 patients) (p=0.17). About 73.1 % were male with a median age of was 60 (55-67) years. The median time interval between 2 CT images were 15.7 (9.4-26.1) weeks and was similar between the groups (for cetuximab, 16.0 (9.1-26.1) months vs for panitumumab, 15.7 (12.5-25.7) months, p=0.81, respectively). Although skeletal muscle area change was not significantly associated with irinotecan (p=0.06) and oxaliplatin (p=0.24) based therapy regimens, there was a trend towards irinotecan-based regimens had more skeletal muscle loss. In subgroup analysis for treatment line, especially second-line treatment with the irinotecan-based regimen in combination with cetuximab was significantly related with skeletal muscle loss (p<0.01) compared to those with panitumumab (Table 1 and 2).

Conclusion: Anti-EGFR inhibition with cetuximab plus FOLFIRI regimen was associated with diminished skeletal muscle area in the second-line. Further studies are needed to clarify the possible association between skeletal muscle loss and anti-EGFR combination therapies in RAS mCRC patients.

Keywords: skeletal muscle area, cetuximab, panitumumab, metastatic colorectal cancer, RAS wild

Table 1. Chemotherapy in combination with anti-EGFR treatment regimens and skeletal muscle area change

Chemotherapy	*Anti-EGFR*	*Count*	*Baseline Median (IQR)*	*During therapy Median (IQR)*	*p value*
Oxaliplatin-based	Cetuximab	10	152 (110-170)	136 (91-174)	0.16
	Panitumumab	1			
Irinotecan-based	Cetuximab	18	131 (110-163)	123 (96-152)	<0.01
	Panitumumab	11	140 (128-148)	138 (128-146)	0.24

Chemotherapy	*Targeted*	*Line*		*Second SMA - Baseline SMA*
Oxaliplatin based	Cetuximab	1st	Z	-1,214
			p value	0.22
		2nd	Z	-0,674
			p value	0.50
Irinotecan based	Cetuximab	1st	Z	-1,183
			p value	0.23
		2nd	Z	-2,845
			p value	<0.01
	Panitumab	1st	Z	-0,135
			p value	0.89
		2nd	Z	-1,363
			p value	0.17

OP-011

RARE BRAIN METASTASIS OF COLORECTAL CANCERS: RISK FACTORS, PROGNOSIS AND CLINICAL FEATURES.

Tarık Demir[1], Altay Aliyev[1]

[1]Bezmialem Vakif University

Aim: Colorectal cancer (CRC) is the second most common cancer in the world. The most common metastasis to liver and recurrence most commonly occurs in the liver. Brain metastases (BM) from CRC are rare and incidence is increasing tends. In recent years, improvements in diagnosis and treatment have improved the survival and it is increases the likelihood of encountering rare metastases, such as brain metastasis. With appropriate and modern treatment methods may prolong survival even BM patients. The aim of this study is to analyze the clinicopathologic, demographic, treatment and survival data of BM in CRC at our clinic.

Patients and Methods: Between June 2013 and December 2017 864 patients with a histological diagnosis of CRC were analyzed from the file and electronic registration system retrospectively. Descriptive statistics were expressed as mean or median for continuous variables, and categorical variables were expressed as number of cases and (%).

Results: Ten patients (1,1%) identified had BM (7 male and 3 female). The median age at diagnosis of CRC was 59 years. The disease stage at time CRC diagnosis: 7 patients had stage IV; 2 patients stage IIIC; and one patient was stage II. The primary site of CRC: sigmoid tumor in 6 patients; rectal in 3 patients; and 1 patient had right flexure. However, during the development of the BM, the median age was 60, and the median survival time was 5 months after BM. During the study, it was determined that 4 of the BM patients were alive and 6 were died. Three CRC patients had synchronous BM and seven patients developed BM metachronously. When assessed for extracerebral metastasis lung metastases were found in all patients, liver in 5 patients, bone in 1 patient and surrenal metastasis. In three patients had only one brain lesion, 2 lesions in 4 patients, 3 lesions in 1 patient and multiple lesions in 2 patients. Treatment for BM included whole-brain radiotherapy (WBRT, n=4), metastasectomy + radiotherapy (n=2), stereotatactic radiotherapy (n=1) and supportive treatment (n=3).

Conclisoun: Brain metastasis is an advanced stage of CRC and the survival time is short after brain metastasis develops. Increased aggressive treatment options are associated with increased survival and unusual metastatic sites in metastatic patients. Brain metastasectomy can improve survival in appropriate and selected cases, even in the presence of extracerebral metastases. Baseline brain imaging can be planned for patients especially initially presented with lung metastasis of left colon tumors.

Keywords: Metastatic Colorectal Cancer, Brain Metastasis, Prognosis

OP-012

OLEUROPEIN AGAINST GASTRIC CANCER: A NEW HOPE OF THERAPY

Mehmed Kursad Türkdoğan[1], Abdurrahim Koçyigit[2], Eray Metin Güler[2], Ömer Faruk Özer[2]

[1]Sabahattin Zaim Universty, Health Sciences Faculty, Department Of Nutrition And Dietetics, Istanbul, Turkey
[2]Bezmialem Vakif Universty, Medical Faculyt, Department Of Biochemistry, Istanbul, Turkey

Aim: Olive and olive oil, the traditional and essential foods of the Mediterranean diet, possesses many nutritional and healthful properties. Oleuropein (OLE), the predominant phenolic compound of the olive fruit and leaves of *Olea europaea* L. (Oleaceae), has many therapeutic effects such as anticarcinogenic, antiatherogenic, anti-inflammatory and antimicrobial etc. Also, it has restorative efficacy in organ injuries induced by chemotherapy. Gastric cancer is the most frequent and fatal malignity in many parts of the world and it is generally related to harmful dietetic factors. The anticarcinogenic role of OLE in gastric cancer has not been studied sufficiently and the underlying mechanisms of its action remains yet unknown. In this study, we aimed to assess cytotoxic, genotoxic, apoptotic and reactive oxygen generating effects of OLE on gastric adenocancer (G.CA) cells in vitro.

Methods: A standard cell line (AGS) from G.CA cells were used and analyzed after a 24 h exposure to OLE with different concentrations. The cytotoxicity, reactive oxygen species (ROS) generation and genotoxicity were investigated by the ATP cell viability assay, 2',7'-dichlorodihydro-fluorescein-diacetate assay (H2DCF-DA) and alkaline single cell gel electrophoresis assay (Comet Assay) respectively. Apoptosis induction was detected by acridine orange/ethidium bromide double staining and Western Blotting method below the half-maximal growth inhibitory concentration (IC_{50}) value.

Results: OLE reduced G.CA cells viability (60%) at the maximum concentration (500 μmol/L) and also resulted in approximately 100% DNA damage and 60% apoptosis depending on the dose in G.CA cells. Cell viability was also significantly reduced in relation to increased intracellular ROS levels ($p < 0.05$-0.001).

Conclusion: Increased doses of olive fruit and leaves' polyphenolic compound OLE may increase ROS production by pro-oxidant activity in G.CA cells, resulting in DNA damage, apoptosis and cytotoxicity. Nutrition rich in olive seems to be both protective and therapeuthic against gastric cancer and OLE may be a new, potential chemotherapeutic agent in the next future.

Keywords: Oleuropein, gastric cancer, apoptosis, DNA damage

OP-013

A REPORT OF SEVEN CASES OF CONCOMITANT RAS AND BRAF MUTATION IN COLORECTAL CANCER

Özturk Ates[1], Suayib Yalcin[2]

[1]Health Science University, Dr. A.y. Ankara Oncology Hospital, Ankara, Turkey
[2]Hacettepe University Cancer Institute, Department Of Medical Oncology, Ankara, Turkey

Introduction: Colorectal cancers (CRC) comprise three distinct pathways such as chromosomal instability, microsatellite instability and CIMP. These pathways involving different genetic or epigenetic abnormalities have been described for the development of CRC. Rat sarcoma viral oncogene homolog (RAS) and B-Raf murine sarcoma viral oncogene homolog B1 (BRAF) are members of the same signaling pathway (RAS-RAF-MAPK) in CRC. It is generally assumed that BRAF mutations are seen only with wild type RAS in CRC. But RAS and BRAF are not mutually exclusive. We evaluated the association of RAS and BRAF mutations with clinicopathological features in Turkish CRC patients.

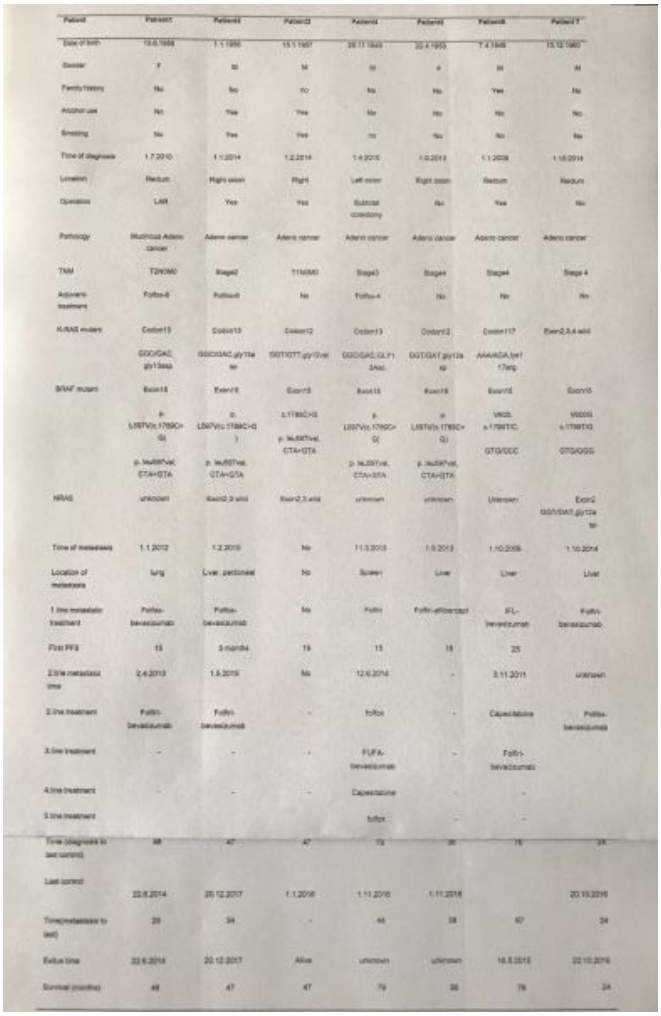
Material and Methods: We conducted a retrospective observational study. DNA was extracted from formalin-fixed paraffin-embedded tumor tissue and the mutation status of the *RAS* gene (exons 2, 3, 4) and BRAF (exon 15 V600, V597) was assessed using a polymerase chain reaction enzyme-linked mini sequence assay based DNA sequencing method. For detection of mutations, the protocol supplied by the manufacturer of PCR products was applied using the ABI PRISM SNaPshot Multiplex Kit (Applied Biosystems).

Results: We've identified concomitant BRAF and RAS mutations in seven patients. Median age was 59 (54-67) years. Five of these patients were males. Three patients had right colon cancer, three patients had rectum and one patient had left colon cancer. Demographic characteristics of the patients are summarized in Table 1. Three patients harbored KRAS with a codon 13 mutation (gly13asp) along with a BRAF variation of L597V in exon 15 (p. L597V(c.1789C>G) p. leu597val, CTA>GTA). Two patients harbored KRAS with codon 12 mutations, one harbored the gly12val mutation with a variation of leu597val in the BRAF exon 15 codon, the other harbored a gly12asp mutation with p. L597V(c.1789C>G) p. leu597val, CTA>GTA in the BRAF exon 15 codon. One patient harbored a codon 117 mutation with a BRAF V600E mutation. The last patient harbored a NRAS exon 2 (gly12asp) mutation with the GGT/GAT, V600G mutation in the BRAF exon 15 codon.

Discussion: KRAS mutations are seen in many parts of the colon at various rates. In the TURKRAS study, a KRAS mutation was detected in 45% of cases. There is a significantly higher KRAS mutation frequency in female patients. The BRAF gene is localized in 7q34 and consists of 18 exons. Usually exon 15 and 11 mutations are observed. The BRAF mutation is rarely seen in KRAS mutant CRC patients. Shen Y et al determined the association of these mutations in 11 patients in their studies. BRAF exon 15 and exon 11 mutations were seen in seven and four patients, respectively. In another trial by Mao C et al, the rate of KRAS, BRAF and NRAS was 43%, 25%, and 8%, respectively. They found that six patients harbored concomitant KRAS and BRAF mutations.

Conclusions: The carcinogenesis of CRC is at present still not understood. Further studies are warranted to elucidate the carcinogenesis of CRC.

Keywords: RAS mutation, BRAF mutation, Colorectal Cancer



OP-014

CAN PLATELET LYMPHOCYTE RATIO AND NEUTROPHIL TO LYMPHOCYTE RATIO BE USED AS PREDICTORS FOR HEPATOCELLULAR CARCINOMA?

Ebru Hatice Ayvazoğlu Soy[1], Hüseyin Onur Aydın[1], Gökhan Moray[1]

[1]Başkent University Faculty Of Medicine, Department Of General Surgery

Aim: To investigate the predictive value of platelet to lymphocyte and neutrophil to lymphocyte ratios for hepatocellular carcinoma (HCC) outcomes

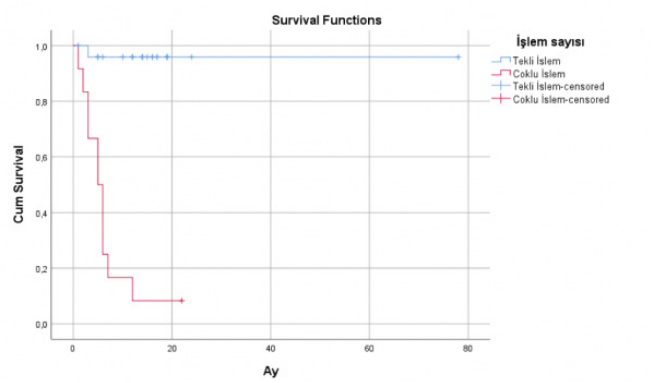
Methods: The clinical data of 37 HCC patients was retrospectively collected. All of the HCC patients were treated with conventional methods; TACE, RF or both. The patient and tumor characteristics, platelet to lymphocyte ratio (PLR) and neutrophil to lymphocyte ratio (NLR) were recorded. The association between PLR, NLR and tumor free survival rates, recurence rates, need of repeated conventional therapy were analysed.

Results: The mean MELD score of 37 HCC patients was 10,75±4,484 (mean age 59,59±17,23 years). High PLR and NLR ratios were found to be asssociated with HCC recurrence ($p<0,01$). However PLR and NLR ratios were irrevelant with tumor size and number ($p>0,05$). PLR and NLR ratios were significantly high in patients who had repated TACE, RF or both ($p<0,01$). The disease free survival of these patients who need

repeated procedures was 6,5 months and it was significantly lower than the other patients (p<0,05)

Conclusion:PLR and NLR were found to be predictive for aggressive tumor behavior, so they can be used as prognostic factors for HCC follow up.

Keywords: Hepatocellular carcinoma, platelet lymphocyte ratio, neutrophil to lymphocyte ratio, recurrence



OP-015

TREATMENT OPTIONS IN PATIENTS WITH METASTATIC PANCREATIC CANCER OLDER 70 YEARS

Abdullah Sakin[1], **Serdar Arıcı**[1]

[1]*Department Of Medical Oncology, Yuzuncu Yil University Medical School, 65090, Van, Turkey*
[2]*Department Of Medical Oncology, University Of Health Sciences, Okmeydani Training And Research Hospital, 34384, Istanbul, Turkey*

Backround: Most of patients with pancreatic cancer die related to disease because of aggressive pattern of disease and commonly diagnosed at advanced stage (1). Only curative treatment option is surgery. lthough, only 15-20% of patients have resectable disease at diagnosis (1,2). Recent trials have shown that systemic chemotherapy is superior than best supportive care (BSC) in terms of overall survival, in first and second line setting (2,3). There are no trial investigated that overall survival (OS) difference between new combination chemotherapy regimens and best supportive care but there are two studies showed that new combination regimens were superior than gemsitabine(3). There is well known that because of performance status and comorbidities, most of elderly patients with pancreatic cancer could not received chemotherapy. According to database of Veterans Affairs, 83% of ≥80 years patients with metastatic pancreatic cancer had no received any systemic therapy (4). In presented study we aimed to compare best supportive care, single agent chemotherapy and combination regimens in higher 70 years patients with metastatic pancreatic cancer.

Material and method: Patients older 70 years with metastatic pancreatic cancer who were followed up okmeydani training and research hospital were included in this trial. Patients were grouped as BSC, single agent chemotherapy and combination chemotherapy.

Results: Totally 53 patients were included in this trial. 34 of patients (64.2%) were men and 19 of patients (35.8%) were women. The number of ECOG PS 3 or higher patiens were 18 (34.0%). 13 of patients (24.5%) had diabetes mellitus, 12 of patients (22.6%) hypertension and 7 of patients (13.2%) chronic ischemic heart disease. The patients number in BSC group was 22. 31 of patiens had received chemotherapy. 19 of patients (61.3% of receiving CT) had received single agent chemotherapy and 12 (38.7%) of combined chemotherapy. The median treatment cycle was 3 (1-6).(table)

The median OS were 2.0 (1.2-2.5) months in BSC group and 7.0 months in patients receiving chenotherapy. The median OS were 11.0 (1,1-22 months) and 5.0 (1,8-8,1 months) months in combination chemotherapy and single agent chemotherapy groups, respectively (log rank p = 0,039)(Figure).

Conclusion: As conclusion, if ECOG PS is appropriate we think that giving chemotherapy instead of BSC in patients with metastatic pancreatic cancer older 70 years and also combined regimens should be given instead of single agent chemotherapy.

Keywords: Pancreatic cancer, Chemotherapy, Survival, Supportive care

OP-016

COMPLETE MESOCOLIC EXCISION: SHOULD WE REVISIT THE 'MEDIAL APPROACH' FROM THE ONCOLOGICAL PERSPECTIVE?

Deniz Atasoy[1], **Afag Aghayeva**[2]

[1]*Istinye University Gaziosmanpasa Medical Park Hospital*
[2]*Acibadem Mehmet Ali Aydinlar University*

By removing the colon and mesocolon with their intact peritoneal envelope, together with central lymph nodes, potential spillage of the cancer cells from the lymph nodes, lymphatic vessels, tumor deposits or tumor cell islands could be prevented thus, preventing the local recurrence. The philosophy behind CME is based on embryological paradigm. Studies demonstrate better oncological results in favor of complete mesocolic excision(CME)over non-mesocolic surgery in Stage I-III colon cancers. For this reason, careful preservation of the mesocolic peritoneum is necessary. Besides, during CME, maximum effort should be undertaken to preserve the enveloped package for quality of surgery and histopathological evaluation. Lymphatic channels are present both in the submesothelial layer and interlobular septations starting from the mesocolic surfaces on every 0.14 mm and within 0.1mm. For this reason, violating the mesocolic surface extensively disrupts this lymphatic network. Lymphatic vessels within the Toldt's fascia that have no communication with the mesocolon's lymphatic network. Inferred from the same perspective, named as 'anatomo-embryological' paradigm, it could be put forth that intentional damage to the peritoneum in the base of the mesocolon in the beginning of the medial-to-lateral dissection appears conflicting with the oncological concept. This approach may pose a higher risk for tumor spread from the lymphatic channels or mesocolic tumor islands. Because the only violation of the avascular planes during the initiation of CME procedure is the step where dissection is performed in the base of the mesocolon for high tie. Lymphatic leak, especially in cases with metastases, will seed the tumoral cells in the surgical field. According to our hypothesis, this could be one of the reasons of the local recurrence after CME. Our current surgical approach may increase the risk of metastatic cell spillage. The reason could be that, during medial-to-lateral dissection, the procedure starts around the apical nodes, thus increasing the tendency to tumoral cell spillage and lymphatic leakage from the beginning of the medial dissection. Additionally, under positive-pressured pneumoperitoneum, tumoral cell seeding may be further increased. Furthermore, all the mesenteric lymphatic vessels coalesce around the mesenteric artery roots where CME starts thus further increasing the

lymphatic channel leakage. From the anatomo-embryological aspect, lateral-to-medial approach for CME seems to be more logical than medial-to-lateral approach. A point yet to be clarified is the thickness of the mesocolon overlying the vessel roots from behind and anteriorly. If it was demonstrated that posteriorly the vessel roots were covered with less mesenteric tissue, than starting from behind/lateral-approach will violate less lymphatic channels, thus causing less tumor spillage. For the verification of this hypothesis animal studies and prospective clinical studies are needed.

Keywords: complete, mesocolic, colon, cancer

OP-017

THE RELATIONSHIP BETWEEN NEUTROPHIL LYMPHOCYTE RATIO AND STAGE IN COLON CARCINOMA

Selim Yalçın[1], Gökhan Celenkoglu[2], Metin Demir[2]

[1]Kırıkkale University Faculty Of Medicine Dep Of Medicaloncology Kırıkkale; [2]Ankara Training And Trainig Hospital Ankara

Aims: Studies have shown that inflammation plays a role in the development of cancer. The importance of inflammation increases in determining survival and progression in most cancer types. In our study, we aimed to compare the neutrophil lymphocyte ratio associated with inflammatory process between advanced stage and early stage colon tumors.

Materials and Methods: We retrospectively reviewed the files of 132 patients with colorectal cancer who were admitted to Kırıkkale University Training and Research Hospital Medical Oncology Department between January 2013 and November 2017. We investigated whether there is a relationship between the stages of neutrophil lymphocyte ratio (NLO) and survival.

Results: The patients were divided into two groups according to TNM (Tumor Node Metastasis) classification and pathology radiological imaging methods as early stage (Stage I, Stage II Stage III) and advanced metastatic Stage IV colon. There were 52 (39.3%) and 80 (60.6%) patients who were defined as advanced colon. 75 (60%) of the patients were male and 47 (40%) were female. NLO at the time of diagnosis was compared. Mean NLR values of patients with early and advanced colon cancer were calculated as 4.33 and 5.01, respectively. There was no statistically significant difference in NLR between the two groups (p = 0.245). Survival rates were found to be statistically lower in advanced stage colon tumors compared to the early stage colon. p = 0.04).

Conclusions: In our study, we could not find a relationship between stage NLO and disease stage in patients with non-metastatic and metastatic colorectal cancer. Survival rates were statistically lower in advanced colon tumors than in the early stage colon. Although there were studies with low NLR in the metastatic process, our study did not support this in a statistically significant way, but the low rate of the patients in the advanced stage explains that it should be continued with more patients.

Keywords: Colorectal cancer, Neutrophil Lymphocyte ratio

OP-018

ROLE OF APPARENT DIFFUSION COEFFICIENT RATIO IN DIFFERENTIAL DIAGNOSIS OF BULKY TUMORS OF RECTUM AND PERIRECTAL REGION

Fatma Kulalı[1]

[1]University Of Health Sciences, Umraniye Training And Research Hospital

Purpose: Our purpose was to evaluate the role of some specific magnetic resonance imaging (MRI) findings and apparent diffusion coefficient (ADC) ratios in differential diagnosis of bulky tumors of rectum and perirectal region.

Methods: A total of 42 patients who had > 5 cm bulky tumors of rectum and perirectal region [21 (50%) women and 21 (50%) men] with a mean age of 53±14 (SD) were enrolled in this retrospective study. Pre-operative MRI with diffusion weighted imaging examinations of patients (n=42) were reviewed by an experienced radiologist. Qualitative (signal intensity, contrast enhancement pattern, the existence of lymphadenopathy and metastasis) and quantitative (ADC ratios) MRI findings were statistically analyzed according to histopathological results.

Results: Of 42 bulky tumors of rectum and perirectal region, 32 were malignant and 10 were benign. Among 32 malignant tumors, there were 26 rectal adenocancers, one prostate adenocancer, two leiomyosarcomas and three rectal gastrointestinal stromal tumors (GISTs). All rectal GISTs (n=3) showed peripheral heterogeneous arterial enhancement. In contrast to other tumors (n= 39), all rectal GISTs had hypointense peripheral components whereas central components were more heterogeneous and iso-/hyper-intense on T2-weighted sequences. Lymphadenopathy was associated with 24 adenocancers, one GIST and one leiomyosarcoma. Most of rectal adenocancers (22/26, 85%) showed homogeneous contrast enhancement. Mean ADC ratios of malignant tumors (0.58±0.09) were significantly lower than those of benign tumors (0.98±0.21) ($p<0.05$).

Conclusions: Some specific MRI findings combining with ADC ratio estimation can be helpful for differential diagnosis of bulky rectal/perirectal tumor and appropriate management of patient.

Keywords: apparent diffusion coefficient, diffusion weighted imaging, gastrointestinal stromal tumor, rectal cancer

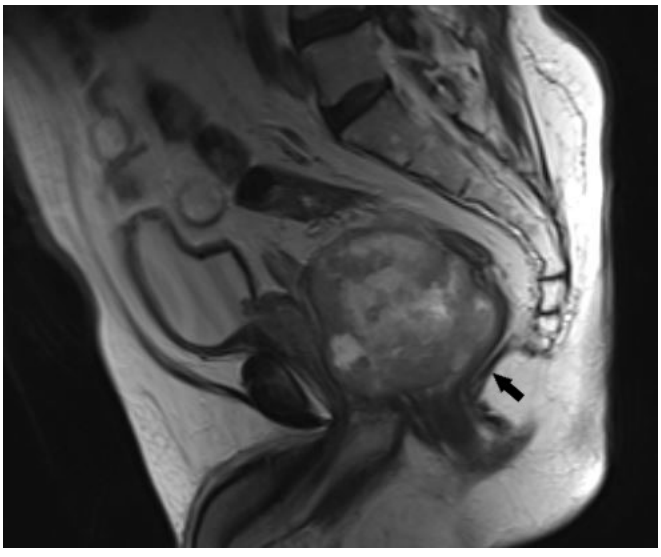


Figure 1. Sagittal T2-weighted MRI sequence showing bulky GIST (arrow) involving anterior wall of rectum

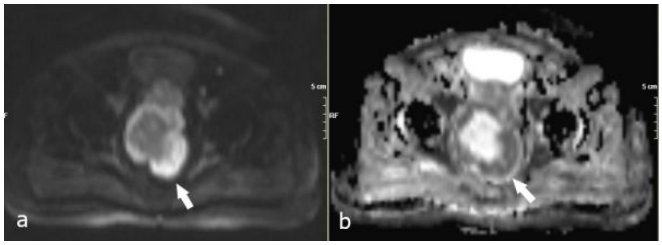


Figure 2. Diffusion weighted image (a) and ADC map (b) showing restricted diffusion in rectal GIST (arrow)

OP-019

STEREOTACTIC BODY RADIOTHERAPY FOR LIVER METASTASIS IN A RECTUM CANCER PATIENT: A CASE REPORT

Aytül Özgen[1], Tuğba Ulu[1], Gizem Kavak[1], Bektaş Kaya[1]

[1]Ankara Oncology Training And Education Hospital

Metastases to the liver are common, and stereotactic body radiation therapy (SBRT) is demonstrated as a well tolerated treatment of liver metastases. Colorectal cancers commonly metastasize to the liver, and long term survival is expected after metastasectomy. However, many patients are not eligible for surgical resection, thus many studies are investigating noninvasive techniques such as liver SBRT. Serious prospective trials have made evident that excellent local control with this approach coupled with an perfect safety record. SBRT allows for the delivery of high dose radiation in few fractions to the tumor with extreme accuracy while minimizing the damage to normal surrounding tissue. The Cyberknife system is an image guided robotic system that delivers SBRT which tracks tumors during respiration and automatically adjusts treatment for any patient movement. The most frequently used indications for SBRT are ≤5 liver metastases with maximum tumor sizes of 6 cm no extrahepatic disease, good performance status and adequate hepatic functions.

We present our treatment plan performed for rectum cancer patient who have only one liver metastasis is located at uncinate lobe. The prescription dose of 35 Gy was delivered in 5 consequtive days with cyberknife. The diameter of metastasis was smaller than 2 cm. The identification of target volumes proved to be challenging on simulation CT, due to the good response to chemotherapy. A radiologist, expert in liver lesion, was involved in target contouring and margin definition. An isotropic margin of 0.5 cm was added to the GTV (6.1 cc) in all directions, obtaining the planning target volume (PTV) (9.4 cc) The upper abdominal organs at risk (duodenum, right and left kidneys, aorta, inferior vena cava vein, lung and liver) were contoured according to the RTOG protocols. The prescribed dose was 35 Gy, the mean liver dose was 1.9 Gy. There were no elevations of the serum liver parameters during and one month after from SBRT.

The presented case report suggest that the SBRT approach is feasible and effective for liver metastases. The literature validation of our liver treatment plan showed that it has the potential for ensuring the effective and patient friendly delivery.

Keywords: SBRT, liver metastases, rectum cancer

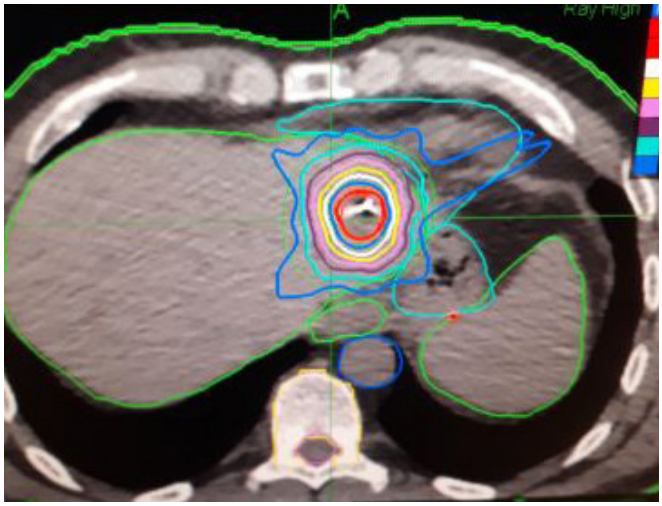


Figure 1. Planning CT of SBRT, axial image

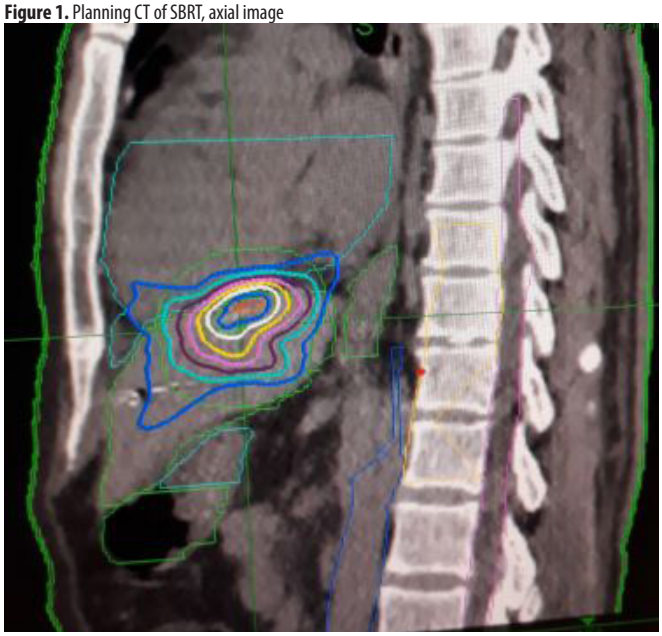


Figure 2. Planning CT of SBRT, sagittal image

Table 1. Targets, OARs, and dose constraints for SBRT

Target volumes	*Constraints*
PTV	V95% > 98%
Mean liver	1.9 Gy
Mean stomach	2 Gy
Mean duodenum	0.2 Gy
Mean heart	2.7 Gy

OP-020

EMERGENT SURGICAL CONDITIONS AND THEIR MANAGEMENT IN PATIENTS WITH GASTRIC CANCER

Semih Hot[1], Metin Yeşiltaş[1], Seracettin Eğin[1], Berk Gökçek[1], Dursun Özgür Karakaş[1]

[1]University Of Health Science, İstanbul Okmeydanı Suam

Purpose: Gastric cancer is the fourth most common type of cancer and has the second highest cause of cancer related mortality rate. Today, management of patients with gastric cancer

who present with various problems in emergency surgery outpatient clinics is still a serious problem. We aimed to present our experience about this subject in this study.

Methods: The clinical data of 59 consecutive patients who were hospitalized due to emergent surgical conditions with gastric cancer between 01 August 2015 and 01 August 2018 at the Emergency Surgery Department University of Health Science, İstanbul Okmeydanı SUAM were retrospectively analyzed.

Results: 59 patients were included in the study. The mean age was 60.1 (22-85). 17 patients (28.8%) were female and 42 patients (71%) were male. 23 patients had small bowel obstruction, while 8 patients had gastrointestinal bleeding. In addition, gastric tumor perforation was detected in 6 patients. However, 6 (10,1%) patients were diagnosed with gastric cancer for the first time in the Emergency Surgery Department. 19 patients underwent emergency surgical treatment and 6 patients underwent planned surgery after medical treatment. 4 patients underwent endoscopic procedure and 4 patients underwent percutaneous procedure in the interventional radiology unit. The mortality rate was 16.9% (10/59).

Conclusion: Especially patients with advanced stage or undiagnosed gastric cancer might present to emergency surgery outpatient clinics because of serious complications. These patients have high mortality and morbidity rates. Surgeons should be aware that surgical treatment and management of these patients is a very difficult clinical condition.

Keywords: Gastric cancer, Emergency, Surgery,

OP-021

CASE REPORT WITH LYNCH SYNDROME

Gizem Kavak[1], Bektaş Kaya[1], Aytül Özgen[1], Ebru Karakaya[1]

[1]Ankara Dr. Abdurrahman Yurtaslan Oncology Hospital Radiation Oncology Department

Lynch syndrome is the most common cause of inherited colorectal cancer (CRC). It is characterized by a significantly increased risk for CRC and endometrial cancer as well as a risk of several other malignancies. Hereditary nonpolyposis colorectal cancer (HNPCC) refers to patients and/or families who fulfill the Amsterdam criteria. Lynch syndrome is an autosomal dominant disorder that is caused by a germline mutation in one of several DNA mismatch repair genes. Total abdominal colectomy with ileorectal anastomosis and continued annual endoscopic surveillance of the remaining rectum is recommended in patients with Lynch syndrome who are found to have colorectal cancer.

Our patient's age is 61. The patient smoked 45 packs a year. The patient's family history revealed that his brother was diagnosed with colon cancer at 35 years old, also brother's daughter diagnosed with colon cancer too. His mother and two sisters were endometrial cancer, two aunts were colon cancer. There was no genetic analysis of the patient. In 2006, total colectomy was performed in another center with the diagnosis of multifocal colon cancer. As a result of the pathology, a synchronous tumor was observed in the synchronous three focus subserosal surface. The pathology result was adenocarcinoma. The column material removed 66 centimeters in length. The patient was diagnosed with stage 2 colon cancer and received 6 cycles of FUFA chemotherapy. The patient's family was not informed. He didn't come regularly to the patient controls. At the last check level of hemoglobin was 7.5 in June 2018. In the colonoscopy report was the tumoral mass lesion was seen between the sixth and fifteenth centimeters of the anal canal and biopsy was adenocarcinoma. Between 02.07.2018-08.08.2018, radiotherapy was aplied to the patient with helical Tomotherapy device; for a first phase 45 Gy in 25 fractions and for a second phase 5.4 in 3 fractions were given. Capecitabine were given simultaneously. In October 2018, the patient underwent segmental resection. Muscle layer and perirectal fat tissue infiltrating tumor. Tumor diameter is 3.5 cm. Tumor adenocarcinoma and staging was performed as T3N0Mx.

Therefore, as can be revealed from the case report, it is important to manage, control and inform patients with Lynch syndrome. As in this case, cancer may develop years later, so controls should not be disrupted. Family members should be informed about the disease and its risks. Control should also be offered to family members.

Keywords: Lynch Syndrome, Lynch Syndrome Management, Rectum Radiationtherapy, Lynch Syndrome Family Relationship, Genetic Information and Patient Education

OP-022

ARE RELATIONSHIP BETWEEN INFLAMMATION BASED SCORES AND INITIAL STAGE IN ELDERLY GASTRIC CANCER PATIENTS?

Canan Karan[1], Burcu Yapar Taşköylü[1], Atike Gökçen Demiray[1], Gamze Gököz Doğu[1], Serkan Değirmencioğlu[1], Arzu Yaren[1], Nail Özhan[1]

[1]Pamukkale University, School Of Medicine, Department Of Internal Medicinei Division Of Medical Oncologyi Denizli Turkey

Introduction: Currently, gastric cancer still remains its popularity among gastrointestinal system malignancies in the elderly. Inflammation has been reported to play an important role in carcinogenesis. The aim of this retrospective study was to evaluate relationship between C-reactive protein to albumin(Crp/Alb) and White blood cell to platelet(Wbc/Plt) at the time of diagnosis in elderly gastric cancer patients.

Method: This study enrolled 63 gastric cancer patients diagnosed and followed up between 2012 to 2018 at Pamukkale University Medical Oncology Clinic were reviewed retrospectively. Demographic data, smoking history, primary surgical operation, presence of metastases, Her2 status ,Crp, alb, Wbc, platelet values were recorded. We examined Crp/Alb , Wbc/Plt results in stage 4 patients compared to the other stage patients. All statistical analyses were performed using the SPSS package (version 18.0;SPSS, Chıcago, IL).

Result: Median age was 77(70-91) years old. Fourty four (69%) of them were male, 21(33%) had smoking history, 34(54%) of them resected primary, 24(38%) of them were initially metastatic stage, 5(7%) of them had her2 positive, 19(30%) of them has higher CEA and CA19-9 levels. The median PFS was 30(3-64) months and median overall survival was 18(1-130) months. There were no statistically significant correlations between CRP/Alb ratio , Wbc/plt ratio and stage (p=0,2, p=0,6).

Conclusions: There were no relationships between Crp/Alb, Wbc/Plt and initial stage in elderly gastric cancer patients. It must be confirmed with large randomise prospective studies.

Keywords: gastric cancer, inflamation, wbc/plt, crp/alb

OP-023

THE RELATIONSHIP BETWEEN NEUTROPHIL LYMPHOCYTE RATIO AND STAGE IN COLON CARCINOMA

Selim Yalçın[1]

[1]*Kirikkale University Medical Oncology Kirikkale*
[2]*Ankara Trainig And Research Hospital Ankara*

Aim: Nowadays, studies on the role of inflammation in the development of cancer are carried out. The importance of inflammation increases in determining survival and progression in most cancer types. In our study, we aimed to compare the neutrophil lymphocyte ratio associated with inflammatory process between advanced stage and early stage colon tumors.

Materials and Methods: We retrospectively reviewed the files of 132 patients with colorectal cancer who were admitted to Kırıkkale University Training and Research Hospital Medical Oncology Department between January 2013 and November 2017. We investigated whether there is a relationship between the stages of neutrophil lymphocyte ratio (NLR) and survival.

Results: The patients were divided into two groups according to TNM (Tumor Node Metastasis) classification and pathology radiological imaging methods as early stage (Stage I, Stage II Stage III) and advanced metastatic Stage IV colon. There were 52 (39.3%) and 80 (60.6%) patients who were defined as advanced colon. 75 (60%) of the patients were male and 47 (40%) were female. NLR at the time of diagnosis was compared. Mean NLR values of patients with early and advanced colon cancer were calculated as 4.33 and 5.01, respectively. There was no statistically significant difference in NLR between the two groups (p = 0.245). Survival rates were found to be statistically lower in advanced stage colon tumors compared to the early stage colon. p = 0.04).

Conclusions: In our study, we could not find a relationship between NLR and disease stage in patients with non-metastatic and metastatic colorectal cancer. Survival rates were statistically lower in advanced colon tumors than in the early stage colon. Although there were studies with low NLR in the metastatic process, our study did not support this in a statistically significant way, but the low rate of the patients in the advanced stage explains that it should be continued with more patients.

Keywords: Colorekctal cancer, NLR

OP-024

COLORECTAL CANCER WITH BONE METASTASES: SINGLE INSTITUTION EXPERIENCE

Dilek Erdem

Bahcesehir University Medical Faculty, Medical Oncology Department

Background: Colorectal cancer (CRC) is the third most seen cancer and one of the leading cause of cancer death. Bone metastases from CRC is not common and data is lacking. The aim of the study is demonstrating the characteristics of bone metastases in CRC.

Materials and methods: We retrospectively evaluated 356 patients underwent CRC surgery and 19 patients (5.3 %) had bone metastases.

Results: Metastatic colorectal cancer patients with bone metastases were mostly women (n=11, 57,8 %). The median age was 64,3 years(36-79 years range).Thirteen patients had rectal cancer (68,4 %). 5 patient had bone metastases initially and the other remaining 15 patients developed bone metastases during the follow up period with median 21.6 month interval. Among 19 patients with bone metastases, 6 patients had RAS-WT fenotype. The most common skeletal-related event was bone pain (80 %) and these are mostly diagnosed by PET-CT (90 %). Bone metastases were involved in multipl sites and the most common metastatic region was sacroiliac region (75 %). Most of the patients had another metastatic region and the most common site was liver (78 %). Treatment included radiotherapy (90 %) and biphosphonate (80 %). There was no patient underwent surgery. 14 patients had stage IV disease initially (73,6 %) and median OS was 19,4 months.

Conclusion: CRC patients with bone metastasis is a rare state and it is the an indicator of poor prognosis.

OP-025

AN İNTERESTING AND VERY RARE PRESENTATION OF EXTRALUMINAL GIST IN A MIDDLE AGED WOMAN

Yonca Yilmaz Urun[1], **Yucel Ustundag**[1], **Fatma Ayca Gultekin**[2], **Ramazan Kozan**[2], **Burak Bahadir**[3]

[1]*Bulent Ecevit University School Of Medicine, Gastroenterology Department*
[2]*Bulent Ecevit University School Of Medicine, General Surgery Department*
[3]*Bulent Ecevit University School Of Medicine, Pathology Department*

A 44 year old woman presented with signs of mild fever, epigastric pain and tenderness in April 2018. Her past medical history was uneventful except for a short duration of mild depression. She was using an antidepressant olanzapine and there was no previous history of any kind of surgery and or allergy. Her vital signs were normal and her physical examination revealed mild abdominal tenderness. Her routine blood test were normal except for mild to moderate elevation of c reactive protein (20 mg/dl) and slightly decreased hemoglobin Hmg 10.9 g/dl with a hypochromic micrositer peripheral blood smear. An upper abdominal ultrasonography revealed a 8x7.5 cm thick walled mass lesion located at the upper right quadrant extending inferiorly to the level of umbilicus. An abdominal computerized tomography revealed similar findings, but additionally CT depicted a connection of the mass with the lumen of 2nd part of the duodenum. There was also appearance of air inside the lesion. An upper endoscopy showed a fistulous opening in the 2nd part of the duodenum on the lateral side with a purulent drainage coming from this opening. A preliminary diagnosis was intra-abdominal abscess and or fistulizing eGIST (extraluminal gastrointestinal stromal tumor). Surgery was undertaken and nearly 8x7 cm tumoral mass lesion was easily removed from the second part of the duodenum and the small defect in the duodenum wall was primarily repaired. Pathology on macroscopy documented tumoral mass with a necrotic core and on microscopy, the tumor was consisted of highly proliferative spindle cells with a mitotic index more than 10. It was positive for vimentin and CD117 and negative for S100 immunostains. Thus, a diagnosis of eGIST fistulising into the duodenum was made and she was put on adjuvant imatinib treatment during her uneventful follow up period.

Keywords: Extraluminal gastrointestinal stromal tumor, fistulizing GIST

OP-026

COMBINATION OF OXALIPLATIN, CAPECITABINE, TRASTUZUMAB AND CHEMORADIOTHERAPY IN PATIENTS WITH GASTRIC CANCER

Huseyin Abali[1], Suayip Yalcin[2], Hüseyin Cem Önal[3], Faysal Dane[4], Berna Oksuzoglu[5], Nuriye Ozdemir[6], Huseyin Mertsoylu[3], Mehmet Artac[7], Celalettin Camci[8], Bulent Karabulut[9], Fatma Bugdayci Basol[5], Burcin Budakoglu[5], Mehmet Ali Nahit Sendur[6], Burce Goktas[10], Fatih Ozdener[10], Arzu Calisgan[11]

[1]King Hamad University Hospital, Al Sayh, Bahrain
[2]Hacettepe University School Of Medicine, Ankara, Turkey
[3]Başkent University School Of Medicine, Adana, Turkey
[4]Marmara University School Of Medicine, Istanbul, Turkey
[5]Dr. Abdurrahman Yurtaslan Ankara Onkoloji Training And Research Hospital, Ankara, Turkey
[6]Ankara Numune Training And Research Hospital, Ankara, Turkey
[7]Necmettin Erbakan University Meram School Of Medicine, Konya, Turkey
[8]Gaziantep University School Of Medicine, Gaziantep, Turkey
[9]Ege University School Of Medicine, Izmir, Turkey
[10]Roche Pharmaceuticals, Istanbul, Turkey
[11]Medstats Consulting, Istanbul, Turkey

Background: In this study, we evaluated the safety and tolerability of trastuzumab (T) in combination with oxaliplatin (O), capecitabine (C) and chemo-radiotherapy in the adjuvant setting in operated, HER-2 positive gastric or gastroesophageal junction adenocarcinoma patients.

Methods: We have screened 212 and enrolled 34 patients. All patients were curatively resected (R0, R1 with partial or total gastrectomy, with D2 lymph node dissection) and were HER2-positive (IHC 2+/FISH+ or IHC 3+). The primary objectives were safety and tolerability of the treatment combination and secondary objectives were disease-free and overall survival rates. Patients received (T) 8 mg/kg intravenously (iv) on Day 1 of cycle 1 and 6 mg/kg iv on day 1 of every following 3-weekly cycle for 1 year as 17 cycles, (O) 100 mg/m2 iv on Day 1 of cycles 1-3 and (C) 850 mg/m2 orally twice daily on days 1-14 of cycles 1-3 and 5 days per week during chemo-radiotherapy. Radiotherapy was given at a total dose of 45 Gy divided into 25 doses 5 treatment days per week for 5 weeks starting from the 1st day of cycle 4.

Results: The median age was 57 years (Min-Max: 35-74). Of the patients, 73.5% were male, 33 (97.0%) had an ECOG PS score ≤ 1,33(97.0%) had D2 lymph node resection. Staging was 3A or higher at the time of diagnosis in 76.4% of patients. Patients had high rate of tolerability to the combination regimen (90.3%) and successfully completed 3 cycles of O+C+T plus chemoradiotherapy followed by continuation with T, achieving the primary goal of the study by showing a better tolerability rate as compared to tolerability reported for INT0116 study (p=0.0068). After 25 months of follow-up confirmed through a telephone visit, 59.8% patients were still alive and median overall survival was not yet reached. Twelve patients died secondary to disease progression. There were no deaths due to toxicity. There were 6 dose reductions overall (1 for T, 2 for O and 3 for C). T was stopped in one patient; C was temporarily interrupted 11 times (mostly during radiotherapy) and stopped in 1 patient.

Conclusions: Trastuzumab in combination with capecitabine, oxaliplatin and radiotherapy in the adjuvant setting for gastric or gastroesophageal junction adenocarcinoma seems safe and tolerable. Clinicaltrials.gov number NCT01748773

Keywords: Trastuzumab, Oxaliplatin, Capecitabine, Adjuvant Therapy, Chemoradiotherapy, HER2+ Gastric Cancer

OP-027

PROGNOSTIC ANALYSIS OF GASTRIC NEUROENDOCRINE TUMORS (G-NETS) ACCORDING TO THE WHO 2017 CLASSIFICATION SYSTEM

Yusuf Karakas[1], Sahin Lacin[2], Olcay Kurtulan[3], Ece Esin[4], Veli Sunar[5], Cenk Sokmensuer[3], Suayib Yalcin[6]

[1]Hakkari State Hospital, Medical Oncology Clinic, Hakkari, Turkey
[2]Diyarbakır Gazi Yasargil Education And Researc Hospital, Diyarbakir, Turkey
[3]Hacettepe University School Of Medicine, Department Of Pathology, Ankara, Turkey
[4]Dr. A. Y. Ankara Oncology Teaching Hospital, Department Of Medical Oncology. Ankara, Turkey
[5]Zekai Tahir Burak Woman's Health Research And Education Hospital, Ankara, Turkey
[6]Hacettepe University Cancer Institute, Department Of Medical Oncology, Ankara, Turkey

Background: G-NETs are rare tumors but their incidence is gradually increasing. Despite the use of many classification systems, determining G-NET prognosis and planning the treatment is still a clinical challenge.

Patients and Methods: A total of 94 G-NET patients who diagnosed as gastric neuroendocrin tumor between 2000-2017 were screened and included to the study. All patients demographic characteristics, treatment details, and survival data were obtained from medical charts. All pathological samples were reevaluated by expert pathologists at our institution, GNETs were classified according to WHO 2017 grading system and the patients had been treated according to the local protocol.

Results: In total evaluated 94 patients, 50 (53.2%) of the patients were classified as G1 NET, 37 (39.4%) of them were G2 NET, 4 (4.2%) were well differentiated G3 NET and the remained 3 patients were poorly differentiated G3 neuroendocrine carcinoma (NEC). Median follow-up was 83.2 months. None of the G1 tumors had lymph node metastasis at the time of diagnosis, and only 1 (2%) G1 patient had a local recurrence during follow-up, and 5 years PFS rate for G1 and G2 tumors 97%, 82% respectively and statisticaly significant (p <0.001). However, the 5-year OS rates for G1 and G2 were 97% , 82%, respectively and there was no statisticaly significant difference (p = 0.141). When G2 and G1 G-NETs were compared according to their surgical approach, radical surgery was more frequently administered in G2 patients, rates were (25/37) 68%, (18/50) 36%, respectively (p <0.001). But there were no stastisticaly significant PFS differences in both G1 and G2 patients who underwent radical surgery or did not.

Conclusion: WHO 2017 NET classification system may has low prognostic value for determining the prognosis of G1 and G2 tumors. Performing radical surgery to G1 and G2 NETs did not add any additional benefit in term of PFS in our study. Therefore, conservative treatments should come into prominence for G1 and G2 tumors.

Keywords: Gastric neuroendocrine tumors, WHO 2017 neuroendocrine tumor classification, Prognosis, Grade.

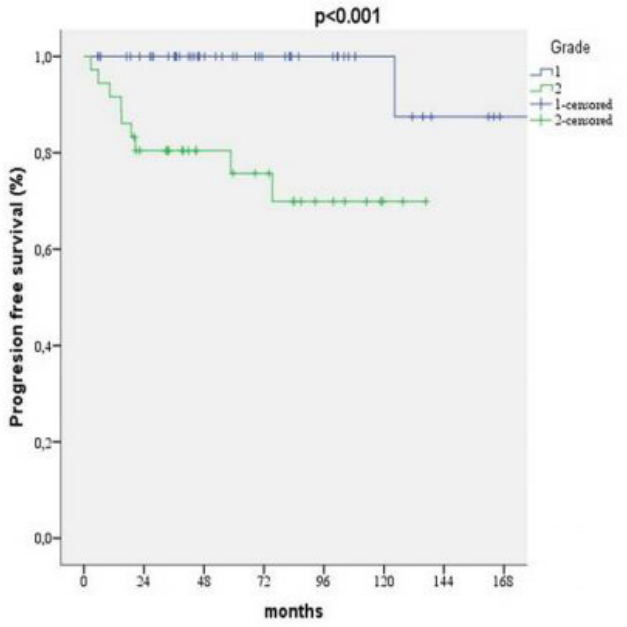


Figure 1. Progression-free survival of the grade 1 and grade 2 GNETs

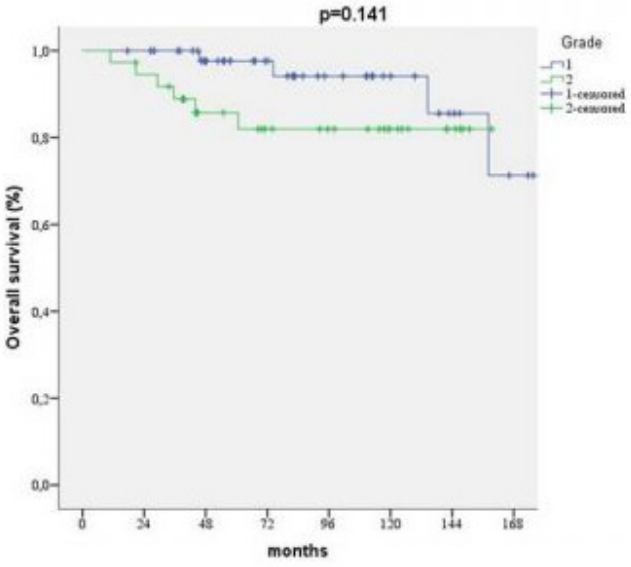


Figure 2. Overal survival of the grade 1 and grade 2 GNETs

OP-028

THE IMPORTANCE OF PRIMARY TUMOR LOCALIZATION IN LOCALLY ADVANCED GASTRIC CANCER WITH NEOADJUVANT CHEMOTHERAPY

Gökhan Uçar[1], Tülay Eren[2], Yakup Ergün[1], Ozan Yazıcı[3], Doğan Uncu[1], Mustafa Özdemir[4], Erdal Birol Bostancı[5], Nuriye Yıldırım Özdemir[6]

[1]Ankara Numune Training And Research Hospital, Department Of Medical Oncology, Ankara,turkey
[2]Dışkapı Yıldırım Beyazıt Training And Research Hospital, Department Of Medical Oncology, Ankara,turkey
[3]Gazi University Faculty Of Medicine, Department Of Medical Oncology, Ankara,turkey
[4]Türkiye Yüksek İhtisas Training And Research Hospital, Department Of Radiology, Ankara,turkey
[5]Türkiye Yüksek İhtisas Training And Research Hospital, Department Of Gastrointestinal Surgery, Ankara,turkey
[6]Yıldırım Beyazıt University Faculty Of Medicine, Department Of Medical Oncology, Ankara,turkey

Introduction: The standard treatment approach for locally advanced gastric adenocarcinoma is surgery after neoadjuvant chemotherapy. Despite different neoadjuvant therapy regimens, long-term survival has still been 20-30%. In the current study, we aimed to evaluate the prognostic significance of primary tumor localization in patients with locally advanced gastric adenocarcinoma who received neoadjuvant chemotherapy.

Methods: In between 2010 and 2017, 110 gastric cancer patients with regional lymph node involvement and/or T3 or T4 tumors who received modified DCF (Docetaxel, Cisplatin, Flourouracil) regimen were examined. Patients who did not have surgery or long-term follow-up data were excluded. Ninety patients were found to be eligible for evaluation. Patients were divided into two groups as cardia and non-cardia according to primary tumor localization. Groups were evaluated for disease-free survival and overall survival (DFS, OS). Disease-free survival from operation to disease recurrence, the overall survival from the operation until the death or the last contact date was taken.

Results: Ninety patients were included in the study. Twenty five patients were included in the cardia group and 65 patients were included in the non-cardia group. Median follow-up was 22.1 months (range; 2.7-96). The median age of patients was 59 years (26-73 year), 74% were male. The patient characteristics were similar in between cardia and non-cardia group. All patients received mDCF as neoadjuvant therapy and the median time between treatment onset and surgery was 2.9 months (0.8-16). Pathologic complete response was observed only in the non-cardia group after neoadjuvant therapy. ORR was 40% in both groups. Median DFS was significantly longer in the cardia group than the non-cardia group (34.9 vs 11.3 months, p=0.008). Median OS was significantly longer in the cardia group than the non-cardia group (NR vs 21.7 months, p<0.001). In multivariant analysis, primary tumor localization was found to be an independent prognostic factor for overall survival.

Discussion: Neoadjuvant therapy was still the standard approach in locally advanced resectable/unresectable gastric adenocarcinomas. Neoadjuvant therapy can be chemoradiotherapy or chemotherapy in cardia tumors and chemotherapy in non-cardia tumors. Recent studies have attempted to identify subgroups with greater potential to benefit from neoadjuvant and adjuvant therapy. There were molecular subtypes identified especially in gastric tumors. Molecular subtypes could be differ according to tumor localization. Cardia tumors may differ in terms of both treatment approach and clinicopathological features. In our

study, we showed that the cardia tumors have longer survival rates with neoadjuvant therapy. Patients with non-cardia tumors demonstrated poor prognosis despite having neoadjuvant therapy. In this patient group, more intensive or different treatment approaches can be considered as a research topic.

Keywords: gastric cancer, neoadjuvant, localization, cardia

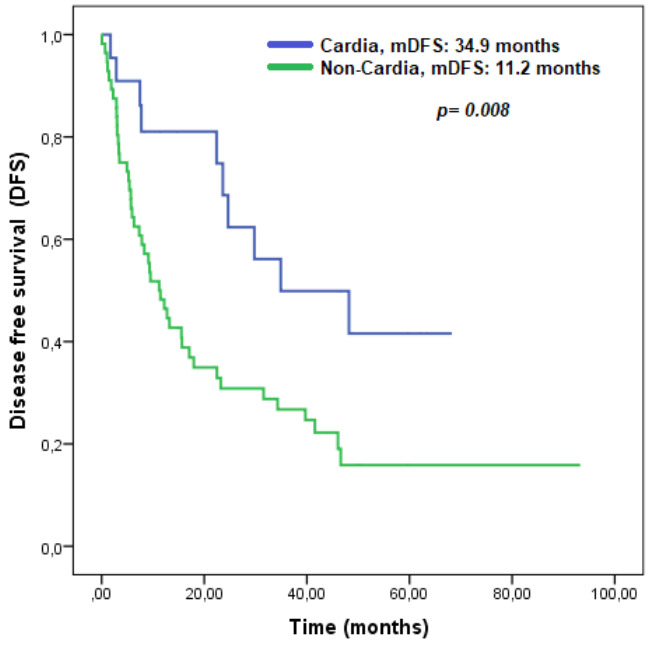


Figure 1. DFS curve

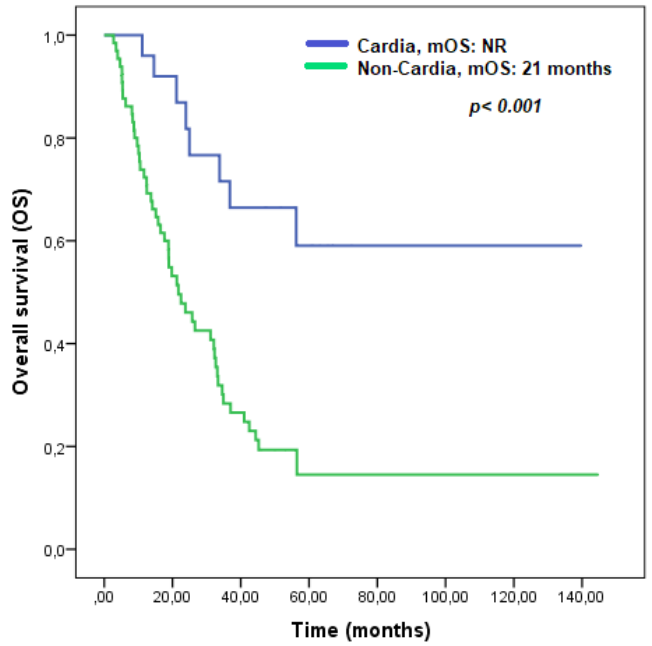


Figure 2. OS curve

Table 1. Baseline Patient Characteristics

Patient characteristics	*Cardia (n:25)*	*Non-Cardia (n:65)*	*p-value*	*Overall (N=90)*
Age, median years (range)	61 (37-71)	58 (26-73)	0.15	59 (26-73)
< 65 years	16 (64%)	50 (77%)	0.2	66 (73%)
≥ 65 years	9 (36%)	15 (23%)		24 (27%)
Gender				
Male	19 (76%)	48 (74%)	0.8	67 (74%)
Female	6 (24%)	17 (26%)		23 (%26)
Histopathological subtype				
Adenocarcinoma	22 (88%)	58 (89%)	0.9	80 (89%)
Signet ring cell	3 (12%)	7 (11%)		10 (11%)
Post-neoadjuvant surgery				
Yes	21 (84%)	56 (86%)	0.8	77 (86%)
No	4 (16%)	9 (14%)		13 (14%)
Neoadjuvat-surgery interval				
median months (range)	3 (0.9-16)	2.9 (0.8-16)	0.4	2.9 (0.8-16)

OP-029

IGF-CTP SCORING SYSTEM FOR ASSESSMENT OF HEPATIC RESERVE IN A TURKISH COHORT WITH HEPATOCELLULAR CARCINOMA

Sahin Lacin[1], Yusuf Karakas[2], Reham Abdel-Wahab[3], Manal Hassan[3], Xiao Lianchun[3], Ahmed Kaseb[3], Suayib Yalcin[4]

[1]Diyarbakir Gazi Yasagil Education And Training Hospital, Diyarbakir, Turkey
[2]Hakkari State Hospital, Hakkari, Turkey
[3]University Of Texas, Md Anderson Cancer Center, Houston, USA
[4]Hacettepe Cancer Institute, Medical Oncology Department, Ankara, Turkey

Background: The majority of patients with hepatocellular carcinoma(HCC) have cirrhosis and the Child-Turcotte-Pugh score (CTP) is the standard tool for hepatic reserve assessment in cirrhotic patients with HCC. Recently, it was reported that integrating plasma insulin-like growth factor-1 (IGF-1) level into the CTP score was associated with better patient risk stratification. In our study we aimed to examine the performance of IGF-CTP scoring our patient population in comparison CTP clasification system.

Method: We prospectively recruited 84 patients, determined demographic features of the patients and calculated their IGF-CTP score compared to CTP score. For the IGF-CTP score system, we modified the CTP score by replacing ascites and encephalopathy grading with plasma IGF-1 value. The prognostic significance of the two scoring systems was assessed in parallel. Univariate Cox model, C-index and U-statistics were used to compare the prognostic performance of the modified and original Child Pugh systems.

Results: There were 84 patients with all stage HCC, the majority of patients were male 71(84.5%) and 13(15.5%) of patients were female. The mean age of the patients at time of diagnosis was 61.7±11.9, 58(69.9%) of patiens were CTP A, 22(26.5%) were CTP B and 3(3.6%) were CTP C. As expected the majority of the patients were cirrhotic, 48(57.8%) were cirrhotic and 35(42.2%) of the patient were classified as non-cirrhotic, 36(42.9%) of the patients were HBV positive while 47(57.1%) of patients were negative for HBV, 8(9.5%) of the patients were HCV positive and 75(89.3%) of them were negative. Next, we reclassified to IGF-CTP scoring system by using the modified classification system: 26(31.3%) of the patients were IGF-CPG A, 47(56.6%) were IGF-CTP B and 10(12%) were IGF-CTP C.

IGF-CTP modified overall survival(OS), IGF-CTP A was 14.87 monts, IGF-CTP B was 4.14 months and IGF-CTP C was 1.97 months(p=0.0036). On the other hand, OS rate of CTP A was 8.36 months, OS rate of CTP B was 2.96 months and OS rate of CTP C was 0.03 month(p=0.0001). The median follow-up time was 23.9 months (95% CI: 10.5 – NA months).

Conclusion: Overall survival rates of each group identified through IGF-CTP scoring system tended to have longer survival compared to patient subgroups classified per CTP system, however, there was no statistically significant difference between two classification systems. In addition, a great number of patients were changed groups when modified system were applied.

Keywords: Hepatocellular Cancer, IGF-1, Child-Turcotte-Pugh, Cirrhosis, Overall Survival

Table 1. Child Pugh score vs. IGF-Child Pugh score

	Child-Pugh class			
IGF-CTP	*A*	*B*	*C*	*Total*
A	24	2	0	26
B	34	13	0	47
C	0	7	3	10
Total	58	22	3	83
Frequency missing	1			

Table 2. Compare OS between groups of IGF <= 26 vs. IGF > 26 in each categorical of Child-Pugh Score system

	Varname	*Level*	*N*	*Event*	*Median OS (95%CI) (M)*	*OS Rate at 1 Years(95%CI)*	*P value*
		"A" patients	58	37	8.36 (4.21 , 16.05)	0.46 (0.34 , 0.62)	
Child Pugh A							
	IGF	0>26	31	20	7.5 (4.34 , NA)	0.45 (0.29 , 0.69)	0.6362
		1<=26	27	17	8.36 (2.2 , NA)	0.46 (0.3 , 0.72)	
		"B" patients	22	18	2.96 (0.72 , NA)	0.09 (0.01 , 0.51)	
Child Pugh B							
	IGF	0>26	7	5	9.67 (0.46 , NA)	0.29 (0.06 , 1)	0.0659
		1<=26	15	13	1.97 (0.3 , NA)		

OP-030

RECURRENCE PATTERNS OF PANCREATIC CARCINOMA TREATED WITH ADJUVANT IMRT AND CHEMOTHERAPY

Halil Cumhur Yıldırım[1], Merve Şahin[1], Şefika Arzu Ergen[1], Didem Çolpan Öksüz[1]

[1]Istanbul University-Cerrahpasa Medical Faculty Radiation Oncology

Introduction: The role of adjuvant radiotherapy in resected pancreatic cancer remains controversial. Out-dated radiotherapy technics used in well-known randomized trials limit the interpretation of the results. We aimed to evaluate the recurrence patterns and survival rates of pancreatic cancer patients treated with Intensity Modulated Radiotherapy (IMRT).

Material-Methods: The study included 38 patients who were treated with postoperative IMRT for pancreatic cancer between 2010 and 2015.Median patient age was 58 (30-73) years old. Extent of resection was R0 in 14 (37%) and R1 in 24 (63%) patients. T stages of patients were 3 (8%) T2, 28 (74%) T3, and 7 (18%) T4 tumors. Regional lymph nodes were involved in 27 (71%) cases. Lymphatic invasion (LI) and vascular invasion (VI) were detected in 35 (%92) and 32 (84%) patients respectively. Following pancreaticoduodenectomy, all patients had 1-3 cycles of adjuvant gemcitabine (1000mg/m2 with 3 weekly infusion every 4 weeks). After exclusion of distant metastases with abdominal computerized tomography (CT), radiotherapy started concomitantly with capecitabine or infusional 5-FU based chemotherapy. Maintenance gemcitabine was given up to 6 months. Radiotherapy was started median 89 (47-138) days after surgery. Treatment volumes were contoured according to the RTOG guidelines. Patients were treated with a dose of 45-50.4Gy. CT imaging of patients with locoregional recurrence (LRR) were matched with radiotherapy planning CT and recurrent tumor volumes reconstructed. Recurrent tumor volumes were classified as in-field, marginal and out-field recurrences.

Results: Median follow up time was 18 months. Thirty-three patients died and 5 were still alive at the time of our analysis. LRR and distant metastases (DM) developed in 11 (29%) and 23 (61%) patients respectively. One patient had isolated local, 2 patients had isolated locoregional and 15 patients had only distant failures. Eight patients had both LRR and DM. LRRs were in-field in 7 patients, marginal in 1 patient and out-field in 3 patients. Median recurrence and metastase free survival was 13 and 11 months. One and 2 year DFS were 55.5%, 27.7%; OS were 73.6% and 37.1% respectively. Patients who had VI (+) and tumor size ≥3 cm had lower DFS. Patients who were younger than 60 years old, who had R0 resection, VI (-) and smaller than 3 cm tumors had higher OS in univariate analysis. In multivariate analysis tumor size ≥3 cm and vascular invasion were significantly associated with worse OS.

Conclusion:LRR mostly occured in the treatment field. This may be related to intrinsic radioresistance and high rates of patients with poor prognostic factors in this study. However, most patients die due to distant failures. Improving systemic targeting is of particular interest.

Keywords: pancreatic neoplasms, radiotherapy

OP-031

EVALUATION OF KRAS AND NRAS MUTATIONS OF 3865 SAMPLES FOR GUIDING THE TREATMENT OF PATIENTS WITH MCRC IN TURKEY

Duygu Cevik[1], Hüseyin Karadayı[2], Hakan Berkil[2]

[1]Amgen
[2]Genetix

Background: Monoclonal antibodies are often used for the treatment of colorectal cancers (CRC). However, nonresponse to these antibodies occur in the presence of RAS mutations. Mainly *Kras* and *Nras* mutations are seen at codons 12, 13 and 61. Mutations are also seen at codons 59, 117 and 146 rarely. This study is performed in order to evaluate the results of 3865 samples from CRC patients which were collected between January 2015 and September 2018 and also to understand the efficacy of the Minisequencing method used in the study.

Methods: Two round nested PCR was performed for the amplification of Exons 1, 2, 3 of *Kras* and *Nras* genes harbouring codons 12, 13, 59, 61, 117, and 146 followed by a multiplex Minisequencing reaction for the detection of potential mutations.

Results: A total of 3865 patients were analysed for the mutations in codons 12, 13, 59, 61, 117 and 146 of *Kras* and *Nras* genes. 13 patients were directly studied for *Nras* mutations.

Results were obtained from 3827 out of 3865 (99 %) patients for *Kras* mutations and no results were obtained from 38 (1%) of the cases. 1998/3784 (52,3%) patients were wild-type for *Kras* mutations while 1821 of them carried a *Kras* mutation (47,7%). 27 of 1821 (1,48%) patients carried two mutations. *Kras* mutation rates were 1113/1643 (67,74%), 347/1643 (21,11%), 15/1643 (0,91%), 61/1643 (3,71%), 15/1643 (0,91%), 92/1643 (5,59%) in codons 12, 13, 59, 61, 117, 146 respectively. Additional *Nras* mutation testing was performed for 131 patients which were found to be wild-type for *Kras* mutations. 9 /131 (6,87%) patients were found to carry *Nras* mutations while 122 (93,12%) of them were wild-type for *Nras* mutations.

Conclusions: After the analysis of CRC 3865 samples, it was shown that there is a high rate (47,7 %) of mutation finding in *Kras* and *Nras* genes. Our turn around time is 9 days. These findings show that *Kras/Nras* molecular testing is highly an effective approach to select patients who are more likely to respond to anti-EGFR therapy or rule out this treatment for those who are not likely to respond. Minisequencing technique used during the study is shown to be an ideal method for studying *Kras/Nras* mutations due to its high sensitivity and low cost.

Keywords: KRAS, NRAS, mCRC, Minisequencing, mutation, turn around time, codons, wild-type

OP-032

SURVIVAL ANALYSIS OF PULMONARY METASTASECTOMY PATIENTS FOR COLORECTAL CARCINOMA

Bülent Mustafa Yenigün[1], Gökhan Kocaman[1], Ferruh İbrahimov[1], Betül Bahar Kazak[1], Elvin Hamzayev[1], Murat Özkan[1], Cabir Yüksel[1], Serkan Enön[1], Ayten Kayı Cangır[1]

[1]Ankara University School Of Medicine Thoracic Surgery Department

Introduction: Colorectal carcinoma (CRC) often have pulmonary metastases. Five year survival rate is about %5 for untreated metastatic colorectal carcinoma. Resection of lung metastases (LM) from CRC is increasingly performed with a curative intent because after metastasectomy survival rates come up to %70. In this study we analysed our patients' survival rates who had pulmonary metastasectomy for colorectal carcinoma metastases.

Methods: We retrospectively reviewed the data of 76 consecutive patients who underwent pulmonary metastasectomy for colorectal carcinoma metastases between January 1998-December 2017 in Ankara University School of Medicine Thoracic Surgery Department. Preoperatively, thoracic computed tomograpy (CT) to asses the primary tumor and positron emission tomography (PET)-CT to evaluate other possible metastases were performed for all of the patients. In order for a metastasectomy to be performed, all of the patients needed to have the following: a complete resection of the primary tumor with no local recurrence or extra pulmonary metastasis, the presence of appropriate lesions for a complete resection in terms of number and localization, an adequate respiratory reserve, and no comorbidities preventing thoracic surgery. Sequentional operations were done for bilateral metastases and only after the curative treatment of primary tumors, metastasectomies were done. Sex, age, localisation of the metastases, resection type and pre-post surgery CEA levels were analysed. Survival analysis was done with Kaplan-Meier method and long-rank test.

Results: 48 (%63,2) male and 28 (%36,8) female patients with mean age 58.5±11,5 (31-88 years). 35 (%46) patients had right, 30(%39,5) patients had left and 11 (%14,5) patients had bilateral operations. 60 (%78,9) patients had wedge resections, 15 (%19,7) had patients had lobectomies and 1 (%1,4) patient had pneumonectomy. There were no perop mortality. 5 year survival rate was %69,9. Pre-thoracotomy measured CEA levels were found to be correlated with survival. (p=0,001).

Discussion: It is possible to achive longer 5 year survival rates after pulmonary metastasectomy for metastatic colorectal carcinoma patients. This study has shown that many prognostic factors are effective on survival.

Keywords: Colorectal, carcinoma,

OP-034

DIAGNOSTIC VALUE OF 18 F-FDG PET/CT FOR STAGING OF GASTRIC SIGNET RING CELL CARCINOMAS

Esra Arslan[1], Ekrem Çakar[2]

[1]Istanbul Health And Science University Istanbul Research And Education Hospital Clinic Of Nuclear Medicine
[2]Istanbul Health And Science University Istanbul Research And Education Hospital Clinic Of General Surgery

Introduction: Gastric cancer is the fifth most common cancer worldwide.1The main and most frequent types of gastric cancers are adenocarcinomas (AC), signet ring cell carcinomas (SRCC) are associated with poor prognosis.2 18F fluoro 2 deoxy glucose positron emission tomography computed tomography (FDG PET CT) documented useful modality for cancer staging and detecting metastasis.3 We aim to evaluate the diagnostic and predictive value of FDG PETCT in staging of SRCC.

Methods: 292 patients (mean age: 62.3±11.4) underwent 18F FDG PETCT for staging of GC. Clinicopathologic characteristics and standardized uptake value (SUV) findings defined for subtypes (AC, SRCC) are compared.

Results: 292 patients included in this study. 220 (75.3%) M and 72 (24.7%) F. 69.9% (n=204) diagnosed AC, 30.1% (n=88) diagnosed SRCC. SRCC (58.1±12.2 years) were younger than AC (64.2±10.6 years) (p=0,000). 18F FDG PET CT performed in 290 patients with total mean value of 12.9±8.7 in primary lesions. 2/292 patients had no FDG uptake. The mean value of FDG uptake found statistically higher in AC (14.3±8.7) than SRCC (9.7±7.7) (P=0,000). 18F FDG PET CT detected regional lymph node metastases(RLN) in 58 (26,9%) with SRCC and 158 (73,1%) with AC (P=0,046). Statistically larger mean size of LN detected in AC (1.6±1.2 cm) than SRCC (1.1±0.8 cm) (p=0,011).SUVmax of RLN found significantly higher in AC than SRCC (respectively mean SUVmax=8.3±9.4, 5.6±8.5; p=0,020). Primary SUVmax were statistically higher in SRCC with positive RLN (11.2±8.7) than SRCC with negative RLN (6.8±3.9) (p=0,002). Primary SUVmax were statistically higher in SRCC with distant organ metastases (15.4±8.6) than SRCC without organ metastases (9.07±7.4) (p=0,019). There were no statistically significant differences observed between AC and SRCC according to gender, gastric wall thickness, primary lesion sizes, SUVmax of lymph nodes, distant lymph node and organ metastases (p>0,05).

Conclusions: Despite recent progress in the diagnosis and therapy of GC, majority of patients diagnosed with locally advanced or metastatic stage of GC4. Role of F 18 FDG PET CT in SRCC is debated due to low sensitivity reports in published data. On the contrary Wu et al. highlighted a prominent role to increased 18F FDG uptake as a prognostic factor in primary lesions of GC.3 Moreover Filik et al. concluded that diagnostic value of

18F FDG PET CT in the preoperative staging of GC is acceptable.5 Kaneko et al. noted 18F FDG PET CT scoring system may contribute in the selection of GC patients.6 In our study although 18F FDG PET CT performed a lower FDG uptake in SRCC lesions, this method found to be safe and less invasive procedure to distinguish between AC and SRCC lesions. F FDG PET CT would improve diagnostic and prognostic accuracy due to significantly increased SUVmax value in SRCC patients with RLN and organ metastases. Further researches should be perform with larger study groups to achieve more assuring results.

Keywords: Gastric cancer, signet ring cell carcinomas,18F-fluoro-2-deoxy-glucose positron emission tomography/computed tomography, FDG-PET/CT

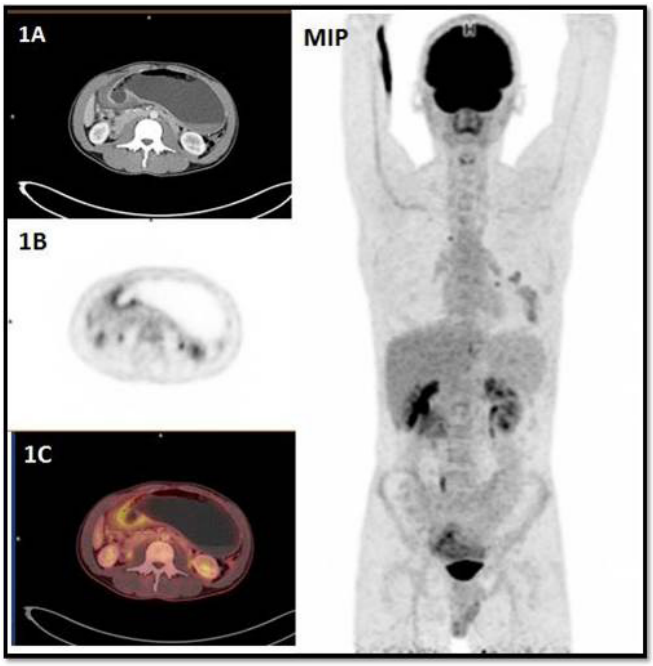
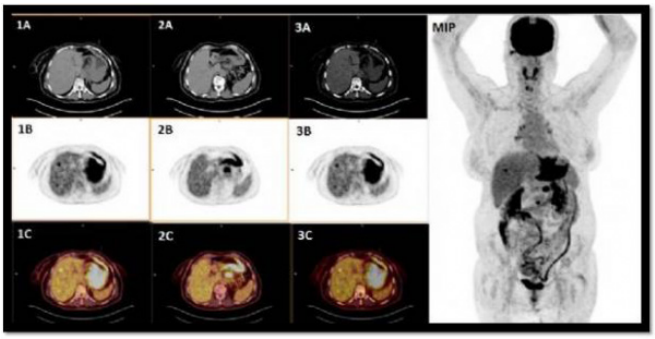


Figure 1. 55 year-old female fundus localised signed ring cell gastric carcinoma (SUVmax=30.23) (1A:PET,1B:CT,1C:PET-CT fusion),locoregional lymph node metastasis (SUVmax=40.78)(2A:PET,2B:-CT,2C:PET-CT fuzyon), liver metastasis (SUVmax=35.79)(3A:PET,3B:CT,3C:PET-CT



OP-035

DETECTION OF PROBLEM COPING ATTITUDES IN PATIENTS WITH COLORECTAL CANCER WHOM UNDER ADJUVANT TREATMENT

Emrah Eraslan[1], Pınar Eraslan[2], Umut Demirci[1]

[1]Dr.a.y. Ankara Oncology Hospital, Medical Oncology
[2]Tbmm Government Hospital, Psychiatry

Background: Patients with operated colorectal cancer can experience psychosocial problems related to both disease and treatment. Overcoming these problems will result in better treatment compliance. The aim of this study was to demonstrate the basic methods of coping with the problem in patients with colorectal cancer who were receiving adjuvant chemotherapy.

Materials and Methods: Patients who were on adjuvant chemotherapy (FOLFOX or Capeox) with colorectal cancer in the Dr.A.Y. Ankara Oncology Hospital Medical Oncology Clinic were included in the study. Beck Depression Inventory and Coping Inventory (COPE) Scale were applied to the patients.

Results: Twelve patients with a mean age of 59.64 ± 6.83 (43.47-69.67) were included in the study. Eight patients were male and 4 patients were female. Three patients had rectum and 9 patients had colon localization. Colostomy was present in 4 patients (33.3%). According to the Beck Depression Inventory, 8 patients (67.6%) were normal, 3 patients (25%) were mild and 1 patient (8.3%) was in the moderate depression group. There were no patients in the severe depression group. According to the COPE Scale, 10 patients (83.3%) were using religious coping. The basic coping method for one patient (8.3%) was positive reinterpretation and growth and for an other patient (8.3%) this was focus on andventing of emotions. Interms of secondary coping attitudes; positive reinterpretation and growth in 5 patients(41.7%), and use of instrumental social support in 2 patients (16.7%) were the main coping methods. The least used coping attitude for all patients was substance use.

Conclusion: It is clear that identifying psychosocial problems in cancer patients and overcoming these problems will increase treatment compliance and treatment success. In the majority of patients in our study, the absence or lack of depression is a very interesting finding. Low-level depression scores suggest that the coping strategies are used effectively in our patients. In addition, it is another interesting finding that the basic coping attitude was religious coping in almost all patients. Determining the coping attitudes of the patients and supporting them through these attitudes may provide additional benefits in terms of oncological treatment success and quality of life.

Keywords: colorectal, cancer

Poster Presentations

PP-002

COMPARING HAND-SEWN AND CIRCULAR STAPLED ANASTOMOSIS FOR ANASTOMOTIC LEAK FOR ESOPHAGEAL CANCER SURGERY

Bülent Mustafa Yenigün[1], Emre Muhammed Koçak[1], Feruh İbrahimov[1], Gökhan Kocaman[1], Ayşe Uğurum Yücemen[1], Murat Özkan[1], Serkan Enön[1], Ayten Kayı Cangır[1]

[1]Ankara University School Of Medicine Thoracic Surgery Department

Introduction: One of the most important early postoperative complication for GİS surgery is anastomotic leak. Mediastinitis and pleural empyema are the life-threatening results of anastomotic leak after esophagectomies. In our study we compared anastomotic leak rates for hand-sewn and circular stapled anastomosis among esophageal cancer patients.

Methods: 380 patients' data operated for esophageal carcinoma between 2003 and 2018 in Ankara University School of Medicine Thoracic Surgery Department were retrospectively reviewed. Patients were divided into two groups according to the anastomosis type. Group 1: Hand-sewn anastomosis, Group 2: Stapled anastomosis. Anastomotic leak rates for groups were compared with MedCalc programme.

Results: 198 (%58) patients were female and 182 (%42) patients were male. In goup 1 there were 238 (%62.6) patients and in group 2 were 142 (%37,4) patients. Anastomotic leak rate was %7,5 (n:18 patients) in group 1 and %1,6 (n:2 patients) in group 2. Anastomotic leak rates were statistically different between group 1 and 2 (p=0,011)

Discussion: Esophageal anastomosis are prone to leaks because esophagus dosen't have serosa, esophageal linear muscular layer is weak for hand suturing and surgical field for esophageal anastomosis is hard to reach. As esophageal anastomotic leaks are very hard to cure and esophageal anastomosis is very demanding procedure, the optimal anastomosis technic is very critical. In our study from the point of anastomotic leaks circular stapled esophageal anastomosis are seemed adtantageous over hand-sewn anastomosis. With detailed statistical analysis over patient groups, corresponding factors may be well understood.

Keywords: esophagectomy, stapled anastomosis, hand-sewn anastomosis, anastomotic leak

PP-003

THE EFFECT OF NEOADJUVANT THERAPY ON ESOPHAGEAL CARCINOMA PATIENTS FOR STAGING AND SURVIVAL

Gökhan Kocaman[1], Tamer Direk[1], Servet Seçkin Tunç Kasap[1], Süleyman Gökalp Güneş[1], Cabir Yüksel[1], Serkan Enön[1], Ayten Kayı Cangır[1]

[1]Ankara University School Of Medicine Thoracic Surgery Department

Introduction: Complete resection is the mainstay of long term survival for esophageal carcinoma (EC). For this reason as other gastrointestinal tumors, neoadjuvant therapy is advised for locally advanced esophageal carcinomas. There are meta-analysis in the literature showing benefits of multimodal treatment for locally advanced esophageal carcinoma for overall and disease free survival and R0 resection. These studies have let the way for studying effects of neoadjuvant therapy on clinical T2N0M0 EC patients. In this study we evaluated the results of cT2-3N0-2M0 EC patients who had esophagectomy after neoadjuvant chemotherapy/chemoradiotheraphy (CT/CRT).

Methods: Between 2010 and 2018 in Ankara University School of Medicine Thoracic Surgery Department there were 150 esophagectomies done for esophageal carcinoma. We included 31 patients who had neoadjuvant CT/CRT with full clinical and pathological staging information. Survival analysis was done with Kaplan-Meier method and long-rank test.

Results: 13 (%41,9) patients were female and 18 (%58,1) were male. 21(%69,7) patients were squamous cell carcinoma and 10 (%30,3)patients were adenocarcinoma. 14 (%45,1) patients had neoadjuvant CT and 17 (%54,9) patients had CRT. All patients have completed their pre-planned neoadjuvant therapy course. 25 (%80,6) patients had partial and 6 (%19,4) patients had total esophagectomy. Only one patient had R1 resection (skip metastasis). There was no perop mortality. Due to pathological staging 7 (%22,6) patients were stable, 23 (%74,2) patients were downstaged and only 1(%3,2) patient up-staged. 14 (%45,1) patients had complete response after neoadjuvant therapy. 5 year overall survival rate was %66,8. Sex (p=0,586), histopathological type (p=0,982), esophagectomy extent (partial/total) (p=0,514), neoadjuvant therapy type (CT/CRT) (p=0,478), complete response state (p=0,714), clinical (p=0,930)and pathological staging (p=0,398) was found statistically insignificant for overall survival.

Discussion: Neoadjuvant therapy is supposed to provide cure for early micrometastasis, downstaging, increase complete resection rates and finally increase survival rates. In our study 5 year survival rates are good for locally advanced and/or N+ esophageal carcinoma. There is also %45.1 complete response rate (ypT0N0M0) which is found irrelevant with survival probably because of insufficent patient number. In conclusion neoadjuvant therapy for cT2-3N0-2M0 EC seems to be beneficial for longer survival.

Keywords: neoadjuvant therapy, esophageal carcinoma, staging

PP-004

DETERMINATION OF THE PROGNOSTIC MARKERS BEFORE SECONDLINE TREATMENT IN METASTATIC PANCREAS CANCER

Burak Bilgin[1], Mehmet Ali Nahit Şendur[1], Ebru Karcı Güner[2], Mutlu Hizal[1], Yakup Ergün[3], Ece Esin[4], Elif Berna Köksoy[2], Muhammed Bülent Akıncı[1], Ahmet Sezer[5], Nuriye Özdemir[3], Berna Öksüzoğlu[4], Bülent Yalçın[1], Güngör Utkan[2], Yüksel Ürün[2]

[1]Ankara Yildirim Beyazit University, Department Of Medical Oncology
[2]Ankara University, School Of Medicine, Department Of Medical Oncology
[3]University Of Medical Sciences, Ankara Numune Research And Education Hospital, Department Of Medical Oncology
[4]University Of Medical Sciences, Dr Abdurrahman Yurtaslan Ankara Oncology Hospital, Department Of Medical Oncology
[5]Baskent University, School Of Medicine, Department Of Medical Oncology

Introduciton: pancreas cancer is one of the most common cancer related death in worldwide. Median overall survival (OS) is less than 12 months in metastatic pancreas cancer. Prognostic markers was evaluated intensively in the treatment naïve metastatic pancreas cancer, previously. However, there was a few study that evaluated to prognostic marker before secondline treatment in metastatic pancreas cancer. In our multicentre trial, we aimed that determinate to prognostic marker before second-line treatment in metastatic pancreas cancer.

Material and Methods: Totally, 161 patients who received second-line treatment were enrolled to study. Demographic,

clinic and pathological features of the patients were recorded as retrospectively. Neutrophil lympocyte ratio (NLR) was calculated and cutoff value was accepted as 3 according to previous trial. All statistical procedures were performed with SPSS 20 (SPSS Inc, Chicago, Illinois). A *P* value < 0.05 was considered to statistically significant. A 5% type-1 error level was used to infer statistical significant.

Results: Thirty-one percent of patients were female and 61.8 % of patient were male. Median age of the patients were 59 (30 – 79). In univariate analyses, ECOG performance status grater than 2, ≥ 65 years old, hypoalbunemia, thrombocytosis, presence of peritone metastatasis, high ALP and CEA levels and NLR ≥ 3 were determinate as poor prognostic factor. Presence of anemia, LDH level and CA 19.9 levels were also found as non statistical significant factors. In multivariate analyses, NLR ≥ 3 was identfied as significantly poor prognostic factor (P=0.04).

Discussion: Metastatic pancreas cancer is the one of the poor survival type of cancer. We found that multible prognostic factor in univariate analyses and also NLR in multivariate analyses as poor prognostic factor. These findings can be help to treatment choice and predict to survival.

Keywords: prognostica markers, neutrophil lymphocyte raito, pancreas cancer, secondline

PP-005

OUTCOMES OF 100 PATIENTS WITH GASTRIC CANCER TREATED WITH SURGERY FOLLOWED BY ADJUVANT CHEMO

Sondos El Khatib[1], Issa Mohammad[1], Fawzi Abuhijla[1], Yousef Ismael[1], Wafa Asha[1], Anoud Nsour[1], Jamal Khader[1], Rim Turfa[2]

[1]Radiation Oncology Department, King Hussein Cancer Center, Amman - Jordan
[2]Medical Oncology Department, King Hussein Cancer Center, Amman – Jordan

Background: Postoperative chemoradiation as per Intergroup-0116 trial ("Macdonald regimen") is considered standard for completely resected high risk gastric cancer. The aim of this report is to address treatment outcomes of patients with locally advanced gastric cancer treated with postoperative chemo-radiotherapy in a single institution. We investigated the effect of postoperative chemo radiotherapy on the relapse rate and survival rate of patients with D2-resected gastric cancer.

Methods: One hundred patients with gastric cancer were treated at King Hussein Cancer Center (Amman, Jordan) between 2007 and 2014. All patients underwent R0 resection with D1, D2 lymph node dissection. We coded D level by using the Japanese general rules. 49 (49%) received D1 dissection; 45(45%) received D2 dissection (removal of Japanese N1 nodal stations), and 6% received a less than D1 dissection (resection of less than Japanese N1 nodal groups). All received adjuvant chemo-radiotherapy The adjuvant CRT consisted of 400 mg/m2 of fluorouracil plus 20 mg/m2 of leucovorin for 5 days, followed by 4,500-5,000 cGy of radiotherapy for 5 weeks, with fluorouracil and leucovorin on the first 4 and the last 3 days of radiotherapy. Two 5-day cycles of fluorouracil and leucovorin were given 4 weeks after the completion of radiotherapy. The follow-up ranged from 2 to 92 months (mean, 21.2 months).

Results: At the time of follow-up; sixty two patients remain alive. Two pts (2%) died of treatment toxicity, neutropenic sepsis. The 2-year relapse-free survival for the entire cohort was 86%. Seven patients developed regional relapse, and ten patients developed local relapse; of which eleven patients (64%) had underwent D1 dissection. Median time to local and regional relapse was 11.5 months (range, 8–44 months) and 11months (range, 3–32 months) respectively. Sites of local and regional failure following resection include the gastric/tumor bed in 40 %, the anastomosis in 25% and the regional nodes in 40% of patients.

Conclusions: The development of local or regional failure is common, with higher rate of recurrence in patient in less than D2 dissection. In our experience, postoperative chemoradiation as per Intergroup-0116 seems to be substantially toxic, with a mortality rate which seems higher than reported in that trial. If postoperative chemo radiotherapy is the treatment choice for patients with gastric cancer, the treatment must be optimized to improve tolerance.

Keywords: radiotherapy

PP-006

MUCINOUS APPENDIX CARCINOMA, SINGLE CENTER EXPERIENCE

Ozturk Ates[1]

[1]Health Sciences University, Dr. A.y. Ankara Oncology Hospital, Ankara, Turkey

Introduction: Primary cancers of the appendix are rare and often diagnosed incidentally with surgery (e.g. acute appendicitis or other). The pathology of appendix tumors has been confusing. Roughly classified as; colonic type adenocarcinoma, mucinous adenocarcinoma, goblet cell adenocarcinoma, and neuroendocrine carcinoma.

Material and method: Patients diagnosed with pure mucinous adenocarcinoma between 2010 and 2018 were retrospectively analyzed. Demographic data, histopathological features, existence of recurrence and adjuvant chemotherapy ere recorded. Relapse free survival or death was noted. The last control dates were recorded. Furthermore, death was confirmed from the central death notification system.

Results: A total of 12 patients included in the study. The mean age of diagnosis of patients is 55.4 (44-72). Seven of these patients were male (%58.3), and 5 (%41.7) were female. Total of 10 patients was grade one, while others were grade 2 and grade 3. Total 3 patients had lymph node involvement. Seven patients had been treated with cytoreductive surgery and HIPEC. Total of 7 patients received chemotherapy (3 of them folfox, 2 of them xelox and xelox-bevacizumab the last one 5FU-IFN. Median overall survival and progression-free survival could not achieve (two patients died and 3 patients developed relapse). Survival at 6 years was 60% and PFS was 56 %.

Discussion: Management of primary appendix cancer is complex and depends on histologic features and extent of disease. Despite complete cytoreduction recurrence of mucinous appendix carcinoma is common. McConnell YJ et al recently published that PFS was 38.1 for patients' low grade and 21.6 months for high-grade disease. Median overall survival at 5 years is %75 to 81 and 45% to 65% for low-grade and high-grade. Low-grade appendix mucinous cancer is slow progressive disease and nonresponsive to systemic chemotherapy. Because of that adjuvant chemotherapy commonly not recommended. Our patient data is consistent with the literature has only 3 patients relapse. Recurrent patient was high-grade.

Keywords: Mucinous cancer, appendix

PP-007

EVALUATION OF SBRT FOR PATIENTS WITH LOCALLY ADVANCED UNRESECTABLE AND BORDERLINE RESECTABLE PANCREATIC CANCER

Aytül Özgen[1], Gizem Kavak[1], Ebru Karakaya[1], Bektaş Kaya[1]

[1]Ankara Oncology Education And Training Hospital

The aim of this study is to assess the efficacy and safety of sequentially integrated treatment of FOLFİRİNOX or Gemcitabine based chemotherapy and SBRT in patients with unresectable locally advanced pancreatic cancer

Although SBRT has been accepted as a standard of care option in pancreatic cancer, it has been increasingly practised in institutions because of several advantages: 1) SBRT can be delivered as a hypofractionated regimen over 3-5 days, 2) SBRT gives good local control while limiting the retard of additional therapies, 3) SBRT results in minimal acute side effects and improves pain, 4) the radiobiology of SBRT along with the ability to increase the dose to more than 50 Gy at the tumor vessel interface may increase the likelihood of a margin negative resection and decrease the risk of a subsequent local recurrence. Therefore, patients with localized pancreatic cancer have an increased likelihood of receiving aggresive trimodality therapy with a hopefor prolonged survival. Because SBRT is well tolerated and typically takes less than 1 week of treatment, patients are able to have chemotherapy quickly or undergo surgical resection.

In our study primary endpoint is to evaluate overall survival (OS), the overall survival time will be calculated from the start of chemotherapy to death. Secondary endpoints are to evaluate acute and late toxicities, pain relief, progression free-survival (PFS). Acute and late gastrointestinal toxicity will be scored according to the Radiation Therapy Oncology Group criteria. Lesions cannot exceed 5 cm in maximum diameter. Placing fiducial markers through EUS guided is permitted. Local progression will be defined according to RECİST criteria. Response to treatment will be determined by serial high resolution computed tomography scanning.

We discuss here first two patients who initially had unresectable pancreas cancer because of >180° involvement of the superior mesenteric artery. After FOLFIRINOX they have had stable disease. İf there is no invasion of the duedonum and stomach according to imaging and endoscopy, then we would recommend SBRT with a total dose of 35 Gy in 5 fractions of 7 Gy/ fractions. One of treatment would be given using intensity modulated radiation therapy with a breath hold technique, and daily on board imaging, matching to implanted fiducial markers (cone beam computed tomography).The other treatment would be given using cyberknife. Dose constraints are listed in Table 1. for both of patients. Any advers event would be recorded (acute pancreatitis, clinically relevant upper GI bleeding requiring blood transfusion, abscesses in the area of the fiducials, sepsis).

At these dose level no Grade 3 or higher acute gastrointestinal toxicity was observed. Symptom relief was achieved at one month follow up in both of patients experiencing abdominal pain. These early results suggest SBRT safe effective and reducing treatment duration for patients who have localized pancreatic cancer.

Keywords: SBRT, Pancreatic cancer

Table 1. Targets, OARs,and dose constraints for SBRT (from Alliance trial A021501) (Helical tomotherapy)

Target volumes	*Constraints*
PTV	V20>95%
Duodenum	V15<1.961cc
	V20<0.186cc
Liver	V12<32%
Combined kidneys	V12<30%
Stomach, spinal cord	V20=na

Table 2. Targets, OARs,and dose constraints for SBRT (from Alliance trial A021501) (cyberknife)

Target volumes	*Constraints*
PTV	V20>95%
Duodenum	V15<22.6cc
	V20<5cc
Liver	V12<5.69%
Combined kidneys	V12<5.69%
Somach, spinal cord	V20=na

PP-008

LONG SURVIVAL OF A HEPATIC EPITHELIOID HEMANGIOENDOTHELIOMA, A CASE REPORT

Ozturk Ates[1]

[1]Health Sciences University, Dr. A.y. Ankara Oncology Hospital, Ankara, Turkey

Background: Hepatic epitheliod hemangioendothelioma (HEH) is a low grade vascular neoplasm of endothelial origin. İt is rare incidence and two thirds of them are women. Most patients present with abdominal pain, a mass, weight loss or malaise. It may arise in various soft tissues and visceral organs. This neoplasm usually a slow-progressing tumor and life expectancy is potentially good. We reported long survival of metastatic HEH case.

Case report: A 25 years old women was admitted to medical oncology with abdominal discomfort in 2016. To The patient's history, She was followed up on pediatric oncology with the diagnosis of hepatic epitheliod hemangioendothelioma since the age of 10. She was diagnosed with hepatic wedge resection. At that time abdominal ultrasonography revealed widespread lesions including biggest size 67x64 mm diameter in the left lobe of liver. She was treated with deltacortyl (6 months), interferon (1 year) and vincristine (4 cure).

In medical oncology evaluation, A computed tomography revealed a large number of mass lesions in size of 80x90 mm in both lobes of liver. Besides there are multiple mm nodules in the lung. The patient had been followed up without any treatment by radiographically and clinically non-progressive disease for 2 years. In April 2018, liver biopsy was performed due to progression of liver mass lesions. Pathological microscopic examination showed that there was spindle tumoral lesion in to the hepatic tissue. Immunohistochemically, tumor cells were stained with CD31, CD34 and fli-1 reported as hepatic epithelioid hemangioendothelioma. Pazopanib treatment was started after ministerial approval. Patient treatment continues with pazopanib.

Discussion: There was no generally accepted standard treatment in HEH. Surgical resection and local ablative treatment are the only curative options. Other treatments options included chemotherapy, radiotherapy, hormone therapy and liver transplantation. Five-year survival has been reported at approximately

43–55%. The case presented is lung metastatic disease and 17 years of follow-up continues.

Keywords: Hepatic epitheloid hemangioendothelioma, survival

PP-009

UNEXPECTED LYMPHATIC DISSEMINATION OF REMNANT GASTRIC CANCER: REVIEW OF LITERATURE IN THE LIGHT OF A CASE

Ismail Ozler[1], Niyazi Karaman[1], Bulent Aksel[1]

[1]Ankara Oncology Training And Research Hospital, Department Of General Surgery, Ankara, Turkey

Purpose: Remnant gastric cancer is a disease condition that develops after distal gastrectomy for a benign disease and has a poor prognosis. The differences between the surgical results of primary cancers and remnant cancers and their lymphatic spread pattern are remarkable. The aim of this article is to emphasize the altered lymphatic spread pattern of remnant gastric cancer that had been developed after 15 years in a female patient with distal gastrectomy.

Case: A 73-year-old female patient was admitted to our hospital with a complaint of epigastric pain. In the anamnesis, it was learned that the patient had underwent surgery for gastric ulcer 15 years ago in another center. It was seen with endoscopic evaluation that she had underwent distal gastrectomy operation (Billroth 2). The biopsy from the ulcerative lesion in the anastomosis line was reported as adenocarcinoma. The patient was operated with the diagnosis of remnant gastric cancer and total gastrectomy and Roux-eN-Y esophagojejunostomy were performed. Postoperative pathology report was reported as T4N2 well-differentiated adenocarcinoma. While perigastric 7 reactive lymph nodes were observed; adenocarcinoma metastasis was detected in 4 of the lymph nodes found in the mesentery of small intestine.

Discussion and conclusion: Regardless of the cause, the risk of gastric cancer in the remaining stomach after subtotal gastrectomy increases over the years. Lymphatic spread pattern may have changed in patients with gastric surgery. In this case report, the lymphatic spread pattern after gastric surgery was different than expected. In the literature, it has been reported that jejunum mesentery (35%) and splenic hilus lymph node metastasis (17%) are frequently detected in T2-T4 advanced stage remnant cancers. It has also been reported that jejunal mesentery lymph node metastasis is seen only in patients undergoing Billroth II reconstruction. Five year survival outcomes in these patient group was reported as 56.5% for the lymph node negative tumors, 32.3% for the tumors without jejunal mesentery node involvement and 17.1% with jejunal mesentery node involvement. Aggressive surgery has been recommended especially in this last patient group. In another study, nonanastomotic recurrences were compared with the anastomosis recurrences and it was reported that TNM stage was more advanced in anastomotic relapses, histological differentiation was worse, curative resection rate was low, the need for combined organ resection and lymph node metastasis was higher with lower 5-year survival rates. It must be kept in mind that the lymphatic drainage pattern may have changed and the operation limits should be expanded accordingly in the preoperative planning of remnant gastric cancer patients.

Keywords: remnant gastric cancer, metastasis, surgery, survival

PP-010

RETROSPECITVE ANALYSIS OF GASTRIC CANCER PATIENTS: PAMUKKALE UNIVERSITY MEDICAL ONCOLOGY DEPARTMENT EXPERIENCE

Serkan Değirmencioğlu[1], Atike Gökçen Demiray[1], Burcu Yapar Taşköylü[1], Nail Özhan[1], Umut Çakıroğlu[1]

[1]Pamukkale University Medical Oncoogy

Aim: Gastric cancer is the fifth most common cancer occurring worldwide. It is also among the top six cancers for mortality, accounting for over 1.1 million deaths worldwide in 2012 (1). The incidence rates of gastric cancers are highest in parts of Eastern Europe, Turkey, Iran, Russia, many parts of South America and East Asia (1). Gastric adenocarcinoma accounts for the most common histological subtype of gastric cancers (~95%), others being lymphomas, neuroendocrine tumors, and mesenchymal tumors (1,2). We aimed to evaluate the diagnostic stage, histologic differantiations and mortality rate for gastric cancer patients in our clinic.

Material – Method: Forty-nine gastric cancer patients who treated with adjuvant chemotherapy between years 2015 and 2017, were retrospectivally analysed. Inclusion criterias were being gastric cancer and treating any chemotherapy regimens. The analyses were carried out using SPSS v21 and $p<0.05$ was accepted as significant. Descriptive studies were analyzed using chi-square test.

Results: Median age of patients was 70, 41 patient was male (83.7%) and 8 was female (16.4%). Demographic characterictics of patients were shown in table-1. Relationship between stage, histology and mortality was shown in table-2.

Discussion: Our study supports the literature as male gender is a risk factor for gastric cancer. Also common histologic type was adenocarcinoma as seen in literature (3). The most important prognostic factor is still TNM system as our results supported. We found no correlation between histologic type and mortality.

Conclusion: Our single center experience had a small number of patients. Multicenter participation will enpower the study. An epidemiologic multicenter study may also present us a national gastric cancer database.

Keywords: Gastric cancer, adenocarcinoma, TNM

Table 1. Characteristics of gastric cancer patients

Sex	Female	8 (16.4%)	Male	41 (83.7%)
ECOG PS	0-1	35 (61.4%)	2-3	14 (28.6%)
Histology	Adenoca	40 (81.6%)	Others	9 (18.4%)
Stage	1-2-3	20 (40.8%)	4	29 (59.2%)
Status	Alive	25 (51%)	Exitus	24 (49%)

Table 2. Chi-square test of stage and histology with status correalation. $p<0.005$ is accepted as statistically significant.

	Alive	*Exitus*	*p*
Stage 1-2-3	18	11	0.05
Stage 4	7	13	
Adenocarcinoma	21	19	0.22
Other histology	4	5	

PP-011

A SOLITARY CUTANEOUS METASTASIS OF RECTAL ADENOCARSINOMA

Nilay Sengul Samanci[1], Mustafa Ozguroglu[1], Fuat Hulusi Demirelli[1]

[1]*Istanbul University Cerrahpasa Medical Faculty, Medical Oncology Department*

Cutaneous metastases from abdominal malignancies are a rare phenomenon, presenting in fewer than 5% of patients and shows poor prognosis. Skin metastases of adenocarcinoma of the rectum are even more rare, occurring in fewer than 4%of patients and usually seems to the abdominal wall and around the umbilicus. In this case we report a patient with metastatic rectum cancer with cutaneus metastasis of head and face.

Case: A 45 year old man admitted with rectal bleeding and diagnosed with adenocarcinoma of the rectum. The patient underwent total-body positron emission tomography– computed tomography (PET–CT) scan to restage the tumoral disease. The PET–CT test showed surrenal metastasis and lung matastasis. K-Ras and N-Ras was revealed as wild type and the paliative chemotherapy was started as 5-fluorouracil, leucovorin, oxaliplatin and cetuximab 12 cycle. After 12 cycle chemotherapy PET–CT showed new multiple mediastinal and hilar lymph nodes, a large tissue mass between kidney and splen. The second line chemotherapy was used for progressed disease. 5-fluorouracil, leucovorin, irinotecan and bevacizumab was started. After six cycle of regimen new lymph nodes appeared in his abdomen and his intraabdominal mass become greater. His treatment changed to Regorafenib 120 mg/day. 5 months later on his physical examination a subcutaneous lump was seen on his scalp and mandibula (Figure). A biopsy of the scalp lesion with a diameter of 0.5 cm was obtained. Histological examination of biopsied tissues showed metastases of rectal adenocarsinom.

Discussion: The frequency of skin metastases ranges between 0.7% and 10.4% of all patients with cancer. Metastases from colorectal adenocarcinoma occur mostly within the first 2 years after resection of the primary tumor, with spread to the liver, peritoneum, pelvis, lung, and bone, in order of decreasing frequency.The most frequent site of skin metastasis from the colorectal tumors is the skin of the abdominal wall . Other skin sites of colorectal metastasis are the pelvis, upper extremities, chest, back, head and neck, and, rarely, in the glans penis, tongue, lip, face, and hand. Cutaneous metastases clinically appears as a subcutaneous or intradermal nodule, a nodulocystic lesion, an ulceration, a cellulitis-like lesion or fibrotic processes. Diagnosis of cutaneous metastasis is confirmed by biopsy, which is still the golden diagnostic standard. In this paper the site of metastasis was on head and face and it is confirmed by biopsy. And cutaneous metastasis has been shown to reflect advanced disease and is associated with a poor prognosis.

Our case is rare because of skin site of metastasis. And the clinicians should pay special attention to all skin nodules, nonhealing ulcers, and persistent indurate erythema.

Keywords: Cutaneus, metastasis, rectal

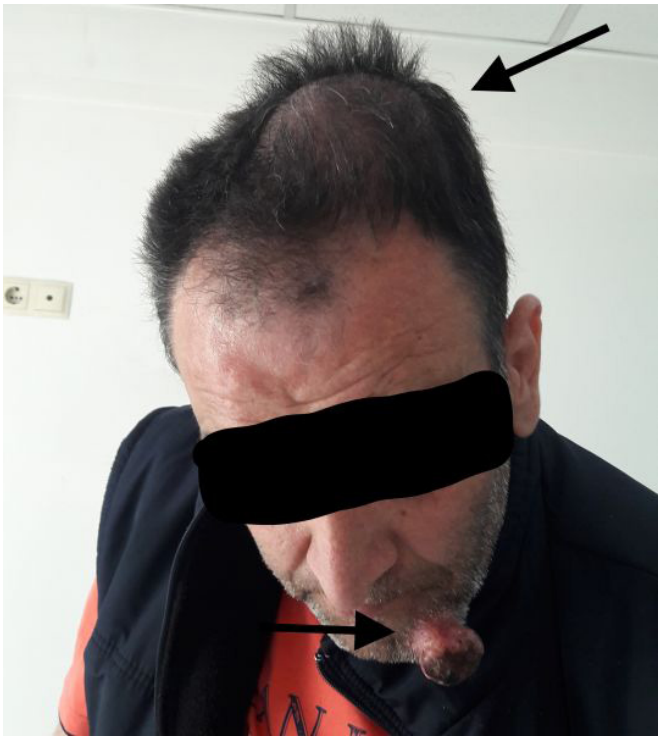


Figure 1.