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European School of Oncology

15TH INTERNATIONAL GASTROINTESTINAL CANCERS CONFERENCE

Regnum Carya Hotel, Belek - Antalya / TURKEY

4 - 7 December 2025

Online course on December 4, 2025
Congress on December 5-7, 2025

ABSTRACT BOOK

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Prof. Dr. Şuayib Yalçın
Hacettepe University Institute of Oncology Department of Medical Oncology
www.igicc.org
syalcin@hacettepe.edu.tr

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Dear Colleagues,

This year we are organizing the 15th International Gastrointestinal Cancers Conference (IGICC2025) between 4 – 7 December 2025 in Regnum Carya Hotel, in Antalya Turkiye.

Considering the success of the first foureen conferences 15th 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. Besides educational sessions high quality abstracts are welcomed for presentation in oral and poster sessions.

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, with presentations of cutting-edge research and clinical practice, clinical case discussions, seminars and with 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.

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 2025.

We are looking forward to meeting you for Antalya IGICC 2025.

Prof. Dr. Şuayib Yalçın
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ORAL PRESENTATIONS

OP-01

IMPACT OF RENIN-ANGIOTENSIN SYSTEM INHIBITORS ON SURVIVAL IN HEPATOCELLULAR CARCINOMA PATIENTS RECEIVING IMMUNOTHERAPY

Merih Yalçıner[1], Joe Ramzi Eid[1], Zafar Siddiqui[1], Lianchun Xiao[2], Ryan Sun[2], Mahesh Kumar Kannan[3], Manal Hassan[4], Asif Rashid[5], Hop Sanderson Tran Cao[6], Hesham Amin[7], Ahmed Omar Kaseb[1]

[1]Department of Gastrointestinal Medical Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[2]Department of Biostatistics, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[3]Department of Hematopathology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[4]Department of Epidemiology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[5]Department of Surgical Pathology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[6]Department of Surgical Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA
[7]The University of Texas MD Anderson Cancer Center UTHealth Houston Graduate School of Biomedical Sciences, Houston, TX, USA

Background and Aims: While immune checkpoint inhibitors (ICIs) have improved hepatocellular carcinoma (HCC) treatment outcomes, overall survival remains suboptimal. Concomitant medications, particularly renin-angiotensin system (RAAS) inhibitors, may influence ICI efficacy through modulation of the tumor microenvironment Moreover, we have shown that, in a preclinical model, inhibition of the angiotensin II receptor ameliorates liver fibrosis and enhances infiltration of HCC by effector T cells. However, clinical data specific to HCC remains limited. This study examines the association between RAS inhibitor use and survival outcomes in HCC patients receiving ICIs.

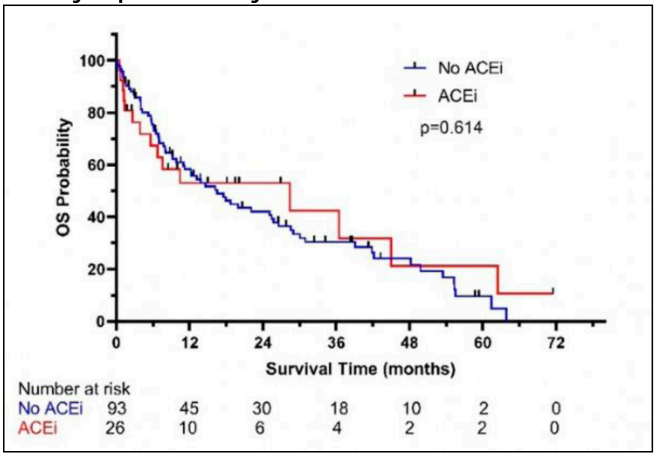
Methods: This retrospective study included 133 HCC patients receiving immunotherapy at MD Anderson Cancer Center (2015-2025). Inclusion criteria were histologically or radiologically confirmed HCC, age >=18 years, treatment with ICIs. Patients were categorized by Angiotensin Converting Enzyme Inhibitor/Angiotensin Receptor Blocker (ACEi/ARB) use: no ACEi/ARB (n=93), ACEi (n=26), and ARB (n=14). Primary endpoint was overall survival (OS); secondary endpoint was progression-free survival (PFS).

Results: The median follow-up time was 11.01 months. The cohort comprised predominantly male (77.4%), elderly (72.9% >60 years), and hypertensive (75.9%) patients. Most received nivolumab monotherapy (53.4%) or atezolizumab/bevacizumab (32.3%). ARB users demonstrated significantly superior outcomes compared to non-users: median OS was not reached versus 16.5 months ($p<0.001$), and median PFS was 27.9 versus 5.6 months ($p=0.006$). In contrast, ACEi users showed no survival benefit: median OS 28.4 versus 16.5 months ($p=0.614$) and median PFS 4.4 versus 5.6 months ($p=0.747$). Multivariate analysis confirmed ARB use as a strong independent predictor of improved survival: OS hazard ratio (HR) 0.151 (95% CI 0.037-0.620, $p=0.009$) and PFS HR 0.296 (95% CI 0.129-0.679, $p=0.004$). ACEi use showed no significant association with either OS (HR 1.059, $p=0.842$) or PFS (HR 1.249, $p=0.382$). The survival benefit of ARBs remained significant even after adjusting for baseline differences.

Conclusions: ARB use, but not ACEi use, was significantly associated with improved OS and PFS in HCC patients receiving ICIs. These findings suggest differential effects of RAAS inhibitor subtypes on ICI efficacy in HCC. Given the high prevalence of hypertension in HCC patients, these results may have important clinical implications for anti-hypertensive medication selection in patients receiving immunotherapy. Further prospective studies are warranted to validate these findings and elucidate underlying mechanisms.

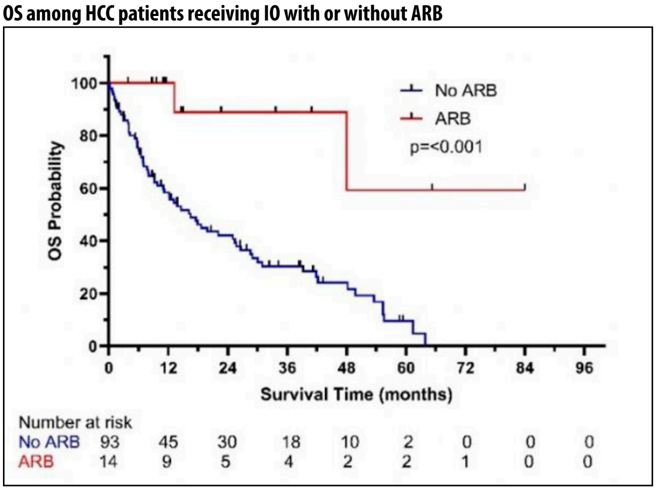
Keywords: Hepatocellular carcinoma, immune checkpoint inhibitors, angiotensin receptor blockers

OS among HCC patients receiving IO with or without ACEi



Kaplan-Meier curves representing OS among HCC patients receiving IO with or without ACEi

OS among HCC patients receiving IO with or without ARB



Kaplan-Meier curves representing OS among HCC patients receiving IO with or without ARB

Table 1. Predictors of overall survival in HCC patients who receive immunotherapy (Survival from time of IO start date)

	Univariate Analysis		*Multivariate Analysis*	
Factor	***HR (95% CI)***	***P-value***	***HR (95% CI)***	***P-value***
Age				
Age >60	1.411 (0.874-2.279)	0.159	1.265 (0.782-2.048)	338
Sex, male	0.826 (0.504-1.355)	0.449		
Race				
Asian	0.986 (0.397-2.447)	0.975		
Black	0.575 (0.246-1.345)	0.202		
White	1.202 (0.732-1.973)	0.467		
Hispanic	1.089 (0.561-2.113)	0.801		
Comorbidities				
Hypertension	0.888 (0.536-1.471)	0.645		
Obesity (BMI>=30)	1.488 (0.801-2.767)	0.209		
Tobacco Use	1.032 (0.654-1.628)	0.892		
Diabetes	0.925 (0.596-1.437)	0.729		
Viral etiology	0.978 (0.629-1.519)	0.920		
AFP level > 400 ng/dL	1.201 (0.775-1.860)	0.412		
Tumor Factors				
Multinodularity	0.823 (0.497-1.363)	0.449		
Vascular Invasion	1.392 (0.897-2.159)	0.141	1.257 (0.806-1.960)	0.313
Lymph node Metastases	1.321 (0.681-2.562)	0.410		
Distant Metastases	0.966 (0.565-1.650)	0.898		
ACE-Inhibitor use	1.059 (0.604-1.856)	0.842		
ARB use	0.134 (0.033-0.547)	0.005	0.151 (0.037-0.620)	0.009
Recurrence after initial curative therapy	0.690 (0.386-1.233)	0.210		
Line of therapy				
IO as first line	0.660 (0.372-1.174)	0.158		
IO as second line	1.085 (0.690-1.707)	0.725		
IO as third line or more	1.188 (0.771-1.829)	0.435		
Child-Pugh score A	0.661 (0.401-1.088)	0.104	0.723 (0.436-1.197)	0.207
BCLC staging: A/B vs C/D	0.799 (0.518-1.231)	0.309		
TNM staging I/II vs III/IV	0.929 (0.551-1.566)	0.783		
Predictors of overall survival in HCC patients who receive immunotherapy (Survival from time of IO start date)				

OP-02

REAL-WORLD OUTCOMES OF HER2-POSITIVE METASTATIC GASTRIC CANCER PATIENTS TREATED WITH TRASTUZUMAB-BASED THERAPY: A SINGLE-CENTER EXPERIENCE

Sercan Ön, Hasan Çağrı Yıldırım

Ege University Department of Medical Oncology

Background: HER2 overexpression occurs in 15–20% of gastric cancers. Trastuzumab-based chemotherapy is the standard of care in the first-line setting; however, real-world outcomes may differ from those reported in clinical trials.

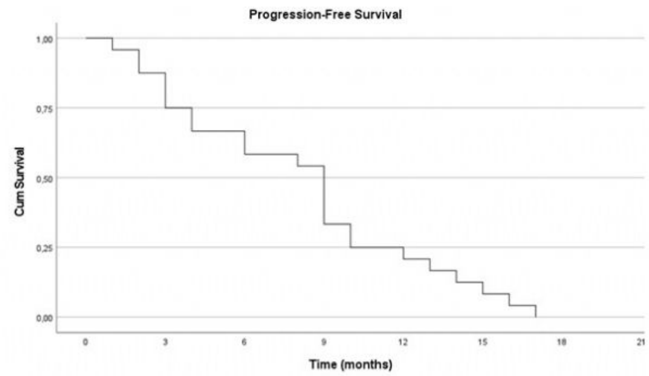
Methods: We retrospectively analyzed 27 patients with HER2-positive metastatic gastric cancer treated between 2016 and 2024 at a tertiary oncology center. Demographic characteristics, histological subtypes, metastatic presentation, treatment patterns, and survival outcomes were assessed. Progression-free survival (PFS) and overall survival (OS) were estimated using the Kaplan–Meier method.

Results: The median age was 64 years (IQR 55–72), and 18 patients (66.7%) were male. Most patients presented with de novo metastatic disease (24, 88.9%), while 3 (11.1%) had recurrent metastases. The most common metastatic sites were lymph nodes (85.2%), liver (63.0%), and peritoneum (44.4%). Histological subtypes comprised intestinal type in 20 cases (74.1%) and diffuse type in 7 cases (25.9%). The primary tumor was located in the corpus (29.6%), antrum (22.2%), cardia (18.5%), linitis plastica (11.1%), pylorus (3.7%), or was unclassified (14.8%). First-line trastuzumab-based chemotherapy was given to 25 patients (92.6%), of whom 16 (59.3%) received a doublet and 9 (33.3%) a triplet regimen. Nine patients (33.3%) proceeded to second-line therapy. Median PFS was 9.4 months (95% CI 4.1–17.2) and median OS was 19.0 months (95% CI 12.7–35.7).

Conlusion: A real-world cohort of HER2-positive metastatic gastric cancer patients treated with trastuzumab-based therapy showed survival outcomes comparable to those in pivotal clinical trials. The predominance of de novo metastatic presentation, the frequent occurrence of signet ring cell and poorly differentiated histology, and the high incidence of liver, lymph node, and peritoneal metastases highlight the aggressive nature of this disease. Limited sequencing into second-line therapy underscores the need for broader access to novel HER2-directed agents to improve patient outcomes.

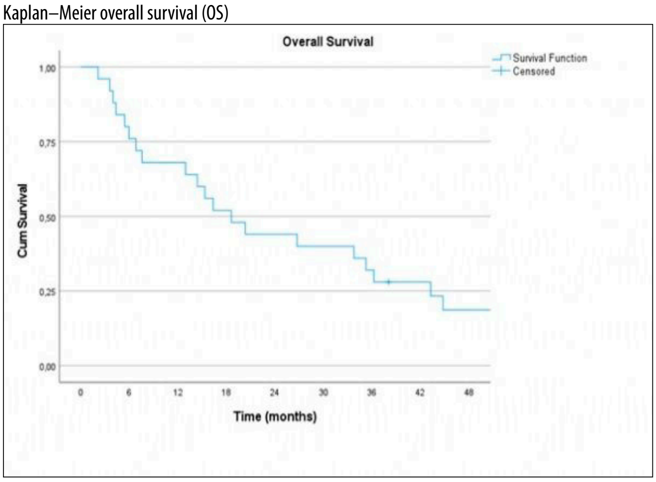
Keywords: gastric cancer, HER2 positivity, trastuzumab

Kaplan–Meier first-line progression-free survival (PFS)



Median PFS 9.4 months (95% CI 4.1–17.2)

Kaplan–Meier overall survival (OS)



Median OS was 19.0 months (95% CI 12.7–35.7)

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Table 1. Baseline patient characteristics

Characteristic	*N (%)*
Age, median (IQR), years	64 (55–72)
Sex Male Female	 18 (66.7%) 9 (33.3%)
ECOG performance status 0–1 >=2 unknown	 23 (85.2%) 3 (11.1%) 1 (3.7%)
Metastasis time Denovo Recurrence	 24 (88.9%) 3 (11.1%)
Tumor location Corpus Antrum Cardia Linitis plastica Pylorus Unknown	 8 (29.6%) 6 (22.2%) 5 (18.5%) 3 (11.1%) 1 (3.7%) 4 (14.8%)
Histology (according to Lauren) Intestinal type Diffuse type	 20 (74.1%) 7 (25.9%)
Metastatic site Liver Lymph node Lung Peritoneum Bone	 17 (63.0%) 23 (85.2%) 9 (33.3%) 12 (44.4%) 3 (11.1%)

Abbreviations: IQR, interquartile range; ECOG, Eastern Cooperative Oncology Group

OP-03

BEYOND TUMOR GENETICS: DO INFLAMMATORY LABORATORY INDICES (NLR, SII, PIV, ACR) SHAPE PROGNOSIS IN METASTATIC COLORECTAL CANCER?

Ece Ulukal Karanci, Halil Göksel Güzel, Derya Kıvrak Salim

Antalya Training and Research Hospital, Antalya, Turkiye

Introduction: Systemic inflammation has emerged as a key player in colorectal cancer (CRC) progression and treatment resistance. Hematologic indices such as the neutrophil-to-lymphocyte ratio (NLR) and systemic immune-inflammation index (SII) are increasingly recognized as prognostic biomarkers in metastatic CRC (mCRC). More recently, the pan-immune-inflammation value (PIV) and albumin-to-CEA ratio (ACR) have been proposed to enhance prognostic precision. However, their relevance in a genomically homogeneous cohort of RAS/RAF wild-type, microsatellite-stable (MSS) mCRC patients remains unclear.

Methods: This retrospective study included patients with RAS/RAF wild-type, MSS mCRC treated with doublet chemotherapy plus biologic agents at Antalya Training and Research Hospital between 2017 and 2024. NLR, SII, PIV, and ACR were calculated from baseline blood counts. ROC curve analysis was used to define optimal cut-offs for each index based on 2-year mortality. Progression-free survival (PFS) and overall survival (OS) were assessed using Kaplan-Meier analysis and Cox regression.

Results: Seventy-four patients were included (median age: 53.5 years; 36.5% female). The median follow-up was 42.7 months. While overall response rates did not differ significantly between low and high index groups, significant survival differences were observed for NLR and SII. Low SII was associated with longer median PFS (12.5 vs. 8.0 months, p=0.037). In multivariate PFS analysis, SII remained an independent predictor (HR: 1.75, p=0.034). Low NLR and low SII were associated with improved OS (NLR: 29.2 vs. 20.9 months, p=0.025; SII: 29.2 vs. 16.9 months, p=0.020). In multivariate OS analysis, age (HR: 1.82, p=0.040) and NLR (HR: 2.03, p=0.017) were independent predictors; SII lost significance. PIV and ACR did not significantly impact PFS or OS in this cohort.

Conclusion: In biologically treated patients with RAS/RAF wild-type, MSS mCRC, baseline NLR and SII were found to be robust prognostic markers for survival outcomes. PIV and ACR were not predictive in this setting, suggesting that their utility may be influenced by tumor biology or treatment context. These results support the integration of simple and cost-effective inflammatory indices in clinical prognostication and encourage future prospective validation in larger, multicenter cohorts.

Keywords: Metastatic colorectal cancer, Systemic inflammation, Neutrophil-to-lymphocyte ratio (NLR)

ORR according to laboratory indices

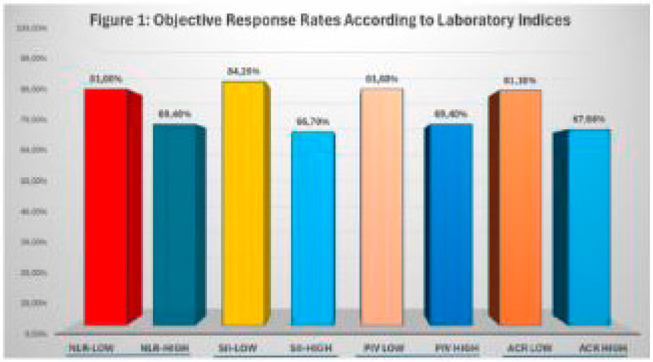


Table 3. Univariate and Mulitivariate Analyses of Clinical Factors and Laboratory Indices for OS

		Univariate Analysis		Multivariate Analysis	
		HR (95% CI)	P Value	HR (95% CI)	P Value
Age (years)			**0.071**		**0.040**
	<60	Reference		Reference	
	≥60	1.69 (0.95-2.98)		**1.82 (1.02-3.23)**	
Liver Metastasis			0.473		
	No	Reference			
	Yes	1.26 (0.66-2.37)			
Chemoterapy Regimen			**0.213**		0.857
	FOLFOX	Reference		Reference	
	FOLFIRI	1.48 (0.79-2.76)		1.06 (0.53-2.10)	
Biological Agent			0.362		
	Anti-EGFR	Reference			
	Bevacizumab	1.40 (0.62-2.89)			
NLR			**0.025**		**0.017**
	Low	Reference		Reference	
	High	1.90 (1.07-3.40)		**2.03 (1.13-3.63)**	
SII			**0.020**		0.238
	Low	Reference		Reference	
	High	1.92 (1.09-3.36)		1.51 (0.76-3.00)	
PIV			**0.178**		0.786
	Low	Reference		Reference	
	High	1.46 (0.83-2.55)		0.90 (0.45-1.80)	
ACR			0.869		
	Low	Reference			
	High	1.04 (0.59-1.86)			

ACR: Albumin to CEA ratio, EGFR: Epithelial Growth Factor Receptor NLR: Neutrophile to Lymphocyte Ratio, PIV: Pan-immune Inflammation Value, SII: Systemic Immune Inflammation Index

OP-04

NOT ALL GISTS ARE GASTRIC: A SINGLE-CENTER COHORT OF NON-GASTRIC GIST

Kübra Canaslan, Özge Yetginoğlu, Tuğba Yavuzşen

Department of Medical Oncology, Dokuz Eylul University, Izmir, Türkiye

Background: Non-gastric gastrointestinal stromal tumors (NG-GIST) comprise a substantial minority of GIST and carry higher recurrence risk than gastric primaries for comparable size and mitotic activity. Evidence guiding site-specific management remains heterogeneous. We described clinicopathologic features, treatment patterns, and long-term outcomes of NG-GIST in a single-center cohort.

Method: We conducted a single-center, retrospective cohort study at Dokuz Eylül University, identifying consecutive adults with histologically confirmed non-gastric GIST treated and/or followed at our institution. Sociodemographic, pathologic, and clinical variables were abstracted from electronic records. Risk was assigned by the AFIP (Miettinen–Lasota) model; mitoses were recorded per 5 mm^2. Overall survival (OS) was estimated by Kaplan–Meier.

Results: Among 114 GIST cases, 41 (36.0%) arose from non-gastric sites. Median age was 55 years (range, 30–83) and 26 (63.4%) were male. Primary locations were jejuno-ileal in 30/41 (73.2%), rectal in 8/41 (19.5%), and esophageal in 3/41 (7.3%). Median tumor size was 6.0 cm (0.4–26.0); the median mitotic count was 6 per 5 mm2 (0–218), and Ki-67 ranged from 1% to 60%. At diagnosis, 34/41 (82.9%) had localized disease and 7/41 (17.1%) had metastatic disease. Surgery was performed in 37/41 (90.2%); overall, 25/41 (61.0%) met high-risk criteria for recurrence. Adjuvant imatinib was given to 17/41 (41.5%); one patient (2.4%) received neoadjuvant imatinib. Among the 34 localized cases, 10/34 (29.4%) developed metastatic relapse; first sites were peritoneum in 5/34 (14.7%) and liver in 4/34 (11.8%). In the metastatic second-line setting, 3 patients received high-dose imatinib and 6 received sunitinib. After a median follow-up of 77 months, 4/41 (9.8%) patients had died; 10-year overall survival was 86%.

Conclusion: In this real-world NG-GIST cohort, most patients presented with localized disease, yet a high proportion met high-risk criteria. Metastatic relapses were predominantly peritoneal or hepatic, and long-term survival was favorable (10-year OS 86%). Given the relative rarity of NG-GIST and the anatomic challenges, optimal care hinges on a multidisciplinary approach. Harmonized multicenter cohorts are needed to validate these real-world observations and enable adequately powered subgroup analyses.

Keywords: Gastrointestinal Stromal Tumors, non-gastric

OP-05

COMPLETE RESPONSE TO TARLATAMAB IN A PATIENT WITH METASTATIC ESOPHAGEAL NEUROENDOCRINE CARCINOMA: A UNIQUE CASE REPORT

Bahadır Köylü, Cevat Ilteriş Kıkılı, Fatih Kemik, Nazan Demir, Şahin Laçin, Fatih Selçukbiricik

Department of Medical Oncology, Koç University School of Medicine, Istanbul, Turkiye

Background: Gastro-entero-pancreatic neuroendocrine carcinomas (GEP-NECs) are the most frequent extrapulmonary NECs, with limited treatment options largely adapted from small-cell lung cancer. The efficacy of tarlatamab, a delta-like ligand 3 (DLL3) targeting bispecific T-cell engager, in GEP-NECs is currently unknown.

Case: A 47-year-old female patient presented with a progressive dysphagia. Esophagogastroduodenoscopy revealed a mass lesion located in the middle third of the esophagus. Pathological assessment demonstrated a high grade neuroendocrine carcinoma (synaptophysin+, chromogranin A+, p63-, p40-, CK7-, CDX2-, Ki67 90%). The ^{18}F-FDG PET-CT scan reported a FDG-avid wall thickening 37 mm in length at the middle part of the esophagus and metastatic mediastinal lymphadenopaties. No metastatic lesion detected at brain MRI. Patient received four cycles of cisplatin (75 mg/m2 Q3W D1) plus etoposide (100 mg/m2 Q3W D1-3) plus atezolizumab (1200 mg Q3W D1) regimen and total 54 Gy IMRT to primary lesion and mediastinal lymphadenopaties. ^{18}F-FDG PET-CT scan for response assessment showed complete metabolic remission, and upper endoscopy revealed a fibrotic scar at the primary tumor site. Maintenance atezolizumab (1200 mg Q3W D1) was initiated. Follow-up imaging after three months revealed new metastatic lesions, including a 20x18 mm lesion in liver segment 4B and a 4.6x4.8 mm lesion in the frontal lobe. Liquid biopsy analysis was conducted and did not identify any actionable genetic alterations. Tarlatamab (10 mg Q2W) was initiated as second-line treatment. After five cycles of tarlatamab, MRI showed complete resolution of metastatic lesions in liver segment 4B and the frontal lobe, with no evidence of new metastases, consistent with a clinical complete response.

Conclusion: To the best of our knowledge, this is the first reported case demonstrating the clinical efficacy of second-line tarlatamab in GEP-NEC. Given the limited therapeutic options for GEP-NECs, tarlatamab warrants further clinical investigation.

Keywords: Tarlatamab, esophagus, neuroendocrine carcinoma

OP-06

FEAR OF RECURRENCE IN PATIENTS WITH LOCAL ADVANCED RECTAL CANCER WHO HAVE EXPERIENCED REMISSION AFTER CURATIVE TREATMENT

Ahmet Oruç[1], Latif Karahan[2], Gamze Emin[3], Ece Ulukal Karancı[4], Galip Can Uyar[5], Atila Yıldırım[3], Osman Sütçüoğlu[6], Deniz Can Güven[2], Derya Kıvrak Salim[4], Melek Karakurt Eryılmaz[1], Murat Araz[1], Mehmet Artaç[1]

[1]*Department of Medical Oncology, Necmettin Erbakan University, Konya*
[2]*Medical Oncology Department, Hacettepe University Oncology Institute, Ankara*
[3]*Department of Medical Oncology, Karadeniz Technical University, Trabzon*
[4]*Department of Medical Oncology, Antalya Training and Research Hospital, Antalya*
[5]*Medical Oncology, Etlik City Hospital, Ankara*
[6]*Department of Medical Oncology, Gazi University, Ankara*

Purpose: Assessing fear of cancer recurrence, depression, and quality of life after curative treatment for locally advanced rectal cancer.

Material-Methods: In the cross-sectional and multicenter study, patients were examined using the Fear of Cancer Recurrence Scale-Short Form (FoCR-SF), Patient Health Questionnaire-9 (PHQ-9), and EORTC Anal Cancer 27 Questionnaire (ANL-27). Clinical and pathological characteristics were obtained from hospital databases.

Results: A total of 95 patients were included in the study. The median age at diagnosis was 60 (53-65). 60 patients were male (63.2%). Among the patients, T3 tumors (63, 66.4%) and N1 (39, 41.1%) were the most frequently detected.

In patients who had surgery after total neoadjuvant treatment (TNT) (n:46), the FoCR score was 18 (9.75-24), while in patients who had surgery after CRT (n:38), it was 14 (8-21), p:0.335. The PHQ9 score was 6 (1–11.25) in patients who had surgery after TNT and 2 (0–8) in those who had surgery after CRT, p:0.029. The ANL-27 Functional Scale (FS) score was 70.6 (62.2-81.1) in patients who had surgery after TNT and 75.3 (63-82.5) in patients who had surgery after CRT, p:0.605. The ANL-27 Symptom Scale (SS) was 29.3 (18.8-37.7) in patients who had surgery after TNT and 24.6 (17.4-36.9) in patients who had surgery after CRT, p:0.605.

Patients who had surgery after TNT were divided into two groups based on whether they received adjuvant chemotherapy (ChT). In those who received ChT (n:17), FoCR was 10 (4-23.5), and in those who did not receive ChT (n:29), FoCR was 20 (16-24), p:0.044. In those who received ChT (n:17) PHQ9 was 2 (0-10.5), and in those who did not receive ChT (n:29), PHQ9 was 9 (2.5-11.5), p:0.047. In those who received ChT (n:17 ANL-27 FS 73 (62.1-81.1) and in those who did not receive ChT (n:29) ANL-27 FS 69 (62.1-81.0), p:0.873. In those who received KT (n:17) ANL-27 SS 26.9 (18.8-37.8) and those not receiving KT (n:29) ANL-27 SS 30.1 (18.9-37.8), p:0.873.

A pathological complete response (pCR) was observed in 17 (17.8%) patients, and 5 (5.3%) patients were followed with watch and wait (WW). In patients with a pCR following surgery (n:17), FoCR 20 (16.5-24) and FoCR 22 (19.5-25.5) in WW patients, p:0.218. PHQ9 5 (1-9) in patients with a pCR and 11 (5.5-17) in WW patients, p:0.085.

ANL-27 FS was 75.3 (65.8-83.3) in patients with pCR and 61.9 (51.6-73.2) in WW patients, p:0.075. The ANL-27 SS was 24.6 (16.6-34.1) in patients with pCR and 38 (26.7-48.3) in WW patients, p:0.075.

Conclusions: The TNT approach is associated with increased fear of recurrence, increased depression, and decreased quality of life, likely due to treatment-related toxicity or the prolonged duration of the process. However, interestingly, not administering adjuvant chemotherapy in this group of patients may also create a feeling of incomplete treatment in patients; therefore, clinicians must clearly explain the process.

Keywords: FoCR, PHQ9, ANL-27

Table 1. Adjuvant chemotherapy status after TNT

	FoCR	*PHQ9*	*ANL-27 FS*	*ANL-27 SS*
Patients with Adjuvant ChT (n:17)	10 (4-23.5)	2 (0-10.5)	73 (62.1-81.1)	26.9 (18.8-37.8)
Patients without adjuvant ChT (n:29)	20 (16-24)	9 (2.5-11.5)	69 (62.1-81.0)	30.1 (18.9-37.8)
p value	0.044	0.047	0.873	0.873

Table 2. Clinic and pathologic characteristics

	n:95
Age at time of questionnaire completion (years) median (IQR)	66 (59-69)
Diagnosis age, median (IQR)	60 (53-65)
Gender (Male/ Female), n (%)	60 (63.2)/ 35 (36.8)
T2 stage, n (%)	5 (5.3)
T3 stage, n (%)	63 (66.4)
T4 stage, n (%)	19 (20)
Tx stage, n (%)	8 (8.3)
N0 stage, n (%)	17 (17.9)
N1 stage, n (%)	39 (41.1)
N2 stage, n (%)	25 (26.3)
Nx stage, n (%)	14 (14.7)
Treatment of TNT, n (%)	46 (48.4)
Surgery after chemoradiotherapy, n (%)	38 (40)
Postoperative chemoradiotherapy plus chemotherapy, n (%)	11 (11.6)
Patients with watch and wait, n (%)	5 (5.3)
Patients with pathological complete response, n (%)	17 (17.8)
Low anterior resection, n (%)	71 (74.7)
Abdominoperineal resection (APR), n (%)	19 (20)
Rerurrence Free Survival, months, median (IQR)	31 (18-69)

Table 3. Pathological complete response after surgery & WW

	FoCR	*PHQ9*	*ANL-27 FS*	*ANL-25 SS*
Patients with pCR after surgery (n:17)	20 (16.5-24)	5 (1-9)	75.3 (65.8-83.3)	24.6 (16.6-34.1)
Patients had WW (n:5)	22 (19.5-25.5)	11 (5.5-17)	61.9 (51.6-73.2)	38 (26.7-48.3)
p value	0.218	0.085	0.075	0.075

OP-07

CLINICOPATHOLOGICAL CHARACTERISTICS AND OUTCOMES OF GASTROINTESTINAL TRACT MUCOSAL MELANOMA: A SINGLE-CENTER EXPERIENCE

Burak Paçacı, Nazım Can Demircan

Departmant of Medical Oncology, Marmara University Pendik Training and Research Hospital, Istanbul, Turkiye

Background: Mucosal melanoma of the gastrointestinal (GI) tract is a rare and aggressive malignancy with limited evidence to guide management. Given its heterogeneous presentation and poor prognosis, real-world data are essential to better understand disease behavior and treatment outcomes. We aimed to evaluate the clinicopathological features, therapeutic approaches and survival outcomes of patients with GI mucosal melanoma treated at our institute.

Methods: We retrospectively analyzed the records of 10 patients diagnosed with GI mucosal melanoma and followed up between 2014 and 2025 at Marmara University Pendik Training and Research Hospital. Demographic, clinical, pathological and treatment characteristics were reviewed. Survival outcomes including progression-free survival (PFS), disease-free survival (DFS), and overall survival (OS) were estimated with Kaplan–Meier method.

Results: Median age was 73 (68–75) years and 60% of patients were women. Primary tumor sites were anal canal in 6 patients, rectum in 2 patients, stomach and esophagus each in 1 patient. Initially, 6 had locally advanced and 3 had metastatic disease. Lymph node involvement was detected in 8 and BRAF mutation in 2 patients, respectively. Median tumor size was 32 mm. Synchronous metastases were present in 3 cases, while metachronous recurrences occurred in 5 patients. Most common metastatic sites were lung (n=4) and bone (n=3). Surgical resection was performed in 8 patients. Temozolomide was the most frequent first-line regimen (n=5). In second line, nivolumab and dabrafenib plus trametinib were used most often, each in 2 patients. Median PFS1 and PFS2 were 3.6 and 3.9 months, respectively. Median DFS for initially non-metastatic patients was 13.3 months and median OS was 20.7 months.

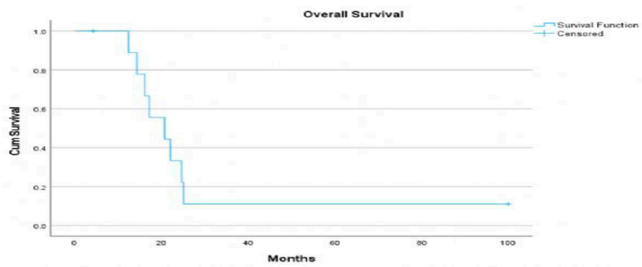
Conclusions: Gastrointestinal mucosal melanoma predominantly affects elderly patients and often presents at an advanced stage with high recurrence rates despite multimodal treatment. Outcomes remain poor, underscoring the need for molecular characterization and integration of immune checkpoint inhibitors and other targeted therapies in earlier disease stages. Collaborative multicenter efforts are warranted to optimize therapeutic strategies in this rare malignancy.

Keywords: Mucosal melanoma, survival, systemic treatment

Demographic Data and Tumor Characteristics	
Median age, years (IQR)	73 (68-75)
ECOG, n (%)	
0-1	9 (90)
>=2	1 (10)
Gender, n (%)	
Female	6 (60)
Male	4 (40)
Location, n (%)	
Anal canal	6 (60)
Rectum	2 (20)
Stomach	1 (10)
Esophagus	1 (10)
Median tumor diameter, mm (IQR)	32 (15-49)

Clinical and Treatment Characteristics	
Initial stage, n (%)	
Local	1 (10)
Locally advanced	6 (60)
Metastatic	3 (30)
Synchronous metastasis, n (%)	3 (30)
Metachronous metastasis n (%)	5 (71)
Lymph node positivity, n (%)	8 (80)
BRAF mutation, n (%)	2 (20)
Metastatic sites, n (%)	
Lung	4 (50)
Bone	3 (37.5)
Liver	1 (12.5)
Brain	1 (12.5)
Other	2 (25)
Primary surgery, n (%)	8 (80)
Recurrence, n (%)	5 (100)
Metastatic	5 (100)
Local	0
First-line treatment, n (%)	8 (100)
Temozolomide	5 (62.5)
Carboplatin plus paclitaxel	1 (12.5)
Nivolumab plus ipilimumab	1 (12.5)
Ipilimumab	1 (12.5)
Second-line treatment, n (%)	5 (100)
Nivolumab	2 (40)
Dabrafenib plus trametinib	2 (40)
İpilimumab	1 (20)
Median PFS1, months (95% CI)	3.6 (2.6-4.5)
Median PFS2, months (95% CI)	3.9 (0-8.9)
Median DFS in initially non-metastatic patients, months (%95 CI)	13.3 (5.4-21.3)
Median OS, months (%95 CI)	20.7 (10.4-30.9)

Overall Survival



OP-08

BAYESIAN DECISION-FOCUSED META-ANALYSIS IN PD-L1–LOW GASTRIC AND GEJ ADENOCARCINOMA

Mehmet Mutlu Çatlı, Arif Hakan Önder

Department of Medical Oncology, Antalya Education and Research Hospital, Antalya, Turkiye

Background: The benefit of chemo-immunotherapy in PD-L1–low (CPS <5) gastric and gastroesophageal junction (GEJ) adenocarcinoma remains uncertain. While Wang et al. (Ther Adv Med Oncol, 2025) reported limited efficacy using classical hazard ratio pooling, statistical significance alone may not capture true clinical utility.

Methods: We independently initiated a meta-analysis evaluating first-line chemo-immunotherapy in CPS <5 subgroups across phase III RCTs (CheckMate-649, KEYNOTE-859, ORIENT-16, COMPASSION-15, SHR-1701). After Wang's publication, we re-assessed the dataset within a Bayesian decision framework, integrating probability of benefit, absolute survival gain, and toxicity-adjusted net clinical value. Posterior probabilities P(HR<1), 24-month absolute OS gain, RMST improvement, and AE-adjusted benefit were calculated under a random-effects model.

Results: Monoclonal ICI + chemotherapy achieved a low benefit probability (61%) and marginal 24-month OS gain (+2.8%). In contrast, bispecific regimens demonstrated >95% probability of benefit with meaningful absolute gains (+1.5–2.0 months). Decision curve modeling showed bispecific regimens maintain positive net benefit up to 15% AE tolerance, while monoclonal regimens never achieve clinical utility.

Mechanistic synthesis indicated PD-1×CTLA-4 agents (Cadonilimab) perform best in priming-limited "cold" tumors, and PD-L1×TGF-β agents (SHR-1701) in TGF-β–rich, excluded phenotypes.

Conclusions: Reinterpreting Wang et al.'s dataset under a Bayesian, decision-oriented lens transforms statistical signals into clinical meaning. Bispecific combinations exhibit high certainty and tangible benefit in CPS <5 disease, while monoclonal regimens provide uncertain value. This framework advances probability- and utility-based patient selection beyond binary significance.

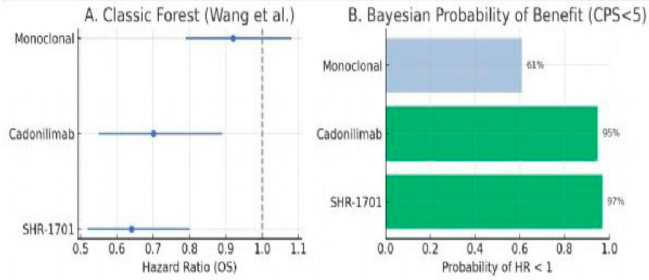
Keywords: gastric cancer, immunotherapy, meta-analysis

Bayesian Ranking Probabilities for Efficacy Endpoints

Regimen	P(best OS)	P(best PFS)	P(best Net Benefit)
Monoclonal ICI + Chemo	0.11	0.09	0.08
Cadonilimab + Chemo	0.43	0.48	0.41
SHR-1701 + Chemo	0.46	0.43	0.51

This table summarizes Bayesian ranking probabilities for overall survival (OS), progression-free survival (PFS), and net clinical benefit across three regimens. SHR-1701 plus chemotherapy shows the highest probability of being the best regimen for all endpoints, particularly for net benefit (P = 0.51).

Comparison of Classic and Bayesian Analyses of Overall Survival (CPS < 5 Subgroup)



Panel A shows the classic forest plot of overall survival (OS) hazard ratios with 95% confidence intervals (Wang et al. method). Panel B presents the Bayesian probability of treatment benefit (Probability of HR < 1) in patients with CPS < 5. Both Cadonilimab and SHR-1701 demonstrate a high probability of OS benefit compared with the monoclonal antibody reference.

OP-09

CLINICOPATHOLOGICAL COMPARISON BETWEEN VERY EARLY-ONSET (<=35 YEARS) AND YOUNG (36–49 YEARS) COLORECTAL CANCER PATIENTS

Sıla Soylu Koçoğlu[1], Imdat Eroğlu[1], Hatice Avşar[2], Kadriye Bir Yücel[3], Fatih Gürler[1], Gözde Savaş[1], Ozan Yazıcı[1], Nuriye Özdemir[1], Uğur Coşkun[1], Aytuğ Üner[1], Ahmet Özet[1]

[1]*Department of Medical Oncology, Gazi University Faculty of Medicine, Ankara, Turkiye*
[2]*Department of Internal Medicine, Gazi University Faculty of Medicine, Ankara, Turkiye*
[3]*Department of Medical Oncology, Ankara Etlik City Hospital, Ankara, Turkiye*

Background: The incidence of early-onset colorectal cancer (EOCRC), defined as diagnosis before age 50, has doubled in many countries over the past two decades. Although lifestyle and environmental factors contribute to this trend, recent genomic studies have identified distinct molecular mechanisms in very young patients, including colibactin-associated mutational processes and germline predispositions. Tumors in patients aged 35 years and younger show distinct biological features compared with older cases. This study compared the clinicopathologic and molecular characteristics of patients aged <=35 and 36–49 years to explore age-related differences in tumor biology.

Methods: We retrospectively analyzed 152 EOCRC patients diagnosed and treated at a single tertiary center between 2010 and 2024. Demographic, clinicopathologic, and molecular data—including MSI/MMR and KRAS status—were extracted from records. Patients were grouped as <=35 or >35 years.

Results: Patients aged <=35 years showed more aggressive disease than those aged 36–49 years, with higher rates of nodal involvement (77.4% vs. 60.6%, p = 0.03) and metastatic presentation (39.6% vs. 22.2%, p = 0.02). Mucinous (26.4% vs. 14.1%) and signet-ring (9.4% vs. 3%) histology were also more common (p = 0.02). T3–4 tumors tended to be more frequent in very young patients, showing a trend toward significance (p = 0.09). MSI-H/dMMR tumors were more frequent among very young patients (45.8% vs. 18.6%, p = 0.01). Female predominance was slightly higher (56.6% vs. 44.4%, p = 0.15). Tumor site distribution was similar, with rectal location most frequent (p = 0.63). Emergency surgery was more frequent in younger patients (21.2% vs. 12.4%, p = 0.15), possibly reflecting delayed diagnosis. Kaplan–Meier analysis showed no OS difference between groups (log-rank p = 0.78). Median OS was not reached in either subgroup, reflecting favorable long-term outcomes. In

the metastatic subset (n = 45), median OS was 27.6 months (95% CI, 10.3–44.8), with no difference by age groups (p = 0.65). In non-metastatic patients, right-sided location, high CEA, nodal positivity, lymphovascular invasion (LVI), and perineural invasion (PNI) predicted worse survival; only LVI remained significant in multivariate analysis (HR = 5.8, 95% CI 1.3–26.4, p = 0.025). In metastatic disease, age >35 years was associated with poorer survival (HR = 2.1, 95% CI 1.1–4.2, p = 0.038).

Conclusion: Very early-onset colorectal cancer (<=35 years) demonstrates distinct clinicopathologic and molecular characteristics, including higher MSI-H/dMMR frequency and mucinous or signet-ring histology, compared with older early-onset cases. Despite these aggressive features, overall survival did not differ significantly, likely reflecting improved detection and multidisciplinary care. Further molecular and translational studies are warranted to elucidate the biological basis of tumor aggressiveness in ultra-young CRC.

Keywords: early-onset cancer, colorectal cancer

Tablo 1. Comparison of clinicopathological features between patients aged <=35 years and those aged 36–49 years diagnosed with colorectal cancer.

		<=35 years (n=53)	*36–49 years (n=99)*	*p-value*
Sex, n (%)	Female	30 (56.6)	44 (44.4)	0.15
Family History of Malignancy, n (%)	Yes	25 (47.2)	31 (31.3)	0.15
Tumor location*, n (%)	Right colon Left colon Rectal cancer	10 (20) 16 (32) 24 (48)	17 (17.9) 38 (40) 40 (42.1)	0.63
T stage, n (%)	T3–T4	47 (88.7)	77 (77.8)	0.09
Nodal involvement, n (%)	N+	41 (77.4)	60 (60.6)	0.03
Metastatic at Diagnosis, n (%)	Yes	21 (39.6)	22 (22.2)	0.02
Histologic type, n (%)	Adenocarcinoma Mucinous Signet-ring cell	33 (62.3) 14 (26.4) 5 (9.4)	82 (82.8) 14 (14.1) 3 (3)	0.02
Tumor Differentiation, n (%)	Poorly differentiated	5 (12.5)	6 (7.7)	0.50
MSI status, n (%)	MSI-H/dMMR	11 (45.8)	8 (18.6)	0.01
KRAS status, n (%)	Mutant	11 (20.8)	17 (17.2)	0.32
Germline Mutation, n (%)	Yes	8 (16)	8 (8.2)	0.06
Emergency Surgery at Diagnosis, n (%)	Yes	11 (21.2)	12 (12.4)	0.15

*Seven transverse colon cases were excluded from tumor location analysis
**Percentages were calculated based on available data for each variable

OP-10

SURVIVAL OUTCOMES OF ADJUVANT RADIOCHEMOTHERAPY VERSUS CHEMOTHERAPY ALONE FOLLOWING NEOADJUVANT TREATMENT IN LOCALLY ADVANCED GASTRIC CANCER

Barbaros Aydın[1], Solin Onder[1], Cagri Duymaz[1], Serhan Derici[2], Koray Atilla[2], Tugba Yavuzsen[3], Ilknur Gorken[1]

[1]*Dokuz Eylul University Medical Faculty Department of Radiation Oncology, Izmir, Türkiye*
[2]*Dokuz Eylul University Medical Faculty Department of General Surgery, Izmir, Türkiye*
[3]*Dokuz Eylul University Medical Faculty Department of Medical Oncology, Izmir, Türkiye*

Introduction: Based on current data, the impact of adding radiotherapy (RT) to adjuvant treatment following the fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) regimen in locally advanced gastric cancer remains unclear. In our study, we assessed the effects of adjuvant RT on local control and survival outcomes in patients who completed both neoadjuvant and adjuvant FLOT treatments.

Materials-Methods: Between January 2018 and June 2024, 32 patients (Group 1) who underwent surgery and adjuvant chemotherapy (ChT) after neoadjuvant ChT (FLOT) and 52 patients (Group 2) who underwent concurrent chemoradiotherapy (CRT) after adjuvant ChT were included. All patients underwent total/subtotal+D2 lymph node dissection. Adjuvant RT was recommended for all patients after surgery. However, patients in Group 1 either refused RT for personal reasons or completed their adjuvant ChT at a different facility, where adjuvant RT was not recommended.

Results: Median follow-up time was 26 (9-94) months. The AJCC 2018-TNM stage distribution for Group 1 and Group 2 was 13% and 12% for Stage 2A, 18%, and 21% for Stage 2B, 58% and 62% for Stage 3, and 5% and 11% for Stage 4A. Two- and three-year overall survival and disease-free survival rates were 65.5% and 54.4%, 57.3% and 51.1% in Group 1 and 86.5% and 74.7%, 76.7% and 65.7% in Group 2 patients (p=0.170, p=0.191), respectively. However, among patients with positive nodal involvement after surgery, the 2- and 3-year overall survival and disease-free survival rates were 57.4% and 49.4%, 45% and 42% in Group 1 and 79.7% and 68.3%, 68% and 61% in Group 2 (p=0.027,p=0.045) patients.

Conclusion: While no difference in survival rates was observed between the two groups, the addition of radiotherapy for node-positive cases after surgery demonstrated statistically significant improvements in both overall survival and disease-free survival. A randomized controlled trial investigating the impact of radiotherapy (RT) combined with adjuvant FLOT chemotherapy after surgery has not yet been published. Our study, particularly the positive results regarding the use of RT in N+ cases, is promising and highlights the need for a randomized study involving a larger patient population.

Keywords: Radiotherapy, Gastric cancer, chemotherapy

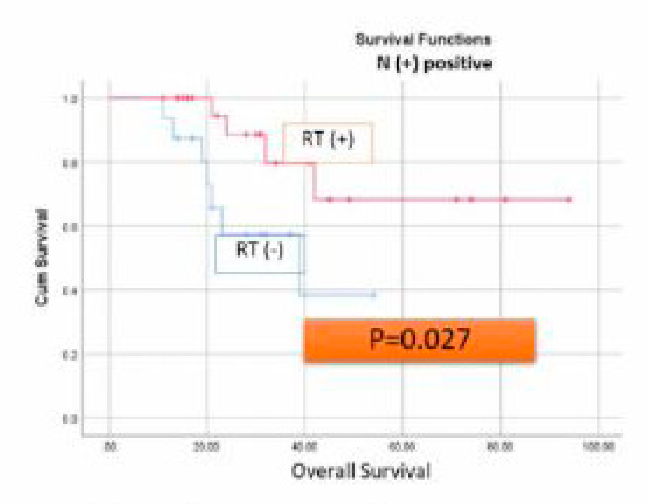


Figure 1. Overall survival in N(+) patients

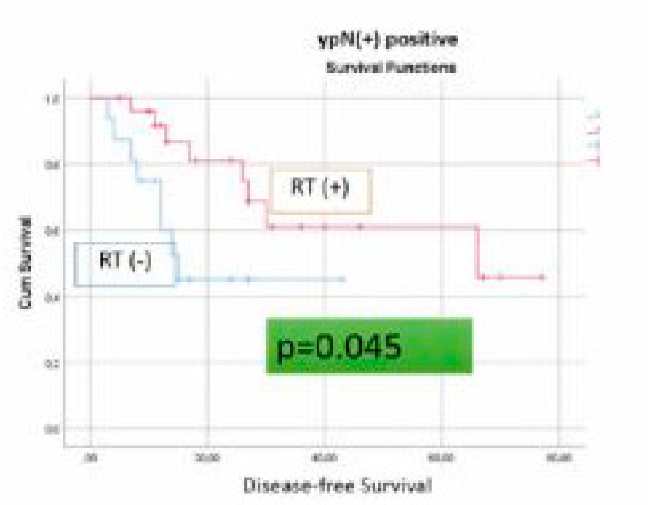


Figure 2. Disease-free survival in ypN(+) patients

OP-11

PRIMARY TUMOR SITE MODIFIES THE PROGNOSTIC IMPACT OF MUCINOUS HISTOLOGY IN NON-METASTATIC COLORECTAL CANCER: AN INTERACTION ANALYSIS OF THE SEER DATABASE

Rashad Ismayilov, Arzu Oguz, Zafer Akcali, Ozden Altundag

Department of Medical Oncology, Baskent University Faculty of Medicine, Ankara, Türkiye

Background: The prognostic significance of mucinous adenocarcinoma (MAC) in colorectal cancer (CRC) remains controversial, with previous studies reporting conflicting survival outcomes. The impact of MAC may differ according to the primary tumor location, reflecting distinct biological characteristics of the colon and rectum. This study aimed to determine whether primary tumor location (colon vs. rectum) modifies the prognostic effect of mucinous histology in non-metastatic CRC.

Methods: Using the SEER 17 Registries Research Database (Nov 2024 Sub), we identified 286,046 adult patients diagnosed with non-metastatic CRC between 2010 and 2022. Patients were categorized by tumor location (colon vs. rectum) and histology (MAC vs. non-MAC). A multivariable Cox proportional hazards model was developed to evaluate overall survival (OS), adjusted for age, sex, race, stage, grade, surgery, radiotherapy, and chemotherapy status. A formal interaction term (histology * location) was included in the model to test for effect modification. Survival curves were generated using the Kaplan-Meier method and compared with the log-rank test.

Results: The final cohort comprised 286,046 patients (mean age, 66.5 ± 13.5 years; 53.2% male), of whom 17,096 (6.0%) had MAC. The primary tumor was located in the rectum in 23.1% of cases. MAC was significantly associated with older age (>=65 vs. <65 years), female sex, White race, higher stage (stage III vs. I–II), right-sided location, and higher grade (grade III–IV vs. I–II) (all $p < 0.001$). After a median follow-up of 76 months, multivariable Cox regression analysis revealed that both mucinous histology (HR: 1.373, 95% CI: 1.326-1.422, $p < 0.001$) and rectal location (vs. colon) (HR: 1.066, 95% CI: 1.027-1.106, $p = 0.001$) were independent predictors of poorer OS. Crucially, a significant interaction was found between mucinous histology and rectal cancer (HR: 1.289, 95% CI: 1.203-1.381, $p < 0.001$), indicating that the prognostic impact of mucinous histology is amplified in rectal tumors (Table 1). The 5-year OS rates were 68.5% for colon non-MAC, 68.7% for rectum non-MAC, 61.1% for colon MAC, and markedly lower at 55.1% for rectum MAC ($p < 0.001$, Figure 1).

Conclusion: Our findings demonstrate that the prognostic significance of mucinous histology in non-metastatic CRC is significantly modified by the anatomical subsite. While MAC is an adverse prognostic factor in colon cancer, its negative impact on survival is markedly exacerbated in rectal cancer. This highlights potential underlying biological differences and suggests that tumor location is a critical effect modifier that should be integrated into the prognostic assessment and risk stratification of patients with mucinous colorectal adenocarcinoma.

Keywords: Mucinous adenocarcinoma, colorectal cancer, SEER Database

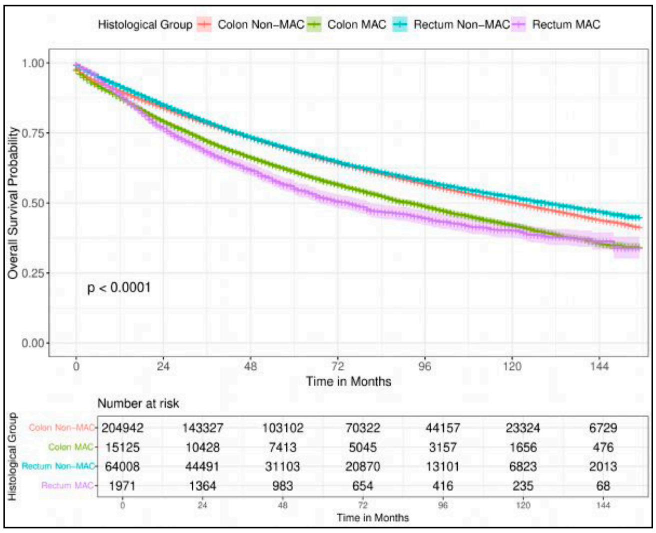


Figure 1. Kaplan-Meier curve for overall survival by histological groups.

Table 1. Multivariable analysis of factors associated with overall survival in non-metastatic colorectal cancer.

Factors	***HR***	***95% CI***	***P value***
Age >=65 years	2.750	2.710-2.791	<0.001
Male sex	1.145	1.130-1.159	<0.001
White race	1.044	1.028-1.060	<0.001
Stage III (vs. I-II)	1.935	1.905-1.965	<0.001
Grade III-IV (vs. I-II)	1.367	1.344-1.391	<0.001
Surgery not performed/unknown	3.771	3.691-3.853	<0.001
Radiotherapy no/unknown	0.921	0.898-0.945	<0.001
Chemotherapy no/unknown	1.754	1.722-1.787	<0.001
Rectal cancer (vs. colon)	1.066	1.027-1.106	0.001
Mucinous histology (vs. non-mucinous)	1.373	1.326-1.422	<0.001
Mucinous histology * Rectal cancer¥	1.289	1.203-1.381	<0.001

¥ The significant interaction term (p<0.001) confirms a quantitative effect modification by rectal location on the prognostic impact of mucinous histology. Abbreviations: CI, confidence interval; HR, hazard ratio.

OP-12

ACTIONABLE MUTATIONS IN CHOLANGIOCARCINOMA: CLINICAL OUTCOMES WITH FGFR2, NTRK1 AND RET TARGETED THERAPIES

Abdurrahman Aykut, Esra Asarkaya, Şüheda Ataş Ipek, Berksoy Şahin, Ismail Oğuz Kara, Tolga Köşeci, Ertuğrul Bayram

Çukurova University Faculty of Medicine, Department of Internal Medicine, Division of Medical Oncology, Adana

Background: Advanced cholangiocarcinoma (CCA) remains a therapeutically challenging malignancy with poor survival, despite first-line chemotherapy. Increasing access to next-generation sequencing (NGS) has revealed clinically actionable genomic alterations that enable targeted treatment approaches. However, real-world outcomes remain underreported, particularly in patients who receive sequential targeted therapy following genomic evolution. Here, we present a single-center case series evaluating the clinical outcomes of three patients with metastatic CCA harboring rare, actionable fusions.

Methods: Three patients with unresectable or metastatic CCA who underwent NGS and received matched targeted therapy between 2020 and 2025 years were retrospectively reviewed. Demographics, molecular alterations, radiologic responses, progression-free survival (PFS), and overall survival (OS) were analyzed.

Results: Case 1: A 63-year-old female diagnosed in October 2020, progressed on paclitaxel–carboplatin and gemcitabine–oxaliplatin. NGS revealed an NTRK1 fusion, and larotrectinib (TRK inhibitor) achieved a sustained metabolic and symptomatic response with ECOG improvement from 2 to 0. PFS on targeted therapy was 16 months, and OS reached 58 months before death in August 2025.

Case 2: A 29-year-old male diagnosed in December 2021, progressed after gemcitabine–cisplatin treatment. NGS detected RET fusion, and selpercatinib (RET inhibitor) induced a profound radiologic response with PFS of 22 months. During disease progression, repeat NGS revealed MET amplification, indicating an acquired resistance mechanism. The addition of crizotinib (MET inhibitor) resulted in an additional PFS of 6 months, underscoring the role of re-biopsy and adaptive targeted treatment. OS was 38 months, and the patient died in February 2025.

Case 3: A 57-year-old male diagnosed in September 2021 with FGFR2–BICC1 fusion–positive CCA progressed after gemcitabine–cisplatin and capecitabine–oxaliplatin treatment. Pemigatinib (FGFR inhibitor) achieved durable disease control with PFS of 18 months. OS was 34 months, and the patient died in July 2024.

Conclusion: This real-world experience demonstrates that NGS-guided targeted therapy can provide clinically meaningful survival benefits in advanced CCA with actionable fusions. Furthermore, the emergence of genomic-driven resistance, such as MET amplification under RET inhibition, highlights the clinical necessity for dynamic molecular reassessment and sequential targeted therapy strategies. The early integration of molecular testing and personalized treatment algorithms may extend s

Keywords: cholangiocarcinoma, targeted therapy, precision oncology

OP-13

PROGNOSTIC FACTORS IN EARLY-STAGE COLON CANCER WITH T4 TUMOR: THE IMPACT OF NODAL STAGE, LYMPH NODE DISSECTION, DIFFERENTIATION, NLR, TUMOR LOCALIZATION, AND TIME TO ADJUVANT CHEMOTHERAPY ON SURVIVAL – A SINGLE-CENTER EXPERIENCE

Esra Asarkaya, Abdurrahman Aykut, Ertuğrul Bayram, Ismail Oguz Kara

Cukurova Univercity Faculty in Medicine

Objective: This study aimed to evaluate multiple clinical and pathological prognostic factors influencing survival in early-stage colon cancer with T4 tumors, and to determine the relationship of N2 stage, number of dissected lymph nodes (LN), pathological differentiation, baseline neutrophil-to-lymphocyte ratio (NLR), tumor localization (right vs left colon) with overall survival (OS) and disease-free survival (DFS).

Methods: Data from 17 patients with T4 colon cancer who underwent surgery between 2015 and 2022 were retrospectively analyzed. Demographic variables (age, sex, comorbidities, ECOG performance status), pathological parameters (T and N stage, number of dissected lymph nodes, lymph node ratio [LNR], vascular and perineural invasion, histologic differentiation), and treatment-related data (type of surgery, margin status, presence of adjuvant therapy) were recorded. Survival curves were generated using the Kaplan–Meier method, and group comparisons were performed with the log-rank test.

Results: The median age was 62 years (range, 48–77); 59% of patients were male and 41% were female. Most tumors were left-sided (64.7%). The comorbidity rate was 65%, and 53% had an ECOG performance score of 0. All patients underwent R0 resection, and 82% received adjuvant chemotherapy, initiated within 8 weeks postoperatively. Baseline tumor markers were within normal ranges. Patients with T4N2 disease had significantly shorter OS (p=0.048), while DFS showed a borderline decrease (p=0.077). N2-positive patients had a higher recurrence rate and shorter DFS.

Lymph node dissection: In 13 patients, >=12 lymph nodes were dissected; in 4 patients, <12 nodes were removed. Median OS was 109.8 months for >=12 LNs and 30.8 months for <12 LNs (p=0.065). Median DFS was 86.9 vs 30.8 months, respectively (p=0.5).

Tumor localization: 6 right-sided and 11 left-sided cases were identified. Median OS was 80.8 months in right-sided and 86.9 months in left-sided tumors (p=0.7).

NLR: Increasing baseline NLR was associated with a trend toward shorter OS and DFS, although not statistically significant. Differentiation: 4 patients had poorly and 13 had well-differentiated tumors. Median OS was 80.8 vs 86.9 months, respectively (p=0.79); no significant difference was observed.

Conclusion: Although pathological differentiation, tumor localization, and baseline NLR levels showed a trend toward poorer survival, statistical significance was not reached due to the limited sample size.Nevertheless, patients with high NLR and right-sided tumors exhibited shorter OS and DFS.N2 stage and inadequate lymph node dissection (<12 nodes) emerged as the most prominent adverse prognostic factors in T4 colon cancer. These findings emphasize the importance of adequate lymphadenectomy and timely initiation of adjuvant therapy, while highlighting the need for larger, multicenter, and multivariate analyses to validate these results and integrate them into prognostic scoring systems.

Keywords: T4 colon cancer, Prognostic factors, Nodal stage

OP-14

NEOADJUVANT RADIOCHEMOTHERAPY FOR LOCALLY ADVANCED/RECURRENT COLON CANCER: IMPROVING RESECTABILITY AND LOCAL CONTROL

Barbaros Aydın[1], Volkan Semiz[1], Funda Barlık[2], Tugba Yavuzsen[3], Selman Sökmen[4], Ilknur Görken[1]

[1]Dokuz Eylul University Medical Faculty Department of Radiation Oncology, Izmir, Türkiye
[2]Dokuz Eylul University Medical Faculty Department of Radiology, Izmir, Türkiye
[3]Dokuz Eylul University Medical Faculty Department of Medical Oncology, Izmir, Türkiye
[4]Dokuz Eylul University Medical Faculty Department of General Surgery, Izmir, Türkiye

Background: Complete surgical resection (R0) is critical for prognosis in colorectal cancer. However, achieving R0 resection is often complicated in cases of locally advanced or postoperative locally recurrent disease due to challenging tumor characteristics and location, and reduce the chance of disease control. This study investigated the impact of neoadjuvant radiotherapy on resectability in these high-risk patients with clinically advanced or recurrent colon cancer.

Materials-Methods: Fourteen patients diagnosed with colon cancer who received neoadjuvant CRT (Chemoradiotherapy) between January 2005 and December 2023 were retrospectively analyzed. According to the treatment protocol, patients with locally advanced colon cancer (T3-4 and/or regional lymph node involvement) received concurrent fractionated radiotherapy (RT) (45/54 Gy in 25/28 fractions) with 5-fluorouracil-based chemotherapy (CT), followed by curative surgery. All cases were histopathologically adenocarcinoma, and the primary tumor was located in the retroperitoneal colon. Statistical analyses were performed using SPSS 24.0 with Kaplan-Meier and Log-rank/Cox Regression tests.

Results: Of the 14 patients in the study group, 9 (64%) were male and 5 (36%) were female, with a median age of 58 (range: 27-85). Neoadjuvant RT was administered to the primary tumor in 3 (21%) patients and to a locally recurrent tumor after primary surgery in 11 (79%) patients. Twelve (86%) cases received oral capecitabine, and 2 (14%) cases received intravenous 5-FU. Post-surgery, all cases continued to receive 5-fluorouracil-based chemotherapy for at least 6 months. Before neoadjuvant RT, all cases were assessed as clinical T4 (cT4). The clinical N positivity (cN+) rate was found to be 44%. Radiotherapy was administered using 3D conformal technique in 2 (14%) patients and IMRT/VMAT technique in 12 (86%) patients, respectively. Surgical resection was performed a median of 9 (range: 4-40) weeks after radiotherapy. R0 resection was achieved in all patients. Postoperatively, a pathological complete response (ypT0N0) was achieved in 5 (35%) cases. For all cases, the 3- and 5-year local recurrence and overall survival rates were calculated as 85.7% and 85.7%; 88.9% and 64.8%, respectively. While local recurrence was rare (detected in only one case), patient mortality was predominantly due to distant metastasis.

Conclusion: Neoadjuvant radiochemotherapy is an effective treatment in selected patients with advanced or locally recurrent colon cancer, providing significant local control and facilitating RO resection without increasing postoperative morbidity.

Keywords: Colon cancer, radiotherapy

OP-15

WHICH PATIENTS WITH COLORECTAL CANCER DEVELOP BRAIN METASTASES? A MULTICENTER ANALYSIS OF CLINICAL AND MOLECULAR PREDICTORS

Fatih Kemik[1], Bahadır Köylü[1], Cevat Ilteriş Kıkılı[1], Nazan Demir[1], Jamshid Hamdard[2], Ali Kaan Güren[3], Sezin Yıldızhan[4], Arda Ulaş Mutlu[5], Çiğdem Yıldırım[6], Nargiz Majidova[7], Nülifer Durankuş Kılıç[8], Uğur Selek[8], Rıza Umar Gürsu[6], Leyla Özer[9], Burak Şakar[4], Senem Karabulut[4], Osman Köstek[3], Ahmet Bilici[2], Nil Molinas Mandel[10], Fatih Selçukbiricik[1], Şahin Laçin[1]

[1]*Department of Medical Oncology, School of Medicine, Koç University, Istanbul, Turkiye*
[2]*Faculty of Medicine, Department of Medical Oncology, Medipol University, Istanbul, Turkiye*
[3]*Division of Medical Oncology, Department of Internal Medicine, Marmara University School of Medicine, Istanbul, Turkiye*
[4]*Department of Clinical Oncology, Oncology Institute, Istanbul University, Istanbul, Turkiye*
[5]*Department of General Surgery, Acıbadem University, Istanbul, Turkiye*
[6]*Department of Medical Oncology, Istanbul Training and Research Hospital, University of Health Sciences, Istanbul, Turkiye*
[7]*Department of Medical Oncology, VM Medical Park Maltepe Hospital, Istanbul, Turkiye*
[8]*Department of Radiation Oncology, School of Medicine, Koç University, Istanbul, Turkiye*
[9]*Department of Medical Oncology, Acıbadem Mehmet Ali Aydınlar University, Istanbul, Turkiye*
[10]*Department of Medical Oncology, American Hospital, Istanbul, Turkiye*

Background: Brain metastases from colorectal cancer (CRC) are rare but clinically significant events with limited data available. This study aimed to evaluate the clinicopathological and molecular features, as well as survival outcomes, of CRC patients who developed brain metastases across multiple centers.

Methods: We retrospectively reviewed CRC patients treated at eight oncology centers. Clinical variables (age, sex, tumor location, timing of brain metastasis), molecular markers (MSI, KRAS, NRAS, BRAF, HER2), and survival outcomes were analyzed. Overall survival (OS) was calculated from CRC diagnosis, and post-brain metastasis survival from the time of cranial involvement.

Results: Among 5617 CRC patients, 94 (1.7%) were identified with brain metastases. The cohort included 57 men (60.6%) and 37 women (39.4%), with a median age of 60 years (range, 26.9–81.3). Primary tumor location was rectum in 42 patients (44.7%), left colon in 31 (33.0%), and right colon in 21 (22.3%). Brain metastases occurred significantly more frequently in left-sided and rectal primaries compared with right-sided tumors (77.7% vs 22.3%, $\chi^2=28.8$, $p<0.001$). Molecular profiling revealed: MSI-H 6.1% (5/82), KRAS mutation 46.3% (38/82), NRAS mutation 2.7% (2/75), BRAF mutation 8.1% (6/74), and HER2 positivity 10.8% (8/74). Notably, HER2 positivity appeared higher than the expected prevalence reported in unselected metastatic CRC cohorts. Brain metastases developed after a median of 1.8 years (range, 0–7.4); 8 patients (13.6%) had de novo brain metastasis, while 51 (86.4%) developed interval metastases. At last follow-up, 83.7% of patients had died. Median OS from diagnosis was 31.2 months, while median survival after brain metastasis was only 4.8 months.

Conclusion: Our multicenter analysis demonstrates that CRC brain metastases occur most often in left-sided and rectal tumors, with an unexpectedly high rate of HER2 positivity and left-sided BRAF mutations. This pattern may reflect a unique molecular biology that distinguishes CRC patients at risk of cranial involvement and could inform future strategies for surveillance and targeted therapy. To our knowledge, this represents one of the largest multicenter series investigating CRC patients with brain metastases.

Keywords: Colorectal cancer, Brain metastases

OP-16

EFFICACY AND TOXICITY OUTCOMES OF TOTAL NEOADJUVANT FLOT VERSUS PERIOPERATIVE FLOT IN RESPECTABLE GASTRIC CANCER: RESULTS FROM THE TURKISH ONCOLOGY GASTROINTESTINAL CANCER WORKING GROUP

Cevat Ilteriş Kıkılı[1], Nur Ilayda Genç[1], Mert Durukan[2], Erdem Sünger[3], Bahadır Köylü[1], Fatih Kemik[1], Nazan Demir[1], Hayrani Kaya[4], Ömer Burak Ekinci[5], Ahmet Demirel[6], Seda Jeral Evinç[7], Didem Divriklioğlu[8], Dilek Erdem[9], Emine Türkmen[10], Aydın Acarbay[11], Fatma Paksoy Türköz[12], Can Saraçoğlu[13], Sezin Yildizhan[14], Ali Inal[15], Ayberk Bayramgil[16], Mesut Yılmaz[17], Nargiz Majidova[18], Didem Tunalı[1], Şeyda Gündüz[1], Ahmet Rencüzoğulları[1], Emre Balık[1], Fatih Selçukbiricik[1], Şahin Laçin[1], Şuayib Yalçın[2]

[1]*Koç University Faculty of Medicine Department of Medical Oncology*
[2]*Hacettepe University Faculty of Medicine Department of Medical Oncology*
[3]*Medipol University Faculty of Medicine Department of Medical Oncology*
[4]*Antalya Education and Research Hospital, Department of Medical Oncology*
[5]*Prof. Dr. Cemil Taşçıoğlu Okmeydanı Education and Research Hospital, Department of Medical Oncology*
[6]*Marmara University Pendik Education and Research Hospital, Department of Medical Oncology*
[7]*Istanbul University - Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Medical Oncology*
[8]*Trakya University Faculty of Medicine, Department of Medical Oncology*
[9]*VM Medicalpark Samsun Hospital, Department of Medical Oncology*
[10]*Celal Bayar University Faculty of Medicine, Department of Medical Oncology*
[11]*Istanbul Göztepe Medeniyet University Faculty of Medicine, Department of Medical Oncology*
[12]*Bahçeşehir University Medical Park Faculty of Medicine, Department of Medical Oncology*
[13]*Acıbadem University Faculty of Medicine, Department of Medical Oncology*
[14]*Istanbul University Oncology Institute, Department of Medical Oncology*
[15]*MERSİN City Education and Research Hospital, Department of Medical Oncology*
[16]*Ümraniye Education and Research Hospital, Department of Medical Oncology*
[17]*Sakarya University Faculty of Medicine, Department of Medical Oncology*
[18]*VM Medicalpark Maltepe Hospital, Department of Medical Oncology*

Introduction: In respectable gastric cancer, most patients are unable to complete the perioperative FLOT regimen (Per-FLOT; 4 cycles of FLOT → surgery → 4 cycles of FLOT) due to treatment intolerance. Consequently, some centers prefer total neoadjuvant FLOT therapy (TNT; 8 cycles of FLOT → surgery). In this study, we aimed to compare the efficacy and toxicity profiles of these two regimens.

Materials - Methods: Our study included newly diagnosed respectable gastric cancer patients from 18 centers across Turkiye between 2018 and 2025. Patients were compared according to their clinical and epidemiological characteristics using appropriate statistical methods, and survival analyses were performed with the Kaplan–Meier method and the log-rank test.

Results: A total of 370 patients were included in the Per-FLOT group and 183 in the TNT group. All-grade toxicity was observed in 39 patients (21.3%) in the TNT group and 212 patients (57.3%) in the Per-FLOT group ($p < 0.001$, OR 5.11, 95% CI 3.38–7.72). In multivariate analyses, treatment type (TNT vs Per-FLOT) remained significantly associated with toxicity ($p < 0.001$) alongside hemoglobin and albumin levels. Anemia (72% vs 40%, $p < 0.001$), thrombocytopenia (32% vs 18%, $p < 0.001$), neutropenia (43% vs 26%, $p < 0.001$), and elevated liver function tests (33% vs 11%, $p < 0.001$) were more frequent in the TNT group, whereas nausea (15% vs 35%, $p < 0.001$), Loss of appetite (13% vs 38%, $p < 0.001$), fatigue (15% vs 43%, $p < 0.001$), diarrhea (2% vs 11%, $p < 0.001$), neuropathy (9% vs 16%, $p = 0.054$), and myalgia (3% vs 10%, $p = 0.004$) were more common in the Per-FLOT group. Survival analyses revealed no significant difference in OS ($p = 0.77$) or PFS ($p = 0.22$). In the TNT group, 23% of patients achieved a complete pathological response, 48.5% a partial response, and 28.5% a minimal response. In the Per-FLOT group, the rates of complete, partial, and minimal pathological responses were 15.8%, 56.5%, and 27.7%, respectively ($p = 0.09$). Treatment completion rates were significantly higher in the TNT group (97.3%) compared with the Per-FLOT group (82.2%) ($p < 0.001$).

Conclusions: TNT FLOT showed similar efficacy but was associated with significantly higher treatment completion and a more favorable overall toxicity profile compared with perioperative FLOT. These findings support TNT FLOT as a promising alternative strategy in respectable gastric adencarcinoma.

Keywords: Total Neoadjuvant FLOT, Perioperative FLOT, Respectable Gastric Cancer

Table 1. Comparison of the baseline characteristics of total neoadjuvant FLOT and perioperative FLOT.

Parameters	Total Neoadjuvant FLOT n=183 (33.1%)	Perioperative FLOT n=370 (66.9%)	p
Age - mean ± SD	57.6 ± 12.1	59.6 ± 10.7	0.14
Gender - n(%)			0.17
Male	116 (63.4%)	256 (69.2%)	
Female	67 (36.6%)	114 (30.8%)	
Histology - n(%)			< 0.001
Intestinal	35 (19.3%)	141 (39.1%)	
Diffuse	12 (6.6%)	24 (6.6%)	
Signet Ring Cell	76 (42.0%)	96 (26.6%)	
Other - NOS Adenocarcinoma	58 (32.0%)	100 (27.7%)	
Diagnostic Laparoscopy - n(%)			0.27
Yes	35 (19.1%)	57 (15.4%)	
NO	148 (80.9%)	313 (84.6%)	
Diagnostic E-USG - n(%)			< 0.001
YES	33 (18.1%)	25 (6.8%)	
NO	149 (81.9%)	345 (93.2%)	
MSI Status - n(%)			0.46
Stable	87 (87.9 %)	193 (90.6%)	
Unstable	12 (12.1%)	20 (9.4%)	
HER-2 Status - n(%)			0.51
0	100 (87.7%)	210 (82.7%)	
+1	5 (4.4%)	13 (5.1%)	
+2	5 (4.4%)	12 (4.7%)	
+3	4 (3.5%)	19 (%7.5)	
Hemoglobin - med(25p.-75p.)	11.9 (10.3 - 13.3)	12.2 (10.4 - 13.8)	0.29
Leukocyte - med(25p.-75p.)	7.2 (6.0 - 8.8)	7.4 (6.0 - 9.2)	0.32
Neutrophil - med(25p.-75p.)	4.6 (3.6 - 5.8)	4.7 (3.6 - 6.0)	0.29
PLT - med(25p.-75p.)	262 (204 -335)	269 (219 - 338)	0.22
Albumin - med(25p.-75p.)	4.1 (3.9 - 4.5)	4.0 (3.7 - 4.4)	0.03
Creatinine - med(25p.-75p.)	0.8 (0.7 - 0.9)	0.86 (0.71 - 1.0)	0.04
AST - med(25p.-75p.)	18 (15 - 25)	16 (13 - 20)	< 0.001
ALT - med(25p.-75p.)	16 (12 - 23.5)	15 (11 - 20)	0.008
Total Bilirubin - med(25p.-75p.)	0.37 (0.27 - 0.56)	0.45 (0.29 -0.60)	0.11
LDH - med(25p.-75p.)	168 (149 - 209)	180 (156 - 219)	0.06
CRP - med(25p.-75p.)	4.8 (1.6 -13.0)	3.7 (1.5 - 10.3)	0.19
CEA - med(25p.-75p.)	2.2 (1.3 - 5.1)	2.3 (1.4 -4.6)	0.96
CA 19-9 - med(25p.-75p.)	14.6 (7.0 -34.0)	11.8 (5.2 - 32.1)	0.08

Table 2. Comparison of the toxicity profiles of total neoadjuvant FLOT and perioperative FLOT.

Toxicities- n(%)	Total Neoadjuvant FLOT n=183 (33.1%)	Perioperative FLOT n=370 (66.9%)	p
Total Toxicity	39 (21.3%)	212 (57.3%)	< 0.001
Infusion Reaction	8 (4.4%)	10 (2.7%)	0.30
G1	5 (2.7 %)	6 (1.6%)	
≥G2	3 (1.7%)	4 (1.1%)	
Nausea	29 (15.8%)	132 (35.7%)	< 0.001
G1	13 (7.1%)	64 (17.3%)	
≥G2	16 (8.7%)	68 (18.4%)	
Loss of appetite	25 (13.7%)	141 (38.1%)	< 0.001
G1	14 (7.7%)	62 (16.8%)	
≥G2	11 (6.0%)	79 (21.3%)	
Diarrhea	4 (2.2%)	42 (11.4%)	< 0.001
G1	2 (1.1%)	19 (5.1%)	
≥G2	2 (1.1%)	23 (6.3%)	
Fatigue	29 (15.8%)	159 (43.0%)	< 0.001
G1	16 (8.7%)	82 (22.2%)	
≥G2	13 (7.1%)	77 (20.8%)	
Anemia	133 (72.7%)	149 (40.3%)	< 0.001
G1	68 (37.2%)	80 (21.6%)	
≥G2	65 (35.5%)	69 (18.7%)	
Thrombocytopenia	59 (32.2%)	70 (18.9%)	< 0.001
G1	46 (25.1%)	55 (14.9%)	
≥G2	13 (7.1%)	15 (4.0%)	
Neutropenia	79 (43.2%)	97 (26.2%)	< 0.001
G1	17 (9.3%)	26 (7.0%)	
≥G2	62 (33.9%)	71 (19.2%)	
Elevated AST	62 (33.9%)	41 (11.1%)	< 0.001
G1	52 (28.4%)	32 (8.6%)	
≥G2	10 (5.5%)	9 (2.5%)	
Elevated ALT	60 (32.8%)	42 (11.4%)	< 0.001
G1	41 (22.4%)	34 (9.2%)	
≥G2	19 (10.4%)	8 (2.2%)	
Neuropathy	17 (9.3%)	61 (16.6%)	0.054
Motor Neuropathy	3 (1.6%)	1 (0.3%)	
Sensory Neuropathy	11 (6.1%)	46 (12.5%)	
Mixed Neuropathy	3 (1.6%)	14 (3.8%)	
G1	12 (6.6%)	30 (8.1%)	
≥G2	5 (2.7%)	31 (8.5%)	
Myalgia	6 (3.3%)	38 (10.3%)	0.004
G1	4 (2.2%)	22 (6.0%)	
≥G2	2 (1.1%)	16 (4.3%)	
Other Toxicities	0 (0.0%)	3 (0.8%)	0.55
G1	0 (0.0%)	1 (0.3%)	
≥G2	0 (0.0%)	2 (0.5%)	

OP-17

THE IMPACT OF ASPIRIN USE ON PATHOLOGICAL OUTCOMES IN LOCALLY ADVANCED RECTAL CANCER PATIENTS UNDERGOING TOTAL NEOADJUVANT THERAPY: REAL-WORLD DATA FROM THE ANKARA UNIVERSITY COLORECTAL CANCER STUDY GROUP

Satı Coşkun Yazgan[1], Cihangir Akyol[2], Mehmet Ayhan Kuzu[2], Mehmet Ali Koç[2], Ayhan Bülent Erkek[2], Serap Akyürek[3], Diğdem Kuru Öz[4], Başak Gülpınar[4], Mine Araz[5], Emre Aktop[6], Mehmet Berk Örüncü[1], Güngör Utkan[1]

[1]Ankara University School of Medicine, Department of Medical Oncology, Ankara, Turkiye
[2]Ankara University School of Medicine, Department of General Surgery, Ankara, Turkiye
[3]Ankara University School of Medicine, Department of Radiation Oncology Ankara, Turkiye
[4]Ankara University School of Medicine, Department of Radiology, Ankara, Turkiye
[5]Ankara University School of Medicine, Department of Nuclear Medicine, Ankara, Turkiye
[6]Ankara University School of Medicine, Department of Internal Medicine, Ankara, Turkiye

Background: Total neoadjuvant therapy (TNT) has become the standard of care for locally advanced rectal cancer (LARC), yet predictors of pathological complete response (pCR) and optimal patient selection remain unclear. Emerging evidence suggests that common cardiometabolic agents, such as aspirin may enhance oncological outcomes, but their impact in the TNT setting is not well established.

Methods: We conducted a single-center retrospective cohort study including 104 patients with locally advanced rectal adenocarcinoma who underwent TNT between January 2022 and June 2025. Comprehensive demographic, clinical, and pathological data were systematically extracted from patient records. Patients were evaluated for pCR and tumor downstaging following TNT. Statistical analyses were performed using univariable and multivariable logistic regression.

Results: Aspirin use was significantly associated with higher pCR rates (50.0% vs. 24.3%, P=0.014) and showed a positive trend for tumor downstaging. In multivariable analysis, aspirin use (OR 3.77; 95% CI, 1.36–10.41; P=0.010), better performance status, and mid-rectal tumor location independently predicted pCR. While aspirin use was more common among patients achieving downstaging, this association did not reach statistical significance after adjustment.

Conclusion: Aspirin use independently predicts higher pCR rates in LARC patients undergoing TNT, supporting its potential as a safe, accessible adjunct to enhance treatment efficacy. Although the effect on downstaging was less pronounced, these findings highlight the promise of drug repurposing in rectal cancer. Prospective, randomized trials are warranted to validate aspirin's role in TNT regimens and inform personalized treatment strategies.

Keywords: Aspirin, Pathological complete response, Total neoadjuvant therapy

Multivariate Analysis of Factors Associated with Pathological Complete Response and Down-Staging Status

Final Model	OR	95% CI	p value
Pathological Complete Response Status*			
ASA	3.77	1.36-10.41	0.010
ECOG PS	1.92	1.05-8.08	0.039
Tumor site			
Proximal vs Distal	3.89	0.74-20.51	0.110
Mid vs Distal	5.32	1.60-17.73	0.006
Mid vs Proximal	1.37	0.35-5.40	0.653
cN (N0-1 vs N2)	2.32	0.87-6.20	0.092
Down-Staging Status**			
ASA	3.42	0.68-17.11	0.133
cN (N2 vs N0-1)	0.052	0.007-0.416	0.005

Abbreviations: **ASA:** Acetylsalicylic Acid (Aspirin), **CI:** Confidence Interval, **cN:** Clinical Nodal Stage, **ECOG PS:** Eastern Cooperative Oncology Group Performance Status, **OR:** Odds Ratio

* The initial multivariate model for pCR included the following variables: sex, tumor site, clinical T stage, clinical N stage, ECOG PS, use of aspirin, and use of statins.

** The initial multivariate model for down-staging status included the following variables: age group (<50 vs ≥50 age), tumor site, clinical N stage, EMVI, MRF involvement, use of aspirin, and aspirin use (patients without CAD).

OP-18

ASSOCIATION OF P53, RAS, AND RAF MUTATIONS WITH RECURRENCE IN STAGE 2 AND 3 COLON CANCER PATIENTS WITH EXTENDED FOLLOW-UP

Satı Coşkun Yazgan[1], Cihangir Akyol[2], Mehmet Ayhan Kuzu[2], Mehmet Ali Koç[2], Ayhan Bülent Erkek[2], Diğdem Kuru Öz[3], Nursima Kanburoğlu[4], Güngör Utkan[1]

[1]*Ankara University School of Medicine, Department of Medical Oncology, Ankara, Turkiye*
[2]*Ankara University School of Medicine, Department of General Surgery, Ankara, Turkiye*
[3]*Ankara University School of Medicine, Department of Radiology, Ankara, Turkiye*
[4]*Ankara University School of Medicine, Department of Internal Medicine, Ankara, Turkiye*

Background: The prognostic value of molecular markers such as p53, RAS, and RAF mutations in stage 2 and 3 colon cancer remains uncertain 1-3. This study aimed to evaluate the association between clinicopathological and molecular features and recurrence in patients with long-term follow-up.

Methods: Patients with stage 2 (n=80) and stage 3 (n=82) colon cancer who underwent curative resection between 2018 and 2025 and had more than 5 years of follow-up were retrospectively analyzed. Demographic, clinicopathological, and molecular data (p53, RAS, RAF) were collected. Recurrence rates and their association with these variables were assessed.

Results: The median follow-up duration was 89.6 months (IQR: 78.5–100.8) for stage 2 and 97.5 months (IQR: 92.7–102.4) for stage 3 patients. The median age at diagnosis was 57.7 years (IQR: 51.9–64.4) for stage 2 and 54.4 years (IQR: 48.4–61.8) for stage 3. In stage 2, 51.3% were male and 48.7% female; in stage 3, 53.7% were male and 46.3% female. The majority of tumors were pT3 in both groups, with pN0 predominating in stage 2 and pN1 in stage 3. Grade 2 differentiation was most common in both cohorts. Disease recurrence was observed in 14 patients (17.5%) with stage 2 and 17 patients (20.7%) with stage 3 disease, with median progression-free survival (PFS) of 15.2 months (IQR: 13.0–17.4) and 27.6 months (IQR: 15.9–39.4), respectively. Among patients for whom molecular analysis was available, all with p53 mutations experienced recurrence in both the stage 2 (n=7, 100%) and stage 3 (n=5, 100%) groups, and no p53-mutant patients were found in the non-recurrence groups. For RAS status, all RAS-mutant patients developed recurrence in stage 2 (n=8, 100%), while 3 of 4 RAS wild-type patients (75%) also developed recurrence. In stage 3, recurrence was observed in 4 of 6 RAS-mutant patients (66.7%) and in 8 of 18 RAS-wild-type patients (44.4%). None of the patients with the RAF mutation developed recurrence in either group. All recurrences occurred in the MSS subgroup, with no MSI cases among patients with recurrence. Despite these findings, statistical analysis revealed no significant association between recurrence and any clinicopathological or molecular variable, including p53, RAS, and RAF status, in either cohort.

Conclusion: In this combined cohort of stage 2 and stage 3 colon cancer patients with long-term follow-up, p53 mutation was observed exclusively in patients with recurrence, suggesting that p53 mutation may be a strong risk factor for disease recurrence. These findings highlight the potential prognostic value of p53 mutation in identifying patients at higher risk for recurrence. Prospective studies with larger cohorts are warranted to further clarify the role of p53 mutation as a predictive biomarker and to guide individualized surveillance and treatment strategies.

Keywords: Colon cancer, Early stage, p53 mutation

Association of Molecular Markers with Recurrence in Stage 2 and Stage 3 Colon Cancer

Stage	Molecular Marker	Total Analyzed	Mutation Positive n (%)	Recurrence in Mutation Positive n (%)	Mutation Negative n (%)	Recurrence in Mutation Negative n (%)
Stage 2	p53	12	7 (58.3)	7 (100)	5 (41.7)	0 (0)
Stage 2	RAS	12	8 (66.7)	8 (100)	4 (33.3)	3 (75)
Stage 2	RAF	12	1 (8.3)	0 (0)	11 (91.7)	11 (100)
Stage 3	p53	24	5 (20.8)	5 (100)	19 (79.2)	7 (36.8)
Stage 3	RAS	24	6 (25.0)	4 (66.7)	18 (75.0)	8 (44.4)
Stage 3	RAF	24	3 (12.5)	0 (0)	21 (87.5)	12 (57.1)

OP-19

LONG-TERM SURVIVAL IN DE NOVO METASTATIC COLORECTAL CANCER: KEY PREDICTORS AND OUTCOMES

Satı Coşkun Yazgan[1], Cihangir Akyol[2], Mehmet Ayhan Kuzu[2], Mehmet Ali Koç[2], Ayhan Bülent Erkek[2], Serap Akyürek[3], Diğdem Kuru Öz[4], Mine Araz[5], Bilge Demirgüneş[6], Güngör Utkan[1]

[1]*Ankara University School of Medicine, Department of Medical Oncology, Ankara, Turkiye*
[2]*Ankara University School of Medicine, Department of General Surgery, Ankara, Turkiye*
[3]*Ankara University School of Medicine, Department of Radiation Oncology Ankara, Turkiye*
[4]*Ankara University School of Medicine, Department of Radiology, Ankara, Turkiye*
[5]*Ankara University School of Medicine, Department of Nuclear Medicine, Ankara, Turkiye*
[6]*Ankara University School of Medicine, Department of Internal Medicine, Ankara, Turkiye*

Background: Metastatic colorectal cancer (mCRC) is a highly lethal disease, with 5-year overall survival (OS) rates typically between 10% and 14%. However, advances in systemic therapy and aggressive local interventions have enabled a subset of patients to achieve long-term survival (LTS), defined as survival beyond five years. This study aims to identify clinical, molecular, and therapeutic factors associated with LTS in patients with de novo mCRC.

Methods: We retrospectively analyzed 34 patients with de novo mCRC who survived at least five years. Data included demographics, tumor location, metastatic burden (oligo-metastatic status), molecular profiles (RAS/RAF status), and treatment modalities, with emphasis on surgical and systemic therapies.

Results: The median follow-up was 99.2 months (IQR: 68.8–129.5). At data cutoff, 30 patients (88.2%) were alive. The cohort included 20 males (58.8%) and 14 females (41.2%). Primary tumors were located in the right colon (35.3%), left colon (47.1%), and rectum (17.6%). Liver metastases were present in 82.4%, with 71.4% oligo-metastatic. Pulmonary metastases occurred in 11.8%, distant lymph nodes in 29.4%, and peritoneal metastases in 8.8%. Primary tumor resection was performed in 97.1%, and metastasectomy in 70.6% (91.3% liver, 8.7% lung). Of 29 patients with molecular data, 69.0% were RAS/RAF wild-type. Microsatellite stability was seen in 94.1%. The most common first-line regimen was FOLFOX (76.5%). Among 18 patients (52.9%) who received targeted therapy, 10 (55.6%) received bevacizumab and 8 (44.4%) received anti-EGFR agents (cetuximab or panitumumab). Local treatments during follow-up were applied in 82.4%, most commonly surgery (60.7%), with additional modalities including radiotherapy, radioembolization, and ablation. The median number of systemic treatment lines was 2 (IQR: 1–3). Five patients (14.7%) received regorafenib after progression on fluoropyrimidine-based therapy.

Conclusion: Long-term survival in de novo mCRC is strongly associated with the feasibility of curative-intent local therapies, particularly in patients with oligo-metastatic disease and RAS/RAF wild-type tumors. These findings highlight the importance of a multidisciplinary approach to identify candidates for aggressive local interventions, optimizing outcomes in this challenging population.

Keywords: Long-term survival, Metastatic colorectal cancer, Local therapy

Baseline Characteristics

Variable	n (%) or Median (IQR)
Age, years (median, IQR)	58.6 (52.3–66.0)
Sex	
Male	20 (58.8)
Female	14 (41.2)
Primary tumor location	
Right colon	12 (35.3)
Left colon	16 (47.1)
Rectum	6 (17.6)
Follow-up duration, months (median, IQR)	99.2 (68.8–129.5)
Vital status at last follow-up	
Alive	30 (88.2)
Deceased	4 (11.8)
Liver metastasis at diagnosis	
Present	28 (82.4)
Absent	6 (17.6)
Oligo-metastatic	20 (71.4)
Multiple metastatic	8 (28.6)
Lung metastasis at diagnosis	
Present	4 (11.8)
Absent	30 (88.2)
Oligo-metastatic	3 (75.0)
Multiple metastatic	1 (25.0)
Distant lymph node metastasis	
Present	10 (29.4)
Absent	24 (70.6)
Peritoneal metastasis	
Present	3 (8.8)
Absent	31 (91.2)
Primary tumor resection	
Yes	33 (97.1)
No	1 (2.9)
Metastasectomy	
Yes	24 (70.6)
No	10 (29.4)
Liver	21 (91.3)
Lung	2 (8.7)
RAS/RAF status	
Wild-type	20 (58.8)
Mutant	9 (26.5)
Missing	5 (14.7)
Microsatellite status	
MSS	32 (94.1)
MSI	2 (5.9)
First-line chemotherapy	
FOLFOX	26 (76.5)
XELOX	4 (11.8)
FOLFIRI	3 (8.8)
FOLFIRINOX	1 (2.9)
First-line targeted therapy	
Anti-VEGF	10 (55.6)
Anti-EGFR	8 (44.4)
Local treatment during follow up	
Yes	28 (82.4)
No	6 (17.6)
Type of local treatment	
Surgery	17 (60.7)
Radiotherapy	2 (7.1)
TARE	1 (3.6)
Radiofrequency ablation	2 (7.1)
Combined	6 (21.4)
Number of systemic treatment lines (median, IQR)	2 (1–3)
Regorafenib use	5 (14.7)

OP-20

DOSE–SIZE RELATIONSHIP DEFINES LOCAL CONTROL AFTER LIVER SBRT: A QUANTITATIVE ANALYSIS OF BED10 AND LESION DIAMETER

Pantea Bayatfard[1], Zeynep Bilge Durmus[2], Gungor Utkan[3], Ramazan Idilman[4], Digdem Kuru Oz[5], Sumerya Duru Birgi[2], Yakup Arslan[2], Serap Akyurek[2]

[1]Denizli Onkomer Oncology Center, Department of Radiation Oncology
[2]Ankara University Faculty of Medicine, Department of Radiation Oncology
[3]Ankara University Faculty of Medicine, Department of Medical Oncology
[4]Ankara University Faculty of Medicine, Department of Gastroenterology
[5]Ankara University Faculty of Medicine, Department of Radiology

Background: Stereotactic body radiotherapy (SBRT) is a curative option for selected hepatic lesions, yet local control (LC) determinants remain controversial. This study aimed to evaluate in-field LC outcomes after SBRT in liver lesions, and to define dose–volume–size relationships associated with local recurrence.

Methods: Medical records of 51 patients with a total of 85 liver lesions treated with X-ray image-guided SBRT between 2020 and 2025 at Ankara University were retrospectively evaluated. All lesions treated with either 4D-CT based (n=30) or breath-hold (BH) (n=85) technique. Statistical analysis conducted with SPSS v23. and p value <0.05 was considered significant.

Results: Median follow-up was 12 months (range: 3–54). Baseline patient, tumor, and treatment characteristics are shown in Table 1. The median prescribed dose was 50 Gy (range: 35–60) in 5 fractions (range, 3–8), corresponding to a median BED10 of 100 Gy (range: 60–132) (Figure 1). Oligometastatic (OM) and oligoprogressive (OP) disease accounted for 18% and 82% of the cohort, respectively. 1- and 2-year in-field LC rates were 80% and 77% (Figure 2). Out-of-field recurrence developed in 41% of patients at a median of 2 months post-SBRT, with no difference between OM and OP groups. The median overall survival (OS) was 14 months (95% CI 10–17.8), with 1- and 2-year OS rates of 51% and 18%. Treatment response was complete in 49.4%, partial in 21.2%, and stable in 15.3%. Univariate logistic regression analysis identified lesion diameter (p = 0.005; OR 1.9, 95% CI 1.2–2.9) and BED10 (p = 0.007; OR 0.94, 95% CI 0.91–0.98) as predictors of in-field recurrence. In multivariate analysis, BED10 remained an independent predictor (p = 0.024, OR 0.95, 95% CI 0.91–0.99), while lesion size showed a borderline association (p = 0.053, OR 1.59, 95% CI 0.97–2.62). Subgroup analysis showed no significant LC difference between OM and OP lesions (p = 0.07). ROC analysis demonstrated a significant predictive value of lesion diameter for local failure (AUC = 0.706, 95% CI 0.553–0.858, p = 0.011). The optimal cutoff was 24 mm, yielding 69% sensitivity and 73% specificity; lesions >=24 mm showed a higher recurrence risk. Combined BED10–size analysis (χ^2 = 15.8, p = 0.001) revealed the highest LC (95.2%) in small lesions (<=25 mm) treated with >=100 Gy, and the lowest LC (50%) in large lesions (>25 mm) treated with <=100 Gy. Five patients (10%) developed grade 1 radiation-induced liver disease at a median of 4 months, all successfully managed with medication.

Conclusions: SBRT provides high in-field control rates in hepatic lesions leaving no room for hesitation. Both tumor size and BED10 independently predict local failure. Since in-field control was strongly influenced by both BED10, treatment decisions should integrate both parameters. Dose escalation strategies or combined-modality approaches should be considered for larger hepatic lesions to maximize local efficacy.

Keywords: liver sbrt, bed10, tumor size

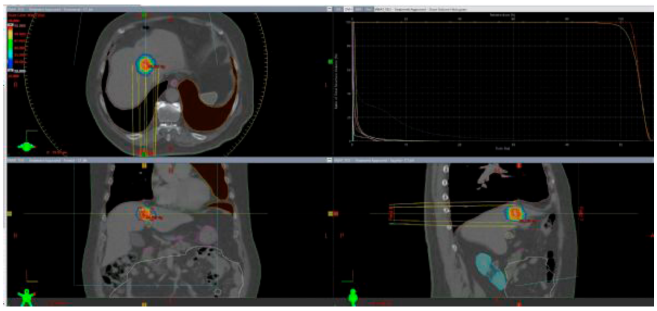


Figure 1. Typical radiotherapy plan and dose-volume histogram of a liver SBRT

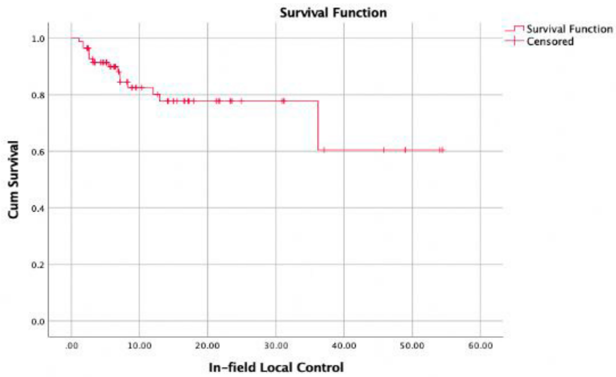


Figure 2. Survival plot of in-field control

Table 1. Baseline patient, tumor, and treatment characteristics

Parameters	***n=85 lesions & n=51 patients (%)***
Sex	Female: 24 (47) Male: 27 (53)
Age	Median 67 (range: 37-90)
ECOG	
0-1 2-3	79 (93) 6 (7)
Primary diagnosis	(lesion based n=85)
- HCC	4 (5)
- Breast	3 (3.5)
- Colon	37 (43.5)
- Rectum	20 (23.5)
- RCC	6 (7.1)
- Lung	1 (1.2)
- Gastric	2 (2.4)
- Ovary	2 (2.4)
- Sarcoma	2 (2.4)
- Others	8 (9.4)
Metastatic Stage	(lesion based) / patient based)
- Oligometastatic	14 / 9 (16.5 / 18)
- Oligoprogresive	71 / 42 (83.5 / 82)
Prior systemic treatment	51 (100)
Other local treatment prior to SBRT	
- Yes	
RF	1 (2)
Surgery	8 (16)
TARE	1 (2)
Combined	5 (10)
- No	36 (70)
Treatment to the same lesion	Yes: 9 (11) No: 76 (89)
Respiratory gating technique	4D: 30 (35) Breath hold: 55 (65)
Lesion size (Median 19 mm (range: 4-62)	< 2.5 cm: 55 (65) >= 2.5 cm: 30 (35)
GTV volume	Median 5. 9 cc (range: 1-119)
PTV margin	Median 7 mm (range: 3-10)
PTV volume	Median 25.7 cc (range: 5-267)
PTV dose	50 Gy (range: 35-60)
Total liver volume	1475 cc (range: 1020-2583)
Liver-GTV Dmean	7.4 Gy (range: 1-25)
Liver-GTV D700 cc	2.7 Gy (range: 1-21)
BED 10 (Median 100 Gy (range: 60-132))	<100 Gy: 29 (34) >=100 Gy: 56 (66)
SBRT response	
- PR	18 (21.2)
- CR	42 (49.4)
- SD	13 (15.3)
- PD	12 (14.1)
Recurrence	Yes: 42 (49) No: 43 (51)
Recurrence location	
- In-field	6 (14)
- Out-field	26 (61)
- Both	10 (25)

OP-21

PROGNOSTIC VALUE OF NAPLES PROGNOSTIC SCORE IN PATIENTS WITH METASTATIC PANCREATIC CANCER: A SINGLE-CENTER EXPERIENCE

Hatice Asoglu Ruzgar, **Berksoy Sahin**

Cukurova University Faculty of Medicine, Department of Medical Oncology, Adana

Background: The Naples Prognostic Score (NPS), composed of serum albumin, total cholesterol, neutrophil-to-lymphocyte ratio (NLR), and lymphocyte-to-monocyte ratio (LMR), has emerged as a comprehensive inflammatory and nutritional scoring system. While its prognostic value has been demonstrated in resectable pancreatic cancer, limited data exist regarding its utility in metastatic disease. This study aimed to evaluate the prognostic significance of NPS in patients with metastatic pancreatic cancer.

Methods: We retrospectively analyzed 37 consecutive patients diagnosed with metastatic pancreatic adenocarcinoma who received systemic chemotherapy at Cukurova University Medical Faculty between January 2020 and December 2024. The NPS was calculated from pretreatment laboratory data, and patients were stratified into three groups according to their NPS scores: Group 0 (NPS = 0), Group 1 (NPS = 1-2), and Group 2 (NPS = 3-4). Clinicopathological characteristics, treatment outcomes, overall survival (OS), and progression-free survival (PFS) were compared among the groups. Univariate and multivariate Cox regression analyses were performed to identify independent prognostic factors.

Results: Of the 37 patients enrolled, 5 (13.5%) were classified into Group 0, 21 (56.8%) into Group 1, and 11 (29.7%) into Group 2. The median OS was significantly different among the three groups (Group 0: 12.4 months; Group 1: 8.2 months; Group 2: 4.7 months; P = 0.008). Similarly, median PFS showed significant differences across NPS groups (Group 0: 7.8 months; Group 1: 5.1 months; Group 2: 2.9 months; P = 0.012). On multivariate analysis, higher NPS (Group 2 vs. Group 0/1) was identified as an independent adverse prognostic factor for both OS (HR = 2.84, 95% CI 1.38-5.86, P = 0.004) and PFS (HR = 2.36, 95% CI 1.24-4.49, P = 0.009). Other independent prognostic factors included Eastern Cooperative Oncology Group (ECOG) performance status and the presence of liver metastases. No significant differences in treatment-related toxicities were observed among the NPS groups.

Conclusions: The Naples Prognostic Score represents a simple, easily calculable, and reproducible prognostic tool in patients with metastatic pancreatic cancer. NPS effectively stratifies patients into distinct prognostic groups and may serve as a valuable biomarker for predicting survival outcomes and guiding treatment decisions in this patient population. Further prospective multicenter studies are warranted to validate these findings.

Keywords: inflammatory markers, metastatic pancreatic cancer, Naples Prognostic Score

OP-22

PROGNOSTIC SIGNIFICANCE OF HEMOGLOBIN, ALBUMIN, LYMPHOCYTE, AND PLATELET (HALP) SCORE IN PATIENTS WITH METASTATIC GASTRIC CANCER: A SINGLE-CENTER RETROSPECTIVE STUDY

Mehmet Mutlu Kidi, Ismail Oguz Kara

Cukurova University Medical Oncology Department

Background: The HALP score (hemoglobin, albumin, lymphocyte, and platelet) is an emerging immunonutritional biomarker with demonstrated prognostic value in solid tumors. However, its significance in metastatic gastric cancer (MGC) remains insufficiently characterized.

Methods: We retrospectively analyzed 114 consecutive patients diagnosed with metastatic gastric adenocarcinoma who received systemic chemotherapy at Cukurova University Medical Oncology Department between January 2016 and December 2023. The HALP score was calculated using the formula: [hemoglobin (g/L) × albumin (g/L) × lymphocytes (/L)]/platelets (/L) from pretreatment laboratory values. Patients were stratified into low and high HALP score groups based on receiver operating characteristic (ROC) curve analysis. Clinical and pathological characteristics, treatment modalities, overall survival (OS), and progression-free survival (PFS) were recorded. Univariate and multivariate Cox proportional hazards regression analyses were performed to identify independent prognostic factors. Kaplan-Meier survival curves were constructed and compared using the log-rank test.

Results: The median age was 63 years (range 31-85), with 76 (66.7%) male patients. The optimal cut-off value for the HALP score determined by ROC analysis was 26.4 (AUC=0.687, 95% CI: 0.589-0.785, P=0.002). Patients were divided into low HALP score (<=26.4, n=68, 59.6%) and high HALP score (>26.4, n=46, 40.4%) groups. The median OS was significantly longer in the high HALP group compared to the low HALP group (11.8 months vs. 6.9 months, P<0.001). Similarly, median PFS was superior in the high HALP group (7.4 months vs. 4.2 months, P=0.003). Patients with low HALP scores were significantly associated with poorer ECOG performance status (P=0.012), presence of liver metastases (P=0.027), higher CA19-9 levels (P=0.018), and lower albumin levels (P<0.001). Multivariate Cox regression analysis identified low HALP score (HR=2.14, 95% CI: 1.42-3.22, P<0.001), ECOG performance status >=2 (HR=2.67, 95% CI: 1.74-4.09, P<0.001), presence of peritoneal metastases (HR=1.86, 95% CI: 1.24-2.79, P=0.003), and lack of second-line chemotherapy (HR=2.42, 95% CI: 1.58-3.71, P<0.001) as independent adverse prognostic factors for OS. For PFS, low HALP score (HR=1.84, 95% CI: 1.26-2.69, P=0.002) and presence of liver metastases (HR=1.72, 95% CI: 1.18-2.51, P=0.005) were identified as independent predictors.

Conclusions: The pretreatment HALP score is a simple, cost-effective, independent prognostic biomarker in MGC, reflecting compromised immunonutritional status. It may facilitate risk stratification, treatment optimization, and clinical trial design. Prospective validation and investigation of HALP-guided interventions are warranted.

Keywords: Metastatic gastric cancer, HALP score

OP-23

INTERACTION BETWEEN METASTATIC ORGAN INVOLVEMENT AND INFLAMMATORY BURDEN INDEX IN PREDICTING PROGRESSION IN RAS-MUTANT MCRC

Fatih Atalah, Onur Alkan

Prof. Dr. Süleyman Yalçın City Hospital

Background: Systemic inflammation-based biomarkers have emerged as prognostic indicators in metastatic colorectal cancer (mCRC). The inflammatory burden index (IBI), calculated as the C-reactive protein/albumin ratio (CRP/Alb), may reflect tumor-related inflammation more accurately than classical indices such as neutrophil-to-lymphocyte ratio (NLR). However, the prognostic significance of IBI across different metastatic organ patterns in RAS-mutant mCRC remains unclear.

Methods: We conducted a single-center retrospective study including 98 patients with RAS-mutant metastatic colorectal cancer. Progression-free survival (PFS) was calculated using the interval between the diagnosis of metastatic disease and radiologic progression. Univariate and multivariate Cox regression models were used to evaluate the prognostic value of IBI and NLR. Subgroup analyses were performed according to metastatic organ involvement (liver, peritoneum, lung, brain). An interaction model was constructed to explore whether the prognostic effect of IBI differed by metastatic site.

Results: In the overall cohort, a higher IBI (CRP/Alb) was significantly associated with increased progression risk (HR=1.09, 95% CI: 1.05–1.13, p<0.001), while NLR showed no prognostic value (HR=0.96, p=0.476). Subgroup analyses demonstrated that IBI remained a significant prognostic marker in patients with liver metastasis (HR=1.075, p<0.001), peritoneal metastasis (HR=1.072, p=0.002), and lung metastasis (HR=1.080, p<0.001), but analysis was inconclusive in patients with brain metastasis due to low sample size (n=2). Interaction analysis revealed that the prognostic effect of IBI was significantly modified by liver metastasis (IBI×liver: HR=0.913, p=0.018), while interactions with peritoneal or lung metastasis were not significant.

Conclusion: IBI (CRP/Alb) is a strong and independent prognostic biomarker for progression in RAS-mutant mCRC, outperforming NLR. Its prognostic effect appears to be most pronounced in patients with liver metastases, suggesting that systemic inflammation may interact with specific metastatic organ biology. IBI may support individualized risk stratification in metastatic colorectal cancer.

Keywords: Inflammatory Burden Index, Metastatic organ involvement, RAS-mutant metastatic colorectal cancer

OP-24

RHABDOID PANKREATIC CARCINOMA: A RARE SUBTYPE OF PANKREATIC CANCER MEHMET YILMAZ, MÜCTEBA BÜYÜKKIROĞLU, METIN DEMIR OSMANGAZI UNIVERSITY FACULTY OF MEDICINE, DEPARTMENT OF MEDICAL ONCOLOGY, ESKIŞEHIR

Mehmet Yilmaz[1], Mücteba Büyükkıroğlu[2], Metin Demir[3]

[1]Mehmet Yılmaz
[2]Mücteba Büyükkıroğlu
[3]Metin Demir

Introduction: Rhabdoid pancreatic carcinoma (RPC) is a rare form of undifferentiated pancreatic carcinomas (PC) and characterized by loss of SMARCAB1/INI1 and the designation "rhabdoid" in PC reflects its histopathologic resemblance to rhabdomyosarcoma. The main subtypes are pleomorphic and monomorphic anaplastic RPC. Herein, we present a case of metastatic RPC.

Case Presentation: A 56-year-old female presented with abdominal and back pain in the last month. Contrast-enhanced upper abdomen-pelvic computed tomography (CT) revealed a 38×29 mm mass lesion located in the gallbladder fundus and a 125×52×75 mm mass surrounding the common bile duct at the pancreatic head, demonstrating invasion to paraaortic paracaval regions. The findings were highly suggestive of a pancreatic head malignancy, in contact with the celiac trunk, superior mesenteric artery, and portal vein, along with multiple metastatic conglomerate lymphadenopathies. Tumor markers were within the normal range and the abnormal laboratory findings were as follows: Aspartate aminotransferase: 78 U/L, alanine aminotransferase: 170 U/L, alkaline phosphatase: 239 U/L, gamma glutamyl transferase: 215 U/L. Thoracic CT revealed multiple pathological lymph nodes within the mediastinum, the largest measuring 2.5 cm in the left upper paratracheal region. Histopathological of the pancreatic head mass revealed findings consistent with PC. The treatment was continued for up to 12 cycles, as partial regression of the pathological lymph nodes in the abdomen was observed after 6 cycles of fluorouracil (5-FU) 2400 mg/m^2 infusion and 400 mg/m^2 intravenous bolus, irinotecan 180 mg/m^2, oxaliplatin 85 mg/m^2, and leucovorin 400 mg/m^2 administered every 14 days (mFOLFIRINOX). At the end of treatment, progression in several lymph nodes was observed while the pancreatic lesion remained stable. The comprehensive next generation sequencing of the tumor tissue revealed no KRAS mutation. The patient was started on a chemotherapy regimen consisting of gemcitabine (900 mg/m^2 on days 1 and 8) plus docetaxel (100 mg/m^2 on day 8), administered every 21 days.

Discussion: RPC is a very rare form and has a worse prognosis, particularly in unresectable tumors. The principal immunohistochemical hallmark of RPC is the loss of SMARCB1/INI1 expression, a core subunit of the SWI/SNF chromatin-remodeling complex that functions as a tumor suppressor. The rapid disease progression on mFOLFIRINOX observed within the first six months in our case suggests an aggressive clinical course. Conclusion: The loss of SMARCB1/INI1 expression is the defining mark of RPC. The responses to mFOLFIRINOX are unsatisfactory. Therefore, target gene mutations as KRAS mutations need to be investigated in all patients. Given its highly aggressive nature and poor prognosis, RPC underscores the urgent need for innovative and personalized therapeutic approaches.

Keywords: Rhabdoid pancreatic carcinoma, loss of SMARCB1/INI1 expression, KRAS mutation

OP-25

PROGNOSTIC IMPACT AND EXPRESSION PATTERNS OF VASOHIBIN-1, CD34, AND VEGF BETWEEN PRIMARY AND METASTATIC COLORECTAL CANCER LESIONS

Oktay Halit Aktepe[1], Tugce Ulasli[1], Olcay Kurtulan[2], Rezan Berkay Izgor[3], Meral Uner[2], Aziz Karaoglu[1], Ilkay Tugba Unek[1], Suayib Yalcin[4]

[1]Department of Medical Oncology, Dokuz Eylül University, Izmir, Turkiye
[2]Department of Pathology, Faculty of Medicine, Hacettepe University, Ankara, Turkiye
[3]Department of Internal Medicine, Faculty of Medicine, Dokuz Eylül University, Izmir, Turkiye
[4]Department of Medical Oncology, Hacettepe University Cancer Institute, Ankara, Turkiye

Background: This study evaluated the prognostic significance of vasohibin-1 (VASH1), cluster of differentiation 34 (CD34) and vascular endothelial growth factor (VEGF) and their expression differences between primary and metastatic colorectal cancer (CRC) lesions.

Methods: Immunohistochemical expression of VASH1, CD34, and VEGF was quantified using tissue microarrays. Receiver operating characteristic (ROC) analysis identified optimal cut-off values for overall survival (OS). Correlations among markers were analyzed with Spearman's test, paired tissue comparisons by Wilcoxon signed-rank test, and survival outcomes by Kaplan–Meier and Cox regression analyses.

Results: The study included 144 CRC patients (median age: 60 years; 59% male). ROC analysis determined optimal thresholds of 6 for VASH1 (AUC: 0.79, 95% CI 0.72–0.87), 37 for MVD (AUC: 0.76, 95% CI 0.68–0.84), and 6 for VEGF (AUC: 0.67, 95% CI 0.58–0.76). Patients with high VASH1, CD34, and VEGF expressions had significantly shorter OS compared with those with low expression (VASH1, $p < 0.001$; CD34, $p < 0.001$; VEGF, $p = 0.0079$). Expression levels of all three markers were significantly reduced in metastatic lesions compared with their matched primary tumors (all $p < 0.01$). In multivariate analysis, VASH1 (HR: 2.05, 95% CI 1.01–4.20, $p = 0.048$) and CD34 (HR: 2.12, 95% CI 1.15–3.89, $p = 0.015$) remained independent predictors of poor OS.

Conclusions: High VASH1 and CD34 expression independently predict unfavorable survival in CRC. Combined evaluation of VASH1, CD34, and VEGF may improve prognostic stratification and guide anti-angiogenic treatment strategies in CRC.

Keywords: vasohibin-1; VEGF; CD34; colon cancer; prognosis

OP-26

DOSIMETRIC AND CLINICAL COMPARISON OF SHORT- AND LONG-COURSE RADIOTHERAPY IN LOCALLY ADVANCED RECTAL CANCER: A SINGLE-CENTER EXPERIENCE

Aliyeva Nigar, **Hacı Günel**

National Center of Oncology, Baku, Azerbaijan

Background: Preoperative radiotherapy is one of the cornerstones in the treatment of locally advanced rectal cancer (LARC). Both short-course radiotherapy (SCRT, 25 Gy/5 fractions) and long-course chemoradiotherapy (LCRT, 50.4 Gy/28 fractions with concurrent 5-FU or capecitabine) are well-established standard approaches. This study aimed to compare the dosimetric parameters, acute toxicities, and disease-free survival (DFS) outcomes of these two modalities in patients treated at the National Oncology Center in Baku, Azerbaijan.

Methods: Between 2022 and 2024, a total of 339 patients diagnosed with stage II–III rectal adenocarcinoma were treated: the SCRT group (n = 57) and the LCRT group (n = 282). All patients underwent treatment using 3D-CRT or IMRT techniques, followed by total mesorectal excision. Dose–volume histograms (DVH) for organs at risk (OARs) were analyzed; mean dose and V40 values were calculated for the bladder and small bowel. Acute and late toxicities were assessed according to CTCAE v5.0 criteria. DFS analysis was performed using the Kaplan–Meier method.

Results: Compared with LCRT, SCRT significantly reduced the mean dose and V40 of the small bowel ($p < 0.05$). The rate of grade 2–3 acute gastrointestinal toxicity was 18.7% in the SCRT group and 32.5% in the LCRT group. No significant differences were found in postoperative complication rates. After a median follow-up of 36 months, the 3-year DFS rate was 74% in the SCRT group and 78% in the LCRT group ($p = 0.62$), with comparable local recurrence rates (9% vs. 7%).

Conclusion: Short-course radiotherapy achieved disease control comparable to that of long-course chemoradiotherapy while reducing small bowel dose and acute toxicity. These findings suggest that SCRT may be an effective and time-efficient alternative for selected LARC patients, particularly in high-volume or resource-limited centers.

Keywords: Short-course radiotherapy, toxicity, disease-free survival

OP-27

DELAYED RESPONSE AND PSEUDOPROGRESSION UNDER ATEZOLIZUMAB–BEVACIZUMAB IN A PATIENT WITH HBV-RELATED HEPATOCELLULAR CARCINOMA: A CASE REPORT

Necla Demir[1], **Irem Bilgetekin**[2], **Aysegul Uckun**[1], **Emrah Eraslan**[1]

[1]*Dr. Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital, Department of Medical Oncology, Ankara*
[2]*Memorial Ankara Hospital, Department of Medical Oncology, Ankara*

Introduction: Immune check point inhibitors (ICIs) have transformed the management of advanced hepatocellular carcinoma (HCC), including HBV-related cases. However, atypical immune-related response patterns such as pseudoprogression and delayed response remain diagnostically challenging. We report an HBV-related HCC case demonstrating apparent progression under atezolizumab–bevacizumab, followed by a delayed radiologic and biochemical response after temporary treatment discontinuation.

Case Presentation: A 52-year-old male with chronic hepatitis B infection (HBsAg> 5000 IU/mL) and no alcohol us epresented in July 2024 with anorexia and 15 kg weight loss over two months. Imaging revealed a 15 × 10 cm right hepatic mass. The patient underwent right hepatectomy and cholecystectomy. Pathology confirmed poorly differentiated HCC (pT2N0M0, Grade 2) with a 0.4 cm negative surgical margin. Postoperative liver function was normal, and entecavir was initiated for HBV suppression. After seven months CT revealed three recurrent lesions in the left hepatic lobe, the largest 75 mm, described as “peripherally enhancing heterogeneous masses suggesting recurrence.” Serum AFP was 11,795 μg/L.The disease was not suitable for local treatments. Atezolizumab–bevacizumab combination therapy was initiated.After four cycles CT showed progression enlargement of the lesions (three confluent nodules, up to 13 × 11 cm) also AFP increased (26,467 μg/L). The patient was referred for clinical trial evaluation, but during this process, he was lost to follow-up and treatment was temporarily discontinued. After four-month treatment-free interval, a follow-up CT showed>50% reduction in hepatic lesions, with central necrosis and decreased enhancement (largest lesion 4 cm, extending toward perihepatic fat). AFP had dropped to 2 μg/L. The findings were interpreted as immune-related pseudoprogression followed by delayed response, and immunotherapy was restarted with continued viral suppression

Discussion: In HBV-related HCC, immunereactivation can cause transient tumor enlargement or necrosis that mimic sprogression. This patient’s clinical course demonstrates that apparent early progression under ICIs may, in fact, represent pseudoprogression. Serial AFP trends and close radiologic assessment were essential to distinguishing immune-related changes from progression.The temporary loss to follow up following clinical trial referral unintentionally provided a treatment-free interval, revealing a spontaneous delayed response highlighting the complexity of immune dynamics in HBV-associated HCC. Recognizing this pattern can prevent premature discontinuation of effective immunotherapy.

Conclusion: This case illustrates pseudoprogression followed by delayed immuneresponse in HBV-related HCC treated with atezolizumab–bevacizumab. Continuous AFP monitoring, serial imaging, and cautious multidisciplinary evaluation are crucial to avoid misinterpretation of immune-mediated radiologic changes.

Keywords: Hepato cellular carcinoma, immunotherapy,

pseudoprogression

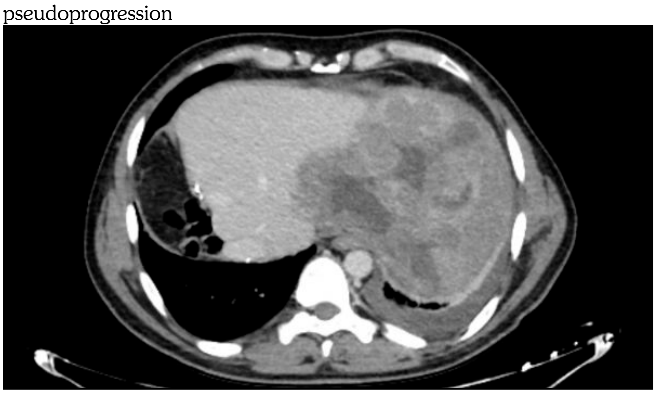


Figure 1. Tomography image after systemic treatment

Figure 2. Tomography image after treatment free interval

OP-28

IMPACT OF PERIOPERATIVE CHEMOTHERAPY ON SURVIVAL OUTCOMES AFTER LIVER METASTASECTOMY IN COLON CANCER

Barış Köksal, **Şuayib Yalçın**

Hacettepe Üniversitesi Tıp Fakültesi, Medikal Onkoloji, Ankara

Background: Surgical resection remains the standard treatment for colon cancer with liver metastases, yet the role of perioperative chemotherapy in improving outcomes is uncertain.

Objective: To evaluate the effect of perioperative chemotherapy on overall survival (OS) and progression-free survival (PFS) in patients undergoing liver metastasectomy for colon cancer.

Methods: This retrospective cohort study included 61 patients diagnosed with colon cancer and liver metastases who underwent curative-intent metastasectomy between 2013 and 2024. Patients were categorized based on receipt of preoperative and/or postoperative chemotherapy. OS was defined as the time from metastasectomy to death, and PFS as the time from metastasectomy to recurrence. Subgroup analyses were conducted according to metastatic burden (oligometastatic: <4 lesions vs. multiple).

Results: The mean age was 57 years, and 60.7% were male. Most tumors were located in the left colon (73.7%). Overall, 37 patients (69.8%) received preoperative chemotherapy, while 16 (30.2%) underwent upfront surgery. Median OS and PFS for the entire cohort were 29.4 months (95% CI: 20.7–38.1) and 10.7 months (95% CI: 9.9–11.5), respectively. No significant difference in OS or PFS was observed between patients receiving preoperative chemotherapy and those who did not. Among oligometastatic patients, preoperative chemotherapy was associated with a non-significant 6.7-month OS advantage (39.0 vs. 32.3 months). In patients with multiple metastases, OS was comparable (22.9 vs. 24.1 months). Patients receiving adjuvant therapy for >=6 months showed longer OS (39.0 vs. 27.6 months), though not statistically significant.

Conclusion: Perioperative chemotherapy did not confer a significant survival benefit compared to surgery alone in patients with colon cancer and liver metastases. A modest trend toward improved OS was seen in oligometastatic patients receiving preoperative chemotherapy. These findings highlight the limited survival impact of perioperative therapy, emphasizing the need for larger prospective studies integrating molecular profiling to identify patients who may derive real benefit.

Keywords: colon cancer; liver metastases; perioperative chemotherapy; metastasectomy; survival

OP-29

INTEGRATION OF OXIDATIVE-STRESS AND CLINICOPATHOLOGIC PARAMETERS IN LOCALLY ADVANCED RECTAL CANCER UNDERGOING NEOADJUVANT CHEMORADIOTHERAPY: A PROSPECTIVE OBSERVATIONAL STUDY

Enes Yesilbas, **Hayriye Sahinli**

Ankara Etlik City Hospital, Medical Oncology Department, Ankara

Background: Response to neoadjuvant chemoradiotherapy (CRT) in locally advanced rectal cancer (LARC) varies considerably, and oxidative stress may modulate radiosensitivity. This study evaluated ischemia-modified albumin (IMA) and thiol–disulfide homeostasis as potential biochemical predictors of pathological tumor regression.

Methods: A prospective dual-center cohort was established to assess pre- and post-treatment oxidative stress biomarkers in patients with LARC receiving capecitabine-based long-course CRT. Serum IMA, native thiol, total thiol, and disulfide levels were quantified spectrophotometrically. Pathologic regression was graded by the Modified Ryan system as good (TRG 0–1) or poor (TRG 2–3). Receiver operating characteristic (ROC) analyses, Firth-penalized logistic regression, and internal validation via cross-validation, calibration, and decision curve analyses were performed.

Results: Of 38 screened patients, 31 met eligibility criteria and completed CRT, alongside 31 matched healthy controls. Compared with controls, patients had higher baseline disulfide (15.7 ± 5.2 vs 11.9 ± 3.1 μmol/L; p = 0.012) and IMA levels (0.886 ± 0.062 vs 0.798 ± 0.048 ABSU; p = 0.006). Poor responders exhibited elevated pre-treatment IMA (0.927 ± 0.045 vs 0.842 ± 0.050 ABSU; p = 0.020) and disulfide levels (18.4 ± 5.2 vs 13.0 ± 3.8 μmol/L; p = 0.012). Pre-treatment IMA demonstrated the highest predictive accuracy for poor tumor regression (AUC = 0.872; 95% CI 0.751–0.993). In multivariable Firth-penalized logistic regression, elevated baseline IMA independently predicted poor pathological response (OR = 3.63; 95% CI 1.22–16.20; p = 0.043), whereas negative circumferential resection margin (CRM) predicted favorable regression (OR = 0.21; 95% CI 0.02–0.17; p = 0.003). The validated model demonstrated excellent discrimination (AUC = 0.948; 95% CI 0.866–0.966) and good calibration.

Conclusions: Baseline IMA and CRM status independently predict pathological response after CRT in LARC. Integrating oxidative-stress biomarkers with clinicopathologic parameters, such as CRM status, may enhance individualized prediction of radiosensitivity and guide treatment personalization.

Keywords: Chemoradiotherapy; Ischemia-modified albümin (IMA); Oxidative stress; Rectal cancer; Tumor regression

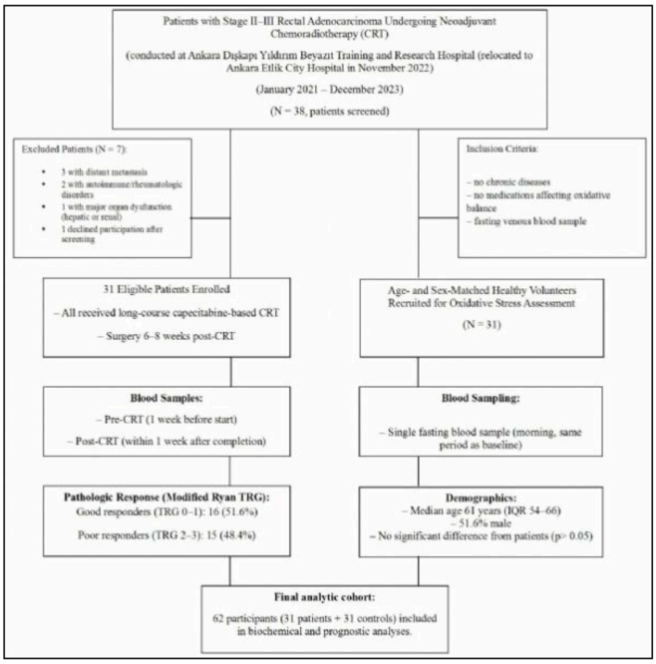


Figure 1. Study flow diagram of the prospective dual-center cohort

Flow diagram showing patient enrollment, exclusion criteria, and final analytic cohort formation. Among 38 screened patients with stage II–III rectal adenocarcinoma evaluated for neoadjuvant chemoradiotherapy (CRT), 7 were excluded (due to distant metastasis, autoimmune/rheumatologic disorders, or organ dysfunction), leaving 31 eligible participants who all received long-course capecitabine-based CRT. Peripheral blood samples were collected at two time points: pre-CRT (one week before treatment) and post-CRT (within one week after completion). Thirty-one age- and sex-matched healthy volunteers (median age 61 years [IQR 54–66]; 51.6% male) provided a single fasting blood sample during the same period for oxidative stress assessment. The final analytic cohort consisted of 62 participants (31 patients and 31 controls) included in biochemical and prognostic analyses. Abbreviations: CRT = chemoradiotherapy; IQR = interquartile range; TRG = tumor regression grade.

OP-30

DIAGNOSIS AND MANAGEMENT OF DRUG ALLERGIES IN CANCER PATIENTS

Tuğçe Yakut

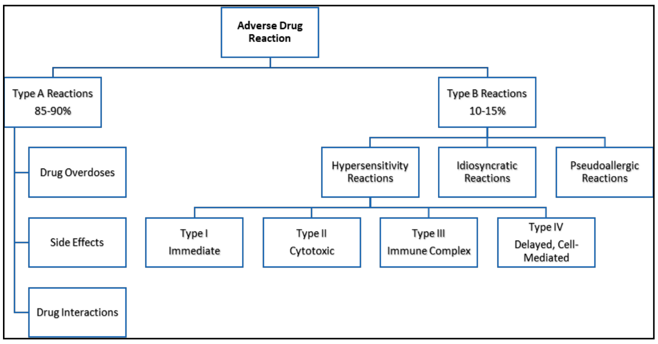
Immunology and Allergy, Koç University Hospital

Presentation Plan
Classification Of Drug Hypersensitivity
Risk Factors For Drug Hypersensitivity
Type I Hypersensitivity, Cytokine Release Reactions, Mixed Reactions
Grading Systems
Treatment And Rechallenge
Desensitization

The global burden of cancer is difficult to fathom, even knowing that the number of new cancer cases in the world in 2022 was 19,976,499, and the number of deaths was 9,743,832.

Around 28% of these patients diagnosed with cancer need chemotherapy as part of their primary cancer treatment

Unfortunately, at least 5% of these patients will experience a hypersensitivity reaction to their chemotherapy



Classification Of Drug Hypersensitivity:
Type I: Mast cell/IgE or non-IgE dependent
Type II: Cytotoxicity
Type III: Antigen-antibody immune complexes
Type IV: T-cell mediated
Cytokine Release Reactions (CRR): Inflammatory mediator release
Mixed Reactions: Combination of Type I and CRR

- **Immediate**
- Symptoms within 1–6 hours of exposure
- IgE-mediated reactions or non-IgE, direct mast cell/basophil activation.
- Can occur with or without prior drug exposure
- Type I, CRR, Mixed Reactions
- **Delayed:**
- Symptoms days to weeks after exposure.
- Can involve single or multiple organ systems.

Risk Factors For Drug Hypersensitivity:

- Female
- Hormonal Factors
    - Cyclical hormonal changes.
- Environmental Exposures
    - Quaternary ammonium compounds in cosmetics and detergents. Cross-reactivity with neuromuscular blocking agents and opioids.
- **Cancer Patients**
- Cystic Fibrosis Patients
- Atopy
- Genetic Predisposition
    - Specific HLA alleles (e.g., HLA-B*57:01).
    - Associated with severe cutaneous adverse reactions (SCARs).
- Cancer patients;
    - Atopy, a history of multiple drug allergies
        - especially with drugs like taxanes
    - After multiple cycles of certain agents
        - Up to 27% of ovarian cancer patients develop carboplatin hypersensitivity after 6+ treatments
    - BRCA mutations increase risk

Type I Hypersensitivity:

- Immediate (within 1–6 hours)
- IgE-mediated reactions and non-IgE (direct mast cell/basophil activation)
    - Urticarial Rash,Pruritus, Flushing,
    - Angioedema (Face, extremities, or laryngeal tissues)
    - Throat Tightness
    - Wheezing
    - Gastrointestinal Symptoms
    - Hypotension
- Anaphylaxis

Type I Hypersensitivity

- Elevated tryptase levels
  - (30 to 120 min after the reaction, Baseline tryptase should also be measured 2 to 3 weeks after the event
  - Positive skin tests
  - at least two weeks after the initial hypersensitivity reaction
  - Carboplatin, Oxaliplatin
  - Taxanes
  - Cetuximab, Rituximab

Cytokine Release Reactions (CRR):

- **Immediate**
- **Mechanism:**
  - Targeted-cell lysis and FcγR activation.
  - TNF-α, INF-α, IL-6,
- Symptoms:
  - Chest pain, back pain, abdominal pain
  - Headache, rigors, chills
  - Numbness, weakness
  - Hypertension, hypotension, fever
  - Rituximab, Brentuximab, obinutuzumab

Cytokine Release Reactions (CRR):

- Elevated IL-6 levels
  - (30 to 120 min after the reaction)
  - Negative skin test

Mixed Reactions

- Mixed reactions involved a combination of type I and CRR symptoms and biomarkers
- Elevated IL-6 and tryptase
- Positive skin test
- Rituximab monoclonal antibody

Symptoms of Allergic Reactions

Skin and Mucosal Symptoms (90%):
Generalized hives, itching, flushing. Swollen lips, tongue, uvula. Periorbital edema, conjunctival swelling.

Respiratory Symptoms (85%):
Nasal discharge, congestion, sneezing. Throat itching, choking sensation, stridor. Shortness of breath, wheezing, cough.

Gastrointestinal Symptoms (45%):
Nausea, vomiting, diarrhea, crampy abdominal pain

Cardiovascular Symptoms (45%):
Collapse, syncope, incontinence. Dizziness, tachycardia, hypotension

Anaphylaxis:

World Allergy Organization criteria

Criterion 1 — Acute onset of an illness (minutes to several hours) with simultaneous involvement of the skin, mucosal tissue, or both (eg, generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

- Respiratory compromise (eg, dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia
- Circulatory compromise: reduced BP or associated symptoms of end-organ dysfunction (eg, hypotonia, collapse, syncope, incontinence)
- Severe gastrointestinal symptoms (eg, severe crampy abdominal pain, repetitive vomiting), especially after exposure to nonfood allergens

Criterion 2 — Acute onset of hypotension, bronchospasm, or laryngeal involvement after exposure to a known or highly probable allergen for that patient (minutes to several hours), even in the absence of typical skin involvement:

- **Hypotension** – Hypotension is defined as: **Adults and children >10 years** – Decrease in systolic BP >30 percent from that person's baseline **or** systolic BP <90 mmHg.
- **Bronchospasm** – The definition of bronchospasm excludes lower respiratory symptoms triggered by common inhalant allergens or food allergens perceived to cause "inhalational" reactions in the absence of ingestion.
- **Laryngeal involvement –** Examples of laryngeal involvement include stridor, vocal changes, and odynophagia.

Table 1. Grading System Of Immediate Hypersensitivity Reactions (Brown's grading system)

	Grade 1	*Grade 2*	*Grade 3*
Severity	Mild	Moderate	Severe
Description	Symptoms are limited to the skin (eg, flushing) or involve a single organ/system and are mild (eg, mild back pain)	Symptoms involve at least 2 organs/systems (eg, flushing and dyspnea), but there is no significant decrease in blood pressure or oxygen saturation	Symptoms typically involve at least 2 organs/systems, and there is a significant decrease in blood pressure (systolic <90 mm Hg and/or syncope) and/or oxygen saturation (<92%)

Table 2. NCI CTCAE v5.0 Infusion-Related Reactions, Allergic Reaction And Anaphylaxis

Adverse event	*Grade 1*	*Grade 2*	*Grade 3*	*Grade 4*	*Grade 5*
Infusion related reaction	Mild transient reaction; infusion interruption not indicated; intervention not indicated	Therapy or infusion interruption indicated but responds promptly to symptomatic treatment (eg, antihistamines, NSAIDs, narcotics [opioids], intravenous fluids); prophylactic medication indicated for less than or equal to 24 hours	Prolonged (eg, not rapidly responsive to symptomatic medication and/or brief interruption of infusion); recurrence of symptoms following initial improvement; hospitalization indicated for other clinical sequelae	Life-threatening consequences; urgent intervention indicated	Death
Allergic reaction	Systemic intervention not indicated	Oral intervention indicated	Bronchospasm; hospitalization indicated for clinical sequelae; intravenous intervention indicated	Life-threatening consequences; urgent intervention indicated	Death
Anaphylaxis			Symptomatic bronchospasm, with or without urticaria; parenteral intervention indicated; allergy-related edema/ angioedema; hypotension	Life-threatening consequences; urgent intervention indicated	Death

Treatment And Rechallenge

- **Mild Reactions:**
  - [NCI] grades 1 and 2
  - Brown's grading system; grade 1
- Temporarily stop the infusion.
- Manage symptoms (e.g., antihistamines, corticosteroids, NSAD).

Rechallenge

- After all symptoms have resolved
- Reduced infusion rate and additional premedication (at least twice the normal infusion time.)
- **Mild Reactions:**
  - Do not recommend rechallenging patients with platinum agents, even with additional premedications

- **Recurrent Reactions Despite Premedication:**
- Desensitization protocols can enable continued drug use.
- Referral to an allergy specialist is recommended

Moderate to Severe Reactions or Anaphylaxis:
[NCI] grades 3 or higher
Brown's grading system; grade 2-3
Stop the infusion
Use Anaphylaxis action plan

- Rechallenge after **Moderate to Severe** Reactions or Anaphylaxis:
    - Rechallenge NOT Recommended
    - High risk of recurrence after anaphylaxis.
    - Referral to an allergy specialist for desensitization.
    - **Desensitization** is recommended if further treatment is essential and no alternatives exist.

Desensitization

- **Definition:**
    - A procedure to modify the immune response, creating temporary tolerance to a drug.
    - Tolerance is lost after 2–3 drug half-lives.
- **Protocols:**
    - Patient- and drug-specific protocols.
    - Typically involve 3+ steps, starting at 1/10,000 th of the final dose.
    - Dose increments double until the target dose is reached.
- **Mechanisms:**
    - Inhibits calcium signaling in mast cells/basophils to prevent activation.
    - Reduces skin sensitivity in most IgE-mediated reactions.
    - Continuous drug exposure is required to maintain tolerance.
    - **Desensitization** is recommended if further treatment is essential and no alternatives exist.
- Contraindications:
    - Type II hemolytic anemia, autoimmune thrombocytopenia
    - Type III serum sickness, urticaria vasculitis
    - Type IV Severe Cutaneous Adverse Reactions (SCARs)
        - Stevens-Johnson syndrome
        - Toxic epidermal necrolysis
        - Drug reaction with eosinophilia and systemic symptoms (DRESS)
        - Erythema multiforme.
        - Acute generalized exanthematous pustulosis
    - Re-exposure can induce irreversible and potentially fatal reactions.
- Desensitization lasts 5 to 8 times longer than normal infusion.
- The last bag delivers the full treatment dose and the concentration is the same as in a normal infusion.
- Effectiveness:
- Reported success rate: 90%
- Studies show no difference in efficacy in patients receiving desensitization compared to patients without allergies.
- Requires allergist supervision and an experienced team
- Safe for most reactions in outpatient clinic.
- Severe reactions (grade 3) or high-risk patients can undergo desensitization in intensive care as a safer option.
- If well tolerated, future desensitizations can be done in standard hospital units.

Key Messages

- Desensitization is recommended only when no equally effective alternatives are available and the treatment is essential
- **Desensitization** is used for Type I, Cytokine Release Reactions (CRR), Mixed Reactions, and Type IV delayed maculopapular rash.
- Rechallenge is not recommended for platinum drugs, even in cases of mild reactions.
- Patients with Grade 2–3 (Brown) reactions should be referred to an allergist
- Patients who undergo desensitization after a reaction typically continue their treatment with desensitization protocols.
    - **As an allergist we help you to administer the proper protocol for your patients who developed allergic reactions to a drug that cannot be replaced!**

POSTER PRESENTATIONS

PP-01

REAL-WORLD OUTCOMES OF BRAF-MUTANT METASTATIC COLORECTAL CANCER TREATED WITH TARGETED THERAPY

Mustafa Ersoy, Selin Meşeli, Ismet Çulcuoğlu

Kütahya Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İç Hastalıkları Ana Bilim Dalı, Kütahya

Background: BRAF mutations are detected in approximately 8–12% of metastatic colorectal cancer (mCRC) cases and are associated with aggressive tumor biology and poor prognosis. Although chemotherapy remains the initial treatment in most cases, targeted combinations involving BRAF, MEK, and EGFR inhibitors have emerged as effective options following disease progression. However, data from real-world clinical settings remain limited.

Methods: Between 2023 and 2025, five patients with BRAF-mutant mCRC who had progressed after first-line chemotherapy (FOLFOX or FOLFIRI ± bevacizumab) were treated at our center with combination targeted therapy. All patients received a BRAF inhibitor (dabrafenib) plus an EGFR inhibitor (cetuximab), and three also received a MEK inhibitor (trametinib). Radiological responses were assessed every 8–12 weeks according to RECIST v1.1. Clinical data, including age, metastatic sites, prior treatments, response rate, and progression-free survival (PFS), were retrospectively analyzed.

Results: The median age was 56 years (range 45–68). All patients had metastatic disease involving the liver and/or lung at baseline. Following initiation of targeted therapy, three patients (60%) achieved partial response and two (40%) achieved stable disease, yielding a disease control rate of 100%. The median PFS was 7.8 months, and median overall survival had not been reached at the time of data cutoff. Treatment was generally well tolerated. The most common adverse events were manageable skin rash (n=2), fatigue (n=2), and mild diarrhea (n=1). No grade >=3 toxicity or treatment-related discontinuation occurred.

Conclusion: This small real-world series demonstrates that combination BRAF-targeted therapy with EGFR ± MEK inhibition provides meaningful clinical benefit in patients with BRAF-mutant mCRC who have progressed after chemotherapy. Despite the historically poor prognosis of this subgroup, targeted therapy achieved encouraging response rates and acceptable toxicity, supporting its role as an effective and tolerable option in daily practice. Further multicenter studies with larger cohorts are warranted to validate these findings.

Keywords: BRAF mutation, Metastatic colorectal cancer, Targeted therapy

PP-02

COMBINED HEPATOCELLULAR–CHOLANGIOCARCINOMA: A RARE AND THERAPEUTICALLY CHALLENGING LIVER MALIGNANCY

Mustafa Ersoy, Selin Meşeli, Ismet Çulcuoğlu

Kütahya Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İç Hastalıkları Ana Bilim Dalı, Kütahya

Background: Combined hepatocellular–cholangiocarcinoma (cHCC–CCA) is an uncommon primary liver malignancy containing both hepatocellular carcinoma (HCC) and intrahepatic cholangiocarcinoma (iCCA) components within the same tumor. It accounts for approximately 3–5% of all primary liver cancers and generally carries an aggressive clinical course with limited therapeutic options. We report a patient with histologically proven cHCC–CCA who underwent locoregional and systemic treatments but showed poor response and short survival.

Case Presentation: A 68-year-old male with a history of hypertension and type 2 diabetes mellitus, but no evidence of chronic liver disease or viral hepatitis, presented in 2023 with fatigue and right upper quadrant discomfort. Laboratory results revealed mildly elevated transaminases; AFP and CA19-9 were within near-normal limits. Hepatitis B and C serologies were negative. Magnetic resonance imaging demonstrated multiple heterogeneous lesions involving both hepatic lobes with arterial enhancement and venous washout. Liver biopsy revealed a combined hepatocellular–cholangiocarcinoma, with areas positive for HepPar-1 and glypican-3 consistent with HCC and glandular areas positive for CK7/CK19 consistent with iCCA differentiation. Given multifocal disease and lack of surgical resectability, the patient initially underwent transarterial chemoembolization (TACE) for local control. After transient stabilization, disease progression was noted at 4 months. Subsequently, systemic chemotherapy with cisplatin and gemcitabine was administered for two cycles without radiologic or clinical response. Due to deterioration in performance status and hepatic function, further therapy was discontinued, and the patient was managed with best supportive care. He died approximately 8 months after diagnosis.

Discussion: cHCC–CCA represents a unique subtype of primary liver cancer with dual histologic and molecular features. The absence of cirrhosis in this case suggests a de novo origin from hepatic progenitor cells. Prognosis remains poor because of early intrahepatic spread and resistance to conventional therapies. While surgical resection offers the best outcomes, most cases are diagnosed at an unresectable stage. Locoregional therapies such as TACE may provide temporary disease control, whereas systemic chemotherapy with gemcitabine and cisplatin or targeted agents generally yields limited benefit. Novel systemic approaches, including immunotherapy combinations, are under investigation.

Conclusion: cHCC–CCA should be considered in patients with atypical imaging and mixed histopathological findings. Despite multimodal treatment including TACE and chemotherapy, prognosis remains poor. Multicenter studies and molecularly guided therapies are needed to improve outcomes in this rare and aggressive malignancy.

Keywords: combined hepatocellular–cholangiocarcinoma, cisplatin–gemcitabine, TACE

PP-03

LUTETIUM-177 DOTATATE THERAPY AFTER LANREOTIDE FAILURE IN NEUROENDOCRINE TUMOR PATIENTS WITH LIVER METASTASES: A THREE-CASE EXPERIENCE

Mustafa Ersoy

Kütahya Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İç Hastalıkları Ana Bilim Dalı, Kütahya

Background: Neuroendocrine tumors (NETs) frequently metastasize to the liver and may initially respond to somatostatin analogs such as lanreotide or octreotide. However, many patients eventually experience progression despite biochemical control. Peptide receptor radionuclide therapy (PRRT) with Lutetium-177 DOTATATE (Lu-177) has emerged as an effective therapeutic option for somatostatin receptor–positive, progressive NETs. We report three patients with liver-dominant metastatic NETs who experienced disease progression under lanreotide and subsequently received Lu-177 DOTATATE.

Case Presentations: Case 1: A 58-year-old male with a well-differentiated ileal NET (Ki-67: 8%) presented with multiple bilobar liver metastases. Despite 18 months of lanreotide therapy, radiologic progression was detected. The patient received four cycles of Lu-177 DOTATATE (7.4 GBq per cycle, every 8 weeks). After the third cycle, partial radiologic response and significant improvement in diarrhea and flushing were observed. No grade >=3 toxicity occurred.

Case 2: A 64-year-old female with a pancreatic NET (Ki-67: 12%) and diffuse liver metastases showed progression after 14 months of lanreotide treatment. Four cycles of Lu-177 DOTATATE were administered. Stable disease was achieved, and the patient remained progression-free for 15 months after completion of therapy. Mild, transient thrombocytopenia (grade 1) was the only toxicity observed.

Case 3: A 61-year-old male with a rectal NET (Ki-67: 10%) and multiple unresectable liver metastases progressed after one year of lanreotide therapy. The patient underwent four cycles of Lu-177 DOTATATE (total activity 29.6 GBq). Partial metabolic response was seen after the second cycle, accompanied by improvement in carcinoid symptoms. Treatment was completed without severe hematologic or renal adverse events. Disease progression occurred 12 months after the final cycle.

Discussion: All three patients had well-differentiated, somatostatin receptor–positive NETs that progressed after lanreotide. PRRT with Lu-177 DOTATATE resulted in either partial response or durable disease stabilization, with favorable tolerability. The observed median progression-free period (12–15 months) aligns with previously published real-world and NETTER-1 trial data. PRRT provides meaningful clinical benefit after somatostatin analog failure, particularly in liver-dominant disease.

Conclusion: Lutetium-177 DOTATATE represents an effective and well-tolerated treatment option for patients with metastatic NETs progressing after lanreotide. In our small case series, all patients achieved disease control and symptomatic improvement with acceptable safety. These findings support the use of PRRT as a standard second-line approach following somatostatin analog failure in receptor-positive NETs.

Keywords: Neuroendocrine tumor, Lanreotide, Lutetium-177 DOTATATE

PP-04

BEYOND EARLY PROGRESSION: EXCEPTIONAL RESPONSE TO CHEMO-IMMUNOTHERAPY IN ADVANCED CHOLANGIOCARCINOMA

Nebil Havvat, Halil Taskaynatan

İzmir City Hospital

Background: Cholangiocarcinoma (CCA) is an aggressive malignancy with limited systemic options and poor outcomes. The TOPAZ-1 trial established gemcitabine–cisplatin plus durvalumab as the new first-line standard for advanced biliary tract cancers. However, real-world response patterns are heterogeneous, and atypical immune-related phenomena such as pseudoprogression or delayed immune response are insufficiently characterized in CCA. Early radiologic progression does not always indicate therapeutic failure, especially in tumors with high PD-L1 expression or concurrent inflammatory processes.

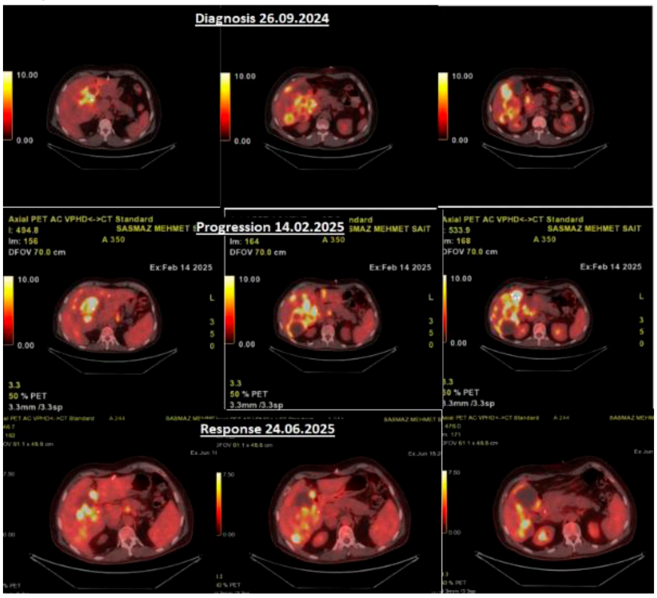
Case Presentation: A 61-year-old male presented with progressive jaundice and right upper quadrant discomfort. Initial labs showed total bilirubin 8.7 mg/dL, direct bilirubin 6.3 mg/dL, with marked cholestatic enzyme elevation (ALP and GGT ~5× ULN) and mild transaminase increase. Ultrasonography revealed intrahepatic bile duct dilatation without gallstones or extrahepatic obstruction. MRCP identified a hilar mass-like stricture with upstream dilatation, consistent with cholangiocarcinoma. Serum CA 19-9 exceeded 1000 U/mL, CEA was mildly elevated, and AFP normal. EUS-guided biopsy confirmed biliary-type adenocarcinoma, and PET-CT showed a hypermetabolic right-lobe mass extending to the hilum without distant metastases. Following percutaneous drainage, gemcitabine (800 mg/m², 20% reduced) plus cisplatin was initiated. PD-L1 expression (CPS 60). Durvalumab was incorporated beginning with the fourth cycle due to drug availability. After five cycles (two with durvalumab), interim PET-CT (February 2025) demonstrated apparent radiologic progression with increased hepatic uptake (SUVmax 15.9), new para-aortic and omental nodes, and rising CA 19-9 (~10 000 U/mL). Despite this, the patient's clinical performance and CEA improved. Considering possible immune-related or inflammatory flare, treatment was continued.

Outcome: After ten total cycles, June 2025 PET-CT showed marked metabolic regression (SUVmax 8.9 ↓ from 18.4) and size reduction of dominant lesions (6 → 3 cm). CA 19-9 decreased to 764 U/mL. Molecular profiling revealed TP53 (p.E285K, p.G245C), PTEN (p.R173C), and KRAS (p.A146T) mutations; IDH1 and FGFR2 were wild-type. The patient remains on durvalumab maintenance with stable metabolic disease and preserved performance.

Conclusion: This case exemplifies a rare yet clinically meaningful scenario of apparent early progression followed by durable response under chemo-immunotherapy. Such patterns may reflect delayed immune activation or inflammatory pseudoprogression rather than treatment failure. In the immunotherapy era, multidisciplinary evaluation integrating clinical, biochemical, and imaging parameters is essential to avoid premature discontinuation of potentially effective therapy.

Keywords: Cholangiocarcinoma, chemo-immunotherapy, atypical response

PET-CT



PP-05

A CASE OF PRIMARY UNKNOWN CARCINOMA WITH LIVER METASTASES AND A HISTORY OF FOUR PRIMARY TUMORS

Bulent Yildiz, **Yasemin Sagdic Karateke, Duygu Bayir Garbioglu, Metin Demir**

Department of Medical Oncology, ESOGU Medical Faculty, Eskisehir

Introduction: Cancers of unknown primary (CUPs) refers to malignancies in which the primary tumor cannot be identified despite thorough investigation. It accounts for 2% of all cancers and has a poor prognosis

Case: A 66-year-old male patient was diagnosed with transitional cell carcinoma without muscle invasion following TUR-M surgery in October 2007. He was followed up after intravesical mitomycin treatment. In February 2009, the patient underwent supraglottic laryngectomy and bilateral radical neck dissection surgery and was diagnosed with T3N1M0 squamous cell carcinoma of the larynx and underwent radiotherapy. In January 2014, a 3.5 cm mass was detected in the middle lobe of the right lung, and a right pneumonectomy was performed. The patient was diagnosed with T2bN0M0 squamous cell lung cancer and received adjuvant Vinorelbine-Cisplatin treatment. In June 2018, radical cystoprostatectomy was performed due to nux. Transitional cell urothelial carcinoma (T3N0M0) and concomitant Gleason 4+5 prostatic adenocarcinoma were detected. The patient was followed up after completing adjuvant gemcitabine-carboplatin therapy in October 2018. In December 2024, a tru-cut biopsy was performed after detecting a 3.5 cm mass and two 2.5 cm masses in segments 4 and 8 of the liver. The pathology report indicated grade 3 carcinoma showing neuroendocrine differentiation. Immunohistochemical examination revealed strong positivity for CK7, keratin, HSP 70, and BerEp4, and focal positivity for CD56-CD19 (Ki-67 99%). The patient was discussed in the Oncology Board based on the investigations (endoscopy, colonoscopy, CT scans), and the fifth tumor was assessed as CUP. After 3 cycles of Gemcitabine-Carboplatin treatment, stable disease was detected and treatment was continued. After the 5th cycle, disease progression was detected on the PET CT scan dated April 2025, and the patient received 6 cycles of Nivolumab treatment. On the August 2025 PET CT scan, new metastatic lesions in the liver and LNs in the abdomen were detected. Due to disease progression, FOLFOX-6 chemotherapy was planned. When the patient was hospitalized in September 2025 due to hyperbilirubinemia, widespread pneumonic infiltrates were detected in the left lung, and the patient was admitted to intensive care. The patient, who was intubated due to Type 1 respiratory failure in intensive care, died on 09/24/2025.

Discussion: Discussion: CUPs are cancers with a poor prognosis, frequently seen in patients aged 60-75 years, with a median survival of less than 1 year. Similarly, our patient was 66 years old and had a survival of 9 months. Immunohistochemical staining and genomic profiling tests are recommended in CUPs. Platinum-based combinations are used in the treatment of CUPs (adenocarcinoma and poorly differentiated carcinoma), and our patient was treated accordingly. Taxane-Platinum or Gemcitabine-Platinum combinations have response rates of 15-20% and an average overall survival of around 9 months.

Keywords: Cancers of unknown primary

PP-06

SYNCHRONOUS PAPILLARY THYROID CARCINOMA AND HEPATOCELLULAR CARCINOMA IN A NON-CIRRHOTIC, NON-VIRAL LIVER: A RARE INCIDENTAL ASSOCIATION

Mustafa Ersoy

Kütahya Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İç Hastalıkları Ana Bilim Dalı, Kütahya

Case Description: A 42-year-old woman with no history of viral hepatitis or cirrhosis was incidentally found to have a hepatic mass during routine imaging. MRI revealed a 5.2 cm hypervascular lesion in the right hepatic lobe with periportal lymphadenopathy. Liver enzymes and tumor markers were within normal limits, and viral serology (HBsAg, anti-HCV) was negative. The patient underwent right hepatectomy with perihepatic lymph node dissection. Histopathologic examination confirmed hepatocellular carcinoma (HCC) arising in a non-cirrhotic, non-viral liver with metastasis limited to regional lymph nodes. Surgical margins were negative, and complete resection was achieved.

For staging and systemic evaluation, FDG-PET/CT demonstrated FDG-avid upper mediastinal and cervical lymphadenopathies. EBUS-guided biopsy revealed metastatic papillary thyroid carcinoma (PTC). Neck ultrasonography showed a 1.5 cm TI-RADS 5 nodule in the right thyroid lobe. The patient subsequently underwent total thyroidectomy and mediastinal lymph node dissection, which confirmed classic variant papillary thyroid carcinoma with nodal metastases.

Postoperative recovery was uneventful. The patient later received radioactive iodine ablation (RAI, 100 mCi I-131) for differentiated thyroid carcinoma. Follow-up imaging demonstrated no evidence of residual or recurrent disease in either the thyroid bed or the liver. Laboratory tests, including liver function and thyroid hormone levels, remained stable under levothyroxine suppression therapy.

Discussion: The coexistence of papillary thyroid carcinoma and hepatocellular carcinoma is exceedingly rare, especially in non-cirrhotic and non-viral livers. To our knowledge, only isolated cases have been reported. The synchronous presentation in this patient likely represents two independent primary malignancies rather than metastatic spread. While both tumors were incidentally detected and surgically treated at potentially curative stages, their coexistence highlights the importance of thorough systemic evaluation when unexpected lesions or lymphadenopathies are identified. This case underscores that HCC can arise in non-cirrhotic livers and that multidisciplinary management ensures favorable outcomes in rare synchronous malignancies.

Conclusion: We report a rare case of synchronous papillary thyroid carcinoma and hepatocellular carcinoma in a non-cirrhotic, non-viral liver. Complete surgical resection and subsequent RAI therapy achieved disease-free status. Careful pathological evaluation and comprehensive systemic assessment are essential for optimal management of such exceptional presentations.

Keywords: Hepatocellular carcinoma, Papillary thyroid carcinoma, Synchronous double primary

PP-07

A RARE COEXISTENCE OF KRAS (G13D) AND BRAF (G464V) MUTATIONS IN METASTATIC UPPER RECTAL ADENOCARCINOMA: A CASE REPORT

Aytaç Terzi[1], Fatma Sema Anar Kutlu[2], Anıl Aysal Ağalar[2], İlkay Tuğba Ünek[1]

[1]*Department of Medical Oncology, Dokuz Eylül University Faculty of Medicine, İzmir, Türkiye*
[2]*Department of Pathology, Dokuz Eylül University Faculty of Medicine, İzmir, Türkiye*

Introduction: KRAS and BRAF mutations are major drivers in colorectal cancer and usually occur mutually exclusively. Dual mutations are seen in <1% of cases and indicate aggressive biology and poor prognosis. We report a rare metastatic upper rectal adenocarcinoma with concurrent KRAS G13D and BRAF G464V mutations.

Case Presentation: A 68-year-old male presented with intestinal obstruction and underwent low anterior resection and liver metastasectomy in October 2023. Pathology showed moderately differentiated adenocarcinoma (pT4N1b) with multiple hepatic metastases. Immunohistochemistry revealed preserved MLH1, MSH2 and MSH6 expression, with loss of PMS2 nuclear staining suggesting possible mismatch-repair deficiency. HER2 testing was pending.

Molecular Findings: Pyrosequencing identified KRAS G13D and BRAF G464V (non-V600E) mutations; NRAS was wild type. MSI testing was recommended because of PMS2 loss.

Treatment and Clinical Course: Systemic chemotherapy with FOLFOX was initiated in November 2023. The patient received three cycles until January 2024. Following the detection of KRAS and BRAF mutations, bevacizumab was added. Two additional cycles of FOLFOX plus bevacizumab were administered until February 2024. Despite treatment, clinical progression occurred, and the patient died of pneumosepsis in March 2024.

Discussion: The KRAS G13D variant may exhibit limited sensitivity to anti-EGFR agents, while BRAF G464V is a rare non-V600E variant activating the MAPK pathway. Coexistence of these mutations likely reflects clonal heterogeneity and predicts poor response to targeted and cytotoxic therapies. Possible dMMR status highlights the relevance of MSI testing to assess potential benefit from immune checkpoint inhibition.

Conclusion: This case emphasizes the rare coexistence of KRAS G13D and BRAF G464V mutations in metastatic rectal adenocarcinoma. Despite combination chemotherapy and anti-VEGF therapy, rapid disease progression and death occurred within five months, underscoring the aggressive nature of dual-mutant colorectal cancer and the need for comprehensive molecular profiling to optimize individualized management.

Keywords: KRAS, BRAF, colorectal cancer

Table 1. Molecular Findings

Gene	Result	Mutation	Interpretation
KRAS	Mutant	Codon 13 (G13D)	Predicts poor response to anti-EGFR therapy
NRAS	Wild type	-	No detected mutation
BRAF	Mutant	Codon 464 (G464V)	Non-V600E, rare variant
MSI Status	Indeterminate	PMS2 loss	MSI testing recommended

PP-08

CLINICAL AND MOLECULAR CHARACTERISTICS OF METASTATIC COLORECTAL CANCER: A SINGLE-CENTER RETROSPECTIVE ANALYSIS

Tayyip Ilker Aydın, Gökhan Öztürk, Aysun Fatma Akkuş

Trakya University Faculty of Medicine, Department of Medical Oncology, Edirne, Türkiye

Introduction: Colorectal cancer (CRC) remains a major cause of cancer-related mortality, with approximately one-fourth of patients presenting with metastatic disease at diagnosis. Tumor sidedness and molecular alterations in RAS, BRAF, and PIK3CA pathways have established prognostic and predictive implications. This study aimed to describe the molecular and clinical characteristics of metastatic CRC and evaluate their associations with overall survival (OS).

Methods: Patients with metastatic CRC followed at our center between 2010–2018 with available survival data were retrospectively analyzed. Demographic, clinical, and molecular parameters (RAS, BRAF, PIK3CA, MSI) were retrieved. Tumors were classified by primary location as right- or left-sided. Survival analyses were performed using the Kaplan–Meier method and log-rank test, with statistical significance set at $p < 0.05$.

Results: A total of 262 patients were included (mean age 63.8 ± 9.8 years; 65.3% male). De novo metastasis occurred in 68.7%, and 31.3% were recurrent. The primary tumor was left-sided in 82.8% (rectum 39.7%) and right-sided in 16.8%. Liver metastases were present in 57.3% at diagnosis.

RAS mutations were detected in 51.1% (KRAS 46.2%, NRAS 5.0%), BRAF in 4.6%, and PIK3CA in 25.2%. Among evaluable cases, 5% were MSI-high. Among patients with RAS/BRAF mutations, 65% received FOLFOX/XELOX plus bevacizumab and 18% FOLFIRI plus bevacizumab, while RAS–RAF wild-type patients predominantly received FOLFOX/XELOX plus anti-EGFR therapy (40%) or FOLFIRI plus anti-EGFR (20%).

Right-sided tumors (n=44) showed higher MSI-high (9.1% vs. 4.1%), BRAF (11.4%), and PIK3CA (20.5%) mutation rates compared to left-sided tumors (n=217). Liver metastases were more frequent in left-sided tumors (60.4% vs. 43.2%).

Median OS was 34.0 months (95% CI, 28.1–40.0). Patients with left-sided tumors had longer, though not statistically significant, OS than those with right-sided tumors (36.1 vs. 27.3 months, p=0.144). BRAF-mutant cases had shorter OS compared with wild-type (12.0 vs. 34.3 months, p=0.437). Among KRAS variants, G12V showed the longest (37.0 months) and G12C the shortest (26.0 months) survival (p=0.727). Recurrent metastatic cases had significantly longer OS than de novo cases (59.4 vs. 31.2 months, p<0.001).

Conclusion: This cohort highlights the biological heterogeneity of metastatic CRC. Right-sided tumors were associated with more adverse molecular features (higher rates of BRAF mutation), whereas left-sided tumors more commonly presented with liver metastases but demonstrated a trend toward better survival. BRAF mutation and de novo presentation were linked to inferior outcomes. These findings reinforce the prognostic relevance of tumor sidedness and molecular profiling in metastatic CRC management.

Keywords: Metastatic Colorectal Cancer, Molecular Profiling, Tumor Sidedness

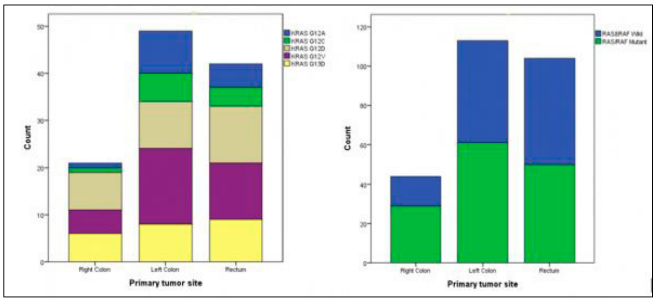


Figure 1. Distribution of KRAS mutation subtypes (left) and combined RAS/RAF status (right) according to primary tumor site.

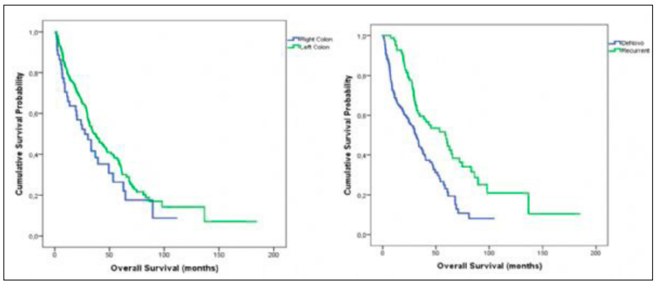


Figure 2. Overall survival curves.
Left graph: Comparison of overall survival between right- and left-sided metastatic colorectal cancer (36.1 vs. 27.3 months, p=0.144). Right graph: Comparison of overall survival between de novo and recurrent metastatic cases (59.4 vs. 31.2 months, p<0.001).

PP-09

CLINICOPATHOLOGICAL FEATURES OF COLORECTAL CANCER PATIENTS, USE OF RADIOTHERAPY IN OLIGOMETASTATIC/ OLIGOPROGRESSIVE DISEASE, AND OVERALL PROGNOSIS: A SINGLE-CENTER EXPERIENCE AT A CYPRUS ONCOLOGY CENTER

Antigoni Protopappa, Katerina Charalambous, Theodosis Antoniou, Rafailla Georgiou, Annett Nicolaou, Anastasios Papadopoulos, Nana Vasileiadou, Eleftherios Vorrias, Asimina Koulouridi

Medical Department, German Oncology Center, German Medica Institute, Limassol, Cyprus

Background: Colorectal cancer (CRC) remains one of the most common malignancies worldwide and a leading cause of cancer-related mortality. Patients present across all stages, with many developing metastatic colorectal cancer (mCRC) either at diagnosis or during the disease course. Advances in systemic therapies and molecular profiling have improved survival, while recognition of oligometastatic and oligoprogressive disease has prompted use of local treatments, including radiotherapy, to complement systemic therapy. Real-world data on clinicopathological and molecular features, treatment patterns, and outcomes remain limited.

Methods: A retrospective single-center study was conducted at the German Oncology Center, Limassol, Cyprus, including adults with histologically confirmed colorectal adenocarcinoma treated over the past three years. Patients with early-stage, locally advanced, and metastatic disease were included. Clinical data collected included age, gender, ECOG performance status, tumor site, grade, TNM stage, and surgical interventions. Molecular profiling included KRAS, NRAS, BRAF, and MSI status; in a subset, extended next-generation sequencing (NGS) identified further mutations (PI3K, HER2, etc). Systemic therapy regimens, lines of therapy, and local treatments were recorded, focusing on radiotherapy use in oligometastatic or oligoprogressive disease. The registry is under statistical evaluation.

Results: Ninety-three patients were analyzed: 56% male, 45% aged 50–70, and 9.5% <50 years. At diagnosis, 39% presented with metastatic disease, 28% with stage III, and 33% with early-stage disease. Adenocarcinoma was predominant (<1% mucinous), and most had PS 0–1. Left-sided tumors were more common (63%), with the liver as the main metastatic site. Radiotherapy in the oligometastatic/oligoprogressive setting was applied in ~10% of patients.

Molecular analysis revealed KRAS mutations in 21% (mostly G12V), BRAF V600E in 4%, and MSI-high in 2.3%. TP53 and APC co-mutations correlated with adverse prognosis. KRAS-mutant tumors showed multifocal progression, whereas BRAF-mutant and MSI-high tumors had distinct organotropism and variable response to therapy. Median OS for stage IV was ~31 months, longer among those receiving SBRT for oligoprogressive/oligometastatic disease.

Conclusion: This single-center experience highlights the diversity of CRC and the multifactorial determinants of mCRC outcomes. A subset with oligometastatic or oligoprogressive disease benefited from radiotherapy, supporting local interventions alongside systemic therapy. Molecular profiling, especially RAS, BRAF, and MSI, remains key for prognostication and treatment selection. A full NGS panel broadens future treatment options. Integrating systemic and local strategies in selected patients may yield durable control and improved outcomes.

Keywords: colorectal cancer, epidemiology, mutations

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