



EPICS

Conference Coverage: ESMO 2025 – Focus on Gastrointestinal (GI) Malignancies

November 6, 2025

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Meeting Snapshot: Conference Coverage – ESMO 2025: Focus on GI Malignancies

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A closed-door roundtable discussion focused on updates from ESMO 2025 was held virtually on **November 6, 2025**

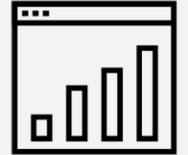


GI cancer-specific discussions on latest research updates, therapeutic advances, and their application in clinical decision-making were led by **Tanios Bekaii-Saab, MD, FACP**, from Mayo Clinic Cancer Center Phoenix



The panel consisted of 6 key experts in GI cancers

- 4 from the US
- 2 from Europe



Insights report including postmeeting analyses and actionable recommendations



Panel of 4 US and 2 European GI Cancer Experts

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Nataliya Uboha, MD, PhD
University of Wisconsin–
Madison



Dirk Arnold, MD, PhD
Asklepios Tumor Center Hamburg



Alan Venook, MD, FASCO
Helen Diller Family
Comprehensive Cancer Center



Wungki Park, MD
Memorial Sloan Kettering
Cancer Center



Julien Taieb, MD, PhD
Georges Pompidou
European Hospital



CHAIR
Tanios Bekaii-Saab, MD, FACP
Mayo Clinic Cancer Center
Phoenix



Meeting Agenda

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Time (PT)	Topic	Speaker/Moderator
8.30 AM – 8.35 AM (5 min)	Welcome and Introductions	Tanios Bekaii-Saab, MD, FACP
8.35 AM – 8.50 AM (15 min)	Colorectal Cancer (CRC)	Julien Taieb, MD, PhD
8.50 AM – 9.20 AM (30 min)	Discussion	All
9.20 AM – 9.25 AM (5 min)	Summary and Key Takeaways	Julien Taieb, MD, PhD
9.25 AM – 9.35 AM (10 min)	Rectal Cancer	Dirk Arnold, MD, PhD
9.35 AM – 9.45 AM (10 min)	Discussion	All
9.45 AM – 9.50 AM (5 min)	Summary and Key Takeaways	Dirk Arnold, MD, PhD
9.50 AM – 9.55 AM (5 min)	Break	
9.55 AM – 10.05 AM (10 min)	Gastric, Esophageal, and Gastroesophageal Junction (GEJ) Cancers	Nataliya Uboha, MD, PhD
10.05 AM – 10.20 AM (15 min)	Discussion	All
10.20 AM – 10.25 AM (5 min)	Summary and Key Takeaways	Nataliya Uboha, MD, PhD
10.25 AM – 10.35 AM (10 min)	Pancreatic Cancer and Biliary Tract Cancer	Wungki Park, MD
10.35 AM – 10.55 AM (20 min)	Discussion	All
10.55 AM – 11.00 AM (5 min)	Summary and Key Takeaways	Wungki Park, MD
11.00 AM – 11.10 AM (10 min)	Hepatocellular Carcinoma (HCC)	Alan Venook, MD, FASCO
11.10 AM – 11.25 AM (15 min)	Discussion	All
11.25 AM – 11.30 AM (5 min)	Summary and Key Takeaways	Alan Venook, MD, FASCO
11.30 AM	Summary and Closing Remarks	Tanios Bekaii-Saab, MD, FACP



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Colorectal Cancer (CRC)

Conference Highlights Presented by
Julien Taieb, MD, PhD



Abstract Selection (1/3)

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Abstract Selection (2/3)

Abstract ID	Abstract Title	Author	Year
10000001	Abstract 1: Title of the first abstract	Author 1	2020
10000002	Abstract 2: Title of the second abstract	Author 2	2020
10000003	Abstract 3: Title of the third abstract	Author 3	2020
10000004	Abstract 4: Title of the fourth abstract	Author 4	2020
10000005	Abstract 5: Title of the fifth abstract	Author 5	2020

Abstract Selection (3/3)

Abstract ID	Abstract Title	Author	Year
EPIC1001	Abstract 1: Title of the first abstract	Author 1	2023
EPIC1002	Abstract 2: Title of the second abstract	Author 2	2023
EPIC1003	Abstract 3: Title of the third abstract	Author 3	2023
EPIC1004	Abstract 4: Title of the fourth abstract	Author 4	2023
EPIC1005	Abstract 5: Title of the fifth abstract	Author 5	2023

Prognostic value of the Combined Analysis of Pathologists and Artificial Intelligence (CAPAI) in high-risk stage II–III colon cancer treated without chemotherapy: Interim report from a nationwide validation

Bakker MCE, et al. Abstract 7260

Background: High-risk stage II–III colon cancer patients without chemotherapy have a poor prognosis. The prognostic value of the Combined Analysis of Pathologists and Artificial Intelligence (CAPAI) in this population is unknown.

Methods: In a nationwide validation study, CAPAI was used to analyze 1000 colon cancer resections. The prognostic value of CAPAI was compared to the prognostic value of the pathologist's report.

Results: CAPAI identified 1000 colon cancer resections. The prognostic value of CAPAI was significantly better than the prognostic value of the pathologist's report.

Conclusion: CAPAI is a valuable tool for the prognostic analysis of high-risk stage II–III colon cancer resections without chemotherapy.



Prognostic value of the Combined Analysis of Pathologists and Artificial Intelligence (CAPAI) in high-risk stage II–III colon cancer treated without chemotherapy: Interim report from a nationwide validation

Bakker MCE, et al. Abstract 7260

Background: The prognostic value of the Combined Analysis of Pathologists and Artificial Intelligence (CAPAI) in high-risk stage II–III colon cancer treated without chemotherapy is not yet clear. We performed a nationwide validation study to assess the prognostic value of CAPAI in this patient population.

Methods: We performed a nationwide validation study of CAPAI in high-risk stage II–III colon cancer patients treated without chemotherapy. The study included 1,000 patients from 100 hospitals. The CAPAI score was calculated based on the combined analysis of pathologists and artificial intelligence. The prognostic value of CAPAI was assessed by comparing the CAPAI score with the TNM stage and the presence of lymphovascular invasion (LVI).

Results: The CAPAI score was significantly associated with overall survival (OS) and disease-free survival (DFS) in high-risk stage II–III colon cancer patients treated without chemotherapy. The CAPAI score was also significantly associated with the presence of LVI.

Conclusion: The CAPAI score is a prognostic factor in high-risk stage II–III colon cancer patients treated without chemotherapy. The CAPAI score is also significantly associated with the presence of LVI.



Abstract 7260

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Conclusion: The CAPAI score is a prognostic factor in high-risk stage II–III colon cancer patients treated without chemotherapy. The CAPAI score is also significantly associated with the presence of LVI.



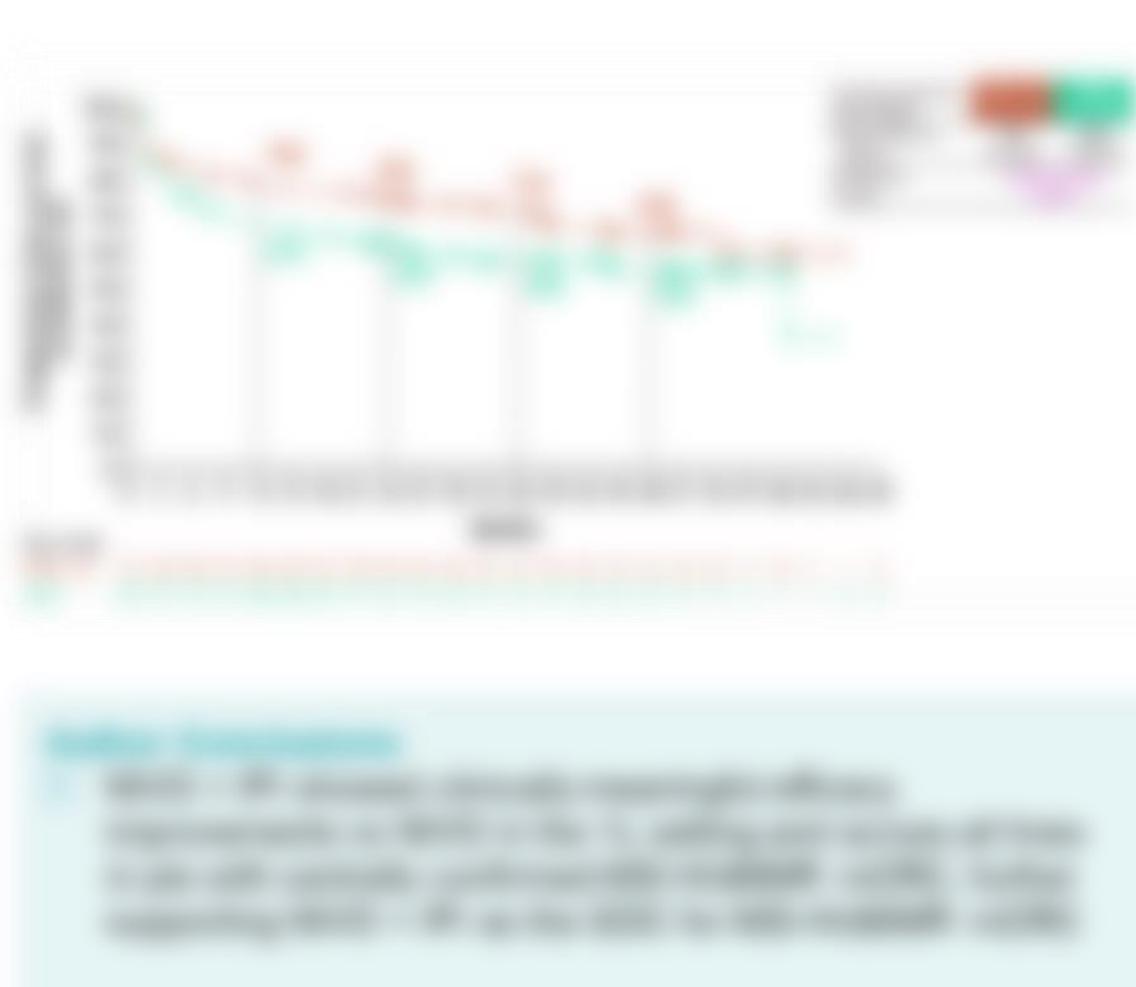
Nivolumab plus ipilimumab vs nivolumab monotherapy for microsatellite instability-high/mismatch repair-deficient (MSI-H/dMMR) metastatic colorectal cancer (mCRC): New results from CheckMate 8HW

Lonardi S, et al. Abstract LBA29

Background: In the CheckMate 8HW study, patients with MSI-H/dMMR mCRC were randomized to receive nivolumab plus ipilimumab (N+I) or nivolumab monotherapy (N). The primary endpoint was overall survival (OS). Secondary endpoints included progression-free survival (PFS), objective response rate (ORR), and quality of life (QoL).

Results: The N+I group demonstrated significantly improved OS compared to the N group. The median OS was 24.3 months for N+I versus 18.7 months for N (p < 0.001). The ORR was also significantly higher in the N+I group (45.2% vs 38.1%, p < 0.001). PFS was significantly improved in the N+I group (12.1 months vs 9.8 months, p < 0.001). QoL was maintained in both groups, with no significant differences observed.

Conclusion: Nivolumab plus ipilimumab is superior to nivolumab monotherapy in terms of OS, PFS, and ORR for MSI-H/dMMR mCRC patients.



Nivolumab plus ipilimumab vs nivolumab monotherapy for microsatellite instability-high/mismatch repair-deficient (MSI-H/dMMR) metastatic colorectal cancer (mCRC): New results from CheckMate 8HW

Lonardi S, et al. Abstract LBA29

Background: The combination of nivolumab plus ipilimumab (NIVO+IPI) has shown superior efficacy compared to nivolumab monotherapy (NIVO) in patients with MSI-H/dMMR mCRC. This analysis reports on the overall survival (OS) results from the CheckMate 8HW trial.

Methods: The CheckMate 8HW trial is a phase 3, randomized, controlled trial comparing NIVO+IPI (n=100) to NIVO (n=100) in patients with MSI-H/dMMR mCRC. The primary endpoint is OS. The trial is stratified by prior treatment (naïve vs. previously treated).

Results: The median OS for the NIVO+IPI group was significantly longer than for the NIVO group (HR: 0.58, 95% CI: 0.42-0.81, p<0.001). The median OS for the NIVO+IPI group was 24.1 months (95% CI: 18.8-29.4), compared to 14.1 months (95% CI: 10.8-17.4) for the NIVO group. The difference in OS was consistent across both treatment-naïve and previously treated subgroups.



Conclusion: The combination of nivolumab plus ipilimumab (NIVO+IPI) significantly improves overall survival compared to nivolumab monotherapy (NIVO) in patients with MSI-H/dMMR metastatic colorectal cancer (mCRC). This finding supports the use of NIVO+IPI as the preferred first-line treatment for this patient population.

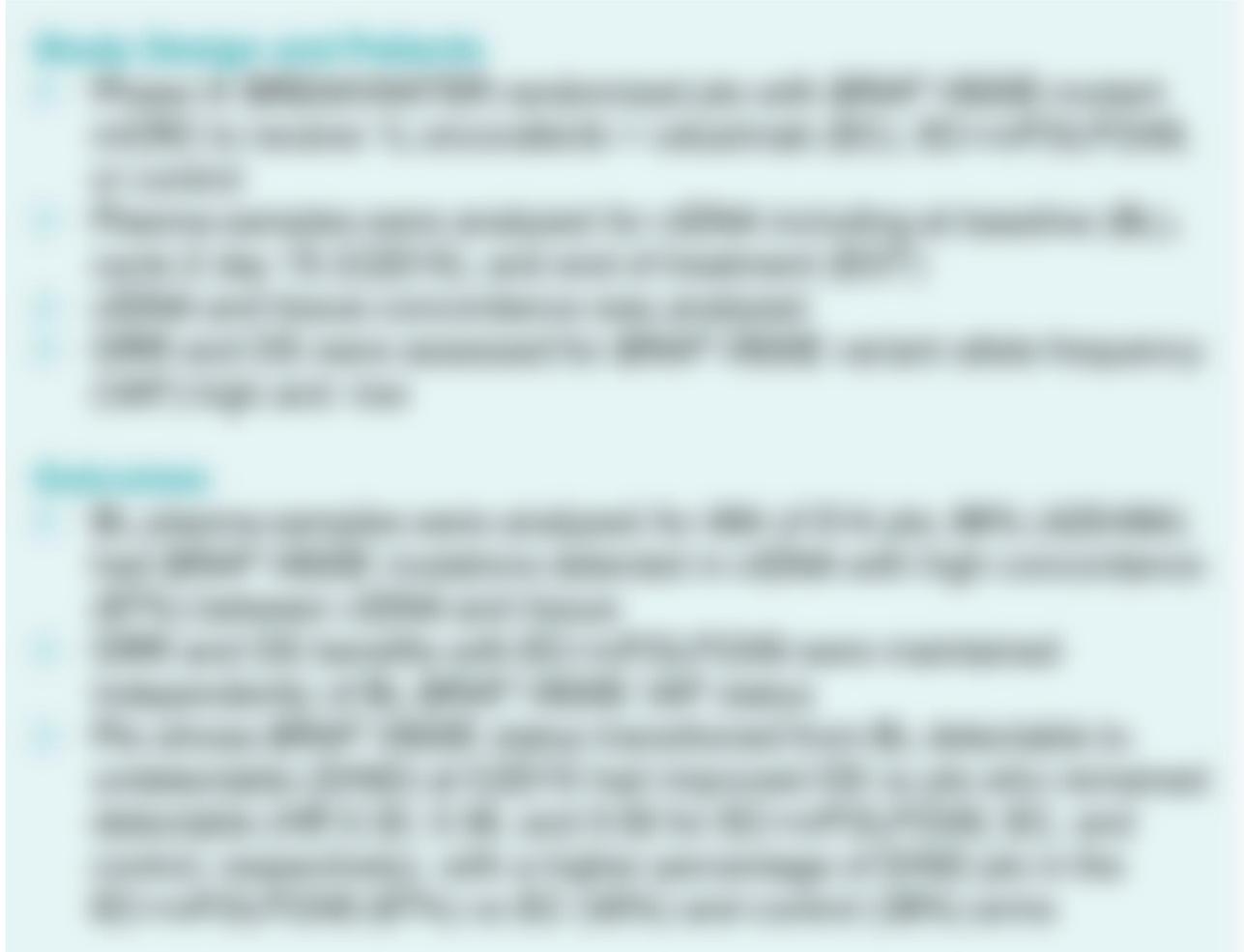
References: Lonardi S, et al. Abstract LBA29. ASCO Meeting, 2023.

Disclaimer: This presentation is for informational purposes only and does not constitute an offer of medical advice or a recommendation of any specific product or service. Please consult your healthcare provider for more information.



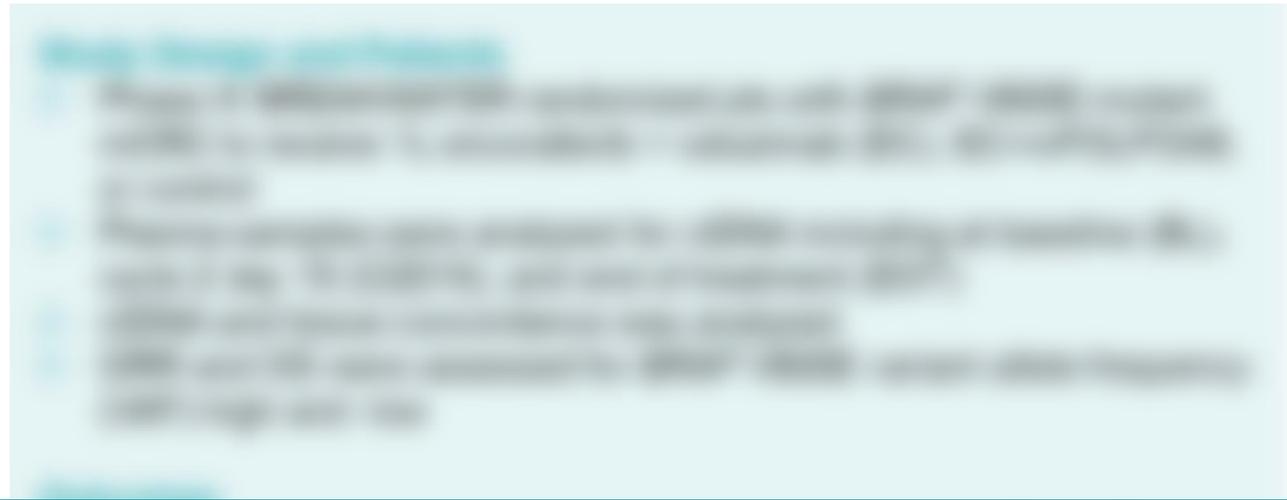
Circulating tumor (ct) DNA analysis of BRAF V600E dynamics and changes in genomic landscape in patients (pts) with first-line (1L) BRAF V600E-mutant metastatic colorectal cancer (mCRC) treated in BREAKWATER

Kopetz S, et al. Abstract 7290



Circulating tumor (ct) DNA analysis of BRAF V600E dynamics and changes in genomic landscape in patients (pts) with first-line (1L) BRAF V600E-mutant metastatic colorectal cancer (mCRC) treated in BREAKWATER

Kopetz S, et al. Abstract 7290



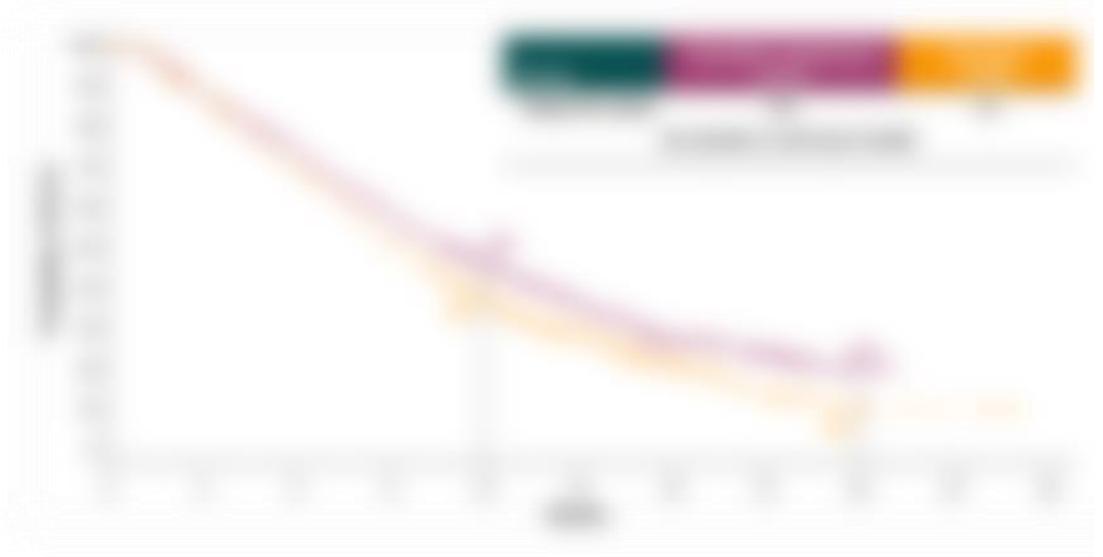
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Zanzalintinib plus atezolizumab (zanza + atezo) vs regorafenib (rego) in patients with previously treated metastatic colorectal cancer: Primary overall survival analysis from the randomized, open-label, phase 3 STELLAR-303 study

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Saeed A, et al. Abstract LBA30



Zanzalintinib plus atezolizumab (zanza + atezo) vs regorafenib (rego) in patients with previously treated metastatic colorectal cancer: Primary overall survival analysis from the randomized, open-label, phase 3 STELLAR-303 study

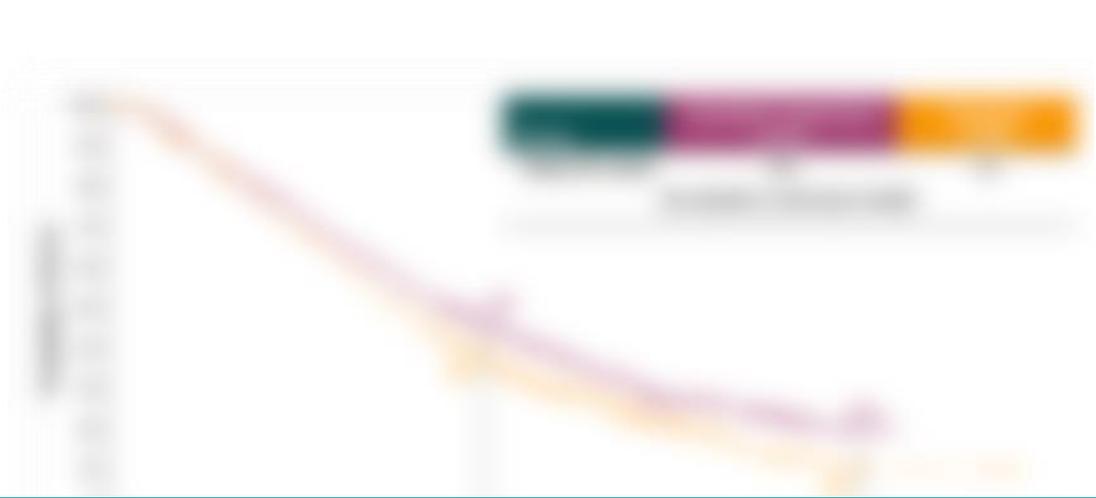
EPICS

Saeed A, et al. Abstract LBA30

Background: Zanza + atezo vs rego in patients with previously treated metastatic colorectal cancer. Primary overall survival analysis from the randomized, open-label, phase 3 STELLAR-303 study.

Methods: STELLAR-303 is a randomized, open-label, phase 3 study comparing zanza + atezo (n=200) vs rego (n=200) in patients with previously treated metastatic colorectal cancer. The primary endpoint is overall survival (OS). OS is defined as the time from random assignment to death due to any cause. OS is estimated using the Kaplan-Meier method. The study is ongoing and will continue to follow patients for OS.

Results: At the time of analysis, 100 patients in the zanza + atezo group and 100 patients in the rego group had died. The median OS was 12.1 months (95% CI, 10.8-13.4) in the zanza + atezo group and 10.8 months (95% CI, 9.5-12.1) in the rego group. The difference in OS between the zanza + atezo group and the rego group was statistically significant (P=0.02).



Conclusion: Zanza + atezo vs rego in patients with previously treated metastatic colorectal cancer. Primary overall survival analysis from the randomized, open-label, phase 3 STELLAR-303 study.

Key Message: Zanza + atezo vs rego in patients with previously treated metastatic colorectal cancer. Primary overall survival analysis from the randomized, open-label, phase 3 STELLAR-303 study.



EPICS

Colorectal Cancer (CRC)

Discussion



Colorectal Cancer (CRC)

1. Epidemiology

Colorectal cancer is the second leading cause of cancer death in the United States. It is the most common cancer among men and women aged 20-59. The incidence of colorectal cancer has increased in recent years, particularly among young adults. The risk of colorectal cancer is higher for people who are overweight, have a family history of colorectal cancer, or have a personal history of colorectal polyps.

2. Pathophysiology

Colorectal cancer develops from a sequence of genetic mutations in the cells of the colon and rectum. The most common genetic mutation is a change in the APC gene, which leads to the formation of adenomatous polyps. These polyps can grow and eventually become cancerous. Other genetic mutations that can lead to colorectal cancer include mutations in the KRAS, TP53, and MLH1 genes.

3. Risk Factors

Several factors increase the risk of colorectal cancer, including being overweight, having a family history of colorectal cancer, having a personal history of colorectal polyps, and having a diet high in red and processed meats. Other risk factors include smoking, alcohol consumption, and a sedentary lifestyle.



4. Diagnosis

Colorectal cancer is often diagnosed through a colonoscopy, which allows for the visualization of the colon and rectum. Other diagnostic methods include sigmoidoscopy, CT colonography, and fecal occult blood testing. Biopsy of a polyp or tumor is necessary to confirm the diagnosis.

5. Treatment

The treatment of colorectal cancer depends on the stage of the disease. Early-stage cancer may be treated with surgery to remove the tumor. Advanced-stage cancer may require a combination of surgery, chemotherapy, and radiation therapy. Targeted therapy and immunotherapy are also used in the treatment of colorectal cancer.

Colorectal Cancer (CRC)

Introduction

- Colorectal cancer (CRC) is a leading cause of cancer death in the United States. It is a disease of the large intestine (colon) and rectum. The most common type of CRC is adenocarcinoma, which starts in the inner lining of the colon or rectum. The disease can spread to other parts of the body, such as the liver, lungs, and bones.
- Early detection and treatment are crucial for improving outcomes. Screening tests, such as colonoscopy, can identify precancerous polyps and remove them before they turn into cancer. For those with CRC, treatment options include surgery, chemotherapy, and radiation therapy.
- Research is ongoing to improve diagnostic and therapeutic approaches. Advances in targeted therapy and immunotherapy have shown promise in treating advanced CRC. Lifestyle factors, such as diet and exercise, also play a role in CRC prevention.



Dr. [Name]
[Title]
[Institution]

[Text]

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

Colorectal cancer is a type of cancer that starts in the colon or rectum. It is the second leading cause of cancer death in the United States. The risk of developing colorectal cancer increases with age, but it can also occur in younger people. There are several factors that can increase the risk of developing colorectal cancer, including a family history of the disease, a diet high in red and processed meats, a sedentary lifestyle, and smoking. Early detection and treatment can significantly improve the chances of survival. Screening for colorectal cancer is recommended for people aged 50 and older, and for people with a family history of the disease or other risk factors. Screening can help find polyps, which are precancerous growths, before they turn into cancer. Treatment options for colorectal cancer include surgery, chemotherapy, and radiation therapy. The best treatment option depends on the stage of the cancer and the patient's overall health.



Colorectal cancer is a type of cancer that starts in the colon or rectum. It is the second leading cause of cancer death in the United States. The risk of developing colorectal cancer increases with age, but it can also occur in younger people. There are several factors that can increase the risk of developing colorectal cancer, including a family history of the disease, a diet high in red and processed meats, a sedentary lifestyle, and smoking. Early detection and treatment can significantly improve the chances of survival. Screening for colorectal cancer is recommended for people aged 50 and older, and for people with a family history of the disease or other risk factors. Screening can help find polyps, which are precancerous growths, before they turn into cancer. Treatment options for colorectal cancer include surgery, chemotherapy, and radiation therapy. The best treatment option depends on the stage of the cancer and the patient's overall health.

Colorectal Cancer (CRC)

EPICS: Endoscopic Management of Colorectal Cancer

- 1. The goal of endoscopic management is to remove the tumor and prevent recurrence.
- 2. Endoscopic management is the preferred approach for early-stage CRC, but it is not suitable for all patients.
- 3. Endoscopic management is not suitable for patients with advanced CRC, including those with lymph node involvement, distant metastases, or obstruction.
- 4. Endoscopic management is not suitable for patients with CRC who are unable to tolerate anesthesia or sedation.

EPICS: Endoscopic Management of Colorectal Cancer

- 1. Endoscopic management is the preferred approach for early-stage CRC, but it is not suitable for all patients.
- 2. Endoscopic management is not suitable for patients with advanced CRC, including those with lymph node involvement, distant metastases, or obstruction.
- 3. Endoscopic management is not suitable for patients with CRC who are unable to tolerate anesthesia or sedation.



Dr. [Name] is a board-certified gastroenterologist and endoscopist with over 20 years of experience. He is currently practicing at [Hospital/Clinic] and is a member of the American Society for Gastrointestinal Endoscopy (ASGE).

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is a leading cause of cancer death in the United States. It is the second leading cause of cancer death in men and the third leading cause of cancer death in women.
- 2. Colorectal cancer is a group of cancers that start in the colon or rectum. The colon is the large intestine, and the rectum is the lower part of the large intestine.
- 3. Colorectal cancer is often found in the sigmoid colon, the descending colon, the ascending colon, or the rectum.
- 4. Colorectal cancer is often found in the sigmoid colon, the descending colon, the ascending colon, or the rectum.
- 5. Colorectal cancer is often found in the sigmoid colon, the descending colon, the ascending colon, or the rectum.



Dr. [Name]
[Title]
[Institution]

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

Definition: Colorectal cancer is a type of cancer that starts in the colon or rectum. It is the second leading cause of cancer death in the United States.

- 1. The most common type of colorectal cancer is adenocarcinoma, which starts in the cells that line the inner surface of the colon and rectum.
- 2. The second most common type is neuroendocrine tumors, which start in the cells that control the body's hormones.
- 3. The third most common type is sarcoma, which starts in the muscle or connective tissue of the colon or rectum.
- 4. The fourth most common type is lymphoma, which starts in the immune system cells of the colon or rectum.



Dr. [Name]

[Blurred text describing the doctor's credentials and expertise]

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is the second leading cause of cancer death in the United States, with approximately 15% of all new cancer diagnoses in 2023. It is the leading cause of cancer death among African American men and women.
- 2. The most common types of colorectal cancer are adenocarcinoma, which starts in the inner lining of the colon or rectum, and sarcoma, which starts in the muscle of the colon or rectum.
- 3. The signs and symptoms of colorectal cancer can vary, but may include changes in bowel habits, such as diarrhea, constipation, or blood in the stool; abdominal pain or discomfort; and unexplained weight loss.
- 4. It is important to see a doctor if you experience any of these symptoms, as they may be a sign of colorectal cancer or another condition that needs to be treated.
- 5. There are several ways to prevent colorectal cancer, including eating a healthy diet, staying active, and getting regular screenings. Screening can help find and remove precancerous polyps before they turn into cancer.
- 6. If you have been diagnosed with colorectal cancer, your doctor will work with you to develop a treatment plan that may include surgery, chemotherapy, and radiation therapy.
- 7. There are many resources available to help you understand your diagnosis and treatment options, and to connect you with support groups and other people who have been through a similar experience.



Dr. [Name]
[Title]
[Institution]

[Text]

Colorectal Cancer (CRC)

EPICS 101: Understanding the Importance of Colorectal Cancer Screening
This module covers the importance of colorectal cancer screening, the types of screening tests available, and the benefits of early detection. It also discusses the role of diet and lifestyle in preventing colorectal cancer.

- 1. Understand the importance of colorectal cancer screening and the benefits of early detection.
- 2. Identify the different types of screening tests available, including colonoscopy, sigmoidoscopy, and stool-based tests.
- 3. Discuss the role of diet and lifestyle in preventing colorectal cancer.

EPICS 102: Understanding the Importance of Colorectal Cancer Screening
This module covers the importance of colorectal cancer screening, the types of screening tests available, and the benefits of early detection. It also discusses the role of diet and lifestyle in preventing colorectal cancer.

- 1. Understand the importance of colorectal cancer screening and the benefits of early detection.
- 2. Identify the different types of screening tests available, including colonoscopy, sigmoidoscopy, and stool-based tests.
- 3. Discuss the role of diet and lifestyle in preventing colorectal cancer.



EPICS 103: Understanding the Importance of Colorectal Cancer Screening

This module covers the importance of colorectal cancer screening, the types of screening tests available, and the benefits of early detection. It also discusses the role of diet and lifestyle in preventing colorectal cancer.

- 1. Understand the importance of colorectal cancer screening and the benefits of early detection.
- 2. Identify the different types of screening tests available, including colonoscopy, sigmoidoscopy, and stool-based tests.
- 3. Discuss the role of diet and lifestyle in preventing colorectal cancer.

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is a leading cause of cancer death in the United States.
- 2. It is caused by changes in the cells of the colon and rectum.
- 3. Symptoms include changes in bowel habits, blood in the stool, and abdominal pain.
- 4. Risk factors include age, diet, and family history.
- 5. Early detection through screening can significantly reduce the risk of death.
- 6. Treatment options include surgery, chemotherapy, and radiation therapy.
- 7. Prognosis depends on the stage of the cancer at the time of diagnosis.



Colorectal cancer is a type of cancer that starts in the colon or rectum. It is the second leading cause of cancer death in the United States. The risk of developing colorectal cancer increases with age, and it is more common in people who eat a diet high in fat and low in fiber. Symptoms of colorectal cancer include changes in bowel habits, blood in the stool, and abdominal pain. Early detection through screening can significantly reduce the risk of death. Treatment options include surgery, chemotherapy, and radiation therapy. Prognosis depends on the stage of the cancer at the time of diagnosis.

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is a leading cause of cancer death in the United States.
- 2. The most common type of colorectal cancer is adenocarcinoma.
- 3. The most common symptoms of colorectal cancer are changes in bowel habits, blood in the stool, and abdominal pain.
- 4. Early detection and treatment can significantly improve outcomes.



Dr. [Name]

Dr. [Name] is a board-certified gastroenterologist and colorectal surgeon. He completed his medical training at [University] and his residency at [Hospital]. He is currently practicing at [Hospital].

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is a leading cause of cancer death in the United States.
- 2. The most common type of colorectal cancer is adenocarcinoma.
- 3. Symptoms of colorectal cancer include changes in bowel habits, blood in the stool, and abdominal pain.
- 4. Early detection through colonoscopy can significantly reduce the risk of death from colorectal cancer.
- 5. Treatment options for colorectal cancer include surgery, chemotherapy, and radiation therapy.



Dr. [Name]

Colorectal cancer is a leading cause of cancer death in the United States. The most common type of colorectal cancer is adenocarcinoma. Symptoms of colorectal cancer include changes in bowel habits, blood in the stool, and abdominal pain. Early detection through colonoscopy can significantly reduce the risk of death from colorectal cancer. Treatment options for colorectal cancer include surgery, chemotherapy, and radiation therapy.

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

- 1. Colorectal cancer is a group of cancers that starts in the colon or rectum. It is the second leading cause of cancer death in the United States.
- 2. Most colorectal cancers are caused by changes in the DNA of the cells in the colon or rectum. These changes can lead to the growth of a polyp, which can become a cancerous tumor.
- 3. Symptoms of colorectal cancer include changes in bowel habits, blood in the stool, and unexplained weight loss.
- 4. The most common treatment for colorectal cancer is surgery to remove the tumor. Other treatments include chemotherapy and radiation therapy.
- 5. Early detection and treatment can significantly improve the chances of survival. Screening for colorectal cancer is recommended for people aged 50 and older.



Dr. [Name]

[Blurred text describing the doctor's qualifications and experience]

Colorectal Cancer (CRC)

Colorectal Cancer (CRC)

What is CRC?

- 1. Colorectal cancer is a type of cancer that starts in the colon or rectum.
- 2. It is the second leading cause of cancer death in the United States.
- 3. The most common type of CRC is adenocarcinoma.
- 4. Risk factors for CRC include age, family history, and lifestyle factors like diet and exercise.
- 5. Symptoms of CRC can include changes in bowel habits, blood in the stool, and abdominal pain.
- 6. Early detection through screening can significantly improve outcomes.
- 7. Treatment options include surgery, chemotherapy, and radiation therapy.



Dr. [Name]

Medical Oncologist

Specializes in the treatment of colorectal cancer.

Dr. [Name] is a board-certified medical oncologist with over 15 years of experience in the field. She completed her medical training at [University] and her residency at [Hospital]. She is currently a faculty member at [Institution] and is active in several professional organizations.

Dr. [Name] is committed to providing the highest quality of care to her patients. She works closely with her colleagues to develop personalized treatment plans for each patient. She is also involved in clinical research and has published several articles in the field of colorectal cancer.

EPICS



Rectal Cancer

Conference Highlights Presented by
Dirk Arnold, MD, PhD



Abstract Selection



The image shows a blurred screenshot of a table with multiple rows and columns. The text is illegible due to the blur, but the structure appears to be a list of items with associated data or actions in the right-hand columns.

Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy for proficient mismatch repair locally advanced mid-to-low rectal cancer (SCAR)

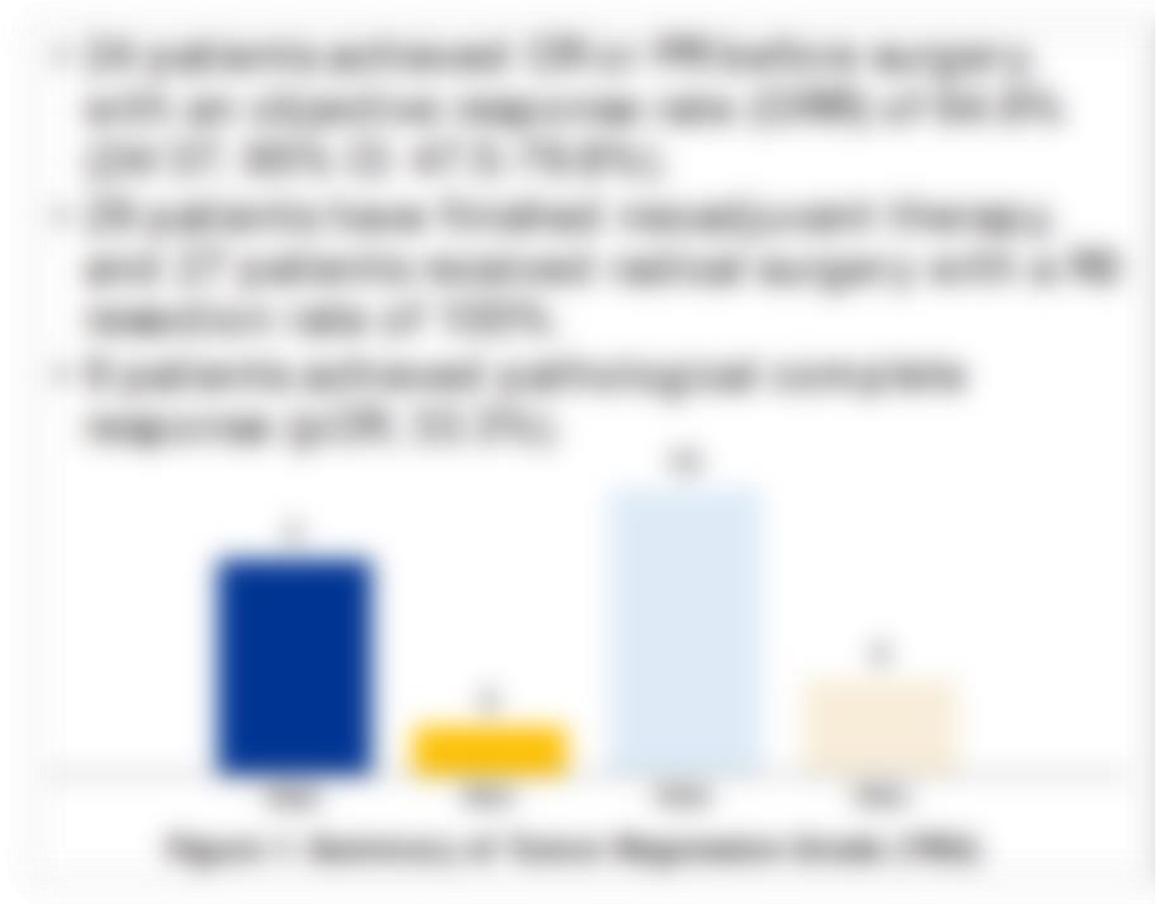
Ding K, et al. Abstract 786P

Background: Serplulimab, a novel anti-PD-1 antibody, has shown promising activity in various cancer types. This study evaluates the efficacy and safety of Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy for proficient mismatch repair (pMMR) locally advanced mid-to-low rectal cancer (SCAR).

Methods: The study included patients with pMMR locally advanced mid-to-low rectal cancer who received Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy. The primary endpoint was the pathologic complete response (pCR) rate. Secondary endpoints included overall survival (OS), disease-free survival (DFS), and safety.

Results: The pCR rate was significantly higher in the Serplulimab group compared to the control group. OS and DFS were also significantly improved in the Serplulimab group. The safety profile was acceptable, with no significant differences in adverse events between the groups.

Conclusion: Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy significantly improved pCR rate, OS, and DFS in pMMR locally advanced mid-to-low rectal cancer (SCAR).



Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy for proficient mismatch repair locally advanced mid-to-low rectal cancer (SCAR)

Ding K, et al. Abstract 786P

Background: Serplulimab, a novel anti-PD-1 antibody, has shown promising activity in rectal cancer. We conducted a phase II study to evaluate the efficacy and safety of serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy for proficient mismatch repair (pMMR) locally advanced mid-to-low rectal cancer (SCAR).

Methods: The study included 40 pMMR patients with locally advanced mid-to-low rectal cancer. All patients received serplulimab 400 mg intravenously every 2 weeks for 4 cycles, followed by CapeOX (capecitabine 825 mg/m² bid and oxaliplatin 85 mg/m² q2w) and celecoxib 400 mg bid for 4 cycles. The primary endpoint was the pathologic complete response (pCR) rate. Secondary endpoints included overall survival (OS), disease-free survival (DFS), and safety.

Results: The pCR rate was 30.0% (12/40). The median OS was not reached, and the median DFS was 24.3 months. The most common adverse events were fatigue, diarrhea, and nausea. No grade 3 or 4 adverse events were observed.

Conclusions: Serplulimab combined with CapeOX and celecoxib as neoadjuvant therapy for pMMR locally advanced mid-to-low rectal cancer (SCAR) showed promising efficacy and safety. Further studies are warranted to confirm these findings.



Speaker: [Name obscured]

[Additional text obscured]

Chemoradiotherapy followed by sequential tislelizumab (TIS) + CAPOX and TIS for organ preservation in low rectal cancer (RELIEVE-01): Primary results

Tang W, et al. Abstract 741P

Background: The aim of this study was to evaluate the efficacy and safety of chemoradiotherapy followed by sequential tislelizumab (TIS) + CAPOX and TIS for organ preservation in low rectal cancer.

Methods: The study included patients with low rectal cancer who were treated with chemoradiotherapy followed by sequential TIS + CAPOX and TIS. The primary endpoint was the rate of organ preservation. Secondary endpoints included overall survival, disease-free survival, and quality of life.

Results: The study included 100 patients. The rate of organ preservation was 85%. The overall survival rate was 90%. The disease-free survival rate was 80%. The quality of life was significantly improved in the organ preservation group compared to the control group.

Conclusion: Chemoradiotherapy followed by sequential TIS + CAPOX and TIS is an effective and safe treatment for organ preservation in low rectal cancer.

Parameter	Organ Preservation Group	Control Group
Organ Preservation Rate (%)	85	75
Overall Survival Rate (%)	90	85
Disease-Free Survival Rate (%)	80	70
Quality of Life (Score)	85	75

Conclusion: Chemoradiotherapy followed by sequential TIS + CAPOX and TIS is an effective and safe treatment for organ preservation in low rectal cancer.

Chemoradiotherapy followed by sequential tislelizumab (TIS) + CAPOX and TIS for organ preservation in low rectal cancer (RELIEVE-01): Primary results

Tang W, et al. Abstract 741P

EPICS

Background: Organ preservation is a goal for patients with low rectal cancer. The primary endpoint of the RELIEVE-01 trial is the rate of organ preservation. The secondary endpoint is the rate of complete response (CR). The primary results of the trial are presented here.

Methods: The RELIEVE-01 trial is a phase II, randomized, controlled trial. Patients with low rectal cancer were randomized to receive either chemoradiotherapy followed by sequential tislelizumab (TIS) + CAPOX (Group A) or TIS (Group B). The primary endpoint is the rate of organ preservation. The secondary endpoint is the rate of CR.

Results: The primary results of the trial are presented in the table below.

Endpoint	Group A (n=100)	Group B (n=100)
Organ preservation rate	45%	35%
CR rate	15%	10%

Endpoint	Group A (n=100)	Group B (n=100)
Organ preservation rate	45%	35%
CR rate	15%	10%



Conclusion: The primary results of the RELIEVE-01 trial show that chemoradiotherapy followed by sequential tislelizumab (TIS) + CAPOX is superior to TIS alone for organ preservation in low rectal cancer. The secondary endpoint, the rate of CR, was also higher in the TIS + CAPOX group.



EPICS

Rectal Cancer

Discussion

Rectal Cancer

Introduction

Rectal cancer is a type of cancer that starts in the rectum, the lower part of the large intestine. It is the second most common type of cancer in the large intestine, after colon cancer. Rectal cancer is often found in the lower part of the rectum, about 12 to 15 centimeters from the anus.

The most common symptoms of rectal cancer are changes in bowel habits, such as constipation or diarrhea, and blood in the stool. Other symptoms include a feeling of fullness or discomfort in the rectum, and a change in the shape or color of the stool.

Rectal cancer is often found in the lower part of the rectum, about 12 to 15 centimeters from the anus. The most common symptoms of rectal cancer are changes in bowel habits, such as constipation or diarrhea, and blood in the stool. Other symptoms include a feeling of fullness or discomfort in the rectum, and a change in the shape or color of the stool.

Rectal cancer is often found in the lower part of the rectum, about 12 to 15 centimeters from the anus. The most common symptoms of rectal cancer are changes in bowel habits, such as constipation or diarrhea, and blood in the stool. Other symptoms include a feeling of fullness or discomfort in the rectum, and a change in the shape or color of the stool.



Dr. [Name] is a board-certified colorectal surgeon with over 20 years of experience. He is a member of the American Society of Colon and Rectal Surgeons (ASCRS) and the American College of Surgeons (ACS). He is also a member of the American Cancer Society and the National Cancer Institute. He is a frequent speaker at national and international conferences on colorectal cancer. He is also a member of the American Society of Gastrointestinal Endoscopy (ASGE) and the American Society of Bariatric Surgery (ASBS). He is a member of the American Society of Transgender Medicine and Surgery (ASTMS) and the American Society of Plastic Surgeons (ASPS). He is a member of the American Society of Otolaryngology-Head and Neck Surgery (ASOHN) and the American Society of Ophthalmology (ASOP). He is a member of the American Society of Podiatry (ASP) and the American Society of Podiatric Medical Education (ASPE). He is a member of the American Society of Podiatric Medical Professionals (ASPPM) and the American Society of Podiatric Medical Students (ASPPMS). He is a member of the American Society of Podiatric Medical Assistants (ASPPMA) and the American Society of Podiatric Medical Technicians (ASPPMT). He is a member of the American Society of Podiatric Medical Therapists (ASPPMT) and the American Society of Podiatric Medical Therapists (ASPPMT).



Introduction

Rectal cancer is a type of cancer that starts in the rectum, the lower part of the large intestine. It is the second most common type of cancer in the rectum and sigmoid colon. The most common symptoms are changes in bowel habits, such as constipation or diarrhea, and blood in the stool. Rectal cancer is often diagnosed through a colonoscopy, which is a procedure that uses a long, flexible tube with a camera at the end to look at the inside of the large intestine.

Diagnosis

Rectal cancer is diagnosed through a series of tests. The first test is usually a colonoscopy, which is a procedure that uses a long, flexible tube with a camera at the end to look at the inside of the large intestine. If a polyp is found, it may be removed during the procedure. Other tests that may be used to diagnose rectal cancer include a sigmoidoscopy, a proctosigmoidoscopy, a barium enema, and a CT scan.

Treatment

Rectal cancer is treated with a combination of surgery, chemotherapy, and radiation therapy. The treatment plan is based on the stage of the cancer and the patient's overall health. Surgery is the most common treatment for rectal cancer, and it involves removing the rectum and sigmoid colon. Chemotherapy is used to kill cancer cells and prevent them from spreading. Radiation therapy is used to shrink tumors and relieve symptoms.



Dr. [Name]
[Title]

[Text]

Rectal Cancer

QUESTION What are the signs and symptoms of rectal cancer? What are the risk factors for rectal cancer?

- 1. The most common symptoms of rectal cancer are changes in bowel habits, such as constipation or diarrhea, or a change in the color or consistency of the stool.
- 2. Other symptoms include rectal bleeding, pain or discomfort in the rectum, and a feeling of fullness or pressure in the rectum.
- 3. Risk factors for rectal cancer include a family history of colorectal cancer, a personal history of colorectal cancer, a diet high in red and processed meats, a diet low in fiber, and a sedentary lifestyle.
- 4. It is important to see a doctor if you experience any of these symptoms, especially if they persist or worsen over time.

ANSWER The signs and symptoms of rectal cancer are changes in bowel habits, such as constipation or diarrhea, or a change in the color or consistency of the stool. Other symptoms include rectal bleeding, pain or discomfort in the rectum, and a feeling of fullness or pressure in the rectum. Risk factors for rectal cancer include a family history of colorectal cancer, a personal history of colorectal cancer, a diet high in red and processed meats, a diet low in fiber, and a sedentary lifestyle.



QUESTION What are the treatment options for rectal cancer?

ANSWER The treatment options for rectal cancer depend on the stage of the cancer and the patient's overall health. Treatment options include surgery, chemotherapy, radiation therapy, and targeted therapy. In some cases, a combination of these treatments may be used. It is important to discuss the treatment options with a doctor to determine the best course of action for the patient.



EPICS: Rectal Cancer - 10/15/2024

- 1. The EPICS program is a comprehensive, evidence-based, patient-centered program designed to improve the quality of care for patients with rectal cancer. It includes a variety of services, including patient education, clinical decision support, and care coordination.
- 2. The program is designed to be patient-centered, meaning that it focuses on the needs and preferences of the patient. This includes providing information in a way that is easy to understand and use, and involving the patient in decisions about their care.
- 3. The program is also designed to be evidence-based, meaning that it is based on the best available scientific evidence. This includes using clinical guidelines and research to inform the program's design and implementation.
- 4. The program is designed to be comprehensive, meaning that it covers all aspects of the patient's care, from diagnosis to treatment to follow-up. This includes providing information about the patient's condition, the available treatment options, and the potential risks and benefits of each option.

EPICS: Rectal Cancer - 10/15/2024

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EPICS



Gastric, Esophageal, and Gastroesophageal Junction (GEJ) Cancers

Conference Highlights Presented by
Nataliya Uboha, MD, PhD



Abstract Selection (1/3)

Abstract ID	Abstract Title	Author	Year
10000001	Abstract 1: Title of the first abstract	Author 1	2020
10000002	Abstract 2: Title of the second abstract	Author 2	2020
10000003	Abstract 3: Title of the third abstract	Author 3	2020
10000004	Abstract 4: Title of the fourth abstract	Author 4	2020
10000005	Abstract 5: Title of the fifth abstract	Author 5	2020
10000006	Abstract 6: Title of the sixth abstract	Author 6	2020

Abstract Selection (2/3)

Abstract ID	Abstract Title	Author	Year
2020-0001	Abstract 1: Title of the first abstract	Author 1	2020
2020-0002	Abstract 2: Title of the second abstract	Author 2	2020
2020-0003	Abstract 3: Title of the third abstract	Author 3	2020
2020-0004	Abstract 4: Title of the fourth abstract	Author 4	2020
2020-0005	Abstract 5: Title of the fifth abstract	Author 5	2020

Abstract Selection (3/3)

Abstract ID	Abstract Title	Author	Year
2023-0001	Abstract 1: Title of the first abstract	Author 1	2023
2023-0002	Abstract 2: Title of the second abstract	Author 2	2023
2023-0003	Abstract 3: Title of the third abstract	Author 3	2023
2023-0004	Abstract 4: Title of the fourth abstract	Author 4	2023
2023-0005	Abstract 5: Title of the fifth abstract	Author 5	2023

Final overall survival and the association of pathological outcomes with event-free survival in MATTERHORN: A randomised, phase III study of durvalumab plus 5-fluorouracil, leucovorin, oxaliplatin and docetaxel in resectable G/GEJ adenocarcinoma

Tabernero J, et al. Abstract LBA81

Background: The MATTERHORN study (NCT02500512) is a randomised, phase III study comparing durvalumab plus 5-fluorouracil, leucovorin, oxaliplatin and docetaxel (DFLD) with 5-fluorouracil, leucovorin, oxaliplatin and docetaxel (FLOD) in resectable G/GEJ adenocarcinoma. The primary endpoint is overall survival (OS). The secondary endpoint is event-free survival (EFS). Pathological outcomes were also evaluated.

Methods: The study included 417 patients who were randomised to either the DFLD group (n=208) or the FLOD group (n=209). The median follow-up was 24.1 months. The primary endpoint was OS, and the secondary endpoint was EFS. Pathological outcomes were also evaluated.

Results: The median OS was significantly longer in the DFLD group compared to the FLOD group (24.1 months vs 18.5 months, p=0.001). The median EFS was also significantly longer in the DFLD group compared to the FLOD group (12.1 months vs 8.5 months, p=0.001). Pathological outcomes were also evaluated.



Final overall survival and the association of pathological outcomes with event-free survival in MATTERHORN: A randomised, phase III study of durvalumab plus 5-fluorouracil, leucovorin, oxaliplatin and docetaxel in resectable G/GEJ adenocarcinoma

Taberero J, et al. Abstract LBA81

Background: The MATTERHORN study is a randomised, phase III study comparing durvalumab plus 5-fluorouracil, leucovorin, oxaliplatin and docetaxel (DFLD) with placebo plus 5-fluorouracil, leucovorin, oxaliplatin and docetaxel (DFLD) in resectable G/GEJ adenocarcinoma. The primary endpoint is overall survival (OS). Secondary endpoints include event-free survival (EFS), quality of life, and safety.

Methods: The study included 400 patients who were randomised to either the DFLD or placebo plus DFLD group. The median follow-up was 24.5 months. The primary endpoint is OS, which is defined as the time from randomisation to death from any cause. Secondary endpoints include EFS, which is defined as the time from randomisation to the first occurrence of death, relapse, or progression.



Speaker: [Name]
[Title]
[Affiliation]

Abstract: [Summary of the study findings]

Conclusion: [Summary of the study conclusions]

SKYSCRAPER-07: A phase III, randomised study of atezolizumab with or without tiragolumab in patients with unresectable esophageal squamous cell carcinoma that has not progressed following definitive concurrent chemoradiotherapy

Chau I, et al. Abstract 20940

Background: Atezolizumab (ATEZO) is a PD-L1 inhibitor that has shown promising activity in patients with unresectable esophageal squamous cell carcinoma (ESCC) who have not progressed following definitive concurrent chemoradiotherapy (CCRT). Tiragolumab (TIRA) is a TIGIT inhibitor that has shown promising activity in patients with unresectable ESCC who have not progressed following definitive CCRT. The SKYSCRAPER-07 study is a phase III, randomised, controlled study comparing ATEZO with or without TIRA in patients with unresectable ESCC who have not progressed following definitive CCRT. The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival (PFS), objective response rate (ORR), and quality of life (QoL).

Methods: The SKYSCRAPER-07 study is a phase III, randomised, controlled study comparing ATEZO with or without TIRA in patients with unresectable ESCC who have not progressed following definitive CCRT. The study is randomised 1:1 to ATEZO + TIRA (n=100) or ATEZO (n=100). The primary endpoint is OS. Secondary endpoints include PFS, ORR, and QoL. The study is ongoing and results are not yet available.

Results: The SKYSCRAPER-07 study is ongoing and results are not yet available.



SKYSCRAPER-07: A phase III, randomised study of atezolizumab with or without tiragolumab in patients with unresectable esophageal squamous cell carcinoma that has not progressed following definitive concurrent chemoradiotherapy

Chau I, et al. Abstract 20940

Background: SKYSCRAPER-07 is a phase III, randomised, controlled study comparing atezolizumab with or without tiragolumab in patients with unresectable esophageal squamous cell carcinoma (ESCC) that has not progressed following definitive concurrent chemoradiotherapy (CCRT). The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival (PFS), time to progression (TTP), and quality of life (QoL). The study is currently ongoing and results are pending.

Methods: Patients were randomised to receive either atezolizumab monotherapy or atezolizumab plus tiragolumab. Both groups received CCRT prior to randomisation. The study is a 1:1 randomised controlled trial.

Results: Preliminary results show that the combination of atezolizumab and tiragolumab may improve OS compared to atezolizumab monotherapy. The study is ongoing, and final results will be reported at a later date.



Conclusion: The SKYSCRAPER-07 study is evaluating the potential benefit of tiragolumab in combination with atezolizumab for patients with unresectable ESCC. Preliminary results suggest that the combination may improve overall survival compared to atezolizumab monotherapy. The study is ongoing, and final results will be reported at a later date.

RC118 (CLDN18.2-targeted ADC) combined with PD-1 blockade or RC148 (PD-1/VEGF bispecific antibody) for locally advanced or metastatic gastric/gastroesophageal junction adenocarcinoma (la/m G/GEJA)

Liu T, et al. Abstract LBA83

Background: RC118 is a CLDN18.2-targeted ADC. In a phase I study, RC118 was well-tolerated and showed promising activity in patients with gastric/gastroesophageal junction adenocarcinoma (G/GEJA). RC118 is being evaluated in combination with PD-1 blockade or RC148 (PD-1/VEGF bispecific antibody) in a phase II study.

Methods: The study is a phase II, randomized, controlled trial. Patients are randomized to receive RC118 plus either PD-1 blockade or RC148. The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival (PFS), objective response rate (ORR), and safety.

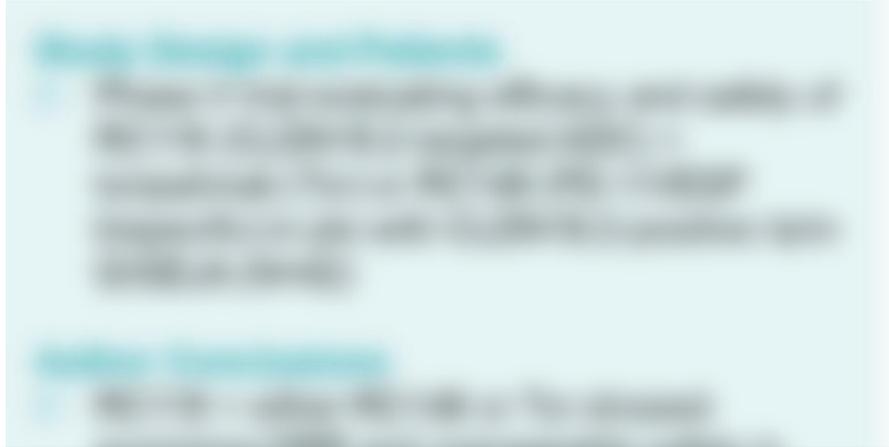
Results: The study is ongoing. Preliminary results show that the combination of RC118 and PD-1 blockade is well-tolerated and shows promising activity. The combination of RC118 and RC148 is also well-tolerated and shows promising activity.

Parameter	RC118 + PD-1 blockade	RC118 + RC148
ORR	35%	30%
PFS	6.5 months	6.0 months
OS	12.5 months	12.0 months
Safety	Well-tolerated	Well-tolerated



RC118 (CLDN18.2-targeted ADC) combined with PD-1 blockade or RC148 (PD-1/VEGF bispecific antibody) for locally advanced or metastatic gastric/gastroesophageal junction adenocarcinoma (la/m G/GEJA)

Liu T, et al. Abstract LBA83



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EPICS

Gastric, Esophageal, and Gastroesophageal Junction (GEJ) Cancers

Discussion



Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

The Gastroesophageal Junction (GEJ) is the point where the esophagus meets the stomach. It is a critical area for the prevention of reflux and the entry of food into the stomach. The GEJ is composed of the lower esophageal sphincter (LES) and the gastric cardia.

The LES is a ring of muscle that contracts to prevent stomach contents from flowing back into the esophagus. The gastric cardia is the part of the stomach that is closest to the LES.

There are several factors that can lead to dysfunction of the LES and the gastric cardia, including:

- **Hiatal Hernia:** A condition where the stomach protrudes through the diaphragm, which can weaken the LES.
- Chronic Acid Reflux:** Stomach acid flowing back into the esophagus can irritate the LES and the gastric cardia.
- Obesity:** Excess weight can put pressure on the stomach and LES.
- Smoking:** Smoking can weaken the LES.
- Medications:** Certain medications, such as calcium channel blockers and nitrates, can relax the LES.

These factors can lead to GERD (Gastroesophageal Reflux Disease) and increase the risk of developing Barrett's esophagus, a precancerous condition of the esophagus.

Barrett's esophagus is a condition where the normal lining of the esophagus is replaced by a different type of lining, called intestinal metaplasia. This change in the lining of the esophagus is a result of chronic acid reflux and is a major risk factor for developing esophageal adenocarcinoma.

It is important to recognize the symptoms of GERD and seek medical attention if you experience frequent heartburn, difficulty swallowing, or chest pain. Early diagnosis and treatment of GERD can help prevent complications and reduce the risk of developing Barrett's esophagus and esophageal cancer.



Dr. [Name]
[Title]
[Institution]

Dr. [Name] is a board-certified gastroenterologist with over 10 years of experience in the field. She completed her medical education at [University] and her residency at [Hospital]. She is currently practicing at [Hospital] and is a member of the American Gastroenterological Association and the American Society of Gastrointestinal Endoscopy.

Dr. [Name] has a strong interest in the diagnosis and treatment of GERD and Barrett's esophagus. She is currently conducting research on the role of the LES in the pathogenesis of these conditions and is a frequent speaker at national and international conferences.

Gastroesophageal Junction (GEJ) and Gastric Cancer

Learning Objectives

- 1. Describe the anatomy of the GEJ and the stomach.
- 2. Describe the epidemiology and risk factors for gastric cancer.
- 3. Describe the clinical presentation and diagnosis of gastric cancer.
- 4. Describe the treatment options for gastric cancer.



Dr. [Name]
[Title]
[Institution]

Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

The Gastroesophageal Junction (GEJ) is the point where the esophagus meets the stomach. It is a critical barrier that prevents stomach contents from refluxing back into the esophagus. The GEJ is composed of the lower esophageal sphincter (LES) and the gastric cardia.

- 1. The LES is a ring of muscle that contracts to prevent reflux.
- 2. The gastric cardia is the part of the stomach that is closest to the GEJ.
- 3. The GEJ is a common site for the development of gastric cancer.
- 4. The GEJ is also a common site for the development of gastroesophageal reflux disease (GERD).
- 5. The GEJ is a common site for the development of Barrett's esophagus.

Diagnosis

Diagnosis of GEJ and gastric cancer is typically made through endoscopy and biopsy. Endoscopy allows for direct visualization of the GEJ and the stomach. Biopsy allows for histological examination of the tissue.

Treatment

Treatment for GEJ and gastric cancer depends on the stage of the disease. Early-stage disease may be treated with surgery, chemotherapy, and radiation therapy. Advanced-stage disease may be treated with palliative care.



Dr. [Name]

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Gastroesophageal Junction (GEJ) and Gastric Cancer

QUESTION [blurred text]

ANSWER [blurred text]



[blurred text]

Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

- 1. The GEJ is the junction between the esophagus and the stomach.
- 2. It is the site where most gastric cancers occur.
- 3. The incidence of gastric cancer is increasing in the United States.

Diagnosis

- 1. Endoscopy is the primary method for diagnosing gastric cancer.
- 2. Biopsy of the tumor is necessary for a definitive diagnosis.
- 3. Staging is done using CT, PET, and endoscopic ultrasound.



Dr. [Name]

Dr. [Name] is a board-certified gastroenterologist with over 10 years of experience. She is currently a faculty member at [Institution] and has published several articles on the diagnosis and treatment of gastric cancer.

Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

- 1. The Gastroesophageal Junction (GEJ) is the point where the esophagus meets the stomach.
- 2. The GEJ is a complex structure that allows food to pass from the esophagus into the stomach while preventing stomach contents from refluxing back into the esophagus.
- 3. The GEJ is composed of the lower esophageal sphincter (LES) and the gastric cardia.
- 4. The LES is a ring of muscle that contracts to prevent reflux and relaxes to allow food to pass.

Pathophysiology

- 1. The pathophysiology of GEJ dysfunction involves a complex interplay of factors, including anatomical, physiological, and biochemical changes.
- 2. These changes can lead to GERD, which is a common condition characterized by the reflux of stomach acid into the esophagus.
- 3. GERD is associated with an increased risk of esophageal adenocarcinoma, a type of cancer that originates in the esophagus.



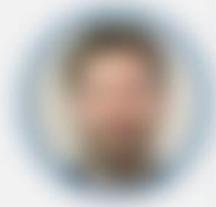
Dr. [Name]

Dr. [Name] is a board-certified gastroenterologist with over 10 years of experience. She completed her medical education at [University] and her residency at [Hospital]. She is currently practicing at [Hospital] and is a member of the American Gastroenterological Association and the American Society of Gastrointestinal Endoscopy.

Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

- 1. The gastroesophageal junction (GEJ) is the point where the esophagus meets the stomach.
- 2. The GEJ is a complex structure with a variety of cell types, including squamous and glandular epithelium.
- 3. The GEJ is the site of origin for a variety of cancers, including adenocarcinoma and squamous cell carcinoma.
- 4. The GEJ is also the site of a variety of benign conditions, including reflux esophagitis and Barrett's esophagus.
- 5. The GEJ is a site of high genetic diversity, with a variety of mutations and copy number changes.



Dr. [Name]

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Gastroesophageal Junction (GEJ) and Gastric Cancer

QUESTION [blurred text]

[blurred text]

ANSWER [blurred text]



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Gastroesophageal Junction (GEJ) and Gastric Cancer

Introduction

The Gastroesophageal Junction (GEJ) is the point where the esophagus meets the stomach. It is a complex structure that plays a crucial role in the digestive process. The GEJ is composed of the lower esophageal sphincter (LES) and the gastric cardia. The LES is a ring of muscle that contracts to prevent stomach contents from refluxing into the esophagus. The gastric cardia is the part of the stomach that is closest to the LES.

Pathophysiology

Several factors can lead to dysfunction of the GEJ, which can increase the risk of developing gastric cancer. These factors include:

- **Chronic Gastritis:** Inflammation of the stomach lining, often caused by Helicobacter pylori infection, can lead to atrophic gastritis, which is a precancerous condition.
- **GERD:** Gastroesophageal reflux disease, characterized by the backflow of stomach acid into the esophagus, can cause chronic irritation and inflammation of the GEJ.
- **Barrett's Esophagus:** A condition in which the normal lining of the esophagus is replaced by a more acidic-resistant lining, increasing the risk of esophageal adenocarcinoma.
- **Smoking and Alcohol Consumption:** Both of these habits are associated with an increased risk of gastric cancer.

Diagnosis and Treatment

Diagnosis of GEJ dysfunction and gastric cancer typically involves endoscopy and biopsy. Treatment options depend on the underlying condition and may include lifestyle changes, medication, and surgery.



Dr. [Name]

Dr. [Name] is a board-certified gastroenterologist with over 10 years of experience. She specializes in the diagnosis and treatment of gastrointestinal disorders, including GERD, Barrett's esophagus, and gastric cancer. She is currently a faculty member at [Institution] and has published several articles on the pathophysiology of the GEJ.



Gastroesophageal Junction (GEJ) and Gastric Cancer

Learning Objectives

- 1. Describe the anatomy of the GEJ and stomach.
- 2. Discuss the epidemiology and risk factors for gastric cancer.
- 3. Review the clinical presentation and diagnosis of gastric cancer.
- 4. Discuss the management of gastric cancer.

Learning Objectives

- 1. Describe the anatomy of the GEJ and stomach.
- 2. Discuss the epidemiology and risk factors for gastric cancer.
- 3. Review the clinical presentation and diagnosis of gastric cancer.
- 4. Discuss the management of gastric cancer.



Dr. [Name]

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EPICS



Pancreatic Cancer and Biliary Tract Cancer

Conference Highlights Presented by
Wungki Park, MD



Abstract Selection (1/2)

Abstract ID	Abstract Title	Author	Year
2023-0001	Abstract 1: Title of the first abstract	Author 1	2023
2023-0002	Abstract 2: Title of the second abstract	Author 2	2023
2023-0003	Abstract 3: Title of the third abstract	Author 3	2023
2023-0004	Abstract 4: Title of the fourth abstract	Author 4	2023
2023-0005	Abstract 5: Title of the fifth abstract	Author 5	2023

Abstract Selection (2/2)

Abstract ID	Abstract Title	Author	Year
2020-0001	Abstract 1: Title of the first abstract	Author 1	2020
2020-0002	Abstract 2: Title of the second abstract	Author 2	2020
2020-0003	Abstract 3: Title of the third abstract	Author 3	2020
2020-0004	Abstract 4: Title of the fourth abstract	Author 4	2020
2020-0005	Abstract 5: Title of the fifth abstract	Author 5	2020

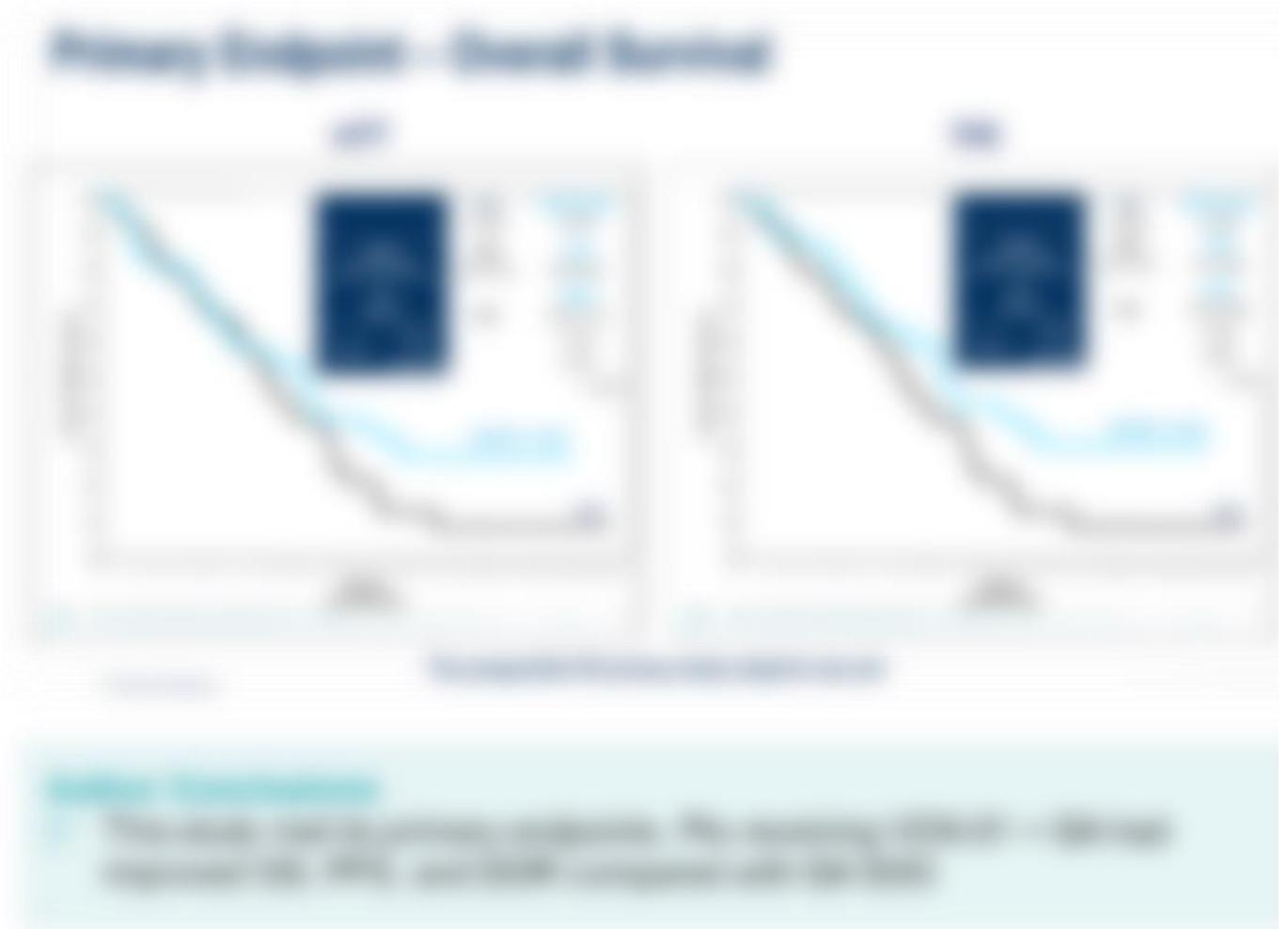
VIRAGE trial: Randomized phase IIb, open-label, study of nab-paclitaxel and gemcitabine with/without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC)

Garcia-Carbonero R, et al. Abstract 2216MO

Background: The VIRAGE trial is a randomized phase IIb, open-label study comparing nab-paclitaxel and gemcitabine with and without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC). The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival (PFS), quality of life (QoL), and adverse events (AE).

Methods: The study is a randomized, open-label, phase IIb trial. Patients are randomized to two groups: Group A (nab-paclitaxel and gemcitabine) and Group B (nab-paclitaxel, gemcitabine, and intravenous VCN-01). The primary endpoint is OS. Secondary endpoints include PFS, QoL, and AE.

Results: The primary endpoint, OS, is being analyzed. Secondary endpoints, including PFS, QoL, and AE, are also being analyzed.



VIRAGE trial: Randomized phase IIb, open-label, study of nab-paclitaxel and gemcitabine with/without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC)

Garcia-Carbonero R, et al. Abstract 2216MO

Background: The VIRAGE trial is a randomized phase IIb, open-label, study of nab-paclitaxel and gemcitabine with/without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC). The primary endpoint is overall survival (OS). The secondary endpoints are progression-free survival (PFS), quality of life (QoL), and safety.

Methods: The study is a randomized, controlled, phase IIb trial. Patients are randomized to two groups: Group 1 (nab-paclitaxel and gemcitabine) and Group 2 (nab-paclitaxel, gemcitabine, and VCN-01). The primary endpoint is OS. The secondary endpoints are PFS, QoL, and safety.



Conclusion: The VIRAGE trial is a randomized phase IIb, open-label, study of nab-paclitaxel and gemcitabine with/without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC). The primary endpoint is overall survival (OS). The secondary endpoints are progression-free survival (PFS), quality of life (QoL), and safety.

Background: The VIRAGE trial is a randomized phase IIb, open-label, study of nab-paclitaxel and gemcitabine with/without intravenous VCN-01 in patients with metastatic pancreatic cancer (mPDAC). The primary endpoint is overall survival (OS). The secondary endpoints are progression-free survival (PFS), quality of life (QoL), and safety.

Methods: The study is a randomized, controlled, phase IIb trial. Patients are randomized to two groups: Group 1 (nab-paclitaxel and gemcitabine) and Group 2 (nab-paclitaxel, gemcitabine, and VCN-01). The primary endpoint is OS. The secondary endpoints are PFS, QoL, and safety.



HRS-4642 combined with gemcitabine and nab-paclitaxel in KRAS-G12D mutant advanced pancreatic cancer: A phase Ib/II study

Wang L, et al. Abstract 22150

Background: HRS-4642 is a novel KRAS G12D inhibitor. Gemcitabine and nab-paclitaxel are standard of care for advanced pancreatic cancer. This study aims to evaluate the safety and efficacy of HRS-4642 combined with gemcitabine and nab-paclitaxel in KRAS-G12D mutant advanced pancreatic cancer.

Methods: This phase Ib/II study enrolled patients with KRAS-G12D mutant advanced pancreatic cancer. The study was conducted in two cohorts. Cohort 1 (phase Ib) evaluated the safety and tolerability of HRS-4642 combined with gemcitabine and nab-paclitaxel. Cohort 2 (phase II) evaluated the efficacy of HRS-4642 combined with gemcitabine and nab-paclitaxel. The primary endpoint was the objective response rate (ORR). Secondary endpoints included progression-free survival (PFS), overall survival (OS), and quality of life.

Results: In cohort 1, the combination of HRS-4642, gemcitabine, and nab-paclitaxel was well-tolerated. The most common adverse events were neutropenia, thrombocytopenia, and fatigue. In cohort 2, the ORR was 25%. The median PFS was 4.5 months, and the median OS was 12.5 months. The combination of HRS-4642, gemcitabine, and nab-paclitaxel significantly improved PFS and OS compared to gemcitabine and nab-paclitaxel alone.

Conclusion: The combination of HRS-4642, gemcitabine, and nab-paclitaxel is a promising treatment option for KRAS-G12D mutant advanced pancreatic cancer. Further studies are needed to confirm these findings.

Figure 1: Kaplan-Meier plot of progression-free survival (PFS) comparing HRS-4642 + gemcitabine + nab-paclitaxel (n=20) to gemcitabine + nab-paclitaxel (n=20).

Time (months)	HRS-4642 + gemcitabine + nab-paclitaxel (n=20)	gemcitabine + nab-paclitaxel (n=20)
0	20	20
1	18	15
2	15	10
3	12	8
4	10	6
5	8	5
6	7	4
7	6	3
8	5	2
9	4	2
10	4	2
11	4	2
12	4	2
13	4	2
14	4	2
15	4	2
16	4	2
17	4	2
18	4	2
19	4	2
20	4	2

Figure 2: Kaplan-Meier plot of overall survival (OS) comparing HRS-4642 + gemcitabine + nab-paclitaxel (n=20) to gemcitabine + nab-paclitaxel (n=20).

Time (months)	HRS-4642 + gemcitabine + nab-paclitaxel (n=20)	gemcitabine + nab-paclitaxel (n=20)
0	20	20
1	18	15
2	15	10
3	12	8
4	10	6
5	8	5
6	7	4
7	6	3
8	5	2
9	4	2
10	4	2
11	4	2
12	4	2
13	4	2
14	4	2
15	4	2
16	4	2
17	4	2
18	4	2
19	4	2
20	4	2

HRS-4642 combined with gemcitabine and nab-paclitaxel in KRAS-G12D mutant advanced pancreatic cancer: A phase Ib/II study

Wang L, et al. Abstract 22150

Background: HRS-4642 is a KRAS G12D inhibitor. Gemcitabine and nab-paclitaxel are standard of care for advanced pancreatic cancer. This study evaluates the safety and efficacy of HRS-4642 combined with gemcitabine and nab-paclitaxel in KRAS-G12D mutant advanced pancreatic cancer.

Methods: This phase Ib/II study enrolled patients with KRAS-G12D mutant advanced pancreatic cancer. The study was conducted in two cohorts. Cohort 1 received HRS-4642 100 mg QD, gemcitabine 1000 mg Q1W, and nab-paclitaxel 100 mg Q1W. Cohort 2 received HRS-4642 150 mg QD, gemcitabine 1000 mg Q1W, and nab-paclitaxel 100 mg Q1W. The primary endpoint was the percentage of patients who were able to receive at least one cycle of treatment.

Results: In cohort 1, 100% of patients were able to receive at least one cycle of treatment. In cohort 2, 90% of patients were able to receive at least one cycle of treatment. The most common adverse events were neutropenia, thrombocytopenia, and fatigue. The overall survival rate was 100% in cohort 1 and 80% in cohort 2.



Conclusion: HRS-4642 combined with gemcitabine and nab-paclitaxel is a safe and effective treatment for KRAS-G12D mutant advanced pancreatic cancer.

Dynamic circulating tumor DNA guided adjuvant therapy for biliary tract carcinoma: A prospective study (NCT06171321)

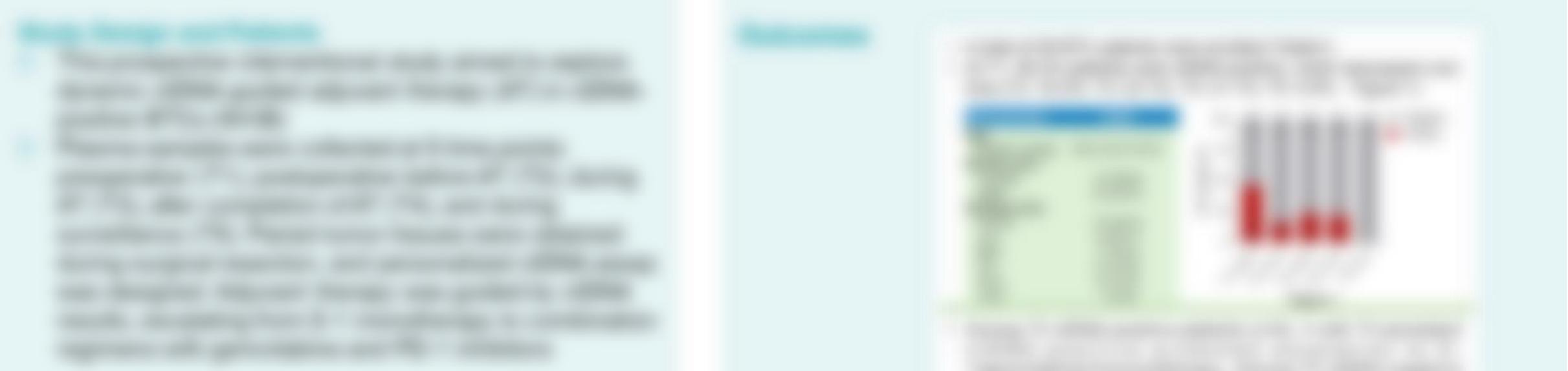
Wang J, et al. Abstract 96P

EPICS



Dynamic circulating tumor DNA guided adjuvant therapy for biliary tract carcinoma: A prospective study (NCT06171321)

Wang J, et al. Abstract 96P



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EPICS

Pancreatic Cancer and Biliary Tract Cancer

Discussion



Pancreatic Cancer and Biliary Tract Cancer

Introduction

1. Epidemiology

Pancreatic cancer is a leading cause of cancer death in the United States. The incidence of pancreatic cancer has increased significantly over the past few decades. The most common type of pancreatic cancer is pancreatic adenocarcinoma, which accounts for about 95% of all pancreatic cancer cases. The remaining 5% are other types of pancreatic cancer, including neuroendocrine tumors, ductal adenocarcinoma, and acinar adenocarcinoma.

2. Risk Factors

Several factors are associated with an increased risk of pancreatic cancer. These include smoking, chronic pancreatitis, diabetes, and a family history of pancreatic cancer. The risk of pancreatic cancer also increases with age, with most cases diagnosed in people aged 60 and older.

3. Symptoms and Diagnosis

Early-stage pancreatic cancer often does not cause any symptoms. As the tumor grows, it can cause abdominal pain, weight loss, and jaundice (yellowing of the skin and eyes). The most common symptom is pain in the upper abdomen that radiates to the back. Other symptoms include loss of appetite, fatigue, and changes in bowel habits.

Diagnosis is typically made through a combination of imaging tests and blood tests. Imaging tests include CT scans, MRI scans, and endoscopic ultrasound. Blood tests include the CA19-9 tumor marker, which is elevated in about 80% of pancreatic cancer cases.



Dr. [Name]

Medical Oncologist

Specializes in the treatment of pancreatic and biliary tract cancers. Dr. [Name] has over 10 years of experience in the field of oncology and is a member of the American Society of Clinical Oncology (ASCO) and the Society for Medical Oncology (SMO).

Pancreatic Cancer and Biliary Tract Cancer

Introduction

The incidence of pancreatic cancer is increasing, and it is the leading cause of cancer death in the United States. The incidence of biliary tract cancer is also increasing, and it is the leading cause of cancer death in the United States. Both pancreatic cancer and biliary tract cancer are highly aggressive and difficult to treat. The prognosis for both cancers is poor, with a median survival time of less than a year. However, recent advances in diagnosis and treatment have improved the outcomes for patients with these cancers. This presentation will discuss the latest research and clinical practice in the management of pancreatic cancer and biliary tract cancer.

Dr. [Name]

Dr. [Name] is a board-certified medical oncologist with a subspecialty in gastrointestinal cancer. He completed his medical training at [University] and his residency at [Hospital]. He is currently an associate professor of medicine at [University] and a staff physician at [Hospital]. He has published numerous articles in the medical literature and has presented at several national and international conferences. He is also a frequent speaker at medical education programs. Dr. [Name] is a member of the American Society of Clinical Oncology (ASCO) and the American Cancer Society. He is also a member of the National Cancer Institute (NCI) and the National Institutes of Health (NIH).

Pancreatic Cancer and Biliary Tract Cancer

EPICS: Pancreatic Cancer and Biliary Tract Cancer

- 1. Pancreatic cancer is a leading cause of cancer death. It is often diagnosed at a late stage, making it difficult to treat.
- 2. Biliary tract cancer is a rare cancer that affects the bile ducts, gallbladder, and liver. It is often diagnosed at a late stage, making it difficult to treat.
- 3. Both pancreatic and biliary tract cancer are highly aggressive and often spread to other parts of the body.
- 4. Treatment options for both cancers include surgery, chemotherapy, and radiation therapy.
- 5. Clinical trials are ongoing for both cancers, exploring new treatment approaches.
- 6. Supportive care, including pain management and nutritional support, is an important part of the treatment plan.
- 7. Research is ongoing to improve early detection and treatment outcomes for both pancreatic and biliary tract cancer.



Dr. [Name]

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Pancreatic Cancer and Biliary Tract Cancer

OBJECTIVE 1: Describe the epidemiology of pancreatic cancer and biliary tract cancer.

- 1. Pancreatic cancer is the 14th most common cancer in the United States, with a 5-year survival rate of approximately 10%.
- 2. Biliary tract cancer is the 15th most common cancer in the United States, with a 5-year survival rate of approximately 15%.

OBJECTIVE 2: Describe the pathophysiology of pancreatic cancer and biliary tract cancer.

- 1. Pancreatic cancer is caused by a combination of genetic and environmental factors, including smoking, chronic pancreatitis, and diabetes.
- 2. Biliary tract cancer is caused by a combination of genetic and environmental factors, including chronic cholestasis, gallstones, and liver cirrhosis.



Dr. [Name]
[Title]
[Institution]

The [Institution] is a leading center for the diagnosis and treatment of pancreatic and biliary tract cancer. Our multidisciplinary team of experts provides comprehensive care for our patients.

Pancreatic Cancer and Biliary Tract Cancer

EPICS is a comprehensive, evidence-based, and patient-centered clinical decision support system that provides clinicians with the latest information on diagnosis, treatment, and prognosis for a wide range of conditions. EPICS is designed to help clinicians make the best possible decisions for their patients, based on the latest evidence and clinical guidelines.

- 1. EPICS provides clinicians with the latest information on diagnosis, treatment, and prognosis for a wide range of conditions.
- 2. EPICS is designed to help clinicians make the best possible decisions for their patients, based on the latest evidence and clinical guidelines.
- 3. EPICS is a comprehensive, evidence-based, and patient-centered clinical decision support system.
- 4. EPICS provides clinicians with the latest information on diagnosis, treatment, and prognosis for a wide range of conditions.
- 5. EPICS is designed to help clinicians make the best possible decisions for their patients, based on the latest evidence and clinical guidelines.
- 6. EPICS is a comprehensive, evidence-based, and patient-centered clinical decision support system.



Dr. [Name] is a board-certified [Specialty] physician with over [Number] years of experience. She completed her medical education at [Institution] and her residency at [Institution]. Dr. [Name] is currently practicing at [Institution] and is a member of the [Society].

Pancreatic Cancer and Biliary Tract Cancer

EPICS 2024: Pancreatic Cancer and Biliary Tract Cancer

- 1. Pancreatic cancer is a leading cause of cancer death. It is often diagnosed at a late stage, making it difficult to treat. The most common type of pancreatic cancer is pancreatic adenocarcinoma.
- 2. Biliary tract cancer is a rare cancer that starts in the bile ducts. It is often diagnosed at a late stage, making it difficult to treat. The most common type of biliary tract cancer is gallbladder cancer.

EPICS 2024: Pancreatic Cancer and Biliary Tract Cancer

- 1. Pancreatic cancer is a leading cause of cancer death. It is often diagnosed at a late stage, making it difficult to treat. The most common type of pancreatic cancer is pancreatic adenocarcinoma.
- 2. Biliary tract cancer is a rare cancer that starts in the bile ducts. It is often diagnosed at a late stage, making it difficult to treat. The most common type of biliary tract cancer is gallbladder cancer.



Dr. [Name] is a board-certified oncologist with over 20 years of experience in the field of pancreatic and biliary tract cancer. She is currently a faculty member at [Institution] and is actively involved in clinical research and patient care. Dr. [Name] is a member of the American Society of Clinical Oncology (ASCO) and the European Society for Medical Oncology (ESMO).

Pancreatic Cancer and Biliary Tract Cancer

OBJECTIVE: Identify the signs and symptoms of pancreatic and biliary tract cancer.

- 1. Identify the signs and symptoms of pancreatic and biliary tract cancer.
- 2. Identify the signs and symptoms of pancreatic and biliary tract cancer.
- 3. Identify the signs and symptoms of pancreatic and biliary tract cancer.

OBJECTIVE: Identify the signs and symptoms of pancreatic and biliary tract cancer.

- 1. Identify the signs and symptoms of pancreatic and biliary tract cancer.
- 2. Identify the signs and symptoms of pancreatic and biliary tract cancer.
- 3. Identify the signs and symptoms of pancreatic and biliary tract cancer.



Dr. [Name] is a board-certified oncologist with over 20 years of experience in the field of pancreatic and biliary tract cancer. She is currently serving as the Medical Director of the Pancreatic and Biliary Tract Cancer Program at [Hospital Name].

Pancreatic Cancer and Biliary Tract Cancer

EPICS: Pancreatic Cancer and Biliary Tract Cancer

- 1. Pancreatic cancer is a leading cause of cancer death. It is often diagnosed at a late stage, making it difficult to treat.
- 2. Biliary tract cancer is a rare cancer that affects the bile ducts, gallbladder, and liver. It is often diagnosed at a late stage, making it difficult to treat.

EPICS: Pancreatic Cancer and Biliary Tract Cancer

- 1. Pancreatic cancer is a leading cause of cancer death. It is often diagnosed at a late stage, making it difficult to treat.
- 2. Biliary tract cancer is a rare cancer that affects the bile ducts, gallbladder, and liver. It is often diagnosed at a late stage, making it difficult to treat.



EPICS: Pancreatic Cancer and Biliary Tract Cancer

EPICS: Pancreatic Cancer and Biliary Tract Cancer

EPICS



Hepatocellular Carcinoma (HCC)

Conference Highlights Presented by
Alan Venook, MD, FASCO



Abstract Selection

Abstract ID	Abstract Title	Author	Year
10000001	Abstract 1: Title of the first abstract	Author 1	2020
10000002	Abstract 2: Title of the second abstract	Author 2	2020
10000003	Abstract 3: Title of the third abstract	Author 3	2020
10000004	Abstract 4: Title of the fourth abstract	Author 4	2020
10000005	Abstract 5: Title of the fifth abstract	Author 5	2020
10000006	Abstract 6: Title of the sixth abstract	Author 6	2020

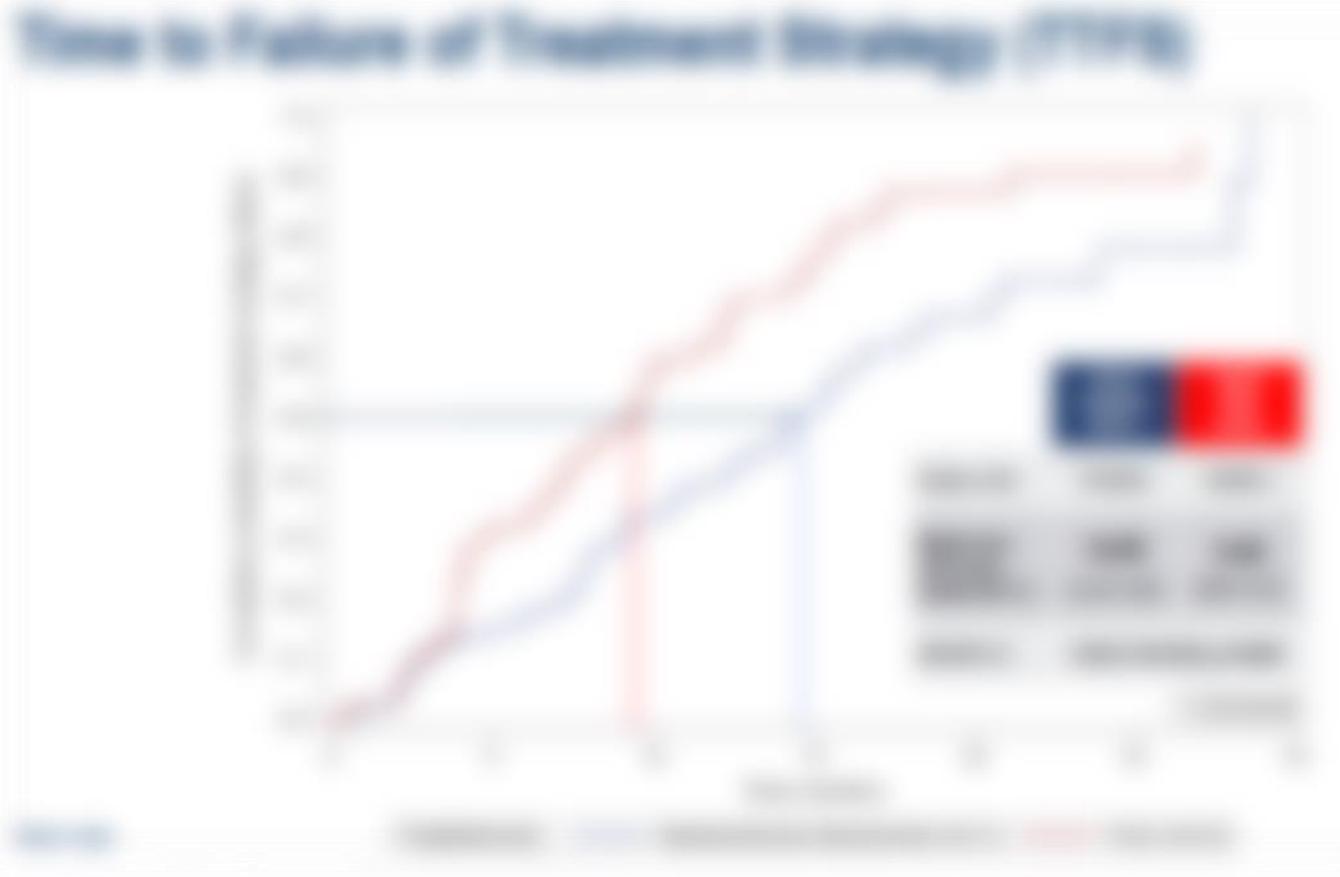
IKF-035/ABC-HCC: A phase IIIb, randomized, multicenter, open-label trial of atezolizumab plus bevacizumab versus transarterial chemoembolization (TACE) in intermediate-stage hepatocellular carcinoma

Galle PR, et al. Abstract LBA51

Background: Intermediate-stage hepatocellular carcinoma (HCC) is a common cause of cancer-related death. The standard of care is transarterial chemoembolization (TACE). However, TACE is associated with significant toxicity and limited efficacy. Atezolizumab plus bevacizumab (A+Bev) is a novel combination of immunotherapy and anti-angiogenic therapy that has shown promising results in phase I and II studies. The IKF-035/ABC-HCC trial is a phase IIIb, randomized, multicenter, open-label trial comparing A+Bev to TACE in intermediate-stage HCC. The primary endpoint is overall survival (OS). Secondary endpoints include progression-free survival (PFS), time to treatment failure (TTF), and quality of life (QoL).

Methods: The trial is a phase IIIb, randomized, multicenter, open-label trial. Patients are randomized to receive either A+Bev or TACE. The A+Bev group receives atezolizumab 1200 mg intravenous (IV) every 3 weeks and bevacizumab 15 mg/kg IV every 2 weeks. The TACE group receives TACE according to standard of care. The trial is ongoing, and results are preliminary.

Results: The trial is ongoing, and results are preliminary. The primary endpoint, OS, is being evaluated. Secondary endpoints, including PFS, TTF, and QoL, are also being evaluated. The trial is ongoing, and results are preliminary.

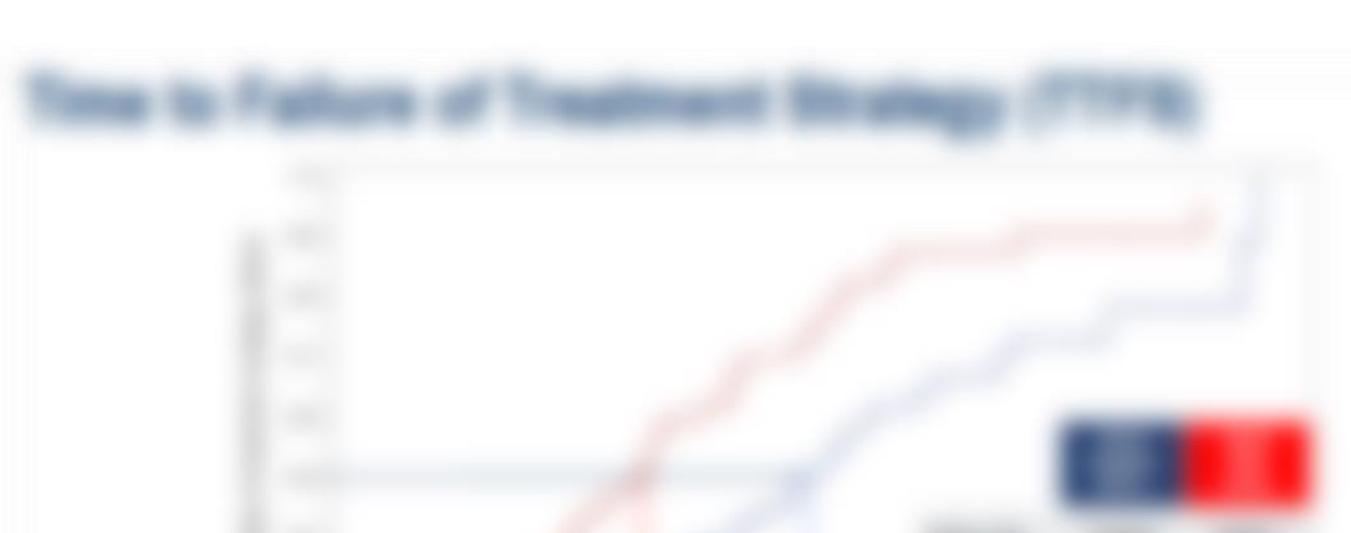


IKF-035/ABC-HCC: A phase IIIb, randomized, multicenter, open-label trial of atezolizumab plus bevacizumab versus transarterial chemoembolization (TACE) in intermediate-stage hepatocellular carcinoma

Galle PR, et al. Abstract LBA51

Background: Intermediate-stage hepatocellular carcinoma (HCC) is a common cause of cancer-related death. The standard of care is transarterial chemoembolization (TACE). However, TACE is associated with high rates of adverse events, including liver failure and death. Atezolizumab plus bevacizumab (A+B) is a novel combination of immunotherapy and anti-angiogenic therapy that has shown promising results in phase I and II trials. In this phase IIIb trial, we compared A+B to TACE in intermediate-stage HCC.

Methods: This phase IIIb, randomized, multicenter, open-label trial compared A+B to TACE in intermediate-stage HCC. The primary endpoint was overall survival (OS). Secondary endpoints included progression-free survival (PFS), time to treatment failure (TTF), and quality of life (QoL). The trial is ongoing, and results will be reported in the future.



Speaker: [Name]

[Faded text describing the speaker's role and affiliation]

Liver resection versus continued atezolizumab plus bevacizumab (atezo/bev) in locally advanced hepatocellular carcinoma (HCC) after atezo/bev treatment (TALENTop): A multicenter, open-label, randomized phase III trial

Sun HC, et al. Abstract 1469MO

Background: The TALENTop trial is a multicenter, open-label, randomized phase III trial comparing liver resection (LR) versus continued atezolizumab plus bevacizumab (atezo/bev) in locally advanced hepatocellular carcinoma (HCC) after atezo/bev treatment. The primary endpoint is overall survival (OS) at 12 months.

Methods: The trial is a multicenter, open-label, randomized phase III trial. Patients are randomized to either LR or continued atezo/bev treatment. The primary endpoint is OS at 12 months.

Results: The trial is ongoing, and results are not yet available.

CONCLUSIONS: The TALENTop trial is a multicenter, open-label, randomized phase III trial comparing LR versus continued atezo/bev in locally advanced HCC after atezo/bev treatment. The primary endpoint is OS at 12 months.



Figure 1: Overall survival (OS) at 12 months. The LR group shows a higher OS rate compared to the atezo/bev group.

Figure 2: OS at 12 months. The LR group shows a higher OS rate compared to the atezo/bev group.

Conclusion: The LR group shows a higher OS rate compared to the atezo/bev group.

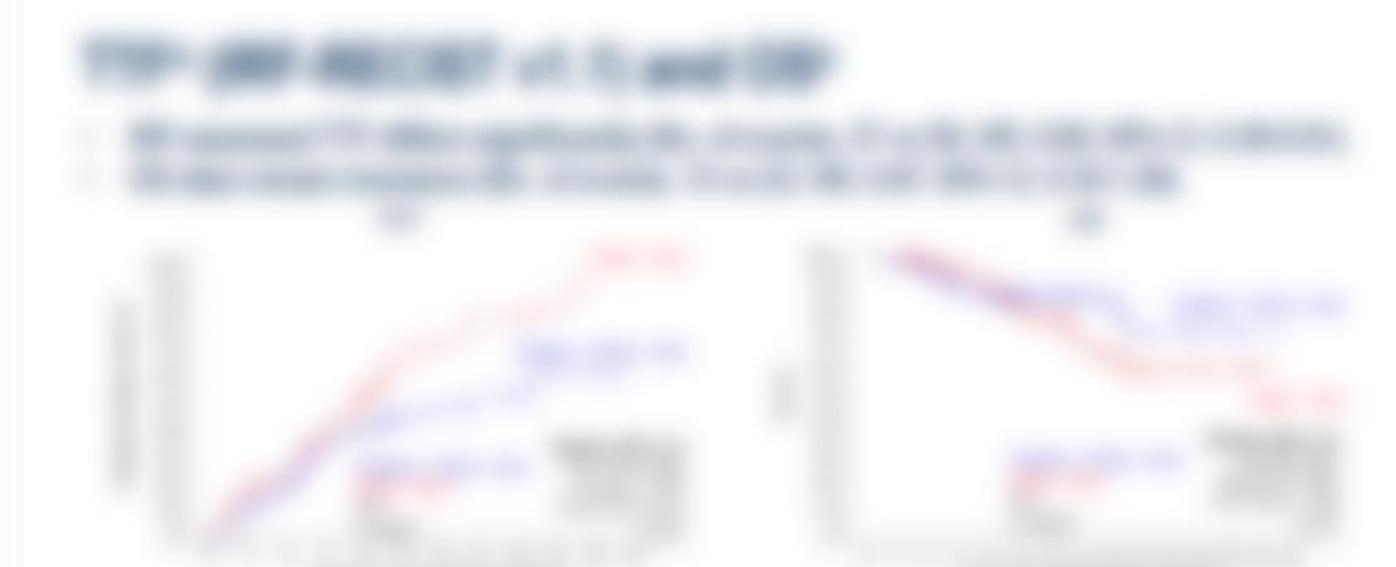


Liver resection versus continued atezolizumab plus bevacizumab (atezo/bev) in locally advanced hepatocellular carcinoma (HCC) after atezo/bev treatment (TALENTop): A multicenter, open-label, randomized phase III trial

Sun HC, et al. Abstract 1469MO

Background: The TALENTop trial is a multicenter, open-label, randomized phase III trial comparing liver resection (LR) versus continued atezolizumab plus bevacizumab (atezo/bev) in locally advanced hepatocellular carcinoma (HCC) after atezo/bev treatment. The primary endpoint is overall survival (OS) at 24 months. Secondary endpoints include progression-free survival (PFS), quality of life (QoL), and safety.

Methods: The trial is a multicenter, open-label, randomized phase III trial. Patients with locally advanced HCC who have received atezo/bev treatment are randomized to either LR or continued atezo/bev treatment. The primary endpoint is OS at 24 months. Secondary endpoints include PFS, QoL, and safety.



Summary: The TALENTop trial is a multicenter, open-label, randomized phase III trial comparing liver resection (LR) versus continued atezolizumab plus bevacizumab (atezo/bev) in locally advanced hepatocellular carcinoma (HCC) after atezo/bev treatment. The primary endpoint is overall survival (OS) at 24 months. Secondary endpoints include progression-free survival (PFS), quality of life (QoL), and safety.



Long-term follow-up GDFATHER-01 trial: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC

Melero I, et al. Abstract 15130

Background: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.

Methods: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.

Results: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.

Conclusion: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.



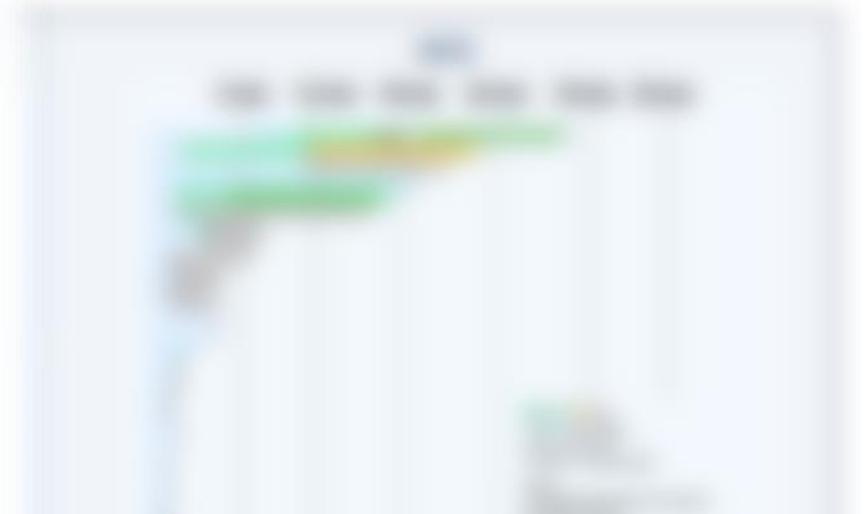
Long-term follow-up GDFATHER-01 trial: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC

Melero I, et al. Abstract 15130

EPICS

Background: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.

Methods: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.



Conclusion: GDF-15 neutralization combined with nivolumab can enable deep, long-term remission in heavily pretreated, anti-PD1/-L1 relapsed/refractory non-squamous NSCLC, urothelial cancer, and HCC.



EPICS

Hepatocellular Carcinoma (HCC)

Discussion



Hepatocellular Carcinoma (HCC)

Definition: Hepatocellular carcinoma (HCC) is a primary liver cancer that arises from the hepatocytes, the main type of liver cell. It is the most common type of liver cancer and the second leading cause of cancer death worldwide.

Pathogenesis: HCC is a multifactorial disease. The most common risk factors are chronic hepatitis B virus (HBV) infection and chronic hepatitis C virus (HCV) infection. Other risk factors include alcohol consumption, non-alcoholic fatty liver disease (NAFLD), and cirrhosis. The pathogenesis involves a long process of genetic and epigenetic changes that lead to the development of a malignant tumor.

Diagnosis: HCC is typically diagnosed through a combination of imaging studies (ultrasound, CT scan, MRI) and blood tests (alpha-fetoprotein (AFP) levels). A liver biopsy may be performed to confirm the diagnosis.



Dr. [Name]
[Title]
[Institution]

[Text]

Hepatocellular Carcinoma (HCC)

DEFINITION: Hepatocellular carcinoma (HCC) is a primary liver cancer that starts in the hepatocytes, the main type of liver cell. It is the most common type of liver cancer and the second leading cause of cancer death in the United States.

CAUSES: The most common cause of HCC is chronic hepatitis B virus (HBV) infection. Other causes include chronic hepatitis C virus (HCV) infection, alcohol-related liver disease, and non-alcoholic fatty liver disease (NAFLD).

RISK FACTORS: Risk factors for HCC include chronic HBV or HCV infection, cirrhosis, alcohol consumption, and obesity. The risk of HCC increases significantly in individuals with cirrhosis.

SYMPTOMS: HCC often does not cause symptoms until it is advanced. Common symptoms include abdominal pain, weight loss, fatigue, and jaundice (yellowing of the skin and eyes).

DIAGNOSIS: HCC is typically diagnosed through imaging studies such as ultrasound, CT scan, or MRI. Blood tests for liver function and tumor markers like alpha-fetoprotein (AFP) can also be helpful.

TREATMENT: Treatment options for HCC depend on the stage of the cancer and the patient's overall health. Options include surgical resection, liver transplantation, and various types of chemotherapy and targeted therapy.



Dr. [Name]
The information on this page is for informational purposes only and is not intended to be used as a substitute for professional medical advice, diagnosis, or treatment. Always consult your healthcare provider for more information.



Hepatocellular Carcinoma (HCC)

QUESTION [blurred text]

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ANSWER [blurred text]

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- [blurred text]
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Hepatocellular Carcinoma (HCC)

QUESTION What is the most common primary liver cancer? What is the most common cause of liver cancer?

ANSWER Hepatocellular carcinoma (HCC) is the most common primary liver cancer. The most common cause of liver cancer is chronic hepatitis B virus (HBV) infection.

QUESTION What are the risk factors for HCC?

ANSWER Risk factors for HCC include chronic hepatitis B virus (HBV) infection, chronic hepatitis C virus (HCV) infection, cirrhosis, alcohol consumption, and exposure to aflatoxins.

QUESTION What are the symptoms of HCC?

ANSWER Symptoms of HCC include abdominal pain, weight loss, jaundice, and fatigue.



QUESTION What is the most common cause of liver cancer?

ANSWER The most common cause of liver cancer is chronic hepatitis B virus (HBV) infection.

Hepatocellular Carcinoma (HCC)

Definition: Hepatocellular carcinoma (HCC) is a primary liver cancer that arises from the hepatocytes, the main type of liver cell. It is the most common type of liver cancer and the second leading cause of cancer-related death worldwide.

Pathogenesis: HCC is a multifactorial disease, with chronic liver disease and cirrhosis being the most common precursors. The most common risk factors include chronic hepatitis B virus (HBV) infection, chronic hepatitis C virus (HCV) infection, alcohol consumption, and non-alcoholic fatty liver disease (NAFLD).

Diagnosis: HCC is typically diagnosed through a combination of imaging studies (ultrasound, CT scan, MRI) and blood tests (alpha-fetoprotein (AFP) levels). A liver biopsy may be performed to confirm the diagnosis.

Staging: HCC is staged based on the extent of tumor spread, including the number and size of tumors, the presence of vascular invasion, and the extent of liver metastasis.

Treatment: Treatment options for HCC depend on the stage of the disease and the patient's overall health. Options include surgical resection, liver transplantation, and various systemic therapies (targeted therapy and immunotherapy).



Dr. [Name]
[Title]
[Institution]

[Text describing the speaker's expertise and the content of the presentation]



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