Visceral and retroperitoneal sarcoma working group

Date: February 4, 2014, 14.00–17.00
Chairmen: *J. Åhlén, Stockholm, T. Hølmebakk, Oslo*

Summary from the meeting

The visceral and retroperitoneal sarcoma working group session on Tuesday 14-17 was well attended by all specialties, both oncologists, radiologists, pathologists and surgeons were represented underlining the importance of multidisciplinary cooperation for correct handling of GIST and the other abdominal and retroperitoneal sarcoma.

Toto Holmebakk presented first their experience from 7 cases treated at the Radiumhospital, Oslo, for retroperitoneal sarcoma, some of which has been included in the STRASS trail. All patients, both those that had got preop radiotherapy and that had not, were generally discussed during the presentation.

Nina Jebsen then presented
Adjuvant radiotherapy in retroperitoneal sarcoma, A Scandinavian sarcoma group study of 98 patients
From 147 patients identified at Lunds and Haukelands university hospital could 98 that underwent curative surgery be included in the study. Median age 62 years and median size 20 cm. Histological type was liposarcoma (61%) and leiomyosarcoma (30%), High-grade malignant in 74%. 43% received radiotherapy, (12% preop). The study showed that radiotherapy in retroperitoneal sarcoma was significantly associated with prolonged local recurrence-free survival, metastasis free survival and overall survival.

Heikki Joensuu, Helsinki, presented two new GIST studies:
SSG XXII: Compare 3 versus 5 year adjuvant treatment in patients with high risk GIST that has got 3 years of adjuvant treatment. Patients that accept to participate will be randomized to either an additional 2 years of treatment with 400 mg Imatinib or just follow up. Dose escalation not allowed except for patients with KIT exon 9 mutations (800mg) but dose reduction to 300 mg is allowed for toxicity. Inclusion criteria is confirmed GIST with mutation analysis done, age ≥18, complete surgery, High-risk GIST and ECOG PS ≤2. Primary endpoint is recurrence-free survival and secondary endpoint is overall survival, GIST-specific survival, adverse events (CTCAEv3.0) and quality of life (EQ-5D instrument) at start of patients within this group will if they to either stop imatinib after 3 years or continue for 2 more years.
300 patients are planed to be included, SSG is sponsor and start is planed to second quarter of 2014.

A second study presented by Heikki Joensuu was the ALT trail
Patient with metastatic or primarily unresectable disease that not has been treated with TKI for metastatic GIST and not have had adjuvant treatment more than 6 month prior to randomization. Additional inclusion criteria, age ≥18, measurable disease, ECOG 0-2, confirmed GIST and tumor tissue available. An exclusion criterion is treatment with warfarin, poorly controlled hypertension, PDGFRA D842 mutation, trombotic or ischemic event, severe heart disease or major surgery within 28 days. The patients will be randomized in two groups, either Imatinib 400mg/day or in the second

arm repeated sequence including 3 weeks of imatininb, 1 week washout, 3 weeks of regorafenib and 1 week washout.
Primary endpoint is progression-free survival and secondary among others overall survival and rate of patients with curative intended surgery.
240 patients with advanced GIST are planed to be included and start within 2014.
Sponsor will be Australasian gastro-intestinal trials group (AGITG)

Mikael Eriksson reported from the PAGIST study, an SSG sponsored study with free drug and administrative support from GSK that started in March 2012. Interim analyses has been done when 22 patients was evaluated and now has 53 of the planed 72 patients been enrolled. It is expected that last patient will be enrolled in May 2014 and results regarding primary endpoint thus expected in August/September.

After the presentations there was a discussion regarding revision of the SSG XVII, guidelines for intra-abdominal and retroperitoneal sarcoma including protocol for neoadjuvant treatment in GIST. The meeting decided to implement the revision and Jan Åhlén, Stockholm, and Toto Hølmebakk, Oslo was appointed responsible for the implementation of this revision.