Visceral and retroperitoneal sarcoma working group

Date: 23 January, 2018

Chairmen: T. Hølmebakk, K. Boye

Summary from the meeting

The visceral and retroperitoneal sarcoma session on Tuesday, 23 January, was well attended by oncologists but unfortunately by only a handful of surgeons.

B. Nilsson, Gothenburg, shared his experience with the use of endoscopic ultrasound in the diagnostic work-up of gastric GIST. He went on to present clinical and experimental data on KIT/PDGFRA sequencing in GISTs considered for neoadjuvant treatment with imatinib.

K. Boye and **T. Hølmebakk**, Oslo, presented a proposal for a clinical trial of neoadjuvant imatinib in GIST. Neoadjuvant treatment is steadily expanding, but there is a paucity of studies supporting its use and international guidelines are vague. In the proposed trial, patients with gastric GISTs larger than 10 cm or intestinal GISTs larger than 5 cm would be included. The end-point would be iatrogenic tumour rupture, and a 50 per cent reduction, as compared with historical data, would be considered positive. Some 90 patients will be needed.

The attendants were generally positive and thought such a trial would be feasible in the main Scandinavian centres. Probably, the inclusion criteria correspond well with current practice except in Oslo where the indications for neoadjuvant treatment have been somewhat more restricted.

There was some concern that this trial would interfere with the SSG XXII trial. However, newly diagnosed patients will only be eligible for the SSG XXII trial three years later, and by 2022-2023, the SSG XXII trial will be closed.

The matter will now be considered more in detail.

K. Boye and **T. Hølmebakk** went on to present data on GIST rupture based on the recently published study (Hølmebakk et al, Ann Surg Oncol 2018) and analyses of the complete Oslo cohort. Whether patients with rupture should be considered metastatic or given adjuvant treatment only is an unsettled question. The data presented strongly indicate that patients with rupture will relapse irrespective of adjuvant therapy and that they should be treated with imatinib, possibly for life. Sounding the audience, this also seems to be the general attitude despite the fact that tumour rupture is an inclusion criterion for the *adjuvant* SSG XXII trial.

M. Eriksson, Lund, gave an up-date on ongoing GIST studies.