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**Neoadjuvant or adjuvant therapy for gastric cancer**

Quéro L *et al*. Gastric cancer treatment

**Laurent Quéro, Sophie Guillerm, Christophe Hennequin**

**Laurent Quéro, Sophie Guillerm, Christophe Hennequin,**Department of Radiation Oncology, Saint Louis Hospital, 75010 Paris, France

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**Correspondence to: Laurent Quéro, MD, PhD,** Department of radiation oncology, Saint Louis Hospital, 1 avenue Claude Vellefaux, 75010 Paris, France. laurent.quero@sls.aphp.fr

**Telephone:** +33-142-499034

**Fax:** +33-142-494081

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**Abstract**

Currently, there is no international consensus on the best treatment regimen for patients with advanced resectable gastric carcinoma. In the United States, where a limited lymph-node dissection is frequently performed, adjuvant chemoradiotherapy after surgery is the standard treatment. In Europe, intensified perioperative chemotherapy is commonly administered. In Japan and South Korea, postoperative S-1-based adjuvant chemotherapy after surgery with D2 lymph-node dissection is the standard treatment. Several ongoing trials are currently evaluating the optimal sequence of chemotherapy, radiotherapy, and surgery, as well as the place of targeted therapeutic agents in the treatment of advanced gastric carcinoma.

**Key words**: Gastric cancer; Radiotherapy; Chemotherapy; Review

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**Core tip:** Gastric cancer (GC) treatment is controversy, particularly between Asia and Western countries. In this paper, we have performed a systematic and up-to-date review of resectable GC treatment strategies and discussed different treatment options. We have also discribed ongoing clinical randomized pahe 3 trials and future directions in GC treatment.

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**INTRODUCTION**

Gastric cancer (GC) is one of the most common cancers worldwide, with a total of 989600 new cases diagnosed and 738000 deaths estimated for 2008, which accounted for 8% of total cancer cases and 10% of total deaths from cancer. Over 70% of new cases and deaths occur in developing countries, with the highest incidence rates in Eastern Asia, Eastern Europe, and South America[1]. In the United States, the incidence of GC is approximately 22000 per year and the mortality rate is nearly 11000 per year[2]. The worldwide incidence of GC has declined rapidly over the last three decades in Western countries.

Patients with resectable gastric carcinoma have a poor prognosis with a 5-year overall survival of approximately 20%–30% worldwide, but, in Japan, patients with gastric carcinoma have a better prognosis with a 70% 5-year overall survival rate. This difference is probably because of screening programs for GC in Japan, where the higher incidence of GC results in detection of disease at an earlier stage in approximately 50% of cases. In contrast, gastric carcinoma is usually diagnosed at a later stage in Western countries where there is no such screening program[3]. Moreover, patients with GC in Western countries more frequently have lesions in the upper third of the stomach, whereas patients from Asia more frequently have lesions in the middle or lower third of the stomach; a lesion in the upper third of the stomach has a worse prognosis than a lesion in the lower third[4,5].

Surgical resection remains the cornerstone treatment for non-metastatic GC. In Asia, particularly in Japan and South Korea, gastrectomy with a D2 lymph-node dissection is the standard surgical treatment. In Europe, two randomized trials, performed in the United Kingdom and the Netherlands, have reported little initial benefit from gastrectomy with a D2 dissection compared to gastrectomy with a D1 dissection[6,7]. However, after a 15-year follow-up, the benefit of a gastrectomy with a D2 dissection was confirmed in the Dutch trial in terms of both locoregional recurrence and gastric-cancer-related death[8]. Gastrectomy with a D2 dissection is now recommended by the National Comprehensive Cancer Networkin the United States[9] and the European Society for Medical Oncology in Europe[10].

Resected GC recurs in multiple patterns: locoregional, peritoneal, and distant sites are common modes of recurrence[11,12].

To improve outcomes in patients with locally advanced GC, several strategies in association with surgical resection have been evaluated, such as neoadjuvant chemotherapy, perioperative chemotherapy, adjuvant chemotherapy, and adjuvant chemoradiotherapy.

**NEOADJUVANT CHEMOTHERAPY**

Several randomized trials have evaluated neoadjuvant chemotherapy before surgery, but have reported conflicting results. To date, four meta-analyses have been published on neoadjuvant chemotherapy for GC[13-16]. The first two meta-analyses were underpowered with only four and five randomized trials analyzed, respectively[13,15]. The third meta-analysis was biased because it included both neoadjuvant chemotherapy and chemoradiotherapy trials[14] (table 1).

In 2014, Xiong *et al*[16] published a meta-analysis based on results extracted from published trial reports on 1820 patients from 12 different studies. Among these 12 studies, six were from Asia and six were from Western countries. The median follow-up period was 53 mo. The meta-analysis showed that patients treated with neoadjuvant chemotherapy plus surgery had only a marginally improved survival benefit over patients treated with surgery alone, with an odds ratio of 1.32 (*p =* 0.001). However, the 3-year progression-free survival rate, the tumor down-staging rate, and the R0-resection rate were better in patients treated with neoadjuvant chemotherapy plus surgery, with odds ratios of 1.85 (*p* < 0.0001), 1.71 (*p =* 0.0006), and 1.38 (*p =* 0.01), respectively. Subgroup analyses showed that patients treated with polychemotherapy or via an IV route had better survival, with odds ratios of 1.14 and 1.42, respectively. Subgroup analyses also showed that 5-year overall survival rates of patients treated with neoadjuvant chemotherapy plus surgery were statistically improved in studies conducted in Western countries, with an odds ratio of 1.39 (*p* < 0.01), whereas similar trials in Asian countries found no significant differences (*p =* 0.32).

**PERIOPERATIVE CHEMOTHERAPY**

In locally advanced disease, preoperative chemotherapy may result in tumor downstaging and eradicate micrometastases. Two randomized trials in Western countries have evaluated perioperative chemotherapy in advanced gastroesophageal junction or GC. The United Kingdom MAGIC randomized trial compared surgery with or without perioperative ECF chemotherapy (epirubicin, cisplatin, infused fluorouracil). A total of 503 patients were enrolled in this trial; most patients had GC (74%), and approximately 50% of patients had a (y)pT3-T4 and 70% had a (y)pN+ tumor[17]. In this study, about 25% and 50% of patients were treated for GC, and received D1 or D2 surgery, respectively. Of the 86% of patients assigned to perioperative-chemotherapy and who received preoperative chemotherapy, only 55% also received postoperative chemotherapy. In this study, perioperative chemotherapy improved overall survival, and local and distant control, when compared with surgery alone. Five-year overall survival rates were 36% for patients treated with perioperative-chemotherapy *vs* 23% for those treated with surgery alone (*p =* 0.009). In the perioperative-chemotherapy group, 14% had local recurrence *vs* 21% in the surgery group. Metastatic progression was also less frequent in the perioperative-chemotherapy group compared to the surgery-only group, at 24% and 37%, respectively (table 2)

In the French ACCORD07/FFCD 9703 multicenter phase-III trial[18], 224 patients with resectable adenocarcinoma of the lower esophagus, the gastroesophageal junction, or the stomach were randomly assigned to receive surgery with or without infused fluorouracil–cisplatin perioperative chemotherapy. In this study, only approximately 25% of the patients had gastric carcinoma; most patients had lower esophageal or gastroesophageal-junction carcinoma (75%). Patients treated with surgery alone had a more advanced tumor than patients treated with surgery plus perioperative chemotherapy. Sixty-eight percent and 80% of patients treated with surgery alone had a (y)pT3-T4 or a (y)pN+ tumor, respectively, compared with 58% and 67% of patients treated with perioperative chemotherapy. Moreover, fewer patients had a R0 resection in the surgery arm compared to the perioperative-chemotherapy arm (74% *vs* 87%, *p =* 0.004). Of the total, 87% of patients received preoperative chemotherapy as planned but only approximately 50% of patients were able to receive postoperative chemotherapy. Patients treated with surgery and perioperative chemotherapy had significantly better 5-year overall survival and disease-free survival rates than patients treated with surgery alone (38% *vs* 24%, *p =* 0.02; 34% *vs* 19%, *p =* 0.003), respectively. In both groups, of the ~80% of patients that had a relapse, this was a distant relapse. In multivariable analyses, perioperative chemotherapy was only significantly effective in patients with cancer within the esophagogastric junction, but not for those with GC; however, the gastric subgroup was too small (*i.e.*, 25% of the population) to distinguish between no effect or a small effect.

**ADJUVANT CHEMOTHERAPY**

Several studies have evaluated adjuvant chemotherapy in GC, but the results are conflicting. Over the past two decades, six meta-analyses have been published regarding the role of adjuvant chemotherapy in GC[19-24]. Five of these six meta-analyses observed improved survival after adjuvant chemotherapy compared to surgery alone[20-24] (table 3).

In 2010, the Global Advanced/Adjuvant Stomach Tumor Research International Collaboration (GASTRIC) group published the largest meta-analysis to date, based on individual data from 3838 patients in 17 different studies. Among these studies, four were conducted in Asia and 13 in Western countries. The median follow-up period was approximately 7 years. This meta-analysis reported a small but significant absolute 5.8% benefit to 5-year overall survival (49.6% *vs* 55.3%, *p* < 0.001) and a 7.4% benefit to 10-year overall survival (37.5% *vs* 44.9%). Adjuvant chemotherapy also improved disease-free survival compared with surgery alone, with an absolute 5.3% benefit at 5 years (48.7% *vs* 54.0%, *p* < 0.001)[24].

The greatest benefit from adjuvant chemotherapy occurred in the Asian studies. Indeed, the Japanese ACTS-GC trial compared surgery with a D2 dissection and either with or without S-1 oral adjuvant chemotherapy in patients with stage-II or -III gastric carcinoma. This trial enrolled 1059 patients between October 2001 and December 2004[25]. Patients treated with surgery plus adjuvant S-1 chemotherapy had significantly better 5-year overall and disease-free survival rates than those treated with surgery alone (71.7% *vs* 61.1% and 65.4% *vs* 53.1%, respectively). Peritoneum and hematogenous metastases represented approximately 80% of the relapses. All tumor subgroups benefited from adjuvant chemotherapy. However, poor outcomes were observed in patients with stage-IIIB gastric carcinoma, with a 5-year overall-survival rate of 50.2% in the S-1 group and 44.1% in the surgery-alone group[26]. This observation suggests the need for therapeutic improvement in advanced gastric carcinoma. Because of these results, adjuvant chemotherapy without radiation for GC has now become the standard-of-care in Japan.

The Asian CLASSIC trial compared surgery with a D2 dissection either with or without adjuvant combined capecitabine/oxaliplatin (XELOX) chemotherapy in 1035 patients with stage II–IIIB gastric carcinoma[27]. After a median follow-up of 34 months, 3-year disease-free and overall-survival rates were significantly better in the XELOX plus surgery group than with surgery only (74% *vs* 59%, *p* < 0.0001; 83% *vs* 78% , *p =* 0.0493, respectively). The most common sites of disease progression were the peritoneum and distant sites (*i.e.*, > 80%).

**ADJUVANT CHEMORADIOTHERAPY**

In the United States, the SWOG 9008/ Intergroup 0116 trial reported a benefit after postoperative chemoradiotherapy. In this trial, 556 patients with locally advanced gastric adenocarcinoma or cancer within the gastroesophageal junction were randomized to receive surgery alone or surgery plus postoperative radiotherapy associated with 5-fluorouracil/leucovorin chemotherapy[28]. Three-year overall survival was 50% in the chemoradiotherapy group *vs* 41% in the surgery-only group (*p =* 0.005). The 3-year relapse-free survival rate was 48% in the chemoradiotherapy group *vs* 31% in the surgery-only group (*p* < 0.001). This benefit from postoperative chemoradiotherapy was confirmed in an update, published by Smalley *et al*[29] in 2012, with 10-year overall survival of 25.9% *vs* 17.3% for surgery only (*p =* 0.0046) and a 10-year relapse-free survival rate of 21.6% *vs* 14.4% (*p* < 0.001).

Local and regional relapses were significantly less frequent in the chemoradiotherapy group, at 2% and 22% *vs* 5% and 31% in the surgery-alone group, respectively (*p =* 0.012). There were no differences in terms of distant relapses between the two groups (16% and 17%, respectively) (table 4).

However, several criticisms have been raised regarding this study. Most patients had limited lymph-node dissection and only 10% of patients received a formal D2 dissection (36% had a D1 and 54% had a D0 dissection) and many patients experienced high rates of acute toxicity (54% and 33% of patients had ≥ grade 3 hematological and gastrointestinal toxicities, respectively). Only 64% of patients completed the protocol treatment in the chemoradiotherapy group: 17% of patients interrupted treatment because of its toxic side-effects and 8% declined further treatment. These high rates of toxicity may be explained by the use of the older 2D radiotherapy technique associated with the 5-fluorouracil Mayo Clinic chemotherapy regimen.

The United States CALGB80101 phase-III trial compared 546 patients with resected gastric or gastroesophageal-junction adenocarcinoma who had adjuvant chemoradiotherapy with the 5-fluorouracil Mayo Clinic chemotherapy regimen (SWOG 9008/Intergroup 0116 protocol) *vs* adjuvant chemotherapy with ECF (epirubicin, cisplatin, 5-fluorouracil) followed by chemoradiotherapy with fluorouracil[30]. Seventy-five percent and 69% of patients completed the planned treatments in the ECF and Mayo 5-fluorouracil arms, respectively. Patients receiving adjuvant ECF chemotherapy had lower rates of grade ≥ 3 diarrhea/mucositis (15% *vs* 7%) and also less grade-4 neutropenia compared to patients receiving the adjuvant fluorouracil Mayo-Clinic chemotherapy regimen (33% *vs* 19%). However, the 3- and 5-year overall survival rates were not significantly improved with ECF compared to fluorouracil (52% *vs* 50% and 44 *vs* 41%, respectively; *p =* 0.8). These results suggest that the intensified chemotherapy in association with adjuvant radiotherapy was better tolerated but was not associated with better outcomes compared to the fluorouracil-based chemoradiotherapy used in the SWOG 9008 / Intergroup 0116 protocol. However, a longer follow-up period is needed to confirm these results.

The Korean phase-3 ARTIST trial randomized 458 patients with locally advanced gastric carcinoma and who had been initially treated with D2 lymph-node dissection. The trial compared postoperative capecitabine–cisplatin chemotherapy *vs* capecitabine–cisplatin chemotherapy plus chemoradiotherapy with capecitabine. In this trial, it is important to note that 60% of patients had early stages of gastric carcinoma (IB and II) and, therefore, had a spontaneously better prognosis than patients with locally advanced-stage carcinoma. Treatment was completed as planned in 75.4% of patients in the chemotherapy arm *vs* 81.7% in the chemoradiotherapy arm.

After a median follow-up of 53.2 months, there was no difference in 3-year disease-free survival (78.2% in the chemotherapy arm *vs* 74.2% in the chemoradiotherapy arm; *p =* 0.0862)[31]. However, in a subgroup analysis of 396 patients with positive pathological lymph nodes, there was statistically better 3-year disease-free survival in patients treated with chemoradiotherapy compared to those treated with chemotherapy (77.5% *vs* 72.3%, *p =* 0.0365). There were no significant differences between the two arms in terms of locoregional recurrence or distant metastases (8.3% *vs* 4.8%; *p =* 0.353 and 24.6% *vs* 20.4%; *p =* 0.557, respectively). Due to the lack of events at the time of analysis, the secondary end point for overall survival was not analyzed.

In a Korean observational study, Kim *et al*[32] compared 544 patients who had received postoperative chemoradiotherapy after a curative D2 dissection with 446 patients who had received surgery without any further treatment. In this study, it is important to note that the proportion of patients with advanced-stage carcinoma was significantly greater in the chemoradiotherapy group than in the surgery-only group (stage IIIA: 34.1% *vs* 26.0%, and stage IV: 21.9% *vs* 13.9%).

Twenty-five percent of patients treated with chemoradiotherapy did not complete the planed protocol: the main reasons for this were its toxic side-effects (40%) and the patient’s refusal to continue (35%). Thirty percent of patients experienced ≥ grade 3 hematological toxicity and 15% experienced ≥grade 3 gastrointestinal toxicity. After a median follow-up of 66 months, the 5-year overall survival and relapse-free survival rates were better in patients treated with chemoradiotherapy compared to those treated with surgery only (57.1% *vs* 51%; *p =* 0.0198, and 54.5% *vs* 47.9%; *p =* 0.0161, respectively). Locoregional recurrence rate was significantly lower in patients treated with chemoradiotherapy compared to those treated with surgery alone (14.9% *vs* 21.7%, *p =* 0.005). The occurrence of distant metastases did not differ between the treatment groups (37.7%).

A Chinese randomized trial compared postoperative fluorouracil–leucovorin chemotherapy *vs* intensity modulated radiation therapy plus fluorouracil–leucovorin chemotherapy in 380 patients initially treated with a D2 dissection for locally advanced gastric carcinoma (70% had stage III or IV disease). Five-year overall survival in those that received postoperative radiotherapy was better than for those treated with chemotherapy only, but this difference was not statistically significant (48.4% *vs* 41.8%, *p =* 0.122). The 5-year recurrence-free survival rate in patients receiving chemoradiotherapy was also better (45.2% *vs* 35.8%, *p =* 0.029)[33]. Patients treated with chemoradiotherapy also had less local relapses than those treated with chemotherapy only (15.6% *vs* 24.2%; *p =* 0.042). However, the occurrence of distant metastases did not differ between the arms (24.2% *vs* 26.7%, *p =* 0.595). In this study, multivariate analyses showed that a positive lymph node and TNM stage were both independent prognostic factors.

**ONGOING TRIALS AND FUTURE DIRECTIONS**

The ongoing CRITICS (ChemoRadiotherapy after Induction chemotherapy In Cancer of the Stomach) phase-III study (NCT00407186) is comparing patients undergoing preoperative ECC (epirubicin, cisplatin, capecitabine) chemotherapy followed by a D1 dissection, with patients receiving postoperative ECC chemotherapy alone, with patients receiving radiotherapy plus concurrent capecitabine + cisplatin[34]. The study plans to accrue 788 patients with gastric carcinoma. The primary endpoint of the study is overall survival; secondary endpoints are disease-free survival, toxicity, health-related quality of life, prediction of response, and recurrence risk, assessed by genomic and expression profiling (table 5).

The international ongoing phase-II/III EORTC 22114–40111 TOP GEAR study (Trial Of Preoperative therapy for Gastric and Esophagogastric junction AdenocaRcinoma) (NCT01924819) is currently testing whether adding chemoradiotherapy to ECF or ECC chemotherapy is superior to ECF or ECC chemotherapy alone for the preoperative treatment of resectable esophagogastric-junction or gastric carcinoma when treated with at least a D1 dissection (D2 dissection recommended). The phase-II part of this study is being conducted in 35 medical centers in nine countries: Belgium, France, Germany, Israel, Czech Republic, Slovenia, Spain, Turkey, and Italy, and is planning to accrue 120 patients. The study is designed to demonstrate the efficacy of chemoradiotherapy. The phase-III trial plans to accrue 752 patients and will determine whether chemoradiotherapy is superior to chemotherapy in these patients.

The Korean ARTIST II phase-III trial (NCT01761461) plans to accrue 1000 patients with stage-II or -III gastric or gastroesophageal carcinoma with positive lymph nodes (AJCC 2010), and who are being treated with curative gastrectomy and more than a D2 lymph-node dissection. This three-arm trial is currently comparing surgery + adjuvant S-1 chemotherapy for 1 year, *vs* surgery + adjuvant SOX (S-1 and oxaliplatin) chemotherapy, *vs* surgery + adjuvant SOX (S-1 and oxaliplatin) chemotherapy + radiotherapy. The primary endpoint of the study is disease-free survival.

The United Kingdom MRC MAGIC-B /ST03 study (NCT00450203) is an ongoing phase-II/III study being conducted in 106 UK centers, which plans to accrue 1100 patients with histological stage Ib (T1 N1, T2a/b N0), II, III or stage IV (T4 N1 or N2) gastric or gastroesophageal-junction carcinoma. This randomized trial is currently comparing standard surgery + ECC (epirubicin, cisplatin, capecitabine) perioperative chemotherapy *vs* standard surgery + ECC perioperative chemotherapy + bevacizumab. Primary endpoints are the safety and efficacy of the phase-II trial and overall survival in the phase-III trial. Secondary endpoints are response rates to preoperative treatment, surgical-resection rates, disease-free survival, quality of life, and cost-effectiveness. A pilot study within ST03, which is randomizing *HER2*-positive patients to standard ECX with modified ECX plus Lapatinib (Tyverb), will assess the safety and *HER2* positivity rate in 40 patients.

The Japanese JCOG 0501 phase-III trial (NCT00252161) plans to accrue 316 patients, from 35 institutions, with type-4 and large type-3 gastric carcinoma and who have undergone a gastrectomy + more than a D2 dissection. The primary endpoint will be overall survival; secondary endpoints will be progression-free survival, response rate, proportion completing treatment, proportion having a curative resection, and adverse events.

The ongoing Korean PRODIGY phase-III randomized trial (NCT01515748) plans to accrue 640 patients with resectable advanced GC (T2–3, N+, or T4 tumors). This study is currently testing neoadjuvant DOS (docetaxel, oxaliplatin, S-1) chemotherapy + surgery + adjuvant S-1 chemotherapy for 1 year *vs* surgery + adjuvant S-1 chemotherapy for 1 year. The primary endpoint is progression-free survival; the secondary endpoints are overall survival, stage distribution between the groups assessed after surgery, and R0 resection rate.

***Targeted therapy in*** *GC*

Several molecular pathways are known to be involved in gastric carcinogenesis, such as HER2, HER3, EGFR, HGFR/c-MET, E-Cadherin, MMP, VEGF/VEGFR, WNT/β-catenin, FGFR and Akt/PI3K/mTOR[35]. Targeted and biological therapies are promising treatments in advanced GC. Combining chemotherapy with a targeted therapy may improve the complete pathological response (pCR) and survival, but also individualize therapies and reduce toxicities.

HER2 is a transmembrane growth-factor receptor encoded by the proto-oncogene *ERBB2*, which is located on chromosome 17q21. The frequency of HER2-positive GC varies considerably between studies, ranging from 6.0%–36.6%[36].

HER2 overexpression has been shown to predict the response to trastuzumab, a humanized recombinant monoclonal antibody that selectively binds to the extracellular domain of HER2, thereby blocking its downstream signaling. In the randomized ToGA trial, the addition of trastuzumab to cisplatin + capecitabine–fluorouracil significantly improved the objective response rate from 35% to 47% (*p* = 0.0017), progression-free survival from 5.5 to 6.7 mo (*p* = 0.0002), and overall survival from 11.1 to 13.8 months (*p* = 0.0046)[37].

The ongoing German HERFLOT AIO-STO-0310 multicenter phase-II study is currently testing perioperative chemotherapy with 5-FU, leucovorin, docetaxel, and oxaliplatin (FLOT) in combination with trastuzumab in patients with HER2-positive, locally advanced, resectable adenocarcinoma of the gastroesophageal junction or stomach (NCT01472029). The primary endpoint is the rate of pCR. Hofheinz *et al*[38] reported the preliminary results from the first 25 patients at the 2014 ASCO meeting: A pCR was found in 22% of patients and near complete regression (< 10 % residual tumor cells) was observed in 24% of patients. The complete resection rate was 90%.

The Spanish NEOHX multicenter phase-II study evaluated the efficacy and toxicity profile for perioperative XELOX-T (capecitabine, oxaliplatin, trastuzumab) followed by adjuvant trastuzumab as a monotherapy in patients with advanced resectable stomach or esophagogastric-junction adenocarcinoma that was HER-2+. The primary endpoint was 18-month disease-free survival. By the end of the study, 36 patients had been included. Preliminary results were reported at the 2013 ASCO meeting: pCR was observed in 19% and complete-resection rate (R0) was observed in 78% of patients. However, the follow-up period was too short for disease-free survival or overall survival to be assessed[39].

The future EORTC randomized phase-II trial (INNOVATION) will test neoadjuvant chemotherapy with cisplatin–capecitabine plus trastuzumab *vs* cisplatin–capecitabine plus trastuzumab plus pertuzumab in HER2-positive resectable gastric or gastroesophageal-junction adenocarcinoma (NCT02205047). Pertuzumab is a humanized monoclonal antibody that binds to extracellular dimerization domain II of HER2, and inhibits heterodimerization of HER2 with other HER family members, especially HER2–HER3, which is the most potent signaling HER heterodimer. The primary endpoint will be the rate of major pathological response (*i.e.*, <10% vital tumor cells).

**CONCLUSION**

Currently, the treatment for locally advanced gastric carcinoma is based on R0 surgical resection with D2 lymph-node dissection. A D1 lymph-node dissection, with at least 15 lymph nodes resected, could also be performed in less experienced centers. Complementary treatment after curative surgical resection in T3 and/or N+ gastric carcinoma should be discussed. Perioperative chemotherapy and adjuvant chemoradiotherapy have significantly improved overall survival compared to surgery alone in Europe and the USA. In Asia, adjuvant chemotherapy, with S-1 or XELOX delivered after surgery + a D2 lymph-node dissection has shown significantly improved survival compared to surgery alone. Ongoing randomized trials are currently testing the efficacy of adjuvant chemoradiotherapy after neoadjuvant chemotherapy; intensified chemotherapy, and targeted therapy plus chemotherapy.

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**Table 1 neoadjuvant chemotherapy in gastric carcinoma: randomized meta-analysis**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Studies** | **Country** | **Years** | **Randomization arms**  | **Surgery** | **Protocol** | **Patients (n)** | **Overall survival** | ***P* value** | **Disease free survival** | ***P* value** |
| **Neoadjuvant chemotherapy** |  |  |
| Xiong *et al*[16] meta-analysis | - | 2014 | chemotherapy | - | - | 753  | 46.6% at 53 mo1 | 0.01 | 41.1% at 3 yr1 | < 0.0001 |
|  |  |  | Surgery only |  | - | 813 | 43.7% at 53 mo |  | 27.5% at 3 yr |  |

1statistically significant result.

**Table 2 perioperative chemotherapy in gastric carcinoma: randomized trials**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Studies** | **Country** | **Years** | **Randomization arms**  | **Surgery** | **Protocol** | **Patients (n)** | **Overall survival** | ***P* value** | **Disease free survival** | ***P* value** |
| MRC MAGIC trial[17] | United Kingdom | 2006 | Chemotherapy and surgery | 42.5% D2 surgery | ECF chemotherapy | 250 | 36.3% at 5 yr1 | 0.009 | 34.8% at 5 yr1 | < 0.001 |
|  |  |  | Surgery alone |  |  | 253 | 23% at 5 yr |  | 24.9% at 5 yr |  |
| ACCORD07/FFCD 9703 trial[18] | France | 2011 | Chemotherapy and surgery | D2 recommended | 5FU-CDDP chemotherapy | 113 | 38% at 5 yr1 | 0.02 | 34% at 5 yr1 | 0.003 |
|  |  |  | Surgery alone |  |  | 111 | 24% at 5 yr |  | 19% at 5 yr |  |

1statistically significant result. ECF: Epirubicin, cisplatin, and 5-fluorouracil; 5FU: 5-fluorouracil; RT: Radiotherapy; CDDP*:* Cisplatin.

**Table 3 adjuvant chemotherapy in gastric carcinoma: randomized trials/meta-analysis**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Studies** | **Country** | **Years** | **Randomization arms**  | **Surgery** | **Protocol** | **Patients (*n*)** | **Overall survival** | ***P* value** | **Disease free survival** | ***P* value** |
| ACTS-GC trial[25,26] | Japan | 2007 | Chemotherapy and surgery | D2 surgery | Oral S1 chemotherapy | 529 | 71.7% at 5 yr1 | - | 65.4% at 5 yr1 | - |
|  |  |  | Surgery alone |  |  | 530 | 61.1% at 5 yr |  | 53.1% at 5 yr |  |
| GASTRIC metaanalysis[24] | - | 2010 | Chemotherapy | - | - | 1924 | 55.3% at 5 yr1 | < 0.001 | 54% at 5 yr1 | < 0.001 |
|  |  |  | Surgery only |  | - | 1857 | 49.6% at 5 yr |  | 48.7% at 5 years |  |
| CLASSIC trial[27] | South Korea | 2012 | Chemotherapy and surgery | D2 surgery | XELOX chemotherapy | 520 | 83% at 3 yr1 | 0.0493 | 74% at 3 yr1 | < 0·0001 |
|  |  |  | Surgery alone |  |  | 515 | 78% at 3 yr |  | 59% at 3 yr |  |

1statistically significant result. XELOX: Xeloda and oxaliplatin.

**Table 4 adjuvant chemoradiotherapy in gastric carcinoma: randomized trials**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Studies** | **Country** | **Years** | **Randomization arms**  | **Surgery** | **Protocol** | **Patients (n)** | **Overall survival** | ***P* value** | **Disease free survival** | ***P* value** |
| INT 0116 trial[28,29] | United States | 2001 | Chemoradiotherapy and surgery | 10% D2 surgery | 5FU Mayo clinic/5FU RT | 281 | 50% at 3 yr1 | 0.005 | 48% at 3 yr1 | < 0.001 |
|  |  |  | Surgery alone |  |  | 275 | 41% at 3 yr |  | 31% at 3 yr |  |
| Chinese multicentre trial[33] | China | 2012 | Chemoradiotherapy and surgery | D2 surgery | 5FU RT | 186 | 48.4% at 5 yr | 0.122 | 45.2% at 5 yr1 | 0.029 |
|  |  |  | Chemotherapy and Surgery  |  | 5FU chemotherapy | 165 | 41.8% at 5 yr |  | 35.8% at 5 yr |  |
| ARTIST trial[31] | South Korea | 2012 | Chemoradiotherapy and surgery | D2 surgery | Xeloda CDDP/Xeloda RT  | 230 | - | - | 74.2% at 3 yr | 0.0862 |
|  |  |  | Chemotherapy and Surgery  |  | Xeloda CDDP  | 228 | - |  | 78.2% at 3 yr |  |
| CALGB80101 trial[30] | United States | 2011 | Chemoradiotherapy and surgery | Not available | ECF/5FU RT | 266 | 52% at 3 yr | 0.8 | 47% at 3 yr | 0.99 |
|  |  |  | Chemoradiotherapy and surgery |  | 5FU Mayo/5FU RT | 280 | 50% at 3 yr |  | 46% at 3 yr |  |

1statistically significant result. 5FU: 5-fluorouracil; RT: Radiotherapy; CDDP*:* Cisplatin.

**Table 5 Ongoing phase-III randomized trials**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study** | **Country** | **No. registration** | **Standard arm** | **Experimental arm** | **Patients (*n*)** |
| **Neoadjuvant chemoradiotherapy** |
| EORTC 22114 - 40111 TOP GEAR study | Europe | NCT01924819 | ECC/ECF preoperative CT | ECC/ECF preoperative CT and RTCT preoperative | 752 |
|  |
| **Perioperative chemotherapy** |
| MAGIC-B/ST03 study | United Kingdom | NCT00450203 | ECC perioperative CT | ECC + bevacizumab perioperative CT | 1100 |
| PRODIGY trial | SouthKorea | NCT01515748 | S-1 adjuvant CT  | Neoadjuvant DOS CT and S-1 postoperative CT | 640 |
|  |
| **Adjuvant chemotherapy** |
| ARTIST II Trial | SouthKorea | NCT01761461 | S-1 adjuvant CT (arm 1) | SOX adjuvant CT (arm 2), S-1 and RT adjuvant (arm 3) | 1000 |
|  |
| **Adjuvant chemoradiotherapy** |
| CRITICS Trial | The Netherlands | NCT00407186 | ECC perioperative CT | ECC preoperative CT and RTCT postoperative | 788 |
|  |

CT: chemotherapy; RTCT: Radiochemotherapy; ECC: Epirubicin, cisplatin and capecitabine; ECF: Epirubicin, cisplatin, and fluorouracil; DOS: Docetaxel, oxaliplatin, and S-1; SOX: S-1 and oxaliplatin.