Esophageal and Esophagogastric Junction Cancers, Version 2.2019

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ABSTRACT

Esophageal cancer is the sixth leading cause of cancer-related deaths worldwide. Squamous cell carcinoma is the most common histology in Eastern Europe and Asia, and adenocarcinoma is most common in North America and Western Europe. Surgery is a major component of treatment of locally advanced resectable esophageal and esophagogastric junction (EGJ) cancer, and randomized trials have shown that the addition of preoperative chemoradiation or perioperative chemotherapy to surgery significantly improves survival. Targeted therapies including trastuzumab, ramucirumab, and pembrolizumab have produced encouraging results in the treatment of patients with advanced or metastatic disease. Multidisciplinary team management is essential for all patients with esophageal and EGJ cancers. This selection from the NCCN Guidelines for Esophageal and Esophagogastric Junction Cancers focuses on recommendations for the management of locally advanced and metastatic adenocarcinoma of the esophagus and EGJ.


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Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

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Clinical trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

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The complete NCCN Guidelines for Esophageal and Esophagogastric Junction Cancers are not printed in this issue of JNCCN but can be accessed online at NCCN.org.

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Disclosures for the NCCN Esophageal and Esophagogastric Junction Cancers Panel

At the beginning of each NCCN Guidelines Panel meeting, panel members review all potential conflicts of interest. NCCN, in keeping with its commitment to public transparency, publishes these disclosures for panel members, staff, and NCCN itself. Individual disclosures for the NCCN Esophageal and Esophagogastric Junction Cancers Panel members can be found on page 883. (The most recent version of these guidelines and accompanying disclosures are available at NCCN.org.)

The complete and most recent version of these guidelines is available free of charge at NCCN.org.
Overview

Upper gastrointestinal (GI) tract cancers originating in the esophagus and esophagogastric junction (EGJ) constitute a major global health problem, especially in low and middle income countries. Globally, there were an estimated 572,000 cases resulting in more than 508,000 deaths in 2018, making esophageal cancer the seventh most frequently diagnosed cancer and the sixth leading cause of cancer-related deaths in the world. In contrast, esophageal cancer is one of the least commonly diagnosed cancers in North America. In 2019, an estimated 17,650 people will be diagnosed and 16,080 people will die of this disease in the United States, making esophageal cancer the 20th most commonly diagnosed cancer and the 11th leading cause of cancer-related death in America.

Esophageal cancers are histologically classified as squamous cell carcinoma (SCC) or adenocarcinoma, which differ in their pathology, tumor location, and prognosis. In contrast to adenocarcinoma, SCC is more likely to localize near the tracheal bifurcation, has a proclivity for earlier lymphatic spread, and is associated with a poorer prognosis. SCC is the most common histology in Eastern Europe and Asia, and adenocarcinoma is most common in North America and Western Europe. Tobacco and alcohol consumption are major risk factors for esophageal SCC and obesity has been established as the strongest risk factor for esophageal and EGJ adenocarcinoma. SCC has become less common in the West over recent decades due to reductions in tobacco and alcohol use, and now accounts for <30% of all esophageal cancers in the United States and Western Europe. In contrast, the incidence of esophageal adenocarcinoma has increased in the West, likely reflecting rising rates of obesity.

In North America, where screening programs for early detection of esophageal and EGJ cancers are not in use or practical because of low incidence, diagnosis is often made late in the disease course. At diagnosis, nearly 50% of patients have cancer that extends beyond the locoregional confines of the primary tumor and <60% of patients with locoregional cancers can undergo a curative resection. Approximately 70% to 80% of resected specimens harbor metastases in the regional lymph nodes. Thus, patients in North America often have advanced-stage disease at the time of initial diagnosis, which is reflected by the low survival rates seen with esophageal and EGJ cancers in this region.

This selection from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Esophageal and Esophagogastric Junction Cancers focuses on the
management of locally advanced and metastatic adenocarcinoma of the esophagus and EGJ (to view the complete and most recent version of these guidelines, visit NCCN.org).

**Staging**

The tumor (T), node (N), and metastasis (M) staging system used by the AJCC is the internationally accepted standard for cancer staging and is a major factor influencing prognosis and treatment decisions. The eighth edition of the *AJCC Cancer Staging Manual* provides additional resources for esophageal and EGJ cancers not available in the seventh edition, including the incorporation of newly constructed clinical (c) and post-neoadjuvant pathologic (yp) stage groupings, to fulfill unmet needs in staging patients under different circumstances. The stage groupings presented in the eighth edition are based on updated data with a significantly increased sample size and number of risk adjustment variables. The current stage groupings were determined using a risk-adjusted random survival forest analysis of collated data generated by the Worldwide Esophageal Cancer Collaboration (WECC) for 22,654 patients spanning 6 continents who were treated with esophagectomy alone or esophagectomy with preoperative and/or postoperative therapy. Use of these data reflects the current preference for treating locally advanced esophageal cancers with preoperative therapy and represents a major advancement over the seventh edition, which was entirely based on data from patients treated with esophagectomy alone. The availability of these data led to the ability to explicitly define cTNM and ypTNM cohorts and stages. The larger dataset also allowed for better separation of SCC and adenocarcinoma staging. However, limitations of this dataset still remain, including missing patient variables, heterogeneity of clinical staging among different centers, and poor representation of patients with untreatable or inoperable cancers, such as T4b and M1 cancers. Additionally, the exact modalities used to arrive at the initial clinical stages were not available for analysis. Nevertheless, the eighth edition of the *AJCC Cancer Staging Manual* represents the best worldwide clinical esophageal cancer staging data currently available.

In esophageal cancer, patient survival is best correlated with pathologic (p) stage, regardless of whether the patient has received preoperative therapy. Survival analysis of these data revealed that survival decreased with increasing anatomic tumor size and depth (pT), presence of regional lymph node metastases (pN), presence
of distant metastases (pM), increasing histologic grade (G1–4), and advancing age.\textsuperscript{13,14} Survival increased with a more distal location of cancer within the esophagus. In addition, survival was significantly affected by histopathologic type, with SCC having worse survival than adenocarcinoma.\textsuperscript{14} Analysis of this larger dataset also illuminated significant differences in outcome when comparing the same stage groups between patients receiving preoperative therapy versus those treated with surgery alone. This emphasizes the importance of having separate p and yp stage groupings to stage patients more accurately within each treatment algorithm. Although surgical pathology yields the most accurate staging, advances in endoscopic techniques and imaging modalities such as endoscopic ultrasound (EUS), CT, and 18-fluorodeoxyglucose (FDG)-PET/CT have greatly improved the accuracy of clinical staging.\textsuperscript{15}

Siewert Classification of EGJ Adenocarcinoma

Siewert classification divides EGJ adenocarcinoma into 3 types based purely on the anatomic location of the epicenter of the tumor or the majority of the tumor mass.\textsuperscript{16} Siewert type I tumors are defined as an adenocarcinoma of the lower esophagus with the tumor epicenter located within 1 to 5 cm above the anatomic EGJ.\textsuperscript{17} Siewert type II tumors are defined as a true carcinoma of the cardia with the tumor epicenter located within 1 cm above and 2 cm below the EGJ. Siewert type III tumors are defined as a subcardial carcinoma with the tumor epicenter located between 2 cm below and 5 cm below the EGJ, which infiltrates the EGJ and the lower esophagus from below. In the eighth edition of the AJCC Cancer Staging Manual, EGJ tumors with epicenters located within 2 cm of the proximal stomach (Siewert types I and II) are staged as esophageal adenocarcinoma.\textsuperscript{7} EGJ tumors with epicenters located 2 cm into the stomach (Siewert type III) are now staged using the gastric cancer staging system. In general, Siewert types I and II tumors should be managed in accordance with guidelines for esophageal and EGJ cancers, while Siewert type III tumors are more appropriately managed in accordance with guidelines for gastric cancer.

**Principles of Biomarker Testing**

Presently, molecular testing for HER2 status, microsatellite instability status, and programmed death-ligand 1 (PD-L1) expression are used in the clinical management of locally advanced, unresectable, and metastatic esophageal and EGJ cancers.
Assessment of HER2 Positivity

Overexpression or amplification of the HER2 gene or protein has been implicated in the development of esophageal and EGJ cancers. However, unlike in breast cancer, the prognostic significance of HER2 status in esophageal and EGJ cancer is unclear. Some studies have reported that HER2 positivity is correlated with tumor invasion and lymph node metastasis, and thus indicates a poor prognosis. Although further studies are needed to assess the prognostic significance of HER2 status in esophageal cancer, the addition of HER2 monoclonal antibodies to chemotherapy regimens is a promising treatment option for patients with HER2-positive metastatic disease. The reported rates of HER2 positivity in esophageal and EGJ cancers vary widely (2%–45%) and is more frequently seen in adenocarcinoma of the esophagus (15%–30%) than in SCC (5%–13%). Additionally, HER2 positivity has been reported to be higher in patients with EGJ adenocarcinomas than in patients with gastric adenocarcinomas. In the ToGA trial that evaluated the addition of trastuzumab to chemotherapy in patients with HER2-positive advanced EGJ or gastric cancers, HER2-positivity rates were 33% and 21%, respectively, for patients with EGJ and gastric cancers. Therefore, classification of gastro-esophageal cancers based on histologic subtype and primary tumor location may have implications for therapy.

HER2 testing is recommended for all patients with esophageal or EGJ cancer at the time of diagnosis if metastatic disease is documented or suspected (see ESOPH-1, page 856). In concordance with HER2 testing guidelines from the College of American Pathologists (CAP), American Society for Clinical Pathology (ASCP), and ASCO, the NCCN Guidelines recommend using immunohistochemistry (IHC) and, if needed, in situ hybridization (ISH) techniques to assess HER2 status in esophageal and EGJ cancers (see ESOPH-B page 3 of 5, page 865). IHC evaluates the membranous immunostaining of tumor cells, including the intensity and extent of staining and the percentage of immunoreactive tumor cells, with scores ranging from 0 (negative) to 3+. In 2008, Hofmann et al refined this 4-tiered scoring system to assess HER2 status in gastric cancer by using a cut-off of ≥10% immunoreactive tumor cells for resection specimens. In a subsequent validation study (n=447 prospective diagnostic gastric cancer specimens), this scoring system was found to be reproducible between different pathologists. This modified HER2 scoring system is therefore recommended by the panel. A score of 0 (membranous reactivity in <10% of cancer cells) or 1+ (faint membranous reactivity in ≥10% of cancer cells)
is considered to be HER2-negative. A score of 2+ (weak to moderate membranous reactivity in ≥10% of cancer cells) is considered equivocal and should be additionally examined by fluorescence in situ hybridization (FISH) or other ISH methods. FISH/ISH results are expressed as the ratio between the number of copies of the HER2 gene and the number of chromosome 17 centromeres (CEP17) within the nucleus counted in at least 20 cancer cells (HER2:CEP17). Alternatively, FISH/ISH results may be given as the average HER2 copy number per cell. Cases that have an IHC score of 3+ (strong membranous reactivity in ≥10% of cancer cells) or an IHC score of 2+ and are FISH/ISH positive (HER2:CEP17 ratio ≥2 or average HER2 copy number ≥6 signals/cell) are considered HER2 positive. Positive (3+) or negative (0 or 1+) HER2 IHC results do not require further ISH testing.

Assessment of Microsatellite Instability and PD-L1 Expression

In its first-ever site-agnostic approval, the U.S. FDA approved pembrolizumab for the treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR) solid tumors in the second-line or subsequent setting. Therefore, MSI-H/dMMR status should be assessed in all patients with esophageal or EGJ adenocarcinoma if metastatic disease is documented or suspected (see ESOPH-1, page 856). MMR status is assessed by IHC staining to measure expression levels of proteins involved in DNA mismatch repair (ie, MLH1, MSH2, MSH6, PMS2). MSI is assessed by polymerase chain reaction to measure gene expression levels of microsatellite markers (ie, BAT25, BAT26, MONO27, NR21, NR24). It should be noted that IHC for MMR and polymerase chain reaction for MSI are different assays measuring the same biological effect. Testing is performed on formalin-fixed, paraffin-embedded tissue and results are interpreted as MSI-H or dMMR in accordance with CAP DNA Mismatch Repair Biomarker Guidelines.

In addition, pembrolizumab has been granted accelerated FDA approval as a third- or subsequent-line treatment option for patients with recurrent locally advanced or metastatic EGJ adenocarcinoma whose tumors express PD-L1 with a combined positive score (CPS) ≥1 as determined by an FDA-approved companion diagnostic test (see ESOPH-B page 4 of 5, page 866). This is a qualitative IHC assay using anti-PD-L1 antibodies for the detection of PD-L1 protein levels in formalin-fixed, paraffin-embedded tumor tissue. CPS is determined by...
the number of PD-L1 staining cells (tumor cells, lymphocytes, macrophages) divided by the total number of viable tumor cells evaluated, multiplied by 100. The panel recommends that this pembrolizumab treatment option also be extended to patients with esophageal adenocarcinomas with PD-L1 expression levels by CPS of ≥1. The panel also recommends second-line treatment with pembrolizumab for esophageal cancers with PD-L1 expression levels by CPS of ≥10 (category 2B). The yp prefix is used to indicate cases in which staging is performed following preoperative therapy.

\[ \text{PD-L1 CPS} = \frac{\text{number of PD-L1 staining cells}}{\text{total number of viable tumor cells}} \times 100 \]

Principles of Surgery

Surgery is a major component of treatment of locoregional esophageal and EGJ cancers. Improvements in staging techniques, patient selection, postsurgical care, and surgical experience have led to a marked reduction in surgical morbidity and mortality in recent years. Additionally, randomized trials have shown that preoperative chemoradiation and perioperative chemotherapy have significantly improved survival in patients with resectable, locoregionally advanced esophageal and EGJ cancers.

All patients should be evaluated to determine whether they are medically fit enough to tolerate general anesthesia and major abdominal and/or thoracic surgery. Before surgery, clinical staging should be performed to assess resectability with CT scan of the chest and abdomen, whole-body FDG-PET (integrated FDG-PET/CT scan is preferred), and EUS. Esophagectomy should be considered for all medically fit patients with resectable esophageal cancer (>5 cm from cricopharyngeus). Cervical or cervicothoracic esophageal cancers <5 cm from the cricopharyngeus should be treated with definitive chemoradiation. Enteral nutritional support should be considered for patients with significant dysphagia and/or weight loss before or during induction therapy. A jejunostomy feeding tube is preferred over a gastrostomy feeding tube for preoperative nutritional support because placement of a gastrostomy tube may compromise the integrity of gastric conduit for reconstruction.

The Siewert tumor type should be assessed in all patients with adenocarcinomas involving the EGJ. The surgical approaches for Siewert type I and II tumors are described in the NCCN Guidelines for Gastric Cancer (available at NCCN.org).
In some cases, additional esophageal resection may be necessary to obtain adequate surgical margins. Laparoscopy may be useful in select patients for the detection of radiographically occult metastatic disease, especially in patients with Siewert type II and III tumors. Positive peritoneal cytology in the absence of visible peritoneal metastases is associated with poor prognosis in patients with EGJ adenocarcinoma. Patients with advanced tumors or node-positive tumors should be considered for laparoscopic staging with peritoneal washings.

Lymph node dissection (lymphadenectomy) can be performed using the standard or extended (en-bloc) technique. The number of lymph nodes removed has been shown to be an independent predictor of survival after esophagectomy. In a retrospective analysis of 4,882 patients in the SEER database, patients diagnosed with invasive esophageal cancer who had ≥12 lymph nodes examined had significantly reduced mortality compared with those who had 0 to 11 lymph nodes examined; patients who had ≥30 lymph nodes examined had the lowest mortality of any group. A report from the WECC database, which analyzed 4,627 patients who had esophagectomy without preoperative therapy, suggested that a greater extent of lymphadenectomy was associated with increased survival for all patients with node-positive cancers. Based on this study, optimum lymphadenectomy in node-positive cancers was 10 nodes for pT1, 15 nodes for pT2, and 29 to 50 nodes for pT3/T4. Therefore, the NCCN Guidelines recommend that a thorough dissection be performed to identify all lymph nodes with at least 15 lymph nodes submitted for pathologic evaluation and adequate nodal staging in patients undergoing esophagectomy without preoperative chemoradiation.

**Combined Modality Therapy**

Combined modality therapy has been shown to significantly increase survival in patients with esophageal or EGJ cancer with locoregional disease compared with resection alone. Preoperative chemoradiation is the preferred approach for localized resectable disease. Perioperative chemotherapy or preoperative chemotherapy are alternative options for adenocarcinoma of the thoracic esophagus or EGJ. Other treatment options include postoperative chemoradiation and postoperative chemotherapy. Definitive chemoradiation should be reserved for patients with unresectable disease or those who decline surgery.
Preoperative Chemoradiation Therapy

Preoperative chemoradiation therapy is associated with improved overall survival (OS), disease-free survival (DFS), and pathologic complete response (pCR) compared with preoperative chemotherapy or surgery alone in patients with locoregional esophageal cancer. Results from the multicenter phase III randomized CROSS trial, the largest trial in its class, showed that preoperative chemoradiation with paclitaxel and carboplatin significantly improved OS and DFS compared with surgery alone in patients with resectable esophageal or EGJ cancers (n = 366; 75% had adenocarcinoma). Median OS was 49 months in the preoperative chemoradiation arm (n = 178) compared with 24 months in the surgery alone arm (n = 188; hazard ratio [HR] = 0.657; 95% CI, 0.495–0.871; P = .003). The R0 resection rate was also higher in the preoperative chemoradiation arm compared with the surgery alone arm (92% vs 69%; P < .001). The 1-, 2-, 3-, and 5-year OS rates were 82%, 67%, 58%, and 47%, respectively, in the preoperative chemoradiation arm compared with 70%, 50%, 44%, and 34%, respectively, in the surgery alone arm.

After a minimum follow-up of 24 months, the overall rate of recurrence was 35% in the preoperative chemoradiation arm compared with 58% in the surgery alone arm. Additionally, preoperative chemoradiation significantly reduced locoregional recurrence from 34% to 14% (P < .001) and peritoneal carcinomatosis from 14% to 4% (P < .001). Importantly, preoperative chemoradiation did not negatively impact postoperative health-related quality of life compared with surgery alone in patients participating in the CROSS trial. A study reporting the long-term results of the CROSS trial verified that median OS was significantly improved in the preoperative chemoradiation group. After a median follow-up of 84.1 months, median OS was 48.6 months in the preoperative chemoradiation group compared with 24 months in the surgery alone group (HR = 0.68; 95% CI, 0.53–0.88; P = .003). Median OS for patients with adenocarcinoma was 43.2 months and 27.1 months, respectively (P = .038). These results confirmed the survival benefit for preoperative chemoradiation therapy with paclitaxel and carboplatin in patients with resectable esophageal or EGJ cancers. Therefore, the panel recommends combined paclitaxel and carboplatin as a category 1 preferred regimen for preoperative chemoradiation.

The panel also recommends FOLFOX (fluorouracil/leucovorin calcium/oxaliplatin) as a category 1 preferred option for preoperative chemoradiation. The efficacy
and safety of preoperative FOLFOX combined with radiation therapy (RT) was evaluated in a single-arm phase II SWOG trial involving 93 patients with clinically staged II or III esophageal adenocarcinoma. Twenty-six patients (28%) had confirmed pCR (95% CI, 19.1%–38.2%) and 19.4% of patients experienced grade 4 treatment-related toxicities. At a median follow-up of 39.2 months, estimates of median and 3-year OS were 28.3 months and 45.1%, respectively. A small trial of 38 patients with stage II-IV esophageal adenocarcinoma also showed that FOLFOX combined with RT is safe and effective in the preoperative setting, with 38% of patients attaining pCR. Other recommended regimens for preoperative chemoradiation include fluorouracil and cisplatin (category 1), irinotecan and cisplatin (category 2B), and paclitaxel and a fluoropyrimidine (fluorouracil or capecitabine [category 2B]). CALGB 9781 was a prospective phase III trial that randomized patients (n = 56) with stage I-III esophageal cancers to receive preoperative chemoradiation with fluorouracil and cisplatin followed by surgery (n = 30) or surgery alone (n = 26). After a median follow-up of 6 years, the median OS was 4.5 years in the preoperative chemoradiation group versus 1.8 years in the surgery alone group (P = .002). Patients receiving preoperative chemoradiation also had an improved 5-year OS rate (39% vs 16%). The results from this trial reflect a long-term survival advantage with the use of preoperative chemoradiotherapy with fluorouracil and cisplatin in the treatment of esophageal cancer. Irinotecan and cisplatin showed modest activity in a single-institution retrospective trial involving patients (n = 44) with locally advanced esophageal carcinoma. All patients underwent R0 resection, and the pCR rate was 25%. The median DFS and OS were 24 months and 34 months, respectively, and the 3-year OS rate was 46%.

Perioperative Chemotherapy

The survival benefit of perioperative chemotherapy in gastroesophageal cancers was first demonstrated in the landmark phase III MAGIC trial. This study, which compared perioperative chemotherapy with epirubicin, cisplatin, and fluorouracil (ECF) to surgery alone, established that perioperative chemotherapy improves progression-free survival (PFS) and OS in patients with nonmetastatic stage II and higher gastric or EGJ adenocarcinoma. In the randomized controlled phase II/III FLOT4 trial, Al-Batran et al compared perioperative chemotherapy with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) to the standard ECF regimen in patients...
with resectable nonmetastatic gastric or EGI adenocarcinoma. In the phase II part of the study, 265 patients were randomized to receive either 3 preoperative and postoperative cycles of ECF (n = 137) or 4 preoperative and postoperative cycles of FLOT (n = 128). Results showed that FLOT was associated with significantly higher proportions of patients attaining pCR than was ECF (16%; 95% CI, 10%–23% vs 6%; 95% CI, 3–11; P = .02). Additionally, FLOT was associated with a reduction in the percentage of patients experiencing at least one grade 3–4 adverse event, including neutropenia, leucopenia, nausea, infection, fatigue, and vomiting (40% of patients in the ECF group vs 25% of patients in the FLOT group). In the phase III part of the trial, 716 patients were randomized to receive FLOT (n = 356) or ECF (n = 360). Results showed that median OS was increased in the FLOT group compared with the ECF group (50 vs 35 months; HR = 0.77; 95% CI, 0.63–0.94). The percentage of patients with serious chemotherapy-related adverse events was the same in the 2 groups (27% in the ECF group vs 27% in the FLOT group). Therefore, ECF should no longer be recommended in this setting. However, because of considerable toxicity associated with the FLOT regimen, the panel recommends its use in select patients with good performance status. The preferred perioperative regimen for most patients who have good to moderate performance status is FOLFOX.

In the FNCLCC ACCORD 07 trial (n = 224 patients; 75% had adenocarcinoma of the lower esophagus or EGI), Ychou et al reported that perioperative chemotherapy with fluorouracil and cisplatin significantly increased the curative resection rate, DFS, and OS in patients with resectable cancer. At a median follow-up of 5.7 years, the 5-year OS rate was 38% for patients in the perioperative chemotherapy group and 24% for patients in the surgery alone group (P = .02). The corresponding 5-year DFS rates were 34% and 19%, respectively. Although this trial was prematurely terminated due to low accrual, the panel believes that perioperative fluorouracil and cisplatin is a viable treatment option for patients with locally advanced resectable esophageal or EGI cancers.

Postoperative Chemoradiation Therapy

The landmark Intergroup-0116 (INT-0116) trial investigated the effectiveness of surgery followed by postoperative chemotherapy plus chemoradiation on the survival of patients with resectable adenocarcinoma of the stomach or EGI. In this trial, 556 patients (stage IB to IV, M0) were randomized to receive surgery followed
by postoperative chemotherapy plus chemoradiation (n=281; bolus fluorouracil plus leucovorin before and after concurrent chemoradiation with the same regimen) or surgery alone (n=275). Most patients had T3 or T4 tumors (69%) and node-positive disease (85%). After a median follow-up of 5 years, median OS in the surgery-only group was 27 months compared with 36 months in the postoperative chemotherapy plus chemoradiation group (P=.005). The postoperative chemotherapy plus chemoradiation group also had better 3-year OS (50% vs 41%) and recurrence-free survival rates (48% vs 31%) than the surgery-only group. There was also a decrease in local failure as the first site of failure in the chemoradiation group (19% vs 29%). After a median follow-up of >10 years, survival remained improved in patients treated with postoperative chemoradiation. Additionally, data from a retrospective analysis showed that postoperative chemoradiation according to the INT-0116 protocol resulted in improved 3-year DFS rates after curative resection in patients (n=211) with EGI adenocarcinoma and positive lymph nodes who did not receive neoadjuvant chemotherapy (37% vs 24% after surgery alone).

The results of the INT-0116 trial established the efficacy of postoperative chemoradiation in patients with resected gastric or EGI adenocarcinoma who have not received preoperative therapy. However, the dosing schedule of chemotherapy agents used in this trial was associated with high rates of grade 3–4 hematologic and GI toxicities (54% and 33%, respectively). Among the 281 patients assigned to the chemoradiation group, 17% discontinued treatment and 3 patients died as a result of chemoradiation-related toxicities, including pulmonary fibrosis, cardiac event, and myelosuppression. Therefore, the doses and schedule of chemotherapy agents used in the INT-0116 trial are no longer recommended due to concerns regarding toxicity. See “Principles of Systemic Therapy—Regimens and Dosing Schedules (ESOPH-F page 8 of 13, available online, in these guidelines, at NCCN.org)” for recommended modifications to this regimen.

Preoperative Chemotherapy
Clinical trials have investigated chemotherapy alone in the preoperative setting for locally advanced esophageal cancer. In the Medical Research Council OEO2 trial, 802 patients with potentially resectable esophageal cancer were randomly assigned to receive either 2 cycles of preoperative fluorouracil and cisplatin followed by surgery or surgery alone. Median survival was 16.8 months...
in the preoperative chemotherapy group compared with 13.3 months in the surgery alone group, and 2-year survival rates were 43% and 34%, respectively. Long-term follow-up confirmed the survival benefit of preoperative chemotherapy, with a 23% 5-year survival rate in the preoperative chemotherapy group compared with 17.1% in the surgery alone group (HR = 0.84; 95% CI, 0.72–0.98; P = .03).80,81 The Medical Research Council OEO5 trial compared preoperative chemotherapy with 2 cycles of fluorouracil and cisplatin to 4 cycles of epirubicin, oxaliplatin, and capecitabine (ECX) followed by surgery in 897 patients with lower esophageal or EGJ adenocarcinoma. Although a trend toward prolonged PFS and DFS was found with ECX, this did not translate into an OS benefit.53 Furthermore, ECX was associated with higher toxicity than fluorouracil and cisplatin (47% vs 30% grade 3–4 toxicities; P < .001). Therefore, the panel recommends preoperative chemotherapy with fluorouracil and cisplatin for adenocarcinoma of the thoracic esophagus or EGJ (category 2B).

Definitive Chemoradiation Therapy

Given the efficacy and safety of combined paclitaxel and carboplatin as a preoperative chemoradiation regimen as reported in the CROSS trial,96 the NCCN Panel also recommends this regimen as a preferred option for definitive chemoradiation. In a retrospective comparison, definitive chemoradiation with paclitaxel and carboplatin resulted in superior OS, disease-specific survival, locoregional control, and palliation in patients with unresectable esophageal cancer compared with cisplatin and irinotecan.83 The FOLFOX regimen and combined fluorouracil and cisplatin have also been proven as effective definitive chemoradiation regimens in clinical trials. The efficacy of chemoradiation therapy with fluorouracil and cisplatin versus RT alone, each without resection, was studied in an early randomized trial (RTOG 85-01).84,85 Compared with patients who received RT alone, patients who received chemoradiation showed a significant improvement in both median survival (14 vs 9 months) and 5-year OS (27% vs 0%) with projected 8-year and 10-year survival rates of 22% and 20%, respectively. The incidence of local failure as the first site of failure (defined as local persistence plus recurrence) was also lower in the chemoradiation arm (47% vs 65% in the RT alone arm). In a randomized phase III trial (PRODIGE5/ACCORD17), 267 patients with unresectable esophageal cancer or who were medically unfit for surgery were randomized to receive definitive chemoradiation with either FOLFOX or
fluorouracil and cisplatin. The median PFS was 9.7 months in the FOLFOX group compared with 9.4 months in the fluorouracil and cisplatin group (P = .64). Although definitive chemoradiation with FOLFOX was not associated with a PFS benefit compared with fluorouracil and cisplatin, the investigators suggest that FOLFOX might be a more convenient option for patients with localized esophageal cancer who may not be candidates for surgery. After a 6-month follow-up, an updated analysis revealed no significant differences in health-related quality of life between patients receiving definitive chemoradiation with FOLF OX versus those receiving fluorouracil and cisplatin. Therefore, FOLFOX and fluorouracil plus cisplatin are both category 1 preferred recommendations for definitive chemoradiation, although FOLFOX is associated with less treatment-related adverse events.

**Postoperative Chemotherapy**

The value of postoperative chemotherapy in treating resectable esophageal and EGJ cancers remains uncertain because phase III randomized controlled trials demonstrating a survival benefit are lacking. Therefore, the regimen listed in the NCCN Guidelines for postoperative chemotherapy (capecitabine and oxaliplatin) is derived from the phase III CLASSIC trial involving patients with stage II or IIB gastric cancer. In this study, patients were randomized to receive either gastrectomy with D2 lymph node dissection alone (n = 515) or gastrectomy with D2 lymph node dissection followed by postoperative chemotherapy (n = 520). After a median follow-up of 34.2 months, postoperative chemotherapy with capecitabine and oxaliplatin significantly improved 3-year DFS (74%) compared with surgery alone (59%) for all disease stages (P < .0001). After a median follow-up of 62.4 months, the estimated 5-year DFS rate was 68% for the postoperative chemotherapy group compared with 53% for the surgery alone group; the corresponding estimated 5-year OS rates were 78% and 69%, respectively. Based on these data, the panel recommends postoperative capcitabine and oxaliplatin to patients with resectable esophageal or EGJ cancers.

**Systemic Therapy for Locally Advanced or Metastatic Disease**

**First-Line Therapy**

Systemic therapy can provide palliation of symptoms, improved survival, and enhanced quality of life in patients with locally advanced or metastatic esophageal or EGJ cancers. First-line systemic therapy regimens...
with 2 cytotoxic drugs are preferred for patients with advanced disease because of their lower toxicity. Three-drug cytotoxic regimens should be reserved for medically fit patients with good performance status and access to frequent toxicity evaluation. Based on the results of the ToGA trial, the guidelines recommend the addition of trastuzumab to first-line chemotherapy for patients with HER2-positive metastatic adenocarcinoma (category 1 for combination with cisplatin and fluoropyrimidine; category 2B for combination with other chemotherapy agents). The use of trastuzumab in combination with anthracyclines is not recommended. See “Targeted Therapies” (page 873) for more information on trastuzumab.

The preferred regimens for first-line systemic therapy include a fluoropyrimidine (fluorouracil or capecitabine) combined with either oxaliplatin or cisplatin (category 2B) (see ESOPH-F page 3 of 13, above). A phase III trial conducted by the German Study Group compared treatment with fluorouracil and cisplatin to FOLFOX in patients (n = 220) with previously untreated advanced adenocarcinoma of the stomach or EGI. Results showed that FOLFOX (referred to as FLO) was associated with significantly less toxicity and showed a trend toward improved median PFS (5.8 vs 3.9 months; P = .77) compared with fluorouracil and cisplatin (FLP). However, no significant difference was seen in median OS (10.7 vs 8.8 months, respectively) between the 2 groups. Interestingly, FOLFOX resulted in significantly superior response rates (41.3% vs 16.7%; P = .12), time to treatment failure (5.4 vs 2.3 months; P < .001), PFS (6.0 vs 3.1 months; P = .029), and improved OS (13.9 vs 7.2 months) compared with FLP in patients >65 years (n = 94). Therefore, FOLFOX offers reduced toxicity and similar efficacy compared with fluorouracil plus cisplatin and may also be associated with improved efficacy in older adult patients.

Recommendations for the use of regimens combining a platinum agent with capecitabine as first-line therapy for advanced or metastatic esophageal or EGI cancers have been extrapolated from trials involving patients with advanced gastric cancer. A phase III randomized trial (ML 17032) that evaluated the efficacy of combined capecitabine and cisplatin (XP) compared with fluorouracil and cisplatin (FP) found that XP was noninferior to FP as first-line therapy in patients with advanced gastric cancer. Additionally, 2 phase II trials concluded that capecitabine in combination with oxaliplatin is active and well-tolerated as first-line therapy for advanced gastric cancer. Furthermore, results of a meta-analysis suggest that OS was superior in patients with advanced gastroesophageal cancer treated
with capecitabine-based combinations compared with patients treated with fluorouracil-based combinations, although no significant difference in PFS between treatment groups was seen.

These results suggest that capecitabine can be considered an effective alternative to fluorouracil in the treatment of patients with advanced gastroesophageal cancers.

Docetaxel, cisplatin, and fluorouracil (DCF) has also demonstrated activity in patients with locally advanced or metastatic gastroesophageal cancer. An international phase III study (V325) that randomized 445 patients with untreated advanced gastric or EGJ cancer to receive either DCF or cisplatin and fluorouracil (CF) found that the addition of docetaxel to CF significantly improved time to progression, OS, and overall response rate (ORR). However, DCF was associated with increased toxicities, including myelosuppression and infectious complications. Various modifications of the DCF regimen have shown improved safety in clinical trials of patients with advanced gastroesophageal cancer compared with the DCF regimen evaluated in the V325 study. In a randomized phase II study, a dose-modified DCF regimen was less toxic than standard DCF and was also associated with improved median OS (18.8 vs 12.6 months; \( P = .007 \)) in previously untreated patients with metastatic gastric or EGJ adenocarcinoma.

In another randomized phase II trial that evaluated docetaxel plus oxaliplatin with or without infusional fluorouracil or capecitabine in patients with metastatic or locally recurrent gastric or EGJ adenocarcinoma, docetaxel, oxaliplatin, and fluorouracil had a better safety profile and was associated with higher response rates and longer median PFS and OS (47%, 7.7 months, and 14.6 months, respectively) compared with docetaxel and oxaliplatin (23%, 4.5 months, and 9 months, respectively) or docetaxel, oxaliplatin, and capecitabine (26%, 5.6 months, and 11.3 months, respectively). Additionally, the frequency of grade 3–4 toxicities was lower among patients treated with docetaxel, oxaliplatin, and fluorouracil (25%) compared with those treated with docetaxel and oxaliplatin (37%) or docetaxel, oxaliplatin, and capecitabine (38%). Therefore, due to concerns regarding toxicity, dose-modified DCF or other DCF modifications should be used as alternative options to the standard DCF regimen for first-line therapy.

First-line treatment with irinotecan-based regimens has been explored extensively in clinical trials involving patients with advanced or metastatic gastroesophageal cancers. In a randomized phase III study comparing FOLFIRI (fluorouracil and irinotecan) to CF in
patients with advanced gastric or EGJ adenocarcinoma (n=337) showed that FOLFIRI was noninferior to CF in terms of PFS (PFS at 6 and 9 months were 38% and 20%, respectively, for FOLFIRI compared with 31% and 12%, respectively, for CF) but not in terms of OS (9 vs 8.7 months).107 FOLFIRI was also associated with a more favorable toxicity profile. Therefore, the NCCN Panel believes that FOLFIRI is an acceptable first-line therapy option for patients with advanced or metastatic esophageal or EGJ adenocarcinoma. Other recommended regimens for first-line therapy include paclitaxel with either cisplatin or carboplatin,113–115 docetaxel with cisplatin,114,116–118 single-agent fluoropyrimidine (fluorouracil or capecitabine),95,117,118 docetaxel,88,119 or paclitaxel.120 Combined docetaxel, carboplatin, and fluorouracil118 as well as ECF122 and ECF modifications123,124 are category 2B recommendations in this setting.

Second-Line and Subsequent Therapy

The selection of regimens for second-line or subsequent therapy depends on prior therapy and performance status (see ESOPH-F page 870). Based on the available data and FDA approvals, the guidelines have included the targeted therapy ramucirumab (category 1 for EGJ adenocarcinoma; category 2A for esophageal adenocarcinoma) as a single agent or in combination with paclitaxel (preferred) as treatment options for second-line or subsequent therapy.125,126 Pembrolizumab has also been included as a first-line treatment for MSI-H/dMMR tumors.32,127 Pembrolizumab has also been included as a second-line therapy option for esophageal cancers with PD-L1 expression levels by CPS of ≥10 (category 2B)37 and as a third-line or subsequent therapy option for esophageal and EGJ adenocarcinomas with PD-L1 expression levels by CPS of ≥1.36 See “Targeted Therapies” (page 873) for more information on ramucirumab and pembrolizumab.

Category 1 preferred options for second-line or subsequent therapy include single-agent docetaxel,118,119 paclitaxel,122,123,128 and irinotecan.122,128–130 In a randomized phase III trial (COUGAR-02), single-agent docetaxel was shown to significantly increase 12-month OS compared with active symptom control alone (5.2 vs 3.6 months, respectively; HR=0.67; P=0.01).125 Additionally, patients receiving docetaxel reported less pain, nausea, vomiting, dysphagia, and constipation. A randomized phase III trial comparing second-line therapy with paclitaxel to irinotecan in patients with advanced gastric cancer (category 1 for EGJ adenocarcinoma; category 2A for esophageal adenocarcinoma) as a single agent or in combination with paclitaxel (preferred) as treatment options for second-line or subsequent therapy.
cancer found similar OS between the 2 groups (9.5 months in the paclitaxel group vs 8.4 months in the irinotecan group; HR = 1.13; P = .38). Therefore, single-agent docetaxel, paclitaxel, and irinotecan are all recommended as preferred second-line treatment options for advanced gastroesophageal cancers.

Second-line therapy with FOLFIRI has also been shown to be active and well-tolerated in patients with metastatic gastroesophageal cancers. A phase II trial investigating the efficacy and toxicity of FOLFIRI in patients (n = 40) with refractory or relapsed esophageal or gastric cancer reported an ORR of 29% and median OS of 6.4 months. Another phase II trial reported similar results with an ORR of 20% and OS of 6.7 months in patients with advanced gastric cancer (n = 59) treated with FOLFIRI in the second-line setting. Additional FOLFIRI was shown to be an effective and safe treatment option in a cohort of patients with metastatic gastric or EGJ cancers refractory to docetaxel-based chemotherapy. In this study, the ORR was 22.8% and median PFS and OS were 3.8 and 6.2 months. The most common grade 3–4 toxicities were neutropenia (28.5%) and diarrhea (14.5%). Therefore, FOLFIRI is considered as a preferred treatment option that can be safely used in the second-line setting if it was not previously used in first-line therapy. Other recommended combined regimens for second-line therapy include irinotecan and cisplatin and irinotecan and docetaxel (category 2B).

A recently published phase III trial (TAGS) has shown activity for the combined regimen of trifluridine and tipiracil in metastatic gastric and EGJ adenocarcinoma in the third-line setting. The trifluridine and tipiracil regimen, which was approved by the FDA in 2019 for previously treated recurrent or metastatic gastric and EGJ adenocarcinoma, was initially investigated in a phase II trial in Japan which reported a median OS of 8.7 months and a disease control rate of 65.5%. In the global phase III TAGS trial, 507 patients with heavily pretreated metastatic gastric or EGJ cancer were randomized 2:1 to receive trifluridine and tipiracil plus best supportive care (n = 337) or placebo plus best supportive care (n = 170). This study reported a significant improvement in median OS by 2.1 months (5.7 vs 3.6 months; HR = 0.69; 95% CI, 0.56–0.85; P = .0003). PFS was statistically significantly longer in the trifluridine and tipiracil group (2.0 vs 1.7 months; HR = 0.57; 95% CI, 0.47–0.70; P < .0001). The most frequently reported grade 3–4 toxicities associated with the
trifluridine and tipiracil regimen were neutropenia (38%), leukopenia (21%), anemia (19%), and lymphocytopenia (19%), which was consistent with other studies involving these agents. Trifluridine and tipiracil is recommended as a preferred category 1 treatment option for patients with recurrent or metastatic EGJ adenocarcinoma in the third-line or subsequent setting after prior fluoropyrimidine-, platinum-, taxane-, or irinotecan-based chemotherapy and anti-HER2 therapy (if HER2-positive). However, trifluridine and tipiracil did not result in any partial or complete responses and produced substantial grade 3–4 toxicities. Therefore, this treatment should be considered for a very select population of patients with low-volume EGJ adenocarcinoma who have minimal or no symptoms and the ability to swallow pills. Other recommended regimens for third-line or subsequent therapy for esophageal and EGJ cancers include regimens recommended for second-line therapy that were not previously used and pembrolizumab for adenocarcinomas with PD-L1 expression levels by CPS of ≥1.

**Targeted Therapies**

At present, 3 targeted therapeutic agents, trastuzumab, ramucirumab, and pembrolizumab, have been approved by the FDA for use in esophageal and EGJ cancers. Treatment with trastuzumab is based on testing for HER2 status. Treatment with pembrolizumab is based on testing for microsatellite instability and/or PD-L1 expression. Trastuzumab

The ToGA trial was the first randomized, prospective, multicenter, phase III trial that evaluated the efficacy and safety of trastuzumab in HER2-positive advanced gastric and EGJ adenocarcinoma. In this trial, 594 patients with HER2-positive, locally advanced, recurrent, or metastatic gastric or EGJ adenocarcinoma were randomized to receive trastuzumab plus chemotherapy (cisplatin plus fluorouracil or capecitabine) or chemotherapy alone. The majority of patients had gastric cancer (80% in the trastuzumab group and 83% in the chemotherapy group). Median follow-up time was 19 months and 17 months, respectively, in the 2 groups. Results showed significant improvement in median OS with the addition of trastuzumab to chemotherapy in patients with HER2-positive disease (13.8 vs 11 months, respectively; \(P=.046\)). This study established trastuzumab in combination with cisplatin and a fluoropyrimidine as the standard treatment of patients with HER2-positive metastatic gastroesophageal adenocarcinoma. The addition of trastuzumab was particularly beneficial in patients with a tumor score of IHC 3+ or IHC 2+ and FISH positivity for HER2. In a post hoc subgroup analysis, the addition of trastuzumab to chemotherapy further improved OS in patients whose tumors were IHC 2+ and FISH positive or IHC 3+ (\(n=446\); 16 vs 11.8 months; HR=0.65) compared with those with tumors that were IHC 0 or 1+ and FISH positive (\(n=131\); 10 vs 8.7 months; HR=1.07).

In a retrospective study of 34 patients with metastatic gastric or EGJ adenocarcinoma, the combination of trastuzumab with a modified FOLFOX regimen (mFOLFOX6) improved tolerability compared with the cisplatin plus fluorouracil regimen in previously untreated patients with HER2-positive tumors. The ORR with this regimen was 41%, and median PFS and OS were 9.0 months and 17.3 months, respectively. The most frequent grade 3–4 toxicities were neutropenia (8.8%) and neuropathy (17.6%). These results suggest that the combination of mFOLFOX6 and trastuzumab is an effective regimen with an acceptable safety profile and warrants further study in patients with HER-2+ gastroesophageal cancers.

**Ramucirumab**

Ramucirumab, a VEGFR-2 antibody, has shown favorable results in patients with previously treated advanced or metastatic gastroesophageal cancers in 2 phase III clinical trials. An international randomized multicenter phase III trial ( REGARD) demonstrated a survival benefit for ramucirumab in patients with advanced gastric or EGJ adenocarcinoma progressing after first-line chemotherapy. In this study, 355 patients were randomized to receive ramucirumab (\(n=238\); 178 had gastric cancer and 60 had EGJ adenocarcinoma) or placebo (\(n=117\); 87 had gastric cancer and 30 had EGJ adenocarcinoma). Median OS was 5.2 months in patients treated with ramucirumab compared with 3.8 months for those in the placebo group (\(P=.047\)). Ramucirumab was associated with higher rates of hypertension than placebo (16% vs 8%), whereas rates of other adverse events were similar.

A more recent international phase III randomized trial (RAINBOW) evaluated paclitaxel with or without ramucirumab in patients (\(n=665\)) with metastatic gastric or EGJ adenocarcinoma progressing on first-line chemotherapy. Patients randomized to receive ramucirumab plus paclitaxel (\(n=330\)) had significantly longer median OS (9.63 months) compared with patients receiving paclitaxel alone (\(n=335\); 7.36 months; \(P<.0001\)). The median PFS was 4.4 months and 2.86 months, respectively, for the 2 treatment groups. Additionally, the ORR was 28% for ramucirumab plus paclitaxel compared with 6% for paclitaxel alone (\(P=.0001\)). However, neutropenia and hypertension were more common with ramucirumab plus paclitaxel. Based on the results of these 2 studies, ramucirumab (as a single agent or in combination with paclitaxel) was approved for patients with advanced gastric or EGJ adenocarcinoma progressing after first-line chemotherapy.
combination with paclitaxel) was approved by the FDA for the treatment of patients with advanced gastric or EGJ adenocarcinoma refractory to or progressive after first-line therapy with platinum- or fluoropyrimidine-based chemotherapy. Interestingly, an exposure-response analysis of these trials revealed that ramucirumab was a significant predictor of OS and PFS in both trials. Higher ramucirumab exposure was associated with longer OS and PFS, but also with higher rates of grade $\geq$3 hypertension, leukopenia, and neutropenia. This exploratory exposure-response analysis suggests a positive relationship between ramucirumab exposure and efficacy with manageable toxicities.

An international randomized phase III trial (RAINFALL) has recently completed investigation of ramucirumab in combination with a fluoropyrimidine and cisplatin in the first-line treatment of gastroesophageal adenocarcinoma. This trial randomized 645 patients to receive capecitabine and cisplatin in combination with ramucirumab (n=326) or placebo (n=319). Preliminary results showed that median PFS was significantly longer in patients treated with ramucirumab versus placebo (5.7 vs 5.4 months, respectively; P=0.011; HR=0.75; 95% CI, 0.61–0.94). However, no improvement in median OS was observed with the addition of ramucirumab (11.2 vs 10.7 months; P=0.68; HR=0.96; 95% CI, 0.80–1.16). The ORR was 41.1% (95% CI, 35.8–46.4) in the ramucirumab arm compared with 36.4% (95% CI, 31.1–41.6) in the placebo arm. The most common grade $\geq$3 adverse events in the ramucirumab arm were neutropenia, anemia, and hypertension. These early results suggest that the addition of ramucirumab may not reduce the risk of disease progression or death in treatment-naïve patients with metastatic gastroesophageal adenocarcinoma. Therefore, the addition of ramucirumab to first-line fluoropyrimidine and cisplatin chemotherapy is not recommended at this time. However, more data are needed to ascertain whether the addition of ramucirumab to other first-line chemotherapy regimens can improve OS in these patients.

**Pembrolizumab**

Pembrolizumab is a monoclonal PD-1 antibody directed against PD-1 receptors that was granted accelerated approval by the FDA in 2017 for the treatment of patients with advanced gastric or EGJ adenocarcinoma who had progressed on prior platinum-based chemotherapy. There were 11 complete responses and 48 partial responses to pembrolizumab and the ORR was similar irrespective of whether patients were diagnosed with colorectal cancer (36%) or a different cancer type (46% across the 14 other cancer types).

One of the trials included in the FDA approval was KEYNOTE-016, a multicenter phase II trial that evaluated the activity of pembrolizumab in 41 patients with metastatic treatment-refractory dMMR colorectal cancers, MMR-proficient colorectal cancers, or dMMR noncolorectal cancers who had received at least 2 previous lines of chemotherapy. In this study, the immune-related ORR for patients with dMMR noncolorectal cancers (n=9) was 71% with an immune-related PFS rate of 67% at 20 weeks. Median PFS was 5.4 months and OS was not reached. Adverse events of clinical interest included rash or pruritus (24%), thyroid dysfunction (10%), and asymptomatic pancreatitis (15%). These events were similar to those reported in other trials involving pembrolizumab. In a recently reported expansion of this study, data from 86 patients with dMMR tumors representing 12 different cancer types, including gastroesophageal cancers, attained an ORR of 53%, with 21% of patients experiencing a complete response. Although median PFS and OS have not yet been reached, estimates of these outcomes at 1 and 2 years are 64% and 53% for PFS and 76% and 64% for OS, respectively. The KEYNOTE-016 trial is still recruiting patients at several institutions (ClinicalTrials.gov identifier: NCT01876511).

Another 2017 FDA approval for pembrolizumab was for the treatment of patients with recurrent, locally advanced, or metastatic PD-L1-positive (CPS $\geq$1) gastric or EGJ adenocarcinoma who have progressed after 2 or more prior lines of therapy, including fluoropyrimidine-and platinum-containing chemotherapy and, if appropriate, HER2-targeted therapy. This approval was based on the results of 2 KEYNOTE studies (KEYNOTE-012 and KEYNOTE-059). KEYNOTE-012 was a multicenter, phase Ib study that evaluated the safety and activity of pembrolizumab in patients with PD-L1-positive recurrent or metastatic gastric or EGJ adenocarcinoma. The ORR was 22%, and 13% of patients had grade 3–4 treatment-related adverse events including fatigue, pemphigoid, hypothyroidism, peripheral sensory neuropathy, and pneumonia. The results of this trial justified the study of pembrolizumab monotherapy in cohort 1 of the phase II KEYNOTE-059 trial, which included 259 patients with gastric or EGJ adenocarcinoma who had progressed on $\geq$2 prior lines of therapy. Of those with PD-L1–positive tumors (57.1%; n=143), the ORR was 15.5% (95% CI, 10.1–22.4), with 2% (95% CI, 0.4–5.8) of patients achieving a complete response. The median duration of response was 16.3 months. Investigations involving cohorts 2 and 3 of the KEYNOTE-059 trial, which will examine the
The recently published KEYNOTE-061 trial directly compared monotherapy with pembrolizumab to paclitaxel in patients with advanced gastric or EGJ cancers that progressed following first-line therapy with combined fluoropyrimidine and platinum-based agents. In this multicenter international phase III trial, 395 patients with PD-L1–positive tumors were randomized to receive either pembrolizumab (n=196) or standard-dose paclitaxel (n=199). Median OS was 9.1 months (95% CI, 6.2–10.7) with pembrolizumab and 8.3 months (95% CI, 7.6–9.0) with paclitaxel (HR=0.82; 95% CI, 0.66–1.03; P=0.021). Median PFS was 1.5 months (95% CI, 1.4–2.0) and 4.1 months (95% CI, 3.1–4.2), respectively (HR=1.27; 95% CI, 1.03–1.57). Grade 3–5 treatment-related adverse events occurred in 14% of the patients treated with pembrolizumab compared with 35% of the patients treated with paclitaxel. Therefore, although pembrolizumab did not significantly improve OS compared with paclitaxel as second-line therapy for advanced PD-L1–positive gastric or EGJ cancer, pembrolizumab had a better safety profile and was better tolerated by patients. Additionally, Doi et al recently analyzed preliminary data from the advanced esophageal cancer cohort (n=23) of the KEYNOTE-028 trial, a multicohort phase Ib trial of pembrolizumab in patients with PD-L1–positive advanced solid tumors that have failed first-line therapy. In patients with adenocarcinoma of the esophagus or EGJ, the ORR was 40%. Median PFS was 1.8 months (95% CI, 1.7–2.9) and the 6- and 12-month PFS rates were 30% and 22%, respectively. Median OS was 7 months (95% CI, 4.3–17.7) and the 6- and 12-month OS rates were 60% and 40%, respectively. Grade 3 immune-mediated adverse events, including decreased appetite and decreased lymphocyte count, occurred in 17% of patients, but no grade 4 adverse events were reported.

Two of the most recently published KEYNOTE trials (KEYNOTE-180 and KEYNOTE-181) examined the efficacy of pembrolizumab in treating PD-L1–positive esophageal or EGJ tumors defined as having a CPS ≥10. This is in contrast to previous studies that have defined PD-L1–positive tumors as having a CPS ≥1. In the phase II single-arm KEYNOTE-180 trial, which evaluated pembrolizumab monotherapy in 121 patients with progressive disease after ≥2 prior lines of therapy, the objective response rate was 9.9% (95% CI, 5.2%–16.7%) among all patients, 5.2% (95% CI, 1.1%–14.4%) among patients with adenocarcinoma (n=58), and 13.8% (95% CI, 6.1%–25.4%) among patients with PD-L1–positive tumors (n=58).

Overall, 12.4% of patients experienced grade 3–5 treatment-related adverse events. These results demonstrated the efficacy and tolerability of pembrolizumab as third-line or subsequent therapy in heavily pretreated esophageal cancers with high PD-L1 expression. The phase III KEYNOTE-181 trial evaluated pembrolizumab versus investigator’s choice of chemotherapy (docetaxel, paclitaxel or irinotecan) as second-line therapy in 628 patients with advanced SCC or adenocarcinoma of the esophagus or EGJ. Patients (401 with SCC and 222 with PD-L1 CPS ≥10) were randomized 1:1 to pembrolizumab or chemotherapy and randomization was stratified by histology (SCC vs adenocarcinoma) and region (Asia vs rest of world). Pembrolizumab significantly improved median OS (9.3 vs 6.7 months; HR=0.69; 95% CI, 0.52–0.93; P=0.0074) and 12-month OS rates (43% vs 20%) compared with chemotherapy in patients whose tumors had a PD-L1 CPS ≥10.

Although the difference in OS was not statistically significant (7.1 vs 7.1 months; HR=0.89; 95% CI, 0.75–1.05; P=0.0560), fewer patients (18% vs 41%) had grade 3–5 treatment-related adverse events with pembrolizumab compared with chemotherapy. These data suggest that pembrolizumab may be an effective second-line therapy for patients with advanced esophageal cancer with a PD-L1 CPS ≥10, with a more favorable safety profile than chemotherapy.

**Treatment Guidelines**

The management of patients with esophageal and EGJ cancers requires the expertise of several disciplines, including surgical oncology, medical oncology, gastroenterology, radiation oncology, radiology, and pathology. In addition, the presence of nutritional services, social workers, nurses, palliative care specialists, and other supporting disciplines are also desirable. Hence, the panel believes in an infrastructure that encourages multidisciplinary treatment decision-making by members of all disciplines taking care of patients with esophageal and EGJ cancers. The recommendations made by the multidisciplinary team may be considered advisory to the primary group of treating physicians of the patient.

**Workup**

Newly diagnosed patients should undergo a complete history and physical examination, complete blood count, comprehensive chemistry profile, and upper GI endoscopy...
with biopsy of the primary tumor (see ESOPH-1, page 856). Histologic evaluation is required for correct diagnosis of SCC or adenocarcinoma. The extent of tumor involvement into the EGJ and cardia should be clearly documented, where applicable. CT scan (with oral and intravenous contrast) of the chest and abdomen should also be performed. Pelvic CT with contrast should be obtained when clinically indicated. EUS and FDG-PET/CT evaluation from skull base to midthigh are recommended if metastatic disease is not evident. HER2, MSI-H/dMMR, and PD-L1 testing are recommended at the time of diagnosis if metastatic disease is documented or suspected. Assessment of Siewert tumor type should be included as part of the initial workup in all patients with EGJ adenocarcinoma. The guidelines also recommend screening for family history of esophageal or EGJ cancers. Referral to a cancer genetics professional is recommended if there is a question of depth of invasion for early esophageal malignancy, endoscopic resection provides both diagnostic and potentially curative therapy for T1a and some early T1b disease. Primary treatment options for patients with cT1b–cT2, N+ or cT3-cT4a, any N tumors include preoperative chemoradiation (category 1; preferred), definitive chemoradiation (only for patients who decline surgery), perioperative chemotherapy, and preoperative chemoradiation. Definitive chemoradiation is the primary treatment option for patients with cT4b (unresectable) tumors and occasionally can facilitate surgical resection in select patients. Chemotherapy alone can be considered for these patients in the setting of invasion of the trachea, great vessels, or heart.

Primary Treatment of Locoregional Adenocarcinoma

**Medically Fit Patients**

Esophagectomy is indicated for patients with cT1b–cT2, N0 low-risk lesions (<2 cm in diameter and well-differentiated; see ESOPH-13, page 858). Endoscopic resection is appropriate for many T1a lesions, but it is important to understand that staging of early esophageal cancer (T1 and even some T2 disease) is challenging via existing imaging techniques, including EUS. Thus, if there is no evidence of metastatic disease after preoperative chemoradiation, patients with cT1b–cT2, N+ or cT3-cT4a, any N tumors include preoperative chemoradiation (category 1; preferred), definitive chemoradiation (only for patients who decline surgery), perioperative chemotherapy, and preoperative chemoradiation. Definitive chemoradiation is the primary treatment option for patients with cT4b (unresectable) tumors and occasionally can facilitate surgical resection in select patients. Chemotherapy alone can be considered for these patients in the setting of invasion of the trachea, great vessels, or heart.

**Non-Surgical Candidates**

Definitive chemoradiation is recommended for nonsurgical candidates with cT1b–cT4b, any N tumors who are able to tolerate chemoradiation (see ESOPH-17, page 862). Palliative RT or palliative best supportive care are the appropriate options for nonsurgical candidates who are unable to tolerate chemoradiation.

**Response Assessment and Additional Management**

Additional management options are based on the assessment of response to primary treatment. FDG-PET/CT scans are useful for the evaluation of patients after chemoradiation and before surgery for the detection of distant metastases. Therefore, assessment with FDG-PET/CT (preferred) or FDG-PET scan should be done =5 to 8 weeks after the completion of preoperative therapy (see ESOPH-14, page 859). Chest/abdominal CT scan with contrast is recommended, but is not required if FDG-PET/CT was done. Pelvic CT with contrast can be considered for distal lesions, if clinically indicated. Upper GI endoscopy and biopsy is recommended following definitive chemoradiation, but it is optional after preoperative chemoradiation if surgery is planned.

Esophagectomy (preferred) or surveillance (category 2B) are recommended for patients with no evidence of disease after preoperative chemoradiation. Esophagectomy is also preferred for those with persistent local disease after preoperative chemoradiation. Patients with...
no evidence of disease following definitive chemoradiation should be managed with surveillance, while esophagectomy should be recommended for those with persistent local disease. Alternatively, patients with persistent local disease or unresectable/metastatic disease after either preoperative or definitive chemoradiation can be managed with palliative or best supportive care.

Postoperative Management

Postoperative management is based on surgical margins, nodal status, histology, and previous treatment. The components of postoperative management have not been established in randomized trials for patients with esophageal cancer. Available evidence for the use of postoperative chemoradiation and postoperative chemotherapy comes from prospective randomized trials involving patients with gastric cancer.54-56

Patients Who Have Not Received Preoperative Chemoradiation or Chemotherapy

Surveillance is recommended for patients with R0 resection and negative nodal status (see ESOPH-15, page 860). Chemoradiation is an alternative option following R0 resection for patients with pT3-pT4a tumors or select patients with pT2 tumors in the lower esophagus or EGJ and high-risk features (category 2B).54,55 High-risk features include poorly differentiated or higher grade cancer, lymphovascular invasion, perineural invasion, or age <50 years. For patients with R0 resection and positive nodal status, chemoradiation54,55 or chemotherapy is recommended. Patients with R1 resection should receive chemoradiation while those with R2 resection can receive either chemoradiation or palliative management.

Patients Who Have Received Preoperative Chemoradiation or Chemotherapy

Observation until disease progression is recommended for all patients with R0 resection who had received preoperative therapy, irrespective of their nodal status (see ESOPH-16, page 861). If received perioperatively, postoperative chemotherapy is a category 1 recommendation for patients with completely resected, node-negative, or node-positive disease.39,40 Based on current data, adjuvant chemo- radiation is not recommended for patients with node-positive disease after R0 resection. Patients with R1 or R2 resection should be treated with chemoradiation, if not received preoperatively. Alternatively, patients with R1 resection can be observed until disease progression or considered for reresection. Palliative management is an alternative option for patients with R2 resection.

Follow-up/Surveillance

All patients should be followed up systematically. However, surveillance strategies after successful local therapy of esophageal and EGJ cancers remain controversial, with no high-level evidence to guide development of algorithms that balance benefits and risks (including cost) within this cohort. The stage-specific surveillance strategies provided in this guideline are based on currently available evidence from retrospective studies58,155-159 and expert consensus. In general, follow-up for asymptomatic patients should include a complete history and physical examination every 3 to 6 months for the first 2 years, every 6 to 12 months for years 3 to 5, and then annually thereafter (see ESOPH-18, page 863). Complete blood count, chemistry profile, upper GI endoscopy with biopsy, and imaging studies should be performed as clinically indicated. In addition, some patients may require dilatation of an anastomotic or a chemoradiation-induced stricture. Nutritional assessment and counseling are also recommended.

Unresectable, Locally Advanced, Recurrent, or Metastatic Disease

When locoregional recurrence develops after prior chemoradiation therapy, the clinician should determine whether the patient is medically fit for surgery and if the recurrence is resectable. If both criteria are met, esophagectomy remains an option (see ESOPH-18, page 863). Palliative management, which includes concurrent chemoradiation (preferred), surgery, chemotherapy, and palliative or best supportive care, is recommended for patients who develop a locoregional recurrence after prior esophagectomy. Those who are medically unable to tolerate major surgery and those who develop an unresectable or metastatic recurrence should also receive palliative management. If not done previously, HER2, MSI-H/dMMR, and PD-L1 testing should be performed in patients with suspected metastatic disease.

Palliative management and best supportive care are always indicated for patients with unresectable locally advanced, recurrent, or metastatic disease (see ESOPH-19, page 864). The decision to offer palliative/best supportive care alone or with systemic therapy depends on the patient’s performance status. The Eastern Cooperative Oncology Group Performance Status Scale (ECOG PS) and the Karnofsky Performance Status Scale (KPS) are commonly used to assess the performance status of patients with cancer.160-162 Patients with a KPS score <60% or an ECOG PS score ≥3 should be offered palliative or best supportive care only. Systemic therapy can be offered in addition to palliative or best supportive care for patients with better performance status (KPS score ≥60% or ECOG PS score ≤2). Dysphagia should also be assessed since it has a significant impact on quality of life and is often amenable to palliation regardless of performance status. Dysphagia is most
often palliated via endoscopic stenting, but patients should be counseled on reflux and chest pain associated with stent placement. Alternatively, external beam radiation therapy or brachytherapy, among other potential modalities, can be used.

The survival benefit of systemic therapy compared with palliative or best supportive care alone has been shown in small cohorts of patients with esophageal or EGJ adenocarcinoma included in gastric adenocarcinoma trials.88,89 A recent Cochrane database systematic review analyzed 5 randomized controlled trials (involving 750 patients) comparing palliative chemotherapy and/or targeted therapy to best supportive care alone in patients with advanced esophageal or EGJ cancer.90 The analysis demonstrated a benefit in OS for patients receiving palliative therapy (chemotherapy or targeted therapy) compared with those receiving best supportive care alone (HR=0.81; 95% CI, 0.71–0.92). The only individual agent found by more than one study to improve both OS and PFS was ramucirumab. Although the addition of palliative chemotherapy or targeted therapy increased the frequency of grade ≥3 adverse events, treatment-related deaths did not increase. Importantly, patient-reported quality of life often improved with the addition of palliative systemic therapy to best supportive care. Therefore, the addition of systemic therapy to best supportive care can improve the quality of life and may prolong survival in patients with advanced esophageal or EGJ cancers.

Summary

The NCCN Guidelines for Esophageal and Esophagogastric Junction Cancers provide an evidence- and consensus-based treatment approach for the management of patients with esophageal and EGJ cancers. Multidisciplinary team management is essential for all patients with esophageal and EGJ cancers. Combined modality therapy, especially preoperative chemoradiation, is recommended for locally advanced disease. Best supportive care is an integral part of treatment, especially in patients with locally advanced or metastatic disease. Targeted therapies have produced encouraging results in the treatment of patients with advanced esophageal and EGJ cancers. Trastuzumab plus chemotherapy is recommended as first-line therapy for patients with HER2-positive metastatic adenocarcinoma. Ramucirumab, as a single agent or in combination with paclitaxel, and pembrolizumab (for MSI-H/dMMR tumors) are included as options for second-line or subsequent therapy for patients with metastatic disease. Pembrolizumab has also been included as a second-line therapy option for esophageal cancers with PD-L1 expression levels by CPS of ≥10 and as a third-line or subsequent therapy option for esophageal and EGJ adenocarcinoma with PD-L1 expression levels by CPS of ≥1. The panel encourages patients with esophageal and EGJ cancers to participate in well-designed clinical trials investigating novel therapeutic strategies to enable further advances.

References

Esophageal and Esophagogastriac Junction Cancers, Version 2.2019

NCCN GUIDELINES®
Esophageal and Esophagogastric Junction Cancers, Version 2.2019


92. Shah MA, Janjigian YY, Stoller R, et al. Randomized multicenter phase II study of modified docetaxel, cisplatin, and fluorouracil (DCF) versus DCF.


## Individual Disclosures for the NCCN Esophageal and Esophagogastric Junction Cancers Panel

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