



**LIVE! | LUNCH REVIEW SESSION 8:**  
**GI Oncology and Sarcomas**

**MODERATOR:** Robert S. Siegel, MD

**FACULTY PANEL:** Mark Agulnik, MD  
Daniel G. Haller, MD, FACP, FROP, FASCO  
David Ilson, MD, PhD  
Hedy Lee Kindler, MD  
John L. Marshall, MD

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**Our Moderator and Faculty Panel**

 <p><b>Robert S. Siegel, MD</b> HEMORO Best Practices Course Director Professor of Medicine The George Washington University Associate Center Director for Education and Training, GW Cancer Center</p>	 <p><b>Mark Agulnik, MD</b> Clinical Professor Sarcoma Section Chief, Department of Medical Oncology and Therapeutics Research, City of Hope</p>	 <p><b>Hedy Lee Kindler, MD</b> Professor of Medicine University of Chicago</p>	 <p><b>Daniel G. Haller, MD, FACP, FROP, FASCO</b> Gretzler-Ahler Professorship in Gastrointestinal Oncology, Emory</p>	 <p><b>David Ilson, MD, PhD</b> Attending Physician Memorial Sloan Kettering Cancer Center</p>	 <p><b>John L. Marshall, MD</b> Director, Research Center for the Cure of GI Cancers Georgetown University</p>
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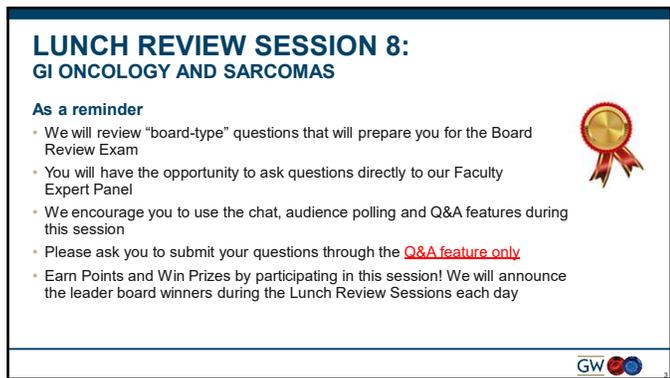
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**LUNCH REVIEW SESSION 8:**  
**GI ONCOLOGY AND SARCOMAS**

**As a reminder**

- We will review "board-type" questions that will prepare you for the Board Review Exam
- You will have the opportunity to ask questions directly to our Faculty Expert Panel
- We encourage you to use the chat, audience polling and Q&A features during this session
- Please ask you to submit your questions through the [Q&A feature only](#)
- Earn Points and Win Prizes by participating in this session! We will announce the leader board winners during the Lunch Review Sessions each day





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### Using the Polling and Q&A features

**Polling Feature**

**Q&A Feature**

Select your answer when prompted during this session

Place your cursor on the Polling or Q&A buttons to activate this tool on your screen

After you type in a question, please click the **SUBMIT** button

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## MOCK QUESTIONS: LET'S PRACTICE!

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### MOCK QUESTION

What is your attendee type for this conference?

- A. Physician
- B. Medical Fellow | Resident
- C. Nurse or Nurse Practitioner
- D. Pharmacist
- E. Other Healthcare Provider
- F. Industry Life Sciences Representative

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**MOCK QUESTION**

Do you consider yourself an “early bird” or a “night owl”?

- A. Early Bird
- B. Night Owl
- C. Happy Combination



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**Audience Polling  
Knowledge Check**

**LET'S GO!**

**Lunch Review Session 8**



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**1. Sarcomas**  
(Aguinik)

Li-Fraumeni syndrome is associated with a germline mutation in which gene?

- A. ATRX
- B. CDK4
- C. NF1
- D. p53
- E. RB1



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**2. Sarcomas**  
(AguInik)

A 35-year-old female presents with a firm, painless mass that has been enlarging on her left forearm for the last year. Her PCP refers her for a biopsy which reveals a synovial sarcoma. Physical exam is otherwise unremarkable besides a 5.5 cm left forearm mass.

**Which of the following is the next step in her management?**

- A. Doxorubicin based neoadjuvant therapy
- B. Surgical Resection
- C. Neoadjuvant Radiation Therapy
- D. Bone scan or PET scan
- E. MRI of the left upper extremity and CT chest

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**3. Gastric Cancer**  
(Ilson)

A 59 yo. male presents with epigastric pain after eating. Endoscopy reveals an ulcer in the antrum with a biopsy showing adenocarcinoma. He is referred for surgery, and is found to have a T4aN2 gastric cancer (stage III), with clear surgical margins, and 3/8 lymph nodes involved.

**Your recommendation in this patient is:**

- A. Adjuvant radiation therapy
- B. Adjuvant chemotherapy
- C. Adjuvant radiation therapy plus concurrent 5-FU chemotherapy
- D. Adjuvant radiation therapy plus ECF chemotherapy
- E. Observation with close follow up

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**4. Gastric Cancer**  
(Ilson)

A 35 yo woman presents with anemia and epigastric pain. Endoscopy reveals an ulcerated mass in the body of the stomach and biopsy shows poorly differentiated diffuse adenocarcinoma. Gastrectomy reveals multifocal disease throughout the stomach. The patient's father died of gastric cancer at age 40, his sister died of gastric cancer at age 45, and another sister was treated for breast cancer at age 40.

**Genomic profiling is most likely to indicate which abnormality?**

- A. BRCA mutation
- B. Lynch syndrome
- C. p53 mutation
- D. CDH-1 mutation
- E. APC mutation

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**5. Pancreatic Cancer**  
(Kindler)

A 57 yo otherwise healthy patient undergoes a pancreaticoduodenectomy for a T2N0M0 adenocarcinoma of the head of the pancreas. All margins are negative. The patient does not want any further therapy, because he thinks "the surgeon got it all".

**You advise him that he should receive:**

- A. No treatment, as he is likely cured of his pancreatic cancer
- B. 6 months of adjuvant mFOLFIRINOX
- C. 6 months of adjuvant gemcitabine-nab-paclitaxel
- D. 2 or 3

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**6. Pancreatic Cancer**  
(Kindler)

A 64 yo patient presents with an adenocarcinoma of the pancreatic body. There are no liver or lung metastases. Ca 19-9 is 600.

**In which of the following scenarios might her tumor be considered resectable?**

- A. There is encasement of the superior mesenteric artery by > 180 degrees
- B. There is regional lymphadenopathy
- C. There is encasement of the celiac artery
- D. The superior mesenteric vein is not patent

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**7. Adjuvant CRC**  
(Haller)

Treatment of stage II colon cancer has always been controversial. Traditionally, patients have been selected for treatment based on unvalidated clinicopathologic factors for high risk such as nodes examined, differentiation, lymphatic and neural invasion, perforation and obstruction. In an attempt to assess adjuvant therapy for stage II colon cancer in practice, a SEER-Medicare database study was performed.

**Which of the following is true?**

- A. Adjuvant therapy was received by over 50% of stage II patients
- B. High-risk features were present in less than 25% of stage II patients
- C. No survival benefit was observed for patients with stage II cancer with any poor prognostic features
- D. Benefit was seen in the patients with high risk patients

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**8. Adjuvant CRC**  
(Haller)

You are asked to see a 48-year-old man who recently underwent surgery for a cecal colon cancer. He had a 3.5 cm moderately-differentiated tumor, with none of 15 nodes positive. You are considering adjuvant chemotherapy and have access to his clinicopathologic data as well as to a gene assay for prognosis (Oncotype DX®).

**Which of the following is most likely to lead to a decision to administer treatment?**

- A. T3 tumor, dMMR (MSI-H), low recurrence score
- B. T3 tumor, pMMR (MSI-L), low recurrence score
- C. T3 tumor, dMMR (MSI-H), moderate recurrence score
- D. T3 tumor, pMMR (MSI-L), moderate recurrence score
- E. T4 tumor, pMMR (MSI-L), moderate recurrence score

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**9. Sarcomas**  
(Aguinik)

A 34-year-old female with metastatic liposarcoma with numerous retroperitoneal tumors and lung metastases is referred to your oncology clinic for treatment options.

**Given that her disease is unresectable, all the following regimens could be considered for her disease, except?**

- A. Trabectedin
- B. Ifosfamide
- C. Pazopanib
- D. Eribulin
- E. Doxorubicin based therapy

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**10. Sarcomas**  
(Aguinik)

A 25-year-old woman with newly diagnosed high grade osteosarcoma is referred to you for treatment of her disease. She was well until she recently developed pain in her chest wall. CT scan confirmed a 3.5 x 6.0 x 5.8 cm mass arising from the 7<sup>th</sup> rib. Staging scans show no other sites of disease.

**What is the best treatment plan for this patient?**

- A. Cyclophosphamide, Adriamycin, Vincristine alternating with Ifosfamide, Etoposide x 14 cycles with Surgical resection after 4 cycles.
- B. Cyclophosphamide, Adriamycin, Vincristine alternating with Ifosfamide, Etoposide x 14 cycles with addition of radiation after 4 cycles.
- C. Methotrexate, Adriamycin, Cisplatin followed by surgical resection
- D. Surgery alone
- E. Radiation followed by Surgery followed by Adriamycin, Ifosfamide

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**11. Gastric Cancer**  
(Ilson)

A 55 yo pt presents with anemia and epigastric pain and an adenocarcinoma in the gastric antrum. Evaluation including PET scan, EUS, and CT scan reveals a T3N1 adenocarcinoma. Laparoscopy reveals no metastatic disease.

**Appropriate treatment should be:**

- A. Primary surgery alone.
- B. Gastrectomy followed by radiation therapy.
- C. Preoperative radiotherapy.
- D. Pre and post op chemo with FLOT.
- E. Palliative chemotherapy with capecitabine.

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**12. Gastric Cancer**  
(Ilson)

A 55 yo pt presents with anemia and epigastric pain and an EGD reveals an adenocarcinoma in the gastric body. A CT scan revealed bilobar hepatic metastases and retroperitoneal lymph nodes. IHC for HER2 tests 3+. The tumor also tests KRAS wild type.

**Appropriate treatment should be:**

- A. FOLFOX
- B. ECF
- C. Trastuzumab + Capecitabine/Cisplatin
- D. Modified DCF
- E. FOLFOX + Cetuximab

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**13. Pancreatic Cancer**  
(Kindler)

A 65 yo male with a cancer in the head of the pancreas metastatic to liver has been losing weight and complains of bloating and loose stools. He denies steatorrhea.

**You advise which of the following:**

- 1. Low fat diet
- 2. Simethicone
- 3. Pancreatic enzyme replacement before each meal and snack
- 4. Pancreatic enzyme replacement during each meal and snack

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**14. Mesothelioma**  
(Kindler)

A 55 year old fireman with newly diagnosed malignant sarcomatoid pleural mesothelioma presents with night sweats, chest pain, and dyspnea on exertion.

**Which treatment option do you recommend?**

- A. Extended pleurectomy/decortication followed by adjuvant pemetrexed/platinum
- B. Neoadjuvant chemotherapy with pemetrexed/platinum followed by extrapleural pneumonectomy and adjuvant hemithoracic RT
- C. Pemetrexed/platinum/bevacizumab
- D. Ipilimumab/nivolumab
- E. 1 or 2



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**15. Adjuvant CRC**  
(Haller)

You have treated a 64-year-old woman with adjuvant FOLFOX for stage III colon cancer.

**In addition to recommending surveillance with periodic physical examination, CT scans and CEA tests, which of the following would NOT be supported by retrospective studies from clinical trials?**

- A. Multivitamins
- B. Exercise
- C. Eating less red meat and more vegetables
- D. Aspirin
- E. Vitamin D



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**16. Adjuvant CRC**  
(Haller)

In your multimodality GI clinic, you are seeing a 54-year-old man who was recently found to have a 3 cm cancer of the rectum, 7 cm from the anal verge. You are considering preoperative chemoradiation. You are planning to obtain a dedicated MRI for staging.

**Based on the data from the German CAO/ARO/AIO-94 Study comparing postoperative to preoperative neoadjuvant chemoradiation in equally well-staged patients, and understanding that adjuvant treatment is directed for patients at high risk for locoregional and distant recurrences, what is the likelihood that a well-staged patient receiving neoadjuvant treatment will have a tumor stage that would be at low risk?**

- A. 0%
- B. 5%
- C. 15%
- D. 25%
- E. 40%



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**17. Sarcomas**  
(AguInik)

A 55 yo male is seen in the ER for a GI bleed. On exam he is found to have a GIST. He is now status post surgery and seen for the prospect of adjuvant imatinib therapy.

**Which of the following features in itself would not be an indication for 3 years of adjuvant therapy?**

- A. Small bowel location
- B. Mitotic index 15/50 high power fields
- C. Size= 14 cm
- D. Tumor rupture
- E. Size= 7 cm with mitotic index 6/50 high power fields



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**18. Sarcomas**  
(AguInik)

A 25-year-old woman with newly diagnosed high grade osteosarcoma is referred to you for treatment of her disease. She was well until she recently developed pain in her chest wall. CT scan confirmed a 3.5 x 6.0 x 5.8 cm mass arising from the 7th rib. Staging scans show no other sites of disease.

**What is the best treatment plan for this patient?**

- A. Cyclophosphamide, Adriamycin, Vincristine alternating with Ifosfamide, Etoposide x 14 cycles with Surgical resection after 4 cycles.
- B. Cyclophosphamide, Adriamycin, Vincristine alternating with Ifosfamide, Etoposide x 14 cycles with addition of radiation after 4 cycles.
- C. Methotrexate, Adriamycin, Cisplatin followed by surgical resection
- D. Surgery Alone
- E. Radiation followed by Surgery followed by Adriamycin, Ifosfamide



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**19. Adjuvant CRC**  
(Haller)

Patients with rectal cancer have typically been offered neoadjuvant chemoradiotherapy with 5-FU. Based on the AIO-04 German trial, in which patients also received postoperative adjuvant treatment with 5-FU/LV. Oxaliplatin has an established role in adjuvant therapy of high-risk colon cancer, and may be a radiosensitizer.

**What is the most likely result of either neoadjuvant or adjuvant oxaliplatin in unselected prognostic groups with rectal cancer, as proven on the results of recent trials?**

- A. Improved pCR
- B. Improved rates of sphincter preservation
- C. Reduced adverse events
- D. Improved overall DFS
- E. Improved OS



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**20. Adjuvant CRC**  
(Haller)

The colon and rectum comprise at least 2 distinct biologic entities, in part based on embryologic origin, midgut and hindgut. Based on SEER data, recent analyses of early stage disease suggest different prognoses based on left vs. right-sided primary tumors.

Which of the following is true from these analyses?

- A. Patients with R-sided tumors had inferior survival.
- B. Differences were more pronounced in stage I and II disease
- C. The hazard ratios for 3-yr survival were more pronounced in stage IV disease
- D. Rectal cancers had inferior survival compared to other left-sided tumors



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**21. Pancreatic Cancer**  
(Kindler)

A 78 yo male with pancreatic adenocarcinoma metastatic to liver has a performance status of 2.

You discuss the various treatment options available, and encourage him to select:

- A. Gemcitabine plus erlotinib because it improves response rate and quality of life over single-agent gemcitabine
- B. FOLFIRINOX because it has the highest response rate and achieves the greatest improvement in survival of any regimen evaluated in phase III trials in this disease
- C. Single agent gemcitabine because it improves survival over 5-FU
- D. Pembrolizumab because it achieves durable responses in pancreatic cancer patients



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**22. Metastatic Therapy for Colon and Rectal Cancer**  
(Marshall)

A 69-year-old female is referred to you for consideration of chemotherapy for newly diagnosed colon cancer. She presented with anemia and on colonoscopy was found to have a lesion in her ascending colon. A CT scan was performed showing several metastases in the liver and the lungs, CEA of 11, and otherwise excellent performance status. She has already undergone surgical resection of the lesion with the findings of a T2N2M1 RAS WT, MSS adenocarcinoma of the colon with biopsy positive liver mets.

True statements about her treatment options include all the following except:

- A. FOLFOX and FOLFIRI have shown similar survival results and are acceptable front-line choices for therapy.
- B. Bevacizumab and cetuximab added to standard chemo backbones have the similar OS in right sided colon cancers
- C. FOLFOXIRI plus biologics is an option as first line therapy
- D. Capecitabine and oxaliplatin with bevacizumab have been shown to be non-inferior to FOLFOX + bevacizumab
- E. Chemotherapy reductions/maintenance therapy intervals are appropriate in selected patients without risking a reduction in clinical outcome



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**23. Metastatic Therapy for Colon and Rectal Cancer**  
(Marshall)

One of your patients who was receiving FOLFOX + bevacizumab for first line stage IV colon cancer has now progressed. Her primary tumor was in the descending colon. Her treatment consisted of 8 cycles of FOLFOX + bevacizumab achieving a PR, then continued therapy with just the 5-FU and bevacizumab (Optimox strategy) for 4 months when she was found on CT scan to have new lesions and growth of the existing ones. She has tolerated the chemotherapy well with no neuropathy. Her tumor is RAS wild type.

**Treatment options include all except:**

- A. Resume Oxaliplatin
- B. Irinotecan based therapy with bevacizumab
- C. Irinotecan based therapy with cetuximab
- D. Increase the dose of bevacizumab and continue the 5-FU
- E. Irinotecan alone



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**24. Sarcomas**  
(Aguinik)

A 34-year-old female with metastatic liposarcoma with numerous retroperitoneal tumors and lung metastases is referred to your oncology clinic for treatment options.

**Given that her disease is unresectable, all the following regimens could be considered for her disease, except?**

- A. Trabectedin
- B. Ifosfamide
- C. Pazopanib
- D. Eribulin
- E. Doxorubicin based therapy



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**25. Sarcomas**  
(Aguinik)

A 35-year-old female presents with a firm, painless mass that has been enlarging on her left forearm for the last year. Her PCP refers her for a biopsy which reveals a synovial sarcoma. Physical exam is otherwise unremarkable besides a 5.5 cm left forearm mass.

**Which of the following is the next step in her management?**

- A. Doxorubicin based neoadjuvant therapy
- B. Surgical Resection
- C. Neoadjuvant Radiation Therapy
- D. Bone scan or PET scan
- E. MRI of the left upper extremity and CT chest



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**26. Metastatic Therapy for Colon and Rectal Cancer**  
(Marshall)

A 68-year-old man with refractory RAS WT metastatic colon cancer that is unresectable is being treated with cetuximab and irinotecan. He has already received FOLFOX plus bevacizumab and irinotecan alone. After four weeks of treatment, he returns to clinic with a grade III rash on his face, scalp and chest. The rash is pruritic, pustular, and disfiguring. He does not go out in public anymore due to his appearance. His CEA has fallen from 250 to 75 in the 4 weeks of treatment and his cancer related RUQ pain has decreased.

**You advise:**

- A. Stop the cetuximab due to obvious allergic skin reaction and do not reintroduce
- B. Treat the reaction with topical and intravenous steroids and maintain the treatment
- C. Reduce the dose of cetuximab and continue the treatment
- D. Hold the cetuximab, treat the rash with antibiotics and have the patient return in a week for consideration of more treatment
- E. Slow the infusion rate of the cetuximab



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**27. Metastatic Therapy for Colon and Rectal Cancer**  
(Marshall)

A 52-year-old woman with metastatic colon cancer is receiving FOLFIRI plus bevacizumab. She is always very anxious when she sees you in your office and today is no exception. She has received three cycles of treatment and has tolerated it well except for alopecia, mild epistaxis, and grade II fatigue. Her physical exam remains unchanged but her blood pressure is recorded at 155/96 and is unchanged on repeat testing. She is very anxious to stay on schedule with her chemotherapy.

**You recommend:**

- A. Stopping the bevacizumab but continue the FOLFIRI
- B. Continue all therapy attributing the hypertension to "white coat" anxiety
- C. Reduce the dose of bevacizumab and continue the therapy
- D. Add an anti-hypertensive agent
- E. Dip her urine and if she has proteinuria, add an anti-hypertensive agent



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**THANK YOU**



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