Conclusion: The early nutritional assessment and the multidisciplinary approach showed a reduction in the percentage of the weight loss, due to an increase of calories and proteins intake (oral food) together with an increase in oral nutritional supplements. Serum proteins and albumin changed from 6,2 mg/dl (+/- 0,6) and 3,2 mg/dl (+/- 0,6) at T0 to 6,3 mg/dl (+/- 0,5) and 3,4 mg/dl (0,6) at T2.

D21 Prediction of overall survival after 3 months of treatment using the NLR-over-the-time curve in pancreatic cancer patients

C. Morelli[1], G. Formica[2], S. Pellicori[3], M. Roselli[3], V. Formica[3]

[1]Policlinico Tor Vergata, Rome; [2]DARC, Roma Tre University, Rome; [3]Tor Vergata' University Hospital, Medical Oncology Unit, Rome

Background: High NLR is an established adverse prognostic feature in pancreatic cancer, however his change over the time during the entire course of the disease and its ability to precisely predict survival have never been investigated.

Methods: We analysed 2975 blood cell counts from 85 metastatic pancreatic cancer patients to build a NLR-over-the-time-curve from the beginning of the disease history until death. The shape of NLR-over-the-time-curve was evaluated and the minumum timepoints needed to predict the entire curve was assessed using the error-vs-partial-measurmnets function.

Results: The NLR-over-the-time-curve was found to have a clear rectilinear shape in all analyzed patients. The best fitting linear curves proved to have a coefficient of determination, namely "R-squared", about of 24-25% for nearly all patients. In order to investigate how linear extrapolations of initial (partial) data can predict the whole phenomenon, we compared such extrapolations with the final best fitting curve in terms of R-squared and considered the prediction to be adequate when the corresponding R-squared attained the same final value of the best fitting curve. Overall, the R-squared of 24-25% could be attained in as early as three months of blood cell count measurements. Since the near-end-of-life NLR was > 4 in 95% of cases, then a precise overall survival prediction was possible using NLR values assessed during the first three months of patient management.

Conclusion: Building the NLR-over-the-time-curve is a precise tool to predict overall survival in pancreatic cancer patients. Future studies need to understand how interventions to change the slope of the curve (such as anti-inflammatory therapies) may impact on prognosis.

D22 Prognostic factors associated with survival and recurrence in resectable gastroesophageal cancer: retrospective analysis of 338 patients operated at the Hospital of Cremona in ten years' time

M. Ghidini[1], B.M. Donida[1], D. Lomiento[2], M. Ratti[1], C. Pizzo[1], F. Aldighieri[2], L. Toppo[1], V. Ranieri[2], C. Senti[1], G. Tanzi[3], M. Martinotti[2], R. Passalacqua[1], G. Tomasello[1], M. Rovatti[2]

[1]U.O. di Oncologia, Dipartimento Oncologico, ASST di Cremona, Cremona; [2]U.O. di Chirurgia, Dipartimento Chirurgico, ASST di Cremona, Cremona; [3]U.O. di Anatomia Patologica, Dipartimento Oncologico, ASST di Cremona, Cremona

Background: Surgical resection remains the only curative treatment for non-metastatic gastroesophageal (GE) cancer. A large cohort of GE cancers derived from a high-volume Italian center was analyzed to describe clinical outcomes and prognostic factors.

Methods: 338 patients (pts) diagnosed with GE cancers who underwent curative resection from 2007 to 2016 were considered. Variables analyzed were: age, sex, tumor location, histology, tumor (T), nodal status (N), resection margin status (R), grade (G), (neo) adjCT, adj CTRT, neutrophil/lymphocyte ratio (NLR) and lymphadenectomy status (D1-D2-D3) . Statistical analysis was performed according to intention to treat principle.

Results: Included pts were 131 women (39%) and 207 men (61%), median age 75 years. Adenocarcinomas (Lauren intestinal type) accounted for 69% (232 cases), 76 cases were diffuse carcinomas (22%) and 30 of mixed histology (9%). In 182 cases TNM stage was I or II (54%), 128 pts had stage III (38%) and 28 stage IV (8%). Median overall survival (mOS) was 33.8 mo and median disease free survival (mDFS) 24 mo. Adj CT was administered in 98 cases (29%); 93 pts (28%) had adj CTRT and 26 (8%) neoadj CT. D2 or D3 lymphadenectomy was performed in 182 pts, 54%. Median NLR was 2.52. Statistically significant variables for mOS and/or DFS at univariate analysis were: age, T, N, R, G, stage, tumor location, NLR and adjuvant chemotherapy. Pts with proximal disease (GE junction-cardias, 41 patients, 12%) had the poorest survival (mOS 17.1 vs 36.4 months for others, p = 0.0025). A low NLR was associated with higher mOS (44. vs 27.8 months for NLR over median value, p = 0.0016). Results of multivariate analysis are shown in Table 1.

Conclusions: Despite a short follow-up, our analysis performed on a large cohort of consecutive pts showed the prognostic value of R for both mDFS and OS. Moreover, disease stage and adj CT administration were significantly correlated with mOS. A longer follow-up is needed to achieve more conclusive data.

Table: D22. Multivariate analysis for mDFS and OS

Variable	mDFS (p value)	mOS (p value)
Sex	n.s.	n.s.
Tumor location (GE-cardia vs others)	n.s.	n.s.
Histology (Lauren)	n.s.	n.s.
T (1-2 vs 3-4)	n.s.	n.s.
N (0 vs 1-2-3)	n.s.	n.s.
R (0 vs 1-2)	0.033*	0.001 *
G (3-4 vs 1-2)	n.s.	n.s.
Stage (I-II vs III vs IV)	n.s.	0.012 *
NLR (> vs < median value)	n.s.	n.s.
Lymphadenectomy (D1 vs D2-D3)	n.s.	n.s.
Adj CTRT (no vs yes)	n.s.	n.s.
Neoadj CT (no vs yes)	n.s.	n.s.
Adj CT (no vs yes)	n.s.	0.001 *

*: statistically significant; n.s.: not significant

D23 Treatment and outcome for small bowel adenocarcinoma (SBA): a real life experience of two Italian centres

M. Occhipinti[1], A. Botticelli[1], C.E. Onesti[1], M. Ghidini[2], R. Righini[3], C. Pizzo[2], A. Milano[1], G. Tomasello[2], F.R. Di Pietro[1], L. Toppo[2], M. Ratti[2], R. Passalacqua[2], P. Marchetti[1], F. Mazzuca[1]

[1]Medical Oncology Unit, Sant' Andrea Hospital, "Sapienza" University of Rome, Rome; [2]Oncology Unit, ASST of Cremona, Cremona; [3]Oncology Unit, Israelite Hospital, Rome

Background: Small bowel adenocarcinomas (SBA) are rare tumours with an increasing incidence. The duodenum is the most common primary location. They are often sporadic, but Crohn's disease and genetic syndromes have been indentified as risk factors. Bowel occlusion and bleeding are common at clinical presentation. Surgical resection represents the best option for resectable tumours. The role of adjuvant treatment has not yet been established by randomised trials and in metastatic disease, the best treatment is fluoropirimidine and platinum based chemotherapy.

Patients and methods: In this retrospective observational study we enrolled patients with histological diagnosis of SBA treated at two Italian Hospitals. Their clinical courses and outcome were evaluated considering tumour location and treatment received. According to Kimora Classification we divided duodenum-ampullary carcinoma in intestinal and bilio-pancreatic type.

Results: 39 patients were evaluated. Median age at diagnosis was 66 years (range 29-88); male/female 21/18. According to tumour location we identified 3 duodenum adenocarcinomas (8%), 30(77%) duodenum-ampullary adenocarcinomas (23(59%) intestinal and 7(17%) biliary type), 3(8%) jujunal and 3(8%) ileal adenocarcinomas. At diagnosis the majority of the cases were stage II (16;41%) and G3 (15;23%) adenocarcinomas, while 8 pts were metastatic/unresectable. 20 of 31 early stage resected patients received adjuvant chemotherapy, mainly fluoropirimidine based (17;85%). 13 of them showed relapse of the disease. Overall, in the cohort of the resected patients we observed a median DFS of 14 m and a median OS of 33 m. 7 of the 8 unresectable/metastatic pts received a 5FU and oxaliplatin based first line chemotherapy and 1 of the 8 underwent a definitive chemoradiation for unresectable primary tumour. The unresectable/metastatic group showed a median PFS of 9 m and a median OS of 26 m. In the subgroup of resected ampullary adenocarcinoma OS was longer for intestinal type respect to biliary type with a median value of 40 m and 17 m respectively.

Conclusions: According to literature data, our analysis confirm the poor prognosis of SBA at all stages. Ampullary intestinal adenocarcinoma may have a better prognosis than ampullary biliary type. Fluropyrimidine based chemotherapy could be an option in the adjuvant setting and its combination with oxaliplatin could be a valid treatment for unresectable SBA.

D24 Small bowel adenocarcinoma (SBA) is a rare and heterogeneous disease: results of a retrospective analysis

K. Andrikou[1], A. Bittoni[2], R. Giampieri[2], G. Pugliese[1], G. Orsi[1], M. Barbolini[1], A. Lanese[2], R. Berardi[2], S. Cascinu[1]

[1]Clinica di Oncologia Medica-Azienda Ospedaliero-Universitaria di Modena, Modena; [2]Clinica di Oncologia Medica-Azienda Ospedaliero Universitaria "Ospedali Riuniti" di Ancona, Ancona

Background: Small bowel adenocarcinoma (SBA) is a rare disease representing about 1-3% of all gastrointestinal malignancies. Risk factors for SBA include inflammatory bowel disease and hereditary colorectal cancer syndromes. Moreover, SBA is sometimes associated with colorectal cancer. Because of its rarity, SBA biology and clinical course