involvement of BRCA2 and BRCA3 genes in the origin of bowel cancer and the propagation of metastases.

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Neoadjuvant/Adjuvant Therapy Shows Improved Survival Following Surgical Resection of Advanced Gastric Cancer H.J. Wanebo,[1] J.T. Tomicic,[1]* H. Safran.[2] *1. Dept. of Surgery, Roger Williams Medical Center, Providence, RI; 2. Brown University Oncology Group, Providence, RI.*

Background: Gastric resection for adenocarcinoma of the stomach has been the mainstay of treatment. Survival rates for early staged lesions (stage I-II) are reported in upwards of 60-65%. Recurrence rate is high and survival remains the same with surgery plus adjuvant chemotherapy versus surgery alone in advanced disease. Our experience using Taxol along with radiation has shown enhanced oportunity for curative resection and improved prolonged survival following a complete surgical resection. We prospectively randomized 778 patients out of 1527 patients from retrospective data obtained in the state of Rhode Island from 1993 to 2002 in an attempt to identify subgroups of patients that would most benefit from this adjuvant therapy approach. Patient selection was based on subset analyses according to location, stage and treatment modaltities. Results: 1527 patients were reviewed and 778 patients were eligible. There were 146 patients excluded due to disease not otherwise specified (NOS). The remaining 603 patients were excluded due to inability to complete treatment protocol or lost to follow-up. Table 1 categorizes the numbers of patients according to location, stage of disease, and whether patients had surgery alone versus adjuvant therapy plus surgery. Two-year survival was then calculated. Conclude: Our results demonstrate that a Taxol-based chemotherapy regimen combined with resection showed improved overall survival among patients with stage II and IV disease and should be considered for patients with higher stage gastric cancers. Our data also confirm that surgery alone should remain as the standard approach for stage I cancers of the stomach.

Subset of Gastric Cancer from 1993-2002 According to Location and Stage								
	Surgery alone----------				----------Surgery+Chemo+Radiation			
#Gastric Cancers by Location	Stage I	Stage II	Stage III	Stage IV	Stage I	Stage II	Stage III	Stage IV
Proximal - 317	60	18	68	50	6	19	32	64
Mid-third - 167	40	22	24	42	6	4	17	12
Distal third -294	70	32	43	90	6	6	23	24
Total # Cancers -778	170	72	135	182	18	29	29	72
2-year Survival rates according to stage	72.3%	50%	26%	11.3%	55.6%	63.2%	53.9%	26.7%

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IS EXTENDED LYMPHADENECTOMY (D2) JUSTIFIED IN PATIENTS WITH EARLY GASTRIC CANCER D. Nitti,* A. Marchet, C. Belluco, M. Olivieri, A. Ambrosi, R. Mencarelli, M. Lise. *Department of Oncological and Surgical Science, University of Padova, Padova.*

Introduction: The incidence of early gastric cancer (GC) is steadily growing in developed countries, and the accuracy of its preoperative diagnosis is now improved by the use of spiral computed tomography and endoscopic ultrasound. Since patients with early GC have a relatively good prognosis, and extended lymphadenectomy (D2) results in a higher postoperative mortality and morbidity compared to limited lymphadenectomy (D1), it is of major importance to define which is the best surgical treatment for these patients. The aim of the present study was, therefore, to investigate survival benefit of D2 lymphadenectomy in patients with early GC in a single European Institution. Methods: A review was made of our prospective gastric database from January 1980 to December 2001. Disease specific survival was estimated using the Kaplan-Meier method. Results: Of 527 patients who underwent surgery for primary gastric adenocarcinoma, 118 (22.4%) with pathology confirmed early GC (61 T1a, mucosal involvement, and 57 T1b, submucosal involvement) underwent a radical resection (R0) with D2 lymphadenectomy. In these 118 patients, the total number of lymph nodes examined was 2949 (median, 25; range, 11-52). The N stage according to the Japanese Gastric Cancer Association (JGCA) was: N1 (station 1 to 6) 11% (13 of 118 patients), and N2 (station 7 to 12) 6.8% (8 of 118 patients). Postoperative mortality occurred in 2 (1.7%) of 118 patients. During a median follow-up of 72.2 months, 5 of the 8 patients with level 2 metastasis died of disease. Therefore, the estimated survival benefit following D2 lymphadenectomy for 116 patients with early GC was 2.6% (3 of 116 cases). Table below reports the N level stage according to T stage and 5-year survival. Conclusions: Our results indicate that D2 lymphadenectomy in patients with early GC has a limited survival benefit because metastasis to level 2 are rare. Therefore, this surgical approach should be reconsidered in adequately preoperatively staged patients.

T stage	N0	N level N1	N2	Total
T1a	53 (88.4%)	5 (8.3%)	2 (3.3%)	60
T1b	42 (75.0%)	8 (14.3%)	6 (10.7%)	56
5-year survival	84.3%	78.6%	75.0%	

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Neoadjuvant Chemoradiation in Locally Advanced Rectal Cancer: Results of a Phase II Study P. Delrio,[1]* A. Avallone,[2] C. Guida,[3] P. Marone,[4] A. Petrillo,[5] F. Tatangelo,[6] M. Di Marzo,[1] D. Scala,[1] V. Parisi.[1] *1. INT Surgical Oncology "C", Napoli, Italy; 2. INT Medical Oncology "A", Napoli, Italy; 3. INT Radiotherapy, Napoli, Italy; 4. INT Endoscopy, Napoli, Italy; 5. INT Radiology, Napoli, Italy; 6. INT Pathology, Napoli, Italy.*

Introduction: Neoadjuvant approach to locally advanced rectal cancer (LARC) is widely investigated. Improved resectability rates and the chances of sphincter saving procedures are fascinating results for patients refusing a terminal colostomy. The aim of the study is to evaluate, in patients with LARC, the efficacy of a neoadjuvant schedule of TOM+OXA+5FU+LFA and radiotherapy (RT) in improving local control and rate of conservative procedures. Methods: A phase II study with OXA+TOM+LFA+5-FU and preoperative concomitant RT in LARC was inaugurated on the basis of a previous phase I study. The recommended doses were respectively 100, 2,5, 250 and 900 mg/m2. RT was given to a total dose of 45 Gy. Chemotherapy was administered every 2 weeks up to 3 courses. Eligible patients underwent pre-treatment assessment by EU, MRI and PET. Distance of the tumour from mesorectal circumferential margin (CRM) <2 mm and node positivity at MRI/EU were included. All patients underwent restaging six weeks after chemoradiation and then operated. Tumour regression grade (TRG) was scored according to the Mandard classification. CRM was evaluated by the Quirke procedure. Twenty patients underwent surgery up to now. Results: All patients had T3/T4 tumours. Chemoradiation was well tolerated in all cases. A down-sizing of the tumor was detected in all patients. A sphincter-saving procedure in patients candidated to a Miles operation was possible in 3/6 patients. TME with nerve sparing technique was performed in all cases. Patients receiving an anterior resection with coloanal anastomosis had a loop ileostomy. An anastomotic dehiscence (5%) and two minor fistulas (10%) occurred. An R0 resection was obtained in 18/20 patients (90%). TRG scores were: TRG1 in 7 patients (35%), TRG2 in 6(30%), TRG3 in 5(25%), TRG4 in 2(10%). No local recurrence has been recorded up to now. Conclusions: The presented chemoradiation preoperative schedule seems to offer good results for local control and tolerability. TRG score appears to be a promising factor to evaluate local response after a neoadjuvant treatment. Long term survival and local recurrence data need a longer follow-up.

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Improving Nodal Harvest in Colorectal Cancer: a simple effective approach L.K. Helyer,* P. Johnson, D. Malatjalian, G. Porter. *Gen. Surg, Dalhousie University, Halifax, NS, NS, Canada.*

BACKGROUND: Accurate staging and appropriate use of adjuvant chemotherapy in colorectal cancer is dependent on adequate nodal harvest. Recent published data, including our own, have demonstrated that such lymph node harvest is frequently inadequate, likely related to both surgical technique