

Ever since chemotherapy has been shown to offer advantages to patients with advanced oesophago-gastric cancer, in terms of overall survival and quality of life, the subsequent improvements in treatment regimen, can at best be described as modest.

In recent years there has been a move towards personalised oncology where treatments are not based on population risks and crude parameters such as stage and organ based tumour origin, but on individual molecular characteristics that predict for response to targeted treatments in that individual.

In patients with breast cancer, probably the most exciting development in the last 10 years has been the benefit of trastuzumab in those patients that over express the epidermal growth factor receptor (Her-2). Initially this led to an improvement in median survival of patients with advanced disease, when combined with non-anthracycline based chemotherapy, by approximately 5 months. These results were considered so persuasive that the then Health Minister Patricia Hewitt decided ahead of NICE to make this treatment to patients with breast cancer. The subsequent benefits for appropriate patients receiving this treatment after surgery were quite remarkable with a reduction in rates of recurrence of disease of approximately 50%.

It was of little surprise therefore that when it is known that Her-2 is over expressed in gastric cancer at similar rates to that seen in breast cancer (~20%), that a trial was designed to assess it's benefit in this setting. The standard of care worldwide was based on cisplatin and fluoropyrimidine chemotherapy. In the UK, the addition of anthracyclines has become standard, although no trial has specifically shown the benefit of this triplet over doublet therapy. Based on previous experience on breast cancer it was certainly felt unacceptably hazardous from a cardiotoxic point of view to combine trastuzumab with an anthracycline. This trial showed that median survival was prolonged by approximately 5 months in Her-2 positive patients (as has been defined for use in breast cancer and in the patient population which would be considered for treatment under it's current license). Of note also was that the comparator arm in this trial appeared to perform as well as any previous combination therapy seen in contemporary published world wide trials.

This negative initial appraisal appears to be partly based on the interpretation that this does not fall under 'end of life' rules because the numbers of patients suitable for this treatment is greater than the threshold (of 7000) because of the inclusion of breast cancer patients. This is intrinsically unfair for patients with gastric cancer and I believe goes in the face of the reason this initiative was initially brought in, and will always unfairly discriminate against appraisals for license extensions smaller cancer populations as trials will always be first performed in more common diagnoses.

Most improvements in cancer care are of course incremental. However the use of trastuzumab in gastric cancer, is, as it was in breast cancer, a step improvement rarely seen and it would be a massive blow for patients with this disease if this decision was not reversed.