Optimal treatment of M0 esophageal squamous cell carcinoma: decisive factors in selection.

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Richard Estes, 1967

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Fig. 1 | Visible and hidden conflicts of interest in medicine. Visible conflicts are only the tip of the iceberg.

Niraula S, et al. Nat Rev Clini Oncol 2025

PREMISE

XXXIII SIMPOSIO INTERNACIONAL INTERNATIONAL SYMPOSIUM
11 - 12 DE DICIEMBRE DE 2025
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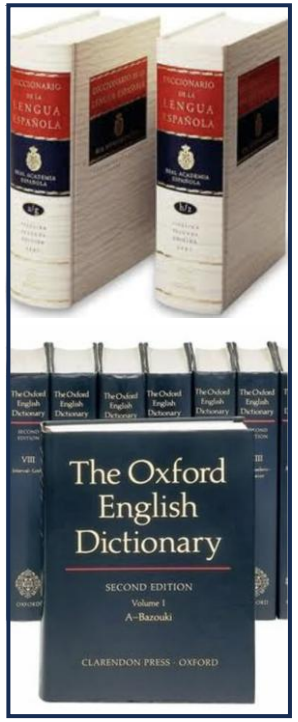
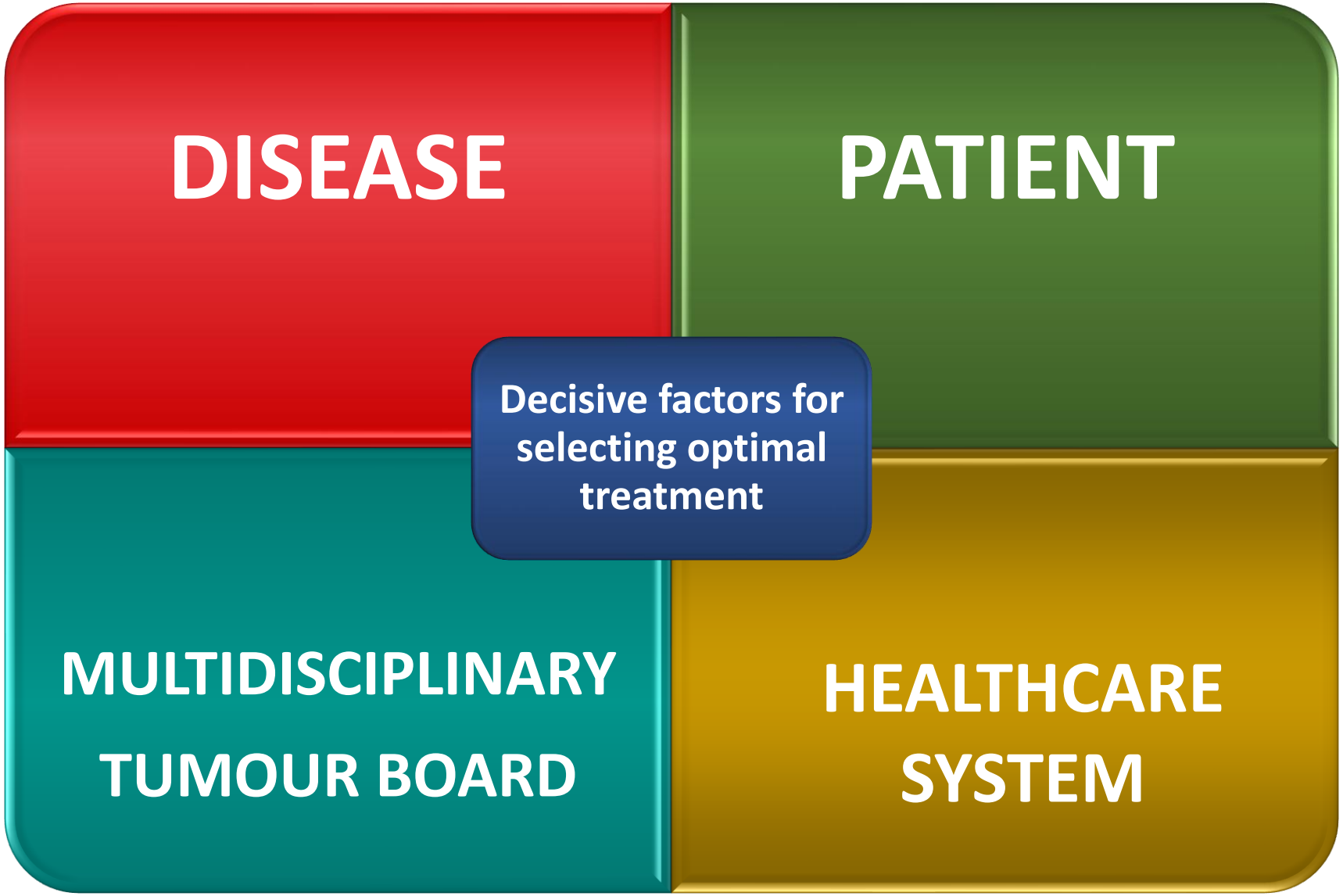


Optimal: the best possible, producing the best possible results.
In a particular situation or circumstance.

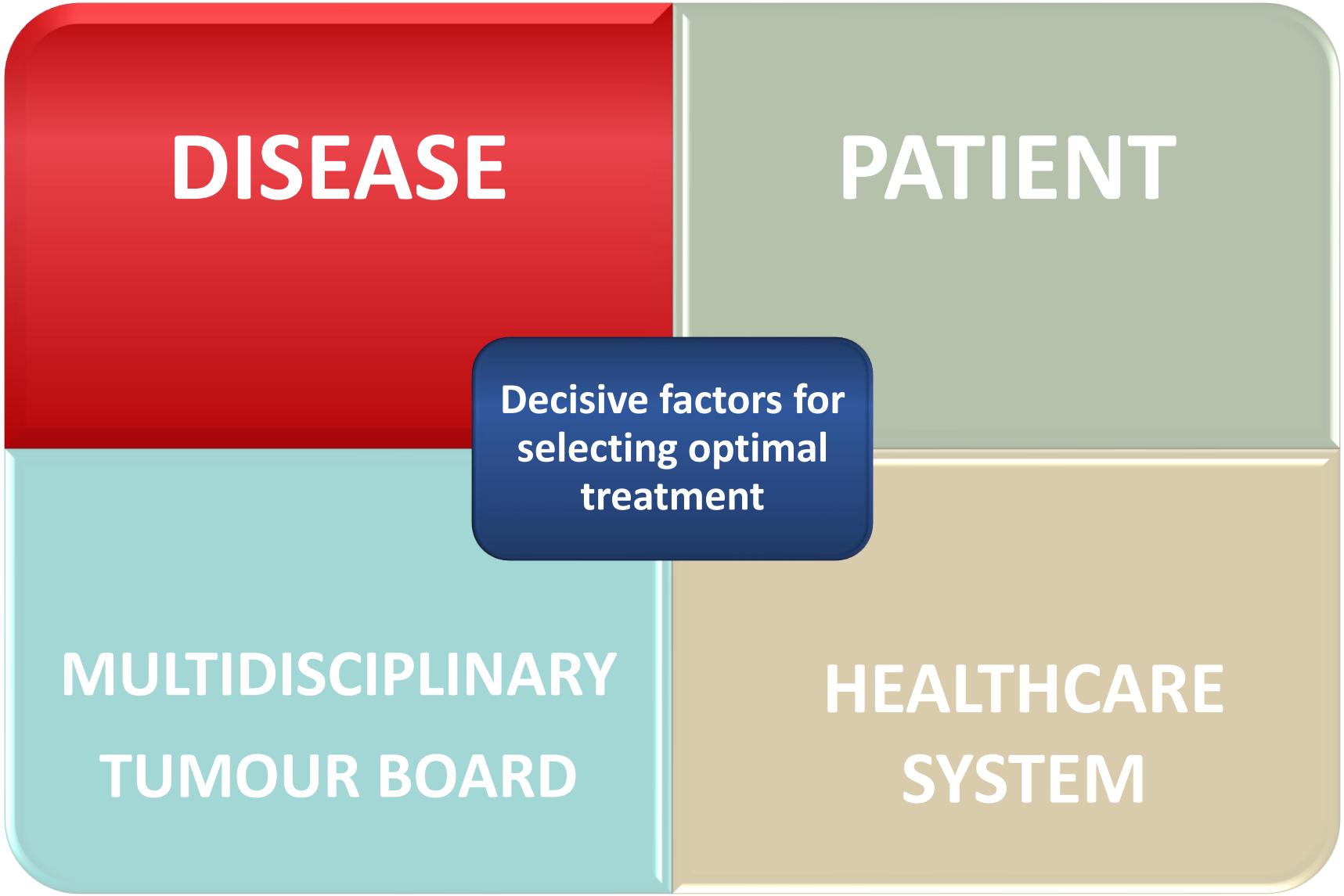
Decisive: showing the ability to make decisions quickly an effectively.
Determines or influences selection.

Decisive factors for selecting the optimal treatment of M0 esophageal SCC

FACTORS


DISEASE
PATIENT
Decisive factors for selecting optimal treatment
MULTIDISCIPLINARY TUMOUR BOARD
HEALTHCARE SYSTEM

FACTORS


DISEASE
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Decisive factors for selecting optimal treatment
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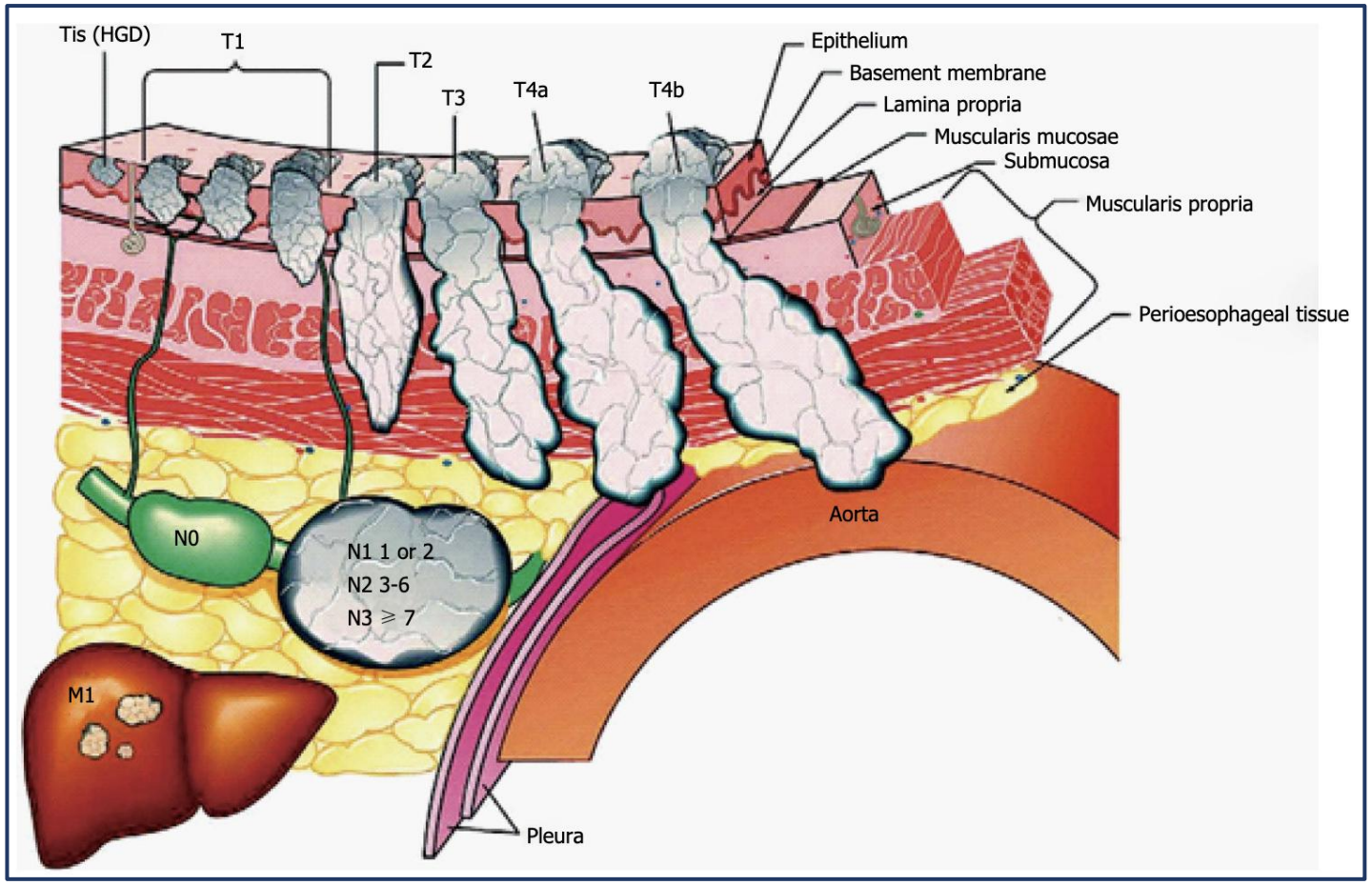
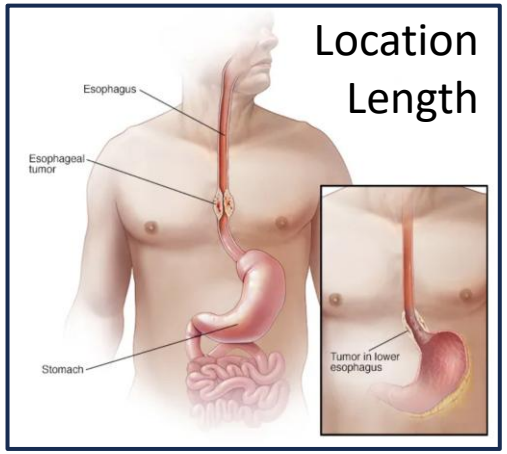
HEALTHCARE SYSTEM

DISEASE: TNM AND LOCATION - LENGTH



	T1	T2	T3	T4 a	T4 b
N0	I	II	II	IV A	IVA
N1	I	II	III	IV A	IVA
N2	III	III	III	IVA	IVA
N3	IVA	IVA	IVA	IVA	IVA

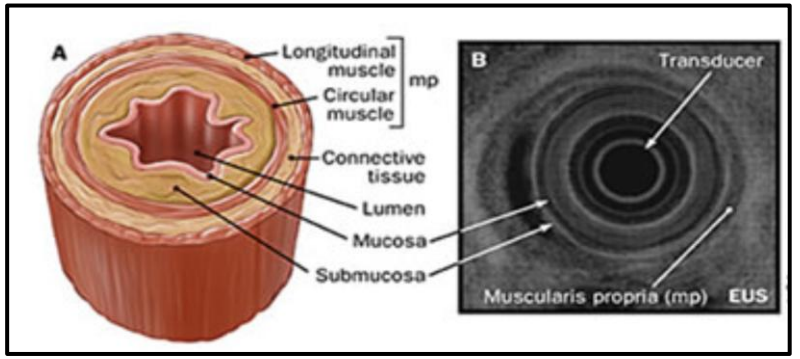
Stage groupings for M0 esophageal squamous cell carcinoma

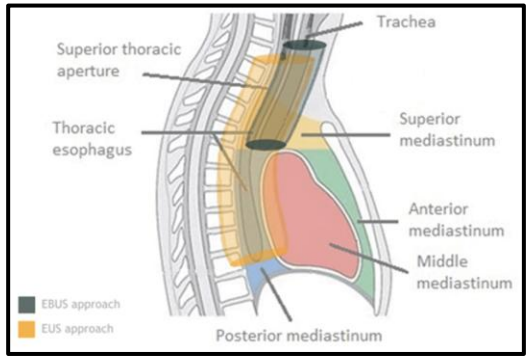


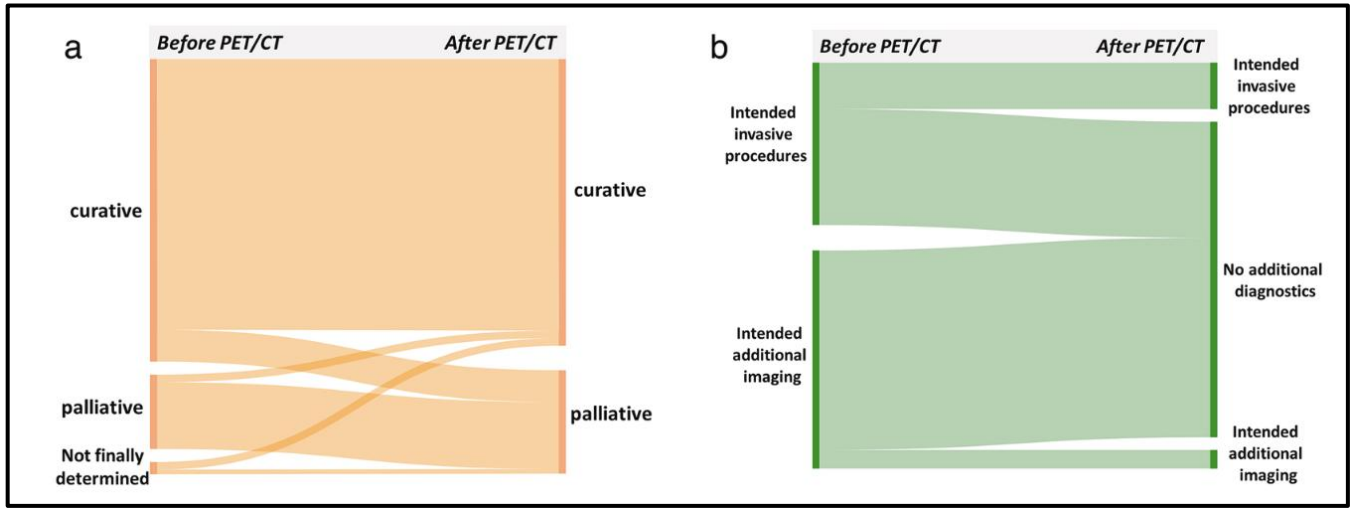
Luo L-N. World J Gastroenterol 2016
www.mayoclinic.org

DISEASE: STAGING PROCEDURES

Procedure	Purpose
FBC	Assess for iron-deficiency anaemia
Renal and liver function	Assess renal and liver function to determine appropriate therapeutic options
Endoscopy and biopsy	Obtain tissue for diagnosis, histological classification and molecular biomarkers, e.g. PD-L1 and HER2 status (AC)
EUS	Accurate assessment of T and N stage in potentially resectable tumours
Bronchoscopy with endobronchial ultrasonography	Assess tumour growth towards central airways; complementary to EUS, especially when tumour stricture precludes EUS
CT of thorax + abdomen ± pelvis	Staging of tumour to detect local/ distant lymphadenopathy and metastatic disease
PET—CT, if available	Staging of tumour to detect local/ distant lymphadenopathy and metastatic disease







Obermmanová R, et al. Ann Oncol 2022
Velasquez-Rodriguez JG, et al. Cureus 2022
Reinert CP, et al. Eur J Radiol 2021

DISEASE: UNRESECTABLE VS INCURABLE

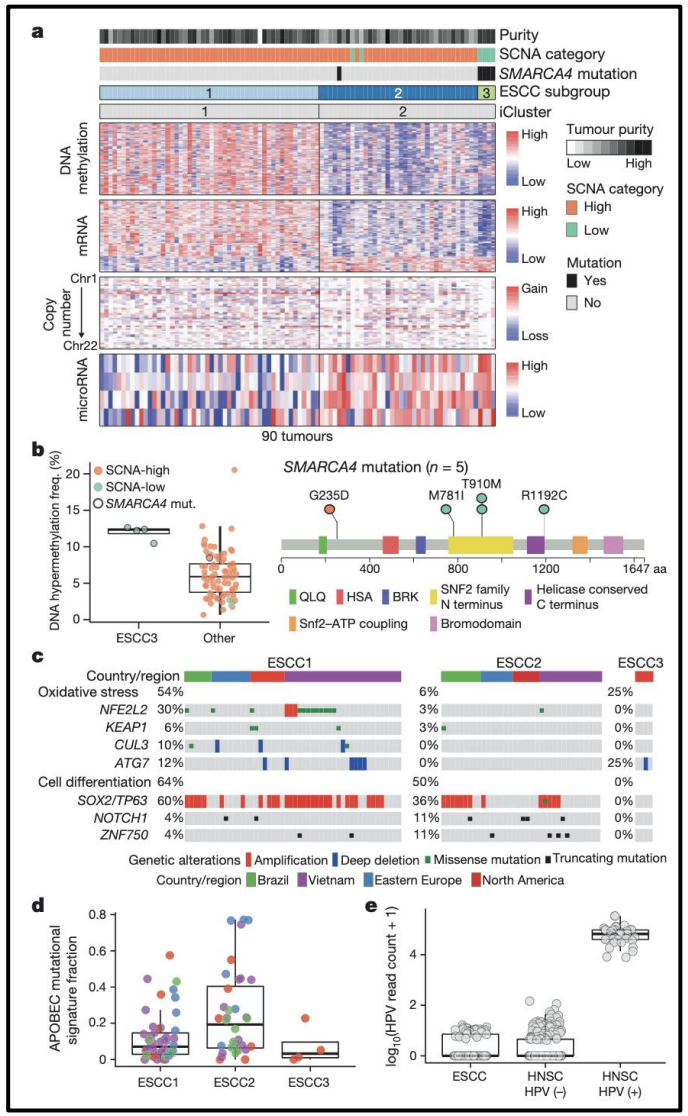
UNRESECTABLE:

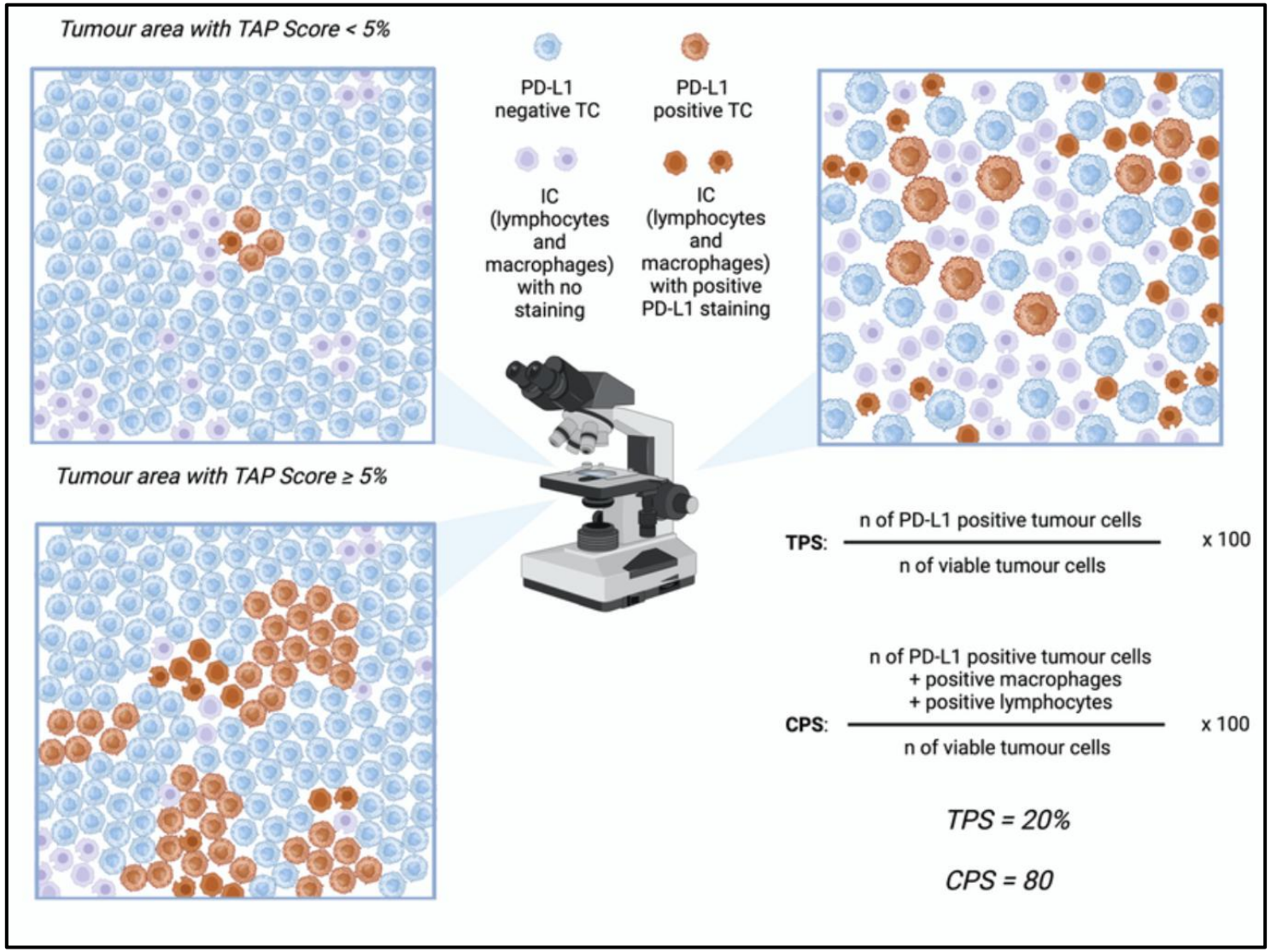
Cancer that can not be completely removed surgically (R0) due to either local tumour invasión into critical adjacent structures or the presence of distante metastatoc disease

NOT AMENABLE TO CURATIVE TREATMENT:

Currently available medical interventions can not reliably achieve the complete and permanente erradication of the disease

DISEASE: MOLECULAR PATHOLOGY



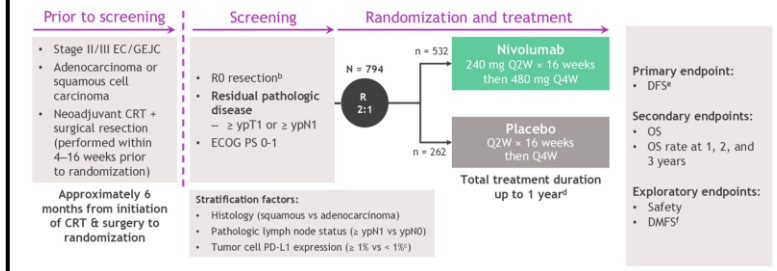


The Cancer Genome Atlas Research Network Nature 2027
Korpan M, et al. Cancers 2025

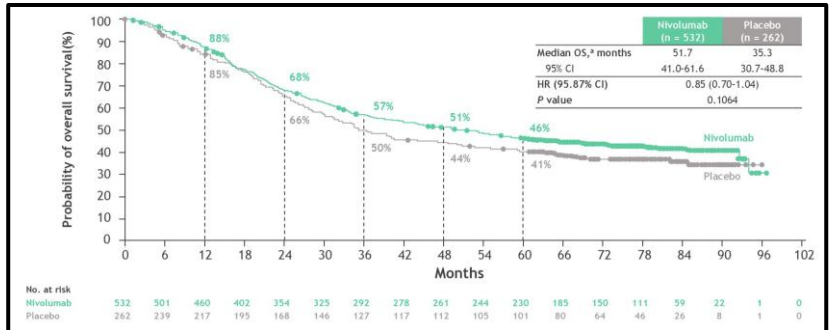
DISEASE: MOL. PATHOLOGY RELEVANCE - LOCALIZED

CheckMate 577 study design

- CheckMate 577 is a global, phase 3, randomized, double-blind, placebo-controlled trial[a]

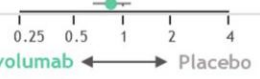


- At the data cutoff (November 7, 2024), the median follow-up was 78.3 months (range, 60.1-96.6)[g]



- Median OS was 16.4 months longer and the 5-year OS rate was higher with nivolumab vs placebo, suggesting clinically meaningful improvement in OS, although statistical significance was not met

Category	Subgroup	Median OS, mo		Unstratified HR (95% CI)
		Nivolumab	Placebo	
Overall	N = 794	51.7	35.3	0.85 (0.70-1.03)
Age, years	< 65 (n = 507)	56.4	36.6	0.83 (0.65-1.06)
	≥ 65 (n = 287)	39.3	35.2	0.87 (0.64-1.19)
Sex	Male (n = 671)	45.5	34.7	0.88 (0.72-1.08)
	Female (n = 123)	NR	48.0	0.70 (0.41-1.19)
Race[a]	White (n = 648)	49.5	34.8	0.84 (0.68-1.03)
	Asian (n = 117)	61.5	NR	1.10 (0.63-1.93)
ECOG PS	0 (n = 464)	60.5	40.3	0.85 (0.66-1.10)
	1 (n = 330)	37.2	32.1	0.84 (0.63-1.12)
Disease stage at initial diagnosis[b]	II (n = 278)	58.2	44.1	0.86 (0.62-1.19)
	III (n = 516)	49.3	32.8	0.84 (0.66-1.06)
Tumor location at trial entry	Esophagus (n = 467)	49.5	31.4	0.69 (0.54-0.88)
	Gastroesophageal junction (n = 327)	54.9	64.2	1.14 (0.83-1.56)
Histologic type[c,d]	Adenocarcinoma (n = 563)	51.7	40.2	0.92 (0.73-1.15)
	Squamous cell carcinoma (n = 230)	50.7	31.4	0.72 (0.51-1.03)
~~Tumor cell PD-L1 expression[c]~~	~~≥ 1% (n = 128)~~	~~68.0~~	~~51.2~~	~~0.88 (0.54-1.43)~~
	< 1% (n = 571)	47.7	34.6	0.82 (0.66-1.02)
PD-L1 CPS[f]	≥ 1 (n = 585)	45.5	33.5	0.79 (0.64-0.99)
	< 1 (n = 81)	39.2	52.8	1.40 (0.77-2.56)
Pathologic lymph node status[d,g]	ypN0 (n = 333)	92.8	68.5	0.81 (0.58-1.14)
	≥ ypN1 (n = 459)	33.6	28.0	0.86 (0.68-1.10)



Kelly RJ, et al. ASCO 2025

DISEASE: MOL. PATHOLOGY RELEVANCE - ADVANCED

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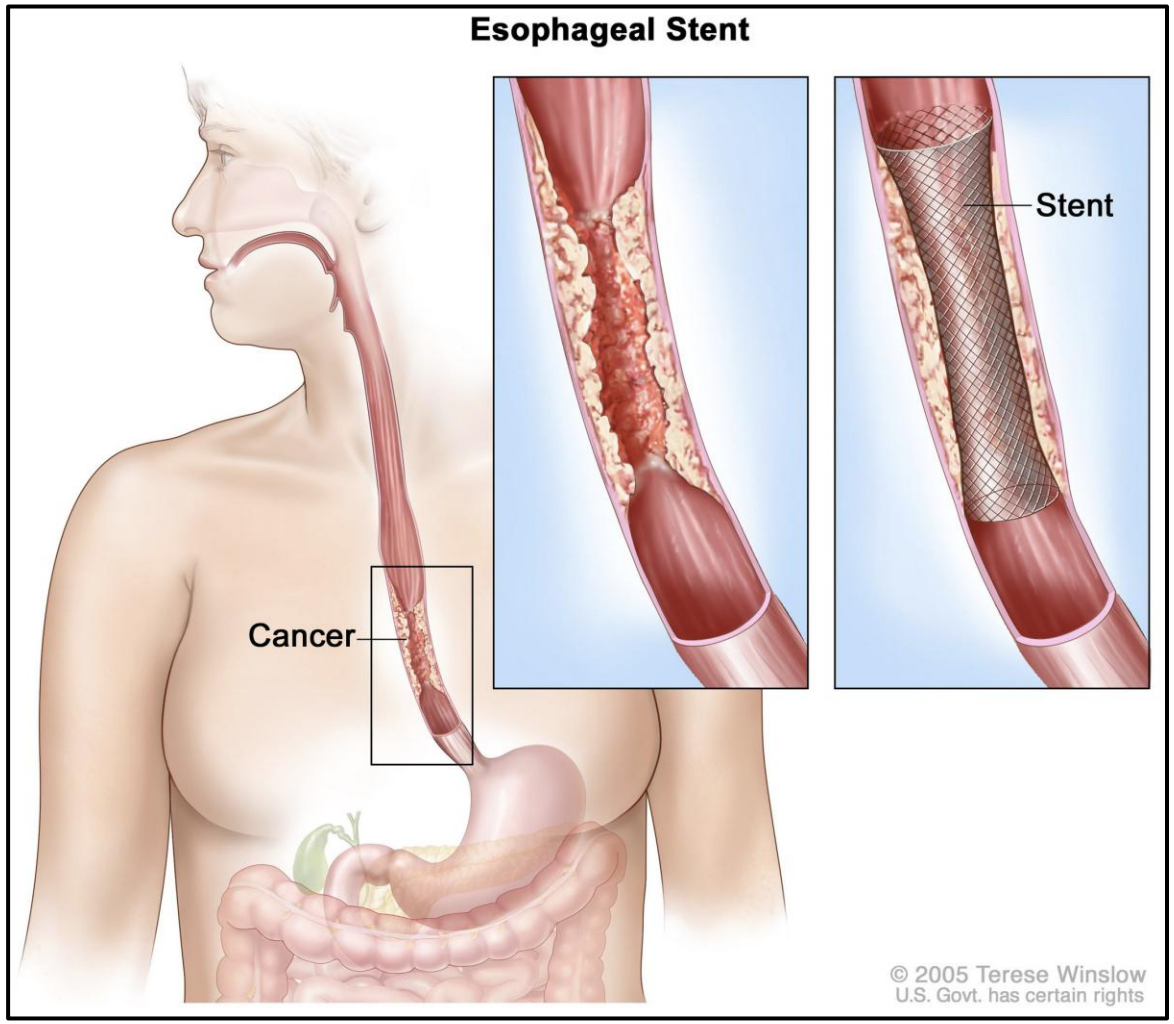
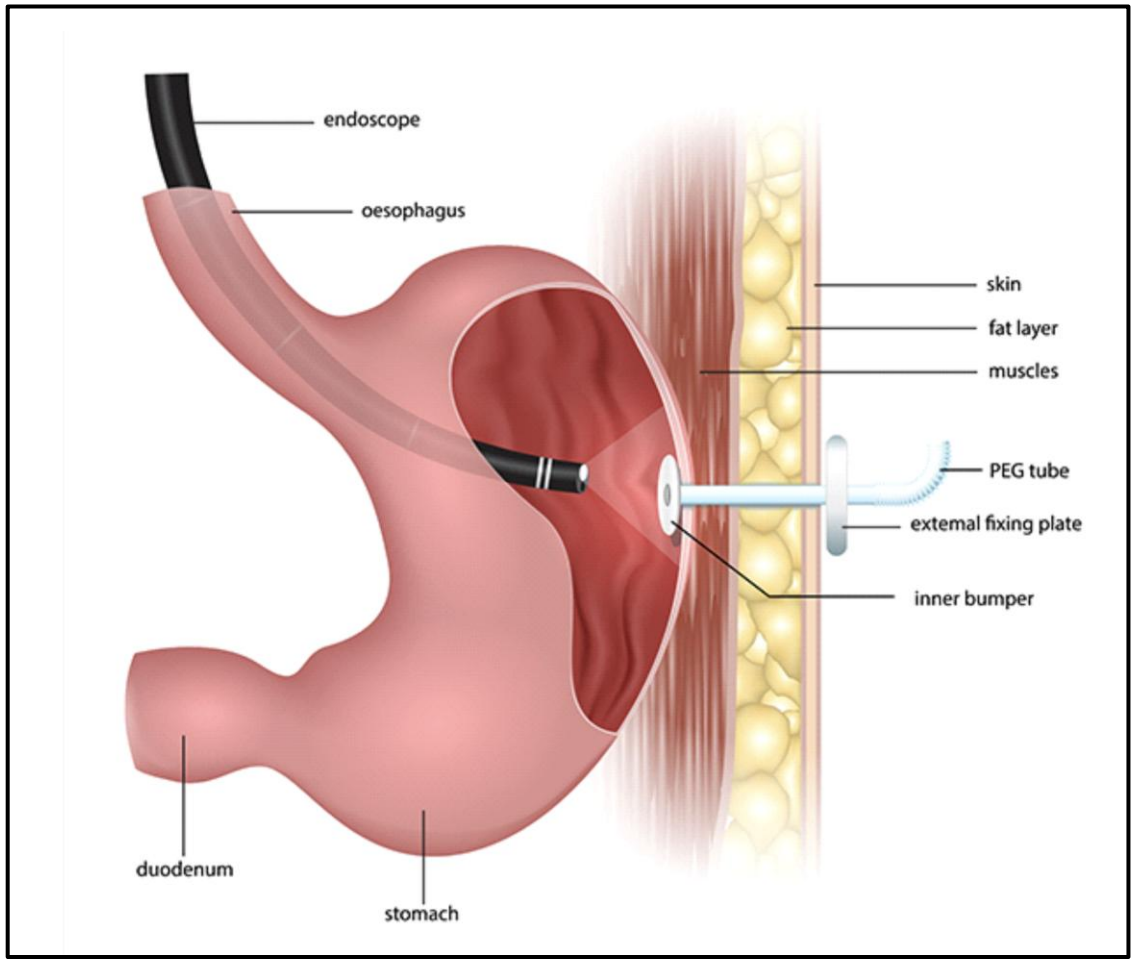
DRUG AND STUDY	DESIGN	BIOMARKER	GLOBAL POPULATION	POPULATION CHARACT.	PRIMARY ENDPOINT	SUBGROUPS	SECONDARY ENDPOINT	TOXICITY	QoL	ESMO MCBS - COST ‡
Pembrolizumab **KEYNOTE - 590** *Lancet 2021* *Oncologist 2024* *ASCO GI 2024*	Phase III CDDP + FU + Pembrolizumab/ placebo Measurable Dis. Sttrat,:ECOG, region, histology	**PD-L1 CPS ≥ 10** ADC.: 13% SCC: 33% Primary endpoint	LA unresect (9%) or MTS (91%). N: 749 p. ADC (27%) and SCC	ECOG 0-1: 90% Age 63 years. male 84%. Asia 54%.	OS in PD-L1 CPS ≥ 10: HR 0.64 (0.52-0.80)* Δ 4.1 monthsat 2 y. * FU: 5 y.	OS in SCC and PD-L1 CPS ≥ 10: HR 0.60 (0.46-0.76) Δ 5.1 m.	SCC and PD-L1 CPS ≥ 10 PFS: HR 0.53 (0.41-0.69) Δ ≈ 2 months. RR:51% vs 28%. DoR: 10.4 vs 4.4 months.	Tox. ≥ G3: 72% vs 68%. Tox. IO: 26% vs 12%. ≥ G3: 7% vs 2% Global population	Similar: - QoL - Time to deterioration Improv. Pain and dysphagia Not ESMO qualified Global population	I, A MCBS 4 v.2.0 – Form 2A SNS financed €€€
Nivolumab **CHECKMATE - 648** *N Eng J Med 2022* *ASCO 2022* *ESMO GI 2024* *ESMO Gastr Oncol 2025*	Phase III CDDP + FU +/- Nivolumab * Measurable Dis. Strat,:ECOG, region, PD-L1 TPS, MTS	**PD-L1 TPS ≥ 1%** SCC.: 49% Primary endpoint	LA unresect. (15%) or MTS (80%). N: 645 p. SCC 100%.	ECOG 0-1: 100% Age 64 years. Males 82%. Asia 71%. MTS ≥ 2: 51%	OS in PD-L1 TPS ≥ 1%: HR 0.60 (0.47-0.77) Δ 5.9 months. FU: 4 y.		PD-L1 TPS ≥ 1% PFS: HR 0.67 (0.51-0.88) Δ 2.4 months. RR: 53% vs 20%. DoR: 8.4 vs 5.7 onths	Tox. ≥ G3: 47% vs 36%. Tox. IO: 90% vs 44%. ≥ G3: 9% vs 5% Global population	Similar: - QoL Improvement Q-TWiST (Post hoc) Not ESMO qualified Global population	I, A MCBS 4 v.2.0 – Form 2A SNS financed €€
Tislelizumab **RATIONALE - 306** *Lancet 2023* *Oncologist 2024* *ASCO GI 2024* *ISPOR 2024*	Phse III Cis/oxa + FP/ pacl+ tislelizum. /placebo Measurable, evaluable Dis. Sttrat:QMT, region, previous treatment	**PD-L1 TAP ≥ 5%** Epiderm.: 55% NO Primary endpoint	LA unresect (14%) or MTS (86%). N: 649 p. SCC 100%.	ECOG 0-1: 100% Age 64 years. Male 87%. Asia 75%. MTS ≥ 2: 17%	OS in PD-L1 TAP ≥ 5%: HR 0.61 (0.48-0.78) Δ 9.1 months. FU: 3.5 y.	LA unresectable TAP≥ %5. N: 45p. OS: HR 0.37 (0.16-0.83) PFS: HR 0.44 (0.19-1.02)	PD-L1 TAP ≥ 5% SLP: HR 0.50 (0.39-0.65) Δ 2.7 months. RR:71% vs 41%. DoR: 7.1 vs 5.4 months.	Tox. ≥ G3: 70.2% vs 66.5%. Tox. IO: 42.7% vs 21.6%. ≥ G3: 8.8% vs 2.2% Pop. TAP ≥ 5	Trend to improvement in pain and les worsening of functional status Not ESMO qualified Global population	I, A MCBS 4 v.2.0 – Form 2A SNS financed €

*Nivolumab-Ipilimumab non-SNS financed. ‡ Simplified QUALY cost (Hospitalaria del HGU Elche).

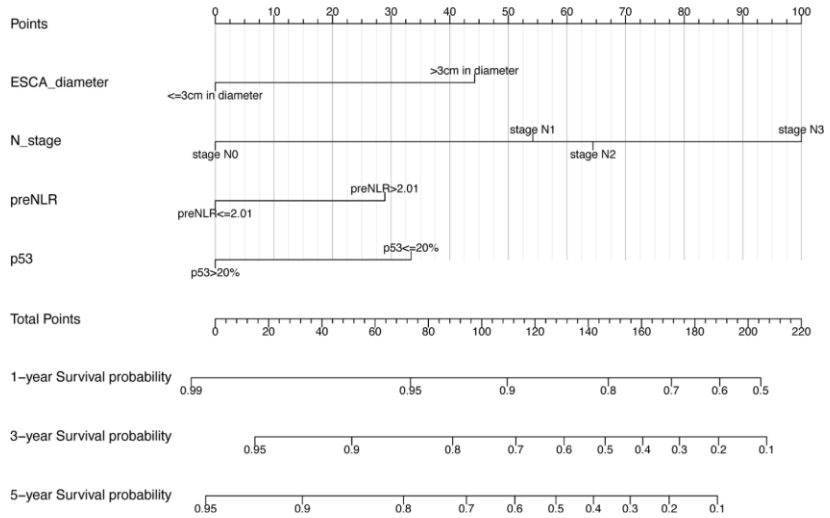
DISEASE: SYMPTOMS

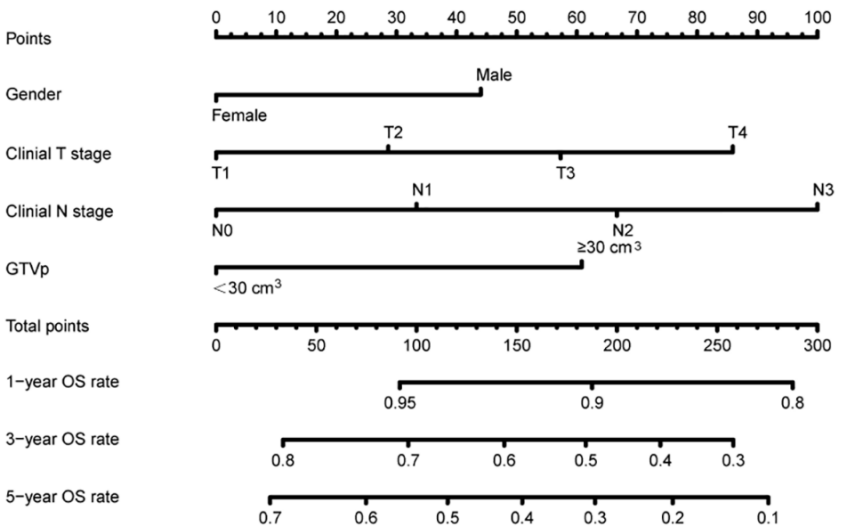


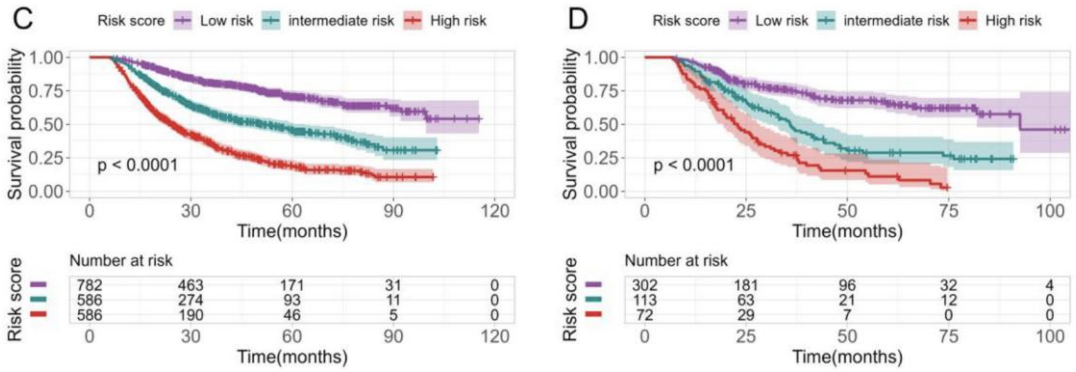


www.cancer.gov
NHS Trust.

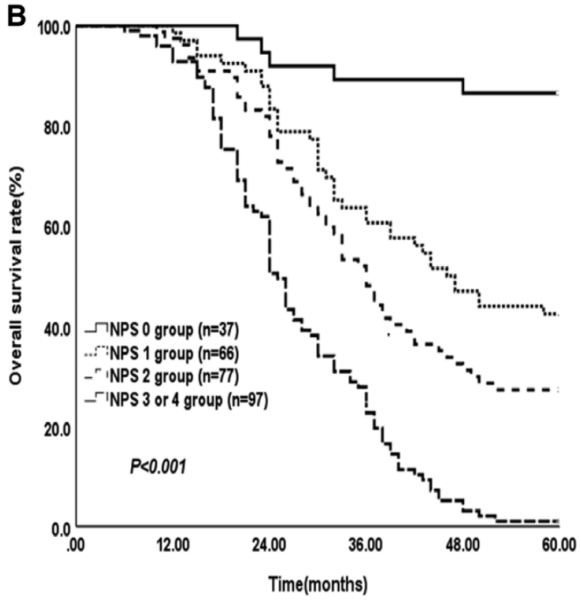
DISEASE: IMPACT - PROGNOSIS







Risk groups	Training cohort		Validation cohort	
	3-year survival	5-year survival	3-year survival	5-year survival
Low risk	80.8% (77.9–84.0)	70.6% (66.5–74.9)	75.4% (70.3–80.9)	65.3% (59.0–72.2)
Intermediate risk	58.2% (53.9–62.7)	45.6% (40.8–51.0)	48.8% (39.6–60.1)	29.7% (20.3–40.6)
High risk	29.5% (25.8–33.7)	18.7%(15.1–23.0)	26.9%(18.1–40.1)	11.0% (5.1–23.6)



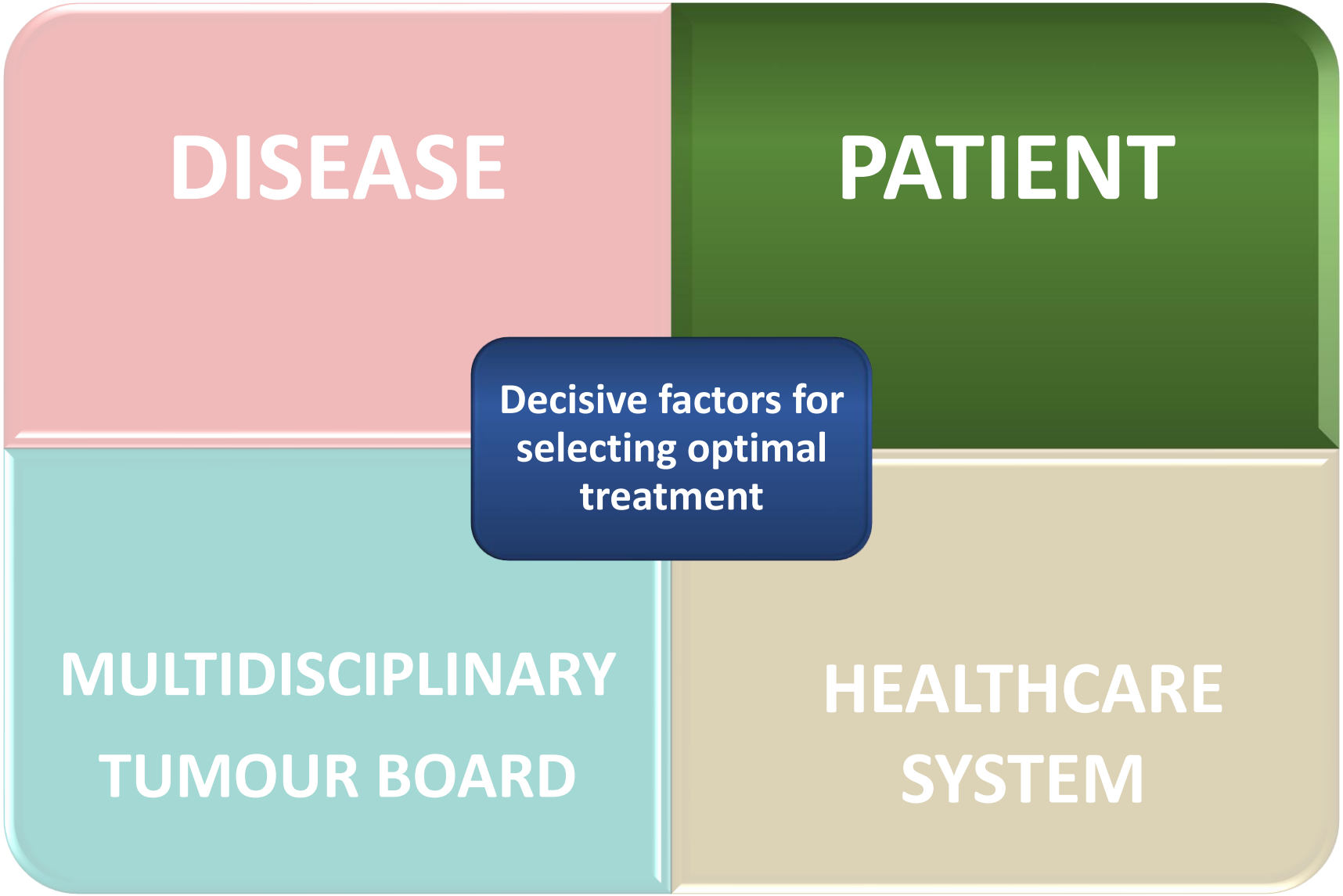
Calculation of Naples prognostic score (NPS).

Variables	PFS		OS	
	Cutoff value	Points	Cutoff value	Points
Alb (g/L)	≥41.1	0	≥41.2	0
	<41.1	1	<41.2	1
TC (mg/dL)	>205.7	0	>202.2	0
	≤205.7	1	≤202.2	1
NLR	≤2.7	0	≤2.8	0
	>2.7	1	>2.8	1
LMR	>3.3	0	>3.1	0
	≤3.3	1	≤3.1	1

Alb = albumin, LMR = lymphocyte to monocyte ratio, NLR = neutrophil to lymphocyte ratio, OS = overall survival, PFS = progression-free survival, TC = total cholesterol.

Lin Y, et al. Front Oncol 2023
Zhang K, et al. Sci Rep 2023
Shi B, et al. Front Oncol 2023
Guo X-W, et al. Medicine 2024

FACTORS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PATIENT: PREFERENCES – PERSPECTIVES - ATTITUDE

ASCO Guideline:

- Treatment decisions should be made through **shared decision-making**, incorporating not only clinical factors but also patient values, preferences, and support systems.
- This includes a **thorough discussion of the risks, benefits**, and potential outcomes of each option, and recognizes that **patient preference** is a key determinant in the decision to pursue surgery, chemoradiotherapy, or other modalities

The NOSANO - study:

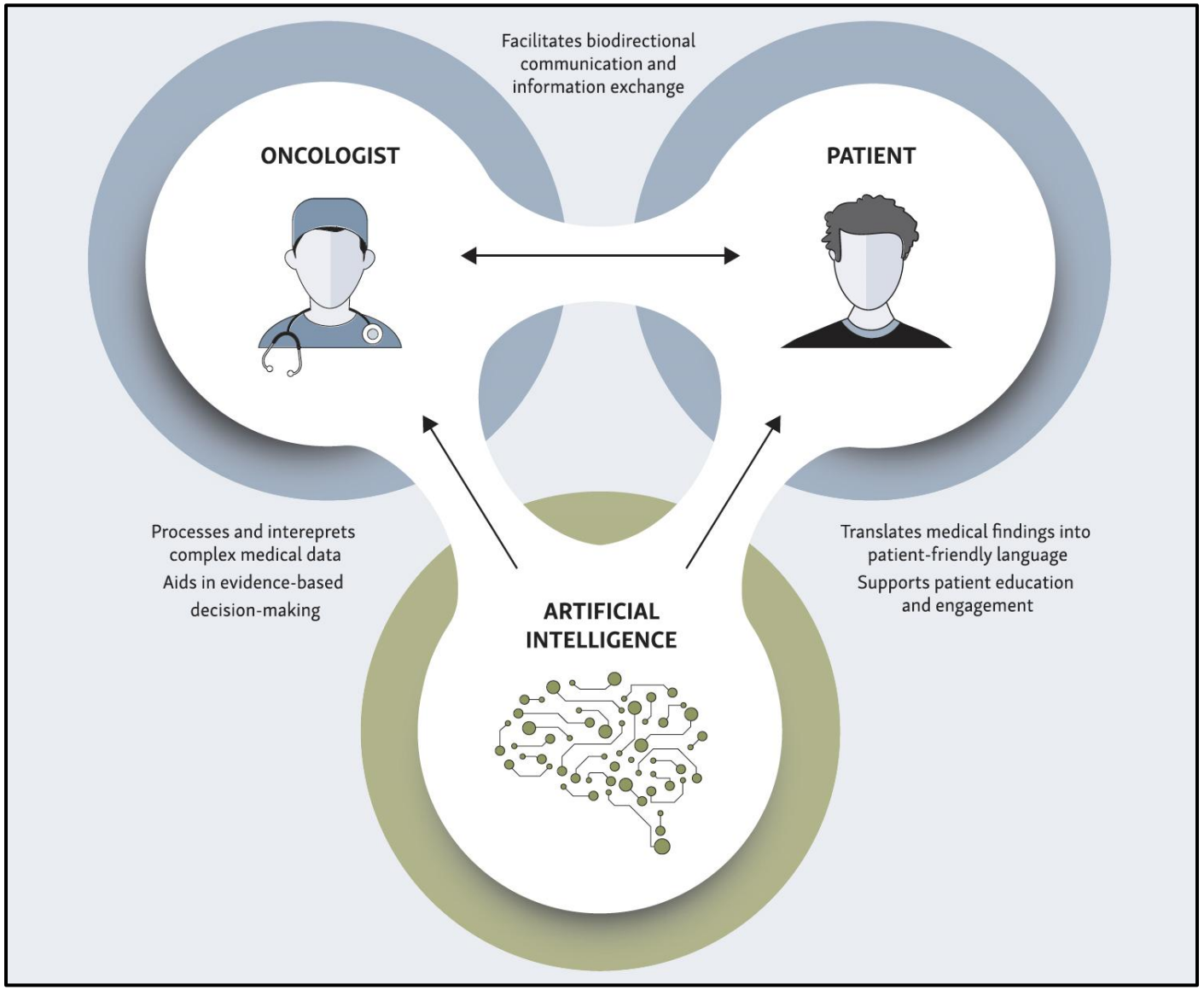
- Patients' coping styles, **attitudes toward uncertainty, and desire for organ preservation or quality of life** are major factors in treatment selection.
- These preferences are not solely determined by medical contraindications or comorbidities.

The JCOG0502 - study:

- Factors such as age, family structure, and the influence of **physician recommendations** also play a role in patient decision-making, with the physician's opinion often being the most influential non-medical factor

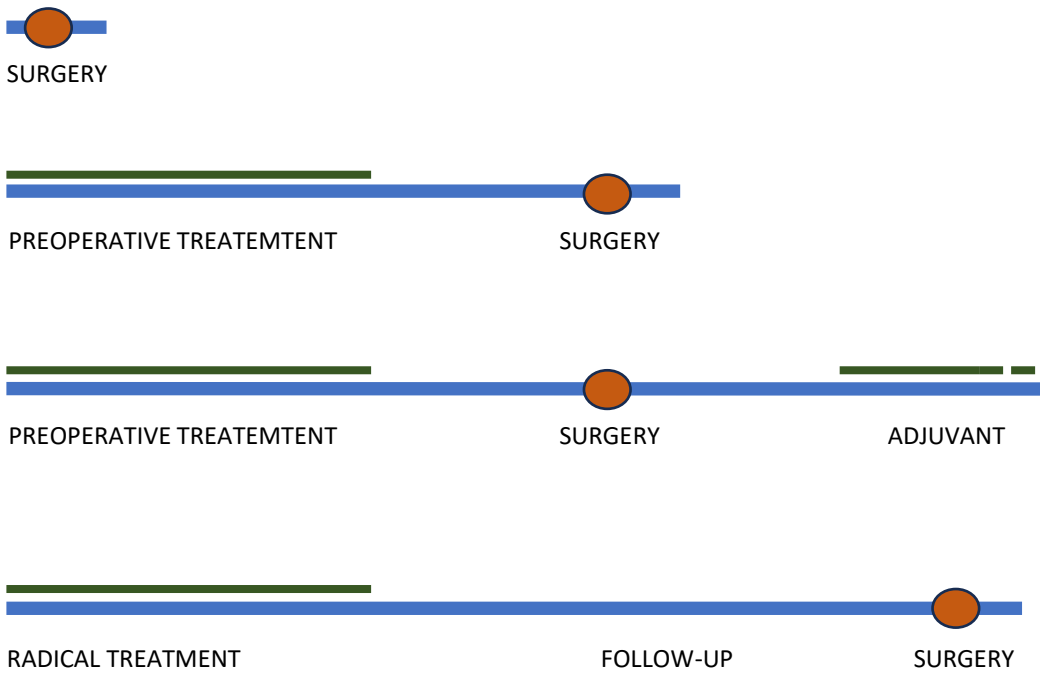
Sha M, et al. J Clin Oncol 2020
Hermus M, et al. Int J Cancer 2023
Yamamoto S, tl Future Oncol 2024

PATIENT: PREFERENCES – PERSPECTIVES - ATTITUDE



Heudel P-E, et al. ESMO RWD Dig Oncol 2024

PATIENT: MEDICAL CONDITION - APTITUDE



ALONG TREATMENT STRATEGY

Functional status

Comorbidities

Polypharmacy

CGA

Nutritional status

Disease – related symptoms

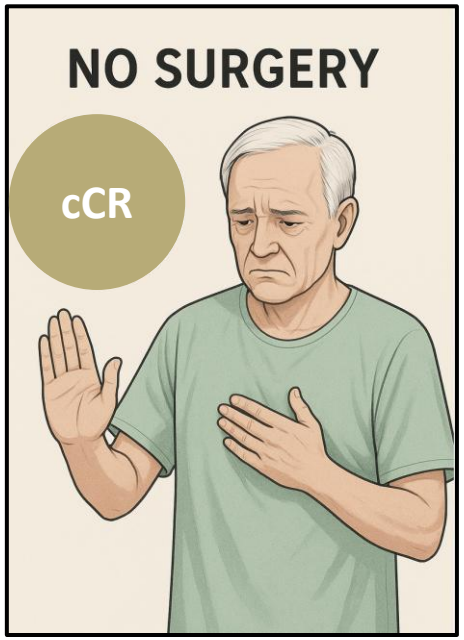
Operabilty

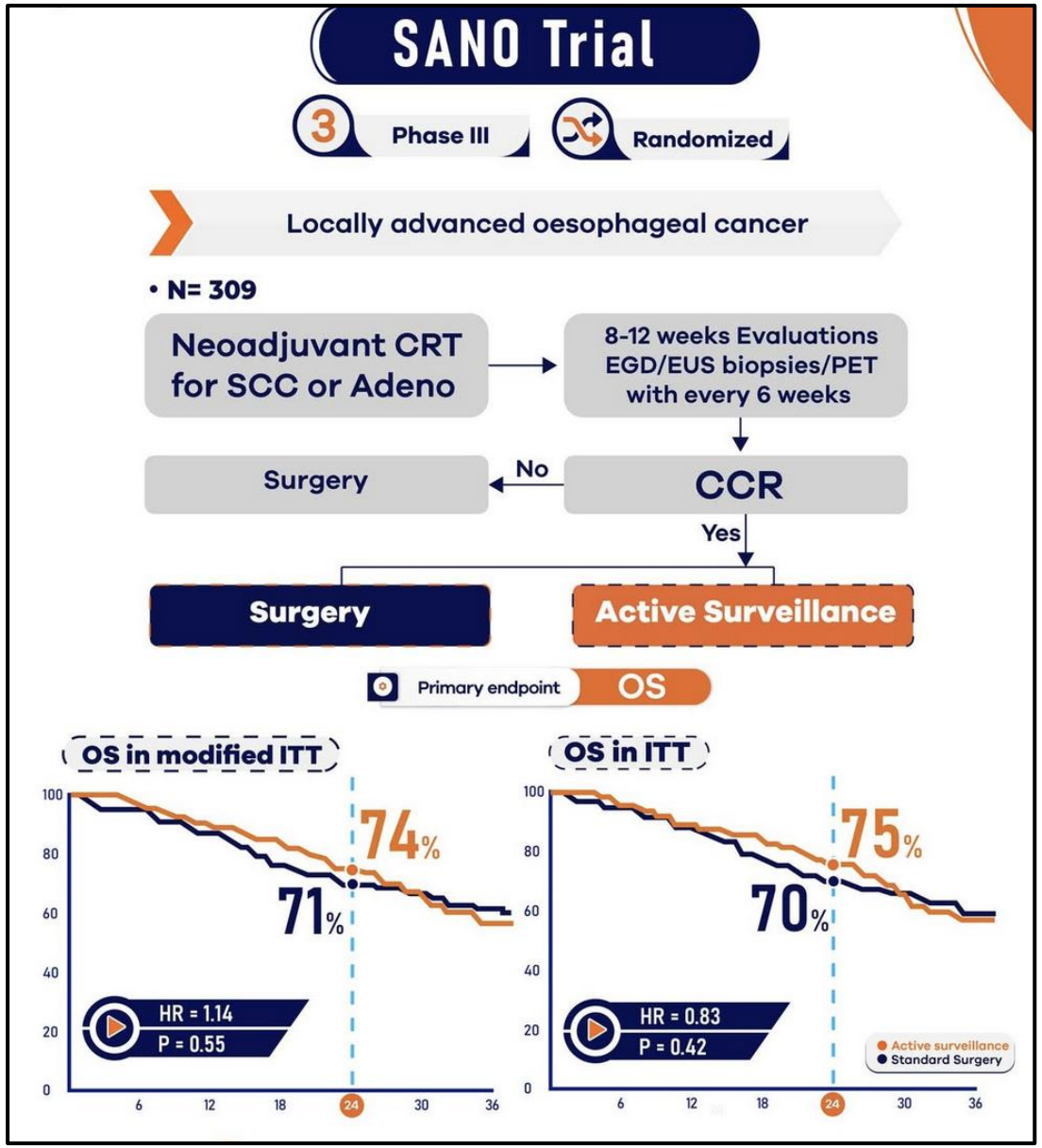
Previous treatments

Treatment adherence

Toxicity - Complications

PATIENT: DYNAMIC CONDITION – PREFERENCES





	Active surveillance (n=83)	Standard surgery (n=101)
Any complication	68 (82%)	85 (84%)
Anastomotic leakage	18 (22%)	27 (27%)
Severity of anastomotic leakage		
Subclinical, spontaneous recovery	2 (2%)	3 (3%)
Subclinical, requiring surgery	1 (1%)	0
Clinical, spontaneous recovery	10 (12%)	15 (15%)
Clinical, requiring surgery	5 (6%)	9 (9%)
Pulmonary complications		
Any	39 (47%)	64 (63%)
Pneumonia	20 (24%)	29 (29%)
Respiratory failure requiring reintubation	2 (2%)	5 (5%)
Cardiac complications		
Any	28 (34%)	44 (44%)
Dysrhythmia requiring intervention	11 (13%)	20 (20%)
Vocal cord outcome		
Normal vocal cord	71 (86%)	94 (93%)
Vocal cord dysfunction, unilateral	3 (4%)	3 (3%)
Vocal cord dysfunction, bilateral	2 (2%)	1 (1%)
Unknown vocal cord dysfunction	7 (8%)	3 (3%)
Thromboembolic complications		
Pulmonary embolus	0	2 (2%)
Adverse events from clinical response evaluations		
PET-CT	0	0
Endosonography with fine-needle aspiration	1 (1%)	0
Endoscopy with biopsies	0	0
Chylothorax, requiring TPN	3 (4%)	10 (10%)
Chylothorax, requiring surgery	0	1 (1%)
Multi-organ failure	1 (1%)	1 (1%)
Length of ICU stay, days	2 (1–2)	2 (1–3)
Length of hospital stay, days	10 (8–17)	11 (8–17)
30-day mortality	1 (1%)	3 (3%)
90-day mortality	3 (4%)	5 (5%)

Data are n (%) or median (IQR). Percentages represent the occurrence of complications, as part of the total. TPN=total parenteral nutrition. ICU=intensive care unit.

Table 2: **Postoperative complications and serious adverse events from clinical response evaluations of patients undergoing oesophagectomy**

Van der Wilk BJ, et al. Lancet Oncol 2025
ChatGPT

PATIENT: DYNAMIC CONDITION – PREFERENCES (II)

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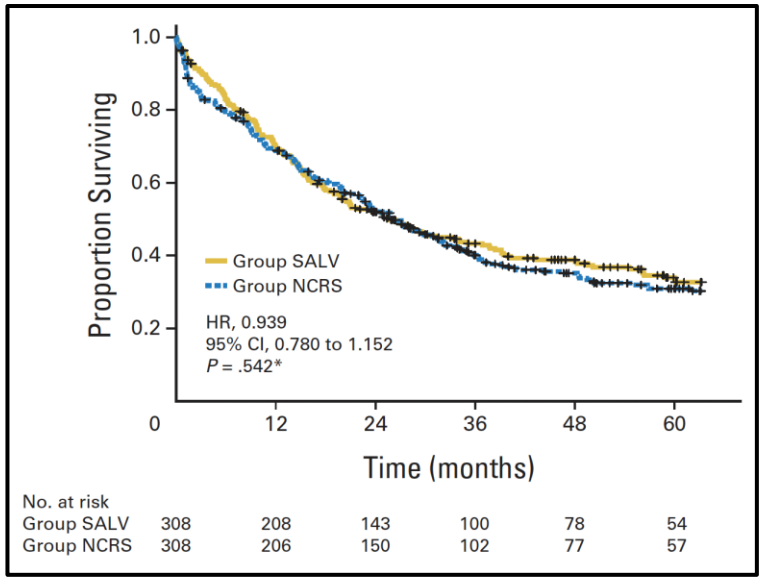


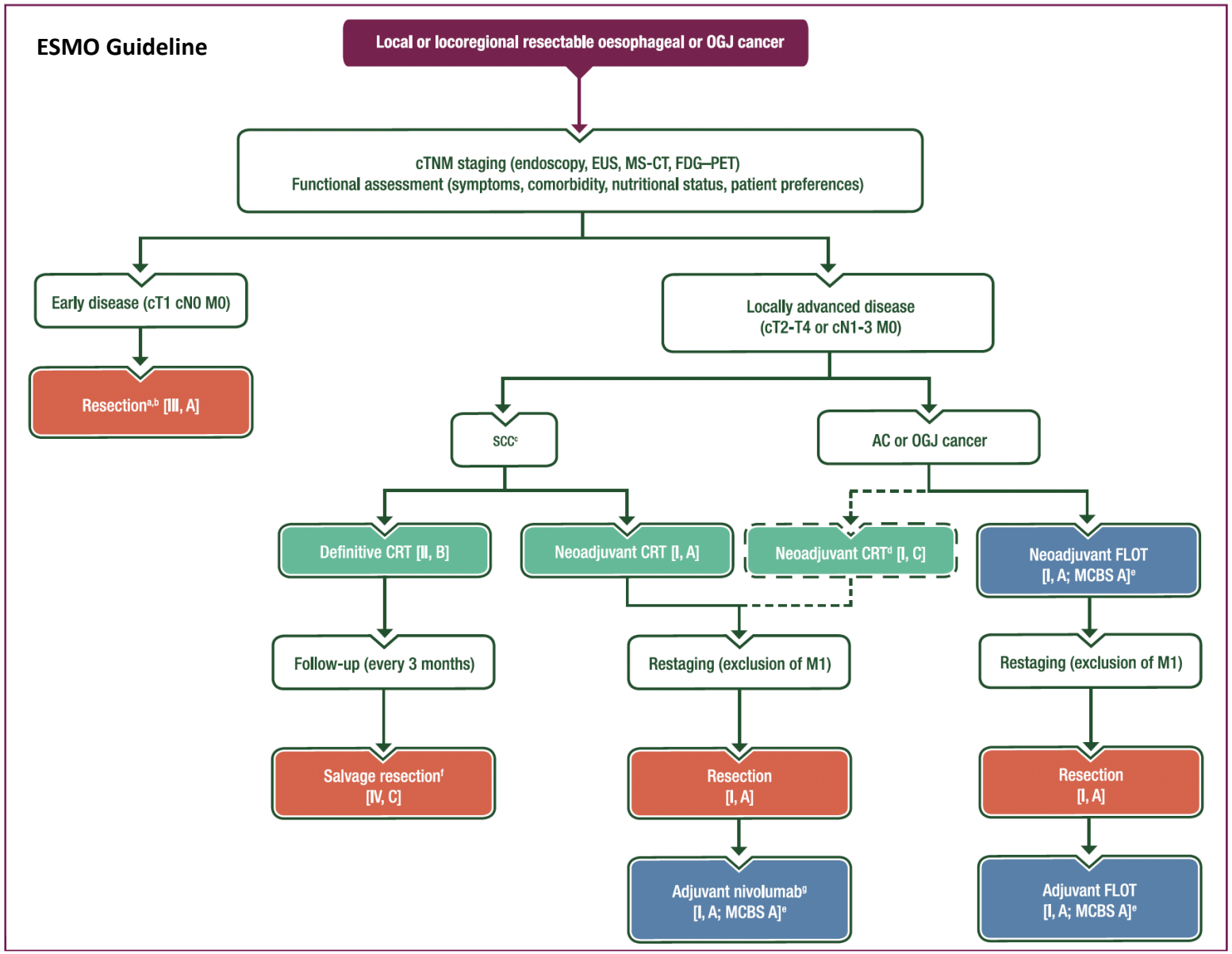
Table 2. Comparison of In-Hospital Mortality and Morbidity in SALV and NCRS Groups

Variable	Overall (N = 848)	Before Matching: SALV (n = 308)	Before Matching: NCRS (n = 540)	Before Matching: OR (95% CI)	Before Matching: *P*	After Matching: SALV (n = 308)	After Matching: NCRS (n = 308)	After Matching: OR (95% CI)	After Matching: *P*
Outcome									
In-hospital mortality, No. (%)	76 (9.0)	26 (8.4)	50 (9.3)	0.904 (0.550 to 1.484)	.688	26 (8.4)	35 (11.4)	0.719 (0.414 to 1.250)	.241
In-hospital morbidity, No. (%)	514 (60.6)	196 (63.6)	318 (58.9)	1.222 (0.915 to 1.630)	.174	196 (63.6)	188 (61.0)	1.117 (0.818 to 1.525)	.506
Complications									
Anastomotic leak, No. (%)	111 (13.1)	53 (17.2)	58 (10.7)	1.727 (1.155 to 2.582)	.007	53 (17.2)	33 (10.7)	1.732 (1.110 to 2.703)	.015
Conduit necrosis, No. (%)	6 (0.7)	4 (1.3)	2 (0.4)	—	NA*	4 (1.3)	1 (0.3)	—	NA*
Surgical site infection, No. (%)	123 (14.5)	57 (18.5)	66 (12.2)	1.631 (1.109 to 2.399)	.012	57 (18.5)	38 (12.3)	1.614 (1.058 to 2.461)	.026
Chylothorax, No. (%)	26 (3.1)	10 (3.2)	16 (3.0)	1.099 (0.492 to 2.453)	.818	10 (3.3)	10 (3.3)	1.000 (0.404 to 2.474)	> .999
Postoperative hemorrhage, No. (%)	5 (0.6)	1 (0.3)	4 (0.7)	—	NA*	1 (0.3)	3 (1.0)	—	NA*
Gastroparesis, No. (%)	10 (1.2)	6 (1.9)	4 (0.7)	—	NA*	3 (1.0)	3 (1.0)	—	NA*
Pulmonary, No. (%)	353 (41.6)	132 (42.9)	221 (40.9)	1.083 (0.815 to 1.437)	.583	132 (42.9)	127 (41.2)	1.069 (0.786 to 1.454)	.672
Cardiovascular, No. (%)	115 (13.6)	42 (13.6)	73 (13.5)	1.010 (0.671 to 1.521)	.962	42 (13.6)	43 (14.0)	0.973 (0.612 to 1.547)	.908
Thromboembolic, No. (%)	25 (2.9)	9 (2.9)	16 (3.0)	0.989 (0.443 to 2.324)	.973	9 (2.9)	10 (3.3)	0.900 (0.374 to 2.167)	.814
Neurologic, No. (%)	25 (2.9)	6 (1.9)	19 (3.5)	1.010 (0.687 to 1.235)	.388	5 (1.6)	8 (2.6)	0.998 (0.876 to 1.113)	.405
Clavien-Dindo score, No. (%)				—	.461			—	.201
I	64 (7.5)	21 (6.8)	43 (8.0)			21 (6.8)	30 (9.7)		
II	168 (19.8)	68 (22.1)	100 (18.5)			68 (22.1)	45 (14.6)		
IIIa	51 (6)	20 (6.5)	31 (5.7)			20 (6.5)	21 (6.8)		
IIIb	49 (5.8)	23 (7.5)	26 (4.8)			23 (7.5)	18 (5.8)		
IVa	86 (10.1)	33 (10.7)	53 (9.8)			33 (10.7)	30 (9.7)		
IVb	20 (2.4)	5 (1.6)	15 (2.8)			5 (1.6)	9 (2.9)		
V	76 (9)	26 (8.4)	50 (9.3)			26 (8.4)	35 (11.4)		

Abbreviations: NA, not applicable; NCRS, neoadjuvant chemoradiotherapy followed by planned esophagectomy; OR, odds ratio; SALV, salvage esophagectomy after definitive chemoradiotherapy.
*Because of low number of events.

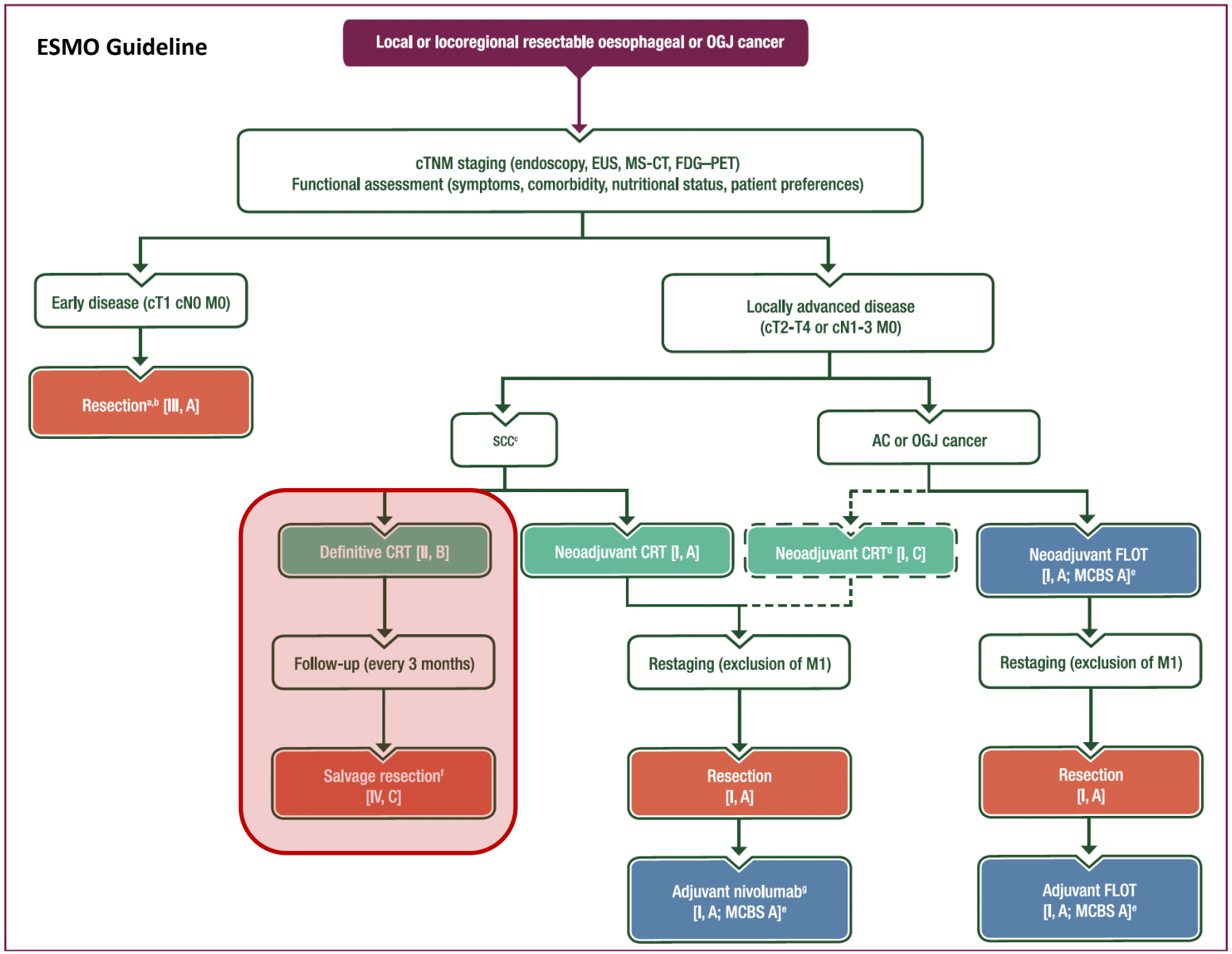
Markar S, et al. J Clin Oncol 2015
Ku GY, et al. J Clin Oncol 2015

DISEASE AND PATIENT: FIXED PATH



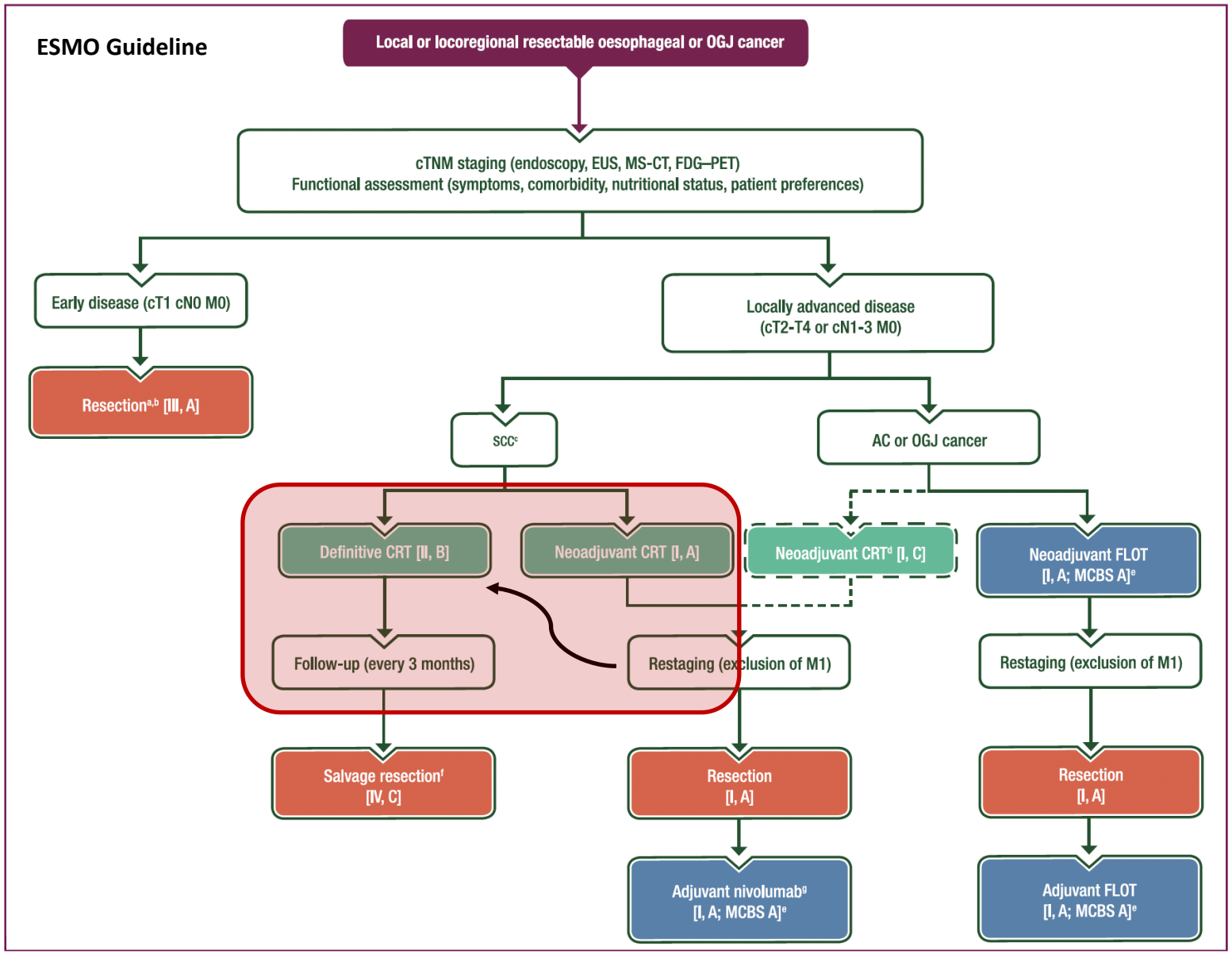
Obermmanová R, et al. Ann Oncol 2022

DISEASE AND PATIENT: DYNAMIC PATH



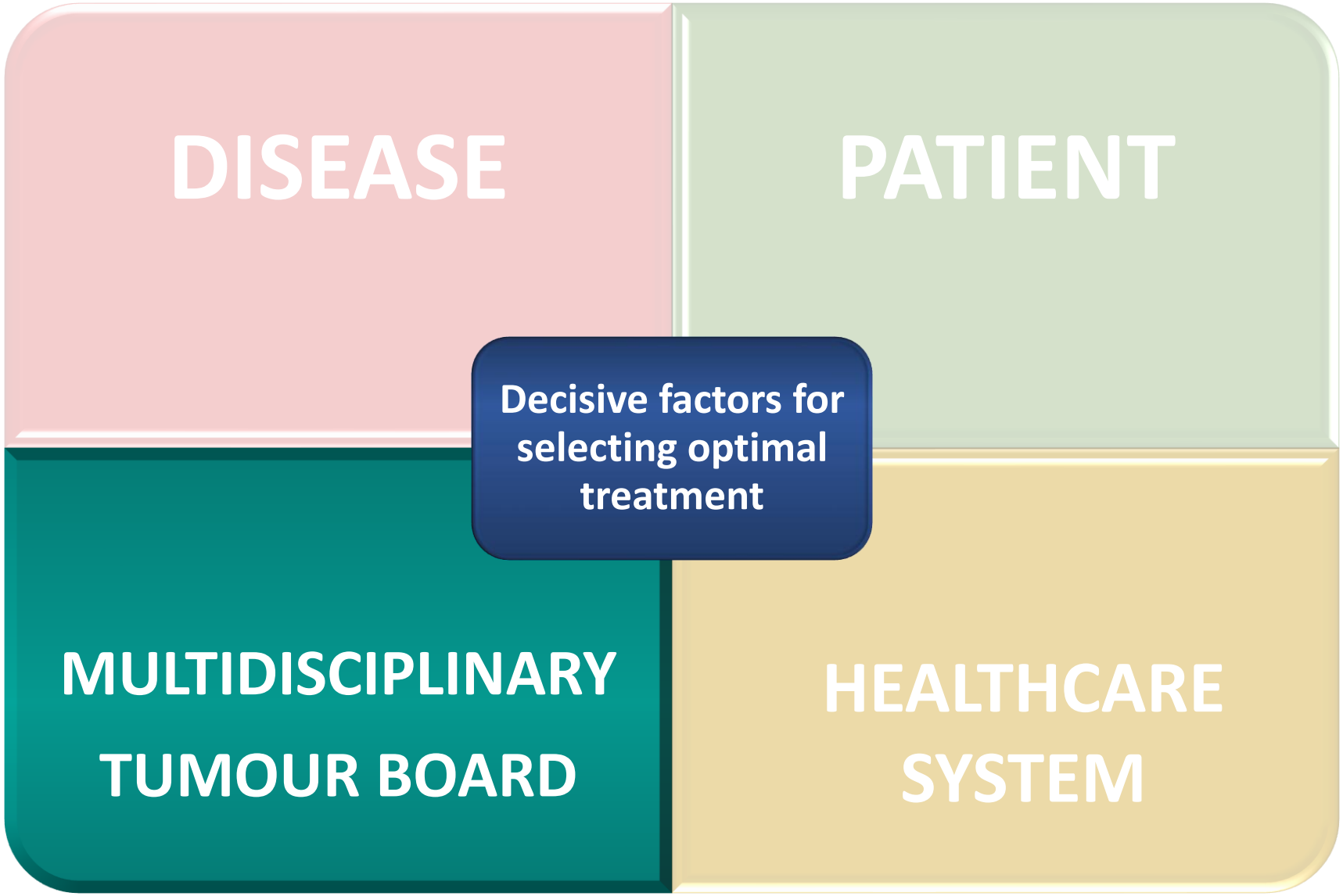
Obermmanová R, et al. Ann Oncol 2022

DISEASE AND PATIENT: DYNAMIC PATH

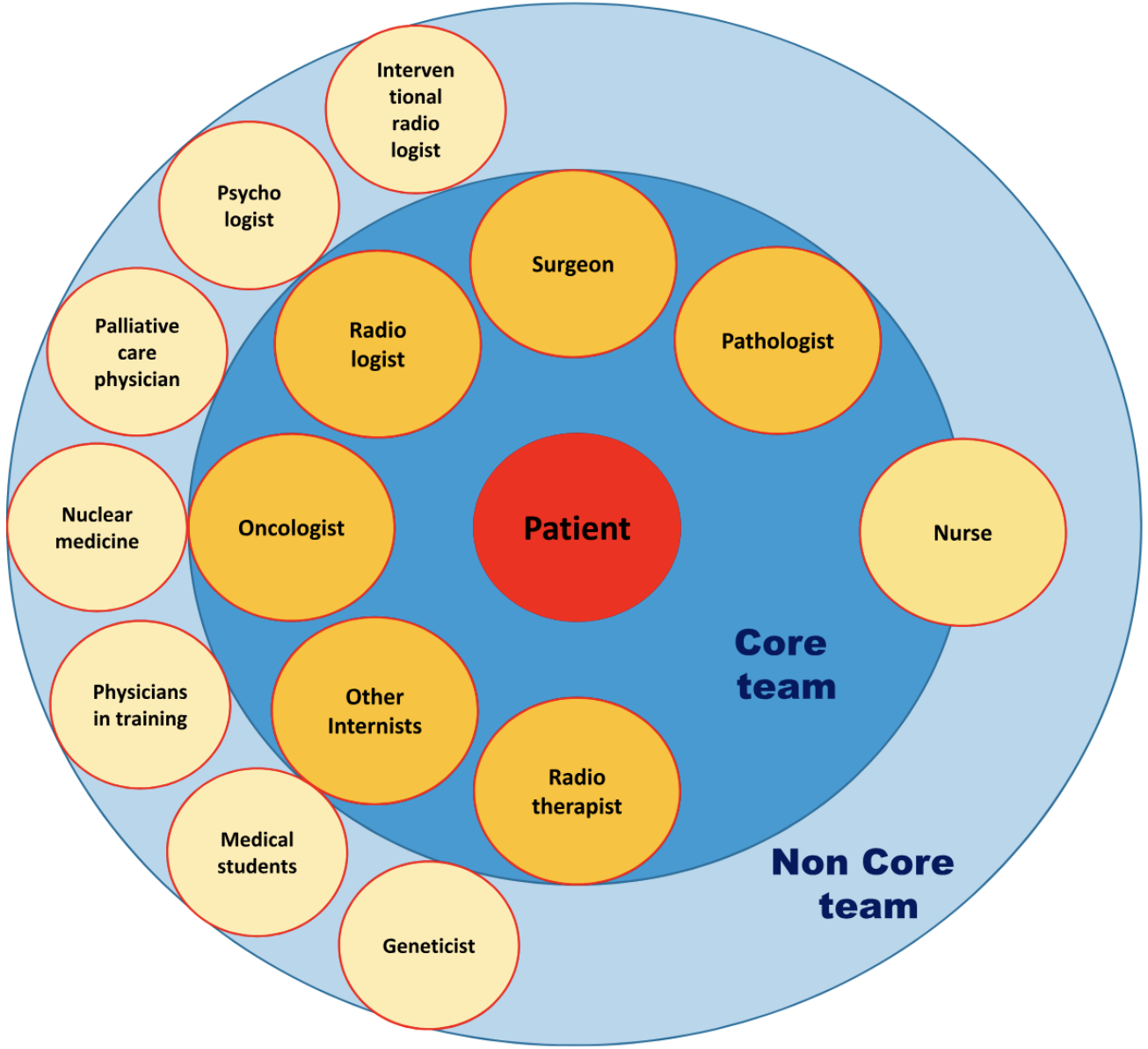


Obermmanová R, et al. Ann Oncol 2022

FACTORS

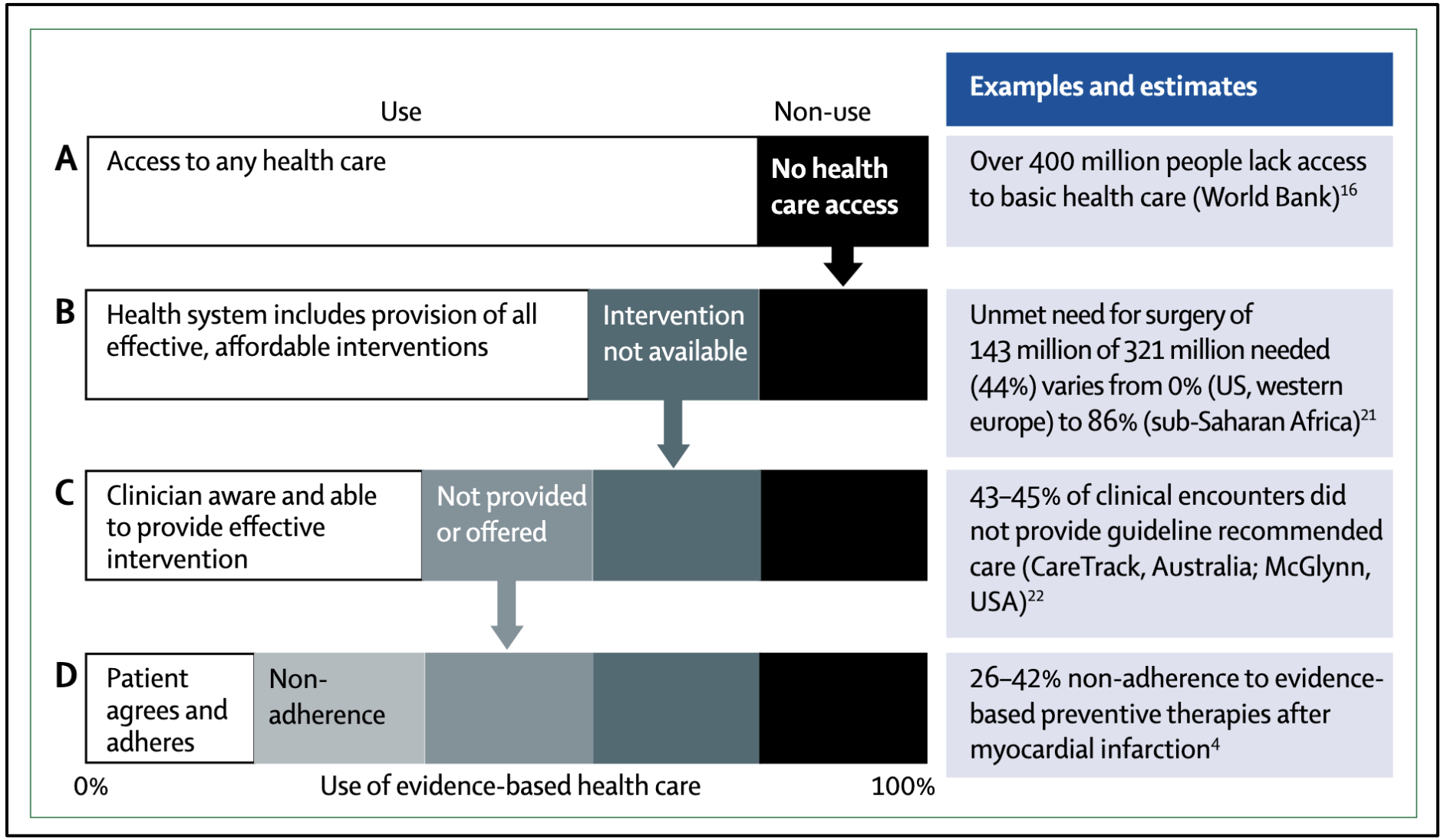

DISEASE
PATIENT
Decisive factors for selecting optimal treatment
MULTIDISCIPLINARY TUMOUR BOARD
HEALTHCARE SYSTEM

MTB: MULTIDISCIPLINARY APPROACH



Berardi R, et al. Cancer Manag Res 2020

MTB: FROM ACCESS TO ADHERENCE



Stages of care, from acces to adherence, and underuse risks

Glasziou P, et al. Lancet 2027

MTB: EXPERTISE – EARLY DISEASE

American Society for Gastrointestinal Endoscopy Guideline

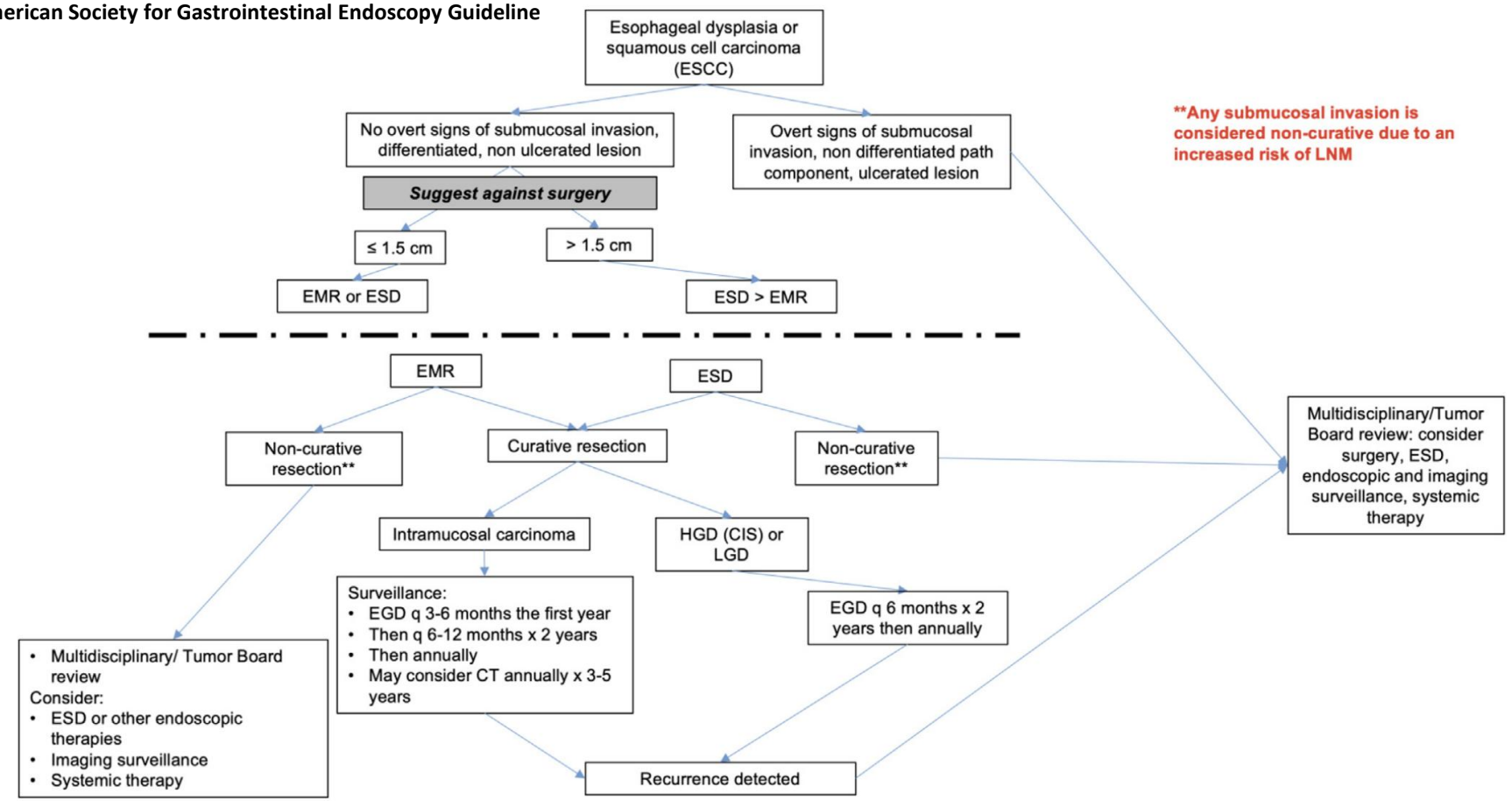
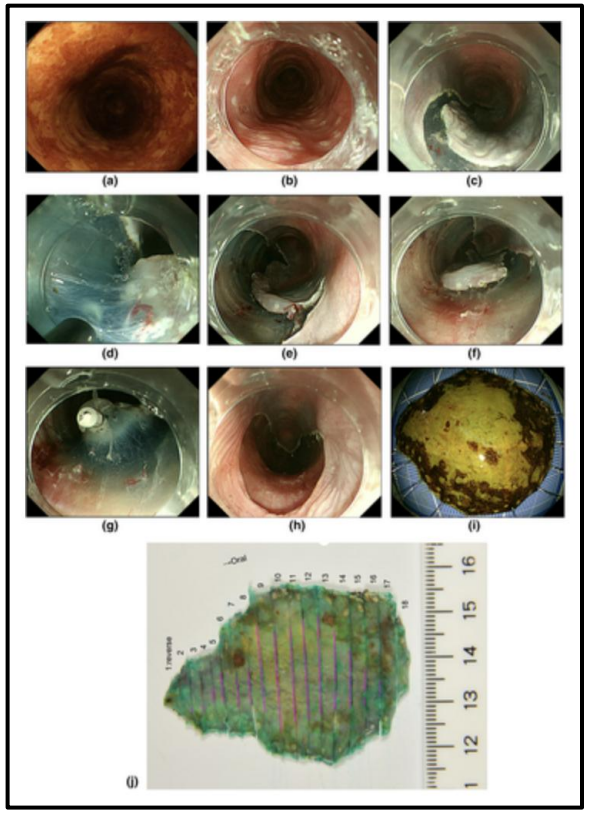
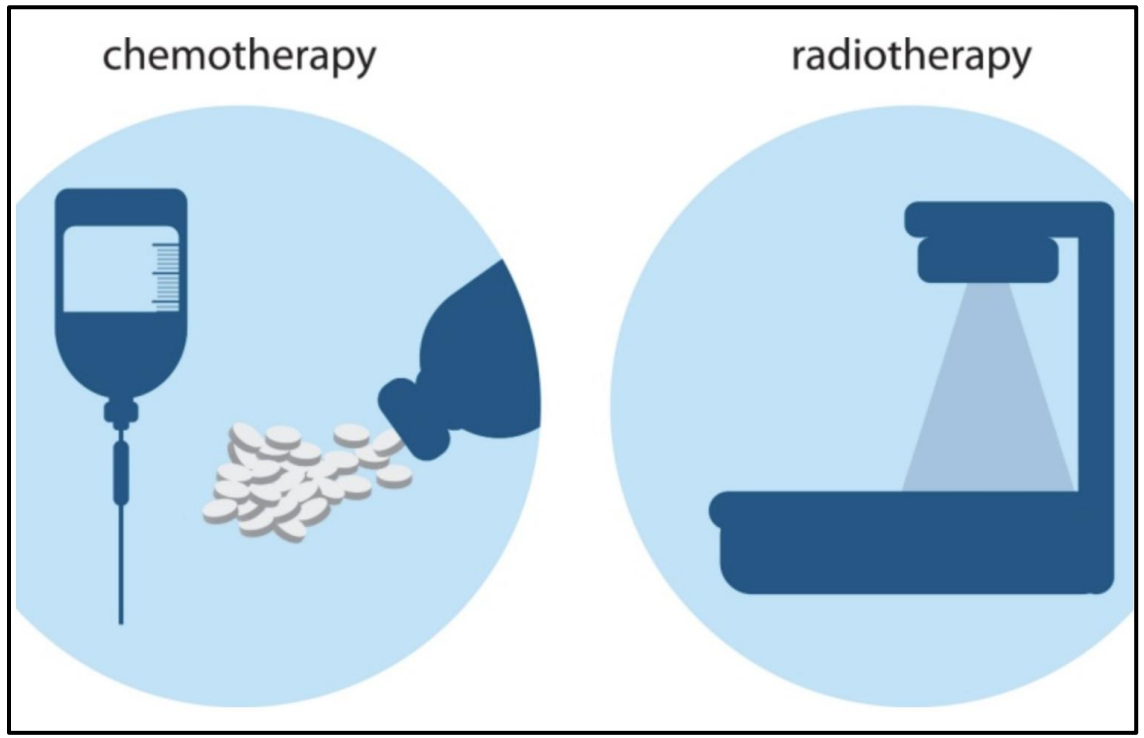


Figure 1. Recommended clinical care algorithm for patients presenting with early-stage ESCC. *ESCC*, Esophageal squamous cell carcinoma; *ESD*, endoscopic submucosal dissection; *LNM*, lymph node metastasis; *HGD*, high-grade dysplasia; *CIS*, carcinoma in situ; *LGD*, low-grade dysplasia.

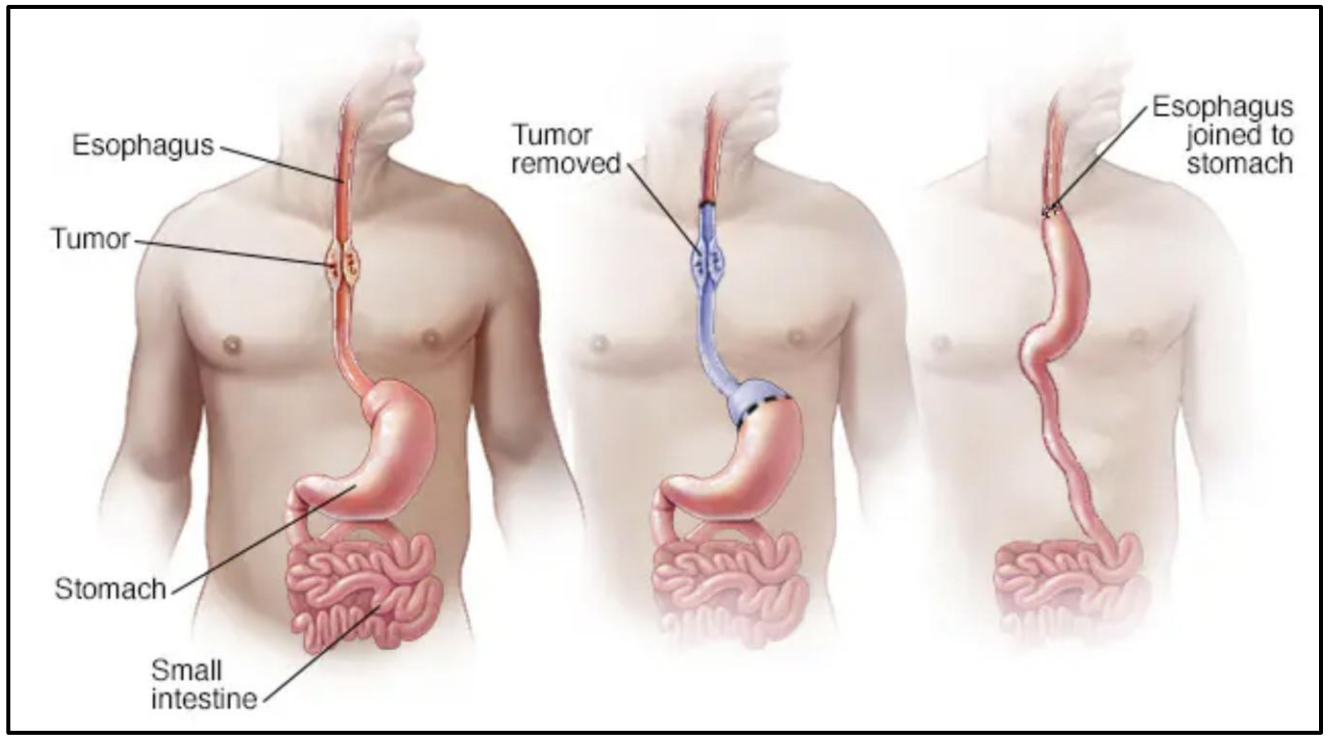


Al-Haddad MA, et al. Gastreointest Endosc 2023
Abe S, et al. DEN Open 2021

MTB: PREFERRED OPTIONS - HABITS



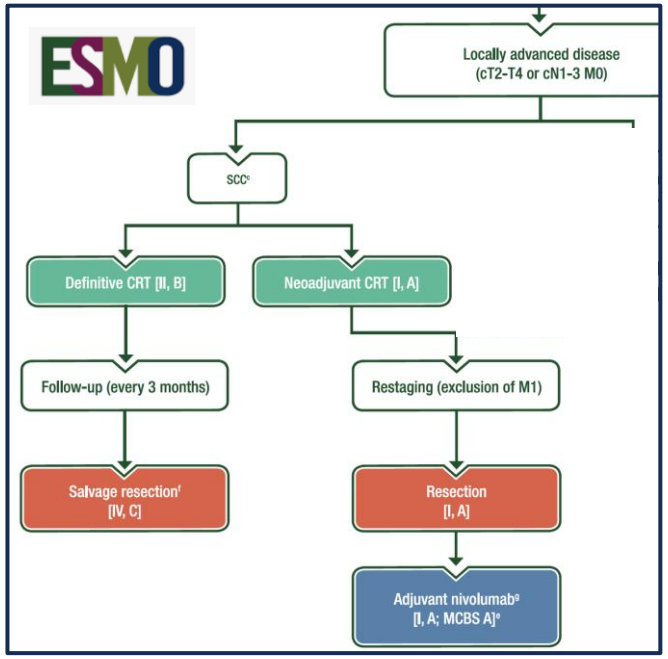
Access to advanced radiation technology.
IMRT – VMAT – SIB-RT.

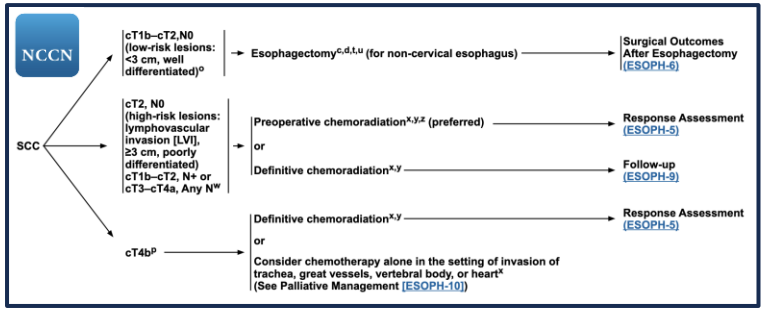


Access to high-volumen esophageal surgeons.
At least 15 esophagectomies per year.

HDF ERGO Team
www.mayoclinic.org
Cellini F, et al. Cancers 2022
Wright FC, et al. J Torac Cardiovasc Surg 2023

MTB: PREFERRED OPTIONS - HABITS





JCOG1109 - NExT

N = 600

Thoracic esophageal cancer
Clinical Stage IB / II / III (excluding T4) *
Age 20-75
ECOG PS 0-1
No prior therapy

* Based on The 7th UICC-TNM classification

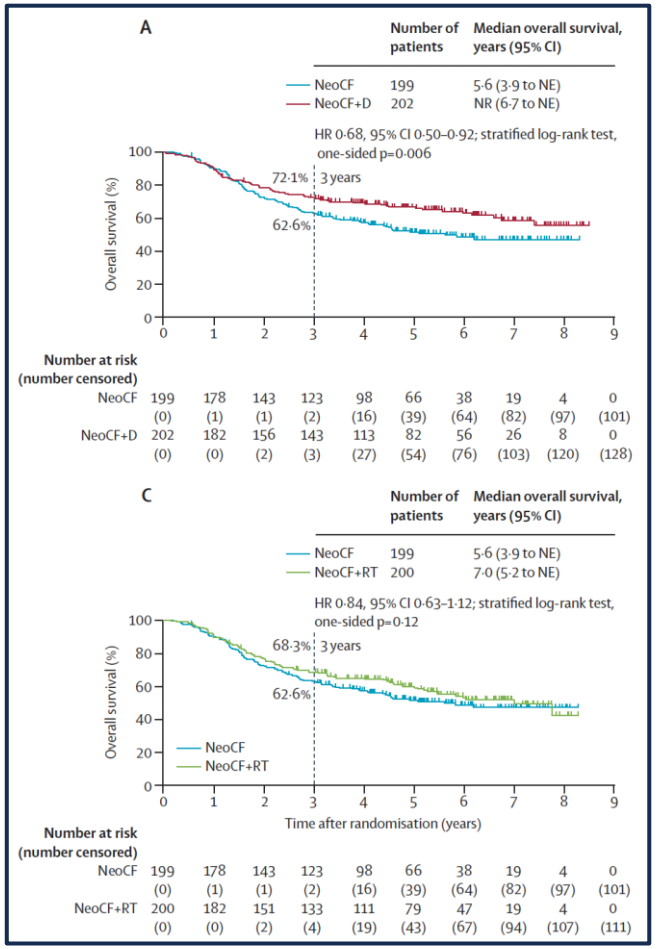
PS performance status

CF
5-FU 800 mg/m^2 d1-5, 22-26
cisplatin 80 mg/m^2 d1, 22

DCF
5-FU 750 mg/m^2 d1-5, 22-26, 43-47
cisplatin 70 mg/m^2 d1, 22, 43
docetaxel 70 mg/m^2 d1, 22, 43

CF-RT
5-FU 1000 mg/m^2 d1-4, 29-32
cisplatin 75 mg/m^2 d1, 29
radiation 41.4Gy/23fr

→ Esophagectomy + D2 lymphadenectomy



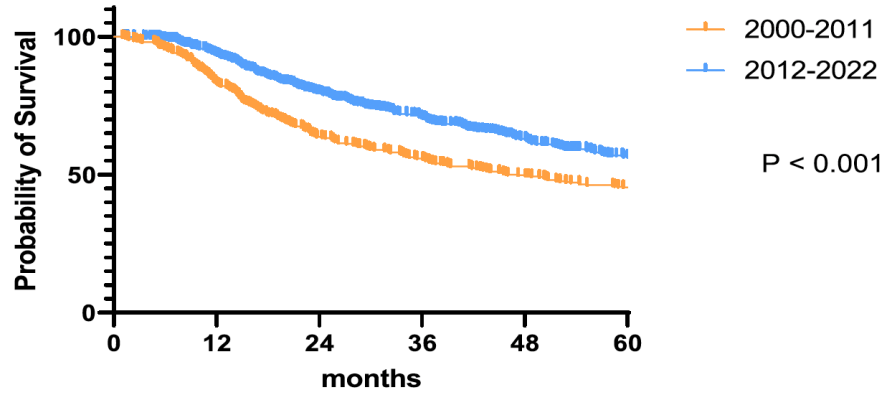
Mayanagi S, et al. Ann Gastroenterol Surg 2019
Kato K, et al. Lancet 2024

MTB: CENTRALIZATION

Impact of centralization on key metrics, outcomes, and patterns of care at the Irish National Centre

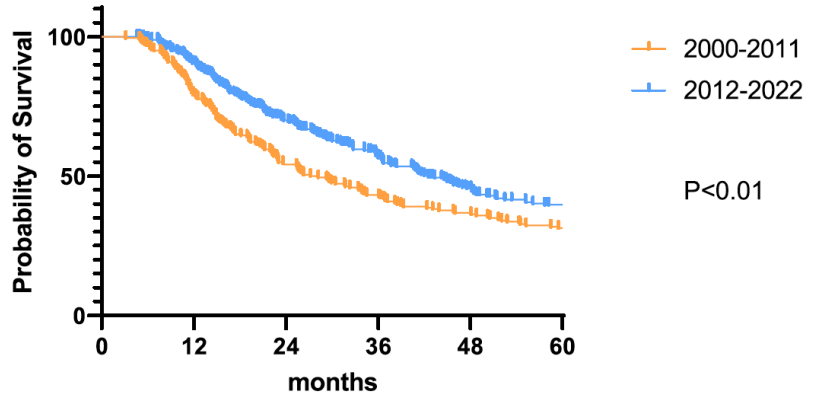
A

Comparison of Overall Survival in entire cohort in both time periods



	2000-2011			2012-2022		
Survival (years)	No at risk	Deaths	% survival	No at risk	Deaths	% survival
1	461	76	83	784	41	94
3	381	119	56	651	130	71
5	256	46	45	359	52	57

Comparison of Overall Survival in both time periods following neoadjuvant therapy



	2000-2011			2012-2022		
Survival (years)	No at risk	Deaths	% survival	No at risk	Deaths	% survival
1	222	46	79	354	32	92
3	174	79	43	297	101	60
5	95	26	31	149	72	40

INCREASED	DECREASED
Endoscopic treatment	Operative morbidity and mortality
Neoadjuvant treatment	Recurrence rates

Donlon NE, et al. Ann Surg 2024

MTB: EVIDENCE ASSUMPTION

Figure S2. Rationale for treatment selection across treatment groups.

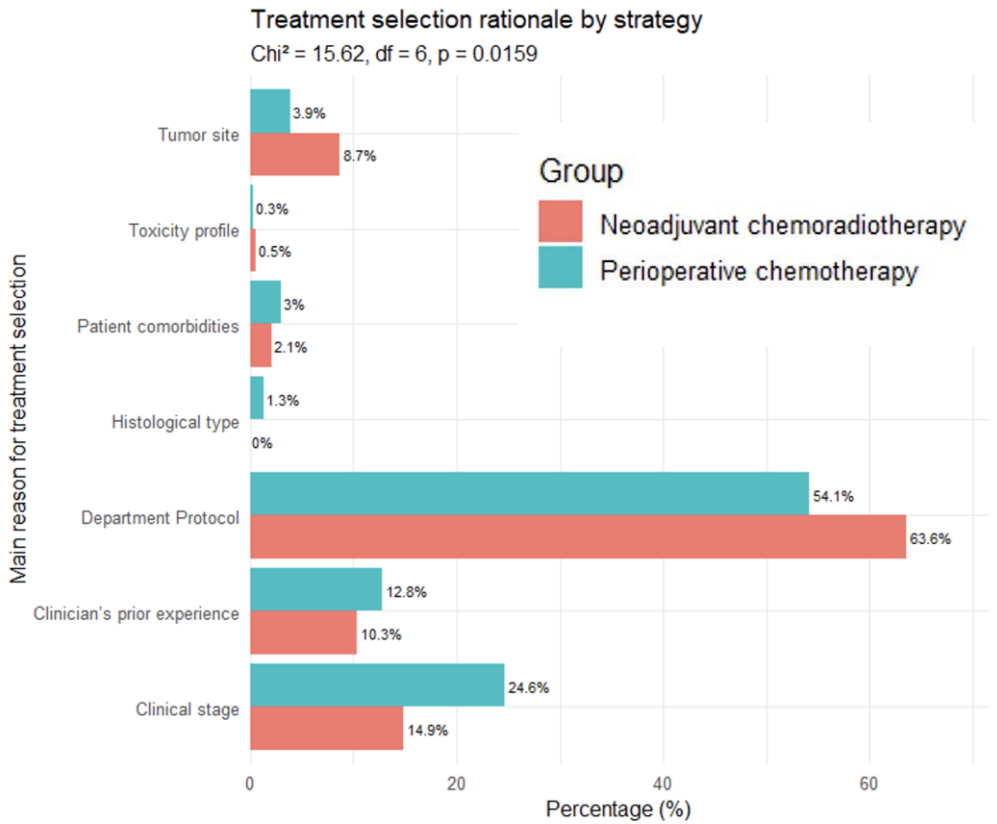
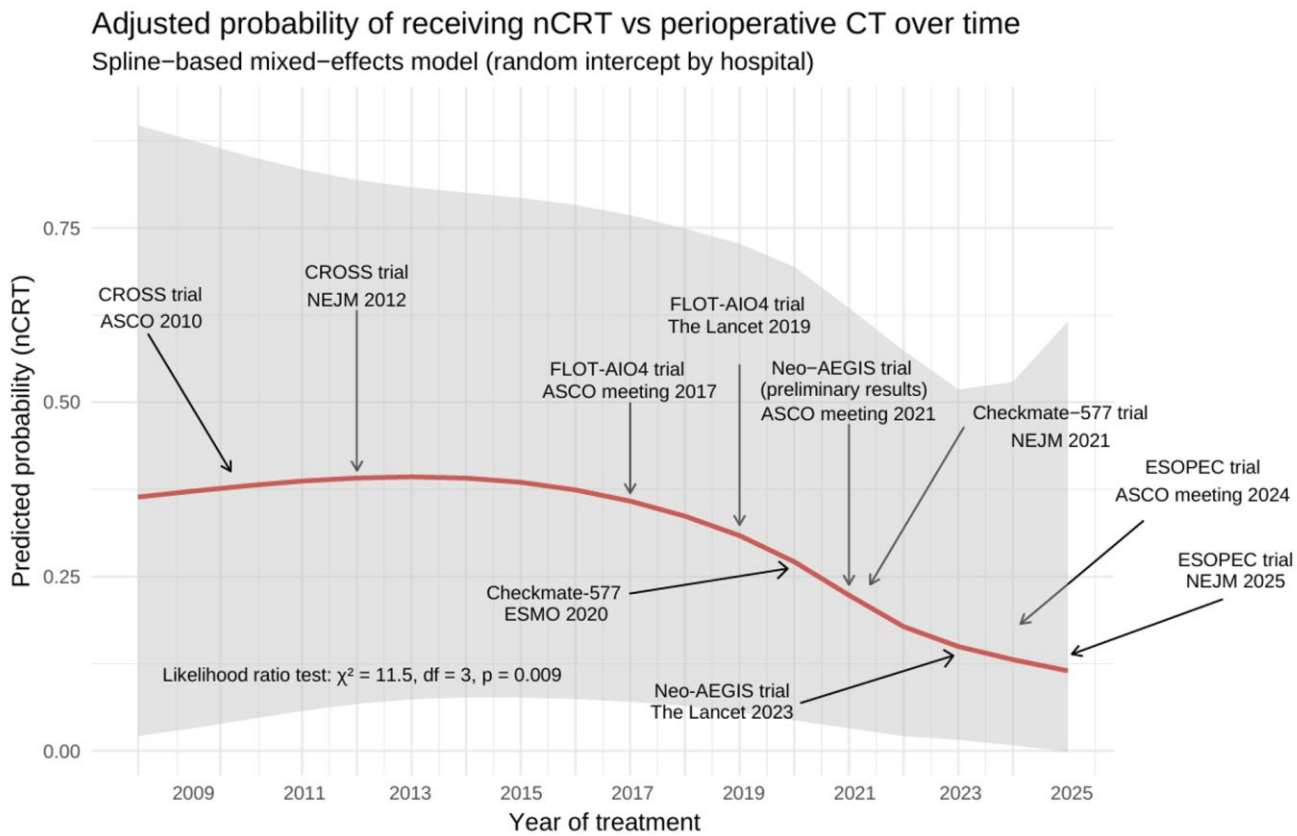


Figure S3. Adjusted probability of receiving nCRT versus perioperative CT over time based on a mixed-effects logistic regression with spline modeling of treatment year.



AGAMENON – SEOM Registry

Mateos L, et al. Br J Cancer 2025 (in press)

MTB: AUDIT

ANNALS OF ONCOLOGY

JOURNAL OF CLINICAL ONCOLOGY

The NEW ENGLAND JOURNAL of MEDICINE

SEOM Sociedad Española de Oncología Médica

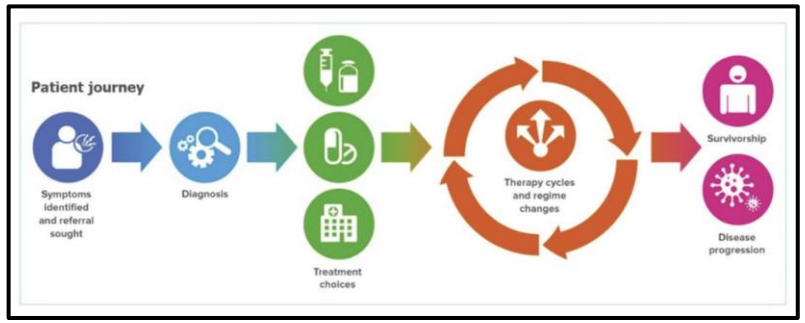
ESMO

ASCO®

AGAMENON

GRUPO ESPAÑOL EURECCA DE CÁNCER ESOFAGOGÁSTRICO

EURECCA
EUROPEAN REGISTRATION OF CANCER CARE



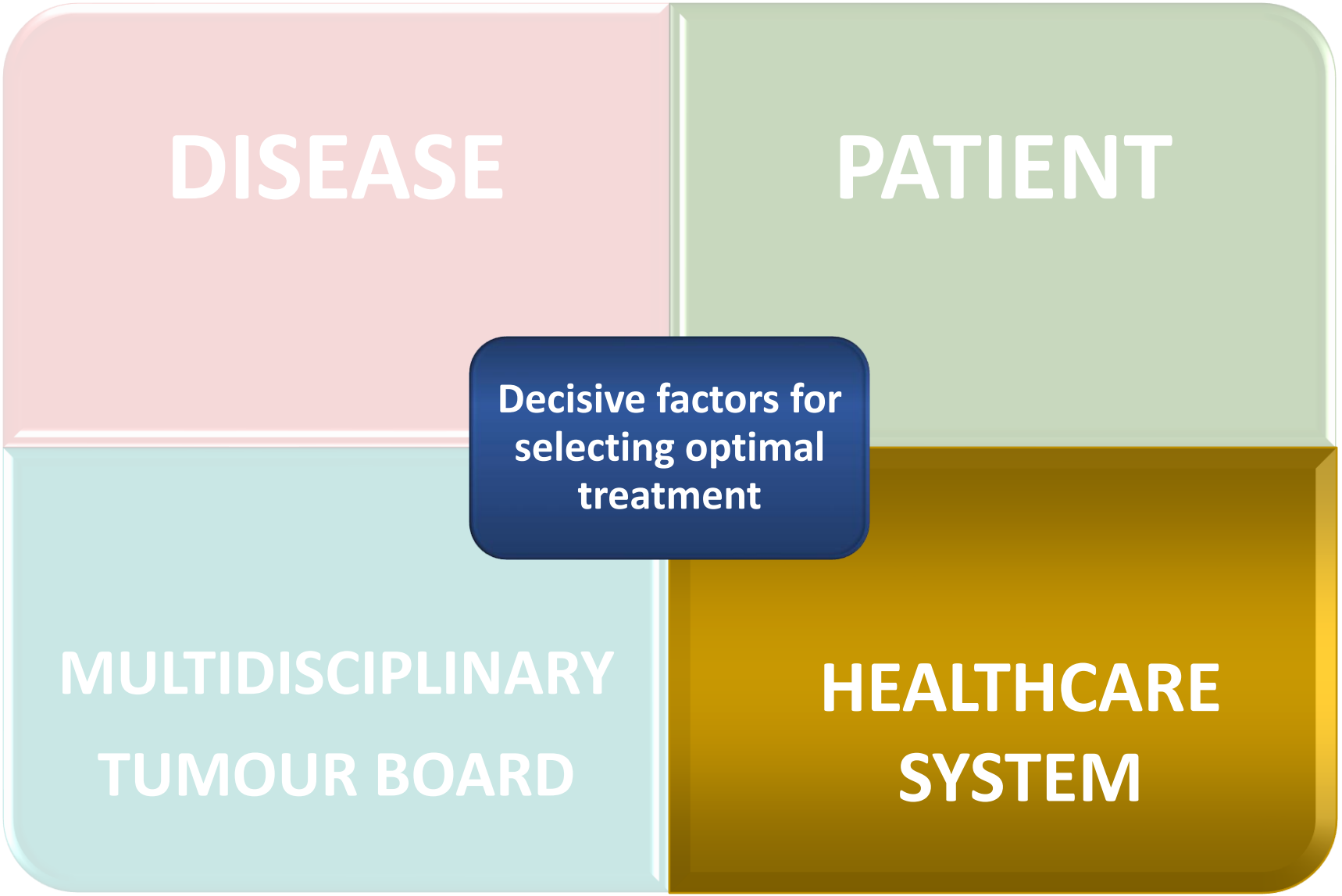
Patient Reported Outcomes Measures

Patient Reported Experience Measures

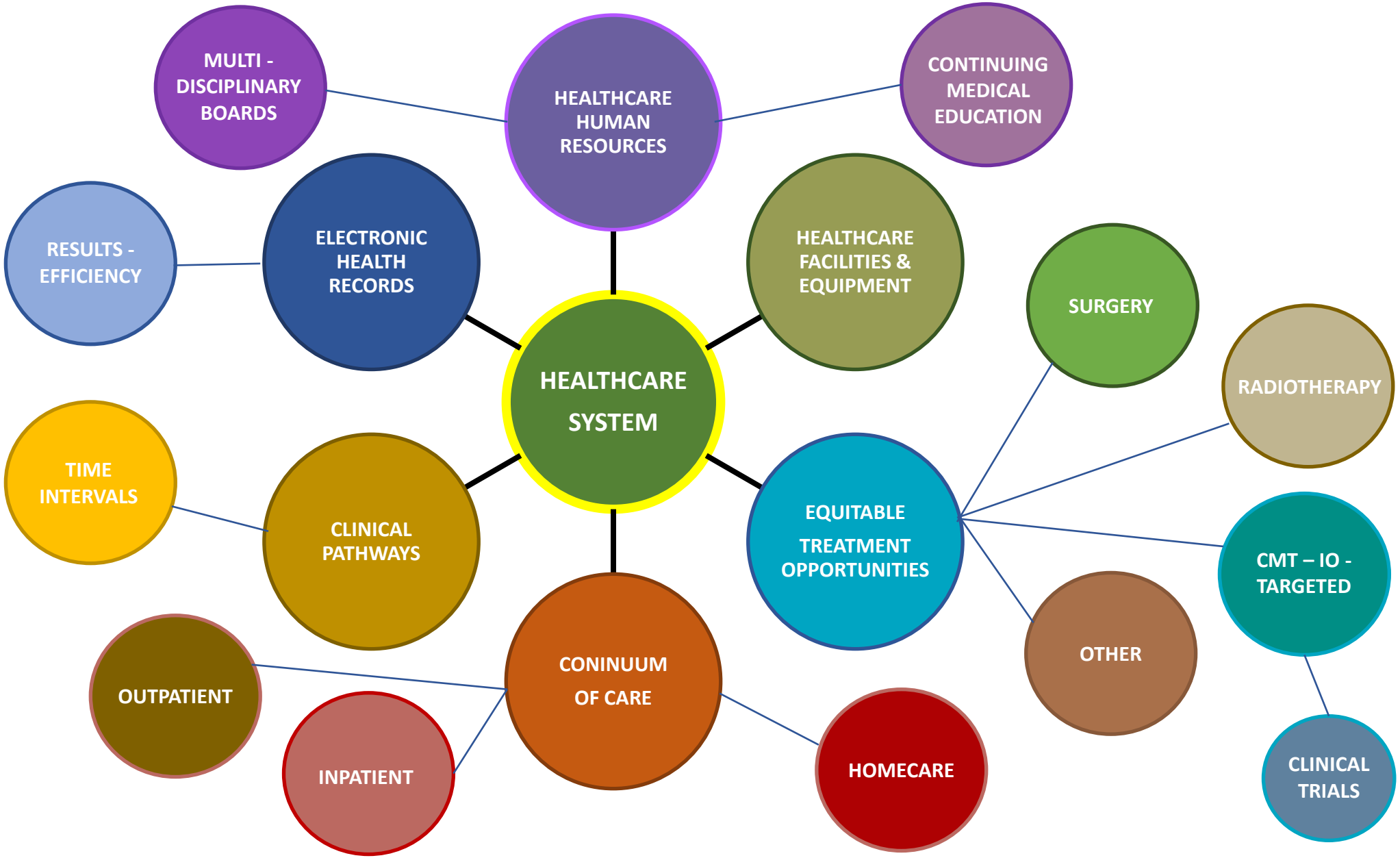
MTB: AUDIT


HOSPITAL
ANNALS OF ONCOLOGY
JOURNAL OF CLINICAL ONCOLOGY
SEOM
Sociedad Española de Oncología Médica
ESMO
ASCO
AREAS TO BE IMPROVED
AGAMENON
GRUPO ESPAÑOL EURECCA DE CANCER
EURECCA
EUROPEAN REGISTRATION OF CANCER CARE
Patient journey
Symptoms identified and referral sought
Diagnosis
Treatment choices
Therapy cycles and regime changes
Survivorship
Disease progression
Patient Reported Outcomes Measures
Patient Reported Experience Measures

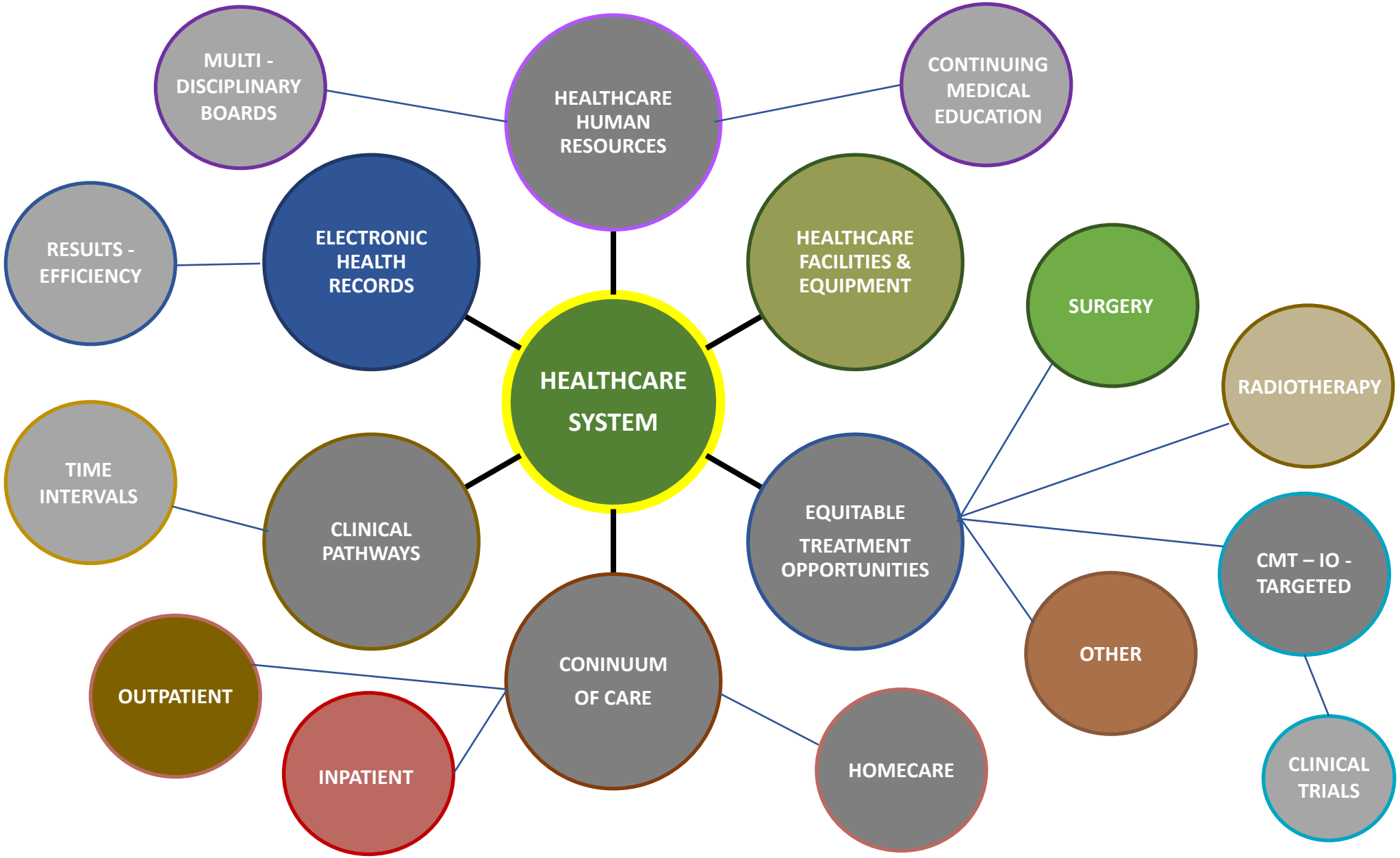
FACTORS


DISEASE
PATIENT
Decisive factors for selecting optimal treatment
MULTIDISCIPLINARY TUMOUR BOARD
HEALTHCARE SYSTEM

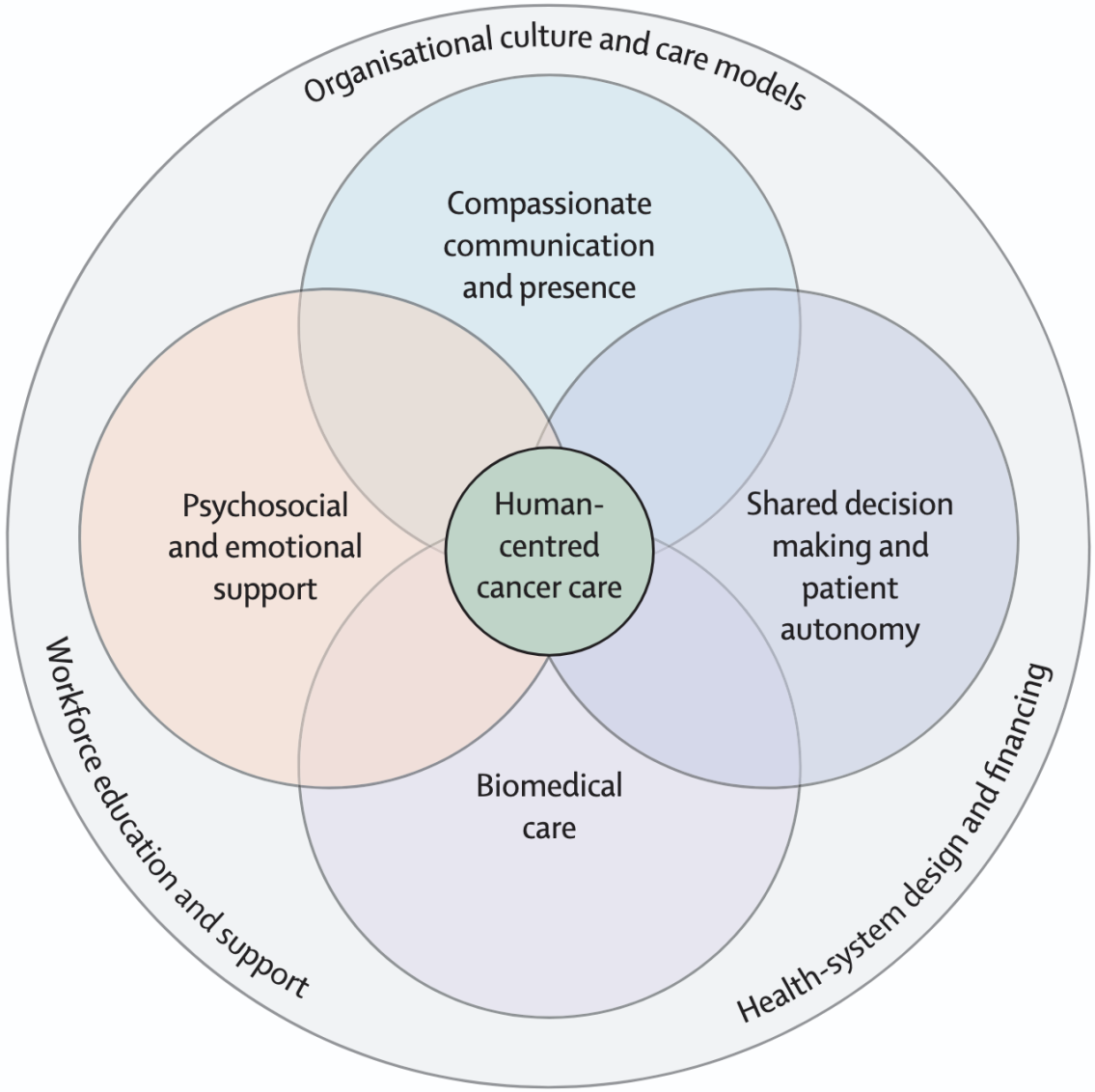
HEALTHCARE SYSTEM



SPANISH PUBLIC HEALTHCARE SYSTEM



HUMAN CRISIS IN CANCER



Lancet Oncology Comission

Amid **unprecedented scientific progress** in oncology, a growing body of evidence reveals a **parallel and profound crisis in the human experience of cancer care**.

This Commission identifies a **growing imbalance between technological innovation and the human dimensions of cancer care**. As the field has increasingly **prioritised biopharmaceutical development**, genomic precision, and market-driven efficiencies, it has often **neglected core practices that uphold dignity, alleviate suffering, and build trust.**

Rodin G, Lancet Oncol 2025

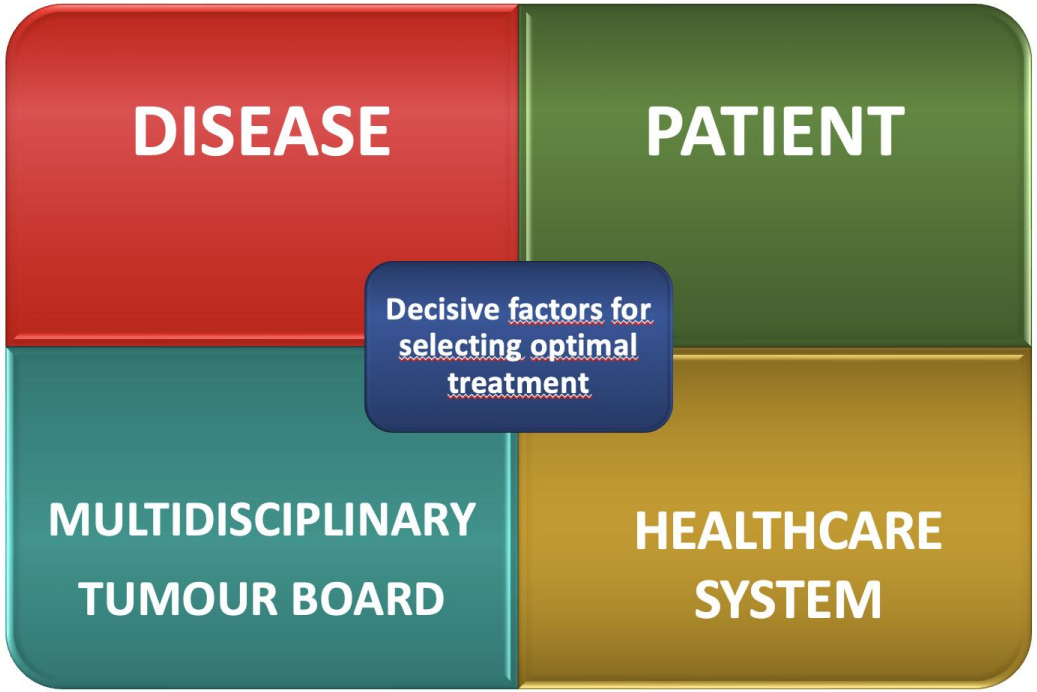
SISYPHUS: KEEP STRIVING

Sísifo.
Tiziano, 1548

The Agnew Clinic.
Thomas Eakins, 1889

CLOSING REMARK

A rigorous evaluation of the disease, considering patient attitude and aptitude, within an constantly updated MTB, and an enabler healthcare system, are decisive factors for selecting the optimal treatment of M0 esophageal SCC.



Optimal treatment of M0 esophageal squamous cell carcinoma: decisive factors in selection.

¡GRACIAS!

Javier Gallego Plazas, MD, PhD.
Medical Oncology Dpt.
Hospital Gral. Univ. Elche

Vilhelm Hammershøi 1901