NCRI Upper Gastro-Intestinal Cancer Clinical Studies Group

Annual Report 2012/2013
<table>
<thead>
<tr>
<th>Section</th>
<th>#</th>
<th>Indicator</th>
<th>Data</th>
<th>National comparison</th>
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<tr>
<td></td>
<td></td>
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<td>Lowest</td>
<td>Highest</td>
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<tr>
<td>Disease</td>
<td>1</td>
<td>Incidence of disease (UK)</td>
<td>24369</td>
<td>2,232</td>
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<td></td>
<td>2</td>
<td>Mortality of disease UK</td>
<td>12651</td>
<td>71</td>
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<td>48,988</td>
<td>35,042</td>
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<td>Members</td>
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<td>Number of Scientific Members on CSG</td>
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<td>14</td>
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<td>Number of Subgroups</td>
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<td>Number of Taskgroups</td>
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<td>Number of Consumers involved in CSG, Subgroup and Taskgroup activities</td>
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<td></td>
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<td>26</td>
<td>4</td>
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<tr>
<td>Portfolio</td>
<td>7</td>
<td>Total number of academic/industry sponsored portfolio studies opening in year</td>
<td>6/11</td>
<td>1/2</td>
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<tr>
<td></td>
<td>8</td>
<td>Number of academic/industry sponsored portfolio studies open</td>
<td>41/19</td>
<td>1/1</td>
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<tr>
<td></td>
<td>9</td>
<td>Total number of portfolio studies (academic and industry sponsored) closing in year</td>
<td>13</td>
<td>1</td>
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<tr>
<td></td>
<td>10</td>
<td>Number of studies conducted internationally (outside UK) open</td>
<td>23</td>
<td>1</td>
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<tr>
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<td>11</td>
<td>Number of industry Alliance Studies open in year</td>
<td>3</td>
<td>1</td>
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<td></td>
<td></td>
<td>39</td>
<td>3</td>
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<td></td>
<td>12</td>
<td>Participation in International Rare Cancer Initiative (IRCI)</td>
<td>No</td>
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<td>Portfolio Delivery</td>
<td>13</td>
<td>Total number of participants recruited (All CSG portfolio studies)</td>
<td>4243</td>
<td>30</td>
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<td></td>
<td>14</td>
<td>Total number of cancer patients recruited (All CSG portfolio studies)</td>
<td>3741</td>
<td>30</td>
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<td></td>
<td>15</td>
<td>Proportion of cancer patients recruited by disease</td>
<td>15.4</td>
<td>3</td>
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<td></td>
<td>16</td>
<td>Proportion of cancer patients recruited to interventional studies (where applicable - all CSG portfolio studies)</td>
<td>11.4</td>
<td>1.1</td>
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<tr>
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<td>17</td>
<td>Number of non cancer participants recruited to studies (All CSG portfolio studies)</td>
<td>502</td>
<td>3</td>
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<tr>
<td></td>
<td>18</td>
<td>Total number of participants recruited to industry sponsored studies (All CSG portfolio studies)</td>
<td>153</td>
<td>2</td>
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<td></td>
<td>19</td>
<td>Proportion of CSG industry sponsored studies closing in year and delivered to time &amp; target</td>
<td>80%</td>
<td>0.1</td>
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<tr>
<td></td>
<td>20</td>
<td>Proportion of other CSG academic studies closing in years and delivered to time &amp; target</td>
<td>50%</td>
<td>17.6</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>100.3</td>
<td>100.1</td>
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<td></td>
<td>21</td>
<td>Number of Local Research Networks active in delivering portfolio</td>
<td>40</td>
<td>11</td>
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<td>Output</td>
<td>22</td>
<td>Number of peer review publications directly associated with CSG portfolio studies</td>
<td>16</td>
<td>0</td>
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<td></td>
<td>23</td>
<td>Awareness raising/educational events</td>
<td>Yes</td>
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<td>Progress Review</td>
<td>24</td>
<td>Date of last Progress Review</td>
<td>Feb-13</td>
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<td></td>
<td>25</td>
<td>Date of next Progress Review</td>
<td>Feb-16</td>
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NCRI Upper GI CSG Annual Report 2012/13

1. Executive Summary
The Upper GI CSG is highly successful with a large portfolio of ongoing trials and a track record in delivering successfully completed studies (see below) which are practice changing. It is the most successful grouping involved in Upper GI cancer research in the world by a large margin. A strategy of avoiding serial renewal of membership and rotation of subgroup chairs has produced a vibrant and cohesive group. The level of success in obtaining funding for studies from CTAAC and HTA is good but it is a challenge to persuade such funding bodies as to the merit of some of the Group’s priorities. Other challenges are developing coherent biomarker based adaptive trials in Upper GI cancer, framing an appropriate study in the more refractory malignancies and running trials of complex interventions, such as surgery and radiotherapy. Making appropriate use of the biological materials collected from the trials is also a challenge but this is in the Group’s strategic plan for 2013.

2. Top three achievements in the year
The Group’s top three achievements this year are:
- The delivery of 7 successful completed RCTs, all of which have been high profile presentations at ASCO or GI ASCO (New EPOC, SCALLOP, TELOVAC, COUGAR-02, COG, SCOPE, NET-01).
- Success in gaining CTAAC funding for a significant proportion of new studies
- Obtaining a positive Progress Review Report on the CSG in February 2013

3. Structure of the Group
The Group structure with 4 subgroups (Oesophagogastric (OG), Pancreas, Hepatobiliary (HB) and Neuroendocrine) is unchanged. Dr Steven Falk has taken over as Chair of the Pancreas Subgroup and Professor Juan Valle the Neuroendocrine Subgroup. Both subgroups have been revitalised with new membership and are actively pursuing grant applications for new studies. The remaining sub-groups (OG and HB) have unchanged membership in the last year.

4. Achievements and challenges of the subgroups

Pancreas Subgroup
The major trials are successfully recruiting, including ESPAC4 and PETPANC, the latter trial now completes in 2013. The future objective is to develop high quality trial designs and protocols in pancreas cancer; this will include early phase clinical trials looking for promising signals in smaller numbers of patients and trials involving chemoradiotherapy. New proposals include the role of Gem Abraxane in locally advanced disease and poorer performance status using an adaptive design.
**Oesophagogastric Subgroup**

REAL-3 has reported and SCOPE has been presented. OEO-5 has completed recruitment and STO-3 is recruiting well and will soon close. COG and COUGAR-02 have been presented. Other major studies are ongoing. The future objective is to develop biomarker driven adaptive trials, trials of XRT and integrating surgery trials into the neo-adjuvant programme.

**Hepatobiliary Subgroup**

The bile duct cancer trials have made this subgroup forefront internationally. The ABC trials are continuing to recruit successfully and more are in set up. BILCAP should close this year and a successor trial is funded by CTAAC. New EPOC has reported a dramatic result and translational work is underway. Future objectives are to set up a successor trial to New EPOC with an adaptive design, a chemoembolization trial colorectal liver metastases and a radiotherapy trial in locally advanced bile duct cancer.

**Neuroendocrine Subgroup**

Two completed studies have been reported, NET-01 and P4NET. A record number of studies (n=10) are in active stages of development; first submissions for funding planned in 2013. Translational research in NETs is being developed alongside the clinical portfolio (TRANSNET group; Chair: Dr Tim Meyer), with the first study planned to open in 2013. The future strategy is to expand the current portfolio (both investigator-initiated and pharma-sponsored studies) from predominantly oncology studies in advanced disease, to include surgical studies (including adjuvant studies), and studies from non-oncology specialties (e.g. gastroenterology, interventional radiology, endocrinology) relating to improving outcomes for patients with NETs; with translational links, where possible, through TRANSNET.

5. Task groups/Working parties

The Group has had no task groups or working parties in the reporting year.

6. Patient recruitment summary for last 5 years

The trend in the recruitment especially randomised trials is very satisfactory. However care must be taken in interpretation because of the distorting effects of high recruiting RCTs e.g. ASPECT and BOSS.

**Table 1 Summary of patient recruitment over 5 years by RCT/Non-RCT**

<table>
<thead>
<tr>
<th>Year</th>
<th>All subjects</th>
<th>Cancer patients only</th>
<th>% of cancer patients relative to incidence</th>
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<tbody>
<tr>
<td></td>
<td>Non-RCT</td>
<td>RCT</td>
<td>Non-RCT</td>
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<tr>
<td>2007/2008</td>
<td>846</td>
<td>1226</td>
<td>841</td>
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<tr>
<td>2008/2009</td>
<td>1180</td>
<td>1733</td>
<td>1158</td>
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<td>2009/2010</td>
<td>2054</td>
<td>1621</td>
<td>1276</td>
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<tr>
<td>2010/2011</td>
<td>3362</td>
<td>3636</td>
<td>3280</td>
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<tr>
<td>2011/2012</td>
<td>4686</td>
<td>2616</td>
<td>4405</td>
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Table 2 Summary of patient recruitment by Interventional/Non-interventional

<table>
<thead>
<tr>
<th>Year</th>
<th>All participants</th>
<th>Cancer patients only</th>
<th>% of cancer patients relative to incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-interventional</td>
<td>Interventional</td>
<td>Non-interventional</td>
</tr>
<tr>
<td>2012/2013</td>
<td>1006</td>
<td>3237</td>
<td>964</td>
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7. Links to other CSGs and international groups
The Group has strong functional links with the Colorectal Group and also links with CTRad (Dr Tom Crosby) and SPED Committee (Professor Rebecca Fitzgerald). The International Biliary Tract Cancer Collaborative set up and Chaired by Dr John Bridgwater which meets at ASCO and elsewhere is an international group with the aim of standardising data collection in biliary tract cancer, coordinating tissue resources and collaborating in clinical trials. The CSG have put the first collaborative trial in biliary tract cancer into CTAAC (ACTICCA-1).

8. Funding applications in last year
An extensive and comprehensive list of studies has been submitted for funding over that last year. However with the move to more complex adaptive and hence more expensive trials it is expected that in the future fewer but larger studies will be funded, each taking more time in the application phase.

Table 3 Successful funding applications for the year

<table>
<thead>
<tr>
<th>Title</th>
<th>Acronym</th>
<th>CI</th>
<th>Funding body</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCALOP-II: Systemic therapy and Chemoradiation in Advanced Localised Pancreas-II</td>
<td>SCALOP-II</td>
<td>Dr S Mukherjee</td>
<td>CTAAC</td>
</tr>
<tr>
<td>ABC-06: a randomised phase III, multi-centre, open-label study of Active Symptom Control (ASC) alone or ASC with oxaliplatin/ 5-FU chemotherapy for patients with locally advanced/metastatic biliary tract cancers previously treated with cisplatin/gemcitabine chemotherapy</td>
<td>ABC-06</td>
<td>Professor Juan Valle</td>
<td>CTAAC</td>
</tr>
<tr>
<td>ORANGE II PLUS Trial</td>
<td>ORANGE II PLUS</td>
<td>Professor John Primrose</td>
<td>CTAAC</td>
</tr>
<tr>
<td>ACTICCA-1 - Adjuvant chemotherapy with gemcitabine and cisplatin compared to observation after curative intent resection of cholangiocarcinoma</td>
<td>ACTICCA-1</td>
<td>Professor John Bridgwater</td>
<td>CTAAC</td>
</tr>
<tr>
<td>PLATFORM - Planning treatment for</td>
<td>PLATFORM</td>
<td>Professor David</td>
<td>CTAAC</td>
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</table>
Table 4 Unsuccessful funding applications for the year

<table>
<thead>
<tr>
<th>Title</th>
<th>Acronym</th>
<th>CI</th>
<th>Funding body</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBC-01: Phase Ib study of pre-operative cetuximab, cisplatin and gemcitabine chemotherapy in patients with localised / borderline resectable biliary tract cancer</td>
<td>BBC-01</td>
<td>Mr Hassan Malik</td>
<td>CTAAC</td>
</tr>
<tr>
<td>A phase Ib/Ila study of AZD2014 in combination with gemcitabine in patients with metastatic pancreatic ductal adenocarcinoma</td>
<td></td>
<td>Professor Jeff Evans</td>
<td>CTAAC</td>
</tr>
<tr>
<td>GALLANT: A feasibility study of FOLFIRINOX vs. GEM-CAP in patients with advanced pancreatic cancer</td>
<td>GALLANT</td>
<td>Professor David Cunningham</td>
<td>CTAAC</td>
</tr>
<tr>
<td>SIEGE: Randomised phase II trial to investigate two different schedules of nab-paclitaxel (Abraxane) combined with gemcitabine with gemcitabine alone as first line treatment for metastatic pancreatic adenocarcinoma</td>
<td>SIEGE</td>
<td>Dr Pippa Corrie</td>
<td>CTAAC</td>
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</table>

Of the 4 outline submissions made, all progressed to full submissions.

9. Industry sponsored trials portfolio
The industry portfolio is active and shown in the Portfolio Maps (Appendix 2).

10. Collaborative partnership studies with industry
The Astra Zeneca collaboration and has been particularly successful with VIP and ABC-03 completing recruitment. ABC-04 has completed a phase 1b component with Selumitinib (AZD6244). ABC-05 (a phase 2/3 study of the same compound) has been approved.

11. Progress towards achieving 3 year strategy
The Group Strategy as outlined in October 2011 and supported by the Group Review in 2013 was:

- Move to adaptive trials as a general rule, with seamless transition from phase 2 to phase 3 comparisons. This has been achieved to a significant degree with adaptive trials in 3 out of 4 sub groups now being submitted for funding.
- Trials of radiotherapy and surgery. Scallop has established a new international standard for chemoradiotherapy in locally advanced pancreas cancer. Scallop 2 has been approved for funding.
SCOPE completed and reported at GI ASCO and SCOPE 2 is being submitted for funding. There is also UK interest in the Irish study of chemotherapy v chemoradiotherapy in oesophageal adenocarcinoma.

- Develop Translational research. All studies have embedded blood and tissue and in October 2013 there will be a Translational meeting to discuss strategy

12. Impact of clinical trials on routine UK clinical practice
The SCALOP trial has led to the establishment of capecitabine with radiotherapy as standard treatment for locally advanced pancreas cancer treated with radiation. GEMCAP is a UK standard therapy for advanced disease. New EPOC has demonstrated substantial harm from cetuximab in patients with operable colorectal liver metastases and may change current NICE guidance. COUGAR-2 has established a second line treatment for advanced gastric cancer. SCALLOP has established a standard of care for locally advanced pancreatic cancer. SCOPE, REAL-3 and COG have shown that EGFR antibodies are not indicated in these respective settings.

13. Consumer involvement
As a policy we have begun to involve consumer members on the sub-groups as this allows consumer input into trial design. On the main group the consumer members have traditionally been very effective but due to rotation we have now one new consumer member and one about to be appointed. The impact of the new representatives should be seen in 2013/14.

14. Open meetings / annual trials days
The annual trials day in December had that largest attendance ever and was highly successful with excellent feedback. The new trials results session was especially successful and was run on this occasion ASCO-style with a discussant.

15. Priorities and challenges for the forthcoming year
The Group’s three priorities for the year are:
- Develop the translational strategy for collected materials
- Develop the adaptive trial approach
- Prioritise trial development in resectable colorectal liver metastases, chemoradiotherapy for operable oesophageal adenocarcinoma and an advanced pancreas cancer study

16. Concluding remarks
The present Group is working well with a good balance of active members and highly functional sub-groups. The productivity in terms of delivered trial is excellent and the present portfolio large. The Group review was highly favourable and agreed with the Groups own view regarding the direction of travel.
17. Appendices
1. Membership of main CSG and subgroups
2. Portfolio Maps
3. Publications in previous calendar year
4. Major international presentations in previous year
5. Strengths & weaknesses from the 3-year Progress Review (21st February 2013)

Professor John Primrose (Upper GI CSG Chair)
**Appendix 1**  
*CSG and Subgroup membership*

**CSG Membership**

<table>
<thead>
<tr>
<th>Member</th>
<th>Location</th>
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<tr>
<td>Mr William Allum</td>
<td>London</td>
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<tr>
<td>Professor Hugh Barr</td>
<td>Gloucester</td>
</tr>
<tr>
<td>Dr Andrew Bateman</td>
<td>Southampton</td>
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<tr>
<td>Dr David Breen</td>
<td>Southampton</td>
</tr>
<tr>
<td>Dr John Bridgewater</td>
<td>London</td>
</tr>
<tr>
<td>Professor Martyn Caplin</td>
<td>London</td>
</tr>
<tr>
<td>Dr Tom Crosby</td>
<td>Cardiff</td>
</tr>
<tr>
<td>Professor David Cunningham</td>
<td>Sutton</td>
</tr>
<tr>
<td>Mrs Susan Dutton</td>
<td>Oxford</td>
</tr>
<tr>
<td>Professor Jeff Evans</td>
<td>Glasgow</td>
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<tr>
<td>Dr Steven Falk</td>
<td>Bristol</td>
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<tr>
<td>Professor Rebecca Fitzgerald</td>
<td>Cambridge</td>
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<tr>
<td>Dr Heike Grabsch</td>
<td>Leeds</td>
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<tr>
<td>Mr Gareth Griffiths</td>
<td>Cardiff</td>
</tr>
<tr>
<td>Dr Thorsten Hagemann</td>
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<tr>
<td>Mr Hassan Malik</td>
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<tr>
<td>Dr Somnath Mukherjee</td>
<td>Northampton</td>
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<tr>
<td>Professor Graeme Murray</td>
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<td>Dr Russell Petty</td>
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<tr>
<td>Professor Daniel Palmer</td>
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<tr>
<td>Professor John Primrose (Chair)</td>
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<td>Dr Deborah Stocken</td>
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<tr>
<td>Dr Anne Thomas</td>
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<td>Ms Olga Tucker</td>
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<tr>
<td>Dr Juan Valle</td>
<td>Manchester</td>
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<tr>
<td>Dr Jon Wadsley</td>
<td>Sheffield</td>
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<tr>
<td>Mr Phil Willan</td>
<td>Blackburn</td>
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</table>
## Subgroup Membership

### Oesophagogastric Subgroup
- Professor David Cunningham (Chair)
- Professor Derek Alderson
- Dr Kate Sumpter
- Professor Jeff Evans
- Mr David Kirby
- Dr Heike Grabsch
- Professor Janusz Jankowski
- Dr Ruth Langley
- Dr Anne Thomas
- Dr Sarah Slater
- Professor Robert Mason
- Mr William Allum
- Mr Tim Underwood
- Dr Tom Crosby
- Dr Hugo Ford
- Professor Jane Blazeby

### Hepatobiliary Subgroup
- Professor John Bridgewater (Chair)
- Dr Harpreet Wasan
- Dr John Primrose
- Professor Philip Johnson
- Dr Tim Meyer
- Mr David Berry
- Professor Juan Valle
- Mr Hassan Malik

### Pancreatic Subgroup
- Dr Stephen Falk (Chair)
- Dr Juan Valle
- Dr Gary Middleton
- Ms Paula Ghaneh
- Professor David Cunningham
- Professor Will Steward
- Professor Daniel Palmer
- Dr Somnath Mukherjee
- Professor Andrew Biankin
- Professor John Bridgewater
- Professor Jeff Evans
- Dr Thorsten Hagemann

### Neuroendocrine Subgroup
- Dr Juan Valle (Chair)
- Professor Ashley Grossman
- Professor Martyn Caplin
- Dr Tim Meyer
- Dr Alan Anthoney
- Dr Pippa Corrie
- Dr Prakash Manoharan
- Dr Nick Reed
- Dr Val Lewington
- Dr John Newell-Price
- Dr Aled Rees
- Professor Andrea Frilling
- Mr Graeme Poston
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<th>Colorectal Metastasis</th>
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<td>Advanced</td>
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<td>Kinase drivers of hepatopancreatic cancer progression</td>
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<td>Immune Responses in HCC</td>
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<td>Bilary Tract Cancer Validation</td>
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YELLOW=OPEN/RECRUITING  PURPLE=IN SET-UP/FUNDED
<table>
<thead>
<tr>
<th>UPPER GI PORTFOLIO MAP</th>
<th>NEUROENDOCRINE</th>
<th>YELLLOW=OPEN/RECRUITING</th>
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<tr>
<td></td>
<td>Pancreas</td>
<td>Intestines</td>
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<td>Low Grade (G1/G2)</td>
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<td>Neo-adjuvant Surgery</td>
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<td>Adjuvant</td>
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<td>Low Grade (G1/G2)</td>
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<td>Advanced 1st Line</td>
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<td>Advanced 2nd Line</td>
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<tr>
<td>Non-Interventional/Transitional</td>
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</tbody>
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- NCRN 328: 77Lu-DOTA-Tyr3-Octreotate vs. Octreotide LAR
- NCRN 333: Everolimus (RAD001) + best supportive care vs. placebo + best supportive care
- NCRN 379: BEZ235 vs. everolimus
- NCRN 411: Oral BEZ235 + best supportive care (BSC) vs. placebo plus BSC

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## UPPER GI PORTFOLIO MAP

### Barrett's Oesophagus
- Pre-Malignant
  - CHOPIN
  - BOOST
  - RECAd
  - Trimodal Imaging
  - BEST 2
  - PRO-BOOST

### Squamous Cell Carcinoma
- 2nd Line
  - VINDALOO 2
  - VINDALOO 2
  - Neo-Scope

### Adenocarcinoma
- 1st Line
  - CHOPIN
  - DEBIOC
  - FACING
  - GO-2
  - NCRN 366

### Adjuvant
- Sentinel Node Biopsy
- NCRN 267: SHINE
- FGFR Study

### Advanced 1st Line
- Rilotumumab (AMG 102) + Epirubicin, Cisplatin, and Capecitabine (ECX)
- TRANS-MAGIC, TRANS-OE02 & TRANS-OE05 studies still active

### Advanced 2nd Line
- NCRN 267: Efficacy and Safety of AZD4547 Monotherapy vs Paclitaxel

### Non-Interventional/Translational
- TRANSGO, RTI Adv Study, OCTAMS, OCCAMS

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### OESOPHAGEAL & TYPE I/II JUNCTIONAL TUMOURS

**YELLOW**=OPEN/RECRUITING

**PURPLE**=IN SET-UP/FUNDED

* - Translational element included
**UPPER GI PORTFOLIO MAP**

**PANCREAS**

- **Adenocarcinoma**
  - NCRN 280: LY2495655
  - NCRN 376: MM-398 vs. 5-Fluorouracil + Leucovorin
  - NCRN 503: Efficacy and Safety of Gemcitabine + TH-302 vs. Gemcitabine + Placebo

- **Neuroendocrine**

see neuroendocrine map

**Adjuvant**

- ESPAC4*

**1st Line**

- CRUK MK-0752
- VIP*
- NCRN503
- NCRN280
- NCRN376: NAPOLI

**2nd Line**

**Non-Interventional/Translational**

- TRANSBIL
- Predictive in-cell bioassy
- Kinase drivers of HGC cancer progression
- Kinase drivers of pancreatic cancer progression
- ESPAC-T Plus
- Study of proliferation α
- Mol & Gen mech
- The SYMPTOM STUDY
- PET-PANC
- F-18 FLT PET Assess Treatment

* - Translational element included
α – Study suspended

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**STOMACH & TYPE II/III JUNCTIONAL TUMOURS**

- **Adenocarcinoma**

### Pre-Malignant

- **Neo-adjuvant**
  - LEO

### Surgery

- **Adjuvant**
  - ST03*

### Advanced 1st Line

- **Non-interventional/Translational**
  - NCRN 416: Efficacy & safety of onartuzumab (MetMab) + 5-fluorouracil, leucovorin & oxaliplatin (mFOLFOX6)
  - NCRN 366: Rilotumumab (AMG 102) + Epirubicin, Cisplatin, and Capecitabine (ECX)
  - NCRN 369: Efficacy & safety of trastuzumab emtansine (T-DM1) vs. taxane (docetaxel or paclitaxel)
  - NCRN 488: A multicentre, open-label, early stopping design, proof of concept study with tasquinimod

### Advanced 2nd Line

- **TRANS-MAGIC study still active**

- **ST03 - Trans**
- **RTL Pre-clinical Study**
- **RTL Advanced Study**

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* - Translational element included

**YELLOW=OPEN/RECRUITING**

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Appendix 3

Publications arising from the Group’s portfolio

P4NET


SCOPE 1


NCRN287 -Dasatinib + Gem advanced pancreatic


SCALOP


ESPAC-3

NCRN012- NET, and the NET-01 studies

TACE

REAL3

TRANSMAGIC/REAL3

TRANSMAGIC
**ST03**

**CHOPIN**

**NCRN092 SEARCH**
Appendix 4
	Presentations arising from the Group’s portfolio

There were no presentations directly relating to the Group’s portfolio.
Appendix 5

Key strengths and issues from the 21st February 2013 Progress Review.

Upper GI CSG

The key strengths of the Group identified at the progress review are:
- excellent high performance
- high productivity, have an excellent research and publication record
- delivering a number of trials, which have changed clinical practice.
- outstanding international standing
- regularly presenting at key international meetings
- embracing the recommendations coming out of the strategic review of CSGs.
- good subgroup chairs that are enthusiastic about their disease areas and are taking them forward
- portfolio that covers all aspects of disease
- Overall good recruitment
- warmth shown towards new investigators
- highly successful annual trials meetings

The CSG needs to:
- develop more trials of local therapy and local control now that RT technology and QA has improved
- include both pragmatic and niche/specialist trials in the portfolio in order to engage the whole research community
- be less modest in promoting and celebrating these achievements
- develop more formal links with other CSGs such as Sarcoma and Biomarkers and Imaging and advisory groups such SPED and CTRad
- develop strategy for its translational work
- hold a day meeting devoted to developing a strategy for tissue use and sharing, and to which relevant external experts are invited to offer advice.
- decide with whom to collaborate internationally with on trials, particularly with the move to develop more trials for specific subsets of patients.
- readdress the gaps in network recruitment
- consider appointing an industry champion

The NCRN/I need to:
- consider refining the format of the report proforma