Dr. Daniel Coit: the challenge of clinical staging of EGJ cancer

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Dr. Daniel Coit (*Figure 1*), MD, a leader at Memorial Sloan-Kettering Cancer Center, is an outstanding surgical oncologist specializes in in the diagnosis and treatment of melanoma, as well as the treatment for gastric cancer. He also made great achievement in medical education by training a lot of young surgeons in the surgical clinical oncology in the past 30 years. During the International Gastric Cancer Congress (IGCC) 2015, Dr. Coit being the invited speaker had several speeches to share his ideas and experience, which were very attractive. He was also one of the chairpersons in the "Controversies in TNM staging in EG-junction tumors" section. This interview was conducted in the IGCC 2015.

Figure 1 Dr. Daniel Coit, MD.

TGH: We realize that you have several speeches in this conference and you are also a chairperson. You must participate more in this conference, so what do you think are the highlights of this 2015 IGCC?

Dr. Coit: This is a very interesting meeting. Because over the years, it has focused mostly on the surgical details of the management of gastric cancer, and increasingly, it is focusing on the overall management of patients with stomach cancer, including the biology of the cancer and the multimodality management of the cancer. It has been wonderful to watch the meeting mature and evolve over the years.

TGH: Being the chairperson, what are your comments on the other speakers?

Dr. Coit: I thought that our section was on staging of gastroesophageal junction. The speakers were very good. This is a very important section because we tend to figure out how to stage the patients before we treat them and always the stage after we treat them. So the pre-treatment stage is very important and we have speakers talked about radiology imaging and pharmacology issue, as well as the overall problem stage. But I think the most important talk in our section was from Prof. Sano, because he was trying to harmonize the staging system of stomach cancer with that of gastroesophageal junction. And I think there is very strong reaction and strong support for that. I am hopeful that the efforts that he has gone through to get together cases from all over the world to provide evidences to support this new staging system will come to fruition. And the AJCC 8th edition on staging is coming out. So I was always impressive again by Prof. Sano and his efforts to bring all of these information into a situation what I think is a very good staging system.

TGH: Your speech is about the clinical staging of EG-junction cancer. Could you share with us the main challenges?

Dr. Coit: I think the main point I was trying to make is that while we are pretty good at deciding who should get multimodality therapy and who should go directly to surgery. We are not as good as we could be, and I think that we have opportunity to combine the imaging that we have and the ultrasound that we have and obviously some of the new techniques, like tumor markers and circulating tumor cells. Most interestingly, I think the genetic signature of the tumor into a risk assessment that will help us tell a treatment to the individual patient, not just whether or

not they get chemotherapy but which chemotherapy they get. And I think increasingly we are going to see molecular fulfilling of the tumors, participate in the pre-treatment risk assessment.

TGH: Facing these challenges, what should we do at present?

Dr. Coit: I think right now, it is imperative that we bank tissue. It is imperative that we preserve and bank the original biopsy and the tumors. So we can study these and study the correlation between the two to see if the genetic signature of the biopsy leads to higher response rate in given types to chemotherapy or if the genetic signature changes with chemotherapy. So the biggest challenge is the tissue to be banked.

TGH: We know that you have trained many young surgeons in the surgical clinical oncology. What do you think is the most difficult thing for them?

Dr. Coit: The most difficult thing for the young surgeons is know what they want to get out of these international experiments. And the point I will make is that they really need to have a plan. This is a big effort to do this in the international exchange and they have to be very active participants involving their visiting. They cannot just come and visit like a tourist. They have to have a plan, they have to know what they want, and they have to have a whole interests in making it happen. This is a very active process. Over the last 30 years, as I watch the visitors who just come and have kind of silently observed. They do not get much out of this. But once they come and engage in the process, they research the institution during their visiting, they research the people they are visiting, they engage in the conversation. There is a back and forth, everybody learns something, hopes to learn something and wishes to learn something. And that is very important. For me, I think the most successful visitors are the ones who really engaged and are active visitors, not passive visitors.

TGH: We know that the next IGCC will be held in Beijing, China. What's your expectation about the next IGCC?

Dr. Coit: I expect the meeting will continue to evolve as it has, and I expect there will be more and more emphasis on the biology of the tumor and how we can understand that biology to create more appropriate treatment plans for patients. I think that would be very exciting.

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Footnote

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