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Small Bowel Adenocarcinoma, Version 1.2020

Al B. Benson III, MD^{1,*}, Alan P. Venook, MD^{2,*}, Mahmoud M. Al-Hawary, MD³, Mustafa A. Arain, MD², Yi-Jen Chen, MD, PhD⁴, Kristen K. Ciombor, MD⁵, Stacey A. Cohen, MD^{6,*}, Harry S. Cooper, MD⁷, Dustin A. Deming, MD⁸, Ignacio Garrido-Laguna, MD, PhD⁹, Jean L. Grem, MD¹⁰, Sarah E. Hoffe, MD¹¹, Joleen Hubbard, MD¹², Steven Hunt, MD¹³, Ahmed Kamel, MD¹⁴, Natalie Kirilcuk, MD¹⁵, Smitha Krishnamurthi, MD¹⁶, Wells A. Messersmith, MD¹⁷, Jeffrey Meyerhardt, MD, MPH¹⁸, Eric D. Miller, MD, PhD¹⁹, Mary F. Mulcah, MD¹, Steven Nurkin, MD, MS²⁰, Michael J. Overman, MD²¹, Aparna Parikh, MD²², Hitendra Patel, MD²³, Katrina S. Pedersen, MD, MS^{13,*}, Leonard B. Saltz, MD²⁴, Charles Schneider, MD²⁵, David Shibata, MD²⁶, John M. Skibber, MD²¹, Constantinos T. Sofocleous, MD, PhD²⁴, Elena M. Stoffel, MD, MPH³, Eden Stotsky-Himelfarb, BSN, RN²⁷, Christopher G. Willett, MD²⁸, Alyse Johnson-Chilla, MS²⁹, Kristina M. Gregory, RN, MSN, OCN²⁹, Lisa A. Gurski, PhD²⁹

¹Robert H. Lurie Comprehensive Cancer Center of Northwestern University

²UCSF Helen Diller Family Comprehensive Cancer Center

³University of Michigan Rogel Cancer Center

⁴City of Hope National Medical Center

⁵Vanderbilt-Ingram Cancer Center

⁶Fred Hutchinson Cancer Research Center/Seattle Cancer Care Alliance

⁷Fox Chase Cancer Center

⁸University of Wisconsin Carbone Cancer Center

⁹Huntsman Cancer Institute at the University of Utah

¹⁰Fred & Pamela Buffett Cancer Center

¹¹Moffitt Cancer Center

¹²Mayo Clinic Cancer Center

¹³Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine

¹⁴O'Neal Comprehensive Cancer Center at UAB

¹⁵Stanford Cancer Institute

¹⁶Case Comprehensive Cancer Center/University Hospitals Seidman Cancer Center and Cleveland Clinic Taussig Cancer Institute

*Discussion Section Writing Committee.

¹⁷University of Colorado Cancer Center

¹⁸Dana-Farber/Brigham and Women's Cancer Center

¹⁹The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute

²⁰Roswell Park Comprehensive Cancer Center

²¹The University of Texas MD Anderson Cancer Center

²²Massachusetts General Hospital Cancer Center

²³UC San Diego Moores Cancer Center

²⁴Memorial Sloan Kettering Cancer Center

²⁵Abramson Cancer Center at the University of Pennsylvania

²⁶The University of Tennessee Health Science Center

²⁷The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

²⁸Duke Cancer Institute

²⁹National Comprehensive Cancer Network

Abstract

Small bowel adenocarcinoma (SBA) is a rare malignancy of the gastrointestinal tract that has increased in incidence across recent years. Often diagnosed at an advanced stage, outcomes for SBA are worse on average than for other related malignancies, including colorectal cancer. Due to the rarity of this disease, few studies have been done to direct optimal treatment, although recent data have shown that SBA responds to treatment differently than colorectal cancer, necessitating a separate approach to treatment. The NCCN Guidelines for Small Bowel Adenocarcinoma were created to establish an evidence-based standard of care for patients with SBA. These guidelines provide recommendations on the workup of suspected SBA, primary treatment options, adjuvant treatment, surveillance, and systemic therapy for metastatic disease. Additionally, principles of imaging and endoscopy, pathologic review, surgery, radiation therapy, and survivorship are described.

Overview

In 2019, an estimated 10,590 new cases of small bowel cancer will occur and 1,590 patients will die of this disease.¹ Compared with cancers of other organs in the gastrointestinal tract, small bowel cancers are relatively rare, accounting for only about 3% of cancers occurring in this organ system.¹ Small bowel cancers affect men and women relatively equally, with an incidence of 2.6 per 100,000 for men and 2.0 per 100,000 for women.² The median age at diagnosis is 66 years. The incidence of small bowel cancers is increasing, with an annual percent increase of 1.8 between 2006 and 2015. This trend is in contrast to other gastrointestinal malignancies, including esophageal, gastric, colon, and rectum, which decreased in incidence across the same timeframe.² The 4 most common histologies

of cancers originating in the small bowel are adenocarcinomas, neuroendocrine tumors, gastrointestinal stromal tumors, and lymphomas.^{3,4} The treatment recommendations in this guideline only refer to small bowel adenocarcinoma (SBA), which comprise an estimated 30% to 40% incidence of small intestinal cancer diagnoses.⁴ Due to the rarity of this disease, very few established guidelines for management of SBA exist. In 2018, a French intergroup published the first clinical practice guidelines for SBA.⁵ These NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Small Bowel Adenocarcinoma are the second.

This discussion summarizes the NCCN Guidelines for SBA. These guidelines begin with the clinical presentation of the patient to the primary care physician or gastroenterologist and address diagnosis, pathologic staging, surgical management, perioperative treatment, patient surveillance, management of recurrent and metastatic disease, and survivorship. When reviewing these guidelines, clinicians should be aware of several things. First, these guidelines adhere to the TNM (tumor, node, metastases) staging system (see definitions of TNM in Table 1, available online, in these guidelines, at [NCCN.org](https://www.nccn.org)).⁶ Furthermore, all recommendations are classified as category 2A except where noted in the text or algorithm. Although the guidelines are believed to represent the optimal treatment strategy, participation in a clinical trial is especially encouraged for patients with SBA based on the dearth of clinical trial data on which to base treatment decisions for this disease.

Literature Search Criteria and Guidelines Update Methodology

Before the development of the NCCN Guidelines for SBA, an electronic search of the PubMed database was performed to obtain key literature in the field of small bowel cancer, using the following search terms: (small bowel cancer) OR (small intestine cancer) OR (jejunum cancer) OR (duodenum cancer) OR (ileum cancer). The PubMed database was chosen because it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.⁷ The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial; Multicenter Study; Practice Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies.

The data from key PubMed articles and articles from additional sources deemed as relevant to these guidelines and discussed by the panel have been included in this version of the discussion section (eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel's review of lower-level evidence and expert opinion.

The complete details of the "Development and Update of the NCCN Guidelines" are available at [NCCN.org](https://www.nccn.org).

Risk Factors for SBA

Risk factors for SBA are similar to those for colorectal cancer (CRC), including lifestyle factors, inflammatory bowel disease (IBD), and certain familial syndromes such as Lynch syndrome (also known as hereditary nonpolyposis colorectal cancer), Peutz-Jeghers

syndrome (PJS), and familial adenomatous polyposis (FAP). Therefore, it is recommended that all patients with small bowel cancer be queried regarding their family history and considered for risk assessment, as detailed in the NCCN Guidelines for Colorectal Cancer Screening (available at [NCCN.org](https://www.nccn.org)).

Lifestyle Factors

Although data on the role of lifestyle factors in relation to the risk of developing SBA are very limited due to low incidence of disease, lifestyle factors that have been reported as raising the risk of SBA generally agree with known risk factors for CRC. A systematic review of the literature has reported that high levels of alcohol consumption, smoking, and dietary factors, including low intake of fiber and high intake of red/processed meat and sugary drinks, may increase the risk of SBA.⁸ Additionally, the results of a pooled analysis of more than 500,000 subjects in the Asia Cohort Consortium reported that elevated body mass index and high alcohol consumption were associated with a nonsignificant trend toward an increased risk of SBA, although this analysis did not identify smoking as a risk factor.⁹

IBD and Celiac Disease

It is well recognized that individuals with IBD (ulcerative colitis or Crohn's disease) are at increased risk for CRC. Several studies have also reported an increased risk of distal SBA in patients with IBD.^{10–13} The results of a retrospective, multicenter observational cohort study of 9,100 patients with IBD found that the relative risk of small bowel cancer was 3.70 (95% CI, 1.23–11.13) for patients with IBD. The rate of death and cancer remission did not differ between patients who maintained IBD treatment compared with those who stopped IBD treatment.¹⁰ Additionally, although the data are mostly limited to case studies and literature reviews, cases of SBA have been reported in patients with celiac disease, suggesting a possible link between these conditions.^{14–16} The association with celiac disease is poorly understood and a distinct difference from CRC, for which celiac disease is not a risk factor.

Familial Syndromes

Due to the relative rarity of SBA and the disease's association with several genetic syndromes, the NCCN panel recommends that all patients with a personal history of SBA should be counseled for familial malignancies and considered for risk assessment of various genetic syndromes, including Lynch syndrome, PJS, FAP, and other polypoid mutations. A brief description of some of these syndromes is included in subsequent sections. See the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal (at [NCCN.org](https://www.nccn.org)) for more information.

Familial Adenomatous Polyposis—FAP is an autosomal dominant condition characterized by a germline mutation in the *APC* gene, located on chromosome 5q21.^{17,18} Patients with FAP develop large numbers of adenomatous polyps in the large bowel, beginning as early as adolescence, and most patients with classic FAP will develop polyps by the age of 25. Patients with attenuated FAP due to a germline *MUTYH* mutation develop fewer numbers of polyps and generally at a later age than those with classic FAP.^{17,18}

Although the incidence of SBA in patients with FAP has not been well established, the lifetime risk has been estimated as 3% to 5%.¹⁹ The duodenum and periampullary region are the most common locations for SB in patients with FAP.¹⁹

Peutz-Jeghers Syndrome—PJS is an autosomal dominant condition mainly characterized by multiple hamartomatous and adenomatous gastrointestinal polyps, predominantly located in the jejunum and ileum.^{19,20} A majority of PJS cases occur due to mutations in the *STK11 (LKB1)* gene.^{21,22} However, other genetic mutations may be involved, because an estimated half of patients with PJS do not have detectable *STK11/LKB1* mutations.²³ SBA can arise from either hamartomatous or adenomatous polyps, predisposing patients with PJS to SBA. The relative risk of developing SBA has been estimated as 520 compared with the general population,²⁴ and the lifetime risk of SBA has been estimated between 1.7% and 13% for individuals with PJS.^{19,24,25}

Lynch Syndrome—Lynch syndrome is a hereditary syndrome resulting from germline mutations in DNA mismatch repair (MMR) genes (*MLH1*, *MSH2*, *MSH6*, and *PMS2*). Individuals with Lynch syndrome are estimated to have a lifetime risk of 4% of developing SBA, representing a relative risk of more than 100 compared with the general population.^{26,27} Although identifying a mutation in an MMR gene through germline sequencing is definitive for Lynch syndrome, patients usually undergo selection for screening by considering family history and performing an initial test on tumor tissue before sequencing. One of two (or both) different initial tests can be performed on SBA specimens to identify individuals who might have Lynch syndrome: (1) immunohistochemical analysis for MMR protein expression, which is often diminished because of mutation; or (2) polymerase chain reaction analysis for microsatellite instability (MSI), which results from MMR deficiency and is detected as changes in the length of repetitive DNA elements in tumor tissue caused by the insertion or deletion of repeated units.²⁸

Many NCCN Member Institutions and other comprehensive cancer centers now perform immunohistochemistry (IHC) and sometimes MSI testing on all newly diagnosed CRC and endometrial cancers regardless of family history to determine which patients should have genetic testing for Lynch syndrome.^{29–32} This approach may also be applied to patients with a personal history of SBA, particularly since it has been reported that SBA has a higher percentage of MSI-high (MSI-H)/MMR-deficient (dMMR) tumors compared with CRC.^{33,34} The NCCN Colon/Rectal/Anal Cancers Panel endorses universal MMR or MSI testing of all patients with a personal history of SBA to identify individuals with Lynch syndrome. This testing is also relevant for treatment selection in stage IV disease [see “Pembrolizumab or Nivolumab With or Without Ipilimumab (for dMMR/MSI-H tumors) as Subsequent-line Therapy,” page 1125]. A more detailed discussion is available in the NCCN Guidelines for Colorectal Cancer Screening (available at [NCCN.org](https://www.nccn.org)).

Clinical Presentation and Workup

The treatment recommendations in this guideline only refer to SBA. For gastrointestinal stromal tumors, see the NCCN Guidelines for Soft Tissue Sarcoma; for neuroendocrine tumors, see the NCCN Guidelines for Neuroendocrine and Adrenal Tumors; and for small

bowel lymphomas see the NCCN Guidelines for B-Cell Lymphomas (all available at [NCCN.org](https://www.nccn.org)).

Most cases of SBA arise in the duodenum, accounting for approximately 52% to 57% of cases. The remainder arise in the jejunum (18%–29%), ileum (10%–13%), or in an unspecified location of the small bowel (4%–14%).^{35–37} Patients with SBA tend to be younger at diagnosis and often present with a higher stage and grade compared with those with CRC.³⁸ SBA often presents with a local complication of the tumor, most often gastric outlet obstruction in the case of a duodenal SBA or cramping abdominal pain in the case of a jejunal or ileal SBA.^{35,39,40} Occult gastrointestinal bleeding is another common presentation for SBA, occurring in approximately onequarter to one-third of cases.

Patients who present with small bowel cancer require a complete staging workup, including biopsy (if appropriate), pathologic tissue review, imaging studies (see “Imaging and Endoscopy,” below), complete blood count, chemistry profile, carbohydrate antigen 19–9, and carcinoembryonic antigen. Depending on the tumor’s location and the patient’s history, studies for celiac disease or IBD may be indicated. As discussed previously, MMR or MSI testing is recommended for all patients with SBA because MMR/MSI status can function as a prognostic and/or predictive marker and can help identify patients who should be tested for Lynch syndrome (see “Risk Factors for SBA,” page 1111).

Imaging and Endoscopy

Esophagogastroduodenoscopy with endoscopic ultrasound is recommended during initial workup and staging for detection and pathologic sampling when a duodenal malignancy is suspected. If obstruction is detected during imaging, palliative diversion or stenting may be considered.⁴¹ Endoscopic ultrasound is useful for pretherapeutic staging of proximal small bowel malignancies and may be used to discern duodenal lesions from ampullary, biliary, or pancreatic primaries.⁴²

Other endoscopic techniques that are not required for routine staging, but may be useful in certain circumstances, include double balloon endoscopy and capsule endoscopy. A number of studies, both prospective and retrospective, have reported on the effectiveness and safety of double balloon endoscopy for workup of patients with small bowel cancer.^{43–45} Specifically, the use of this method may be of particular benefit for patients with small bowel strictures.⁴⁶ Although capsule endoscopy allows for a more detailed examination of the entire small bowel mucosa, possibly resulting in the diagnosis of SBA when other imaging methods have failed to reveal a primary lesion, it is not the preferred method for initial workup due to its inability to biopsy tissue for diagnosis.^{47–49} In the case of a small bowel obstruction or stricture, the capsule may not be excreted naturally, requiring surgical removal. Therefore, capsule endoscopy is contraindicated for these conditions.⁴¹

CT or MRI may be used during initial workup of SBA to evaluate the extent of local tumor invasion and to assess for distant metastases. CT or MR enterography or enteroclysis, techniques involving administration of enteric contrast agent to the gastrointestinal system via oral intake or nasogastric tube, respectively, may improve imaging of the small bowel and, therefore, may be considered when conventional CT or MRI with contrast have failed

to show a tumor.^{50–53} A prospective study comparing CT enterography to MR enterography in 150 patients with suspected small bowel disease, but negative findings on endoscopy, reported that MR enterography was more accurate than CT enterography, particularly for neoplastic diseases ($P=.0412$).⁵⁴

Although PET/CT has not been formally evaluated for ability to detect metastatic SBA, or compared with MRI or CT, reports describing its usefulness for this disease have been published.⁵⁵ Therefore, although PET/CT is not routinely indicated, it may be considered when CT or MR results are equivocal.

See “Posttreatment Surveillance” (page 1128) for the use of these imaging methods for posttreatment surveillance and for use in individuals with IBD, celiac disease, or familial syndromes.

Pathology and Staging

SBA staging is based on the TNM staging system.⁶ In the 8th edition of the AJCC Staging Manual, T1 tumors involve the lamina propria or submucosa; T2 tumors penetrate through the submucosa into the muscularis propria; T3 tumors penetrate through the muscularis propria into the subserosa or extend into non-peritonealized perimuscular tissue; and T4 tumors perforate the visceral peritoneum or directly invade other organs or structures. Regional lymph node classification includes N0 (no regional lymph node metastasis), N1 (1–2 positive lymph nodes), and N2 (3 or more positive nodes). SBA is classified as M1 when distant metastasis is present.⁶

SBA is staged as I or II when a tumor is present without regional lymph node or distant metastases (any T, N0, M0). Stage III disease includes disease with regional lymph node, but not distant metastasis (any T, N1–2, M0). Stage IV is distant metastatic disease (any T, any N, M1).⁶ A number of sources have reported stage III or IV SBA as having significantly worse outcomes compared with earlier stage disease.^{6,56,57}

Other factors that may be useful for prognostication, but not used for staging, include the primary tumor site (ie, duodenum, jejunum, ileum); histologic grade; number of lymph nodes evaluated; margin status; lymphovascular invasion; MSI/MMR status; evidence/presence of celiac or IBD; and presence of polyps.⁶ The NCCN panel recommends reporting of these parameters during pathologic review.

Lymph Node Evaluation

Regional lymph nodes differ based on the site of the primary tumors: retropancreatic, hepatic artery, inferior pancreaticoduodenal, and superior mesenteric nodes are regional to the duodenum; cecal or ileocolic (terminal ileum only, superior mesenteric, or mesenteric [not otherwise specified]) nodes are regional to the jejunum and ileum.

Multiple analyses of patients with SBA in the SEER database have found that longer survival after resection is strongly associated with a lower ratio of positive-to-negative lymph nodes as well as with a higher number of regional lymph nodes assessed during surgery.^{38,58–60} Two of these analyses, which considered duodenal and jejunoileal

adenocarcinomas separately, concluded that, for adequate staging, a minimum of 5 lymph nodes should be retrieved for duodenal tumors and a minimum of 9 lymph nodes for jejunal or ileal tumors.^{59,60} Analyses that pooled duodenal and jejunoileal tumors found that 8 regional lymph nodes should be assessed for adequate staging,^{38,58} although some data have suggested that harvesting even higher numbers of lymph nodes may better predict SBA survival outcomes.⁶¹ Based on these studies, NCCN recommends that a goal for all SBA resections should be the retrieval of at least 8 regional lymph nodes for evaluation.

Treatment of Stage I–III Small Bowel Adenocarcinoma

Surgical Management of Localized Resectable Disease

For local (stage I–III) SBA, primary treatment consists of surgical resection with en bloc removal of the regional lymph nodes. Although no prospective, randomized trials have been published to inform surgical technique, retrospective reviews on the subject have been published.^{62–64} Intraoperative staging of the abdomen—particularly including the mesentery, omentum, and peritoneum—should be completed in all cases.

The type of resection used to treat localized SBA depends on the location of the primary tumor. Segmental resection of the small bowel is often the mainstay of treatment, although duodenal tumors may require either pancreaticoduodenectomy or segmental duodenal resection. For tumors of the jejunum or ileum, segmentectomy is the preferred method of resection.

Pancreaticoduodenectomy, also known as the Whipple procedure, should be considered for all duodenal cancers and is particularly appropriate for those arising in the second portion of the duodenum or invading into any portion of the ampulla or pancreas. Minimally invasive procedures, such as laparoscopic surgery, may be considered for pancreaticoduodenectomy but should only be used by experienced surgeons. Limited segmentectomy may be considered in SBA involving the third and fourth segments of the duodenum and on the antimesenteric side of the intestine, although this approach is controversial based on reports of lower lymph node yields.⁶⁴ However, a retrospective study of 1,611 patients with duodenal adenocarcinoma found that patients who were treated with radical resection did not show an improvement in overall survival (OS) or disease-specific survival compared with a simple removal of the primary site, after controlling for confounding factors.⁶⁵ This finding was despite greater lymph node retrieval with radical resection. Case reports have suggested that segmentectomy and other limited resection methods may be considered for lesions in the first portion of the duodenum, particularly for those <2 cm in size and located on the mesenteric side of the intestine.⁶³

NCCN recommends that a goal for all SBA resections should be the retrieval of at least 8 regional lymph nodes for evaluation based on the strong prognostic impact of lymph node metastases and studies showing improved outcomes with higher numbers of lymph nodes assessed during surgery.^{58–60} See “Lymph Node Evaluation” (page 1116) for more information on pathologic review of dissected lymph nodes.

Adjuvant Therapy

Localized SBAs are treated with surgical resection, but local and distant recurrences are common, and optimal perioperative therapy is unknown.⁶⁶ Therefore, participation in a clinical trial is preferred for all patients with SBA who are considering adjuvant therapy. For discussion of neoadjuvant therapy, see “Primary Treatment of Unresectable Disease” (page 1120).

The ongoing, international phase III BALLAD trial is the first prospective trial investigating the role of adjuvant 5-FU/leucovorin (5-FU/LV) or 5-FU/LV plus oxaliplatin (FOLFOX) compared with observation alone for patients with stage I–III SBA.^{67,68} Until the results of BALLAD have been reported, the potential benefits of adjuvant therapy for SBA can be estimated only through retrospective reports. The data from retrospective studies or meta-analyses that have sought to assess the efficacy of adjuvant therapy (either chemotherapy or chemoradiotherapy) for SBA have been mixed, with some showing a benefit to adjuvant therapy,^{69–71} some showing no benefit,^{36,72,73} and some showing an equivocal or nonsignificant benefit.^{74,75} Data supporting the use of adjuvant chemoradiation are especially limited, with a recent retrospective review of patients with resected, nonmetastatic duodenal adenocarcinoma showing that patients who received adjuvant chemoradiotherapy (n=550) had no significant improvement in survival compared with those who received chemotherapy alone (n=694), even in high-risk cases.⁷⁶ Therefore, chemoradiation should be considered only in highly selected patients.

MSI/MMR Status for Adjuvant Therapy—MSI/MMR is an important piece of information to consider when deciding whether to use adjuvant chemotherapy in patients with stage II SBA. Mutation of MMR genes or modifications of these genes (eg, methylation) can result in MMR protein deficiency and MSI.⁷⁷ Tumors showing the presence of MSI are classified as either MSI-H or MSI-low, depending on the extent of instability in the markers tested, whereas tumors without this characteristic are classified as microsatellite-stable (MSS).⁷⁸ Patients determined to have dMMR status are biologically the same population as those with MSI-H status.

Data from several large studies in colon cancer have shown that MSI-H (ie, dMMR) tumors have a decreased likelihood to metastasize and that MSI-H/dMMR may function as a prognostic marker for favorable outcomes in stage II disease.^{79–81} Some of these same studies also show that a dMMR/MSI-H tumor status may be a predictive marker of decreased benefit and possibly a detrimental impact from adjuvant therapy in patients with stage II colon cancer.^{80–82} However, a recent study of 1,913 patients with stage II CRC from the QUASAR study, half of whom received adjuvant chemotherapy, showed that although dMMR was prognostic, it did not predict benefit or detrimental impact of chemotherapy.⁸³ A study of patients in the CALGB 9581 and 89803 trials came to a similar conclusion, though notably this used older, nonstandard chemotherapy regimens.⁸⁴ Extrapolating from these colon cancer data, patients with stage II MSI-H/dMMR SBA may have a good prognosis and the benefit from adjuvant therapy is unclear.

NCCN Recommendations for Adjuvant Therapy—Based on the limited data available from retrospective studies of SBA, and extrapolation from studies of colon cancer, the NCCN Small Bowel Adenocarcinoma Panel recommends:

- Six months of adjuvant treatment with FOLFOX, capecitabine plus oxaliplatin (CAPEOX), 5-FU/LV, or capecitabine for any locally advanced SBA with positive lymph nodes (stage III). Chemoradiation with capecitabine or infusional 5-FU is another option for stage III duodenal cancer that is margin-positive after resection.
- Observation or 6 months of adjuvant treatment with FOLFOX, CAPEOX, 5-FU/LV, or capecitabine for stage II tumors that are MSS or MMR proficient (pMMR) and have high-risk features. High-risk features include T4 stage, close or positive surgical margins, few lymph nodes examined (<5 for duodenal or <8 for jejunal/ileal primary tumor location), or tumor perforation.^{38,58,72} Studies in CRC, and a retrospective report in SBA, have identified lymphovascular or perineural invasion and poorly differentiated histology as poor prognostic factors.^{72,85–87} Therefore, adjuvant therapy may be considered for patients with these factors as well. Chemoradiation with capecitabine or infusional 5-FU is another option for duodenal cancer that meets these criteria and is margin-positive after resection.
- Observation or 6 months of adjuvant treatment with 5-FU/LV or capecitabine for T3, N0, M0 (stage IIA) tumors that are MSS or pMMR and have no high-risk features.
- Observation after surgical treatment of all stage I tumors and for stage II tumors that are MSI-H or dMMR.

Due to poorer survival in stage III SBA compared with CRC and the fact that the trial enrolled no patients with SBA, extrapolation from the IDEA collaboration (wherein 3 months of fluoropyrimidine/oxaliplatin was shown to be noninferior to 6 months of therapy for CRC)⁸⁸ is not currently recommended for SBA.

Primary Treatment of Unresectable Disease

For some patients with locally unresectable or medically inoperable SBA, conversion to resectable disease may be a goal. A limited amount of data has shown that neoadjuvant therapy may be beneficial in converting unresectable SBA to resectable disease. A retrospective study of patients with unresectable or recurrent duodenal adenocarcinoma who were treated with neoadjuvant chemotherapy or chemoradiation found that 9 of 10 patients showed conversion to resectable disease after neoadjuvant therapy. At data collection, 5 patients were still alive (ranging from 18–83 months postoperatively), suggesting prolonged survival after conversion to resectable disease.⁸⁹ In addition, neoadjuvant chemoradiation was studied in 2 small prospective trials. A phase II trial including patients with duodenal or pancreatic adenocarcinomas reported that 4 of 5 patients with tumors in the duodenum were able to undergo resection after neoadjuvant chemoradiation.⁹⁰ Another small prospective study of patients with duodenal or pancreatic adenocarcinomas reported that all 4 patients

with duodenal cancer underwent curative resection after neoadjuvant chemoradiation and experienced a complete pathologic response.⁹¹

Because many small bowel cancers present at an advanced stage, malignant small bowel obstruction is a common complication. One retrospective Eastern European study reported that most patients with small bowel cancer presented due to an emergency situation.³⁹ Obstruction was a common complication for SBA, accounting for 22% to 57.9% of these cases.^{39,92–94} Malignant small bowel obstruction may be treated palliatively with either surgical diversion or stenting. Although most of the literature on palliative treatment of malignant small bowel obstruction comes from pancreatic cancer, there are a few studies that include SBA cases.^{39,95–97} One retrospective study concluded that there was no difference in poststent survival between patients with pancreatic and nonpancreatic cancers, and that patients with nonpancreatic cancers (including SBA) showed a longer OS.⁹⁵

Based on these data, the panel recommends that patients with locally unresectable or medically inoperable SBA may undergo neoadjuvant therapy, during which they should be routinely monitored for conversion to resectable disease. Neoadjuvant chemoradiation may be indicated for duodenal disease that remains unresectable after a course of induction chemotherapy, but this is controversial and should be considered on an individual case basis. Alternatively, in cases where conversion to resectable disease is not feasible, palliative chemotherapy may be considered. Palliative diversion or stenting is recommended if a small bowel obstruction is present.

Treatment of Distant Metastatic (Stage IV) SBA

Approximately 32% of patients diagnosed with SBA have stage IV (distant metastatic) disease.³⁸ The most common sites for metastatic spread include the peritoneal cavity and liver, consistent with other gastrointestinal malignancies.⁶ Although 5-year survival is relatively high (85%) for localized disease, patients with stage IV SBA have a 5-year relative survival of only 42%.⁹⁸ In addition, recurrence rates of localized SBA treated with surgery are high, with many of these patients developing distant metastases.³⁵ The NCCN recommendations for treatment of stage IV SBA are discussed subsequently.

Metastasectomy

Although resectable metastases are rare for SBA and the data supporting metastasectomy for SBA are limited, a retrospective analysis of patients with non-CRC, nonendocrine liver metastases (including 28 patients with small bowel cancers and 12 patients with duodenal cancers) showed promising survival rates after resection of liver metastases.⁹⁹ The 5-year survival rate for small bowel cancers was 49% with a median survival of 58 months. For duodenal cancers, the 5-year survival rate was 21% with a median survival of 34 months. Recently, another retrospective study of 34 patients undergoing resection of SBA metastases reported a median OS of 28.2 months and a relapse-free survival of 18.7 months.¹⁰⁰ In this study, 41.2% of patients survived more than 3 years; 88.2% of patients in this study received perioperative chemotherapy. Poor differentiation, invaded margins, and lymphatic invasion of the primary tumor were identified as poor prognostic factors. Therefore, certain patients with SBA and limited metastasis to visceral organs may be

candidates for metastasectomy. If metastasectomy is being considered, a multidisciplinary team, including a surgeon experienced in the resection of metastases, should be consulted.

Peritoneal Carcinomatosis

Peritoneal carcinomatosis (peritoneal metastases) has been shown to affect 25% to 50% of patients with stage IV SBA. Peritoneal carcinomatosis occurs more frequently in tumors arising from the jejunum or ileum and less commonly in duodenal tumors.¹⁰¹ Peritoneal carcinomatosis generally carries a poor prognosis with a reported median OS of 5.9 months.¹⁰² The goal of treatment of unresectable peritoneal metastases is palliative and primarily consists of systemic therapy (see “Systemic Therapy for Metastatic Disease,” next section).

For resectable peritoneal carcinomatosis, surgical cytoreduction may be considered. For peritoneal metastases that present synchronously with the primary tumor, resection of the primary and cytoreduction of peritoneal metastases may be performed concurrently. A multidisciplinary team evaluation at an experienced center is important if considering this treatment approach. Data supporting the use of hyperthermic intraperitoneal chemotherapy (HIPEC) for SBA with peritoneal carcinomatosis are extremely limited, consisting entirely of small, retrospective studies.^{102–107} In addition, the recent phase III PRODIGE 7 study showed no benefit of oxaliplatin-based HIPEC in patients with CRC compared with cytoreduction alone.¹⁰⁸ Significant morbidity and mortality are associated with this procedure. Various studies have reported morbidity rates ranging from 19% to 31% for serious adverse events and mortality rates ranging from 0% to 4%.^{103–107} Furthermore, recurrences after the procedure are common.^{106,107} Based on this lack of evidence, HIPEC cannot be recommended for this population unless more robust data become available.

Systemic Therapy for Metastatic Disease

Data supporting systemic therapy for advanced adenocarcinoma of the small bowel were also almost entirely limited to retrospective reports,^{109–112} although recently several small phase II trials for SBA have been reported. Based on the results from these studies, several systemic therapy regimens are recommended for treatment of metastatic SBA. However, participation in clinical trials is especially encouraged for patients with SBA, based on the lack of data.

The choice of therapy is based on consideration of the goals of therapy, the type and timing of prior therapy, and the differing toxicity profiles of the constituent drugs. Furthermore, an evaluation of the efficacy and safety of these regimens for an individual patient must take into account the performance status of the patient. As initial therapy for advanced disease in a patient appropriate for intensive therapy (ie, one with a good tolerance for this therapy for whom a high tumor response rate would be potentially beneficial) without prior platinum resistance, the panel recommends a choice of 3 chemotherapy regimens: FOLFOX, CAPEOX, or FOLFOXIRI (infusional 5-FU, LV, oxaliplatin, irinotecan); any of which may be combined with bevacizumab. For patients who are not appropriate for intensive therapy, treatment options would exclude the more toxic components of these regimens, with

5-FU/LV or capecitabine with or without bevacizumab recommended as first-line therapy for these patients.

The choice of second-line therapy depends on the MMR/MSI status of the tumor. For tumors that are dMMR or MSI-H, checkpoint inhibitor therapy with anti-PD-1 inhibitors, alone or in combination with an anti-CTLA4 inhibitor, is recommended in the second-line setting. FOLFIRI or taxane-based chemotherapies are options in the second line for pMMR/MSS tumors, or those that are refractory to checkpoint inhibitor therapies. Larotrectinib is an option in subsequent lines of therapy for metastatic SBA with neurotrophic tyrosine receptor kinase (*NTRK*) gene fusion and no satisfactory alternative treatments.

Genetic Alterations in SBA—Emerging research has shown that SBA has a distinct genetic profile, which sets it apart from CRC or gastroesophageal cancers, the 2 cancer types SBA is most often likened to. Although *KRAS* and *TP53* alterations are frequently identified in both SBA and CRC, *APC* mutations are significantly less common in SBA (27% in SBA vs 76% in CRC; $P<.001$).³⁴ Considering the near ubiquity of *APC* mutation and its well-established role in CRC carcinogenesis, this suggests that neoplastic transformation in SBA is unique compared with CRC.^{33,34}

SMAD4 and *CDKN2A* mutations are more commonly seen compared with gastroesophageal cancers and CRC. Though *BRAF* mutations occur at a similar rate as seen in CRC, only 10% of *BRAF*-mutant SBAs have a V600E alteration, compared with >70% in *BRAF*-mutant CRC.³⁴ Importantly, human epidermal growth factor receptor 2 (HER2) alterations, MSI-H/dMMR, programmed death-ligand 1 (PD-L1) expression, and high tumor mutational burden are enhanced in SBA compared with CRC,^{34,113–115} and may reveal greater importance of targeted or immunotherapeutic treatments compared with current CRC treatment algorithms.

Regimens Not Recommended for SBA—Although many of the systemic therapy regimens recommended for treatment of metastatic SBA are extrapolated from data for CRC, several regimens are commonly used for metastatic CRC that are not recommended for SBA based either on a lack of data supporting their use or data suggesting that these regimens do not work for metastatic SBA.

A 2017 retrospective analysis reported that the efficacy of cetuximab-containing chemotherapy for *RAS* wild-type SBA was inconclusive.¹¹⁶ Subsequently, a phase II trial published in 2018 showed that panitumumab has no clinically meaningful activity in *RAS* wild-type SBA¹¹⁷; therefore, cetuximab or panitumumab should not be used for treatment of SBA.

While trifluridine-tipiracil or regorafenib are recommended as subsequent therapy options for metastatic CRC, no data are available to support their use for SBA. They are, therefore, not recommended.

FOLFOX or CAPEOX as First-line Therapy—Both FOLFOX and CAPEOX have been evaluated prospectively for first-line treatment of advanced SBA in phase II clinical trials.

One of these trials evaluated CAPEOX in 30 patients with advanced adenocarcinomas of the small bowel and ampulla of Vater. The overall response rate (ORR) (the primary endpoint) was 50%, with 10% achieving complete response.¹¹⁸ A similar response rate of 48.5% (95% CI, 31%–67%) was seen in another small phase II study of 33 patients that assessed the efficacy of FOLFOX in first-line treatment of advanced SBA.¹¹⁹ Likewise, another phase II study reported an ORR of 45% for 24 patients with metastatic or unresectable SBA who were treated with FOLFOX, with a median progression-free survival (PFS) and OS of 5.9 and 17.3 months, respectively.¹²⁰ These response rates to CAPEOX and FOLFOX were much higher than the 18% response rate seen in another small phase II study that evaluated 5-FU/doxorubicin/mitomycin C in patients with metastatic SBA.¹²¹ Adverse events reported across these 3 trials were similar, with neutropenia, thrombocytopenia, nausea, vomiting, diarrhea, peripheral neuropathy, and fatigue reported most frequently.^{118–120} Retrospective studies have supported the results of these trials, reporting that the combination of a fluoropyrimidine with oxaliplatin was the most effective first-line therapy for advanced SBA.^{111,122,123} Based on these data, FOLFOX or CAPEOX are recommended as first-line therapy options for treatment of patients with advanced SBA who are appropriate for intensive therapy.

FOLFOXIRI as First-line Therapy—Although the role of FOLFOXIRI for treatment of SBA has not been formally evaluated, CAPIRINOX (capecitabine, irinotecan, oxaliplatin) has been tested as first-line treatment in a phase II trial of 33 patients with advanced SBA.¹²⁴ In this trial, CAPIRINOX—dose-adjusted according to *UGT1A1* genotype—showed a response rate of 37.5% (95% CI, 21%–56%), with a median PFS and OS of 8.9 and 13.4 months, respectively. Neither hematologic toxicity nor tumor response rate differed significantly by *UGT1A1* genotype, supporting the feasibility of genotype-directed dosing for CAPIRINOX. The NCCN panel does not recommend use of CAPIRINOX for SBA due to concerns about toxicity, but the recommendation for FOLFOXIRI is extrapolated from the results of this study.

FOLFOX, CAPEOX, or FOLFOXIRI Plus Bevacizumab as First-line Therapy—Although data supporting the addition of biologics to FOLFOX, CAPEOX, or FOLFOXIRI are currently extremely limited, a single-phase II trial has reported that CAPEOX in combination with bevacizumab is safe and efficacious in patients with SBA.¹²⁵ Retrospective analyses have supported these results, reporting favorable outcomes in patients treated with bevacizumab-containing chemotherapy regimens without adding significant toxicity.^{116,126} Based on these data, FOLFOX, CAPEOX, or FOLFOXIRI may be given with or without bevacizumab as first-line therapy for advanced SBA.

Pembrolizumab or Nivolumab With or Without Ipilimumab (for dMMR/MSI-H tumors) as Subsequent-line Therapy—Pembrolizumab is a PD-1 inhibitor that was evaluated as a subsequent-line therapy for treatment-refractory metastatic cancers in a phase II study that included 3 cohorts: (1) dMMR colorectal adenocarcinomas, (2) MMR-proficient colorectal adenocarcinomas, and (3) dMMR cancers of types other than CRC.¹²⁷ This third cohort included 2 patients with small bowel cancers. The immune-related objective response rate and immune-related PFS rate were 40% and 78%, respectively, for

patients with dMMR CRC and 71% and 67% for patients with dMMR non-CRC. Common adverse events of clinical interest included rash or pruritus; thyroiditis, hypothyroidism, or hypophysitis; and asymptomatic pancreatitis.¹²⁷ Based on the results of this study, the FDA granted accelerated approval to pembrolizumab in May 2017 for patients with unresectable or metastatic dMMR or MSI-H solid tumors that have progressed after prior treatment and have no satisfactory alternative treatment options.¹²⁸ More recently, an abstract reported results of ZEBRA, a multicenter, phase II study of pembrolizumab in patients with previously treated, advanced SBA.¹²⁹ The results of this study confirmed efficacy of pembrolizumab for dMMR/MSI-H SBA. Furthermore, although pembrolizumab did not achieve the goal ORR for this study, there was some evidence that this therapy may control disease in some patients with MSS SBA. In 18 patients with confirmed MSS SBA, a 50% disease control rate was shown, although further study is needed to confirm this result.¹²⁹

Another PD-1 inhibitor, nivolumab—alone or in combination with the CTLA-4 inhibitor, ipilimumab—has been studied in patients with dMMR metastatic CRC in the phase II, multicohort CheckMate-142 trial.^{130,131} One cohort of this trial included 74 patients with dMMR CRC who were treated with nivolumab. ORR for these patients was 31.1% (95% CI, 20.8–42.9), with 69% of patients having disease control for at least 12 weeks. Median duration of response had not yet been reached at the time of data collection. PFS and OS were 50% and 73%, respectively, at 1 year. Grade 3 or 4 drug-related adverse events occurred in 20% of patients, with increased amylase and increased lipase being the most common.¹³⁰ Another cohort of the CheckMate-142 trial included 119 patients with dMMR CRC who were treated with nivolumab in combination with ipilimumab. For this cohort, ORR was 55% (95% CI, 45.2–63.8) and the disease control rate for at least 12 weeks was 80%. PFS and OS were 71% and 85%, respectively, at 1 year. In addition, significant, clinically meaningful improvements were observed in patient-reported outcomes of functioning, symptoms, and quality of life. Grade 3 to 4 treatment-related adverse events occurred in 32% of patients, but were manageable.¹³¹

Based on these positive results for CRC and the data showing benefit of pembrolizumab in SBA, the NCCN panel recommends either pembrolizumab or nivolumab, with or without ipilimumab, as second-line treatment options for dMMR/MSI-H advanced SBA. SBA has been reported to have a higher incidence of dMMR/MSI-H and higher rates of PD-L1 IHC positivity compared with CRC,^{33,34,113} making checkpoint inhibition an important treatment option for some SBA patients.

Taxane-Based Chemotherapy as Subsequent-Line Therapy—Although almost all of the phase II trials of systemic therapy for SBA have focused on first-line therapy, a phase II trial including 13 patients with SBA studied the efficacy of nab-paclitaxel in the refractory disease setting.¹³² Patients with SBA in this trial had received a median of 2 prior lines of therapy including a fluoropyrimidine and oxaliplatin. Of the 10 patients with SBA who were evaluable for efficacy, 2 showed a partial response to nab-paclitaxel and an additional 3 had stable disease per RECIST criteria, yielding a disease control rate of 50%. Common grade 3 or 4 toxicities across the entire study population included fatigue (12%), neutropenia (9%), febrile neutropenia (9%), dehydration (6%), and thrombocytopenia (6%).¹³²

A single-center, retrospective review reported on 20 patients with advanced SBA who were treated with taxane-based therapy (either as single therapy or in combination).¹³³ Of these cases, 30% showed disease response, 35% showed stable disease, and 35% showed progression. Median time to progression was 3.8 months (95% CI, 2.9–4.6) and median OS was 10.7 months (95% CI, 3.1–18.3). Based on these data, taxane-based chemotherapy is a recommended option for second- or subsequent-line therapy, although only nab-paclitaxel has prospective, published data to support its use for treatment of SBA.

FOLFIRI as Subsequent-Line Therapy—A retrospective, multicenter study evaluated the efficacy of FOLFIRI as second-line therapy for patients with advanced SBA who had received platinum-based chemotherapy in the first-line setting.¹³⁴ Of the 28 patients who fit this treatment paradigm, the ORR was 20% and disease control rate was 52%. The median PFS and OS were 3.2 and 10.5 months. Grade 3–4 toxicity was reported in 48% of patients. Based on these data, FOLFIRI is recommended as a treatment option for second- or subsequent-line treatment of advanced SBA.

Larotrectinib as Subsequent-Line Therapy—A pooled analysis of 3 studies (a phase I including adults, a phase I-II involving children, and a phase II involving adolescents and adults) studied the safety and efficacy of larotrectinib in patients with *NTRK* gene fusion-positive tumors, including 4 patients with colon cancer and 1 with cancer of the appendix.¹³⁵ For the whole population, the ORR was 75% (95% CI, 61%–85%) by independent review and 80% (95% CI, 67%–90%) by investigator assessment. Larotrectinib was found to be well-tolerated as the majority (93%) of adverse events were grades 1 or 2 and no treatment-related adverse events of grades 3 or 4 occurred in more than 5% of patients.¹³⁵ Based on these data, the FDA approved larotrectinib for metastatic solid tumors with *NTRK* gene fusion and no satisfactory alternative treatments on November 26, 2018.¹³⁶

Posttreatment Surveillance

After curative-intent surgery and adjuvant chemotherapy, if administered, posttreatment surveillance of patients with SBA is performed to evaluate for possible therapeutic complications, identify disease recurrence, and discover new metachronous neoplasms at a preinvasive stage. A retrospective study of 146 patients with SBA who underwent cancer-directed surgery found that 39% subsequently developed disease recurrence, with a median time to recurrence of 25 months. Of the patients with disease recurrence, 57% developed distant metastases, 19% developed carcinomatosis, 7% recurred in the abdominal wall, and 17% developed local recurrences.³⁵ Due to the lack of data regarding optimal surveillance following curative-intent treatment of SBA, a similar approach to CRC surveillance is recommended—including history and physical examination; carcinoembryonic antigen and/or carbohydrate antigen 19–9 measurement; and CT of the chest, abdomen, and pelvis. For data supporting the recommended surveillance approach for CRC, see the “Posttreatment Surveillance” section in the NCCN Guidelines for Colon Cancer, available at [NCCN.org](https://www.nccn.org).

Patients with SBA who were determined to have Crohn’s disease or familial syndromes (ie, Lynch, FAP, PJS) may require more intensive surveillance due to their elevated risk of

developing further SBAs.^{11,12} Endoscopy may be a feasible method for SBA surveillance in patients with Crohn's disease,^{12,137} although one prospective study found a low (33%) sensitivity rate for SBA endoscopic screening.¹³⁸ A number of studies have supported the use of endoscopy/enteroscopy for small bowel surveillance in patients with Lynch syndrome, FAP, or PJS.^{139–146} For further details on endoscopic small bowel evaluation, see “Imaging and Endoscopy” (page 1114).

Survivorship

Based on the rarity and poor prognosis of SBA, there is a dearth of data regarding survivorship for this disease. The panel recommendations for survivorship are largely extrapolated from the NCCN Guidelines for Colon Cancer, with some specific recommendations included for patients with celiac or Crohn's disease who are at elevated risk of developing additional SBAs.^{11,12,14} This section provides an overview of the panel recommendations for survivorship; for more detailed information, see the “Survivorship” section in the NCCN Guidelines for Colon Cancer (available at [NCCN.org](https://www.nccn.org)).

The panel recommends that a prescription for survivorship and transfer of care to the primary care physician be written.¹⁴⁷ The oncologist and primary care provider should have defined roles in the surveillance period, with roles communicated to the patient. Other recommendations include monitoring for late or long-term sequelae of treatment, such as oxaliplatin-induced peripheral neuropathy, fatigue, pain, sexual dysfunction, and emotional or social distress.^{148–152} Specific management interventions to address these and other side effects are described in a review.¹⁵³ Disease preventive measures, such as immunizations; early disease detection through periodic screening for second primary cancers (eg, breast, cervical, or prostate cancers); and routine good medical care and monitoring are recommended. The NCCN Guidelines for Survivorship (at [NCCN.org](https://www.nccn.org)) provide screening, evaluation, and treatment recommendations for common consequences of cancer and cancer treatment to aid health care professionals who work with survivors of adult-onset cancer in the posttreatment period, including those in specialty cancer survivor clinics and primary care practices.

Summary

SBA is a rare malignancy, with a rising incidence in recent decades. Compared with CRC, SBA is more often diagnosed at advanced stages, suggesting the difficulty of detecting these cancers and highlighting the lack of screening programs, even for high-risk individuals. The majority of SBAs arise in the duodenum and are associated with poorer prognosis, with up to a third of resectable patients experiencing early relapse. To date, the only curative therapy for SBA is surgery.

For local disease, segmental resection of the small bowel is the mainstay of treatment, though duodenal tumors may require either pancreaticoduodenectomy or segmental duodenal resection. Database analyses have reported significantly improved outcomes when 8 or more lymph nodes are resected. In addition, the use of radiation therapy for retroperitoneal-based duodenal adenocarcinomas is a complex decision-making process.

Fluoropyrimidine-based adjuvant therapy may be considered for some patients with SBA, though no studies have yet shown a definitive benefit of this approach. Results from the international, phase III adjuvant clinical study (BALLAD) investigating observation versus 5-FU versus FOLFOX for patients with resected stage I–III SBA should shed light on this approach in the coming years.

Metastatic SBA may rarely be treated with curative intent via primary tumor resection and metastasectomy; however, most patients with metastatic SBA are treated with systemic therapy. Systemic therapy options include fluoropyrimidine-based chemotherapy, taxane-based chemotherapy, or checkpoint inhibitors. Recently, SBA's unique genetic profile has been a topic of research, which may lead to new targeted or immunotherapeutic treatment options for SBA.

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NCCN CATEGORIES OF EVIDENCE AND CONSENSUS

Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.

Clinical trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

PLEASE NOTE

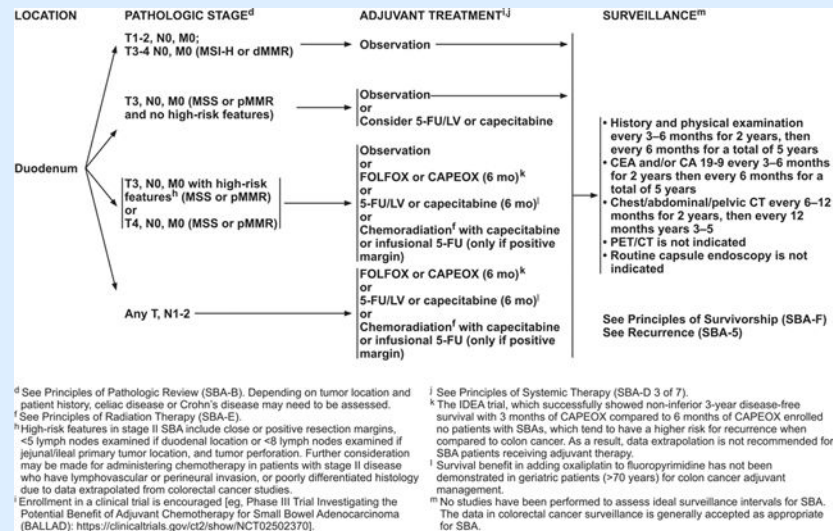
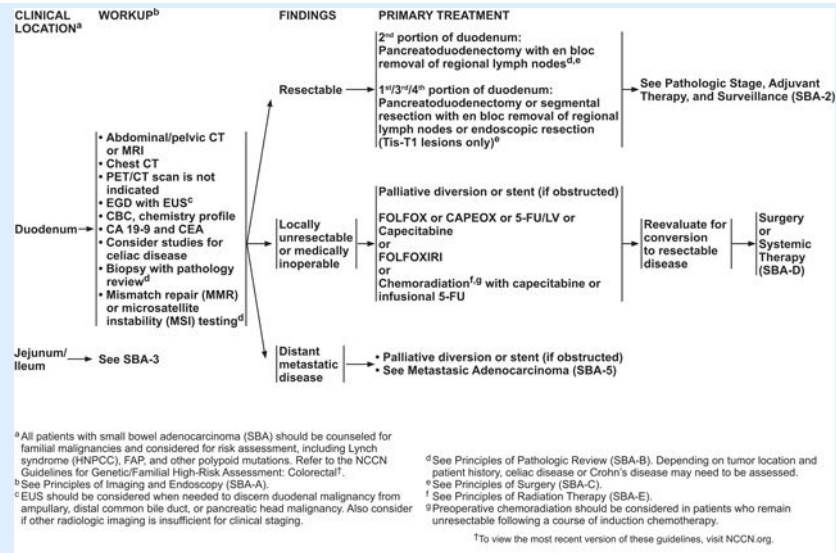
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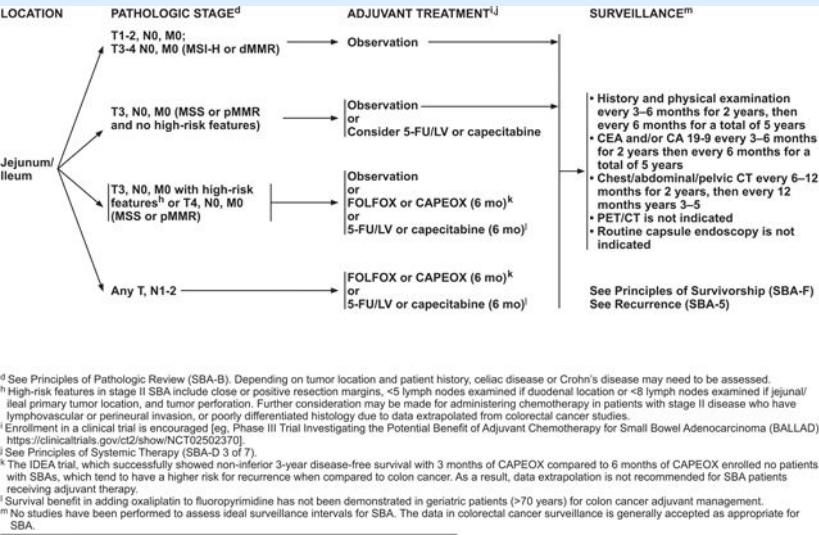
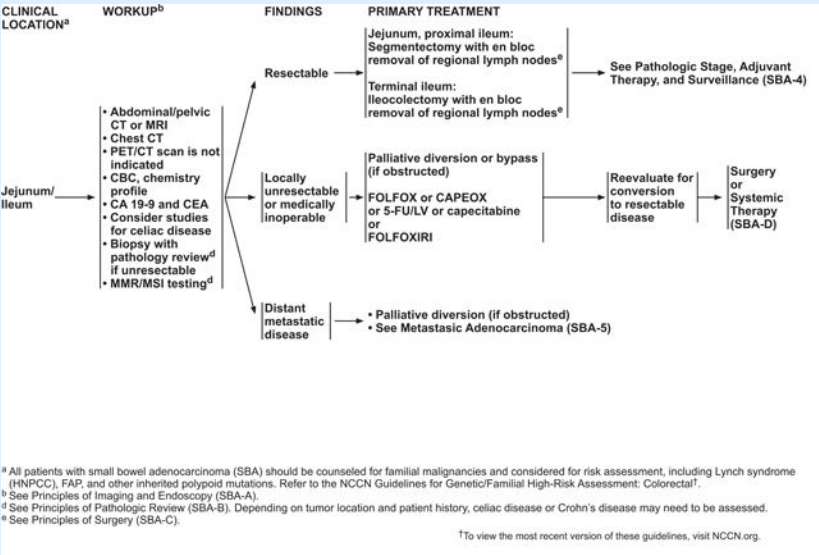
Disclosures for the NCCN Small Bowel Adenocarcinoma Panel

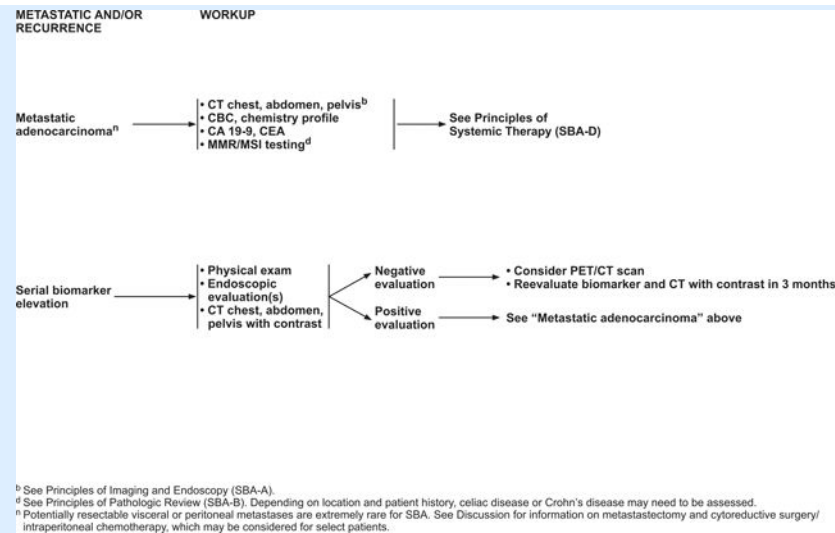
At the beginning of each NCCN Guidelines Panel meeting, panel members review all potential conflicts of interest. NCCN, in keeping with its commitment to public transparency, publishes these disclosures for panel members, staff, and NCCN itself.

Individual disclosures for the NCCN Small Bowel Adenocarcinoma Panel members can be found on page 1133. (The most recent version of these guidelines and accompanying disclosures are available at [NCCN.org](https://www.nccn.org).)

The complete and most recent version of these guidelines is available free of charge at [NCCN.org](https://www.nccn.org).







PRINCIPLES OF IMAGING AND ENDOSCOPY

Initial Workup/Staging

- Chest, abdomen, pelvis CT
 - Evaluate local extent of tumor infiltration into surrounding structures.
 - Assess for distant metastatic disease to lungs, lymph node, liver, peritoneal cavity, and other organs.
 - CT abdomen/pelvis should be performed with intravenous iodinated contrast and oral contrast agents unless contraindicated.
 - CT chest does not require contrast (though may be given if performed with abdominal CT).
 - Consider CT enterography or enteroclysis for specific cases where primary tumor is poorly visualized by standard methods.¹
 - If IV iodinated contrast is contraindicated, then MR examination of the abdomen/pelvis with IV gadolinium-based contrast may be obtained instead. Gadolinium-based contrast is contraindicated in patients on dialysis. In patients with chronic kidney failure stage IV who are not on dialysis, IV gadolinium-based contrast may be administered in select cases using gadofosveset trisodium, gadoxetate disodium, gadobenate dimeglumine, or gadoteridol.
- MRI
 - MR of the abdomen/pelvis may be considered where there is contraindication to CT.² MR enterography or enteroclysis may similarly be considered when conventional CT or MR with contrast have failed to discern a tumor.^{3,4}
 - Consider MR of the abdomen with contrast for further evaluation of indeterminate liver lesions on CT scan.
 - Magnetic resonance cholangiopancreatography (MRCP) may need to be obtained in the initial workup of suspected duodenal malignancies to further ascertain tumor site of origin, particularly in cases of biliary obstruction.
- PET/CT is not indicated as efficacy and clinical benefit have not been examined compared to CT or MR.⁵
- Consider obtaining PET/CT in instances of equivocal CT or MR results, including the evaluation of potential peritoneal disease, particularly where potential lesions are sized greater than the lower limits of PET detection.

¹ Boudial M, Jaff A, Soyer P, et al. Small-bowel diseases: prospective evaluation of multi-detector row helical CT enteroclysis in 107 consecutive patients. *Radiology* 2004;233:338-344.
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PRINCIPLES OF IMAGING AND ENDOSCOPY

Initial Workup/Staging

- Endoscopy
 - EGD
 - ◊ May be used for detection and pathologic sampling where duodenal malignancy is suspected. If simultaneous intestinal obstruction is detected, palliative stenting may be considered.⁶
 - EUS
 - ◊ Useful for enhanced pre-therapeutic clinical staging of proximal small intestinal malignancies and to discern duodenal from ampullary, biliary, or pancreatic primaries.⁷
 - Push- or device-assisted enteroscopy (double- or single-balloon enteroscopy)
 - ◊ Not required for routine staging workup, though may be considered in patients with small intestinal strictures for diagnostic and/or palliative benefit. Biopsy may be performed during these procedures.⁸⁻¹⁰
 - Capsule endoscopy
 - ◊ Consider when radiographic imaging and other forms of endoscopy fail to reveal a suspected primary lesion.^{11,12} This is not the preferred primary method for diagnostic workup due to inability to obtain tissue for diagnosis.
 - ◊ Contraindicated where small bowel obstruction or strictures exist.
- Monitoring
 - Chest, abdomen, pelvis CT with contrast
 - Prior to adjuvant therapy to assess response to resection or primary therapy.
 - During re-evaluation of conversion to resectable disease (neoadjuvant therapy).
 - CT enterography is not routinely indicated for monitoring and should be reserved for instances of clinical necessity.
- Surveillance
 - Surveillance for recurrence should be judiciously applied. Recommend similar approach to colorectal surveillance due to lack of SBA-specific data.
 - Patients with confirmed Lynch syndrome should have appropriate screenings commensurate with their genotype and family cancer history. This may include small intestinal screening moving forward.¹³

⁶ Hara AK, Leighton JA, Sharma VK, et al. Imaging of small bowel disease: comparison of capsule endoscopy, standard endoscopy, barium examination, and CT. *Radiographics* 2005;25:697-711; discussion 711-8.
⁷ Nyland K, Odegaard S, Hausken T, et al. Sonography of the small intestine. *World J Gastroenterol* 2009;15:1319-1330.
⁸ Cazzato IA, Cammarota G, Nista EC, et al. Diagnostic and therapeutic impact of double-balloon enteroscopy (DBE) in a series of 100 patients with suspected small bowel diseases. *Dig Liver Dis* 2007;39:463-467.
⁹ Sunada K, Yamamoto H, Kita H, et al. Clinical outcomes of enteroscopy using the double-balloon method for strictures of the small intestine. *World J Gastroenterol* 2005;11:1087-1089.
¹⁰ Chen WG, Shan GD, Zhang H, et al. Double-balloon enteroscopy in small bowel diseases: Eight years single-center experience in China. *Medicine (Baltimore)* 2016;95:e5104.
¹¹ Bailey AA, Debinski HS, Appleyard MN, et al. Diagnosis and outcome of small bowel tumors found by capsule endoscopy: a three-center Australian experience. *Am J Gastroenterol* 2006;101:2237-2243.
¹² Cobrin GM, Pittman RH, Lewis BS. Increased diagnostic yield of small bowel tumors with capsule endoscopy. *Cancer* 2006;107:22-27.
¹³ Koomstra JJ. Small bowel endoscopy in familial adenomatous polyposis and Lynch syndrome. *Best Pract Res Clin Gastroenterol* 2012;26:359-368.

PRINCIPLES OF PATHOLOGIC REVIEW

Small bowel adenocarcinoma appropriate for resection

- Prefer pathologic confirmation of disease prior to resection, where possible

Discrimination of duodenal malignancy from other primary sites

- To differentiate SBA from ampullary malignancies in duodenal cancers of the second portion, the epicenter of the tumor or precursor lesion should not be at the ampulla, and >75% of the mass should not be within the ampulla

Pathologic stage

- Following parameters should be reported
 - Primary tumor site (duodenum, jejunum, ileum, overlapping, not otherwise specified [NOS])
 - Grade of cancer
 - Tumor depth of invasion (T stage)
 - Number of lymph nodes evaluated and number lymph nodes positive (N)
 - Status of proximal, distal, radial or mesenteric, uncinate, bile duct, pancreas, and other margins, as appropriate
 - Specimen orientation and inking involves both the pathologist and surgeon as this will help to ensure accurate assessment of the size and extent of the tumor. There should be either direct communication between the surgeon and pathologist for proper orientation and margin identification, or the surgeon should identify the important margins with a clearly understood and documented method (eg, written on the pathology requisition); see above – Status of margins.
 - Lymphovascular invasion
 - MSI/DNA MMR deficiency
 - Evidence of celiac disease
 - Presence of Crohn's disease
 - Presence of polyps

Lymph node evaluation

- The AJCC recommends a minimum evaluation of 8 lymph nodes, though the College of American Pathology notes no clear number of minimum lymph nodes to predict complete lymph node negativity have been established
- Regional lymph nodes differs by site of primary tumor:
 - Duodenum: retropancreatic, hepatic artery, inferior pancreaticoduodenal, and superior mesenteric
 - Jejunum/ileum: cecal (terminal ileum only), ileocolic (terminal ileum only), superior mesenteric, mesenteric, and NOS

Microsatellite instability/DNA mismatch repair testing

- Universal MMR or MSI testing is recommended in all patients with a personal history of small bowel adenocarcinoma
- Incidence of deficient MMR (dMMR)/MSI-high (MSI-H) and the possibility of germline mutation is enriched in SBA patients compared to those with colon and rectal cancer, making this an important prognostic and/or predictive biomarker^{1,2}
- Stage II dMMR/MSI-H patients may have improved survival compared to proficient MMR (pMMR)/microsatellite stable (MSS) patients; however, this has not been confirmed in the SBA population and is extrapolated from colorectal cancer data
- MMR or MSI testing should be performed only in CLIA-certified laboratories
- Testing for MSI may be performed by validated next-generation sequencing (NGS) panels

¹ Aparicio T, Svrcek M, Zaanen A, et al. Small bowel adenocarcinoma phenotyping, a clinicobiological prognostic study. *Br J Cancer* 2013;109:3057-3066.

² Schrock AB, Devore CE, McWilliams R, et al. Genomic profiling of small-bowel adenocarcinoma. *JAMA Oncol* 2017;3:1546-1553.

PRINCIPLES OF SURGERY

Principles for all primary sites:

- Intraoperative staging of the abdomen, particularly including the mesentery, omentum, and peritoneum, should be completed in all cases.
- Adequate lymph node dissection, consisting of the resection and evaluation of at least 8 lymph nodes, should be the goal for all resections.^{1,2}

Duodenum

- Pancreaticoduodenectomy (Whipple)
- Should be considered for all duodenal malignancies, particularly if arising in the second portion of the duodenum or invading any portion of the ampulla or pancreas.
- Pylorus preservation is acceptable in the absence of a hereditary condition.
- Minimally invasive procedures should be employed only by experienced surgeons.
- Margins should be considered for frozen section at the time of resection if there are concerns about the margins. If margins <5 mm, the surgeon should consider re-excision of involved margin.
- Limited segmentectomy
- Though controversial, may be considered for select cases in the absence of a hereditary condition, particularly in lesions on the anti-mesenteric side of the intestine that involve the third and fourth segments of the duodenum.
- Due to reported lower yield of lymph nodes sampled during segmental resection, particular attention will need to be made for complete lymph node dissection and evaluation.³
- Case reports suggest segmentectomy and other limited resection methods may be considered for lesions of the first portion of the duodenum,⁴ particularly for lesions located on the mesenteric side of the intestine and for those <2 cm in size.

Jejunum/Ileum

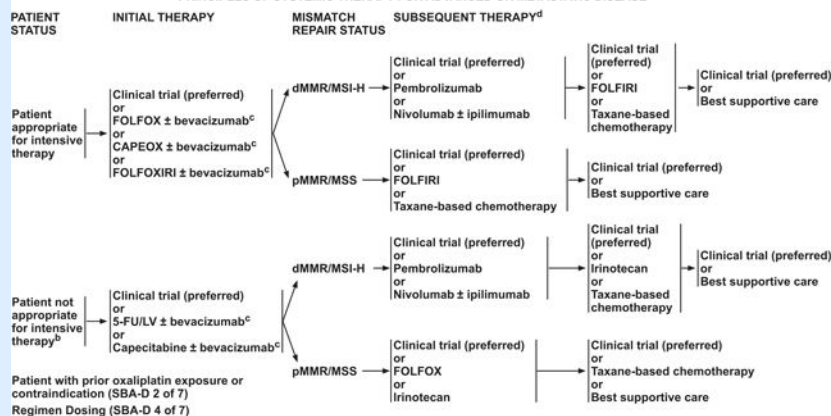
- Segmentectomy
- Lymph nodes should be identified and resected down to the origin of feeder vessels. Clinically suspicious nodes outside of the field of resection should be biopsied or resected whenever possible.
- Margins of at least 5–10 cm on either side of the tumor should be obtained.
- Terminal ileal resection with right hemicolectomy should be used for distal ileal tumors.

¹ Overman MJ, Hu CY, Kopetz S, et al. A population-based comparison of adenocarcinoma of the large and small intestine: insights into a rare disease. *Ann Surg Oncol* 2012;19:1439-1445.

² Overman MJ, Hu CY, Wolff RA, Chang GJ. Prognostic value of lymph node evaluation in small bowel adenocarcinoma: analysis of the surveillance, epidemiology, and end results database. *Cancer* 2010;116:5374-5382.

³ Onkendi EO, Boostrom SY, Sarr MG, et al. 15-year experience with surgical treatment of duodenal carcinoma: a comparison of periampullary and extra-ampullary duodenal carcinomas. *J Gastrointest Surg* 2012;16:682-691.

⁴ Hashimoto D, Arima K, Chikamoto A, et al. Limited resection of the duodenum for nonampullary duodenal tumors, with review of the literature. *Am Surg* 2016;82:1126-1132.

PRINCIPLES OF SYSTEMIC THERAPY FOR ADVANCED OR METASTATIC DISEASE^a

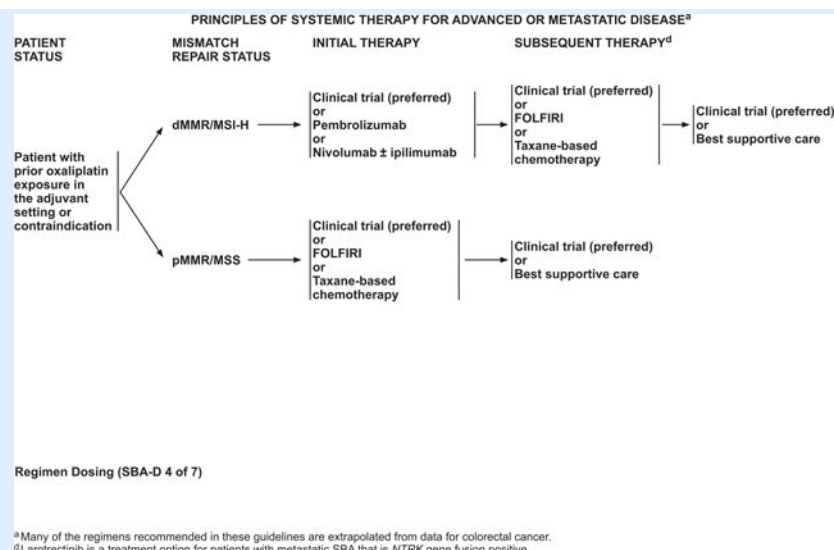
^aMany of the regimens recommended in these guidelines are extrapolated from data for colorectal cancer.

^bFor elderly patients, please complete geriatric assessment to aid appropriate prediction of treatment risks. See NCCN Guidelines for Older Adult Oncology, OAO-21.

^cBevacizumab has been shown to be safe in advanced SBA, though efficacy has not been proven.

^dLarotrectinib is a treatment option for patients with metastatic SBA that is *NTRK* gene fusion positive.

^eTo view the most recent version of these guidelines, visit NCCN.org.



ADJUVANT THERAPY REGIMENS^{a,b}

• mFOLFOX¹⁻³ ➤ Oxaliplatin 85 mg/m² IV, day 1^f ➤ Leucovorin 400 mg/m² IV, day 1^g ➤ 5-FU 400 mg/m² IV bolus on day 1, then 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) continuous infusion ➤ Repeat every 2 weeks • 5-FU/leucovorin¹⁻³ ➤ Leucovorin 500 mg/m² given as a 2-hour infusion and repeated weekly x 6^g ➤ 5-FU 500 mg/m² given bolus 1 hour after the start of leucovorin and repeated weekly x 6 ➤ Every 8 weeks for 4 cycles • Simplified biweekly infusional 5-FU/LV (sLV5FU2)¹⁻³ ➤ Leucovorin 400 mg/m² IV day 1^g ➤ followed by 5-FU bolus 400 mg/m² and then 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) continuous infusion ➤ Repeat every 2 weeks	• Capecitabine¹⁻³ ➤ Capecitabine 1000–1250 mg/m² twice daily days 1–14 every 3 weeks x 24 weeks • Capecitabine + XRT⁴ ➤ Capecitabine 825 mg/m² PO twice daily on Days 1–7 for 5 weeks with XRT • 5-FU with XRT⁴ ➤ 5-FU 225 mg/m² over 24 hours daily on days 1–7 for 5 weeks with XRT • CAPEOX¹⁻³ ➤ Oxaliplatin 130 mg/m² IV day 1^f ➤ Capecitabine 1000 mg/m² twice daily days 1–14 every 3 weeks x 24 weeks^h
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See References (SBA-D 7 of 7)

^aMany of the regimens recommended in these guidelines are extrapolated from data for colorectal cancer.
^bThe role for adjuvant chemotherapy remains controversial due to conflicting results across a number of retrospective analyses. Participation in clinical trials is strongly recommended.
^fOxaliplatin may be given either over 2 hours, or may be infused over a shorter time at a rate of 1 mg/m²/min. Leucovorin infusion should match infusion time of oxaliplatin. Cerek A, Park V, Yaeger R, et al. Faster FOLFOX: oxaliplatin can be safely infused at a rate of 1 mg/m²/min. J Oncol Pract 2016;12:e548-553.
^gLeucovorin 400 mg/m² is the equivalent of levoleucovorin 200 mg/m².
^hThe majority of safety and efficacy data for this regimen have been developed in Europe, where a capecitabine starting dose of 1000 mg/m² twice daily for 14 days, repeated every 21 days, is standard. Evidence suggests that North American patients may experience greater toxicity with capecitabine (as well as with other fluoropyrimidines) than European patients, and may require a lower dose of capecitabine.

ADVANCED OR METASTATIC THERAPY REGIMENS^a

• FOLFOX ➤ mFOLFOX⁵⁻⁷ ➤ Oxaliplatin 85 mg/m² IV day 1^f ➤ Leucovorin 400 mg/m² IV day 1^g ➤ 5-FU 400 mg/m² IV bolus on day 1, then 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) IV continuous infusion ➤ Repeat every 2 weeks ➤ mFOLFOX⁷⁻⁸ ➤ Oxaliplatin 85 mg/m² IV day 1^f ➤ Leucovorin 400 mg/m² IV day 1^g ➤ 5-FU 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) IV continuous infusion ➤ Repeat every 2 weeks • FOLFOX + bevacizumab^{9,10} ➤ Bevacizumab 5 mg/kg IV, day 1^f ➤ Repeat every 2 weeks • CAPEOX¹¹ ➤ Oxaliplatin 130 mg/m² IV day 1^f ➤ Capecitabine 1000 mg/m² twice daily PO for 14 days^h ➤ Repeat every 3 weeks • CAPEOX + bevacizumab^{9,10,12} ➤ Oxaliplatin 130 mg/m² IV day 1^f ➤ Capecitabine 1000 mg/m² PO twice daily for 14 days^h ➤ Bevacizumab 7.5 mg/kg IV day 1^f ➤ Repeat every 3 weeks	• FOLFIRI¹³ ➤ Irinotecan 180 mg/m² IV over 30–90 minutes, day 1 ➤ Leucovorin 400 mg/m² IV infusion to match duration of irinotecan infusion, day 1^g ➤ 5-FU 400 mg/m² IV bolus day 1, then 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) continuous infusion ➤ Repeat every 2 weeks • FOLFOXIRI^{14,15} ➤ Irinotecan 165 mg/m² IV day 1 ➤ Oxaliplatin 85 mg/m² IV day 1^f ➤ Leucovorin 400 mg/m² day 1^g ➤ Fluorouracil 1600 mg/m²/d x 2 days (total 3200 mg/m² over 48 hours) continuous infusion starting on day 1 ➤ Repeat every 2 weeks ➤ The dose of 5-FU was used in European studies. U.S. patients have been shown to have poorer tolerance for 5-FU. A starting dose of 5-FU consistent with the dose recommended in FOLFOX or FOLFIRI should be strongly considered for U.S. patients. • FOLFOXIRI + bevacizumab^{9,10} ➤ Bevacizumab 5 mg/kg IV, day 1^f ➤ Repeat every 2 weeks
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See Additional Regimens (SBA-D 5 of 7)
See References (SBA-D 7 of 7)

^aMany of the regimens recommended in these guidelines are extrapolated from data for colorectal cancer.
^fOxaliplatin may be given either over 2 hours, or may be infused over a shorter time at a rate of 1 mg/m²/min. Leucovorin infusion should match infusion time of oxaliplatin. Cerek A, Park V, Yaeger R, et al. Faster FOLFOX: oxaliplatin can be safely infused at a rate of 1 mg/m²/min. J Oncol Pract 2016;12:e548-553.
^gLeucovorin 400 mg/m² is the equivalent of levoleucovorin 200 mg/m².
^hThe majority of safety and efficacy data for this regimen have been developed in Europe, where a capecitabine starting dose of 1000 mg/m² twice daily for 14 days, repeated every 21 days, is standard. Evidence suggests that North American patients may experience greater toxicity with capecitabine (as well as with other fluoropyrimidines) than European patients, and may require a lower dose of capecitabine.
ⁱBevacizumab may be safely given at a rate of 0.5 mg/kg/min (5 mg/kg over 10 minutes and 7.5 mg/kg over 15 minutes).

ADVANCED OR METASTATIC THERAPY REGIMENS^a

- Capecitabine + XRT⁴
 - Capecitabine 825 mg/m² PO twice daily on Days 1–7 for 5 weeks with XRT
 - 5-FU with XRT⁴
 - 5-FU 225 mg/m² over 24 hours daily on days 1–7 for 5 weeks with XRT
 - 5-FU/leucovorin
 - Roswell Park regimen¹⁶
 - ◊ Leucovorin 500 mg/m² IV over 2 hours, days 1, 8, 15, 22, 29, and 36⁹
 - ◊ 5-FU 500 mg/m² IV bolus 1 hour after start of leucovorin, days 1, 8, 15, 22, 29, and 36
 - ◊ Repeat every 8 weeks
 - Simplified biweekly infusional 5-FU/LV (sLV5FU2)¹⁷
 - ◊ Leucovorin 400 mg/m² IV over 2 hours on day 1,⁹
 - ◊ followed by 5-FU bolus 400 mg/m² and then 1200 mg/m²/d x 2 days (total 2400 mg/m² over 46–48 hours) continuous infusion
 - ◊ Repeat every 2 weeks
 - Weekly¹⁸
 - ◊ Leucovorin 20 mg/m² IV over 2 hours on day 1⁹
 - ◊ 5-FU 500 mg/m² IV bolus injection 1 hour after the start of leucovorin,
 - ◊ Repeat every week
 - or
 - ◊ 5-FU 2600 mg/m² by 24-hour infusion on day 1
 - ◊ Leucovorin 500 mg/m² over 2 hours on day 1
 - ◊ Repeat every week
 - Capecitabine¹⁹
 - Capecitabine 850–1250 mg/m² PO twice daily, days 1–14
 - Repeat every 3 weeks
 - Irinotecan^{20,21}
 - Irinotecan 125 mg/m² IV over 30–90 minutes, days 1 and 8
 - Repeat every 3 weeks
 - or
 - Irinotecan 180 mg/m² IV over 30–90 minutes, day 1
 - Repeat every 2 weeks or
 - Irinotecan 300–350 mg/m² IV over 30–90 minutes, day 1
 - Repeat every 3 weeks
 - Pembrolizumab (dMMR/MSI-H only)²²
 - Pembrolizumab 2 mg/kg every 3 weeks
 - or
 - Pembrolizumab 200 mg every 3 weeks
 - Nivolumab (dMMR/MSI-H only)²³
 - Nivolumab 3 mg/kg every 2 weeks
 - or
 - Nivolumab 240 mg IV every 2 weeks
 - or
 - Nivolumab 480 mg IV every 4 weeks
 - Ipilimumab + nivolumab (dMMR/MSI-H only)²⁴
 - Nivolumab 3 mg/kg (30-minute IV infusion)
 - Ipilimumab 1 mg/kg (30-minute IV infusion)
 - Once every 3 weeks for four doses, then
 - Nivolumab 3 mg/kg IV or nivolumab 240 mg IV every 2 weeks
- See Additional Regimens (SBA-D 6 of 7)
See References (SBA-D 7 of 7)

^aMany of the regimens recommended in these guidelines are extrapolated from data for colorectal cancer.
⁹Leucovorin 400 mg/m² is the equivalent of levoleucovorin 200 mg/m².

ADVANCED OR METASTATIC THERAPY REGIMENS^a

- Nab-paclitaxel²⁵
 - Albumin-bound paclitaxel 260 mg/m² IV every 21 days
 - Docetaxel²⁶
 - Docetaxel 75–100 mg/m² IV on day 1 every 21 days
 - Paclitaxel²⁶
 - Paclitaxel 135–250 mg/m² IV on day 1 every 21 days
 - or
 - Paclitaxel 80 mg/m² IV weekly
 - or
 - Paclitaxel 80 mg/m² IV on days 1, 8, 15 every 28 days
 - Gemcitabine + albumin-bound paclitaxel²⁶
 - Albumin-bound paclitaxel 125 mg/m² IV on Days 1, 8, 15
 - Gemcitabine 1000 mg/m² IV on Days 1, 8, 15
 - Every 28 days
 - Gemcitabine + docetaxel²⁶
 - Gemcitabine 1000 mg/m² IV on days 1 and 8
 - Docetaxel 75 mg/m² IV on Day 8
 - Every 21 days
 - Gemcitabine + paclitaxel²⁶
 - Gemcitabine 1000 mg/m² IV on days 1, 8, 15
 - Paclitaxel 110 mg/m² on days 1, 8, 15
 - Every 28 days
 - Carboplatin + paclitaxel²⁶
 - Paclitaxel 175 mg/m² IV on Day 1
 - Carboplatin AUC 5 IV on Day 1
 - Every 21 days
 - Gemcitabine, docetaxel, and capecitabine (GTX)²⁶
 - Gemcitabine 750 mg/m² IV at a rate of 10 mg/m²/min on days 4 and 11
 - Docetaxel 30 mg/m² IV on days 4 and 11
 - Capecitabine 750 mg/m² PO twice daily on days 1–14
 - Every 21 days for 2–6 cycles
 - Larotrectinib²⁷ (NTRK gene fusion positive)
 - 100 mg PO twice daily
- See References (SBA-D 7 of 7)

^aMany of the regimens recommended in these guidelines are extrapolated from data for colorectal cancer.

PRINCIPLES OF SYSTEMIC THERAPY - REFERENCES

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- 2 Ecker BL, McMillan MT, Datta J, et al. Efficacy of adjuvant chemotherapy for small bowel adenocarcinoma: A propensity score-matched analysis. Cancer 2016;122:693-701.
- 3 Overman MJ, Kopetz S, Lin E, et al. Is there a role for adjuvant therapy in resected adenocarcinoma of the small intestine. Acta Oncol 2010;49:474-479.
- 4 Allegra CJ, Yothers G, O'Connell MJ, et al. Neoadjuvant 5-FU or Capecitabine Plus Radiation With or Without Oxaliplatin in Rectal Cancer Patients: A Phase III Randomized Clinical Trial. J Natl Cancer Inst 2015;107:pii: dv248.
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- 9 Aydin D, Sendur MA, Kefeli U, et al. Evaluation of bevacizumab in advanced small bowel adenocarcinoma. Clin Colorectal Cancer 2017;16:78-83.
- 10 Takayoshi K, Kusaba H, Uenomachi M, et al. Suggestion of added value by bevacizumab to chemotherapy in patients with unresectable or recurrent small bowel cancer. Cancer Chemother Pharmacol 2017;80:333-342.
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- 12 Gulhas P, Raghav K, Shroff RT, et al. Bevacizumab combined with capecitabine and oxaliplatin in patients with advanced adenocarcinoma of the small bowel or ampulla of Vater: A single-center, open-label, phase 2 study. Cancer 2017;123:1011-1017.
- 13 Zaanen A, Gauthier M, Malka D, et al. Second-line chemotherapy with fluorouracil, leucovorin, and irinotecan (FOLFIRI regimen) in patients with advanced small bowel adenocarcinoma after failure of first-line platinum-based chemotherapy: a multicenter AGE0 study. Cancer 2011;117:1422-1428.
- 14 Masi G, Allegrini G, Cupini S, et al. First-line treatment of metastatic colorectal cancer with irinotecan, oxaliplatin, and 5-fluorouracil/leucovorin (FOLFOXIRI): results of a phase II study with a simplified biweekly schedule. Ann Oncol 2004;15:1766-1772.
- 15 McWilliams RR, Foster NR, Mahoney MR, et al. North Central Cancer Treatment Group N0543 (Alliance): A phase 2 trial of pharmacogenetic-based dosing of irinotecan, oxaliplatin, and capecitabine as first-line therapy for patients with advanced small bowel adenocarcinoma. Cancer 2017;123:3494-3501.
- 16 Wolmark N, Rockette H, Fisher B, et al. The benefit of leucovorin-modulated fluorouracil as postoperative adjuvant therapy for primary colon cancer: results from National Surgical Adjuvant Breast and Bowel Project protocol C-03. J Clin Oncol 1993;11:1879-1887.
- 17 Andre T, Louvet C, Maindault-Goebel F, et al. CPT-11 (irinotecan) addition to bimonthly, high-dose leucovorin and bolus and continuous-infusion 5-fluorouracil (FOLFIRI) for pretreated metastatic colorectal cancer. Eur J Cancer 1999;35(9):1343-7.
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PRINCIPLES OF RADIATION THERAPY

Duodenum:

- Database analysis suggests no survival benefit from the addition of adjuvant chemoradiation versus chemotherapy alone in patients with surgically resected duodenal adenocarcinoma.¹ A separate retrospective study showed mixed results regarding the efficacy of either preoperative or postoperative chemoradiation for the management of locally advanced or margin-positive duodenal adenocarcinomas.² Therefore, chemoradiation should be considered only in highly select patients.
- Preoperative chemoradiation should be considered in patients who remain unresectable following a course of induction chemotherapy.
- Patients should be evaluated by multidisciplinary teams at high-volume centers in cases where either preoperative or postoperative radiation therapy is being considered.
- Treatment Information:
 - Fluoropyrimidine-based chemotherapy should be delivered concurrently with radiation therapy.
 - Treatment can be delivered using 3-D conformal radiation therapy. When appropriate, advanced treatment planning, such as intensity-modulated radiation therapy (IMRT), should be considered to limit toxicity to adjacent normal organs.
 - Image-guided radiation therapy (IGRT) with kilovoltage (kV) imaging, MR guided imaging, and cone-beam CT imaging should be routinely used during the course of treatment with IMRT.
- Target Volumes:
 - The primary site and regional lymph node basins should be included in the radiation therapy fields.
- RT Dosing:
 - Doses of 45–54 Gy in 1.8–2 Gy daily fractions should be used based on tolerance limits of adjacent normal tissues.
 - Adjacent small bowel dose should be limited to 45 Gy, if possible.

Jejunum/Ileum:

- Radiation therapy is not generally indicated for lesions arising in these sites. Any consideration for such therapy must be made on a highly selected basis by a multidisciplinary team.

¹Ecker BL, McMillan MT, Datta J, et al. Adjuvant chemotherapy versus chemoradiotherapy in the management of patients with surgically resected duodenal adenocarcinoma: A propensity score-matched analysis of a nationwide clinical oncology database. *Cancer* 2017;123:967-976.

²Kelsey CR, Nelson JW, Willett CG, et al. Duodenal adenocarcinoma: patterns of failure after resection and the role of chemoradiotherapy. *Int J Radiat Oncol Biol Phys* 2007;69:1436-1441.

PRINCIPLES OF SURVIVORSHIP

- Small bowel adenocarcinoma surveillance, see SBA-2
- Survivorship Care Planning
 - Should have defined roles for the oncologist and the primary care provider following curative-intent therapy
 - Overall summary, including dates, of all diagnostic and surgical procedures, chemotherapy received (including drug and number of cycles), and radiation (including dose) should be provided to the patient at end-of-treatment
 - Description of long-term toxicities and when they may resolve, as well as potential delayed toxicity
 - Surveillance recommendations and schedule
 - Health behavior recommendations
- Management of Late/Long-Term Sequelae of Treatment
 - For issues related to distress, pain, neuropathy, fatigue, or sexual dysfunction, see NCCN Guidelines for Survivorship
- Oxaliplatin-related Neuropathy
 - Only consider duloxetine, pregabalin, or gabapentin in cases where pain is present, as these are ineffective in treating numbness or tingling associated with the long-term use of oxaliplatin
 - Consider non-pharmacologic interventions, including balanced physical activity, acupuncture, heat or ice, or other methods
- Lifestyle Modifications
 - Avoid gluten in patients with confirmed celiac disease
 - Eat a plant-based diet
 - Maintain healthy body weight throughout life
 - Engage in regular physical activity
 - Undergo all age- and gender-appropriate preventive health and cancer screenings at recommended intervals with primary care provider
 - Avoid the use of alcohol or tobacco
- Crohn's Disease
 - Patients with Crohn's disease and history of SBA remain at elevated risk for developing further small bowel adenocarcinomas. Surveillance screening should be considered for these individuals.^{1,2}

¹Groffieu C, Pote NM, Guedj NS, et al. Small bowel adenocarcinoma complicating Crohn's disease: a single-centre experience emphasizing the importance of screening for dysplasia. *Virchows Arch* 2017;471:611-617.

²Cahill C, Gordon PH, Petrucci A, Boutros M. Small bowel adenocarcinoma and Crohn's disease: any further ahead than 50 years ago? *World J Gastroenterol* 2014;20:11486-11495.

Individual Disclosures for the NCCN Small Bowel Adenocarcinoma Panel

Panel Member	Clinical Research Support/Data Safety Monitoring Board	Scientific Advisory Boards, Consultant, or Expert Witness	Promotional Advisory Boards, Consultant, or Speakers Bureau	Specialties
Mahmoud M. Al-Hawary, MD	None	None	None	Diagnostic/Interventional Radiology
Mustafa A. Arain, MD	None	None	Boston Scientific Corporation	Gastroenterology
Al B. Benson III, MD	Acerta Pharma, LLC; Amgen Inc.; Astellas Pharma US, Inc.; Bristol-Myers Squibb Company; Celgene Corporation; Infinity Pharmaceuticals, Inc.; MedImmune, Inc.; Merck & Co., Inc.; Novartis Pharmaceuticals Corporation; and Taiho Pharmaceuticals Co., Ltd.	Astellas Pharma US, Inc.; Bayer HealthCare; Bristol-Myers Squibb Company; Eli Lilly and Company; Exelixis Inc.; Genentech, Inc.; Merck & Co., Inc.; Purdue Pharma LP; and Taiho Pharmaceuticals Co., Ltd.	None	Medical Oncology
Yi-Jen Chen, MD, PhD	None	None	None	Radiotherapy/Radiation Oncology
Kristen K. Ciombor, MD	AbbVie, Inc.; Amgen Inc.; Array Biopharma Inc.; Bayer HealthCare; Bristol-Myers Squibb Company; Daiichi Sankyo Co.; Incyte Corporation; Merck & Co., Inc.; National Cancer Institute; NuCana Plc; Pfizer Inc.; and sanofi-aventis U.S. LLC	Bayer HealthCare, and Taiho Pharmaceuticals Co., Ltd.	Foundation Medicine	Medical Oncology
Stacey A. Cohen, MD	Taiho Pharmaceuticals Co., Ltd.	None	None	Medical Oncology
Harry S. Cooper, MD	None	None	None	Pathology
Dustin A. Deming, MD	Bristol-Myers Squibb Company; Genentech, Inc.; and Merck & Co., Inc.	Array Biopharma Inc.; Bayer HealthCare; Bristol-Myers Squibb Company; Genentech, Inc.; Ipsen; Novocure; and Taiho Pharmaceuticals Co., Ltd.	None	Medical Oncology
Ignacio Garrido-Laguna, MD, PhD	Agiros, Inc.; Bayer HealthCare; Bristol-Myers Squibb Company; Eli Lilly and Company; Flatiron Health, Inc.; Halozyme, Inc.; Incyte Corporation; MedImmune, Inc.; Novartis Pharmaceuticals Corporation; OncoMed Pharmaceuticals; Inc.; Pfizer Inc.; and Taiho Pharmaceuticals Co., Ltd.	Array Biopharma Inc.	None	Medical Oncology
Jean L. Grem, MD	Elion Oncology, and ICON plc	None	None	Medical Oncology
Sarah E. Hoffe, MD	Varian Medical Systems, Inc.	None	None	Radiotherapy/Radiation Oncology
Joleen Hubbard, MD	Bayer HealthCare; Boston Biomedical, Inc.; Incyte Corporation; Medpace; Merck & Co., Inc.; Senhwa Pharmaceuticals; Taiho Pharmaceuticals Co., Ltd.; and Treos Bio	Bayer HealthCare	None	Hematology/Hematology Oncology

Panel Member	Clinical Research Support/Data Safety Monitoring Board	Scientific Advisory Boards, Consultant, or Expert Witness	Promotional Advisory Boards, Consultant, or Speakers Bureau	Specialties
Steven Hunt, MD	None	None	None	Surgery/Surgical Oncology
Ahmed Kamel, MD	Boston Scientific Corporation	Boston Scientific Corporation, and Sirtex Medical	Bard Peripheral Vascular, Inc., and Boston Scientific Corporation	Diagnostic/Interventional Radiology
Natalie Kirilcuk, MD	None	None	None	Surgery/Surgical Oncology
Smitha Krishnamurthi, MD	AbbVie, Inc.	None	None	Medical Oncology, and Internal Medicine
Wells A. Messersmith, MD	Aduro Biotech, Inc.; ALX Oncology; D3 Pharma; Genentech, Inc.; Immunomedics, Inc.; Incyte Corporation; Pfizer Inc.; Roche Laboratories, Inc.; and Tanabe Research Labs USA Inc.	Five Prime Therapeutics, Inc., and Gilead Sciences, Inc.	None	Medical Oncology
Jeffrey Meyerhardt, MD, MPH	Cota Healthcare	Taiho Pharmaceuticals Co., Ltd.	None	Medical Oncology
Eric D. Miller, MD, PhD	None	None	None	Radiotherapy/Radiation Oncology
Mary F. Mulcahy, MD	None	None	None	Hematology/Hematology Oncology, and Medical Oncology
Steven Nurkin, MD, MS	None	None	None	Surgery/Surgical Oncology
Michael J. Overman, MD	Bristol-Myers Squibb Company; MedImmune, Inc.; Merck & Co., Inc.; Nektar Therapeutics; and Roche Laboratories, Inc.	Bristol-Myers Squibb Company; MedImmune, Inc.; Novartis Pharmaceuticals Corporation; and Roche Laboratories, Inc.	None	Medical Oncology, and Hematology/ Hematology Oncology
Aparna Parikh, MD	Array Biopharma Inc.; Bristol-Myers Squibb Company; Guardant Health Inc.; Novartis Pharmaceuticals Corporation; Plexikon Inc.; and TESARO, Inc.	Foundation Medicine, and Puretech Health	None	Medical Oncology
Hitendra Patel, MD	Bristol-Myers Squibb Company, and MedImmune, Inc.	None	None	Medical Oncology
Katrina S. Pedersen, MD, MS	Merck & Co., Inc.	None	None	Medical Oncology
Leonard B. Saltz, MD	Taiho Pharmaceuticals Co., Ltd.	None	None	Medical Oncology; Hematology/ Hematology Oncology; and Internal Medicine
Charles Schneider, MD	None	None	None	Medical Oncology
David Shibata, MD	None	None	None	Surgery/Surgical Oncology
John M. Skibber, MD	None	None	None	Surgery/Surgical Oncology
Constantinos T. Sofocleous, MD, PhD	Ethicon, Inc.	Ethicon, Inc., and Terumo Corporation	Ethicon, Inc.	Diagnostic/Interventional Radiology

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Panel Member	Clinical Research Support/Data Safety Monitoring Board	Scientific Advisory Boards, Consultant, or Expert Witness	Promotional Advisory Boards, Consultant, or Speakers Bureau	Specialties
Elena M. Stoffel MD, MPH	None	None	None	Gastroenterology
Eden Siotsky-Himelfarb, BSN, RN	None	None	None	Patient Advocate
Alan P. Venook, MD	Halozyme, Inc., and Pierre Fabre	Genentech, Inc., and Roche Laboratories, Inc.	None	Medical Oncology, and Hematology/ Hematology Oncology
Christopher G. Willett, MD	None	None	None	Radiotherapy/Radiation Oncology

The NCCN Guidelines Staff have no conflicts to disclose.