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Curative treatment for patients with esophageal cancer consists of neoadjuvant treatment and radical surgical resection. Two different strategies exist; patients can either be treated with perioperative chemotherapy (CT) or neoadjuvant chemoradiotherapy (CRT). Both strategies improve 5-year survival rates, it is however not known if these treatments affect long-term Health-Related Quality of Life (HR-QoL) differently. The aim of this study was to compare HR-QoL between patients following CT and CRT followed by esophagectomy for esophageal cancer.

Methods: The LASER study database comprises data of a multicenter European study, with focus on HR-QoL among disease-free patients at least one year following an esophagectomy for esophageal or junctional cancer. Included patients completed the LASER, EORTC-QLQ-C30 and EORTC-QLQ-OG25 questionnaires. From this database we extracted patients either treated with CT or CRT for analysis. The primary endpoint was the mean difference in all long-term HR-QoL domains and LASER key symptom scores, using univariable and multivariable logistic regression analysis. The secondary endpoint was to compare the reported HR-QoL domain scores in the study population to the reference values of the general population.

Results: Among the 565 included patients, 349 (61.8%) received CRT, and 216 (38.2%) were treated with CT. The mean age was 63.7 years (±SD 8.6), and mean time since surgery was 4.3 years (±SD 1.7). After multivariable analysis, patients treated with CT reported worse outcomes on 'Social Functioning' (Δmeans 4.56, p-value$<$0.05), more symptomatology on domains 'Insomnia' (Δmeans 5.65 p-value$<$0.05) and 'Diarrhea' (Δmeans 5.93 p-value$<$0.05) of the QLQ-C30 questionnaire, and more symptomatology on domains 'Reflux' (Δmeans 7.40, p-value$<$0.05), 'Odynophagia'(Δmeans 4.66 p-value$<$0.05) and 'Pain and discomfort'(Δmeans 4.34, p-value$<$0.05) of the QLQ-OG25 questionnaire. No differences were observed for the LASER key symptoms.

Conclusion: Significant differences in favor of CRT were observed in several long-term HR-QoL domains for patients following esophagectomy for cancer. However, none of the observed differences in the reported long-term HR-QoL domains between patients treated with CT or with CRT, were clinically relevant (Δmeans $\neq \geq 10$ points). Selection of neoadjuvant therapy should therefore be based on patient characteristics.

740 CAMRELIZUMAB IN COMBINATION WITH PREOPERATIVE CHEMOTHERAPY FOR LOCALLY ADVANCED ESOPHAGEAL SQUAMOUS CELL CARCINOMA: A SINGLE-ARM, OPEN-LABEL, PHASE II STUDY

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At present, ESCC has a dismal prognosis with huge unmet clinical needs. With the potential benefit of combining PD-1 inhibitor with nCT, we conducted a phase II trial to assess the efficacy and safety of Camrelizumab plus nCT for locally advanced ESCC.

Methods: 45 patients (pts) with histologically confirmed stage II/III/IVa(cT2-4aN0-3 M0) ESCC were enrolled from February 2020 to March 2021.The study was divided into two stages, stage1: we administered 1 cycle of Camrelizumab for induction therapy (200 mg q2 weeks); stage2: pts received 2 cycle of Camrelizumab (200 mg every 3 weeks) plus docetaxel and nedaplatin, followed by surgery within 4～6 weeks after neoadjuvant therapy completion. Primary endpoint was major pathologic response (MPR). Secondary endpoints included pathologic complete response (pCR), R0 resection rate, disease-free survival (DFS) and overall survival (OS).

Results: At the cutoff date of Mar 9, 2021, 45 eligible pts were enrolled, neoadjuvant treatment was completed in 39 pts. Thus far 32 pts were resected, all patients underwent an R0 resection. Postoperative pathology showed that TNM stage decreased in 28 pts with 87.5% reduction rate. 19 pts (59.38%) reached major pathologic response, 9 pts (28.13%) reached pathologic complete response (no surgery related mortality). A total of 75.56% had AEs with 13.33% of grade $\geq$ 3 AEs. Date for median DFS and OS were not matured.

Conclusion: Camrelizumab in combination with preoperative chemotherapy followed by surgery for locally advanced ESCC showed promising downstaging effect and MPR with good tolerance, and its efficacy and safety could be further studied in later trials. Clinical trial information: NCT03917966.

742 INITIAL RESULTS OF THE 'TUBELESS' OESOPHAGUECTOMY: LESS IS MORE

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Oesophageal cancer surgery is a complex procedure with high morbidity and mortality rate. High volume centres, complete multidisciplinary support and clear clinical guidelines are required to obtain adequate results. One of the objectives of multimodal rehabilitation programs in this field is to reduce surgical aggression. Initial experience with the tubeless oesophagectomy technique is described.

Methods: Description of the technique and perioperative management of tubeless oesophagectomy. We performed a 3-stage esophagectomy with a minimally invasive approach, without NGT placement or any type of drainage. The procedure includes the so-called phantom jejunostomy, which require of fixing the first jejunal loop to the parietal peritoneum in order to position a percutaneous catheter if necessary. All patients were extubated at the end of the surgery, remaining in the ICU with high-flow glasses for the first 24–48 hours. Also in the first 2 days, the urinary catheter and the epidural catheter were removed, sitting and fluid tolerance began.

Results: Beteween June–November 2020 6 patients were operated on. Median age was 60 years (range: 52–70), 83.3% were squamous cell carcinoma located in the middle oesophagus, 4 patients received neoadjuvant CROSS treatment. No intraoperative complications reported and a median stay of 7 days (range: 6–28). There was no anastomotic leak, nor need to place a jejunostomy, nor need to place a nasogastric tube and neither reoperation. A thoracic tube was necessary for chylothorax and another for pneumothorax (in a patient with acute respiratory distress). There was no mortality at 30 and 90 days after the procedure.

Conclusion: Tubeless oesophagectomy is a feasible concept that can improve postoperative recovery in selected cases, reducing pain associated with drains and tubes, facilitating early mobilization and correct performance of respiratory physiotherapy exercises. Improving functional recovery and quality of life during the postoperative period. Studies with a greater number of cases and well designed are necessary to strongly evaluate this type of procedure.

743 SIEWERT TYPE II GASTRIC CARDIA CANCER: ANALYSIS OF THE RESULTS OF DIFFERENT SURGICAL OPTIONS

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The management of gastric cardia tumors should be carried out from a multidisciplinary approach, there is currently a clear controversy regarding the most appropriate surgical approach to use in type II tumors. Depending on their topographic anatomical characteristics based on the degree of gastric invasion and esophageal, the surgical technique may change: esophagectomy, gastrectomy with distal esophagectomy, or total esophageal gastrectomy.

Methods: Retrospective and analytical study of patients diagnosed with type II gastric cardia adenocarcinoma (based on the results of the pathological study of the resection specimen) who underwent surgical treatment in our center from June 2012 to June 2020. Different preoperative parameters, the surgical techniques used and the results obtained were analyzed.

Results: 25 patients were studied, 84% male. 60% were locally advanced tumors with 56% affected nodes. 12 Ivor-Lewis esophagectomies, 5 esophagogastrectomies with coloplasty, and 5 extended total gastrectomies were performed. There was no resection proximal or distal margin involvement, but circumferential margin was affected in 60% of cases of extended gastrectomy and in 1 case of Ivor-Lewis esophagectomy. Median number of lymph nodes removed was 22(5–37) and 2(0–12) affected, being higher in total esophagogastrectomy. Postoperative morbidity was 40% and 90-day mortality 4% (1 case). The mean follow-up was 37 months, noting recurrence in 9 cases (36%), with disease-free survival of 44%.