APGCS™ 2026

13th Asia-Pacific Gastroenterology Cancer Summit 2026

31 JULY & 01 AUGUST 2026

ACADEMIA, SINGAPORE

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INDEX® CONFERENCES & EXHIBITIONS

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WELCOME TO **APGCS 2026**

Dear Esteemed Colleagues & Friends,

It is with great pleasure that we welcome you to the **13th Asia-Pacific Gastroenterology Cancer Summit (APGCS 2026).**

Building on the success of the previous editions, APGCS has established itself as a premier platform dedicated to advancing the diagnosis, treatment, and multidisciplinary management of gastrointestinal cancers. This summit brings together leading clinicians, researchers, healthcare professionals, and industry experts from across the Asia-Pacific region and beyond to exchange knowledge, foster collaboration, and shape the future of GI cancer care.

Taking place on **31 July – 1 August 2026 in Singapore,** APGCS 2026 will showcase the latest breakthroughs in gastrointestinal oncology through an engaging scientific program featuring keynote lectures, plenary sessions, debates, panel discussions, symposia, poster presentations, and real-world clinical case discussions. Participants will gain valuable insights into evolving evidence, innovative technologies, and emerging therapeutic strategies that are transforming patient outcomes.

Beyond scientific excellence, APGCS continues to serve as a collaborative forum where ideas are shared, partnerships are strengthened, and meaningful discussions inspire progress in precision medicine and multidisciplinary cancer care.

We are delighted to have you join us in Singapore and look forward to your active participation. Your expertise, experiences, and contributions are what make APGCS a truly impactful gathering.

We wish you an inspiring, engaging, and rewarding experience at **APGCS 2026.**

Warm Regards,
APGCS 2026 Organizing Committee

APGCS 2026 **COMMITTEE**

Upper GI, Esophageal & Gastric Cancers

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	Type of Cancer	Trial	Indication	
	Biliary Tract Cancer	**TOPAZ**	IMFINZI in combination with cisplatin and gemcitabine, is indicated for the treatment of patients with locally advanced or metastatic biliary tract cancer.	**CDL**
	Hepatocellular Carcinoma	**HIMALAYA**	IMFINZI in combination with tremelimumab is indicated for the treatment of patients with unresectable hepatocellular carcinoma who have not received prior systemic therapy.	**MAF**
	Gastric or Gastro-Esophageal Junction Adenocarcinoma (GC/GEJC)	**MATTERHORN**	IMFINZI in combination with fluorouracil, leucovorin, oxaliplatin and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment, followed by adjuvant IMFINZI monotherapy, is indicated for the treatment of patients with resectable gastric or gastroesophageal junction adenocarcinoma.	

CDL: Cancer Drug List; **MAF:** Medication Assistance Fund

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PROGRAM AT **A GLANCE**

31 JULY 2026

08:00 – 08:30	Registration and Coffee
08:30 – 08:40	Welcome & Opening Remarks
08:40 – 10:25	**Session 1:** Keynotes & Updates: Upper GI
08:40 – 09:00	**Scientific Talk** *Supported by Servier*
09:30 – 09:55	**Scientific Talk** *Supported by Daichii Sankyo*
09:30 – 10:25	**Scientific Talk** *Supported by AstraZeneca*
10:25 – 10:40	Coffee Break & Networking
10:40 – 12:40	**Session 2:** Esophageal and Gastric Cancers
11:05 – 11:50	**Scientific Talk** *Supported by MSD*
11:50 – 12:10	**Scientific Talk** *Supported by Astellas*
12:40 – 12:55	Pre-Lunch Break (Food Collection)
12:55 – 13:35	**Lunch Break &** *Satellite Symposium by AstraZeneca*
13:35 – 16:25	**Session 2:** Hepatobiliary Malignancies
16:30	Day 1 Takeaways

01 AUGUST 2026

08:30 - 09:00	Registration and Coffee
09:00 – 10:50	**Session 4:** Colorectal Cancers
09:20 – 09:50	**Scientific Talk** *Supported by Pierre Fabre + Merck*
10:20 – 10:50	**Scientific Talk** *Supported by BMS*
10:50 – 11:15	Coffee Break & Networking
11:15 – 12:55	**Session 4:** Colorectal Cancers
11:55 – 12:10	**Scientific Talk** *Supported by Guardant Health*
12:10 – 12:30	**Scientific Talk** *Supported by GSK*
12:55 - 13:00	Closing Remarks and Takeaways from APGCS 2026

BRAFTOVI® + ERBITUX®

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The treatment approved specifically for patients with *BRAF*^{V600E}-mutant mCRC who have received prior systemic therapy[1,2,4]

A BREAKTHROUGH IN OVERALL SURVIVAL

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Overall survival[1]

9.3 months		**5.9 months**
(95% CI: 8.0-11.3)	VS	**(95% CI: 5.1-7.1)**
BRAFTOVI® + ERBITUX® (n=220)		**Control: FOLFIRI + ERBITUX® or irinotecan + ERBITUX® (n=221)**

(HR 0.61 (95% CI: 0.48–0.77) P<0.0001)
The cut off date was August 2019

BRAFTOVI® is indicated in combination with ERBITUX® for the treatment of adult patients with metastatic colorectal cancer (mCRC) with a *BRAF*^{V600E} mutation who have received prior systemic treatment'. The BEACON CRC trial was a positive study, and both primary end points (OS and ORR for BRAFTOVI® + binimetinib + ERBITUX® vs control arm) were met. BRAFTOVI® + binimetinib + ERBITUX® is not approved for the treatment of patients with *BRAF*^{V600E}-mutant mCRC in any country except Japan

***Singapore Cancer Drug List https://www.moh.gov.sg/home/our-healthcare- system/medishield-life/what-is-medishield-life/what-medishield-life-benefits/cancer-drug-list**

Reference
1. Braftovi® Singapore Product Information. May 2026. **2.** Van Cutsem E, Cervantes A, Adam R et al. ESMO consensus guidelines for the management of patients with metastatic colorectal cancer. Ann Oncol 2016;27(8):1386–1422. **3.** Tabernero J, Grothey A, Van Cutsem E et al. Encorafenib plus cetuximab as a new standard of care for previously treated *BRAFV*^{600E}–mutant metastatic colorectal cancer: updated survival results and subgroup analyses from the BEACON study. J Clin Oncol 2021;39:273–284. **4.** Erbitux® Singapore Product Information. March 2024.

Please scan to view the full product information for BRAFTOVI® (encorafenib). Please review the full product information before prescribing.

Please scan to view the full product information for ERBITUX® (cetuximab). Please review the full product information before prescribing.

BRAFTOVI® (encorafenib) in combination with ERBITUX® is registered in Singapore. This treatment regimen may not be available in countries outside of Singapore. Please always follow your local health authority regulations.

To report an adverse event involving BRAFTOVI®, please contact qrvi_singapore@pierre-fabre.com
To report an adverse event invovling ERBITUX®, please contact icsr_sea@merckgroup.com

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SCIENTIFIC **AGENDA**

DAY ONE

31 July 2026
FRIDAY

08:30 – 16:30 HRS
SINGAPORE TIME

Session 1: Keynotes & Updates: Upper GI
Chairpersons: **Shaheenah Dawood, UAE | Robert Walsh, Singapore**

08:30 - 08:40	**Welcome & Opening Remarks** **Toh Han Chong, Singapore**
08:40 – 09:00	From Evidence to Practice: Optimizing Outcomes for Patients with IDH1-mutated CCA Beyond First Line ***Satellite Symposium by Servier*** Chairperson: **Lee Suat Ying, Singapore** Speaker: **Choong-Kun Lee, South Korea**
09:00 – 09:30	Wrapping Up the Year: Updates in GI Malignancies **Shaheenah Dawood, UAE**
09:30 – 09:55	Optimizing Second-Line Therapy in HER2-Positive Gastric Cancer ***Supported by Daiichi Sankyo*** Chair and Speaker: **Yong Wei Peng, Singapore** Panelists: **Matthew Ng, Singapore | Kong Hwai Loong, Singapore** **Jens Samol, Singapore**
09:55 – 10:25	Perioperative GC Care: Experience Sharing in Perioperative Gastric Cancer Care ***Satellite Symposium by AstraZeneca*** Chair and Speaker: **Elizabeth Smyth, UK** Panelists: **Kim Guowei, Singapore | Robert Walsh, Singaporee**
10:25 – 10:40	**Coffee Break & Networking**

Session 2: Esophageal and Gastric Cancers
Chairpersons: **Herdee Luna, Philippines | Robert Walsh, Singapore**
Mohamed Ibrahim A Wahid, Malaysia

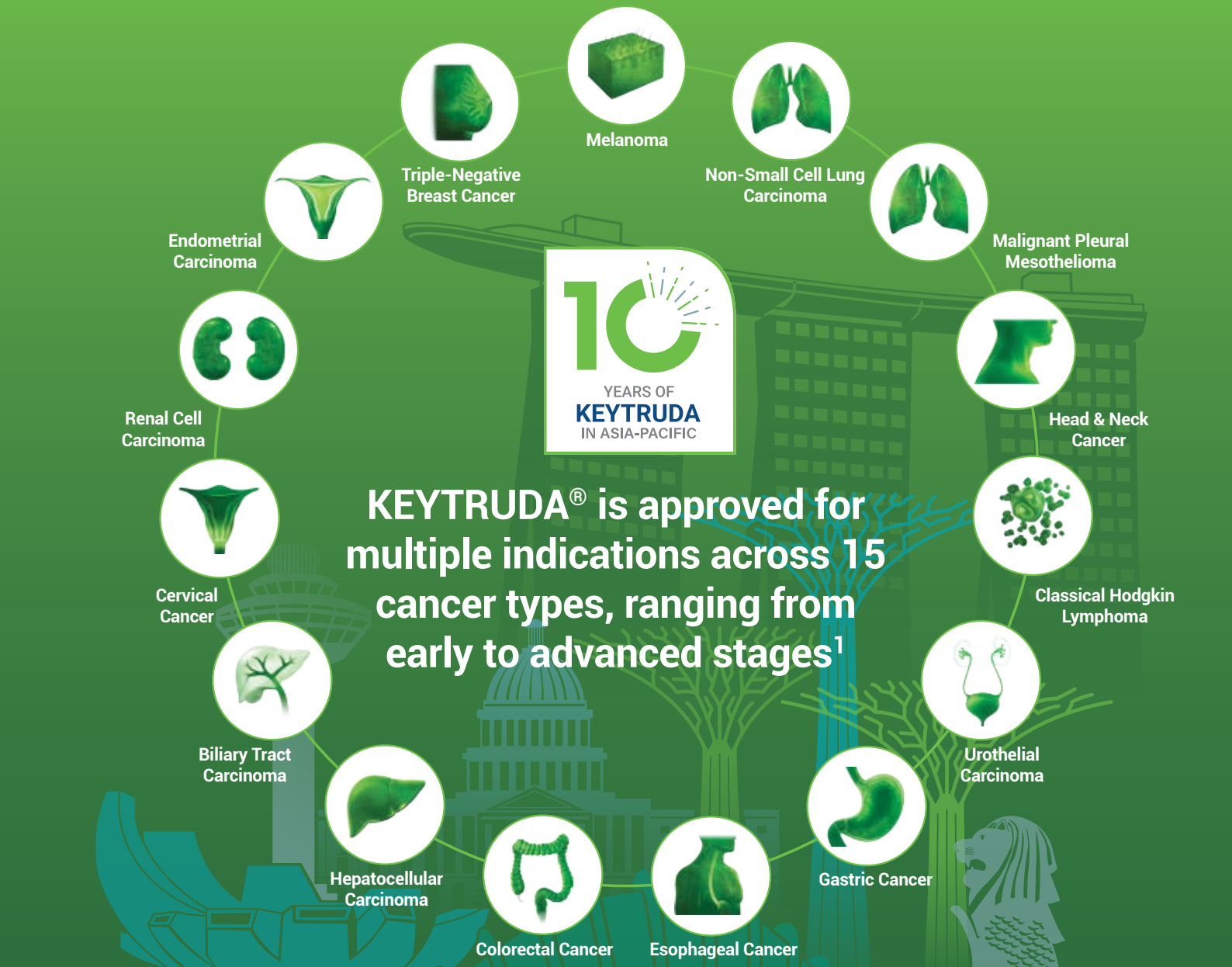
10:40 – 11:05	Tumor Board – Gastric Early Stage/Oligometastatic Moderator: **Robert Walsh, Singapore** Panelists: **Aru Sudoyo, Indonesia | Herdee Luna, Philippines |** **Jimmy So, Singapore | Matthew Ng, Singapore | Kai-Keen Shiu, UK**
11:05 – 11:50	From Biomarkers to Bedside: Immune Checkpoint Inhibitors in Gastric Cancer ***Satellite Symposium by MSD*** Chairperson: **Evelyn Wong, Singapore** Speaker: **Sylvie Lorenzen, Germany**
11:50 – 12:10	Navigating the CLDN18.2 Landscape: The role of Zolbetuximab in Advanced Gastric/GEJ Cancers ***Supported by Astellas*** **Elizabeth Smyth, UK**

SCIENTIFIC **AGENDA**

12:10 – 12:40	Tumor Board – Metastatic Upper GI Moderator: **Tan Hon Lyn, Singapore** Panelists: **Jens Samol, Singapore | Elizabeth Smyth, UK | Bhawna Sirohi, India** **Elizabeth Chuk, Singapore | Claramae Chia, Singapore**
12:40 – 12:55	**Pre-Lunch Break (Followed by Lunch & Satellite Symposium)**

Session 3: Hepatobiliary Malignancies
Chairpersons: **Toh Han Chong, Singapore | Pierce Chow, Singapore**
Feng Xiaobin, China

12:55 – 13:35	Advancing Frontline Strategies in HCC: Evidence, Challenges, and Opportunities ***Lunch Satellite Symposium by AstraZeneca*** Is It Time to Bring Immunotherapy Forward in HCC treatment? **Stephen Chan, Hong Kong** Case-Based Panel Discussions Panelists: **David Tai, Singapore | Lim Yueh Ni, Malaysia | Stephen Chan, Hong Kong**
13:35 – 14:00	Downstaging HCC to surgical resection – TalenTop and more **Kuang Ming, China**
14:00 – 14:20	The Evolution of Ablative SIRT-90 Strategies and their Impact on Clinical Outcomes in HCC **Ammar Sarwar, USA**
14:20 – 14:40	Trans-Arterial Radioembolisation for HCC – Looking East, Looking West **Kaina Chen, Singapore**
14:40 – 15:00	Systemic Therapy for Advanced HCC – How to Make the Right Choices **Thomas Yau, Hong Kong**
15:00 – 15:15	**Coffee Break & Networking**
15:15 – 15:45	This House Believes that Combining Locoregional & Systemic Therapy is the Future of Treating Intermediate Stage HCC Proposition: **Chiun Hsu, Taiwan** Opposition: **Stephen Chan, Hong Kong**
15:45 – 16:05	Chemoimmunotherapy as a new first-line for advanced biliary tract cancer (BTC) **Bhawna Sirohi, India**
16:05 – 16:25	Challenges in the Management of Pancreatic Cancer: An MDT Moderator: **Shailesh Shrikhande, India** Panelists: **Brian Goh, Singapore | Joycelyn Lee, Singapore** **Michael Wang, Singapore | Feng Xiaobin, China | Chan Wan Ying, Singapore** **Vishalkumar Shelat, Singapore**
16:25 – 16:30	**Day 1 Takeaways**



This is only a list of cancer types. For the full list of approved indications, please refer to the SSI section below or the local Product Information.
Reference: 1. KEYTRUDA® Product Insert. Available at: Register of Therapeutic Products, Health Science Authority, http://www.hsa.gov.sg/e-services/infosearch)

SELECTED SAFETY INFORMATION

Indications Melanoma KEYTRUDA® (pembrolizumab) is indicated for the treatment of patients with unresectable or metastatic melanoma. KEYTRUDA® is indicated for the adjuvant treatment of adult and pediatric (12 years and older) patients with Stage IIB, IIC or III melanoma who have undergone complete resection. Non-Small Cell Lung Carcinoma KEYTRUDA®, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of patients with metastatic non-squamous non-small cell lung carcinoma (NSCLC), with no EGFR or ALK genomic tumour aberrations. KEYTRUDA®, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of patients with metastatic squamous NSCLC. KEYTRUDA® as monotherapy is indicated for the first-line treatment of patients with metastatic NSCLC whose tumours express PD-L1 with a ≥50% tumor proportion score (TPS) as determined by a validated test, with no EGFR or ALK genomic tumour aberrations. KEYTRUDA® as monotherapy is indicated for the treatment of patients with locally advanced or metastatic NSCLC whose tumors express PD-L1 with a ≥1% TPS as determined by a validated test and who have received platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumour aberrations should have received prior therapy for these aberrations prior to receiving KEYTRUDA®. KEYTRUDA® is indicated for the treatment of patients with resectable Stage II, IIIA, or IIIB (T3–4N2) NSCLC in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as monotherapy as adjuvant treatment. KEYTRUDA®, as monotherapy, is indicated as adjuvant treatment following resection and platinum-based chemotherapy for adults patients with Stage IB (T2a ≥4 cm), II, or IIIA NSCLC. Malignant Pleural Mesothelioma KEYTRUDA®, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of adult patients with unresectable non-epithelioid malignant pleural mesothelioma (MPM). Head and Neck Cancer KEYTRUDA® is indicated for the treatment of adult patients with resectable locally advanced head and neck squamous cell carcinoma (HNSCC) whose tumours express PD-L1 with a CPS ≥1 as determined by a validated test, as neoadjuvant treatment, continued as adjuvant treatment in combination with radiotherapy (RT) with or without cisplatin and then as monotherapy. KEYTRUDA®, as monotherapy or in combination with platinum and 5-fluorouracil (5-FU) chemotherapy, is indicated for the first line treatment of patients with metastatic or unresectable recurrent head and neck squamous cell carcinoma (HNSCC) whose tumours express PD-L1 with a CPS ≥ 1. Classical Hodgkin Lymphoma KEYTRUDA® is indicated for the treatment of adult and pediatric patients aged 3 years and above, with relapsed or refractory classical Hodgkin lymphoma (cHL), who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. Urothelial Carcinoma KEYTRUDA®, in combination with enfortumab vedotin, is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma. KEYTRUDA®, as monotherapy, is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma whose tumours express PD-L1 with a combined positive score (CPS) ≥ 10 as determined by a validated test, and who are not eligible for cisplatin-containing chemotherapy. KEYTRUDA®, as monotherapy, is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have received prior platinum-containing chemotherapy. Gastric Cancer KEYTRUDA®, in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of patients with locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma. KEYTRUDA®, in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of patients with locally advanced unresectable or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma, whose tumours express PD-L1 [Combined Positive Score (CPS) ≥1] as determined by a validated test. Esophageal Cancer KEYTRUDA®, in combination with platinum and fluoropyrimidine based chemotherapy, is indicated for the first-line treatment of patients with locally advanced or metastatic carcinoma of the esophagus or HER2 negative gastroesophageal junction (GEJ) adenocarcinoma (tumours with epicenter 1 to 5 centimeters above the GEJ) that is not amenable to surgical resection or definitive chemoradiation. Colorectal Cancer KEYTRUDA® is indicated for the first-line treatment of patients with metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC). Hepatocellular Carcinoma KEYTRUDA® is indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with an anti-angiogenic tyrosine kinase inhibitor (TKI). Biliary Tract Carcinoma KEYTRUDA®, in combination with gemcitabine and cisplatin, is indicated for the treatment of patients with locally advanced unresectable or metastatic biliary tract carcinoma (BTC). Cervical Cancer KEYTRUDA®, in combination with chemoradiotherapy (CRT), is indicated for the treatment of patients with FIGO 2014 Stage III-IVA locally advanced cervical cancer. KEYTRUDA®, in combination with chemotherapy with or without bevacizumab, is indicated for the treatment of patients with persistent, recurrent, or metastatic cervical cancer whose tumours express PD-L1 with a CPS ≥ 1. Renal Cell Carcinoma KEYTRUDA®, in combination with axitinib, is indicated for the first-line treatment of patients with advanced renal cell carcinoma (RCC). KEYTRUDA®, in combination with lenvatinib, is indicated for the first-line treatment of patients with advanced RCC. KEYTRUDA®, as monotherapy, is indicated for the adjuvant treatment of patients with RCC at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions. Endometrial Carcinoma KEYTRUDA®, in combination with carboplatin and paclitaxel, followed by KEYTRUDA® as monotherapy, is indicated for the treatment of patients with primary advanced or recurrent endometrial carcinoma who are candidates for systemic therapy. KEYTRUDA®, in combination with lenvatinib, is indicated for the treatment of patients with advanced endometrial carcinoma who have disease progression following prior systemic therapy in any setting and are not candidates for curative surgery or radiation. Triple Negative Breast Cancer KEYTRUDA® is indicated for the treatment of patients with high-risk early-stage triple-negative breast cancer (TNBC) in combination with chemotherapy as neoadjuvant treatment, and then continued as monotherapy as adjuvant treatment after surgery. KEYTRUDA®, in combination with chemotherapy, is indicated for the treatment of patients with locally recurrent unresectable or metastatic TNBC whose tumours express PD-L1 (CPS ≥ 10) as determined by a validated test and who have not received prior chemotherapy for metastatic disease. **Dosing** KEYTRUDA® is administered as an intravenous infusion over 30 minutes. The recommended dose of KEYTRUDA® in adults with MPM, HNSCC, cHL, urothelial carcinoma, gastric cancer, esophageal carcinoma, CRC, HCC, biliary tract carcinoma, cervical cancer, RCC, endometrial carcinoma, TNBC, previously untreated NSCLC, or for the adjuvant treatment of melanoma, NSCLC or RCC is either: • 200 mg every 3 weeks or • 400 mg every 6 weeks. The recommended dose of KEYTRUDA® in adults with previously treated NSCLC or for unresectable or metastatic melanoma is 2 mg/kg every 3 weeks. In melanoma and cHL, the recommended dose of KEYTRUDA® in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks. For use in combination, see the prescribing information for the concomitant therapies. When administering KEYTRUDA® as part of a combination with intravenous chemotherapy, KEYTRUDA® should be administered first. For urothelial carcinoma patients treated with KEYTRUDA® in combination with enfortumab vedotin, administer KEYTRUDA® after enfortumab vedotin when given on the same day. For urothelial carcinoma patients treated with KEYTRUDA® in combination with enfortumab vedotin, the recommended initial dose of enfortumab vedotin is 1.25 mg/kg (up to a maximum of 125 mg for patients ≥ 100 kg) as an intravenous solution on Days 1 and 8 of a 21-day cycle until disease progression or unacceptable toxicity. For RCC patients treated with KEYTRUDA® in combination with axitinib, see the prescribing information regarding dosing of axitinib. When used in combination with KEYTRUDA®, dose escalation of axitinib above the initial 5 mg dose may be considered at intervals of six weeks or longer. For endometrial carcinoma and RCC patients treated with KEYTRUDA® in combination with lenvatinib, the recommended initial dose of lenvatinib is 20 mg orally once daily until disease progression or unacceptable toxicity. Patients should be treated with KEYTRUDA® until disease progression or unacceptable toxicity. Atypical responses (i.e., an initial transient increase in tumor size or small new lesions within the first few months followed by tumor shrinkage) have been observed. Clinically stable patients with initial evidence of disease progression should remain on treatment until disease progression is confirmed. For the adjuvant treatment of melanoma, NSCLC or RCC, KEYTRUDA® should be administered for up to one year or until disease recurrence or unacceptable toxicity. For the neoadjuvant and adjuvant treatment of resectable NSCLC, patients should be treated with neoadjuvant KEYTRUDA® in combination with chemotherapy for 12 weeks or until disease progression that precludes definitive surgery or unacceptable toxicity, followed by adjuvant treatment with KEYTRUDA® as monotherapy for 39 weeks or until disease recurrence or unacceptable toxicity. For the neoadjuvant and adjuvant treatment of high-risk early-stage TNBC, patients should be treated with neoadjuvant KEYTRUDA® in combination with chemotherapy for 8 doses of 200 mg every 3 weeks or 4 doses of 400 mg every 6 weeks or until disease progression that precludes definitive surgery or unacceptable toxicity, followed by adjuvant treatment with KEYTRUDA® as monotherapy for 9 doses of 200 mg every 3 weeks or 5 doses of 400 mg every 6 weeks or until disease recurrence or unacceptable toxicity. Patients who experience disease progression that precludes definitive surgery or unacceptable toxicity related to KEYTRUDA® as neoadjuvant treatment in combination with chemotherapy should not receive KEYTRUDA® monotherapy as adjuvant treatment. Neoadjuvant treatment with KEYTRUDA® for 2 doses of 200 mg every 3 weeks or 1 dose of 400 mg every 6 weeks or until disease progression that precludes definitive surgery or unacceptable toxicity, continued as adjuvant treatment in combination with RT with or without concomitant cisplatin for 3 doses of 200 mg every 3 weeks or 2 doses of 400 mg every 6 weeks followed by 12 doses of 200 mg every 3 weeks or 6 doses of 400 mg every 6 weeks as monotherapy or until disease recurrence or unacceptable toxicity. For the complete list of dosing regimens for other indications, please see prescribing information. **Contraindications** KEYTRUDA® is contraindicated in patients with hypersensitivity to pembrolizumab or any of the inactive ingredients. **Precautions/Warnings** Immune-mediated adverse reactions, including severe and fatal cases, have occurred in patients receiving KEYTRUDA®. List of immune-mediated adverse reactions include but are not limited to: pneumonitis; colitis; hepatitis; nephritis; endocrinopathies; severe skin reactions. Transplant-related adverse reactions such as risk of rejection in solid organ transplant recipients; complications of allogeneic haematopoietic stem cell transplantation (HSCT) after treatment with KEYTRUDA®; graft-versus-host disease (GVHD) and hepatic veno-occlusive disease (VOD) have been observed. Elevated liver enzymes when KEYTRUDA® is given in combination with axitinib for RCC. Increased mortality in patients with multiple myeloma when KEYTRUDA® is added to a thalidomide analogue and dexamethasone. Infusion-related reactions including hypersensitivity and anaphylaxis. **Adverse Reactions** Most frequent adverse reactions (reported in ≥ 20% patients) were: KEYTRUDA® as monotherapy: fatigue, diarrhoea, and nausea. KEYTRUDA® in combination with chemotherapy or chemoradiotherapy (CRT): anaemia, nausea, diarrhoea, fatigue, constipation, vomiting, neutrophil count decreased, and decreased appetite. KEYTRUDA® in combination with axitinib or lenvatinib: diarrhoea, hypertension, hypothyroidism, fatigue, decreased appetite, nausea, arthralgia, vomiting, weight decreased, dysphonia, abdominal pain, proteinuria, palmar-plantar erythrodysaesthesia syndrome, rash, stomatitis, constipation, musculoskeletal pain, headache, and cough.

Before prescribing KEYTRUDA®, please consult full prescribing information. Full prescribing information is available upon request.

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SG-KEY-00960 APR/2026

SCIENTIFIC **AGENDA**

DAY TWO

01 AUGUST 2026
SATURDAY

09:00 - 13:00 HRS
SINGAPORE TIME

Session 4: Colorectal Cancers
Chairpersons: **Evelyn Wong, Singapore | Kai-Keen Shiu, UK**

09:00 – 09:20	AI in Colorectal MDT: From Concept to Clinic **Iain Tan, Singapore**
09:20 – 09:50	Breakthrough in BRAFV600E Mutant mCRC: An Update in Clinical Trials and Guidelines in 2026 ***Satellite Symposium by Pierre Fabre + Merck*** Chairperson: **Dawn Chong, Singapore** Speaker: **Jeanne Tie, Australia**
09:50 – 10:20	Motion: In dMMR stage II/III CRC, Neoadjuvant Immunotherapy Should Be Standard of Care Moderator: **Evelyn Wong, Singapore** Pro: **Kai-Keen Shiu, UK** Con: **Cathy Eng, USA**
10:20 – 10:50	Evolving Treatment Landscape in MSI-H/dMMR CRC: What is the Role of Dual IO Therapy? ***Supported by BMS*** Moderator: **Evelyn Wong, Singapore** Speaker: **Heinz-Josef Lenz, USA**
10:50 – 11:15	**Coffee Break & Networking**
11:15 – 11:35	Building an Early Onset Gastrointestinal Cancer Service **Cathy Eng, USA**
11:35 – 11:55	Adjuvant Adjuncts Beyond Chemotherapy: Aspirin, Vaccines and the prevention-adjuvant continuum **Toh Han Chong, Singapore**
11:55 – 12:10	Beyond Hotspot: Why Comprehensive Genomic Profiling Matters in Metastatic Colorectal Cancer ***Supported by Guardant Health*** **Vashishth Maniar, India**
12:10 – 12:30	Organ Preservation in dMMR Rectal Cancer: Selecting the Right Patient, Strategy, and Surveillance ***Satellite Symposium by GSK*** **Koo Si-Lin, Singapore**
12:30 – 12:55	Challenge the Experts: Colorectal MDT Moderator: **Kai-Keen Shiu, UK** Panelists: **Chee Cheng Ean, Singapore | Jeanne Tie, Australia** **Wang Fuqiang, Singapore | Isaac Seow, Singapore** **Heinz-Josef Lenz, USA | Ekaphop Sirachainan, Thailand**
12:55 - 13:00	**Closing Remarks and Takeaways from Day Two**

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