APPENDICEAL GOBLET CELL ADENOCARCINOMA

GCA-GLOBE Centre Participation Guide

International Treatment and Outcome Study of Appendiceal Goblet Cell Adenocarcinoma

CENTRE PARTICIPATION GUIDE VERSION 1.0 · JUNE 2026

What Does a Participating Centre Need to Do?

GCA-GLOBE is an international multicentre retrospective cohort study of appendiceal goblet cell adenocarcinoma. The core study is designed to be feasible for centres with only a small number of eligible patients. Colonoscopy yield, CT interpretation and exploratory texture analysis, patient experience and survivorship, and selected healthcare-utilisation analyses are separate optional modules.

Centres interested in participating can contact **interested@gca-europe.org** or visit **https://gca-europe.org**.

Radiology and CT texture-analysis lead: **Isabelle De Kock, UZ Gent, Ghent, Belgium**.

Minimum Requirements for Core Study Participation

Each participating centre should:

1. Appoint one local surgical or clinical lead and one local pathology investigator.
2. Obtain the required local ethics, governance or institutional approval.
3. Identify all potentially eligible adult patients diagnosed during the agreed study period, provisionally 1 January 2010 to 31 December 2025.
4. Search using contemporary and historical diagnostic terms, including goblet cell adenocarcinoma, goblet cell carcinoma, goblet cell carcinoid, adenocarcinoid and adenocarcinoma ex-goblet cell carcinoid.
5. Confirm locally that each submitted case is compatible with primary appendiceal GCA.
6. Complete the core study variables from existing medical records and pathology reports.
7. Submit only coded or pseudonymised data. The local centre must retain the re-identification key.
8. Verify submitted data and respond to a limited number of data-quality queries.

No study-specific treatment, additional investigation or direct patient contact is required for the core retrospective cohort.

Core Data to Be Collected

Centres should prioritise:

- Patient demographics, presentation and date of diagnosis.
- Preoperative imaging impression and whether tumour was suspected.
- Index operation and whether completion right hemicolectomy was performed.

- Original pathology terminology, WHO grade, pT/pN stage, margins, lymphovascular and perineural invasion.
- Perforation, distinguishing tumour perforation from perforation through a non-tumour-bearing appendix segment where possible.
- Number of lymph nodes examined and positive at index and completion surgery.
- Residual tumour, nodal upstaging and postoperative morbidity after completion surgery.
- MDT recommendation and definitive treatment received.
- Relevant guideline or local-policy context, concordance with MDT advice and reasons for differences where documented.
- Ovarian involvement and ovarian surgery in female patients, where applicable.
- Systemic treatment, recurrence, last follow-up and vital status.

The most important completion-surgery outcome is whether at least one previously unrecognised positive regional lymph node was found in a clinically non-metastatic patient.

Local Team

Required for the core cohort:

- One surgical or clinical investigator.
- One pathology investigator.

Recommended where locally relevant:

- A second surgical investigator, trainee, research coordinator or data manager to support case identification and data entry.
- Medical oncology or peritoneal malignancy input for patients receiving systemic treatment or CRS/HIPEC.

Only required for optional modules:

- A radiology investigator for centres participating in CT review.
- Staff able to contact and consent patients for the patient-reported experience study.

Optional Modules

Guideline Concordance and Colonoscopy Yield

These analyses mainly use routinely available records and form part of the core or extended dataset. Centres should record the relevant guideline or local-policy context where identifiable, alongside MDT advice and treatment received. Colonoscopy timing, completeness, detected lesions and management-changing findings should be collected where available.

CT Interpretation and Exploratory Texture-Analysis Substudy

Participating centres may identify de-identified acute-phase contrast-enhanced CT examinations for cross-centre blinded review and exploratory quantitative texture analysis. Radiologists who routinely report acute abdominal CT may participate as readers. Dedicated radiology oversight and suitable software are required for segmentation and texture analysis. Where feasible, GCA examinations will be compared with matched non-neoplastic appendicitis controls and linked to WHO grade and other adverse pathological characteristics.

Patient-Reported Experience Substudy

Centres may invite eligible patients to complete a questionnaire or participate in interviews addressing communication, decision-making and survivorship. This module requires separate ethics approval, informed consent and appropriate arrangements for direct patient contact.

Healthcare Utilisation in Localised Low-Grade GCA

Centres with reliable records may contribute an exploratory analysis of additional investigations, consultations, operations, admissions, complications, readmissions and surveillance. A formal cost-effectiveness analysis is not required for initial participation.

Initial Feasibility Survey

Before full data collection, each interested centre will be asked to report:

- Estimated number of eligible patients.
- Available years of case capture.
- Availability of pathology reports and follow-up data.
- Availability of preoperative CT examinations.
- Availability of oncology treatment data.
- Interest in optional radiology, patient-experience/survivorship or healthcare-utilisation modules.

Practical Workload

The workload will depend on the number and complexity of cases. The core dataset should be completed using routinely available records. Extended variables and optional substudies should only be collected where feasible and reliable. A centre can participate in the core cohort without participating in any optional module.

Authorship and Recognition

Centre participation, eligible case identification and timely delivery of sufficiently complete and verified data will qualify contributors for collaborator recognition. Writing-group authorship will additionally require a substantial contribution to study design, analysis, interpretation or manuscript preparation.

Contact

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