ESMO Clinical Practice Guidelines

Metastatic colorectal cancer: Clinical Case Presentation

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Disclosures

Dirk Arnold has declared no potential conflicts of interest

Patient profile and presentation

Patient details
- 68-year-old woman
- Teacher
- Single
- Enjoys hiking

Patient presented with
- Constipation and weight loss
- ECOG PS 0

Colonoscopy/biopsy
- Adenocarcinoma in descending colon

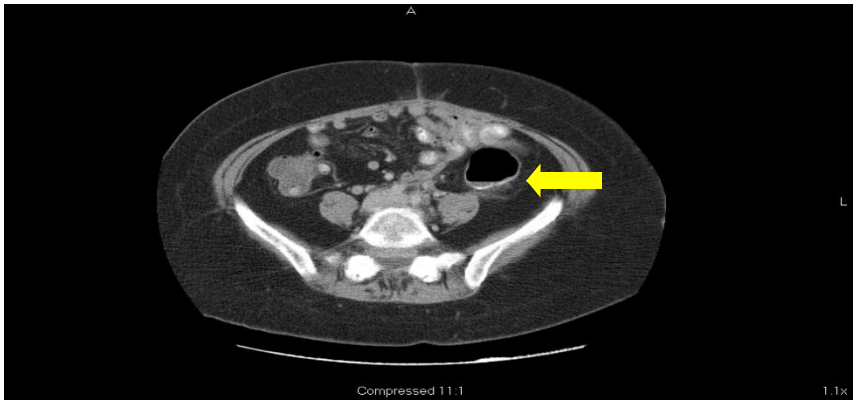
Laboratory tests
- CEA: 68 ng/mL

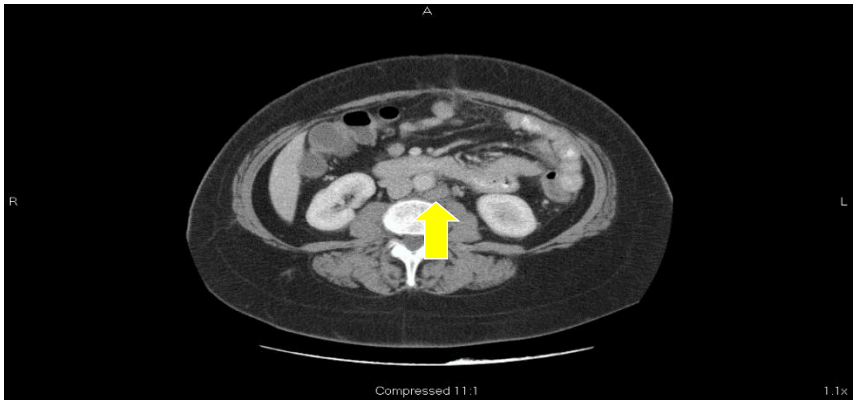
CT scans
- No distant metastases

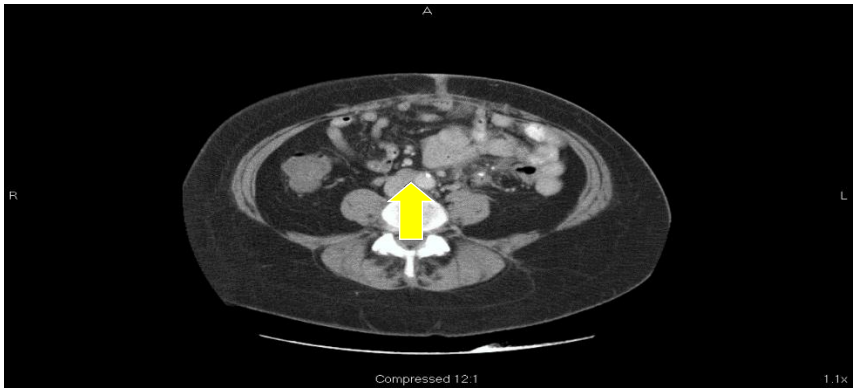
Initial management: Surgical procedure

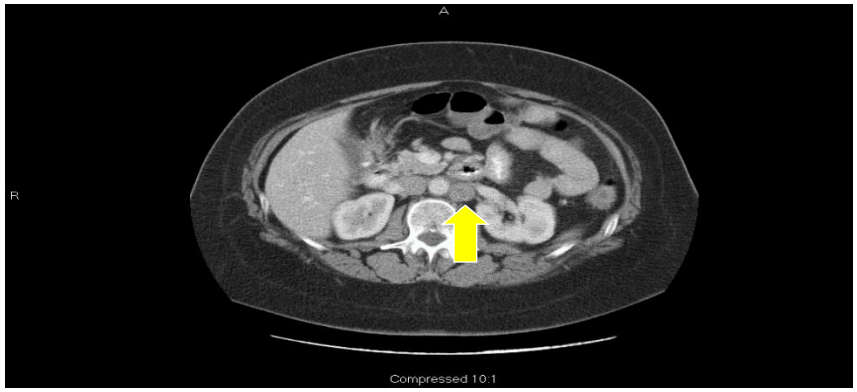
- Left-sided hemicolectomy
- Pathology:
  - pT3 N1 M0 R0 G3
  - 3 of 15 lymph nodes positive
  - KRAS (exon 2) wild type
- Post-operative CEA: 15 ng/ml
- Adjuvant therapy refused by her (toxicity concerns)

At 6 month follow-up visit: CT scan









Patient case: 68 y/o female patient

- CT proven peritoneal and lymphatic relapse
- No symptoms, ECOG PS 0
- CEA: now 266 ng/ml
- Pathology:
  - Primary tumour: Adenocarcinoma G3; WT KRAS (exon 2)

Q1: What else is undoubtedly needed before decision making ?

1. Nothing - information are complete
2. (expanded) RAS status only
3. RAS and BRAF status
4. RAS, BRAF and MSS status
5. all of those information are less relevant than PET

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- Pathology:
  - Primary tumour: Adenocarcinoma G3; wild-type KRAS (exon 2)
  - wild-type RAS; wild-type BRAF

Q2: What would be your preferred suggestion for a 1st line (induction) treatment?

1. Fluoropyrimidine alone +/- bevacizumab
2. Combination chemo* alone
3. Combination chemo with Bevacizumab
4. Combination chemo with anti-EGFR (Cetuximab or Panitumumab)
5. Triplet chemotherapy (FOLFOXIRI) +/- Bevacizumab

* any fluoropyrimidine (5FU or Capecitabine) with oxaliplatin or FOLFIRI

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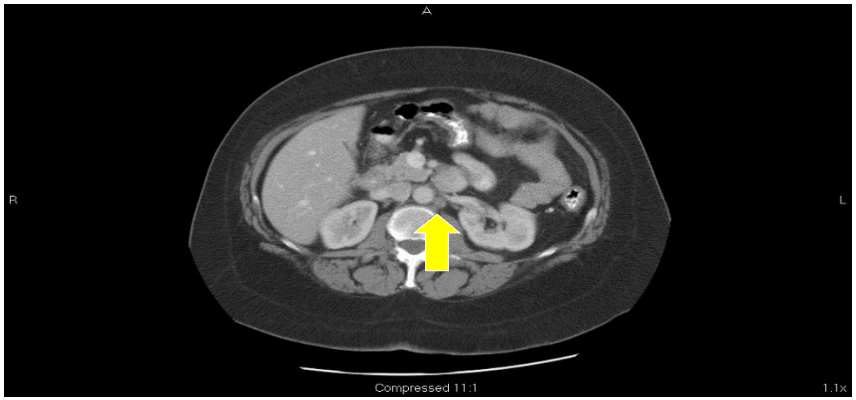
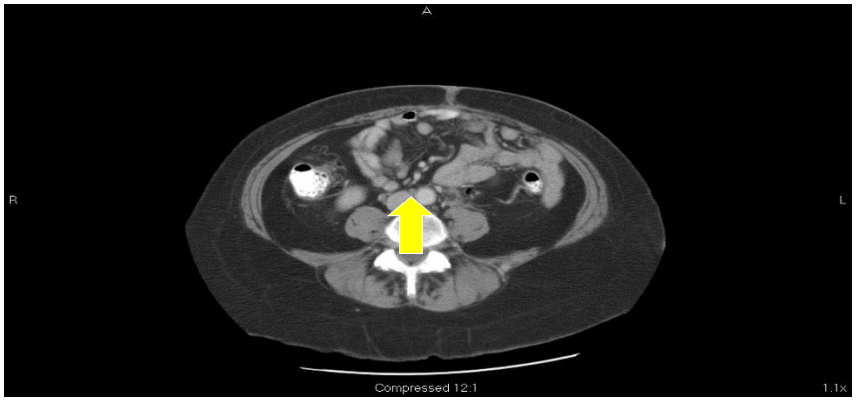
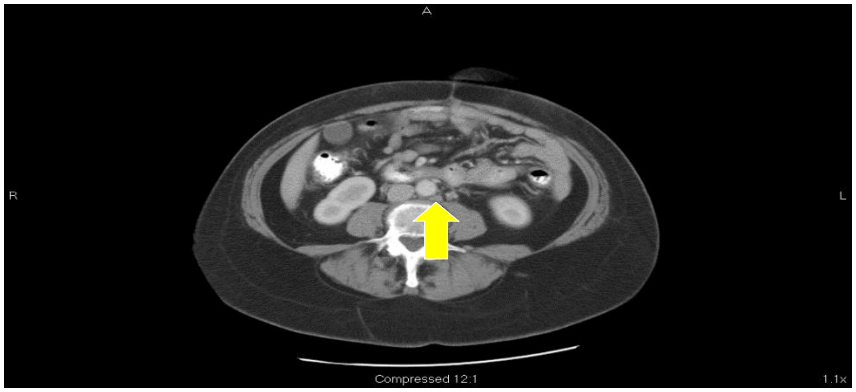
Patient case: 68 y/o female patient

- Discussion with the patient on decision making
  - „too aggressive“ disease for monotherapy
  - wanted to avoid symptomatic toxicity
  - upfront consideration of de-escalation
- after 2 mos.: CEA decreased
- after 4.5 mos.: Asthenia, neuropathy CTC 2°

At 4 mos.: Follow-up visit CT scan







- “minor response” (= “stable disease” according to RECIST)
- no tumour-related symptoms, mild neuropathy
- CEA now normalized

Q3: What would be your preferred management here?

1. Stop all treatment – until progression
2. Continue with Bevacizumab alone
3. Continue with FP* alone
4. Continue with FP* plus Bevacizumab
5. Continue with FOLFIRI

* any fluoropyrimidine (5FU or Capecitabine)

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Patient case: 68 y/o female patient

- So far: 4 mos. FOLFOX/Bev → 9 mos. Cape/Bev
  - well tolerated
  - discontinued for 4 weeks for holiday (cruise)
- Now:
  - CEA increases, lymph nodes with progressive disease
  - clinically excellent, neuropathy recovered

Q4: What would be your preferred management here?

1. Wait until she gets symptomatic
2. Re-start Oxaliplatin (Re-Induction)
3. FOLFIRI
4. FOLFIRI plus anti-EGFR
5. FOLFIRI plus Bevacizumab
6. FOLFIRI plus Aflibercept

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Patient case: 68 y/o female patient

- So far:
  - 4 mos. FOLFOX/Bev → 9 mos. Cape/Bev (= 13 in total)
  - 7 mos. FOLFIRI/Aflibercept (with some interruptions), stable disease
- Now:
  - (Few) ascites, CEA increases again
  - Some fatigue
  - ECOG PS 1

Q5: What would be your preferred management now?

1. Best supportive care
2. EGFR alone
3. Irinotecan & EGFR
4. Re-Induction of FOLFOX
5. Regorafenib
6. TAS 102 (if available)

Q5: What would be your preferred management now?

1. Best supportive care
2. EGFR alone
3. Irinotecan & EGFR
4. Re-Induction of FOLFOX
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  - 4 mos. Panitumumab single agent → some response, then progression
- What now?
  - FOLFOX (Re-Induction) → Regorafenib ?
  - Regorafenib → FOLFOX (Re-Induction) ?
  - How to integrate TAS 102 ?

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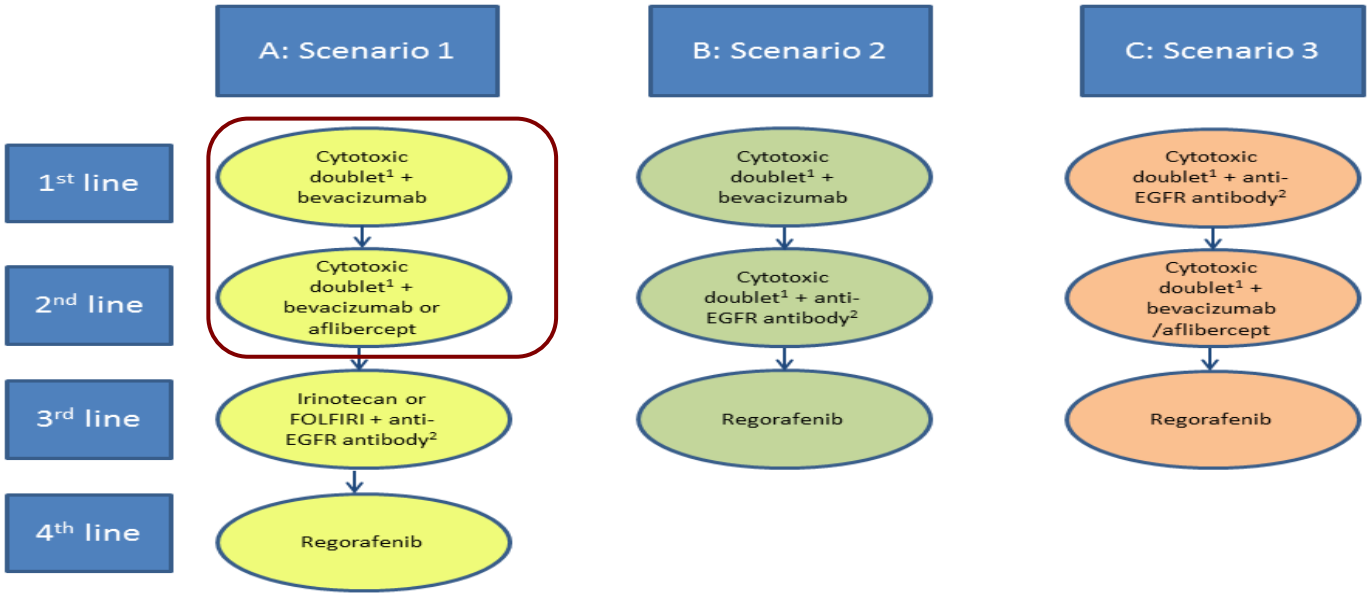
Treatment “lines“: Scenarios

Figure 1. Strategic scenarios in the continuum of care of metastatic CRC



[1]cytotoxic doublets: fluoropyrimidine + oxaliplatin or irinotecan; [2]RAS wild type

Van Cutsem, Cervantes, Nordlinger & Arnold; Ann Oncol 2014