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## Impact of anti-VEGF therapy in metastatic colorectal cancer with an intact primary tumour.

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Randomized, Phase III Trial of Panitumumab With Infusional Fluorouracil, Leucovorin, and Oxaliplatin (FOLFOX4) Versus FOLFOX4 Alone As First-Line Treatment in Patients With Previously Untreated

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650

**Background:** The management of metastatic colorectal cancer (mCRC) with anti-VEGF therapy and a fluoropyrimidine-containing chemotherapy is well established in first and second line therapy. However the role, safety and benefits of anti-VEGF therapy (Bevacizumab)

Metastatic Colorectal Cancer: The PRIME Study  
 Jean-Yves Douillard et al., J Clin Oncol

Pharmacogenetic analysis in metastatic colorectal cancer (mCRC) patients (pts) treated with second-line irinotecan (IR)+/- cetuximab (CB): The EPIC experience  
 D. Yang, J Clin Oncol

First-line treatment with modified FOLFOX6 (mFOLFOX6) + panitumumab (pmab) or bevacizumab (bev) in wild-type (WT) RAS metastatic colorectal carcinoma (mCRC): Tumor response outcomes beyond RECIST.  
 Fernando Rivera et al., J Clin Oncol

Randomized Phase III Study of Panitumumab With Fluorouracil, Leucovorin, and Irinotecan (FOLFIRI) Compared With FOLFIRI Alone As Second-Line Treatment in Patients With Metastatic Colorectal Cancer  
 Marc Peeters et al., J Clin Oncol

Pharmacogenomic analysis of the triplet combination of gemcitabine, oxaliplatin, and cetuximab as salvage therapy for metastatic colorectal cancer (mCRC) patients  
 A. Hernandez, J Clin Oncol

Panitumumab regimen improved OS in metastatic colorectal cancer  
 Healio

Early tumor shrinkage after cetuximab predicts survival in metastatic colorectal cancer  
 Healio

Clinical outcome of patients with chemorefractory metastatic colorectal cancer treated with trifluridine/tipiracil (TAS-102): a single Italian institution compassionate use programme  
 Alfonso Reginelli et al., ESMO open.

in specific subgroups including those with an intact primary tumour (IPT), are not well described. **Methods:** Consecutive mCRC pts enrolled from January 2009 were identified from a prospective multi-site Australian registry. Survival and key safety endpoints were explored for pts with an IPT versus pts with a resected primary (RPT). Differences in outcomes were compared using log-rank test and Kaplan-Meier curves. **Results:** Of 1,204 pts with mCRC, 826 (69%) eligible pts were identified. Anti-VEGF therapy use in the first-line setting was similar in pts with an IPT [200/313 (64%)] vs. a RPT [357/513 (70%)]. In both groups the addition of anti-VEGF therapy was associated with greater PFS; IPT 8.5 vs. 4.7 months (HR 0.73,  $p=0.017$ ) and RPT 10.8 vs. 5.8 months (HR 0.67,  $p=0.0002$ ). OS was longer in anti-VEGF treated pts; IPT 20 vs. 14.8 months (HR 0.66,  $p=0.0046$ ) and RPT 24.4 vs. 17.3 months (HR 0.71,  $p=0.0039$ ). A trend for more GI perforations with anti-VEGF therapy use was seen in pts with IPT (4.5% vs. 1.8%,  $p=0.33$ ), but not RPT (1.7% vs. 1.9%). The rate of bleeding and thrombosis was lower in the IPT group treated with bev: 1.5% vs. 5.3%,  $p=0.05$  and 1.5% vs. 2.7%,  $p=0.47$  respectively. In comparison, RPT pts treated with and without anti-VEGF therapy had a bleeding rate of 3.4% vs. 0.6%,  $p=0.07$ , and a thrombosis rate of 5.9% vs. 0.6%,  $p=0.007$ . **Conclusions:** In routine clinical practice clinicians appear comfortable using anti-VEGF therapy in pts with an IPT. Superior PFS and OS outcomes were seen with addition of anti-VEGF therapy, with no evident impact of primary tumor status. There was a trend for a higher GI perforation rate in anti-VEGF treated IPT pts, but a lower rate of other adverse events. This may reflect clinicians avoiding anti-VEGF therapy in pts considered at increased risk of these complications. Further analysis is underway to explore this possibility.

A randomized phase II study of weekly paclitaxel with or without pelareorep in patients with metastatic breast cancer: final analysis of Canadian Cancer Trials Group IND.213.

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