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TRANSCRIPT

Transcript Details

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Recent Advances in the Use of Anti-EGFR for Metastatic Colorectal Cancer

In the last 5 years, what is the most significant change in the use of anti-EGFR?

If we think of the last 5 years. I think of 2 major changes, or refinement at least into 2 direction. First is the fact that it's only been in the last 3-4 years, that the side effects of biologics are focused on. I think this is major change because whenever you see advance colorectal cancer that is left sided, and Ras wt, not starting with an anti-EGFR as companion to Chemo I think may be regarded as is a big mistake in most cases, I can only think of rare exception where this dogma is not implemented. The 2nd most important, which is less important than the 1st one. The 2nd is the idea of reusing anti-EGFR compounds in RAS wt patients, when thy have already been used. Two different conditions which can be done. 1 is RAS wt is discontinued despite the continued response at the first time it was used, called reintroduction. The 2nd setting is when the tumour is first exposed to anti-EGFR in 1st line and then progressed and a window therapy has been implemented and a rechallenge can be done. This is the 2 most advances in the use of anti-EGFR that I think.

Role of tumour sidedness in treatment decision and do you think it is here to stay?

I already emphasised the role of tumour sidedness and tumour location which is not the same thing. And I think it is certainly here to stay because of the huge difference in the efficacy of the two biologics among our armamentarium in the treatment of this disease. If we do not use anti-EGFR on the left side; 3 trials have shown that you may lose 6-11 months in median OS time. Whereas in the right side, if you use Bevacizumab, you may gain 5- 8 months of life, compared to using anti- EGFR, because of the concordance of these trials. I think this message is so strong that it is here to stay.

Are you using Liquid Biopsy in clinical practice and in which cases?

We are not using liquid biopsy for colorectal cancer management at present time. We are using it for management for no small lung cancer. Sometimes, in order to make diagnosis, in those people who are not candidate for invasive procedures. But in terms of advance CRC, so far, outside clinical trail we are not using it.

What are the clinical considerations when initiating adjuvant therapy?

When you're dealing with adjuvant phase of this disease. Of course, Your mind goes to the end point of that. And the end point of that is increasing the cure rate. We consider. 1st consideration is the risk of the patient. If its high, of course you are more inclined Doublet regiment. If its low, then you may be inclined to use single agent Capecitabine. 2nd The extent of benefit. Again, the patient measures or interpret this, only when benefit is express in terms of absolute benefit long term, like 5 years, disease free survival, absolute gain.

And by coupling this 2, risk and benefit, we end up with the 3-potential decision. 1st is nothing, 2nd is Capecitabine alone and 3rd FOLFOX or CAPOX for 3 or 6 months depending on the risk.