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TRANSCRIPT

Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/medical-industry-feature/a-closer-look-at-the-ras-wild-type-crc-treatment-landscape/11115/

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A Closer Look at the RAS Wild-Type CRC Treatment Landscape

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

I recon 2 significant changes that we have witnessed. The 1st is the combination CT together with an anti EGFR inhibitor, we can downsize the tumours and make them resectable. So, this gives hope to the patient for cure which was not the case couple years ago. The 2nd important improvement is that we learned that patients with left sided tumours who are RAS wt have a substantial benefit when they are treated with an EGFR inhibitor plus doublet in 1st line. So their median OS is extended to more than 13 months.

What is the evolving role of ICI in CRC?

Compared to other diseases like a melanoma and lung cancer, the role of checkpoint inhibitors if you look at the number of patients who may benefit from those treatments are smaller. We know that 5% of patients have tumours that are suitable for treatment of check point inhibitors. And for this 5% we have seen very promising data in 2nd line treatment that Checkpoint Inhibitors can induce long lasting responses and patients who have received all other possible treatment before. And we have also seen in 1st line for combination of a CTLA4 and PDL1 inhibitor, very promising responses with long lasting responses and short-term observation time of these patients tell us that they may enjoy a very long survival. However, the data are a bit to early to be sure about the plateau that may develop in the end.

What is the role of Rechallenge in clinic practice and how to select patients for Rechallenge?

Rechallenge is a real issue in CRC. Because we would like to have our options for later line therapies as long as possible. So if we have a patient with a nice response with CT plus an EGFR Inhibitor in Ras wt disease, and after discontinuation of treatment and we see that this response is long lasting, I would always try to Rechallenge this patient with the same regiment, same CT and an anti-EGFR antibody, because it is very likely that this patient has a tumour that is very sensitive to EGFR pathway. I have observed personally patients who are treated for 4 years on and off with this kind of approach. And this is for me is still 1st line treatment, we should be very aware of whether there is a possibility to continue or Rechallenge our 1st line treatment.

It's a different issue of course if you have patient who has a very limited response, in very early has a tumour progression, in this patient I would change the CT and most likely change would the antibody. Also, we have very interesting data, if we do sequential liquid biopsy on those patients who had Ras WT disease, and still remain RAS wild type on liquid biopsy, these are the patient who are most likely benefit on the rechallenging approach.