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/managing-mcrc-based-on-prognostic-factors/11116/

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Managing mCRC Based on Prognostic Factors

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

I think in the last 5 years the most important finding was that anti EGFR agents have different activities in left vs right sided CRC. We have results meanwhile specifically from CALGB but also Fire 3 study that anti EGFR agents are effective with regard to response rate and overall survival superficially in left sided left CRC. However, in right we have evidence, that anti EGFR agents does not act beneficial on overall survival, but if we focus on the response rate or conversion therapy, we can see that in this case anti-EGFR maybe beneficial.

What are your thoughts on the use of CMS in mCRC? Do you think it is ready for clinical practice or can be used in clinical practice in the future?

The Consensus Molecular Subtype have been developed as a prognostic tool. We see that CMS 1 is association with very poor survival, and CMS 1 is immunogenic subtypes, while CMS 2 subtypes are associated with most longest survivals. In my view, the evaluation of CMS subtypes presently, is purely academic, has been published for Fire 3 and CALGB. And we can see comparable outcome specifically for CMS 2 but we also have divergent results with regards to other subtypes. We can see for example in FIRE 3 that in CMS 4 subtype the addition of Cetuximab + FOLFIRI is more markedly beneficial that addition of Bevacizumab + FOLFIRI. In contrast to CALGB study, the CMS 1 addition of Cetuximab + Oxalipatin, is detrimental, while Bevacizumab + Oxalipatin appears to be better.

So, I think we have much to learn in addition we are visiting new CMS classification is on the way and being produce. In the moment, CMS no true value in daily clinical practice.

Detection of the *BRAF* V600E mutation has important genetic, prognostic, and therapeutic implications for patients with metastatic colorectal cancer. What are the current and future advances in management of those patients in light of the newly released studies?

While what we know is BRAF mt mCRC is associated with very poor prognosis, and that overall survival typically on the range of 11 -14 months. Now based on the small subgroup analysis, we have data from TRIBE study supporting the use of very intensive and aggressive therapy of FOLFOXIRI and Bevacizumab and in that subgroup we got an overall survival of 19 months, a recommendation went into on ESMO guideline.

Most important study now is the BEACON study, patient that have been pre-treated, the triple agent was anti-EGFR for example: Cetuximab +BRAF inhibitor + MET inhibitor is in fact beneficial for these patients. Presently, awaiting for the registration of triplet therapy, and from then on I personally believe, based on the significance survival gains as compared to the controlled arm, this triplet therapy most likely will become the standard of treatment.