

Cetuximab treatment in metastatic CRC

Gilbert Morgan MD
Skåne University Hospital

Our patient

68 year old woman, vital for her age

Obesitas, diabetes, hypertension

3 months of diarrhea and fatigue

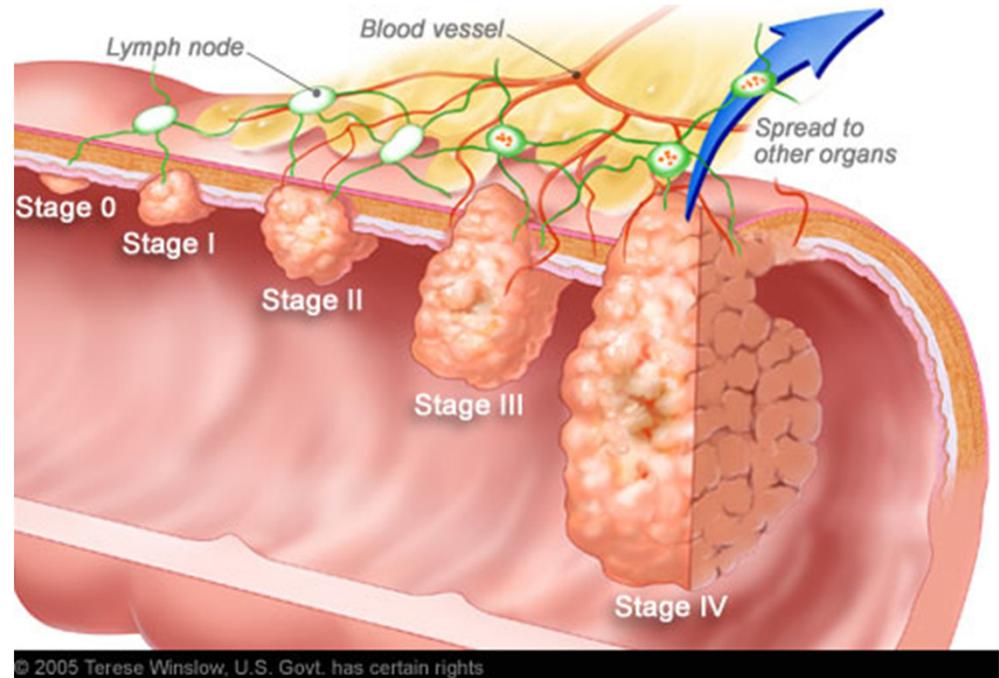
Went to the primary care physician: blood tests showed Hb 95

PC physician referred to surgery dept for colonoscopy which found a 5 cm mass

Sent for CT of thorax and abdomen: no sign of metastasis

No adjuvant therapy was recommended & underwent right hemicolectomy:

PAD: Adenocarcinoma, T3N0 with 0 of 8 lymph nodes.



5 years down the road

With a Routine Check up:

ASAT and ALAT were elevated & pain in RUQ

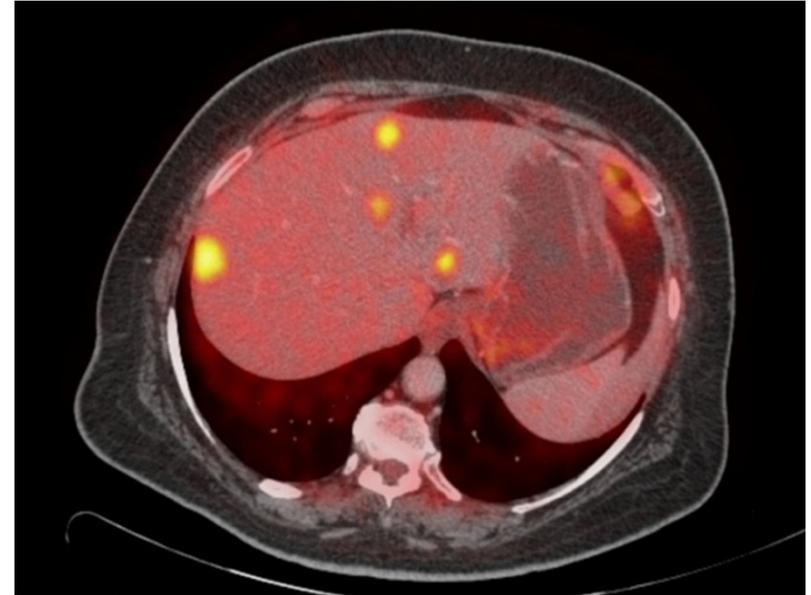
CEA levels were rising and PET CT was ordered

PET: 6 lesions in the liver and 2 in the right lung

Biopsy of the liver confirmed metastatic cancer, KRAS and NRAS WT

FOLFIRI & bevacizumab 3 months- moderate regress of both lung and liver mets, after another 3 months liver progression.

FOLFIRI and Cetuximab was recommended.



Skin Toxicity with Cetuximab

Cetuximab/FOLFIRI and *RAS* Mutation Status in Colorectal Cancer

- The addition of cetuximab to FOLFIRI was associated with significant improvements in overall survival and progression-free survival among patients with wild-type *RAS* at all loci.
- No benefit of adding cetuximab was observed among patients with any *RAS* mutation.

The patient developed massive pruritus after the first cycle Folfiri Cetuximab

With the first checkup there was a need to reduce to 80% cetuximab

Nothing helped the skin toxicity and it was affecting her psychosocial well being

After 3 months of treatment- decrease of both liver and lung lesions

However regardless of the positive effect of treatment, the patient was depressed, was very much affected by the skin toxicity and did not want to continue.

Changed treatment to FOLFOX which after 3 months showed stable disease

Skin toxicity of Cetuximab

Cetuximab is a monoclonal antibody directed to the epidermal growth factor receptor (EGFR) binding site.

The major side effect is skin toxicity, skin rash, dry skin, pruritus, and nail changes.

The most common toxicity is a papulo-pustular eruption (60%–80% of patients).

Incidence and severity are normally dose-related

The rash is reversible after 4 weeks without treatment

The papulo-pustular eruption are made of erythematous follicular papules that evolve into pustules. These may become infected, with *S.*

aureus



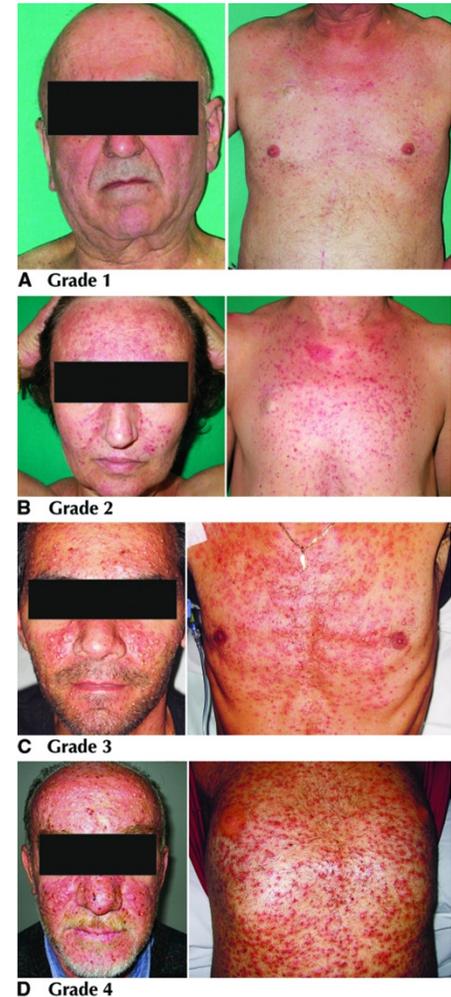
How to intervene with skin toxicity

Grade 1: There are no dose modifications needed or specific treatments started. General interventions recommended

Grade 2: There are no dose modifications needed or specific treatments started. Topical antibiotic (clindamycin 1% gel, erythromycin 3% gel/cream, or metronidazole 0.75%–1% cream/gel) can be used 2 times per day until improvement to grade

Grade 3: Interrupt treatment for ≤ 21 days, until there is improvement to grade ≤ 2 .

Grade 4: Interrupt EGFR-i treatment immediately and definitively. Provide topical treatment as indicated for grades 2 and 3. Treat with steroids



THANK YOU!!!!



European Society for Medical Oncology

ESMO PRECEPTORSHIP PROGRAM