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The value of everolimus as II. line treatment in pancreatic NEN
DISCLOSURE OF INTEREST

- No conflict of interest
About the patient...

- Pain in the abdomen, bloatness > pancreatic tm.
- 4/2009: resect. tm. corp. pancreatis
  - Dg: tm. endocrinum pancreatis, 2x1.5x2 cm, Ki67 >2%, 2-10 mitosis on 10 HPF
  - MSCT thorax, abdomen, pelvis: no metastasis

- Decision: active surveillance
Beginning of the treatment...

- Mild abdominal discomfort, mild nausea
- 9/2013 MSCT > multiple nodes (11 in total) in liver, around tail of pancreas and stomach, max 2x1.6 cm
  - Octreotid scan: significant expression recorded

- Decision: octreotide treatment
  - octreotide LAR 20 mg 9/2013 - 3/2014 > progression
  - octreotide LAR 30 mg 3/2014 – 9/2014 > progression
  - Octreotide LAR 40 mg 9/2014 – 5/2015 > mild progression > 9/2015 > signif. progression (hepatic. met. 64 mm max.)
Before II. line of CT (9/2015)
Changing the treatment...

- 9-10/2015: everolimus 10 mg/day
  - Initial severe stomatitis, mild rash, intermittent dyspnoea, loss of weight, new-onset DM
  - 12/2015 MSCT: regression of all nodes (max 42 mm)
  - 4/2016 MSCT: partial regression of non-hepatal nodes
  - 8/2016 – 12/2018 MSCT: stable disease

- Continuation of everolimus 10 mg/day, milder symptoms
Usually everolimus has:

- PFS 9.7 mths
  - Our patient currently has **40 mth PFS** on everolimus after no response on octreotide
- PR 9.6%
  - Our patients had dramatic response (**35% reduction** in tm. size after 3 months of treatment)

Even in patients with heavy tm. burden, poor response to octreotide, and many comorbidities everolimus might offer significant response

The importance of therapeutic compliance & treating the side effects!