Clinical cases in colorectal cancer: Adherence to the ESMO Clinical practice guidelines

Dirk Arnold, MD
Medical Director, Hubertus Wald Tumor Center
University Comprehensive Cancer Center
Hamburg-Eppendorf (UCCH), Germany
CASE #1:

75 year old lady with stage III disease
Mrs. O.W., 75 years old

- Mild anemia in "routine" control
- FOBT positive
- Colonoscopy: non-obstructing mass in sigmoid colon
- Biopsy: adenocarcinoma
- CEA: not elevated
- CT: no evidence for further mets.

→ Left hemicolecctomy

Courtesy of University Cancer Center Hamburg
Factors to be considered for decision making

- Tumor characteristics
  - Which information is really needed and useful – clinically, and/or in molecular testing?
- Patient condition and comorbidities
  - What is our aim – and are there limitations by non-tumor related factors?
- Patient preferences
  - Adjuvant therapy is never a "must"!
Mrs. O.W., 75 years old

Pathology report:

- Adenocarcinoma, G3 differentiation
- R0 resection
- N2 status (6/15)
- Lymphatic and venous invasion
- Tumor budding high
- no KRAS mutation
Mrs. O.W., 75 years old

**Patient conditions:**

- Karnofsky PS 0-1
- Comorbidities: mild hypertension only (no tx.), chronic back pain (NSAR)
- Well educated, living with 75 year old husband (who needs some supporting care from her)
Mrs. O.W., 75 years old

*Patient’s preferences and thoughts (on consultation):*

- "Doctor, you are the expert – tell me what has to be done..."
- "...of course, I want to be cured from that disease..."
- willing to accept tx.-related toxicities
- would accept either port-a-cath or oral medication, if indicated
**Question 1**

*What is your preferred option for therapy?*

1. No treatment
2. 5FU/FA – infusional regimen
3. Capecitabine single agent
4. FOLFOX
5. XELOX
6. Any other
Mrs. O.W., 75 years old

03 May 2011: Hemicolectomy done

07 May 2011: Fluid in abdominal cavity → radiography, CT scan: suspected anastomotic leakage → re-laparotomy

Mid May 2011: Again re-laparotomy: biliary fistula, lavage, external draining, etc.
Wound dehiscence after re-laparotomy
Secondary wound closure
Mrs. O.W., 75 years old

03 May 2011: Hemicolecctomy done

26 May 2011: Immediate shortness of breath → spiral CT: Pulmonary embolism
Diagnosis of extended TVT → anticoagulation

11 June 2011: Severe fever, infection → diagnosis of pneumonia.
Bronchocopy.

18 June 2011: Improved → discharged from hospital
03 May 2011: Hemicolecotemy done

13 July 2011: re-presentation after recovery:
No fever, CRP normalized
Wound closure almost completed (1.5 cm dehiscence)
No shortness of breath on excercise
Anticoagulation therapy without problems

→ Adjuvant treatment to be initiated (in stage IIIb disease) 10.5 weeks after resection?
Question 2

What is your preferred option for therapy?

1. No adjuvant treatment - because of adverse events / post-OP conditions
2. No treatment - because of delay of initiation
3. No treatment - because of both reasons
4. Adjuvant treatment with fluoropyrimidine plus oxaliplatin
5. Adjuvant treatment with fluoropyrimidine alone
CASE #2:

64 year old male patient with stage II colon cancer
Mr. M.F., 64 years old

- Complains of abdominal pain, changes in stool frequency
- Colonoscopy: semicircular, obstructing mass in right colon
- Biopsy: invasive adenocarcinoma
- CEA: slightly elevated
- CT: no evidence for further mets.

→ Right hemicolecetomy

Courtesy of University Cancer Center Hamburg
Mr. M.F., 64 years old

Patient conditions:

- Karnofsky PS 0-1
- Mild metabolic syndrome: BMI 28.5
- Diabetes IIb (oral antidiabetics), well controlled, no evident neuropathy
- Mild hypertension (ACE inhibitor)
Mr. M.F., 64 years old

Pathology report

- adenocarcinoma
- T4 (peritoneal adherence)
- G3 differentiation
- R0 resection, No
- No lymphatic invasion, No venous invasion, N0 (0/16)

University Cancer Center Hamburg
Question 1

Can you make a recommendation based on this?

1. Yes, my recommendation is clear
2. No, would like to have more *personal / clinical information* (e.g. on motivation etc.)
3. No, would like to have more *molecular* information from the tumor specimen
4. Need both – *personal and molecular information* – for decision making
Mr. M.F., 64 years old

- Highly motivated, understands well
- T4 (adherence)
- G3 differentiation
- R0 resection,
- No lymphatic invasion, Venous invasion,
- N0 (0/16)
Mr. M.F., 64 years old

- Highly motivated, understands
- T4 (adherence)
- G3 differentiation
- R0, L0, V1, N0 (0/16)

**Molecular pathology**
- no KRAS mutation, BRAF mutant
- MMR deficient
Question 2

What is your preferred option for therapy?

1. No treatment
2. Postoperative radio(chemo)therapy
3. 5FU/FA – as infusional regimen
4. Capecitabine single agent
5. FOLFOX or Cape/Ox
6. Any other
…and, just to consider (in this "intermediate risk" situation):

in case a combination of Oxaliplatin and 5-FU is chosen, what is your estimated best option?

1. Therapy should always be given for six months
2. Three months of therapy is maybe a good option – and it is likely more efficacious than 5FU alone for six months
3. Three months of therapy is maybe a good option – but it is likely as efficacious as 5FU alone for six months
Thank You!