Management strategies for patients with colorectal cancer and selected gastrointestinal cancers

SUMMARY REPORT FROM THE EASTERN CANADIAN COLORECTAL CANCER CONSENSUS CONFERENCE 2013

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The annual Eastern Canadian Colorectal Cancer Consensus Conference was held in Montreal from October 17 to 19, 2013. It is the tenth-year anniversary of this meeting, which is attended by leaders in medical, radiation and surgical oncology whose goal is to improve the care of patients affected with gastrointestinal malignancies. Topics discussed during this year’s conference included pancreatic cancer, rectal cancer and metastatic colorectal cancer. This article is a brief overview of some of the points brought forth during the conference. A full report will appear in Current Oncology in 2014.

PANCREATIC CANCER

Staging
Triphasic computed tomography (CT) is the preferred pre-operative imaging modality for the regional staging of pancreatic cancer. If resectability is still questionable, endoscopic ultrasound (EUS) or magnetic resonance imaging (MRI) can be complementary to CT. As well, selective use of laparoscopy and positron emission tomography (PET) can be considered to rule out metastatic disease.

Systemic therapy
Potential advantages to neoadjuvant treatment in pancreatic cancer include sparing of surgical morbidity and mortality in patients who have rapidly progressive noncurative disease; early treatment of micrometastatic disease; increased rates of R0 resection; and high uptake of patients completing upfront treatment.

Potential disadvantages of neoadjuvant treatment include the requirement for preoperative biopsy and risk of tumour seeding; chemotherapy and radiation toxicity delaying surgical resection; potential for more postoperative complications; as well as the possibility of disease progression during neoadjuvant treatment that would make the patient ineligible for surgery (though the probability of surgery being curative in the setting of quick progression is low).

RECTAL CANCER

Staging and treatment planning
Discussion of rectal cancer patients in multidisciplinary cancer conferences (MCC) prior to the initiation of primary treatment is recommended in order to evaluate the patient and tailor an individual treatment plan.

The report of the synoptic pelvic MRI should be available at the time of the case presentation.

Chemoradiation
As per current North American treatment guidelines, trimodality therapy with neoadjuvant chemotherapy (either
infusion 5FU or capecitabine) and concurrent radiation is considered an acceptable standard of care for T3/T4 or lymph node (LN)-positive disease. Evidence for upfront long-course chemoradiation for less advanced (stage I) disease is lacking.

For resectable stage II or III rectal cancer, there is no difference in OS or disease-free survival (DFS) between short- and long-course radiotherapy. Both options have been validated. Short-course radiotherapy has less acute toxicity and may be preferable for the elderly or if there are concerns that the patient may not be able to complete long-course treatment.

We do not endorse the addition of oxaliplatin-containing chemoradiotherapy (CRT), given the lack of evidence that oxaliplatin combinations are superior to fluoropyrimidines alone, and given oxaliplatin’s greater toxicity.

Surgical resection
No trial to date has randomized patients with clinical complete response (cCR) after neoadjuvant treatment to assess outcomes with observation versus surgery. Therefore, we still endorse surgical resection following neoadjuvant CRT, even in those patients with cCR.

Adjuvant treatment of rectal cancer
Due to downstaging effects, we still recommend making chemotherapy decisions based on clinical stage estimate prior to concurrent CRT.

Acceptable adjuvant chemotherapies based on extrapolation from colon cancer data include FOLFOX (fluorouracil + leucovorin + oxaliplatin), CAPOX/XELOX (capecitabine + oxaliplatin), 5FU/LV (fluorouracil + leucovorin) or capecitabine alone for 4 to 6 months.

METASTATIC COLORECTAL CANCER (CRC)

Although patients should be enrolled in a clinical trial when possible, regorafenib should be considered as a treatment option in patients with refractory metastatic CRC who have previously been treated with standard treatment, including fluoropyrimidines, oxaliplatin, irinotecan and cetuximab or panitumumab if applicable.

Treatment with regorafenib has shown benefit in patients with KRAS wild type and those with KRAS mutations and good performance status (ECOG 0–1).

Regorafenib’s modest survival benefit needs to be considered against the risk of side effects and lack of quality-of-life improvement.

COMMENTARY: Jean Maroun, MD, FRCPC, Medical Oncologist, The Ottawa Hospital Cancer Centre

We are very pleased to be able to present reports from the Western and Eastern Consensus Conferences together this year — and so soon after the conclusion of the Eastern Conference. This is a first! However, we believe the effort is worthwhile as there are many questions around treatment of this complex group of cancers. Timely dissemination of the consensus statements should help to ensure that patients everywhere in the country receive an adequate standard of care.

This year, both Western and Eastern Consensus Conferences emphasized the benefits of a multidisciplinary approach. The Western Conference evaluated the multidisciplinary approach in hepatocellular carcinoma, and the Eastern conference stressed the importance and complexity of a multidisciplinary approach in resectable pancreatic and rectal cancers.

The 2012 Conferences both recommended regorafenib as fourth-line therapy in patients with metastatic CRC who have been exposed to all available and funded antineoplastic and targeted therapies. Both groups also recommended continuing bevacizumab beyond disease progression on initial chemotherapy. Studies have demonstrated ongoing benefit when bevacizumab is continued through the appropriate change in chemotherapy regimen. This phenomenon has also been demonstrated in other tumour types, such as breast cancer. These statements represented the first national consensus that these drugs should be made available to patients who met these criteria.

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