

Conference Report

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Highlights of the Joint ECCO 15–34th ESMO Multidisciplinary Congress

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With a strong commitment to unite oncology in Europe, the European CanCer Organisation (ECCO) and the European Society for Medical Oncology (ESMO) have joined forces to combine the two leading educational opportunities in European oncology – the ECCO and ESMO congresses – every other year. Offering a unique platform to embrace all oncology specialities, the joint congress reflects the mission of both societies to promote a multidisciplinary focus on oncology and uphold the right of all patients to the best treatment and care available. The first joint ECCO 15–34th ESMO Multidisciplinary Congress took place in Berlin, Germany, 20–24 September 2009 and attracted a record-breaking number of over 15,000 delegates from all over the world, among them some 500 pharmacists.

Thanks to the tremendous efforts of Professor Alexander Eggermont, ECCO President and 2009 Congress President, Professor José Baselga, ESMO President, Professor Chris Twelves, Co-Scientific Chair (ECCO), Dr Fortunato Ciardiello, Co-Scientific Chair (ESMO) and other leading figures, the Scientific Committee assembled an in-depth and comprehensive programme. This report discusses some of the highlights of the congress scientific programme.

Colorectal Cancer

Researchers have been trying for some time to identify biomarkers that may be predictive and/or prognostic for anti-epidermal growth factor receptor mono-

clonal antibodies cetuximab and panitumumab and thereby improve patient outcomes in first-line metastatic colorectal cancer (mCRC). Several studies confirmed the importance of *KRAS* mutation status as a biomarker predictive of response to these agents in combination with chemotherapy, reported by Peeters.

The randomised phase III study of panitumumab with FOLFIRI versus FOLFIRI alone as second-line treatment in patients with mCRC was presented by Peeters. A total of 1,186 patients were randomised. For patients with wild-type (WT) *KRAS*, median progression-free survival (PFS) was 5.9 months with, and 3.9 months without, panitumumab ($p = 0.004$); median overall survival was 14.5 months with, and 12.5 months without, the monoclonal antibody; and response rate (by blinded central review) was 35% and 10%. So panitumumab improved the treatment for patients with the wild-type *KRAS* gene, but made no difference in patients with mutated *KRAS*.

The results of the randomised phase III study of panitumumab with FOLFOX4 compared to FOLFOX4 alone as first-line treatment for metastatic colorectal cancer (PRIME trial) were reported by Douillard. A total of 1,183 patients were randomised. For patients with WT *KRAS*, median PFS was 9.6 months for the panitumumab combination and 8.0 months for FOLFOX4 alone ($p = 0.0234$). For patients with mutated *KRAS*, median PFS was 7.3 months for the panitumumab combination and 8.8 months for FOLFOX4 alone ($p = 0.0227$).

Intermittent versus continuous oxaliplatin-based combination chemotherapy was tested in a randomised non-inferiority trial (MRC COIN) in 1,630 patients with advanced colorectal cancer¹. Median overall survival on continuous treatment was 15.6 months versus 14.3 months on intermittent treatment.

The trade-off for slightly longer survival was that patients in the arm with continuous treatment experienced significantly greater grade 3/4 diarrhoea, skin rash, lethargy, hand-foot syndrome, and hypomagnesaemia, but significantly less grade 3/4 peripheral neuropathy. The researchers observed no evidence of any differences in treatment-related or 60-day all cause mortality between the two arms. Presenting results, Maughan said that the estimated difference in favour of continuous treatment needs to be balanced against the reduced toxicity observed with intermittent treatment.

Breast cancer

A randomised phase III study comparing epirubicin, docetaxel, and capecitabine (EDC) to epirubicin and docetaxel (ED) as neoadjuvant treatment for early breast cancer was reported by Steger². The primary aim of the study was an improvement of the pathological complete response rate. Five hundred and twelve patients were eligible for this toxicity and efficacy study. In the intention-to-treat analysis there was no significant difference in the incidence of serious adverse events. In the EDC arm significantly more patients had a pathological complete response (23.8% vs. 15.2%; $p = 0.036$) despite the fact that significantly fewer patients completed the scheduled six cycles (EDC: 75% vs. ED: 97%; $p <$

0.0001) mainly due to capecitabine-induced side effects.

Results of a randomised phase III study comparing denosumab, a new monoclonal antibody binding to the RANK ligand, thereby inhibiting the maturation of osteoclasts, thus protecting the bone, versus the bisphosphonate zoledronic acid for the treatment of breast cancer patients with bone metastases was presented by Stopeck³. Denosumab significantly delayed the time to first on-study skeletal-related event (SRE) compared with zoledronic acid ($p = 0.01$) in this 34-month study. The median time to first on-study SRE was not reached for denosumab, and was 806 days for zoledronic acid. Denosumab also significantly delayed the time to first and subsequent on-study SRE (multiple event analysis) compared with zoledronic acid ($p = 0.001$).

Lung cancer

Several presentations focused on patients with advanced non-small cell lung cancer (NSCLC) harbouring epidermal growth factor receptor (EGFR) mutations underlying the growing body of evidence of genotyping tissue for taking clinical decisions, similar to that of *KRAS* in colorectal cancer.

Firstly, Tsurutani presented on behalf of the West Japan Oncology Group results of a comparison of gefitinib (an EGFR inhibitor) versus cisplatin plus docetaxel for patients with advanced or recurrent NSCLC harbouring activating mutation of the EGFR gene⁴. Two hundred patients were randomised showing that gefitinib significantly prolonged response rate (56.3% vs. 25.3%) and PFS (9.2 months vs. 3.6 months; $p < 0.001$) compared to chemotherapy. Haematological toxicity was more pronounced in the chemotherapy arm while skin rash and liver function test disturbances were seen more in the gefitinib arm.

Similar results were found by Kris⁵ who presented pooled results of the four main studies comparing gefitinib (ISEL, V-15-

32-INTEREST-IPASS) versus placebo or chemotherapy in 1006 patients with EGFR mutations. In every study, Objective Response Rate (ORR) was numerically better for gefitinib than comparator in EGFR-mutation positive patients, and similar or poorer than comparator in EGFR-mutation negative patients.

Within the group of patients with EGFR mutations, the best treatment sequence was also investigated. ORR with gefitinib was 71% when it was used first and ranged from 38–67% in studies where gefitinib was given after chemotherapy. Similar trends were observed for PFS and time to treatment failure. The best results were obtained in EGFR-mutation positive patients who were treated with gefitinib.

Taken together, these analyses indicate that efficacy of gefitinib in EGFR-mutated patients is consistent across all lines and ethnicities (Asians versus non-Asians) and stresses the importance of the knowledge of EGFR mutation status when selecting a treatment with tyrosine kinase inhibitors regardless of line of therapy.

Head and neck cancer

The treatment of locally advanced head and neck cancer has recently undergone important changes with the introduction of new radiotherapy techniques and the addition of chemotherapy or targeted agents to radiotherapy. These techniques can produce better treatment outcomes in terms of local control and survival but add higher acute and late toxicity. However, long-term results of newer treatment modalities in relation to outcome are still scarce.

Rivera looked at the recurrence patterns in 50 patients with squamous cell carcinoma of the head and neck (SCCHN) treated with intensity-modulated radiotherapy (IMRT) with or without chemotherapy⁶. At a median follow-up of 22 months, 14 loco-regional failures (persistent disease or relapse) were observed. Five were in-field, five were marginal, and four occurred out-field.

Two of those marginal failures had received more than 95% of the prescribed radiation dose on more than 95% of the failure gross tumour volume (GTVf). The 2-year overall survival, local disease-free survival and loco-regional disease-free survival rates were 73%, 78% and 72%, respectively. The authors concluded that radiotherapy techniques need to be improved further because local failure remains a major issue.

The 35th ESMO Congress, 8–12 October 2010 in Milan, Italy, will build upon the success of last year's ECCO-ESMO Congress. Likewise, the ECCO 16–36th ESMO Multidisciplinary Congress, 23–27 September 2011 in Stockholm, Sweden, will capitalise on the 2010 Congress, resulting in continual and dynamic advances in research and technology as well as a wealth of oncology resources and best practices to be shared by oncology professionals across Europe.

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¹Maughan Abstract 15LBA

²Steger Abstract 4BA

³Stopeck Abstract 2LBA

⁴Tsurutani Abstract O-9002

⁵Kris Abstract O-9003

⁶Rivera Abstract P8515