Chemo for Metastatic Colorectal Ca May Allow Curative Resection

BY SHARON WORCESTER
Tallahassee Bureau

HOLLYWOOD, FLA. — The goal of chemotherapy for metastatic colorectal cancer is shifting, with greater emphasis now on reducing tumor size to allow for curative resection, Paulo Hoff, M.D., said at the annual meeting of the American College of Surgeons.

The ever-expanding arsenal of chemotherapeutic agents is increasing the likelihood that this goal will be met in a greater number of patients.

"The future is very bright—we have been able to improve dramatically the efficacy of chemotherapy for colorectal cancer," said Dr. Hoff, deputy chairman of gastrointestinal medical oncology at M.D. Anderson Cancer Center, Houston.

Reducing tumor size would make more patients eligible for surgical resection, which is important, because it has long been known that patients with single or localized metastases who are able to undergo surgery have a 25%-35% chance of cure. However, only 10%-30% of patients are operable at the time of presentation, Dr. Hoff explained.

Data show that chemotherapy can indeed change a patient's status from nonresectable to resectable. In one retrospective study, an oxaliplatin-based regimen used in more than 700 previously nonresectable patients with liver metastases reduced tumor size enough to allow resection in 14% of the patients. Overall 5-year survival rates among 87 patients for whom 5 years of follow-up data were available were similar to those in patients who were resectable at presentation.

In several other studies, oxaliplatin as part of a combination regimen known as FOLFOX, which also includes fluorouracil and leucovorin, was consistently associated with a doubling of the rate of patients whose tumors shrunk by at least 50%, compared with any single drug. Survival also was improved.

Similar outcomes have been shown with irinotecan used in combination with 5FU-LV (a combination known as FOLFIRI).

Even more impressive results were seen when the monoclonal antibody bevacizumab was added to any of these regimens, Dr. Hoff said.

When bevacizumab was added to an irinotecan-based regimen, response rates climbed about 10% to a response rate of 45%, and median survival increased by about 5 months to a median survival of more than 20 months.

Another monoclonal antibody, cetuximab, also showed promise in preliminary trials. In a phase II study that combined the drug with the FOLFOX regimen, the response rate was 81%.

Another benefit of these emerging chemotherapeutic regimens for colorectal cancers is improved treatment of micrometastatic disease. Micrometastases that may remain following resection can lead to recurrence.

Several studies have shown that there is no significant improvement in survival or cure rates following incomplete resection, but tumor reduction may improve the chances of complete resection, Dr. Hoff said.

When tumor reduction isn't possible, the traditional goals of chemotherapy, including promoting survival, delaying tumor progression, and preventing tumor-related complications, still apply.

But with the recent advances—especially if they are combined with advances in surgery and radiation therapy techniques, as well as with systemic chemotherapy agents that target metastases beyond the liver—a major impact will be made on the treatment of colorectal cancer, Dr. Hoff said. ■

Virtual Colonoscopy Not Always Favored by Patients

BY TIMOTHY F. KIRN
Sacramento Bureau

CHICAGO — Patients do not necessarily prefer virtual colonoscopy to standard colonoscopy, probably because they are not given sedation to ease them through the virtual procedure, Nighat Ullah, M.D., said at the annual Digestive Disease Week.

In a survey of 55 patients who underwent both procedures, 43% preferred virtual colonoscopy, 31% preferred standard colonoscopy, and 26% had no preference, Dr. Ullah said in a poster presentation.

Overall, the survey found no significant differences between the procedures in the patients' experience of pain or embarrassment. The patients' willingness to recommend the two procedures to others and their satisfaction with the experience also did not differ significantly.

However, among those who said they preferred standard colonoscopy, the most common objection to virtual colonoscopy was the discomfort and subsequent bloating that the patients experienced as a result of the procedure, which entails insufflation of the colon, said Dr. Ullah of the division of gastroenterology at Stanford (Calif.) University.

Their survey found that about 50% of the patients reported pain associated with virtual colonoscopy, a figure consistent with other studies, Dr. Ullah said.

Obese patients tend to experience more discomfort, and the elderly, less, she added.

Patients who liked virtual colonoscopy said they preferred it because it was more convenient, mainly because there was no sedation. The exam took less time (15 minutes, compared with 40 minutes), and then the patients were up and out the door with no wait for sedation to wear off and no feeling groggy for the rest of the day, Dr. Ullah said.

In related study, conventional colonoscopy was more sensitive than virtual colonoscopy as a method of examining patients at risk for colon cancer, and was more cost effective as well, in part because if the physician finds a lesion on virtual colonoscopy, the patient still needs a conventional colonoscopy to remove it.

In that study, the sensitivity of conventional colonoscopy for large lesions (10 mm or greater) was 98%, while that of virtual colonoscopy was 59%, said Gillian D. Sanders, Ph.D., of Duke University, Durham, N.C. ■

Rectal Ca Surgery Outcomes Better in High-Volume Hospitals

BY MITCHEL L. ZOLER
Philadelphia Bureau

PHILADELPHIA — An analysis of more than 5,000 rectal cancer patients in New York state linked superior outcomes with high-volume hospitals, compared with low-volume institutions, Salvatore Savatta, M.D., reported at the annual meeting of the American Society of Colon and Rectal Surgeons.

The study found that patients treated at high-volume hospitals were less likely to die in the hospital, had fewer medical complications, and had shorter lengths of stay, Dr. Savatta said.

In addition, patients who were older, African American, and on Medicaid were more likely to have their rectal surgery done at low-volume hospitals, said Dr. Savatta, of Memorial Sloan-Kettering Cancer Center in New York. This trend may be associated with the fact that these patients tend to have a lower socioeconomic status, he said.

"Patients who wind up in hospitals that don't do as many surgeries may not be plugged into the medical system very well," Dr. Savatta suggested.

The analysis included all patients who had surgery for stage I-III rectal cancer in New York state during 1998-2002. The demographic, hospital volume, and outcome data were collected by the New York State Department of Health through the Statewide Planning and Research Cooperative System.

During this period, 5,143 patients had rectal surgery for cancer at one of 209 hospitals in New York. The hospitals were stratified into four groups based on the number of procedures performed: very low volume, low volume, medium volume, and high volume. (See table.)

The distribution of patients by gender and by cancer stage was similar in all four hospital categories. But patients in the low-volume hospitals were on average significantly older than those in the high-volume hospitals. In addition, the average proportion of African American patients and the percentage of patients on Medicaid were higher in the very-low-volume hospitals, compared with the high-volume hospitals.

Patients treated in the very-low-volume and low-volume hospitals also had significantly higher comorbidity, in-hospital mortality, and rates of acute admissions, medical complications, and average length of stay, compared with patients in the high-volume hospitals, Dr. Savatta said.

Some outcome differences were independent of the demographic factors. For example, in-hospital mortality remained significantly lower in the high-volume hospitals compared with the very-low-volume hospitals even after adjustment for baseline demographic differences. But the difference in hospital length of stay was no longer statistically significant after adjustment for demographic differences, he added. ■

Hospital Volume, Patient Demographics Linked With Rectal Surgery Outcomes

	Hospital Volume			
	Very low	Low	Medium	High
Number of hospitals	141	43	19	6
Demographics				
Median number of patients	8	30	67	130
Average age	69.1yr	68.7 yr	66.9 yr	63.2 yr
Percentage of African American	9.1%	6.1%	8.4%	5.2%
Percentage on Medicaid	9.3%	3.9%	6.3%	2.9%
Outcomes				
Mortality	2.8%	2.0%	1.5%	0.9%
Percentage with medical complications	16.5%	14.2%	13.0%	8.1%
Average length of stay	12.4 days	11.2 days	10.5 days	8.7 days

Notes: Based on 1998-2002 data. Hospital volume is based on the number of procedures performed.
Source: Dr. Savatta