Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/conversations-colorectal-cancer/mcrc-case-review-how-to-make-informed-decisions-for-personalized-treatment/10275/

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mCRC Case Review: How to Make Informed Decisions for Personalized Treatment

Announcer:
This is ReachMD, and you are listening to *Conversations on Colorectal Cancer,* sponsored by Lilly. On this episode, titled “mCRC Case Review: How to Make Informed Decisions for Personalized Treatment” we will hear from Dr. Richard Kim from Moffitt Cancer Center.

Dr. Kim:
So the patient that I saw is a patient who is a 48-year-old gentleman who presented with abdominal pain and bright red blood per rectum. Patient went to see a primary care doctor and had a colonoscopy done and was found to have a tumor from 20 cm from the anal verge.The biopsy comes back as poorly differentiated adenocarcinoma. Patient then goes to see a medical oncologist and gets a PET scan done and a CAT scan done for staging purposes, and the CAT scan shows that patient has multiple lesions in the liver and the lung. Therefore, patient is definitely not resectable. Now, the first thing we do when I see this patient with newly diagnosed stage IV colorectal cancer is that we do a molecular profiling to determine what kind of mutation the patient has that will help us manage the patient, so we look at the KRAS mutation, we look at the BRAF mutation; we also look at the MMR status. Looking at the RAS status will determine if the patient is a candidate for EGFR drugs. If you have a BRAF mutation, those patients tend to have much worse outcome. Therefore, those patients we tend to be more aggressive with such as a triplet regimen for chemotherapy. And last but not least, we look at the mismatch repair status to see if the patient is a candidate for immunotherapy.

Once we have the molecular profiling done, then the first thing we choose is a backbone of chemotherapy. The most commonly used chemo backbone in the first-line setting is either FOLFOX or FOLFIRI. Then we determine to see which patient will benefit from the biologic therapy, such as anti-EGFR drugs such as cetuximab or panitumumab, or anti-VEGF drugs such as bevacizumab. In this case, because the tumor is left-sided tumor, there is clearly data that anti-EGFR drugs may have a benefit over anti-VEGF drugs in this setting. However, there are concerns of toxicity or the rash that patients face with anti-EGFR drugs. Therefore, I would have a discussion with the patient to determine which biologic to use in this case.

Announcer:
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