Session E. Gastrointestinal (colorectal) cancer

E19 Chemotherapy rechallenge after regorafenib treatment in metastatic colorectal cancer. Still hope after the last hope?
F. Aroldi1, P. Bertocchi1, T. Prochilo1, L. Rota1, A. Rizzi1, F. Meriggi1, B. Di Biasi1, C. Abeni1, C. Ogliosi1, G.D. Beretta2, A. Zaniboni1
1Fondazione Poliambulanza, Brescia
2Humanitas Gavazzeni, Bergamo

Introduction: The introduction of biological agents is changing the natural history of metastatic (CRC). Nowadays the mechanisms of resistance to biological agents is an emerging problem; the disease progression is caused by the development of resistant clones. According to some authors, these clones can be resensitized to traditional and previously utilized chemotherapy agents. The results of CORRECT study demonstrated the efficacy of regorafenib monotherapy both in KRAS wild type and mutant pretreated patients (pts). Recently, two reports showed the possibility to reintroduce chemotherapy even after regorafenib.

Methods: We performed a retrospective review of clinical data of pts treated with regorafenib at our institution, from March 2012 to March 2013. We analyzed pts characteristics, KRAS/NRAS status, responses to treatments (evaluated by RECIST v1.1 criteria) and survival.

Results: Regorafenib was given to 128 pts, 11 (8.6%) of them received post regorafenib therapy (to our knowledge). Median age was 56 years (range 42-59), male/female ratio 6/5, median PS (ECOG) 1 (range 0-2). 7 (63.6%) pts were KRAS/NRAS wild type. Post regorafenib therapy represented for all the pts at least the fourth line: all the pts received both oxaliplatin and irinotecan based chemotherapy, all of them were treated with bevacizumab and 7 pts received also cetuximab. Regorafenib represents the 3rd line of therapy for 4 pts, the 4th line for 5 pts, the 5th line for 1 patient (pt) and the 6th line for 1 pt. 8 pts (72.7%) were treated with standard chemotherapy after regorafenib (irinotecan monotherapy, capecitabine plus oxaliplatin or irinotecan, dacarbazine, raltitrexed) while 3 (27.3%) received experimental therapy (clinical trial). 9 pts out of 11 (81.8%) had PD and 2 (18.2%) had SD. Median PFS was 1.6+ months (range 0.5-3.5), median OS post regorafenib was 2.1+ months (range 0.5-10.2) and 6-months OS was 27.3%+

Conclusion: Our retrospective analysis shows that after regorafenib, re-introducing chemotherapy is possible. Unfortunately we reported a high percentage of progression beyond regorafenib; this is probably due to the high percentage of heavily pretreated pts (some received four or five lines therapy before regorafenib). We think that regorafenib could represent a chemotherapy resensitizing agent but further studies are need in less pretreated patients.