Prospective pooled analysis of four randomized trials investigating duration of adjuvant (adj) oxaliplatin-based therapy (3 vs 6 months (m)) for patients (pts) with high-risk stage II colorectal cancer (CC).

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Abstract Disclosures

Background:
6m of oxaliplatin-based treatment is an option as adj chemotherapy for patients with high risk stage II CC (T4, inadequate nodal harvest, poorly differentiated, obstruction, perforation or vascular/perineural invasion). The IDEA collaboration showed shorter treatment duration to be appropriate for most pts with stage III colon cancer. The results of the 4 IDEA studies with stage II pts are presented here.

Methods:
A prospective, pre-planned pooled analysis of high-risk stage II patients from 4 concurrently conducted randomized phase III trials (SCOT, TOSCA, ACHIEVE-2, HORG) was performed to evaluate non-inferiority (NI) of 3m compared with 6m (ref) of adj FOLFOX/CAPOX (regimen preselected, not randomized). The primary endpoint was disease-free survival (DFS), NI was to be declared if the 2-sided 80% confidence interval (CI) for DFS hazard ratio (HR 3m v 6m) estimated by a stratified Cox model was below 1.2. 542 DFS events were required to provide 80% power to declare NI. NI was also examined within regimen, T4 (Yes v No) and inadequate nodal harvest (Yes v No) as pre-planned subgroups.
Results:
The primary analysis included 3273 randomised pts of which 1254 had FOLFOX and 2019 had CAPOX. There were 552 events and the median follow-up was 60.2 m. There was significantly less grade 3-5 toxicity with 3m treatment (p < .0001). The 5-year DFS rate was 80.7% and 84.0% for 3m and 6m treatment with an estimated DFS HR of 1.18 (80% CI:1.05-1.31, p for NI = 0.404). For CAPOX the estimated HR was 1.02 (80% CI: 0.88-1.17, p for NI = 0.087) and for FOLFOX the estimated HR was 1.42 (80% CI: 1.19-1.70, p for NI = 0.894). The test for interaction between duration and regimen was not statistically significant (p = .174 adjusted for multiple testing) but was stronger than that for the other subgroups examined.

Conclusions:
In the overall population non-inferiority for 3m adj treatment in pts with high-risk stage II CC was not shown. As with the stage III population the choice of adj regimen appears important (although this did not reach statistical significance) with a small difference in DFS between 3 and 6 m treatment if CAPOX is used. Clinical trial information:
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