Personal statement on the use of Oxaliplatin and Capecitabine for the adjuvant treatment of colorectal cancer

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The current recommended adjuvant treatment in the UK on behalf of the Association of Coloprotology following potentially curative surgical resection in colorectal cancer is 5FU following the QUASAR trial of the 1990s. This is most commonly given with lose dose Folinic Acid by weekly bolus injection or sometimes by MAYO regime, treating Monday to Friday 1 week per month. 5FU is occasionally used also and there is now data to support this use. I work as a Consultant Clinical Oncologist at the Christie Hospital and see approximately 500 new cases of colorectal cancer annually, treating about 150 of these with adjuvant chemotherapy. I have taken part in the drug sponsored MOSAIC trial using infusional 5FU and Oxaliplatin, and the X-ACT trial using Capecitabine compared with MAYO regime. I am aware of the evidence from these trials that Oxaliplatin and infusional 5FU produced a significant increase in survival at 3 years, compared with 5FU alone and that Capecitabine also has shown a tread towards improved disease free survival and a significant increase in tolerability compared with the MAYO regime. Furthermore, the recently published C-07 trial on the use of adjuvant Oxaliplatin with 5FU also showed a significant improvement in survival compared with 5FU alone.

In view of the above trials, an increase in patient expectations together with patient desire to avoid injections whenever possible, it seems clear to me that there is a role for both Oxaliplatin and Capecitabine in the adjuvant treatment of colorectal cancer. Data is still

somewhat immature especially from the X-ACT trial, and it is as yet uncertain as to whether Oxaliplatin and Capecitabine should be used separately on different occasions or combined. There may be some help from sub-groups analysis over time when it will become more obvious whether the patients with more advanced disease, eg positive resection margins, Dukes C2 cancer benefit more from these new drugs than those with less advanced disease. To some extent the cost of these drugs will also be offset by reduced clinic attendances and in the case of Capecitabine the need for fewer injections. What can be done in the interim whilst the data accumulates further?

My personal view is that whilst waiting for data from these studies to mature further, there is now sufficient evidence for patients with locally advanced disease especially those with positive resection margins, perforated tumours or Dukes C2 cancers (and possibly those with more than 6 involved lymph glands), be offered a choice of either Capecitabine or infusional Oxaliplatin and 5FU as well as standard Bolus 5FU and Folinic Acid. I regret that I am unable to attend the meeting on the 5th October, but look forward to working with the committee and providing further submissions and help along the appraisal process.

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