Bowel Cancer UK
raising awareness, saving lives

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Bowel Cancer UK: Cetuximab, Bevacizumab and Panitumumab monotherapy for the treatment of metastatic colorectal cancer that has progressed after first line chemotherapy (review)

Introduction

The case for the three biological agents in the treatment of mCRC - Cetuximab, Bevacizumab and Panitumumab - has been well made, including in previous submissions to NICE, by ourselves, clinicians, patients and other stakeholders.

Our own previous submissions to NICE regarding these treatments have included detailed summaries of the outcomes of trials of these drugs, made by leading clinicians on our behalf; case studies of patients who have benefitted from them; and our own assessment of the drugs, made, in part, from what patients and clinicians tell us about them. While most of these previous submissions have been for the treatments in the first or third line setting, they apply in the second line setting as well.

I presume that NICE still has access to all these submissions, so rather than repeat myself, let me just summarise the salient points here.

Efficacy

As numerous clinical trials have shown and continue to show, each of these three treatments are effective in tackling metastatic CRC tumuors, e.g. in the liver and the lungs, including those that are resistant to chemotherapy alone.

Adding one of these treatments to chemotherapy can increase a patient's length of life, by weeks, months or even years, including for patients who are receiving treatments in the second and third line settings.

In the case of Cetuximab and Panitumumab, the decision to treat is helped by the existence of the K-Ras gene in the EGFR pathway, which - if the patient has the wild type gene - can help determine whether the treatments have an increased chance of working.

While there is no equivalent bio-marker for Bevacizumab - or at least none that has been found yet - the treatment is also proven to be effective for metastatic CRC patients in shrinking previously resistant tumours. All three treatments offer patients an increased chance of liver resection.

Quality of Life

As we have said before in other NICE submissions, it is disappointing that NICE doesn't consider quality of life more highly than it does, because for many patients an improved quality of life is a significant benefit of receiving these treatments.

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While the biological agents have side effects and do not suit everyone, they are considerable less toxic than chemotherapy. They can also help to alleviate pain and reduce other symptoms of the disease, such as tiredness, enabling patients to have a more active lifestyle.

Also, it is easier to determine whether the biological agents are working more quickly than it is chemotherapy, usually after five or six doses. This benefits both patients and their clinicians. If a biological treatment is working for a patient, then that is obviously of benefit to them; if it isn't working, they will be taken off it, reducing the time they are on ineffective treatments and also reducing costs.

The importance of treatments being available at all stages

It is important that clinicians are able to offer their patients appropriate treatments at all stages of their pathway, including second line. This is equally true of the biological agents, which are designed to work with chemotherapy to shrink metastatic tumours and enable resection.

If a patient has the K-Ras mutant gene, for example, they are unlikely to benefit from Cetuximab or Panitumumab. They should be able to receive Bevacizumab, therefore, if their clinician believes it could benefit them. Similarly, if a patient is K-Ras wild type, they have a 65% chance of Cetuximab or Panitumumab working for them, so should be offered one of these treatments, again if their clinician believes it could benefit them.

And if a patient doesn't respond to combination chemotherapy alone first line, e.g. FOLFOX or FOLFIRI regimens, then clinicians should be able to add a biological treatment to their treatment second line.

Conclusion

As NICE will be aware, the UK lags behind the rest of Europe in making cancer treatments available to patients, including bowel cancer treatments. This is a contributory factor in the UK also having some of the highest death rates from cancer in Europe, again including bowel cancer, with many patients dying in the first year of having the disease.

These are two of the main reasons why the Cancer Drugs Fund has been created and, in the case of the high death rates from cancer, why efforts are being made to encourage people to act on their symptoms sooner, to increase earlier diagnosis and reduce the need for them to have treatments in the first place.

We hope that NICE will do more to increase patients' access to effective treatments, including Cetuximab, Bevacizumab and Panitumumab. All three of these drugs have a key role to play in the treatment of metastatic colorectal cancer, including second line, and we hope that NICE will recognise this and approve them for access on the NHS in this and other settings.

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