

intolerant to imatinib and dasatinib. Results: A total of 42 pts are reported – CP (16), AP (9), and BC (17 total; 13 myeloid, 4 lymphoid). Overall 10 (24%) pts had extramedullary disease at baseline. For all pts, median time from first diagnosis was 16.8 (0.6-265) months. The median duration of nilotinib exposure was 81 days with median dose intensity of 800mg/day. A total of 13 (31%) pts with dasatinib failure remain on treatment, 29 (69%)

discontinued (6 for AEs, 16 for disease progression). CP: Of the 16 pts, 5 (31%) had a MCyR (3 complete, 2 partial). Complete hematologic response (CHR) was reported in 5/13 (39%) pts without CHR at baseline. Disease progression only occurred in 2 pts. AP: 2/9 (22%) pts had a return to chronic phase (RTC), 6 pts were not evaluable and there was 1 death. Disease progression occurred in 5 pts. BC: 3/17 (18%) achieved CHR, 1 (6%) had RTC, and

4 (24%) pts had disease progression. For all pts, the most common Grade 3/4 AEs reported were thrombocytopenia (26%), neutropenia (24%), and anemia (7%) pts.

Conclusions

Nilotinib has significant clinical activity in CML-CP, AP, and BC patients who have failed imatinib and dasatinib. Nilotinib is safe and well tolerated, consistent with its kinase selectivity profile. ★

PHASE III TRIAL OF CAPECITABINE + OXALIPLATIN (XELOX) VS. 5-FLUOROURACIL (5-FU), LEUCOVORIN (LV), AND OXALIPLATIN (FOLFOX4) AS 2ND-LINE TREATMENT FOR PATIENTS WITH METASTATIC COLORECTAL CANCER (MCR)

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Background

Capecitabine is an oral fluoropyrimidine that has demonstrated similar efficacy to 5-FU/LV in the 1st-line treatment of MCR. Most patients now receive multi-agent chemotherapy and FOLFOX4 has become a popular regimen in this setting. We conducted a phase III study comparing XELOX with FOLFOX4 in patients who had received prior treatment with irinotecan in combination with bolus and/or infusional 5-FU/LV for MCR. The primary endpoint of the study was time-to-tumor progression (TTP). With 610 patients, this study had 80% power to detect non-inferiority of the XELOX vs. FOLFOX, defined by a progression hazard ratio (HR) of <1.3.

Methods

Patients were treated with XELOX

(oxaliplatin 130mg/m² i.v., capecitabine 1,000mg/m² bid oral x 14 days, q3w) or FOLFOX4 (as described previously).

Results

The study recruited 627 patients (the intent-to-treat – ITT – group). Baseline characteristics were well balanced. The primary objective of the study was met with a progression HR of 0.97 for the XELOX group (95% CI, 0.83-1.14). Median TTP was 4.8 months for XELOX- and 4.7 months for FOLFOX4-treated patients. Overall survival was also similar between the groups with a death HR of 1.03 for the XELOX group (95% CI, 0.87-1.23). Median survival was 11.9 months for XELOX- and 12.6 months for FOLFOX4-treated patients. Grade 3/4 toxicities occurred in 60.1% of XELOX- and 72.4% of FOLFOX4-treated

patients. The most common treatment-related grade 3/4 adverse events (XELOX vs. FOLFOX4) were: diarrhea (20 vs. 5%), neutropenia (5 vs. 35%), fatigue (5 vs. 8%), paresthesia (9 vs. 8%), nausea/vomiting (6 vs. 5%). The rate of grade 3 hand-foot syndrome was 3.5% with XELOX and 0.6% with FOLFOX4. The 60-day all cause mortality was 3.9% in XELOX- and 4.2% in FOLFOX4-treated patients. Conclusions: These results demonstrate that second-line treatment with XELOX is non-inferior to FOLFOX4 in terms of PFS. Results for overall survival and response rates were also similar between the two groups. The safety profile was similar to previous studies, with no unexpected toxicities. Study supported by Hoffmann-La Roche. ★