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Chapter 1 : Adjuvant therapy: Treatment to keep cancer from returning - Mayo Clinic

Adjuvant therapy given before the main treatment is called neoadjuvant therapy. This type of adjuvant therapy can also decrease the chance of the cancer coming back, and it's often used to make the primary treatment â€" such as an operation or radiation treatment â€" easier or more effective.

The results indicated that the adjuvant therapy given after the initial radical mastectomy "significantly decreased recurrence rate in pre-menopausal women with four or more positive axillary lymph nodes. His results, published in , indicated increased disease-free survival for the former group. Neoadjuvant therapy[edit] Neoadjuvant therapy , in contrast to adjuvant therapy, is given before the main treatment. For example, systemic therapy for breast cancer that is given before removal of a breast is considered neoadjuvant chemotherapy. The most common reason for neoadjuvant therapy for cancer is to reduce the size of the tumor so as to facilitate more effective surgery. In the context of breast cancer, neoadjuvant chemotherapy administered before surgery can improve survival in patients. It remains unclear whether pCR can be used as a surrogate end point in breast cancer cases. Systemic therapy consists of chemotherapy , immunotherapy or biological response modifiers or hormone therapy. The aim of adjuvant treatment is to improve disease-specific symptoms and overall survival. Because the treatment is essentially for a risk, rather than for provable disease, it is accepted that a proportion of patients who receive adjuvant therapy will already have been cured by their primary surgery. Adjuvant systemic therapy and radiotherapy are often given following surgery for many types of cancer, including colon cancer , lung cancer , pancreatic cancer , breast cancer , prostate cancer , and some gynaecological cancers. Some forms of cancer fail to benefit from adjuvant therapy, however. Such cancers include renal cell carcinoma , and certain forms of brain cancer. Hyperthermia therapy or heat therapy is also a kind of adjuvant therapy that is given along with radiation or chemotherapy to boost the effects of these conventional treatments. Heating the tumor by Radio Frequency RF or Microwave energy increases oxygen content in the tumor site, which results in increased response during radiation or chemotherapy. For example, Hyperthermia is added twice a week to radiation therapy for the full course of the treatment in many cancer centers, and the challenge is to increase its use around the world. Controversy[edit] A motif found throughout the history of cancer therapy is the tendency for overtreatment. From the time of its inception, the use of adjuvant therapy has received scrutiny for its adverse effects on the quality of life of cancer patients. For example, because side effects of adjuvant chemotherapy can range from nausea to loss of fertility, physicians regularly practice caution when prescribing chemotherapy. One of the most notable side effects of adjuvant therapy is the loss of fertility. For pre-pubescent males, testicular tissue cryopreservation is an option for preserving future fertility. For post-pubescent males, this side effect can be assuaged through semen cryopreservation. For pre-menopausal females, options to preserve fertility are oftentimes much more complex. In the some low-risk, low-benefit situations, forgoing adjuvant treatment altogether can be a reasonable decision, but in cases where the risk of metastasis is high, patients may be forced to make a difficult decision. Though options for fertility preservation exist e. The standards for dose intensity of adjuvant treatments and treatment duration are regularly updated to optimize regimen efficiency while minimizing toxic side effects that patients must shoulder. Concomitant or concurrent systemic cancer therapy[edit] Concomitant or concurrent systemic cancer therapy refers to administering medical treatments at the same time as other therapies, such as radiation. Adjuvant hormonal therapy is given after prostate removal in prostate cancer, but there are concerns that the side effects , in particular the cardiovascular ones, may outweigh the risk of recurrence. In breast cancer, adjuvant therapy may consist of chemotherapy doxorubicin , herceptin , paclitaxel , docetaxel , cyclophosphamide , fluorouracil , and methotrexate and radiotherapy, especially after lumpectomy , and hormonal therapy tamoxifen, femara. Adjuvant therapy in breast cancer is used in stage one and two breast cancer following lumpectomy, and in stage three breast cancer due to lymph node involvement. In glioblastoma multiforme , adjuvant chemoradiotherapy is critical in the case of a completely removed tumor, as with no other therapy, recurrence occurs in 1â€"3 months[citation needed]. In early stage one small cell lung carcinoma , adjuvant chemotherapy with gemzar, cisplatin , paclitaxel ,

docetaxel , and other chemotherapeutic agents, and adjuvant radiotherapy is administered to either the lung , to prevent a local recurrence, or the brain to prevent metastases. In testicular cancer , adjuvant either radiotherapy or chemotherapy may be used following orchidectomy. Previously, mainly radiotherapy was used, as a full course of cytotoxic chemotherapy produced far more side effects then a course of external beam radiotherapy EBRT. Prophylactic cranial irradiation for acute lymphoblastic leukemia ALL is technically adjuvant, and most experts agree that cranial irradiation decreases risk of central nervous system CNS relapse in ALL and possibly acute myeloid leukemia AML , but it can cause severe side effects, and adjuvant intrathecal methotrexate and hydrocortisone may be just as effective as cranial irradiation, without severe late effects , such as developmental disability , dementia , and increased risk for second malignancy. Dose-Dense Chemotherapy[edit] Dose-dense chemotherapy DDC has recently emerged as an effective method of adjuvant chemotherapy administration. DDC uses the Gompertz curve to explain tumor cell growth after initial surgery removes most of the tumor mass. Cancer cells that are left over after a surgery are typically rapidly dividing cells, leaving them the most vulnerable to chemotherapy. Standard chemotherapy regimens are usually administered every 3 weeks to allow normal cells time to recover. This practice has led scientists to the hypothesis that the recurrence of cancer after surgery and chemo may be due to the rapidly diving cells outpacing the rate of chemotherapy administration. DDC tries to circumvent this issue by giving chemotherapy every 2 weeks. To lessen the side effects of chemotherapy that can be exacerbated with more closely administered chemotherapy treatments, growth factors are typically given in conjunction with DDC to restore white blood cell counts. In a multicenter study reported improved long-term and disease-free survival in melanoma patients using interferon alpha 2b as an adjuvant therapy. Thus, later that year the U. Food and Drug Administration FDA approved interferon alpha 2b for melanoma patients who are currently free of disease, to reduce the risk of recurrence. Since then, however, some doctors[who? Those claims have not been validated by scientific research. Adjuvant chemotherapy has been used in malignant melanoma, but there is little hard evidence to use chemotherapy in the adjuvant setting. However, melanoma is not a chemotherapy-resistant malignancy. Multiple studies have shown that adjuvant radiotherapy improves local recurrence rates in high-risk melanoma patients. The studies include at least two M. Anderson cancer center studies. However, none of the studies showed that adjuvant radiotherapy had a statistically significant survival benefit. A number of studies are currently underway to determine whether immunomodulatory agents which have proven effective in the metastatic setting are of benefit as adjuvant therapy for patients with resected stage 3 or 4 disease. Colorectal cancer[edit] Adjuvant chemotherapy is effective in preventing the outgrowth of micrometastatic disease from colorectal cancer that has been removed surgically. Studies have shown that fluorouracil is an effective adjuvant chemotherapy among patients with microsatellite stability or low-frequency microsatellite instability , but not in patients with high-frequency microsatellite instability. A series of studies has established that 6 months of chemotherapy with either gemcitabine or fluorouracil, as compared with observation, improves overall survival. Newer trials incorporating immune checkpoint inhibitors such as the inhibitors to programmed death 1 PD-1 and the PD-1 ligand PD-L1 are under way. The toxicity resulting from adjuvant chemotherapy was believed to be manageable. While it may shrink tumors in some patients, others may not respond to the treatment at all. It has been demonstrated that a delay in surgery of greater than 12 weeks from the time of diagnosis can decrease overall survival. Thus, the timing for neoadjuvants becomes critical, as a course of neoadjuvant therapy could delay a cystectomy and allow the tumor to grow and further metastasize.

Chapter 2 : Adjuvant therapy - Wikipedia

This volume contains the complete proceedings of the Eighth International Conference on the Adjuvant Therapy of Cancer, Held in Scottsdale, Arizona, presenting recent research findings, treatment stategies, and results in the area.

No longer one size fits all Duration of adjuvant therapy for stage III colon cancer: No longer one size fits all By Jeffrey A. At least three trials showed improved disease-free survival DFS with the addition of oxaliplatin. Multiple trials to test supportive agents to reduce or prevent neuropathy were unsuccessful. Given that neuropathy from oxaliplatin is cumulative and dependent on total dose delivered, researchers have expressed great interest in testing shorter duration of therapy. This margin for relapse practically translates to the fact that the upper limit of the 95 percent confidence interval CI of the hazard ratio HR needed to be less than 1. Trials included in IDEA collaboration Over the span of nearly a decade, 12, patients from around the world were enrolled, treated, and followed in the IDEA collaboration on six randomized clinical trials. As anticipated, toxicities were significantly less after three versus six months of therapy. When considering all patients randomized who received at least one dose of chemotherapy, the disease relapse HR comparing three versus six months of therapy was 1. Since the CI crossed 1. IDEA results Notably, several preplanned subgroup analyses also were presented. The biological rationale for this apparent difference by treatment regimen is unclear. Chance or bias by indication are possible reasons, but the difference in fluoropyrimidine dosing more continuous with CAPOX or total dosage of oxaliplatin in the initial month of the treatment also are possible explanations. Additionally, subgroup analyses by T and N stage were presented. However, higher-risk tumors T4 or N2 , which constituted 40 percent of the cohort, had a clinically meaningful worse three-year DFS 60 percent as compared with better-risk tumors T1â€”3, N1; 80 percent three-year DFS. When considering risk groups, the HR for three versus six months of therapy for patients with T1â€”3 N1 tumors was 1. DFS by regimen and T and N stage-based risk groups Unanswered questions remain The IDEA collaboration is the largest prospective effort in colon cancer conducted, demonstrating the feasibility of publicly funded international research. While the intention was to arrive at a simple answer of whether three months is sufficient or six months is necessary, stepping back, it is not surprising that it is more complicated because stage III colon cancer is not a single disease biologically. Many unanswered questions remain, including how to apply these data to rectal cancer or stage II colon cancer, whether a mixed strategy of three months oxaliplatin-based therapy followed by three months of fluoropyrimidine only would be a better option, and the possibility of further refining prognostic features that can be considered to determine duration of therapy. Although IDEA will not answer all of these questions, many ongoing efforts seek to further classify phenotype and molecular markers to eventually develop a model that can be used to individualize the duration of adjuvant therapy for each stage III patient. Adjuvant therapy for patients with colon and rectal cancer. Final report of Intergroup Prospectively randomized trial of postoperative adjuvant chemotherapy in patients with high-risk colon cancer. Adjuvant chemotherapy in stage III colon cancer with 5-fluorouracil and levamisole versus 5-fluorouracil and leucovorin. Oxaliplatin combined with weekly bolus fluorouracil and leucovorin as surgical adjuvant chemotherapy for stage II and III colon cancer: Oxaliplatin, fluorouracil, and leucovorin as adjuvant treatment for colon cancer. N Engl J Med. Capecitabine plus oxaliplatin compared with fluorouracil and folinic acid as adjuvant therapy for stage III colon cancer. Duration of adjuvant chemotherapy for stage III colon cancer.

Chapter 3 : Adjuvant therapy for elderly patients with stage III colon cancer - Cancer Guidelines Wiki

Get this from a library! Adjuvant therapy of cancer VIII: proceedings of the Eighth International Conference on the Adjuvant Therapy of Cancer, Scottsdale, Arizona, March,

JM Stage II and III colon cancer patients both have staging scans and surgical exploration that do not show evidence of disease spread outside the local colon cancer. In stage II colon cancer, the disease has grown through the muscle layer to the subserous layer T3 or beyond, including adhesion to other organs or penetration through the parietal peritoneum T4 , but no local lymph nodes have disease involvement. From a prognostic standpoint, stage II patients generally have a better prognosis than stage III patients, which translates to a lower recurrence rate. However, there are some stage II patients that have a higher recurrence rate than stage III patients. Patients with stage III colon cancer should be treated with adjuvant therapy after surgery. Adjuvant treatment for stage II colon cancer is controversial, primarily due to the lack of definitive data demonstrating a clear benefit; the evidence to date is either inadequate in power or is mixed in terms of potential benefit. JM There are multiple prognostic factors that appear to have an effect on prognosis, such as bowel perforation, clinical bowel obstruction, T4 disease, poorly differentiated histology, and an inadequate number of lymph nodes. However, there are no definitive data confirming that patients who have these poor prognostic factors will benefit from adjuvant therapy. Therefore, while these factors are prognostic, they are not necessarily predictive. However, because there is a lack of data or inadequate sample sizes in subgroup analyses to provide a definitive correlation, the prognostic factors are often used to determine who should be considered for adjuvant therapy. In patients who do not have these factors, it has been more difficult to determine an appropriate treatment course. Other factors that are considered when determining treatment are molecular markers. Microsatellite instability and 18q loss of heterozygosity are 2 molecular markers that have received the most attention in colon cancer, with microsatellite instability being the more readily examined marker. Most studies have shown that patients with microsatellite instability have a more favorable prognosis. However, the data are mixed on whether microsatellite instability is a predictive marker for adjuvant therapy. Retrospective studies have demonstrated that patients with stage II or III disease and microsatellite instability who receive adjuvant 5-fluorouracil 5-FU chemotherapy after surgery have no benefit from such therapy, or may even have an inferior outcome, compared to surgery. However, not all studies have confirmed this association, and data remain retrospective at this point. There are no data to date regarding 5-FU and oxaliplatin combinations. As a result, there is some hesitancy in adopting microsatellite instability testing on all stage II and III patients due to the retrospective nature of the data and the lack of data with oxaliplatin-based regimens. It is evident that this is an area which needs further research in order to determine whether microsatellite instability, as well as other molecular factors, could help determine who should be given adjuvant therapy. JM One challenge is who should get therapy. The other challenge is establishing the best therapy. The chemotherapy treatment options for colon cancer patients are fluoropyrimidine, which could be given as intravenous 5-fluorouracil 5-FU , plus leucovorin or oral capecitabine, or a combination regimen of 5-FU, oxaliplatin, and leucovorin FOLFOX. Issues have also been raised in the treatment of stage III colon cancer patients. One debate is the use of oxaliplatin in older patients; there have been some analyses in patients older than 70 years that have shown no additional benefit to oxaliplatin compared to fluoropyrimidine alone, but one recent study contradicted this finding. All of these data are retrospective subgroup analyses and, ultimately, a prospective study may be important to mount. However, it is likely that numeric age alone should not be the basis of choice of treatment in elderly patients; assessments of function as well as performance status are being actively studied to determine better ways to develop a treatment program for an elderly patient. Both endpoints were also significant in the stage III-only cohort. The analyses did suggest that high-risk stage II patients may benefit from FOLFOX compared to fluoropyrimidine alone, although the benefit was not statistically significant because the sample size was small. However, the low-risk stage II patients had no benefit from the addition of oxaliplatin to 5-FU and leucovorin in these analyses. This study compared a bolus regimen of 5-FU, leucovorin, and oxaliplatin versus 5-FU and leucovorin. The third trial

was a European trial that looked at capecitabine plus oxaliplatin versus intravenous 5-FU plus leucovorin. All the oxaliplatin-based regimens that have been investigated to date have been administered for 6 months. There are currently 4 ongoing trialsâ€”3 in Europe and 1 in the United Statesâ€”looking at the duration of adjuvant therapy. The data analysis, pooled from all 4 studies, will examine the noninferiority of a shorter course of treatment duration. JM There are currently 3 drugs that have been utilized in metastatic colorectal cancer that have demonstrated no benefit when tested in the adjuvant setting: There have been 3 studies comparing irinotecan to fluoropyrimidine plus irinotecan, and none of them established a statistically significant benefit in disease-free survival. There was a trial in the United States that studied cetuximab limited to KRAS wild-type patients, which did not produce a benefit in cetuximab-treated patients. There is also a European trial looking at cetuximab that is fully enrolled, for which we do not yet have results. It is not clear why these drugs that have efficacy in the metastatic setting do not seem to produce any response in the adjuvant setting, but we hope that the ongoing trials that are examining molecular features of colon tumors will provide an explanation. For patients who have higher risk features, one has to realize that those are prognostic and not necessarily predictive of a benefit from chemotherapy. In patients who have low-risk stage II disease, there should be a discussion with the patient about the unclear benefit of chemotherapy and about the justification of using a combination regimen versus fluoropyrimidine alone. For stage III patients, one should offer adjuvant chemotherapy. For these patients, enrollment in a clinical trial is strongly recommended. The latter hypothesis is based on the strong evidence of a protective benefit of aspirin and COX-2 inhibitors in preventing polyps and colorectal cancer, as well as observational data demonstrating improvement in disease-free survival in colorectal cancer survivors that regularly used aspirin or COX-2 inhibitors. Oxaliplatin, fluorouracil, and leucovorin as adjuvant treatment for colon cancer. N Engl J Med. Oxaliplatin combined with weekly bolus fluorouracil and leucovorin as surgical adjuvant chemotherapy for stage II and III colon cancer: Oxaliplatin, leucovorin calcium, and fluorouracil with or without celecoxib in treating patients with stage III colon cancer previously treated with surgery. Risk assessment in stage II colorectal cancer.

Chapter 4 : Adjuvant Therapy for Stage II and III Colon Cancer â€“ Hematology & Oncology

Background. Patients with stage III (T1 to T4, N) or Dukes C colon cancer have 5-year disease-free survival of around 49%, improving to 64% with the addition of adjuvant chemotherapy.

Sign up now Adjuvant therapy: Treatment to keep cancer from returning Understand your options before you decide whether adjuvant therapy is for you. Balance the side effects with the benefits of treatment when making your decision. Your doctor says the surgery to take out your tumor was a success, but then refers you to another doctor to consider more treatment â€" called adjuvant therapy. What is adjuvant therapy? Adjuvant therapy is often used after primary treatments, such as surgery, to lessen the chance of your cancer coming back. Even if your surgery was successful at removing all visible cancer, microscopic bits of cancer sometimes remain and are undetectable with current methods. Adjuvant therapy given before the main treatment is called neoadjuvant therapy. Which treatments are used as adjuvant therapies? Types of cancer treatment that are used as adjuvant therapy include: Chemotherapy uses drugs to kill cancer cells throughout the body. For cancers sensitive to hormones, certain treatments can stop hormone production in your body or block the effect of hormones. Radiation therapy uses high-powered energy beams, such as X-rays or protons, to kill cancer cells. It can be given internally or externally. Targeted therapy is designed to alter specific abnormalities present within cancer cells. For example, a targeted therapy is available to block the action of a protein called human epidermal growth factor receptor 2 HER2 in women with breast cancer. How effective is adjuvant therapy? The following factors can help you and your doctor determine whether adjuvant therapy is appropriate for you and, if so, which type: Treating certain types of cancer, such as breast and colon cancer, with adjuvant therapy can be very beneficial. For some other types of cancer, there might not be a benefit. If the cancer is at a very early stage â€" before it has had time to spread â€" then the chance of cancer recurring after surgery may be very small. Adjuvant therapy may offer little benefit in this case. But if a cancer is at a later stage or it has spread to nearby lymph nodes, adjuvant therapy may be more beneficial. Number of lymph nodes involved. The more lymph nodes involved, the greater the chance that cancer cells will be left behind after local therapy, such as surgery. Certain cancers may have specific changes within their cells that indicate the likelihood that your cancer will return, making adjuvant therapy more likely to be beneficial. If tests show your cancer is unlikely to recur, adjuvant therapy may offer little benefit. It can, however, help reduce the risk that your cancer will come back. Is adjuvant therapy for you? What procedures are you considering? Find out exactly what will be expected of you during adjuvant therapy. Do you have to see your doctor for injections or will you take pills at home? What are the side effects? What side effects are you willing to live with? What might be too much to tolerate? Do you plan to work or stay active during treatment? Could side effects interfere with your plans? How long will these side effects last? Are any of these side effects permanent? How long will you need to take this therapy? Adjuvant treatments may last from just a few weeks to as long as 10 years. Understand what the recommendations are and why. Understand how likely it is that your cancer will return if you decide against further therapy and how much improvement you might experience if you do undergo additional therapy. Your doctor can estimate how well your treatment will work based on comparisons with data from studies of other people with your same type of cancer, at the same stage and given the same treatment. How is your overall health? People who are otherwise healthy may experience fewer side effects during adjuvant therapy and are more likely to benefit from the therapy. People with severe health problems may be more likely to experience side effects during adjuvant therapy and may be less likely to benefit from the therapy. If you have significant other health problems, such as heart disease or severe lung disease, then the adjuvant treatments may not help you achieve your health goals. What is your preference? Some people want to do everything possible to reduce the chance that their cancer will return, no matter the side effects. Others choose not to tolerate extra side effects if there is likely to be little benefit. Ask your doctor what they recommend and why. These decisions can be very difficult, and your doctor can help you decide whether or not the benefits of adjuvant therapy outweigh the risks for you. What is the cost of the therapy? Most adjuvant therapies recommended by your doctor will be covered by health insurance. However,

some medications and procedures can carry substantial out-of-pocket expenses or copays. Make sure you understand how adjuvant treatment may impact your finances and if the benefits are worth the expense to you.

Chapter 5 : Adjuvant therapy for stage III colon cancer - Cancer Guidelines Wiki

Additional cancer treatment given after the primary treatment to lower the risk that the cancer will come back. Adjuvant therapy may include chemotherapy, radiation therapy, hormone therapy, targeted therapy, or biological therapy.

When he is not in his clinic, he can generally be found at major oncology meetings and often at the microphone, where he stands ready with critical questions for presenters of new data. The opinions expressed in this report are those of the author. If the 6-month course had a 3-year disease-free survival of The six studies asked how much of this gain is lost if only 3 months of oxaliplatin are given and the fluoropyrimidine 5-FU or its oral prodrug capecitabine course also is reduced to 3 months. The long-term toxicity is entirely neurotoxicity from oxaliplatin. Had the only variable been the duration of oxaliplatin, we would not now be having a discussion analyzing the results by which fluoropyrimidine was used. We do not know how the 6-month patients did according to their dose, toxicities, treatment delays and modifications, performance status, and blood cell counts during and at the conclusion of the first 3 months of receiving FOLFOX or CAPOX capecitabine and oxaliplatin. By chance, the group assigned to 6 months could have had more mucosal, hematologic, or neurologic toxicity in the first 3 months than the group assigned to 3 months of chemotherapy. Some of this toxicity in the first 3 months especially neurotoxicity may have led to premature cessation of all chemotherapy short of the 6-month point. To ensure comparability of the assigned groups and that all patients completed the first 3 months of therapy, randomization should have occurred after the completion of 3 months of therapy. Treatment assignment should have been stratified by patient condition, prior toxicity, and current characteristics performance as well as restricted according to organ function, blood cell counts, neurologic function, and willingness of the patient to proceed with treatment at the time treatment arms diverge. Fairness and ethics would have been better served by obtaining patient consent at the 3-month point, when he or she has experienced the toxicitiesâ€”skin and mucosal for 5-FU or capecitabine and cold intolerance, infusional pain, and sensory neuropathy for oxaliplatin. The consent at this point would have been better informed, and the study would have been more likely to answer the question by excluding those who already had stopped chemotherapy or, if toxicity was already severe, would have been likely soon to refuse to proceed with more chemotherapy. Vogl, MD Tweet this quote It makes sense to stratify by events during the first 3 months of therapy and to exclude some patients based on these events. Those who have much more toxicity during the first 3 months likely will have more toxicity in the second 3 monthsâ€”as well as more dose reductionsâ€”and more often will fail to complete therapy. They may prove to gain no benefit at all from trying to complete 6 months. Cautious investigators also would exclude these patients with grade 2 neuropathy from further neurotoxic oxaliplatin as well. Shi herself suggested the duration of therapy for higher-risk patients should be determined in part by tolerability of the chemotherapy during the first 3 months. Too Late to Compare Toxicities? IT MAY NOT be too late to compare toxicities in the first 3 months for both groups to assure both groups were comparable at the point the treatments diverged. Unfortunately, the SCOT trial stopped collecting toxicity data after the first patients were enrolled. Disease-free and overall survival also should be evaluated according to toxicity during the first 3 months of therapy. It may be that those patients with grade 2 or worse neuropathy in the first 3 months obtained no benefit from an attempt to prolong therapy. This information would be very helpful in counseling already numb patients considering whether to endure 3 more months of progessively more toxic therapy. The analyses of progression-free and overall survival should be redone to exclude patients in both groups who stopped therapy before the 3-month point. They might even appear in the lower-risk group. What Would Your Patient Want? This could happen if poorly reversible toxicity such as peripheral neuropathy during initial therapy was severe or moderately severe, if there were early distant relapse, or if some intercurrent catastrophic event occurred. Similarly, if a patient adamantly wants to avoid a venous access device, and infusional pain in the accessed vein during the first few oxaliplatin administrations was nearly intolerable, the decision becomes easy. These events are fairly uncommon, however. A patient would want information on how many patients with early first 3 months grade 1 or 2 peripheral neuropathy go on to develop grade 3 neuropathy with an additional 3 months of oxaliplatin, and

how many actually stop treatment with oxaliplatin before reaching the 6-month point. The patient would ask whether the early onset of neuropathy from oxaliplatin predicts neuropathy that will last longer and remain more severe. And the patient would ask whether the absence of neuropathy after 3 months predicts a lower rate of severe and long-lasting neuropathy after 6 months of therapy are complete. Most important, the patient would ask for the best estimate of the absolute benefit in terms of disease-free and overall survival from an additional 3 months of oxaliplatin. In the near future, once the tests are standardized, the rate of benefit should also include risk estimates based on tumor genetics and gene expression. Concert pianists and violinists, guitar virtuosi, and microvascular surgeons would likely require much greater benefits to risk career-ending toxicities to increase 5-year overall survival by percentages in the low single digits. The IDEA collaborators owe it to our patients to analyze 6-month toxicity by the toxicity observed after 3 months. They should add tumor location right vs left side of the colon to the risk profiles of the tumors. They have already shown that 3 months of CAPOX is a pretty good adjuvant treatment for colon cancer that has not penetrated the colon serosa or invaded adjacent organs and is metastatic to no more than three nodes, although defects in study design and analysis have not nailed this down completely. Vogl reported no conflicts of interest. Prospective pooled analysis of six phase III trials investigating duration of adjuvant oxaliplatin-based therapy 3 vs 6 months for patients with stage III colon cancer: Presented June 4, J Clin Oncol Oxaliplatin-based chemotherapy for patients with stage III colon cancer: Presented June 5, An international phase III randomised 1:

Chapter 6 : Duration of adjuvant therapy for stage III colon cancer: No longer one size fits all | The Bulletin

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Chapter 7 : Duration of Adjuvant Oxaliplatin-Based Therapy for Stage III Colon Cancer - The ASCO Post

Adjuvant therapy for patients with colon and rectal cancer. JAMA. ;(11) Haller DG, Catalano PJ, Macdonald JS, et al. Phase III study of fluorouracil, leucovorin, and levamisole in high-risk stage II and III colon cancer: Final report of Intergroup