response, Ascites disappeared for 15 patients, decreased for 1, showed no change for 4 and increased for 8.
Median progression free survival time was 4.7 months (95% confidence interval (95% CI): 4.7−7.1 months) and median overall survival was 12.3 months (95% CI: 7.3–17.3 months).
Conclusion: FOLFOX in treatment of PC from CRC may be effective but further study is still required.

6093 POSTER

The Absolute Rise in Blood Pressure Better Predicts the Outcome of Bevacizumab in Metastatic Colorectal Cancer (mCRC) Patients Compared to CTCAE

L.H.J. Simkens[1], L. Mol[2], S. Teerenstra[3], C.J.A. Punt[1], M. Koopman[4].
[1]Radboud University Nijmegen Medical Centre, Medical Oncology, Nijmegen, The Netherlands; [2]Comprehensive Cancer Centre, Trial Office, Nijmegen, The Netherlands; [3]Radboud University Nijmegen Medical Centre, Epidemiology Biostatistics and Health Technology Assessment, Nijmegen, The Netherlands; [4]University Medical Centre Utrecht, Medical Oncology, Utrecht, The Netherlands

Background: Hypertension (HT) is a common side-effect of bevacizumab, a monoclonal antibody against VEGF which is currently part of standard first-line treatment in patients with mCRC. We investigated the predictive value of early bevacizumab-induced HT for outcome in mCRC patients using both the National Cancer Institute Common Terminology Criteria for Adverse Events (CTCAE) and absolute rise in blood pressure (BP).
Patients and Methods: We evaluated 378 mCRC patients treated in a randomized phase III trial with first-line chemotherapy and bevacizumab (arm A of the CAIRO2 study of the Dutch Colorectal Cancer Group). Patients with and without HT were evaluated using CTCAE and absolute BP data separately. BP was measured at every visit before start of the next treatment cycle. Patients were divided in 2 groups according to the maximal grade hypertension during the first 3 cycles (group with HT defined as grade 2−3, group without HT defined as grade 0−1), and according to a rise in diastolic or systolic BP of 20 or more mmHg during the first 3 cycles (group with and without rise in BP). Patients who received at least 3 cycles of therapy were evaluated.
Results: According to the CTCAE criteria, 55 (16%) of 340 evaluable patients developed grade 2−3 HT during the first 3 cycles. Patient characteristics were comparable between the 2 groups. Patients with HT had a significantly better median overall survival (OS) (Table). Median progression-free survival (PFS) was not significantly different between patients with and without HT. No effect of HT on OS was seen in multivariate analysis (HR 0.70, 95% CI 0.49–1.01).

Arm A	CTCAE data (n = 340)				Absolute blood pressure data (n = 311)			
	No HT (n = 285)	HT (n = 55)	HR	p	No HT (n = 218)	HT (n = 93)	HR	p
Median PFS	10.6	12.7	0.81	0.19	10.6	13.5	0.86	0.26
(95% CI), mo	(9.4–12.3)	(9.8–15.0)	(0.59–1.11)		(9.3–12.2)	(10.6–14.5)	(0.66–1.11)	
Median OS	20.2	25.0	0.70	0.05	18.4	27.8	0.61	<0.001
(95% CI), mo	(17.5–24.1)	(20.4–32.2)	(0.49–1.00)		(16.7–21.3)	(23.0–32.6)	(0.46–0.82)	<0.001

Absolute BP data were available of 311 patients, 93 (30%) patients developed HT. Patients with HT had a better median OS, with a HR of 0.61 (95% CI 0.46–0.82). We did observe an increase in median PFS in patients with HT however this difference was not statistically significant. In multivariate analysis, HT was an independent prognostic factor for OS (HR 0.59, 95% CI 0.44–0.80).
Conclusions: We found HT defined as an absolute increase of at least 20 mmHg to be better predictive for the outcome of treatment with bevacizumab plus chemotherapy in mCRC patients compared to HT defined according to CTCAE grade 2−3. When further validated, HT defined as a rise in BP of at least 20 mmHg may be used in clinical practice to identify patients that benefit from bevacizumab treatment.

6094 POSTER

Impact of Early Tumour Shrinkage on Long-term Outcome in Metastatic Colorectal Cancer (mCRC) Treated With 5FU+Irinotecan+Leucovorin (FOLFIRI) or Capecitabine+Irinotecan XELIRI Plus Bevacizumab

J.L. Ichante[1], A. Adenis[2], E. François[3], E. Boucher[4], J.P. Pignon[5], M. Ychou[6], J.Y. Pierga[7], C. Montotot-Grillo[8], T. Conroy[9], M. Ducreux[10].
[1]Institut Gustave Roussy, Biostatistics, Villejuif, France; [2]Centre Oscar Lambret, Medicine, Lille, France; [3]Centre Antoine Lacassagne, Medicine, Nice, France; [4]Centre Eugène Marquis, Medicine, Rennes, France; [5]Institut Gustave Roussy, Biostatitics, Villejuif, France; [6]Centre Val d'Aurelle, Medicine, Montpellier, France; [7]Institut Curie, Medicine, Paris, France; [8]Fédération des Centres de Lutte Contre le Cancer, Bect, Paris, France; [9]Centre Alexis Vautrin, Medicine, Nancy, France; [10]Institut Gustave Roussy, Medicine, Villejuif, France

Background: The measurement of tumour shrinkage at the first evaluation (8 weeks) was reported to predict long-term outcome in first line mCRC treated with irinotecan based chemotherapy (CT) + cetuximab. In the CRYSTAL study, the predictor power of early tumour shrinkage (ETS) was restricted to pts treated with CT + cetuximab (Piessevaux, et al. ESMO 2010, abstract 596P). This study has for aim to evaluate the impact of ETS on long-term outcome in patients (pts) receiving irinotecan based CT + bevacizumab.
Material and Methods: The pts treated in the randomized phase II trial ACCORD 13 (Folfiri + bevacizumab vs. XELIRI + bevacizumab) previously reported (Ducreux et al, ASCO 2009, abstract 4086) were included in this post-hoc analysis with a 36 months follow-up. Based on the 8-weekly radiological assessments reported by the investigators, relative changes of the tumour size from baseline were dichotomized using a 20% decrease cut-off value. Univariable analyses for progression-free survival (PFS), and overall survival (OS) were based on Kaplan–Meier curves and logrank test. Multivariable analysis used Cox model and included ETS, Köhne prognostic score; age, sex, and treatment arm.
Results: Two pts out of 145 were excluded from this analysis because of early death. One patient had GI perforation at week 6 leading to stop the study treatment and was considered as non responder. Tumour measurements after 8 weeks of treatment were available in the remaining pts. ETS was observed in 87 pts out of 143 (61%). All the RECIST responders (46) had early shrinkage. Median PFS were 10 months and 9 months in pts with and without ETS, respectively. PFS rates were 97% and 75% at 6 months 23% and 20% at 12 months in the pts with and without ETS, respectively, (Hazard ratio [HR] = 0.84; [0.59–1.20], p = 0.35). The multivariable analysis did not show significant impact of adding ETS to the model. Median OS were 33 months and 22 months for pts with or without ETS, respectively. OS rates were respectively 93% and 79% at 12 months in the pts with or without ETS, the corresponding rates at 24 months were 52% and 36% (HR = 0.59; [0.36–0.97], p = 0.04). The multivariable analysis showed that ETS had the strongest independent prognostic value when it was added to the OS prognostic model (HR = 0.54 [0.32–0.92] p = 0.02), age: p = 0.07, other variables: $p \geqslant 0.28$.
Conclusions: Combination of fluoropyrimidines + bevacizumab gives rapid responses. ETS is able to determine a group of patients with prolonged survival that is rarely observed in mCRC. Despite the absence of effect of ETS on PFS, these results are similar or even better to those observed with CT + cetuximab and their relevance in terms of daily clinical practice remains debatable and need to be confirmed on a large population.