

Momentum

C3: COLORECTAL CANCER COALITION

News from C3: Colorectal Cancer Coalition

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Minimally Invasive Surgery: Thinking Differently About a Colon Surgery

In 2006, Julie Libman, 45, of Bronxville, NY, was diagnosed with stage II colon cancer and learned that she required surgery to remove the tumor in her colon. As she reeled from the diagnosis, she also had to consider the impact of the hospital stay and the recovery time required by the surgery. "I'm a single mom, and had to juggle all of my responsibilities."

After looking into other options, Julie found that she was a candidate for minimally invasive colon surgery (MIS). She thought that, "the possibility of a shorter hospital stay and recovery time was very appealing."

What is MIS?

Open colectomy is currently the most common approach to colon surgery. In an open colectomy, a six to twelve inch incision is made in the abdomen to remove cancerous tumors from the colon. Post-surgical hospital stays average six days, four of which require the patient to receive narcotic pain medication.

MIS (also known as laparoscopic colectomy) was first used in 1990 as an alternative to open colectomy. During MIS, surgeons make two dime-sized incisions and one four-inch incision, insert a tiny lighted camera and use specially-designed surgical instruments to remove the tumor.

Patients receive intravenous pain medication for an average of three days, and take a pain-relief pill for one additional day. The average hospital stay is five days, one day less than with open colectomy.

A 2007 review of published research comparing open colectomy to MIS found that patients receiving MIS had smaller incisions, less pain, and a shorter hospital stay than patients receiving open colectomy. In addition, MIS patients had fewer wound infections and cases of pneumonia. Patients were also able to resume eating and bowel activity sooner.

Several studies have demonstrated:

- » Short-term benefits of minimally invasive surgery
- » No greater risk of cancer recurrence or death

In 2002, Spanish surgeons reported on a trial of 219 patients randomized between open colectomy and MIS. MIS patients recovered faster and spent less time in the hospital. There was no difference in death from any cause. In their study, there was a reduced risk for cancer recurrence with MIS, seen primarily in stage III patients.

Published in 2004, the American COST trial studied 872 patients in 48 hospitals who received either open colectomy or MIS. Again, results showed almost identical rates of overall survival at three years, cancer recurrence, recurrence at the surgical site, and surgical complications. Hospital stays were shorter and patients experienced less pain in the MIS arm.

In Europe, the COLOR trial showed better short-term outcomes with less blood loss, earlier recovery, and shorter stays for MIS patients when compared to patients undergoing an open colectomy. There were no

A 2007 review of all published research comparing open colectomy to MIS found that patients receiving MIS had smaller incisions, less pain, and a shorter hospital stay when compared to patients receiving open colectomy.



JULIE LIBMAN, OF BRONXVILLE, NY FOUND THE BENEFIT OF MIS.

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www.FightColorectalCancer.org



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Put Money Where Our Work Is



CARLEA BAUMAN
EXECUTIVE DIRECTOR

I used to hate asking people for money.

But to my surprise, I have found that asking for donations to C3 is easy.

In my role as Executive Director, I am proud to tell donors that their support goes a long way to winning the fight

against colorectal cancer.

As proof, I show them:

- » Our newsletter, which has thoroughly-investigated, medically-reviewed articles on the latest and best in colorectal cancer research and treatment;
- » Our web site, which is updated almost daily; and
- » The thousands of emails and phone calls to Congress that we've generated through our Action Center.

The fact is that the support of donors allows C3 to provide:

- » A free quarterly newsletter;
- » A web site chock-full of medically-reviewed treatment information;
- » Our Call-on Congress event, where colorectal cancer advocates get the opportunity to sit down with their Members of Congress and make progress in the war against colorectal cancer; and
- » Our Research Advocate Training Program, where we help patient advocates gain the tools they need to make a difference on committees that are forming and shaping clinical trails (we're recruiting for next year's training on page 3).

The support of our donors also allowed C3 to tell you about minimally invasive surgery (page 1), send advocates to the largest gathering of cancer researchers this summer so they could tell you about the latest findings in colorectal

cancer treatment (page 7), submit comments to the Centers for Medicare and Medicaid Services which changed policy to benefit seniors who have colorectal cancer (page 3), and inform patients on FOLFOX that calcium/magnesium supplements could be negatively impacting their chemo regimen (page 5).

C3 does the work that it does because it is committed to winning the fight against colorectal cancer. We know that that war must be fought in Congress and at research centers throughout the country—as well as in your home and your

doctors' offices.

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To do that, we need your help.

As you make your charitable giving decisions this year, please consider C3. There are several ways you can help.

Log onto www.FightColorectalCancer.org

You can feel safe making an online contribution with our secure donation system. You may also send a check to our office in Alexandria, VA

or call us at 703-548-1225 with your credit card information.

Ask your Employer about Corporate Matching
Many companies offer matching gift programs to encourage employees to contribute to charitable 501(c)3 organizations like C3.

Consider a Planned Gift

Talk to your financial advisor on how to list C3 as a recipient of a gift through bequests, trust agreements, life insurance, and retirement accounts. In the coming months, C3 will have more information on its web site explaining the various ways you can contribute.

And when you do, you'll know that your donation is making a difference in the lives of the millions of Americans who have been affected by colorectal cancer. ❖

CMS ISSUES DECISION ON COVERAGE OF ERYTHROPOIESIS STIMULATING AGENTS (ESAs) — C3 CITED

In May 2007, the Centers for Medicare and Medicaid Services (CMS) announced a proposal to discontinue coverage for Erythropoiesis Stimulating Agents (ESAs), a type of drug that can be part of supportive care for patients with colorectal cancer.

ESAs, better known under brand names Procrit, Epogen and Aranesp, were approved by the Food and Drug Administration (FDA) to aid with chemotherapy-induced anemia.

C3 was concerned about several aspects of the proposed ruling and submitted comments to CMS on June 13, 2007. In July, CMS issued its final ruling on ESA coverage.

The concerns raised by C3 made a difference for the thousands of Americans who rely on Medicare for their colorectal cancer care. Every issue we raised in our comments impacted CMS's final decision. In fact, C3 was specifically mentioned in the decision as one of only three patient groups who met with CMS to discuss the proposed ruling (page 7 of 61 of "Decision Memo for Erythropoiesis Stimulating Agents (ESAs) for Non-Renal Disease Indications (CAG-00383N)".

C3 is proud to have represented the colorectal cancer community on this issue, and we are grateful to CMS for its willingness to listen to our concerns.

For a detailed list of C3's concerns and CMS's responses, log on to www.FightColorectalCancer.org/news/2007/08/. ❖

Drug User Fee Act Expected to Pass

The Prescription Drug User Fee Act (PDUFA) is a law that allows the Food and Drug Administration (FDA) to fund the review of new drugs through fees paid by companies that submit new drug applications. PDUFA was first enacted in 1992 and has been reauthorized twice, in 1997 and 2002.

PDUFA IV's reauthorization date is September 30, 2007. FDA does not receive enough funding from the federal government alone to adequately bring safe, life-saving therapies to market in a timely fashion. If the User Fee Program does not get reauthorized in time, FDA will be unable to retain its current review staff. This will compromise the safety of millions of Americans.

FDA worked in conjunction with patient groups, industry and other stakeholders for most of 2007 to develop a new proposal for the reauthorization of PDUFA.

In May, the Senate passed PDUFA with an increase of \$30 million to improve post-approval drug safety by a vote of 93-1. Post-approval drug safety monitoring will help catch negative side effects that may become apparent only after the drug is used by the general public. Post-marketing surveillance can find and correct problems like increased risk of heart attacks associated with the use of VIOXX for arthritis.

PDUFA passed in the House over the summer. At press time, both bills were in Conference Committee (a committee comprised of Senators and Representatives) to work out differences between the two. Once the final bill is agreed upon, the President is expected to sign it.

Be sure to check the Advocacy blog at www.FightColorectalCancer.org for updates. ❖

Calling All GI Cancer Research Advocates!



C3 RESEARCH PROGRAM
MANAGER ANDREW GIUSTI
AT THE 2007 TRAINING

C3 is pleased to announce that the third annual Gastrointestinal (GI) Research Advocate Training will be held on January 25-28, 2008 in Orlando, FL.

The goal of the training is to strengthen the advocacy skills of

patient representatives who serve on various research groups throughout the country.

This training will again be held in conjunction with the Gastrointestinal Cancers Symposium: Multidisciplinary Approaches to the Prevention, Diagnosis, and Therapy of Gastrointestinal Cancers. The Symposium is jointly developed by the American Society of Clinical Oncology (ASCO), the American Gastroenterological Association Institute, the American Society for Therapeutic Radiology and Oncology, and the Society of Surgical

Oncology. This Symposium brings together leading experts on gastrointestinal cancers to present and discuss new research on prevention, screening, and treatment.

Want to Join Us?

Are you currently serving as a patient advocate with a focus on GI cancers on:

- The National Cancer Institute's CARRA program?
- The Food and Drug Administration's Patient Consultant Program?
- A cooperative group or SPORE?
- An institutional review board (IRB) or data safety monitoring board (DSMB)?
- A nationally recognized patient advocacy group?

If so, the Research Advocate Training is a great opportunity to improve your skills as an advocate and to learn about the latest clinical trial results across all GI cancers.

Applicants accepted to attend will have all of their travel and lodging expenses paid, and will be registered to attend the GI Symposium. ❖

For more information or to apply for the training go to www.FightColorectalCancer.org/research/advocacy_training

Palmetto State Advocacy: How Anjee Davis is Making a Difference



Anjee Davis first worked with C3 when she joined us for our Lobby Day and Training in Washington, DC, in 2006. She works at the Center for Colon Cancer Research (CCCR) at the University of South Carolina, a basic science research organization

funded by the National Institutes of Health.

Judi Sohn spoke with her recently about her commitment to reaching every South Carolinian with information about colorectal cancer.

Why did you start working for the Center for Colon Cancer Research (CCCR) at USC?

I am not a cancer survivor myself. My first job in cancer was as a clinical research coordinator.

That job provided me with an intimate look at the challenges faced by cancer patients and their families. I was deeply touched by my experiences at the "front line" of this fight. Working directly with cancer patients, for any period of time, inevitably affects one's outlook on life.

CCCR was awarded over \$11 million to develop a state-of-the-art research facility and to support young, up-and-coming researchers focused on colon cancer. Initially, I performed mostly administrative tasks. I quickly learned that South Carolina faces many challenges in fighting back against colorectal cancer, with over 2,000 new cases and nearly 800 deaths a year.

CCCR has developed an initiative to bridge the laboratory to the community. My job duties now include engaging and collaborating with patient advocates, policy makers, service providers, and community leaders to support and strengthen colon cancer research and its impact. I work with our state cancer coalition, the South Carolina Cancer Alliance, the Department of Health and Environmental Control, the American Cancer Society, and organizations like C3.

C3 was proud to be a silver sponsor of the masquerade gala for colorectal cancer awareness held at the Citadel in February 2007. You helped organize the gala. How did that come about and what was the event's impact?

The gala was the dream of fellow C3 advocate, JoEllen DeLuca. Months before the event, JoEllen invited local advocates to her home and laid out her vision of a gala for South Carolina colorectal cancer awareness. We formed a committee and together we pulled the event into shape. In addition to the CCCR, we reached out to the Gibbs Regional Cancer Center in Spartanburg, SC, and to C3 to support our successful efforts. We had over 200 in attendance on February 28, 2007 and we raised over \$30,000.

"Anjee has brought together a number of professional and lay communities, and has nurtured them into a substantive dialogue about this very preventable disease. Her efforts have earned the deep respect and admiration of people all around the state. We are truly fortunate to have her here in South Carolina!"

*Dr. Frank Berger
Director, Center for Colon Cancer Research*

there is still work to be done to improve education and awareness in our state. Our second annual gala is set for March 1st, 2008!

What's next for Anjee Davis, colorectal cancer advocate?

My family has a long history of cancer but it wasn't until I was an adult and was personally involved did I understand the complexities of cancer and how its effects go far beyond diagnosis and treatment. Working at the CCCR has been a turning point for me professionally and personally. We can't ignore the fact that colorectal cancer is largely preventable. There is an opportunity to do so much in the areas

of research, education, and outreach and this is what drives my professional aspirations.

I didn't feel like an "advocate" until C3 invited me to attend their first Lobby Day and Training in 2006. That was an experience I won't forget. I came back from that trip having met so many wonderful people and inspired for action. In South Carolina we could do great things to increase screening and awareness for colorectal cancer. I feel very fortunate to have a job that I am able to be passionate about. ❖



DUSTY WEAVER
GRASSROOTS
COORDINATOR

DUSTY'S RECIPE FOR ACTION

The President's Fiscal Year 2008 budget cut the National Institutes of Health's (NIH) funding by about 1%. NIH is the federal entity that leads medical research in the US, including research for cures for cancer.

Bills passed in the House and Senate increased NIH funding but neither came close to even meeting the rate of inflation for biomedical research (3.7%), to say nothing of the 6.7% increase that C3 advocated for.

Outraged? You should be. Put that anger to good use:

- ✓ Log onto www.FightColorectalCancer.org/OneMinuteAdvocate and take action today.
- ✓ Use the Internet. Post comments on blogs, MySpace, Facebook and other social networking sites. Help raise awareness online that cancer funding is under attack.
- ✓ Write a letter to the editor of your hometown newspaper.
- ✓ Talk about this issue with your family and friends. Get them involved in the fight.
- ✓ Regularly visit the C3 website for up to date information. The Advocacy News blog on the main page at www.FightColorectalCancer.org is updated weekly with information that will help you.

A final decision on FY08 funding will be made this fall. Advocates can still make a difference. Get on the bandwagon! ❖

Minimally Invasive Surgery *Continued from page 1*

differences in complications or deaths during the month after surgery. COLOR also found that elderly and obese patients could safely undergo minimally invasive surgery.

Finally, long term outcomes of the 794 patient United Kingdom CLASICC randomized trial were recently published in the Journal of Clinical Oncology. CLASICC was the first trial to include rectal cancer patients. After three years there was no significant difference in overall survival, disease-free survival or quality of life. Outcomes for rectal cancer patients, including local recurrence, were the same whether laparoscopic or open surgery was used.

MIS Limitations:

- » About 15 to 20 percent of MIS procedures must be converted to open surgeries when problems are encountered.
- » Operations take longer and surgical techniques are complex with a higher learning curve. However, while longer surgeries translate into higher costs, a cost-analysis done as part of the COLOR trial found that the shorter hospital stays balanced out the higher surgical costs. CLASICC also found a very small difference in overall cost.
- » MIS is not appropriate for all patients. Scar tissue from previous surgeries, large bulky tumors, bowel obstruction, morbid

obesity, or pulmonary problems may make a laparoscopic approach more difficult for some patients.

"At the end of the day, patients facing colon surgery should work with an experienced surgeon to determine which type of surgery is best for that person," says Kate Murphy, C3's Director of Research Communication. ❖

What is a colon and rectal surgeon?*

Colon and rectal surgeons are experts in the surgical and non-surgical treatment of colon and rectal problems. They have completed advanced training in the treatment of colon and rectal problems in addition to full training in general surgery. Colon and rectal surgeons treat benign and malignant conditions, perform routine screening examinations and surgically treat problems when necessary.

What does it mean to be board-certified?

The surgeon who has attained Certification by the American Board of Colon and Rectal Surgery (ABCRS) has specialized knowledge and skill with regard to problems of the colon, rectum, anus and small bowel.

Finding a board-certified colorectal surgeon:

The American Society for Colon and Rectal Surgeons website allows you to search for board-certified colon and rectal surgeons.

**Adapted from the American Society of Colon and Rectal Surgeons, www.FASCRS.org*

*Reviewed by Nicholas Petrelli MD,
Helen F Graham Cancer Center*

Warning for Patients on FOLFOX Using Calcium/Magnesium for Neuropathy

Preliminary data indicate that the use of calcium/magnesium to reduce neuropathy caused by Eloxatin (oxaliplatin) in FOLFOX chemotherapy might also reduce its effectiveness.

In the CONCEPT* trial, patients receiving FOLFOX and bevacizumab were also randomized to an infusion of magnesium sulfate and calcium gluconate before and after oxaliplatin in a double-blind placebo controlled fashion. The preliminary data from the first 174 patients in the trial showed that patients who had received calcium/magnesium had significantly less tumor shrinkage than patients who did not receive calcium/magnesium.

As a result, the trial was closed and all patients on the trial will receive future treatment without calcium/magnesium. Data verification is ongoing, and results will be reported in 2008.

On July 31, 2007, the Journal of Clinical Oncology published a letter from the trial's primary investigators. They conclude that "... Oncologists should recognize the possibility that calcium and magnesium may reduce the activity of FOLFOX and bevacizumab in the treatment of colorectal cancer ...For the time being, we would urge that calcium and magnesium salts particularly be avoided in the adjuvant setting ..."

What this means for patients

If you are receiving calcium/magnesium as treatment for neuropathy related to your FOLFOX regimen, talk to your doctor to be sure that he or she is aware of this preliminary data. If your doctors need more information, they can contact sanofi-aventis Medical

POSITION STATEMENT OF THE AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS (ASCRS)

Laparoscopic colectomy for curable cancer results in equivalent cancer-related survival to open colectomy when performed by experienced surgeons. Adherence to standard cancer resection techniques including, but not limited to, complete exploration of the abdomen, adequate proximal and distal margins, ligation of the major vessels at their respective origins, containment and careful tissue handling, and en bloc resection with negative tumor margins using the laparoscopic approach will result in acceptable outcomes. Based upon the COST trial, pre-requisite experience should include at least 20 laparoscopic colorectal resections with anastomosis for benign disease or metastatic colon cancer before using the technique to treat curable cancer. Hospitals may base credentialing for laparoscopic colectomy for cancer on experience gained by formal graduate medical educational training or advanced laparoscopic experience, participation in hands-on training courses and outcomes.

Source: www.FASCRS.org

Information Service at 1-800-633-1610, option 1.

While this data is preliminary, patients and doctors should take it into account when planning treatment. ❖

Resources:

Hochster et al, Journal of Clinical Oncology, Vol 25, No 25 (September 1), 2007. Published online ahead of print on July 31 2007

* CONCEPT Trial — a Phase IV, Randomized, Prospective Multicenter comparison of an Intermittent Schedule of Oxaliplatin combined with 5-Fluorouracil/Leucovorin (FOLFOX) / Bevacizumab Versus the Conventional Mode of Administration of FOLFOX/Bevacizumab PLUS Neuroprophylaxis With Calcium/Magnesium for the Optimization of First-Line Therapy of Metastatic Colorectal Cancer.



CALL-ON CONGRESS

There comes a time when you must take your fight against colorectal cancer out of your doctor's office and into the halls of Congress.

This is that time.

Join C3: Colorectal Cancer Coalition at the second annual Call-on Congress

March 9 – March 12, 2008
Washington, DC

*Join your fellow colorectal cancer advocates and
make your voice heard on Capitol Hill.*

Schedule of Events:

Sunday, March 9th

Meet your fellow advocates at our Welcome Dinner

Monday, March 10th

Receive training in grassroots lobbying from the professionals

Tuesday, March 11th

Meet with your elected officials on Capitol Hill during the day
and celebrate your newfound inner-lobbyist at our
Advocate Awards Dinner that evening!

Register today at
www.FightColorectalCancer.org/ConC2008

ASCO Research Review by C3 Advocates

The annual American Society of Clinical Oncology (ASCO) meeting brings oncologists together to communicate important research results and the implications for patient care. This year's meeting, held June 3 – 6 in Chicago, IL, attracted over 30,000 attendees. Research presented ranged from small, exploratory studies to large, randomized studies; from information about new treatments to information about the best way to use existing treatments.

Kate Murphy and Pam McAllister are long-time colorectal cancer research advocates who keep C3 up-to-date on research findings. C3 sent Pam and Kate to ASCO 2007, and asked them to review and comment on some of the presentations they considered important.

A detailed version of this article containing additional research presentations and resources is online at www.FightColorectalCancer.org/momentum/Fall2007/research.

Can we decrease oxaliplatin-induced neuropathy without decreasing treatment efficacy?

When patients have metastatic colorectal cancer that cannot be removed by surgery, they may still receive treatment with chemotherapy plus a biologic treatment (e.g. Avastin (bevacizumab) or Erbitux (cetuximab)). Current practice is to provide continuous chemotherapy until tumors grow, with the goal of increasing survival time. However, long-term chemotherapy can cause intolerable side effects, such as neuropathy.

In the OPTIMOX trials, European researchers compared ways to decrease neuropathy due to treatment with FOLFOX, using an induction – maintenance strategy:

- » Induction treatment: intense initial treatment to shrink tumor(s)
- » Maintenance period: Time off from treatment to allow the body to recover

Final results from OPTIMOX-2 were presented in June 2007 by Dr. Frederique Maindrault-Goebel, and results from the two trials were compared. The trial arms and conclusions from the presenter are in the chart below.

What does this mean to patients?

Maintenance treatment with LV5FU2 alone is the appropriate choice for patients.

These conclusions should be taken into account when choosing a treatment strategy, and do not apply to patients receiving short periods free of chemotherapy to recover from toxicity or for other reasons such as the wish for a vacation from treatment.

Reviewed by Axel Grothey MD, Mayo Clinic

Source :
OPTIMOX-2: Maindrault-Goebel F, et al. ASCO 2007. Abstract 4013
OPTIMOX-1 : De Gramont A, et al. ASCO 2004. Abstract 3525

What is the best treatment for patients with liver metastases (mets) that can be surgically removed (resected)?

Medical and surgical oncologists generally agree that elimination (by surgery or ablation) of liver mets is the only potentially curative treatment for colorectal liver metastases.

Research is evaluating different ways to combine chemotherapy and surgery. In the EORTC 40983 (EPOC) trial, European researchers compared surgery alone to surgery with chemotherapy before and after surgery. 364 patients with up to 4 resectable liver mets were randomized between two arms.

Results from the trial were not clear-cut. Bernard Nordlinger MD, presented the data, and concluded that:

“This treatment (chemotherapy before and after surgery) should be proposed as the new standard for these patients (patients with resectable liver mets), and should be delivered by a multidisciplinary team.”

However, Nicholas Petrelli MD, offered a different perspective in his discussion of the results. He concluded that surgical removal of liver mets before chemotherapy is a good option for patients with resectable mets, because harm to healthy liver tissue from chemotherapy is a risk. These risks were reported in the EORTC EPOC trial where reoperations, biliary fistulae, liver failure and intra abdominal infections were greater in the chemotherapy plus surgery versus the surgery alone group.

Take-away for patients:

A single preferred first-line treatment does not exist for newly-diagnosed patients with stage IV colorectal cancer and resectable liver mets. Pre-surgical chemotherapy may or may not be appropriate. Patients must work with a multi-disciplinary treatment team that includes medical and surgical oncologists to evaluate options and make a decision that works best for each patient.

Source: Nordlinger B, et al. ASCO 2007. Abstract LBA5

*Reviewed by Nicholas Petrelli MD,
Helen F Graham Cancer Center*

For answers to questions such as:

- » *Is first-line treatment of Erbitux (cetuximab) and FOLFIRI for patient with metastatic colorectal cancer effective?*
- » *Does FOLFOX improve survival in patients with stage II or stage III colorectal cancer?*
- » *Can we use biological markers to predict who will benefit from which treatments for colorectal cancer?*

And for links to specific ASCO presentations relevant to colorectal cancer, and credible discussions by leading oncologists go to www.FightColorectalCancer.org/momentum/Fall2007/research

Trial Name	Trial Arms	Conclusion
OPTIMOX-1	1. Continuous FOLFOX	Continuing FOLFOX until treatment failure is no more effective and has more toxicities than induction treatment with FOLFOX and maintenance treatment with LV5FU2.
	2. Induction treatment with FOLFOX followed by maintenance with infusional 5-FU/leucovorin (LV5FU2)	
OPTIMOX-2	1. Induction treatment with FOLFOX followed by maintenance with infusional LV5FU2	Maintenance treatment with LV5FU2 increases patient survival when compared to a CFI.
	2. Chemotherapy-free interval (CFI)	



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info@FightColorectalCancer.org
or call our office at 703-548-1225.

www.FightColorectalCancer.org

Current Colorectal Cancer News and Events www.FightColorectalCancer.org/news Stay up-to-date with what's happening in the colorectal cancer field: media reports, new clinical trials, current research results, conferences and other events, and advocacy action opportunities. Reported by Kate Murphy. Also available via RSS feed to your desktop at feeds.feedburner.com/c3news

Personalized Clinical Trials Search www.FightColorectalCancer.org/patients/clinicaltrials Use the C3 interactive interview to find clinical trials that meet your individual needs and get telephone assistance in choosing and enrolling in a trial.

Information for Patients www.FightColorectalCancer.org/patients Learn all you can about colorectal cancer diagnosis and treatment, how to manage side effects, and how to cope with life with CRC. Discover resources for support and strength on the internet and in your community.

Grassroots Communities of Engagement www.FightColorectalCancer.org/advocacy Policy & Grassroots Manager Joe Arite and Grassroots Coordinator Dusty Weaver provide advocates with clear, effective messaging that helps us produce the results we need for colorectal cancer research and screening. Become a One Minute Advocate at www.FightColorectalCancer.org/advocacy/oneminuteadvocate.



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