By Stacey Small

Chemotherapy Plus Radiation Extends Survival in Patients With Anaplastic Oligodendroglial Tumors: Long-Term Follow-Up Results of EORTC 26951

Van Den Bent and associates presented long-term follow-up results of a phase III study conducted by the European Organisation for Research and Treatment of Cancer (EORTC 26951; Abstract 2). The study demonstrated that administration of combination chemotherapy after standard radiation therapy delayed tumor growth and extended survival in patients with anaplastic oligodendroglial tumors. According to a subanalysis of the study, patients whose tumors contained 1p/19q co-deletions appeared to have the most benefit from chemotherapy. A total of 368 patients with newly diagnosed, previously untreated anaplastic oligodendroglial tumors were enrolled. Patients were randomized to receive either radiotherapy 59.4 Gy alone or radiotherapy followed by 6 cycles of lomustine (CCNU) 110 mg/m^2 on day 1, procarbazine (Matulane, Sigma-Tau Pharmaceuticals) 60 mg/m^2 on days 8–21, and intravenous (IV) vincristine 1.4 mg/m^2 on days 8 and 28 (PCV). Progression-free survival (PFS) was 24.3 months in the radiation/PCV group and 13.2 months in the radiation-only group. Median overall survival (OS) was 42.3 months in the radiation/PCV arm and 30.6 months in the radiation-only arm (hazard ratio [HR], 0.75; 95% confidence interval [CI], 0.60–0.95). Patients with tumors containing 1p/19q co-deletions (n=76) had improved median OS when treated with radiation/PCV versus radiation alone (median OS not reached vs 113 months, respectively; HR, 0.54; *P*=.0487). There was no significant difference in median OS among patients without 1p/19q co-deletions between treatment arms (25 months in the radiation/PCV arm vs 22 months in the radiation-only arm; HR, 0.82; *P*=.18). There was a slight trend for improved OS in patients with *MGMT*-methylated and *IDH*-mutated tumors versus unmethylated and *IDH* wild type tumors.

Regorafenib Significantly Improves Progression-Free Survival in Patients With GIST: Results of the GRID Trial

According to results from a randomized, phase III trial presented by Demetri and colleagues (Abstract LBA10008), the oral multikinase inhibitor regorafenib reduced the risk of disease progression by 73% in patients with gastrointestinal stromal tumors (GISTs). The GIST-Regorafenib in Progressive Disease (GRID) trial involved 199 patients with metastatic and/or unresectable GIST that had become resistant to imatinib (Gleevec, Novartis) and sunitinib (Sutent, Pfizer). Patients were randomized to receive best supportive care plus regorafenib (160 mg orally once daily on a 3-weeks-on, 1-week-off cycle; 133 patients) or placebo (66 patients). For patients assigned to placebo, crossover to open-label regorafenib was allowed upon disease progression; 85% of patients in the placebo arm went on to cross over to regorafenib. Treatment with regorafenib led to a statistically significant 3.9-month improvement in PFS, as compared with placebo (4.8 months vs 0.9 months; HR, 0.27; 95% CI, 0.19–0.39; *P*<.0001). Disease control rates were 53% and 9% with regorafenib and placebo, respectively. The median OS was not reached at the time of analysis. Given the high rate of crossovers, there were no survival differences between arms (HR, 0.77; 95% CI, 0.42–1.41; *P*=.199). The safety profile of regorafenib was commensurate with previous studies. The most common adverse events of grade 3 or higher associated with regorafenib were hand-foot skin reaction (21%), hypertension (28%), and diarrhea (8%). These events were managed with dose modifications and did not result in higher rates of discontinuation.

Continuous Androgen Therapy Better Than Intermittent Therapy for Most Prostate Cancer Patients: Results of the S9346 (INT-0162) Trial

Hussain and coworkers reported results of the international phase III S9346 (INT-0162) trial (Abstract 4), which demonstrated that intermittent hormonal therapy is less effective than continuous therapy in patients with metastatic prostate cancer who have minimal disease. The trial included 1,535 patients whose prostate-specific antigen (PSA) fell to 4 ng/mL or lower after 7 months of continuous hormonal therapy. Patients were randomized to either continuous or intermittent therapy. Patients in the intermittent arm received approximately half the dose of hormonal therapy as patients in the group treated continuously. The primary endpoint was OS, and a co-primary endpoint was quality of life (QOL). After a follow-up of 9.2 years, patients with minimal disease spread had a median OS of 7.1 years in the continuous group versus 5.2 years in the intermittent group. In contrast, patients with extensive disease spread had a median OS of 4.4 years in the continuous group versus 5 years in the intermittent group. For patients with extensive disease, intermittent therapy was found to be noninferior to continuous therapy, whereas continuous therapy was the preferred treatment in patients with minimal disease.