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***Retrospective Cohort Study***

**Hepatic artery infusion with raltitrexed or 5-fluorouracil for colorectal cancer liver metastasis**

Guo JH *et al.* HAIC for colorectal liver metastasis patients.

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**Abstract**

***AIM***

To evaluate the efficiency and safety of hepatic artery infusion chemotherapy (HAIC) using raltitrexed or 5-fluorouracil for colorectal cancer (CRC) liver metastasis.

***METHODS***

A retrospective analysis of unresectable colorectal liver metastasis patients who failed systemic chemotherapy and were subsequently treated with HAIC at our institute from May 2013 to April 2015. A total of 24 patients were treated with 5-fluorouracil, and 18 patients were treated with raltitrexed.

***RESULTS***

The median survival time (MST) from diagnosis of CRC was 40.8 mo in the oxaliplatin plus raltitrexed (TOMOX) arm and 33.5 mo in the oxaliplatin plus 5-fluorouracil (FOLFOX) arm (*P* = 0.802). MST from first HAIC was 20.6 mo in the TOMOX arm and 15.4 mo in the FOLFOX arm (*P* = 0.734). Median progression-free survival (PFS) from first HAIC was 4.9 mo and 6.6 mo, respectively, in the TOMOX arm and FOLFOX arm (*P* = 0.215). Leukopenia (*P* = 0.026) was more common in the FOLFOX arm, and hepatic disorder (*P* = 0.039) was more common in the TOMOX arm. There were no treatment-related deaths in the TOMOX arm and one treatment-related death in the FOLFOX arm. Analysis of prognostic factors indicated that response to HAIC was a significant factor related to survival.

***CONCLUSION***

No significant survival difference was observed between the TOMOX and FOLFOX arms. HAIC treated with both treatments was demonstrated as efficient and safe alternative choices.

**Key words:** Hepatic artery infusion chemotherapy; Raltitrexed; Colorectal cancer; Liver metastasis; FOLFOX

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**Core tip:** Our study finds out that hepatic artery infusion chemotherapy (HAIC) treated with both TOMOX (oxaliplatin plus raltitrexed) and FOLFOX (oxaliplatin plus 5-fluorouracil) were proven to be efficient and safe alternative choices for chemotherapy refractory CRCLM patients and no significant survival difference was found between these two treatments. Cox univariate analysis shows that response to HAIC was a significant predictive factor.

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**INTRODUCTION**

Colorectal cancer is considered the third leading cause of cancer death and the third leading incidence of new cases in western country[[1](#_ENREF_1)]. The situation in China is similar; there were 376.3 thousand new colorectal cancer cases in 2015, and colorectal cancer was the fifth leading cause of cancer death[[2](#_ENREF_2)]. Approximately 30%-50% patients develop liver metastasis, and no more than 20% of liver metastasis patients are candidates for liver resection[[3](#_ENREF_3),[4](#_ENREF_4)]. Chemotherapy is the primary treatment for advanced colorectal cancer. The efficiency and survival benefit of standard first- or second-line systemic therapy has been improved by the combination of targeted therapy[[5](#_ENREF_5),[6](#_ENREF_6)], and the overall survival time of effective first-line therapy is nearly 30 mo[[7-9](#_ENREF_7)]. However, the survival of chemotherapy refractory patients, who failed previous systemic treatment, is expected to improve. Third-line chemotherapy could result in a 9.3 mo overall survival time[[10](#_ENREF_10)]. Alternative treatments, such as TACE and HAIC, are greatly needed.

HAIC with FOLFOX in patients pre-treated with CRCLM has also been demonstrated as a feasible and low-toxicity treatment, with a local overall disease control rate of 50%-79.2%[[11](#_ENREF_11),[12](#_ENREF_12)]. However, 5-Fu should be administered intra-arterially for approximately 42 h, and a higher incidence of catheter thrombosis and catheter-associated infection is required[[13](#_ENREF_13)]. As a specific inhibitor of thymidylate synthase, raltitrexed has been used in CRC patients and could be infused in approximately 1 h. Several previous studies have shown that TOMOX showed efficiency similar to other traditional first-line treatments in CRC patients and was associated with less neutropenia and gastrointestinal toxicity and uncommon cardiotoxicity[[14-16](#_ENREF_14)]. However, studies concerning HAIC with TOMOX are rare. Cedric *et al*[[3](#_ENREF_3)] examined seventeen patients who underwent HAIC with TOMOX, and the treatment was demonstrated as a safe alternative choice. The goal of this retrospective study was to report a head-to-head study comparing the TOMOX and FOLFOX arms treated at our center.

**MATERIALS AND METHODS**

***Study design and patient population***

From May 2013 to April 2015, 42 patients were treated with oxaliplatin-based HAIC at our center. All of the patients were histologically confirmed with colorectal adenocarcinoma with unresectable liver metastasis and failed two lines of systemic chemotherapy. The following treatment criteria for HAIC were as considered: ECOG performance status no more than 2 points; life expectancy ≥ 3 mo; tumor involvement less than 70% of liver volume; and adequate liver and renal dysfunction (total bilirubin serum levels < 3 mg/dL, serum albumin level > 20 g/L, serum creatinine level < 2 mg/dL). Patients with extrahepatic metastases were included if their main lesion remained in the liver.

***Operative technique***

The Seldinger technique was used to access the femoral artery after the rejection of local anesthesia. Then, arteriography was routinely performed prior to chemoembolization to gather information for the abdominal aortic, celiac trunk. Subsequently, a coaxial catheter (Renegade Hi Flo, Boston Scientific, United States/Stride ASAHI INTECC, Japan) was inserted into the hepatic artery and subsegmental arteries. According to tumor stain, Spongostan particles (Jinling, Nanjing, China) and iodized oil (Lipiodol; Laboratoire Andre Guerbet, Aulnaysous- Bois, France) mixed with 20–40 mg epirubicin hydrochloride (Main Luck Pharmaceutical, Shenzhen, China) was injected. The temporary indwelling catheter was inserted into the hepatic artery until the end of HAIC. HAIC was performed via the catheter with OXA (Hengrui Medicine Co., Ltd., Jiangsu, China) administered at 85 mg/m2 in 4 hours, 5-Fu (Jinyao aminoacid Co., Ltd., Tianjing, China) administered at 2000 mg/m2 in approximately 44 h and CF (Hengrui Medicine Co., Ltd. Jiangsu China) administered at 200 mg/m2 in 2-4 h *via* the peripheral vein and raltitrexed (Tianqing Pharmaceutical Co., Ltd., Nanjing, China) administered at 3 mg/m2 in approximately 1 h. At the end of perfusion, the catheter was removed every cycle.

HAIC was regularly treated every 3 wk, until the patient died or liver function was Child-Pugh C or disease progressed. Enhanced CT or MRI and laboratory tests were regularly performed, and all patients were followed up until death or loss to follow-up. Objective response rate (ORR) was evaluated using Response Evaluation Criteria in Solid Tumor (RECIST) version 1.1, and adverse reaction was evaluated using Common Terminology Criteria for Adverse Events (CTCAE) 2.0. Peripheral neuropathy was graded according to a modified Levi Scale.

***Statistical analysis***

Overall survival time (OS) after diagnosis was calculated from the date of diagnosis of colorectal cancer to the date of death or last follow-up time, OS after first HAIC was calculated from the date of first HAIC to the date of death or last follow-up time. PFS was calculated from the date of the initiation of therapy to the date of disease progression. A biomedical statistician conducted the statistical review in the present study. The SPSS software program (version 19; SPSS, Chicago, Illinois) was used for the analyses. GraphPad Prism 6 (GraphPad Software, Inc., La Jolla, CA) was used to generate the charts. For all tests, a *P* value < 0.05 was defined as significant. Student’s t-test was used to analyze the continuous variables. These variables were reported as the means ± SD if normally distributed or as a median and range if skewed. The *χ*2 test was used to analyze the categorical variables. These variables were reported as a proportion (%) of the overall cohort. The Kaplan–Meier method was used to approximate the progression-free disease and overall survival, and the significance of survival differences between the TOMOX and FOLFOX arms was determined using the log-rank test.

**RESULTS**

***Patient characteristics***

There were 18 patients in the TOMOX arm and 24 patients in the FOLFOX arm. The baseline characteristics of the patients are shown in Table 1. The baseline demographics were similar between the two treatment groups, with no significant imbalances in sex, age, primary tumor site, time of liver metastasis, KRAS mutation rate, extrahepatic metastasis and additional radiofrequency ablation. Patients in the TOMOX arm received a median of 2.2 cycles of treatment, and those in the FOLFOX arm received a median of 2.1 cycles of treatment.

***Efficacy and toxicity***

With a median follow-up of 18 months, the overall survival after the first HAIC in the FOLFOX and TOMOX arms was 15.4 and 20.6 mo (*P* = 0.734), respectively. The PFS in the FOLFOX and TOMOX arms was 6.6 and 4.0 months (*P* = 0.215), respectively. The response rate of the two different treatment groups is shown in the Table 2. The overall response rate was 29.2% in the FOLFOX arm and 11.1% in the TOMOX arm (*P* = 0.158). No significant difference was observed between the FOLFOX and TOMOX groups.

Cox univariate analyses (Table 4) showed that the response to HAIC was a predictive factor for prognosis. However, age, histology grade, primary tumor site, serum tumor markers and extrahepatic metastasis showed no significance as a predictive factor.

All patients were evaluated for toxicity assessments. The toxicity of the two groups is shown in Table 3. The most common adverse events were transient elevation of serum liver enzymes and bilirubin and abdominal pain. The transient elevation of serum liver enzymes was more frequent in the TOMOX arm than in the FOLFOX arm (100% *vs* 79%, *P* = 0.039). Hematologic AEs were more frequent in the FOLFOX arm than in the TOMOX arm (Leukopenia: 16% *vs* 50%, *P* = 0.026; Anemia: 39% *vs* 46%, *P* = 0.212; and Thrombocytopenia: 44% *vs* 54%, *P* = 0.533). No significant differences were observed in fever, asthenia, nausea and vomiting and neuropathy between these two treatment groups. Treatment associated cardiotoxicity was not observed in either group. One treatment-related death, diagnosed as neutropenic sepsis, occurred in the FOLFOX arm. No treatment-related death was observed in the TOMOX arm.

**DISCUSSION**

Without an efficient treatment, systemic chemotherapy refractory patients show a median OS of 3.5 mo[[17](#_ENREF_17)]. HAIC has been demonstrated as an alternative choice for advanced CRC patients. Most studies report the efficiency and survival data of HAI with FOLFOX, while reports concerning HAI with TOMOX are rare. Raltitrexed has been demonstrated as a considerable first-line treatment for patients with advanced CRC. Herein, we present the first head-to-head study comparing HAI with TOMOX or FOLFOX in systemic chemotherapy refractory CRC patients.

The median OS after first HAIC in the present study was 15.4 mo in the FOLFOX arm and 20.6 mo in the TOMOX arm, which was favorable compared with that of the third-line systemic chemotherapy, which achieved a median OS of 9.3 mo[[10](#_ENREF_10)]. When TOMOX was used as a first-line treatment, the ORR was 16-50%, and the median PFS was 5-11 mo[[18-20](#_ENREF_18)]. Among all patients in the present study who failed in previous systemic chemotherapy, the ORR (11.1%) and median PFS (4.9 mo) were relatively low. The ORR in the FOLFOX arm was 29.2% with a median PFS of 6.6 mo, consistent previous studies[[11](#_ENREF_11),[21](#_ENREF_21),[22](#_ENREF_22)]. Similarly, the median OS of 15.4 mo in the present study is consistent with the 11 and 18.3 mo reported in two previous studies[[11](#_ENREF_11),[21](#_ENREF_21)].

The most common adverse events were the transient elevation of serum liver enzymes and bilirubin and abdominal pain. These common adverse events could be sufficiently controlled by efficient treatments. Similar to previous studies, the incidence of leukopenia grade was significantly higher in the FOLFOX arm, and the elevation of transient hepatic enzymes was significantly higher in the TOMOX arm. The TOMOX arm had no treatment- related deaths, while the FOLFOX arm had one case of neutropenic sepsis. These findings suggest that HAIC with TOMOX could represent tolerable treatments for refractory CRC patients. Survival predictor analysis suggested that early tumor response is a meaningful predictor for patients receiving oxaliplatin-based HAIC. Other factors, including age, primary tumor site and serum tumor markers, did not show significant significance, partly reflecting the limited sample size in the present study.

The limitation of the present study is a single-center retrospective study with a limited sample size. We could not avoid some bias for the evaluation of clinical outcome and the incomplete patient data. However, the present study was the first to compare the efficiency, survival data and toxicity of HAIC with TOMOX and FOLFOX in advanced CRC patients, and the results provided new directions for clinical practice.

**COMMENTS**

***Background***

Although liver metastasis develops in approximately 30%-50% colorectal cancer patients, efficient treatments for advanced colorectal cancer are rare. Third-line chemotherapy confers only a 9.3 mo survival time. Alternative treatment, such as hepatic artery infusion, is greatly needed. Previous studies have shown that hepatic artery infusion with oxaliplatin and 5-Fu is a safe and efficient choice for these patients; however, 5-Fu should be administered intra-arterially for approximately 42 h and is associated with a higher incidence of catheter thrombosis and infection. Raltitrexed, which could be infused in one hour, is a specific inhibitor of thymidylate synthase and has been reported as an efficient agent in colorectal cancer.

***Research frontiers***

The authors propose that hepatic artery infusion with raltitrexed and oxaliplatin (TOMOX) is a safe and efficient treatment for colorectal liver metastasis patients. Herein, we provide support for this hypothesis, showing similar response rates and survival data between the FOLFOX and TOMOX arms.

***Innovations and breakthroughs***

Previous studies have shown that raltitrexed is a considerable first-line treatment for patients with advanced colorectal cancer. The present study is the first head-to-head study comparing hepatic artery infusion (HAI) with TOMOX or FOLFOX in systemic chemotherapy refractory colorectal cancer patients.

***Applications***

Patients with colorectal liver metastasis, who failed systemic chemotherapy, were treated with hepatic artery infusion with TOMOX or FOLFOX.

***Terminology***

HAI chemotherapy is designed to improve the chemotherapy benefits for liver cancer by increasing the amount of chemotherapy delivered to the site of the tumor. Chemotherapy is dispensed from a specialized infusion system in which a catheter is placed into the hepatic artery to directly deliver the chemotherapy to the liver.

***Peer-review***

This study, concerning hepatic artery infusion with raltitrexed or 5-fluorouracil for colorectal cancer liver metastasis, is interesting.

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Grade C (Good): 0

Grade D (Fair): 0

Grade E (Poor): 0

**Table 1 Summary of patient baseline characteristics**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Overall cohort (*n* = 42)** | **TOMOX (*n* = 18)** | **FOLFOX (*n* = 24)** | ***P* value** |
| Gender  |  |  |  | 0.7 |
| Male | 29 | 13 | 16 |  |
| Female | 13 | 5 | 8 |  |
| Age at first TACE (yr) | 59 ± 10.7 | 60 ± 9.1 | 58 ± 11.8 | 0.473 |
| Primary tumor site |  |  |  | 0.601 |
| Right hemicolon | 10 | 5 | 5 |  |
| Left hemicolon | 32 | 19 | 13 |  |
| Time to liver metastasis  |  |  |  | 0.508 |
| Synchronous | 28 | 11 | 17 |  |
| Metachronous | 14 | 7 | 7 |  |
| Primary tumor grade |  |  |  | 0.639 |
| Poor  | 6 | 3 | 3 |  |
| Well to mod  | 36 | 15 | 21 |  |
| Genetic condition |  |  |  | 0.459 |
| KRAS mutation | 8 | 5 | 3 |  |
| KRAS wild type | 21 | 8 | 13 |  |
| Unknown | 13 | 5 | 8 |  |
| Extrahepatic metastasis |  |  |  | 0.927 |
| Present | 27 | 12 | 15 |  |
| Absent | 15 | 6 | 9 |  |
| Combined with other local treatments |  |  | 0.209 |  |
| Yes | 10 | 6 | 4 |  |
| No | 32 | 12 | 20 |  |

**Table 2 Response evaluation *n* (%)**

|  |  |  |
| --- | --- | --- |
| **Response**  | **Treatment group** | ***P* value** |
| **FOLFOX (*n* = 24)** | **TOMOX (*n* = 18)** |
| Partial response | 7 (29.2) | 2 (11.1) | 0.158 |
| Stable disease | 14 (58.3) | 11 (61.1) | 0.856 |
| Progressive disease | 3 (12.5) | 5 (27.8) | 0.734 |

**Table 3 Observed toxicity according to common terminology criteria for adverse events grading *n* (%)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Adverse events** | **TOMOX (*n* = 18)** | **FOLFOX (*n* = 24)** | ***P* value** |
|  | **All grade** | **Severe** | **All grade** | **Severe** |
| Hematological |  |  |  |  |  |
| Anemia | 7(39) |  | 11 (46) |  | 0.212 |
| Leucopenia | 3(16) |  | 12 (50) | 1 (4) | 0.026 |
| Neutropenia | 1(5) |  | 6 (25) | 1 (4) | 0.094 |
| Thrombocytopenia | 8(44) |  | 13 (54) | 3 (12) | 0.533 |
| Nonhematological |  |  |  |  |  |
| Elevation ofLiver enzymes | 18(100) | 9(50) | 19 (79) | 7 (29) | 0.039 |
| Elevation of bilirubin | 17(94) | 3(17) | 23 (95) | 4 (17) | 0.834 |
| Nausea/vomiting | 14(78) |  | 17 (71) |  | 0.839 |
| Asthenia | 13(72) |  | 12 (50) |  | 0.414 |
| Neuropathy | 5(28) |  | 7 (29) | 1 (4) | 0.921 |
| Pain  | 14(78) | 7(39) | 19 (79) | 13 (54) | 0.914 |
| Fever | 6(33) |  | 11 (46) |  | 0.558 |

**Table 4 Predictors for overall survival**

|  |  |
| --- | --- |
| **Factors** | **Univariate analysis** |
|  | **HR** | **95% CI** | ***P* value** |
| TOMOX/FOLFOX | 0.877 | 0.410-1.876 | 0.736 |
| Male sex | 0.915 | 0.411-2.035 | 0.827 |
| Age (> 60/60 yr) | 0.758 | 0.353-1.627 | 0.477 |
| Histology (poorly/well and mod) | 1.768 | 0.686-4.554 | 0.238 |
| Primary tumor site (left/right hemicolon) | 0.715 | 0.285-1.797 | 0.476 |
| Serum CA19-9 (high/normal) | 1.725 | 0.803-3.706 | 0.162 |
| Serum CA72-4 (high/normal) | 1.325 | 0.536-3.278 | 0.542 |
| Serum CEA (high/normal) | 1.339 | 0.463-3.873 | 0.590 |
| Extrahepatic metastasis (present/absent) | 1.220 | 0.550-2.706 | 0.624 |
| Time to liver metastasis (Synchronous/ Metachronous) | 1.281 | 0.560-2.932 | 0.558 |
| Response to TACE |  |  | 0.047\* |
| PD | 1 | 1 |  |
| SD | 0.275 | 0.081-0.931 |  |
| PR | 0.272 | 0.095-0.783 |  |



**Figure 1 Kaplan–Meier curves showing the survival data after hepatic artery infusion chemotherapy.** The MST of the TOMOX arm was 20.6 mo (curve A), and that of the FOLFOX arm was 15.4 mo (curve B).