

**SO-16** **Quality of life in Finnish metastatic colorectal cancer patients actively treated with the aim of maximizing resection and/or local ablative therapy (RAXO-study NCT01531595)**

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**Background:** Surgical resection of metastases in patients with metastatic colorectal cancer (mCRC) has improved long-term survival, being median (mOS) 80 months in resected vs. 21 months in “systemic therapy only” if no resection was possible (Osterlund et al. TLRHE 2021). The health-related quality of life (HRQoL) data in patients actively treated with the aim of resection is limited.

**Methods:** In the nationwide Finnish mCRC RAXO-study evaluating resectability repeatedly (n=1086; enrolling 6/2012-10/2018), a HRQoL substudy was initiated in July 2017. Generic HRQoL instruments 15D and EuroQoL-5D-3L (scale 0-1 with highest being best) were used, and minimum important changes were considered  $\geq 0.03$  for EQ-5D and  $\geq 0.02$  for 15D. Mean values per patient and treatment group were analysed.

**Results:** Cross-sectional questionnaire completion rate was 62% (425 of 675 patients alive at substudy initiation) with 1515 questionnaires in total (multiple [2-13] responses in 76%). Age >70 years was seen in 27% of the HRQoL substudy/32% for all RAXO patients, male sex in 58%/60%, ECOG PS 0-1 in 91%/87%, left-sided primary in 76%/75%, one metastatic site in 64%/61% and resections/LAT performed in 57%/50%. Mean HRQoL improved slightly over time in resected/LAT patients; from post-resection (within 6 months from resection/LAT, n=58), to rehabilitation phase (6-18 months, n=56) and remission (disease-free >18 months from last resection; n=113) (with EQ-5D/15D, mean 0.85/0.88 vs. 0.88/0.91 vs. 0.88/0.90). In the post-resection phase, HRQoL was slightly better for upfront resectable than for converted with induction therapy ([n=33] 0.86/0.89 vs. [n=25] 0.84/0.86), but >6 months from resection/LAT no differences were seen (rehabilitation: upfront resectable [n=35] 0.87/0.91 vs. converted [n=21] 0.89/0.91 and remission: upfront resectable [n=85] 0.87/0.90 vs. converted [n=29] 0.88/0.89). HRQoL in remission >18 months after last resection was 0.85/0.90 for single resection/LAT (n=76) and 0.91/0.90 for multiple resections/LATs (n=38). During neoadjuvant/conversion therapy before resection/LAT HRQoL was slightly higher compared to the first-line “systemic therapy only” ([n=60] 0.85/0.89 vs. [n=130] 0.83/0.86). HRQoL during neoadjuvant therapy in upfront resectable was slightly better than during induction therapy in converted resectable ([n=30] 0.86/0.90 vs. [n=28] 0.83/0.87). After relapse that was not re-resectable, HRQoL during palliative first-line treatment was similar for previously resected/LAT vs. “systemic therapy only” ([n=22] 0.86/0.88 vs. [n=130] 0.84/0.86), and the same was seen during treatment pauses ([n=33] 0.86/0.89 vs. [n=43] 0.84/0.85). HRQoL remained stable during palliative first- and second-line treatment (n=107), but deteriorated in later line ([n=152] 0.83/0.86 vs. [n=107] 0.82/0.86 vs. [n=88] 0.78/0.85), and was clearly lower during the best supportive care phase ([n=30] 0.64/0.77).

**Conclusions:** Mean HRQoL with both EQ-5D and 15D is at a high level (range in subgroups 0.78–0.91) during active treatment for mCRC. The best HRQoL ( $\geq 0.85/0.91$ ) is seen for patients >6 months after curative resection/LAT and is similar for upfront resectable, converted or for single resections/LAT over multiple procedures. Lower values were seen in patients treated beyond the second line and particularly during a best supportive care phase. Further analyses of QLQ-C30 and CR-29, and a comparison to the age-matched Finnish population are underway.

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