Bevacizumab plus capecitabine as a salvage therapy in advanced adrenocortical carcinoma

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Abstract
Objective: No standard therapy for advanced adrenocortical carcinoma (ACC) is established by any randomized trial but a consensus conference 2003 recommended mitotane as monotherapy or combined with etoposide, doxorubicin and cisplatin or with streptozotocin as first-line systemic therapy. However, there is no evidence for any therapy beneficial in patients failing these therapies. Therefore, we evaluated the effects of the anti-VEGF antibody bevacizumab plus capecitabine as salvage therapy in ACC.

Methods: Patients registered with the German ACC Registry with refractory ACC progressing after cytotoxic therapies were offered treatment with bevacizumab (5 mg/kg body weight i.v. every 21 days) and oral capecitabine (950 mg/m² twice daily for 14 days followed by 7 days of rest) in 2006–2008. Evaluation of tumour response was performed by imaging according to response evaluation criteria in solid tumours every 12 weeks.

Results: Ten patients were treated with bevacizumab plus capecitabine. None of them experienced any objective response or stable disease. Two patients had to stop therapy after few weeks due to hand-foot syndrome, and three patients died on progressive disease within 12 weeks. Other adverse events were mild (grade I–II). Median survival after treatment initiation was 124 days.

Conclusions: Bevacizumab plus capecitabine has no activity in patients with very advanced ACC. Hence, this regimen cannot be recommended as a salvage therapy.

Introduction
Owing to the rarity of adrenocortical carcinoma (ACC), there is no treatment established by any randomized trial (1). Surgery is regarded as therapy of choice in all patients with resectable tumour, but 25% of patients already have distant metastases at the time of primary diagnosis and the majority of patients develop metastases even after assumed curative surgery (2–12). In 2003, an international consensus conference on the management of ACC recommended for patients with advanced metastatic disease mitotane as monotherapy or combined with etoposide, doxorubicin and cisplatin (13) or with streptozotocin (14) as first-line systemic treatment based on two phase II trials leading to an evidence level not better than 2 (1). The two latter regimens are currently compared in the first randomized trial in this disease (FIRM-ACT trial, www.firm-act.org). Up to now, more than 280 patients have been enrolled, but results will not be available before 2011 after analysis of 300 patients. Regarding second-line therapies, the consensus conference acknowledged that only anecdotal evidence is available and recommended to use the aforementioned regimens that were not used as first-line. For patients failing these treatment regimens, no recommendations could be given and it is obvious that new treatment options are needed.

The initiation of the FIRM-ACT trial has led to a profound change in the care of patients with ACC in Germany (15). Since 2004, an increasing number of patients with ACC consult few specialized centres regarding treatment options. However, as expected from previous experience with cytotoxic chemotherapy, many patients fail both FIRM-ACT protocols or progress after initial response leading to an urgent demand for salvage therapy in these often young patients. The FIRM-ACT investigators in Germany (organized in the German Adrenal Network Improving Treatment and Medical Education (GANIMED) network) responded to this growing need by developing several defined salvage protocols for compassionate use in this patient group. These protocols were offered to clinicians caring for patients with progressive ACC registered in the German ACC Registry (www.nebennierenkarzinom.de;
Clinicaltrials.gov identifier: NCT00453674) allowing local investigators and the patient to choose between different options and to prospectively evaluate the response to therapy with the aim to identify new active treatment protocols. The aim of this standardization of therapeutic efforts in all GANIMED centres was to provide some evidence for potentially valuable treatment regimens in a relatively short period of time. These protocols were influenced by preclinical data concerning, e.g. receptor expression, theoretical considerations on tumorigenesis and promising advances in other carcinoma entities with limited prognosis.

Anti-angiogenic substances have been discussed in several reviews as an interesting option for advanced ACC (16–18). Although none of the clinically approved drugs have been tested in preclinical or clinical studies in ACC, there was some evidence that an anti-angiogenic approach might be of benefit for patients with ACC. The majority of more than 160 investigated ACC tumour samples showed specific staining against vascular endothelial growth factor (VEGF) and its most important receptor (VEGF receptor 2) in immunohistochemical analysis (unpublished data). Furthermore, elevated VEGF levels were reported in tumour samples and in serum of patients with ACC (19, 20). In addition, encouraging results in advanced colorectal (21), breast (22), lung (23) and renal (24) cancer were recently published showing significant prolongation of survival and good tolerance of bevacizumab, a monoclonal anti-VEGF antibody. Therefore, we adapted protocols of these entities for patients with advanced ACC. To enforce the power of the therapy regime, we combined bevacizumab and capecitabine on a compassionate use basis in ten patients with advanced ACC refractory to several cytotoxic chemotherapies. 

**Materials and methods**

**Patients**

Between January 2006 and June 2008, physicians of the GANIMED network offered patients with advanced ACC treatment with bevacizumab and capecitabine when they fulfilled the following inclusion criteria: histologically proven ACC in an unresectable, locally advanced, recurrent or metastatic stage after progression despite treatment with mitotane and at least two cytotoxic chemotherapies including etoposide, doxorubicin, cisplatin and streptozotocin. All patients had radiologically measurable target lesions as defined by response evaluation criteria in solid tumours (RECIST) criteria (28), were aged over 18 years, in acceptable clinical condition (Eastern Cooperative Oncology Group stage of 0–2) including adequate haematological, renal and hepatic function, and desired further treatment. Exclusion criteria were prior exposure to anti-VEGF antibody or capecitabine/fluorouracil, other malignancies within the last 5 years, or active infections. All patients were informed of the experimental nature of the treatment and signed informed consent.

**Treatment protocol**

Bevacizumab (Avastin, F Hoffmann-La Roche) was given intravenously every 3 weeks in a dosage of 5 mg/kg body weight as an infusion. Capecitabine (Xeloda, F Hoffmann-La Roche) was administered orally 950 mg/m2 twice daily for 14 days followed by 7 days of rest. Dose of capecitabine was increased to 1250 mg/m2 in case of good tolerance. In general, the therapy was carried out on an outpatient basis. Continuation of concomitant administration of mitotane was permitted in patients in whom some clinical benefit was assumed despite progression during prior mitotane treatment (e.g. in patients with Cushing’s syndrome).

**Evaluation**

Baseline evaluations included a documentation of patient history, physical examination, and performance status. A complete blood cell count, serum chemistry profile (Na, K, Ca, Po4, creatinine, glucose, aspartate aminotransferase (AST)/serum glutamate oxalacetate transaminase (SGOT), alanine aminotransferase (ALT)/serum glutamate pyruvate transaminase (SGPT), alkaline phosphatase, total bilirubin, albumin), and chest and abdominal computed tomography (CT) or magnetic resonance imaging scans were performed. This evaluation was repeated every 12 weeks, and tumour response was determined. Response was assessed using the RECIST (28). All radiological images were reviewed by the local radiologists and an independent radiologist who finally determined response. In case of progressive disease, it was recommended to stop treatment.

Drug-related adverse events and toxicities were recorded, according to the Common Toxicity Criteria of the National Cancer Institute (version 3.0).

**Results**

**Patient characteristics**

Ten patients (7 male and 3 female) with advanced ACC were treated with bevacizumab and capecitabine between May 2006 and June 2008. Patient’s
characteristics including initial tumour stage, hormonal activity and previous surgical, radiological or medicinal therapies are given in Table 1. Median age was 46 years, and median time from diagnosis of distant metastases to start of therapy with bevacizumab plus capecitabine was 19 months. Most patients had a history of several surgeries, and all were heavily pretreated with systemic therapies. Median number of administered drug regimens was 4 (range 3–5; Table 1). Etoposide, doxorubicin and cisplatin plus mitotane as well as streptozotocin plus mitotane were administered in all patients (nine of them within the FIRM-ACT trial). Furthermore, six patients were pretreated with gemcitabine plus erlotinib (29), three with sunitinib and three with radiotherapy and chemoembolization necessary. Five patients had concomitant mitotane, because it was at the discretion of the local physician to continue with mitotane when some clinical benefit was presumed. In two patients, endogenous glucocorticoid excess was treated with metyrapone \( (n=1) \) and RU486 \( (n=1) \) respectively.

All patients had significant tumour burden with a median sum of longest diameter of the pre-specified target lesions of 205 mm (range 93–501 mm), and progressing disease was documented before initiation of bevacizumab plus capecitabine. Six patients had local recurrence, and all suffered from tumour manifestations in at least two different organs as shown in Table 2.

In all four patients, in whom tumour samples were stained with anti-VEGF antibody, expression of VEGF protein was detectable in the tumour cells.

### Table 1 Patient characteristics and previous therapies.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Hormonal activity</th>
<th>Time from diagnosis of ACC to start of BC (months)</th>
<th>Time from diagnosis of metastasis to start of BC (months)</th>
<th>Number of previous surgeries</th>
<th>Prior systemic therapies (months)</th>
<th>Other prior therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>46</td>
<td>N</td>
<td>20</td>
<td>20</td>
<td>1</td>
<td>M (5), EDP-M (8), Sz-M (2), EG-M (3)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>38</td>
<td>A</td>
<td>19</td>
<td>12</td>
<td>4</td>
<td>Sz-M (2), EDP-M (5), EG (3)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>45</td>
<td>N</td>
<td>18</td>
<td>18</td>
<td>1</td>
<td>M (5), Th-M (4), EDP-M (4), Sz-M (4), EG-M (2)</td>
<td>RT skull</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>45</td>
<td>N</td>
<td>20</td>
<td>20</td>
<td>2</td>
<td>M (4), EDP-M (2), EG-M (1)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>50</td>
<td>N</td>
<td>16</td>
<td>12</td>
<td>1</td>
<td>M (3), EDP-M (4), Sz-M (2), EG-M (3)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>73</td>
<td>A</td>
<td>32</td>
<td>32</td>
<td>1</td>
<td>M (2), Sz-M (6), EDP-M (10), EG (8), Su (3)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>62</td>
<td>N</td>
<td>22</td>
<td>11</td>
<td>1</td>
<td>M (11), EDP-M (4), Sz-M (2)</td>
<td>CE liver, RT spin</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>46</td>
<td>C</td>
<td>22</td>
<td>22</td>
<td>4</td>
<td>M (4), Sz-M (8), M (3), EDP-M (2), Su-M (3)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Male</td>
<td>68</td>
<td>C</td>
<td>42</td>
<td>15</td>
<td>4</td>
<td>M (4), Sz-M (2), EDP-M (3), Su-M (3)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>42</td>
<td>A,C</td>
<td>48</td>
<td>27</td>
<td>2</td>
<td>M (1), EDP-M (5), Sz-M (3), EDC-M (3), Su-M (3)</td>
<td>RT lymph node</td>
</tr>
</tbody>
</table>

N, hormonally inactive or with no initial hormonal work-up; A, androgen excess; C, cortisol excess. BC, bevacizumab and capecitabine. Duration of prior systemic therapies is given in months in parentheses: M, mitotane mono; EDP-M, etoposide, doxorubicin, cisplatin, mitotane; EDC-M, etoposide, doxorubicin, carboplatin, mitotane, Sz-M, streptozotocin and mitotane, EG, erlotinib and gemcitabine; EG-M, erlotinib, gemcitabine, mitotane; Th-M, thalidomide, mitotane; Su-M, sunitinib, mitotane; Su, sunitinib; RT, radiotherapy; CE, chemoembolization.

### Outcome

None of the ten patients experienced any objective response or stable disease during therapy with bevacizumab plus capecitabine. Three of them had already died due to progressive disease before first scheduled restaging at 12 weeks. Two patients (nos 1 and 4) experienced relevant hand-foot syndrome and had to stop therapy after 2 and 3 weeks respectively, without any detectable benefit. In patient no. 4, clear tumour progress was detectable at the time of stopping bevacizumab and capecitabine (Table 2).

The median increase in sum of the longest diameter of target lesions at the first staging was 57 mm (range 21 to 139 mm; Table 2, Fig. 1). Median survival without progression after starting bevacizumab/capecitabine was 59 days, and median overall survival was 124 days (Fig. 2). Only two patients had an increase in target tumour mass \( >25\% \). Patient no. 2 had stable target lesions after 12 weeks and benefited clinically from bevacizumab and capecitabine. Therefore, therapy was continued despite formally progressive disease due to two new metastases in liver and abdomen. However, after an additional 12 weeks, tumour had progressed tremendously (including multiple new metastases). Patient no. 10 was radiologically stable, but developed acute superior vena cava syndrome after 8 weeks requiring an emergency radiation therapy and was, therefore, judged as progressive disease.

With exception of the two cases of therapy limiting hand-foot syndrome, adverse events were minor and treatment was in general well tolerated. Particularly,
### Table 2 Disease status and results of evaluation.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Sites of tumour manifestations</th>
<th>VEGF expression</th>
<th>Concomitant mitotane (maximum plasma level mg/l)</th>
<th>Cumulative dose of C (g)</th>
<th>Cycles of B</th>
<th>Baseline</th>
<th>1st staging</th>
<th>Number of new mets (1st staging)</th>
<th>Overall response</th>
<th>Treatment after BC</th>
<th>Survival since start BC (months)</th>
</tr>
</thead>
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<tr>
<td>1</td>
<td>lr, ab, li, lu, hi</td>
<td>NA</td>
<td>12.7</td>
<td>112</td>
<td>1</td>
<td>97 (3)</td>
<td>125 (3)</td>
<td>3 lu</td>
<td>PD</td>
<td>vac</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>lr, lu, mu, ab, ax</td>
<td>NA</td>
<td>No</td>
<td>308</td>
<td>6</td>
<td>129 (3)</td>
<td>132 (3)</td>
<td>2 ab, li</td>
<td>PD</td>
<td>su</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>lr, li, lu, bo, ab</td>
<td>+</td>
<td>9.0</td>
<td>234</td>
<td>3</td>
<td>378 (10)</td>
<td>-a</td>
<td></td>
<td>PD</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>ab, lu, mu</td>
<td>NA</td>
<td>10.6</td>
<td>56</td>
<td>1</td>
<td>200 (6)</td>
<td>306 (6)</td>
<td>1 li</td>
<td>PD</td>
<td>vac</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>lr, ab, li, lu</td>
<td>+</td>
<td>17.0</td>
<td>112</td>
<td>1</td>
<td>482 (10)</td>
<td>-a</td>
<td></td>
<td>PD</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>ab, lu, li, hi</td>
<td>+</td>
<td>No</td>
<td>168</td>
<td>4</td>
<td>197 (10)</td>
<td>318 (10)</td>
<td></td>
<td>PD</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>li, lu</td>
<td>+</td>
<td>13.4</td>
<td>237</td>
<td>4</td>
<td>93 (7)</td>
<td>232 (7)</td>
<td>2 li</td>
<td>PD</td>
<td>su</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>bo, lu, li, mu</td>
<td>NA</td>
<td>No(^a)</td>
<td>112</td>
<td>3</td>
<td>385 (10)</td>
<td>-a</td>
<td></td>
<td>PD</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>lr, ab, li, lu, hi</td>
<td>NA</td>
<td>No</td>
<td>112</td>
<td>2</td>
<td>209 (10)</td>
<td>266 (10)</td>
<td></td>
<td>PD</td>
<td>RIT, th</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>lr, li, hi, sc</td>
<td>NA</td>
<td>No(^a)</td>
<td>168</td>
<td>4</td>
<td>501 (10)</td>
<td>480 (10)</td>
<td></td>
<td>PD(^d)</td>
<td>RT, RCT</td>
<td>6</td>
</tr>
</tbody>
</table>

**Notes:**
- B, bevacizumab; C, capecitabine. Mets, metastases. Site of tumour manifestation: lr, local recurrence; li, liver; lu, lung; bo, bone; ab, abdominal; mu, muscular lesion; ax, axillary lesion; sc, supraclavicular lesion; hi, hilar lesion. NA, not available; +, positive VEGF staining. PD, progressive disease. su, sunitinib; vac, vaccination with survivin peptide; RIT, radioiodine therapy with iodometomidate; th, thalidomide; RT, radiotherapy; RCT, rosiglitazone, celecoxib and trofosfamide.
- \(^a\)Patient died before first control staging.
- \(^b\)Concomitant RU486.
- \(^c\)Concomitant metyrapone.
- \(^d\)Despite stable target lesions the need for an emergency radiation therapy due to superior vena cava syndrome led to the diagnosis of PD.
no episode of hypertension was documented. Regarding
the non-specific adverse events like nausea, vomiting
or fatigue, we cannot exclude that mitotane has
contributed to some of the negative effects. However,
since only newly developed events were registered, it is
not likely that mitotane is responsible for many of these
events (Table 3).

Discussion
In our patient series, we found no evidence that
the combination of bevacizumab and capecitabine
is of benefit as salvage therapy for very advanced
ACC. The disease was progressing in all patients
with a median time to progression of only 59 days.

Furthermore, all but one patient died within 9 months
after initiation of bevacizumab and capecitabine.
Clearly, our patient sample represented a negative
selection due to advanced disease stage and several
prior systemic treatment regimens. However, the
complete lack of response to bevacizumab and capeci-
tabine indicates a very limited potential in patients
suffering from advanced ACC.

These disappointing results raise several questions:
i) does this study indicate that both bevacizumab
and capcitabine are not beneficial in patients with
ACC at all? ii) was the relatively low dosage of
bevacizumab and capcitabine responsible for the
missing effectiveness? iii) does the combination of
both drugs have even negative impact on the effects of
the individual drugs? iv) would it be more effective to
use this combination of drugs in patients not as
heavily pretreated as our cohort? Although we cannot
answer these questions with certainty; we caution
against the assumption that both bevacizumab and capcitabine have in general no effect in patients
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heavily pretreated patients with progressive malignancy, we aimed at avoiding toxicity. Furthermore, our dosage of 950 mg/m² capecitabine twice daily remained below the standard recommendation of 1250 mg/m² twice daily in breast, colorectal or gastric cancer. Capecitabine is absorbed through the intestine and converted to 5'-deoxy-5'-fluorouridine (5'-DFUR) and finally, thymidine phosphorylase (TP) converts 5'-DFUR to the active drug 5-FU. This occurs in both tumour and normal tissues; however, TP is found at higher concentrations in most tumour tissue compared with normal healthy tissue. TP expression has been shown to be associated with response to capecitabine in lung cancer (30) and colorectal cancer (31). Although TP activity was detected in ACC (19), we cannot exclude that in advanced disease, dedifferentiation leads to downregulation of TP activity hampering the required conversion into the active compound. Furthermore, with this case series, we cannot verify whether the lack of benefit might be related to pharmacokinetic interactions, but there is no evidence that both drugs interfere with each other. In contrast, data from metastatic colorectal cancer showed a positive effect on progression-free survival by combining bevacizumab and XELOX (capecitabine plus oxaliplatin) versus XELOX alone (27). In addition, it is important to emphasize that our patients had a median of four affected organ sites and had received a median of 4 (range 3–5) prior systemic treatments. These pretreatment regimens might have induced a selection of aggressive dedifferentiated tumour cells not responding to any drugs.

The observed adverse events in our cohort were mainly mild and anticipated. In two patients, treatment had to be stopped due to hand-foot syndrome. This is a common adverse effect of capecitabine, and the percentage of treatment interruptions was not a common adverse effect of capecitabine, and had to be stopped due to hand-foot syndrome. This is mainly mild and anticipated. In two patients, treatment not responding to any drugs.

Our study confirms the disappointing results of salvage therapies in ACC reported in other studies (29, 33, 34). It further demonstrates that the natural course of ACC is progressive and that spontaneous tumour regressions as described for other tumour entities, e.g. melanoma (35), hepatocellular carcinoma (36) or colorectal cancer (37) are extremely unlikely.

We are well aware of the limitations of our study. One of the main drawbacks of our study is that it is not a formal phase II trial. However, until recently, pharmaceutical companies showed no interest to support clinical trials in such a rare disease, and also public funding resources for salvage concepts in rare tumour entities are virtually non-existent. However, our case series has several advantages in comparison with previous case series: the treatment protocol and the evaluation of response were performed prospectively in a standardized manner, and all images were reviewed centralized by an independent radiologist according to RECIST criteria. In addition, the number of reported patients might seem to be low. However, ten patients with clearly progressive disease are probably enough to conclude that bevacizumab plus capecitabine is not effective in ACC refractory to several cytotoxic drug regimes. In this context, it seemed not justifiable to enlarge our series.

In conclusion, we found no benefit of bevacizumab plus capecitabine in pretreated patients with advanced ACC. Therefore, this regimen cannot be recommended as salvage therapy in this disease.

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding
This study was supported by grants of the Deutsche Krebshilfe (grant no. 107111 to M Fassnacht and grant no. 106 080 to B Allolio and M Fassnacht).

Acknowledgements
The case series was only feasible due to the efforts of many colleagues organized in the German Adrenal Network Improving Treatment and Medical Education (GANIMEDE) network and the German ACC Registry. We are thankful to all colleagues, who followed our protocol suggestion, as most of the therapies were carried out on an outpatient basis, and provided us with the clinical and radiological data of their patients: Cornelia Weiand and Maria Bahike (Kahl), Waclaw Junkiewicz (Drochtersen), Felix Marquardt (Celle), Thorsten Kiencke (Bad Bederkesa), Christina Klattitter (Linzum), Stefan Gneipel (Mulda), Wolfgang Schmidt (Raunheim) and Antonius Mutz (Osnabrück). For providing original files of CT and MRI imaging, we thank Gemeinspraxis Radiologie Mainzer Landstrasse & Höchst (Frankfurt), Radiologie, Klinikum Osnabrück, Radiologische Abteilung, Allgemeines Krankenhaus (Celle) and Institut für Radiologie, Charité Campus Mitte (Berlin). We are grateful to Michaela Hauf for her support in running the database of the German ACC Registry. We thank Kathrin Zopf, Clinical Endocrinology, Charité Berlin, for organizational help. We appreciate the immunohistochemical staining and evaluation of four tumour samples with anti-VEGF antibody by Dr Patrick Adam (Department of Pathology of the University of Würzburg).

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Received 16 October 2009
Accepted 9 November 2009