A Retrospective Study of the Novel Combination of Paclitaxel and S1 for Pretreated Advanced Non-Small Cell Lung Cancer

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Key Words
Non-small cell lung cancer • Chemotherapy • Paclitaxel • S1 • Multivariate analysis • Shared frailty Cox model

Introduction

Lung cancer is the leading cause of cancer-related deaths worldwide. Approximately 85% of lung cancer patients have non-small cell lung cancer (NSCLC). Most NSCLC patients have advanced disease at presentation, and a combination of platinum with third-generation anticancer agents is now considered as standard first-line chemotherapy for advanced NSCLC patients [1, 2]. However, most NSCLC patients are either refractory to first-line chemotherapy or show relapse after an initial response, indicating the importance of treatment with second- and later-line drugs.

S1 (Taiho Pharmaceutical Co. Ltd., Tokyo, Japan) is an oral fluoropyrimidine formulation which combines tegafur, 5-chloro-2,4-dihydroxy-pyridine and potassium oxonate in the molar ratio of 1:0.4:1 [3]. Tegafur is a prodrug of 5-fluorouracil (5-FU), and approximately 90% of 5-FU is metabolized by the liver enzyme dihydropyrimidine dehydrogenase [4, 5]. 5-Chloro-2,4-dihydroxy-pyridine increases the plasma concentration of 5-FU by inhibiting dihydropyrimidine dehydrogenase, whereas it attenuates the cardiotoxicity and neurotoxicity of 5-FU by reducing the production of fluoro-β-alanine [6, 7]. Oxonate is distributed selectively to the small and the large intestines; here, it inhibits the phosphorylation of 5-FU by suppress-
ing orotate/pyrimidine phosphoribosyltransferase, thereby reducing the incidence of gastrointestinal toxicity of 5-FU [8]. Thus, S1 is designed to enhance antitumor activity and reduce the gastrointestinal toxicity of 5-FU. Recently, S1 has been used to treat several types of cancer, in addition to gastric cancer [9–11]. In a phase II trial involving 59 advanced NSCLC patients, a 4-week duration of S1 therapy every 6 weeks showed a response rate of 22.0% and a median survival time (MST) of 10.2 months [12]. The combined use of paclitaxel and S1 (PTX+S1) showed additive synergistic antitumor effects [13]. This combination was shown to be safe and effective, with a response rate of 45% and an MST of 8.5 months in a phase II study involving 39 patients with advanced gastric cancer [14]; however, there is almost no evidence of the efficacy of this combination in NSCLC. Therefore, we studied the treatment of advanced NSCLC with PTX+S1 and retrospectively analyzed the results. Triweekly regimens are common in chemotherapy for NSCLC, but biweekly regimens have also been studied [15].

Although parameters such as progression-free survival (PFS) and overall survival (OS) are important endpoints in clinical trials for lung cancer, they are known to be influenced by treatments administered after progression and/or patient selection. The purpose of this study was to evaluate the efficacy of PTX+S1 in itself and in comparison with other regimens administered to the study population.

**Patients and Methods**

From September 2007 to April 2010, 46 pretreated advanced NSCLC patients received PTX+S1. S1 was administered twice a day, orally, from day 1 to day 14, followed by a 2-week off period. PTX was administered intravenously on day 1 and day 15. Cycles were repeated every 4 weeks. Eligibility criteria of this study included cytologically or histologically diagnosed NSCLC, inoperable and not amenable to curative radiation, second- or later-line treatment, an Eastern Cooperative Oncology Group performance status (PS) of 0–1, as well as consent for treatment with PTX+S1. The use of PTX or S1, but not PTX+S1 itself, in preceding treatments was accepted.

On the basis of the trial of PTX+S1 for advanced gastric cancer, we adopted the doses of PTX and S1 to be 120 and 80 mg/m², respectively. The dose of PTX ranged from 70 to 120 mg/m², depending on patient conditions, and the dose of S1 was 80 mg/m²/day, except when dose reduction was required. When myelosuppression was prolonged, PTX on day 15 was skipped in the subsequent cycles. Treatment was continued until disease progression, appearance of unacceptable toxicity, withdrawal of consent by the patient, or termination of treatment by the attending physician.

Tumor response was evaluated using the Response Evaluation Criteria for Solid Tumors, version 1.0. Because this was a retrospective analysis, tumor response could not be confirmed. Toxicities were graded according to the Common Terminology Criteria for Adverse Events, version 3.0. The median follow-up period was 639 days. The mean ± SD interval time of tumor assessment by using chest and abdominal computed tomography or positron emission tomography/computed tomography was 60.5 ± 34.3 days. In addition, almost all patients visited our hospital once or twice a month during the treatment, and chest radiography and blood examination were performed during their visit.

One way to test the efficacy of a regimen is to compare the PFS of the regimen with that of historical controls. However, it is well known that PFS is influenced by patient selection. Patients with a good prognosis may show a long PFS for a regimen, which is independent of the efficacy of a therapy. Therefore, comparison with historical data sometimes leads to wrong conclusions. To avoid this, we defined the duration of a regimen as the period between the start of that regimen and the start of the next regimen (time to next regimen, TNR) and tried to approximate PFS with TNR. This method is expected to make it possible to evaluate the efficacy of a regimen in comparison with other regimens used in the same patient population.

**Statistical Analysis**

Statistical analysis was done using SPSS Statistics version 17.0 and Stata version 11.2. To detect the factors contributing to a long TNR, the effect of gender, Eastern Cooperative Oncology Group PS (0 vs. 1/2), stage (III vs. IV), histology (adenocarcinoma vs. non-adenocarcinoma), line of treatment (first, second, third vs. ≥fourth) and chemotherapy regimens were analyzed using Kaplan-Meier analysis. We categorized the treatment regimens as follows: platinum doublets, non-platinum doublets, PTX+S1, pemetrexed or docetaxel (L+D), epidermal growth factor receptor (EGFR) tyrosine kinase inhibitors (TKI), single cytotoxic drugs mainly of third generation, and other than pemetrexed and docetaxel. First-line chemotherapy with curative thoracic radiation was excluded from the analysis because it contained radiation. When combined with cytotoxic drugs, bevacizumab (6 regimens) and EGFR-TKI (4 regimens) were neglected. Exon 19 deletion and L858R mutation in the exon 21 of EGFR were classified as active mutations; other EGFR mutations and wild-type EGFR were classified as non-active EGFR. TNR was also analyzed using the Cox proportional hazard model with shared frailty to consider the intra-patient correlation of TNR and by setting each patient’s identification as a random effect [16]. PFS and TNR in PTX+S1 were compared in 29 patients, for whom the data of both PFS and TNR were available.

**Results**

**Patient Characteristics**

Characteristics of 46 patients are presented in table 1. Most were men, and almost all patients had a PS of 0–1. Histologically, 35 patients (76.1%) had adenocarcinoma. There were 1 (2.2%), 9 (19.6%) and 36 (78.3%) patients with stage IIIA, IIIB and IV, respectively. PTX+S1 was performed as second- (n = 12), third- (n = 11) and
fourth-line (n = 23) chemotherapy. Thirty-eight patients (82.6%) had measurable lesions. EGFR-active mutations were detected in 12 patients (26.1%). The median number of cycles of PTX+S1 was 6 (range 1–26). Three patients were on PTX+S1 treatment at data cut-off time. Seven, 4 and 2 patients had a history of treatment with chemotherapy containing PTX, S1 and both, respectively, before treatment with PTX+S1.

Toxicity and Efficacy
Toxicity data are summarized in table 2. Grade 3 or higher neutropenia was observed in 3 (6.5%) patients. Grade 3 fatigue and grade 3 sensory neuropathy occurred in 1 (2.2%) and 2 (4.3%) patients, respectively. Three patients (6.5%) developed pneumonitis; pneumonitis was mild and appeared to be ascribed to prior treatment in 2 patients (carboplatin plus PTX with radiation and gemcitabine, respectively). Although a grade 4 cerebrovascular event occurred in 1 (2.2%) patient, it was unclear whether it had any relevance to PTX+S1. There were no treatment-related deaths.

Fifteen patients exhibited partial response and 15 stable disease. The response rate was 32.6% and the disease control rate was 65.0%. MST and median PFS were 735 and 253 days, respectively (fig. 1).
The highest difference observed was attributable to the type of regimen (fig. 2a); median TNR ranged from 87 days (EGFR-TKI) to 23.9 days (PTX+S1). TNR of the L+D group was 104 days. PTX+S1 showed the longest TNR among the regimens studied.

Multivariate analysis was performed using the Cox proportional hazard model with shared frailty. The Cox model with shared frailty of patients’ identification showed that the estimated frailty variance was $\hat{\theta} = 0.147$, which was the level of the likelihood ratio test of $H_0: \theta = 0$ ($p = 0.008$). Therefore, TNR scores were analyzed as stratified data of individual patients. When stage, line of treatment, EGFR mutation status and type of regimen were included in the analysis, PTX+S1 was only one factor to show statistically significant prolongation of TNR (table 3). Non-platinum doublets exhibited the tendency of prolonged TNR (HR = 0.523, $p = 0.077$), and TNR and PFS were well correlated in PTX+S1 treatment (correlation coefficient = 0.963, $p < 0.0001$; data not shown).

Table 3. Multivariate analysis of TNR

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Patients</th>
<th>HR</th>
<th>p</th>
</tr>
</thead>
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<tr>
<td>Type of regimen</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>L+D</td>
<td>48</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>NonP doublet</td>
<td>12</td>
<td>0.523 (0.255–1.073)</td>
<td>0.077</td>
</tr>
<tr>
<td>P doublet</td>
<td>54</td>
<td>0.775 (0.475–1.262)</td>
<td>0.305</td>
</tr>
<tr>
<td>PTX+S1</td>
<td>34</td>
<td>0.378 (0.235–0.606)</td>
<td>0</td>
</tr>
<tr>
<td>TKI</td>
<td>28</td>
<td>1.380 (0.816–2.335)</td>
<td>0.229</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>0.910 (0.509–1.629)</td>
<td>0.752</td>
</tr>
<tr>
<td>EGFR status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Wild</td>
<td>80</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>56</td>
<td>1.025 (0.650–1.615)</td>
<td>0.917</td>
</tr>
<tr>
<td>Mutant</td>
<td>60</td>
<td>0.960 (0.556–1.657)</td>
<td>0.883</td>
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<tr>
<td>Stage</td>
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<td></td>
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<tr>
<td>III</td>
<td>64</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>IV</td>
<td>162</td>
<td>1.043 (0.623–1.748)</td>
<td>0.872</td>
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<tr>
<td>Line</td>
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<td></td>
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</tr>
<tr>
<td>1st</td>
<td>34</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>2nd</td>
<td>41</td>
<td>0.946 (0.551–1.625)</td>
<td>0.840</td>
</tr>
<tr>
<td>3rd</td>
<td>33</td>
<td>0.992 (0.540–1.822)</td>
<td>0.980</td>
</tr>
<tr>
<td>≥4th</td>
<td>88</td>
<td>1.455 (0.831–2.546)</td>
<td>0.189</td>
</tr>
</tbody>
</table>

Figures in parentheses are 95% confidence intervals.

In our study, PTX+S1 produced a high response rate with a good toxicity profile. Since PFS observed in standard second-line treatments for NSCLC ranges between 2.0 and 7.5 months, PFS of 253 days by PTX+S1 is impressive. However, there is a possibility that these results are attributable to selection bias. Actually, OS in this study was 1,308 days when calculated from the start of the first-line treatment, suggesting that patients with a good prognosis were recruited for the study. This is possible because there was no restriction to the number of preceding lines of treatment before PTX+S1, which may have led to an

Figure 1. OS and PFS of the patients treated with PTX+S1. mPFS = Median PFS.

Discussion

In the phase III Lung Cancer Evaluation of TS1 trial, a 3-week cycle of carboplatin (on day 1) plus S1 (on days 1–14) was compared with carboplatin plus PTX in chemotherapy-naïve advanced NSCLC patients. Carboplatin plus S1 showed non-inferiority to carboplatin plus PTX with generally milder toxicities [18]. Non-platinum doublets containing S1 were also studied in phase II studies. Irinotecan plus S1 produced a response rate of 28.6%, a median PFS of 4.9 months and an MST of 15 months in the first-line setting [19]. In chemotherapy-naïve patients, S1 in combination with gemcitabine showed a response rate of 23.1–30.6%, with an MST of 15.5–18.8 months [20]. When combined with docetaxel, a response rate of 18.4%, a median PFS of 4.4 months and an MST of 16.1 months were reported for previously treated NSCLC patients [21]. These results are comparable to those of standard platinum-based regimens.
increase in the chance of accrual of patients who had received multiple lines of chemotherapy and therefore were endowed as long survivors.

To evaluate the contribution of PTX+S1 per se to long PFS, we analyzed TNR of whole regimens that were used for the patients in this study. As a result, PTX+S1 appeared to be the only factor that produced statistically significant prolongation of TNR in univariate and multivariate analyses. The median TNR of L+D was 104 days, indicating that our patients showed a standard response to pemetrexed or docetaxel. Long PFS by PTX+S1 appears to be derived, at least partly, from the effect of PTX+S1 itself. It may look strange that the ratio of TNR of platinum doublets, the strongest regimen, was 0.775. This may

**Fig. 2.** Kaplan-Meier analysis of TNR. Numbers in parentheses indicate median TNR in days. 

- **a** L+D (106), platinum doublets (P double, 157), non-platinum doublets (NonP doublets, 182), PTX+S1 (239), EGFR-TKI (TKI, 87).
- **b** First line (152), 2nd line (160), 3rd line (133), 4th line (115).
- **c** Wild-type EGFR (N, 120), EGFR mutation not tested (NM, 131), active EGFR mutation (P, 140).
- **d** Stage III (140), stage IV (127).
be explained by the fact that platinum doublets are not administered over 4–6 cycles, which may give some idea in understanding recent developments in maintenance therapy. Our study has several limitations. First, TNR was not established sufficiently. However, PFS and TNR are well correlated, at least in PTX+S1 treatment in this study, indicating that TNR may become a surrogate of PFS. New lines usually start at disease progression in the treatment of NSCLC. Therefore, it is reasonable to postulate that TNR approximates PFS. TNR can be determined for almost all regimens administered to a study population. Long TNR may be attributable to treatment toxicities, but it is not so frequent in the treatment of advanced NSCLC. Second, long survivors may have been recruited for the study, as mentioned above. We cannot exclude the possibility that PTX+S1 is able to produce long PFS only in long survivors. Third, this study included lung cancer patients who harbored activated EGFR mutations. Recent data clearly show the distinct activity of EGFR-TKI in patients who harbored activated EGFR mutations. In our study, 12 patients (26.1%) had tumors with activated EGFR mutations, but only 3 of them underwent treatment with EGFR-TKI after PTX+S1 treatment, and 1 of them had squamous cell carcinoma. Therefore, the effect of EGFR-TKI on OS by PTX+S1 will be limited.

Long TNR may be able to contribute to prolongation of OS. In recent NSCLC clinical trials, sometimes prolongation of PFS was observed without its translation to OS. This discrepancy is partly explained by the effect of post-trial treatments. Actually, multiple lines of chemotherapy are performed in recent treatments of NSCLC. In this situation, it may be critical to evaluate not only the regimen of interest but also the total regimens administered. However, unfortunately, it is difficult to analyze the PFS effect of post-trial treatments on OS, because PFS is not generally assessed so rigorously outside a trial setting. TNR analysis may partly address this shortcoming.

In conclusion, because PTX+S1 was effective and showed long treatment duration in our study population, further evaluation of this combination is necessary. The analysis of duration of treatments may be useful to evaluate chemotherapy regimens.

References


