malnutrition, injury, and inflammation. The purpose of this study was to evaluate the ef- 
ficacy of BCHE as a tool for the diagnosis of SSI in elective operations for colorectal 
cancer.

Methods: Between June 2019 and March 2021, 196 consecutive patients who un- 
derwent elective colorectal cancer surgery were enrolled prospectively. Serum BCHE 
concentrations were measured preoperatively and on postoperative (POD) days 1, 3, and 5. 
Group A included patients with SSI and Group B non-SSI patients. The normal range of 
BCHE is roughly from 2800 U/L to 7400 U/L in our hospital laboratory. Statistical analyses 
were done using Stata13. Student’s t-test for normally distributed variables and Mann- 
Whitney U test for skewed variables were used to compare results between groups.

Results: SSI developed in 38 of the 196 patients (19.4%). Prior to surgery, there was 
no statistically significant difference in concentrations of BCHE between the SSI and 
non-SSI groups (mean level of BCHE for Group A = 5490, Group B = 5190; P = 0.840). 
On POD 1 the mean level of BCHE was 4680 in patients with wound infections, and 4670 
in non-SSI patients (P = 0.530). However, on POD 3 and 5 patients with SSI had 
significantly lower levels of serum BCHE (mean level of BCHE Group A = 3920 vs Group 
B = 4586; P = 0.001, and Group A = 4170 vs Group B = 4770; P = 0.002, respectively).

Conclusions: The current study demonstrates that BCHE on POD 3 and 5 is a reliable 
marker for the presence of SSI in patients undergoing elective operations for colo-
rectal cancer. According to the results of our study, serum BCHE assessment could be 
included in routine clinical diagnostic procedures to evaluate patient postoperative 
infectious complications like SSI.

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Disclosure: All authors have declared no conflicts of interest.

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**414P Does adjuvant chemotherapy compared to surveillance improve recurrence free and overall survival in stage 3 rectal cancer patients?**

S.M. Adeleke1, S. George1, J.R. Galante1, M. Karova1, L. Dahal1, A. Choy1, F. Elwes1, 
N.F. Brown1, J. Summers1, A.A. Edwards3, M. Durve1, C. Mikropoulos1, K. Lees1, 
J. Hall1, R. Shah1, M. Hill1, R. Raman1, A. Clarke1

1Kent Oncology Centre, Maidstone and Tunbridge Wells NHS Trust, Kent, UK; 2Kent 
Oncology Centre, Kent and Canterbury Hospital - East Kent Hospitals University 
NHS Foundation Trust, Canterbury, UK; 3Kent Oncology Centre, Kent and Can-

terbury Hospital - East Kent Hospitals University NHS Foundation Trust, 
Canterbury, UK; 4Kent Oncology Centre, Maidstone and Tunbridge Wells NHS 
Trust, Kent, UK; 5Kent Oncology Centre, Darent and Gravesend NHS Trust, 
Dartford, UK

Background: No broad consensus exists for the adjuvant management of patients with 
rectal cancer (RC) who are down-staged following neoadjuvant chemoradiotherapy (nCRT) 
and total mesorectal excision (TME). This study evaluated clinical outcomes of adjuvant 
chemotherapy (AC) versus surveillance(S) in a real-world setting across multiple sites.

Methods: We retrospectively evaluated the records of radically resected RC patients 
who had nCRT, were down-staged and then offered either S or AC based on clinician’s 
judgement. Data was extracted from the electronic patient records from 4 NHS trusts in 
Kent that covers a population of 1.8 million people.

Results: 589 patients with rectal cancer between 1 Jan 2014 and 31 Dec 2019 were 
identified. Of these, 149 who had MD disease and were later downstaged at TME were 
assessed. Median age was 67 (24-89). All patients had nCRT (45Gy/25 + Capecitabine 
(CAPE/5FU/25Gy/5). They then had TME. 94 (63%) had AC, (CAPE/5FU, CAPOX or 
FOLFOX) while 55 (37%) were kept under surveillance. Patients with AC had a lower age 
(mean 62 vs 68; p=0.0045); higher baseline tumour stage (p=0.012); longer time be-

 tween RT and TME (89 vs 86 days, p=0.027); higher EMVI (70 vs 41%, p=0.00345); higher 
rates of threatened/positive CRM (83 vs 65%, p=0.01481), and post op tumour stage 
(p=0.0001). There was no significant difference in tumour grade, distance from anal 
verge,TRG, post RT staging, and resection margin status. Overall, there was no significant 
difference in survival between AC & S with RFS of 70% in 75% (p=0.1233) and 2-year OS of 
94% vs 98% (p=0.1661), table1. Higher tumour grade at diagnosis (p=0.0314), post op 
stage (p=0.042) & resection margin(p=0.003) were associated with risk of death.

Conclusions: Results in our real-world cohort did not find any significant benefit of AC 
versus receiving nCRT and TME. Surveillance may avoid chemoradiotherapy related toxicities without 
compromising survival. Randomised trials are necessary to address this important issue.

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**415P Comparison of cetuximab every 2 weeks versus standard once-weekly administration for the first-line treatment of 
RAS wild-type metastatic colorectal cancer among patients with left- and right-sided primary tumor location**

S. Kasper1, A-L. Cheng1, M. Rouyer1, C. Fecho1, F-X. Lamy2, R. Esser3, M. Batech4, 
C-M.J. Wong5, A. Zhang5, T. Brodowicz10, C. Zielinski11

1Medical Oncology Department, University Hospital Essen Westdeutsches Tumor-
zentrum, Essen, Germany; 2Department of Internal Medicine and Oncology, National 
Taiwan University Cancer Center, Taipei City, Taiwan; 3Bordeaux pharmacoeP, 
université de Bordeaux, Bordeaux, France; 4R&G Global Biostatistics, Epidemiology 
& Medical Writing, Merck KGaA, Darmstadt, Germany; 5Global Epidemiology Depart-
ment, Merck KGaA, Darmstadt, Germany; 6Global Medical Affairs, Merck KGaA, 
Darmstadt, Germany; 7Medical Oncology, Merck KGaA, Darmstadt, Germany; 8Project 
Based Services, Cytel Singapore Pte. Ltd, Singapore; 9R&G Global Biostatistics, Merck 
Serono, Beijing, China; 10Department of Medical Oncology, Internal Medicine 1, 
General Hospital - Medical University of Vienna, Vienna, Austria; 11Oncology, 
Comprehensive Cancer Center, Vienna General Hospital and Medical University of 
Vienna, Vienna, Austria

Background: In patients with RAS wild-type (wt) metastatic colorectal cancer (mCRC) 
receiving first-line treatment with cetuximab (CET) in combination with chemo-
therapy, the noninferiority of the off-label schedule of CET 500 mg/m2 every 2 weeks 
(q2w) compared with the approved schedule of CET at an initial dose of 400 mg/m2 
followed by weekly doses of 250 mg/m2 (q1w) was shown in a pooled analysis of 
patient-level data from 2 noninterventional studies (EREBUS, EBBITAG) and 3 clinical 
trials (CEBIFOX, CECOG/CORE 1,2.002, APEC). In terms of overall survival (OS), 
consistent findings were shown in patients with left- and right-sided primary tumors 
We present the results in terms of overall response rate (ORR), disease control rate 
(DCR), response rate of lung/liver metastases, and serious adverse events (SAEs) by 
primary tumor location (PTL).

Methods: The main analyses were repeated in subgroups of patients with left- and 
right-sided primary tumors. Outcomes were assessed via logistic regression models 
after inverse probability of treatment weighting (IPTW) using a propensity score 
considering the same variables as in the main analysis, to account for differences in 
baseline characteristics between treatment schedules.

Results: A total of 830 (79%) and 227 (21%) patients presented with left- and right-
side PTLs, respectively. After IPTW, baseline confounders were balanced. No major 
differences were seen between the 2 administration schedules in ORR, DCR, response 
rates, or SAEs (Table) in either PTL subgroup.

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Table: 414P Patient characteristics

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Group</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Adjuvant</td>
<td>0.0045</td>
</tr>
<tr>
<td>Grade</td>
<td>Surveillance</td>
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</tr>
<tr>
<td>Baseline Stage (2 &amp; 3)</td>
<td>Adjuvant</td>
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</tr>
<tr>
<td>EMVI (+) or (-)</td>
<td>Surveillance</td>
<td>0.00345</td>
</tr>
<tr>
<td>CRM (+) or (-)</td>
<td>Adjuvant</td>
<td>0.01481</td>
</tr>
<tr>
<td>Anal verge(&lt;5cm or &gt;5cm)</td>
<td>Surveillance</td>
<td>0.5962</td>
</tr>
<tr>
<td>Post RT staging: 2: 3: 3</td>
<td>Adjuvant</td>
<td>0.6212</td>
</tr>
<tr>
<td>Post op staging: 2: 3: 3</td>
<td>Surveillance</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Resection margin (R1/R2 vs R0)</td>
<td>Adjuvant</td>
<td>0.0795</td>
</tr>
<tr>
<td>Time btw RT and surgery</td>
<td>Surveillance</td>
<td>0.1233</td>
</tr>
<tr>
<td>Recurrence free survival (RFS)</td>
<td>Adjuvant</td>
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</tr>
<tr>
<td>OS 1 year</td>
<td>Surveillance</td>
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<tr>
<td>OS 2 year</td>
<td>Adjuvant</td>
<td>0.0270</td>
</tr>
</tbody>
</table>

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