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DOI:  
[10.1093/annonc/mdw645](https://doi.org/10.1093/annonc/mdw645)

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Document Version  
Peer reviewed version

Citation for published version (Harvard):  
Seligmann, JF, Fisher, D, Smith, CG, Richman, SD, Elliott, F, Brown, S, Adams, R, Maughan, T, Quirke, P, Cheadle, J, Seymour, M & Middleton, G 2017, 'Investigating the poor outcomes of BRAF-mutant advanced colorectal cancer: Analysis from 2530 patients in randomised clinical trials', *Annals of Oncology*, vol. 28, no. 3, pp. 562-568. <https://doi.org/10.1093/annonc/mdw645>

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## Investigating the poor outcomes of *BRAF*-mutant advanced colorectal cancer: Analysis from 2530 patients in randomised clinical trials

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### Key words

Colorectal cancer; *BRAF*-mutant; chemotherapy; prognosis

**Word count: 3609**

## **Abstract**

### **Background:**

To improve strategies for the treatment of *BRAF*-mutant advanced colorectal cancer (aCRC) patients we examined individual data from patients treated with chemotherapy alone in three randomised trials to identify points on the treatment pathway where outcomes differ from *BRAF* wild-types.

### **Patients and Methods:**

2530 aCRC patients were assessed from three randomised trials. End-points were progression free survival (PFS), response rate (RR), disease control rate (DCR), post-progression survival (P-PS) and overall survival (OS). Treatments included first-line oxaliplatin/fluorouracil (OxFU), and second-line irinotecan. Clinicians were unaware of *BRAF*-status

### **Results**

231 patients (9.1%) had *BRAF*-mutant tumours. *BRAF*-mutation conferred significantly worse survival independent of associated clinicopathological factors known to be prognostic. Compared with wild-type, *BRAF*-mutant patients treated with first-line OxFU had similar DCR (59.2% vs 72%; adjusted OR=0.76, p=0.24) and PFS (5.7 vs 6.3 months; adjusted HR=1.14, p=0.26). Following progression on first-line chemotherapy, *BRAF*-mutant patients had a markedly shorter P-PS (4.2 vs 9.2 months, adjusted HR=1.69, p<0.001).

Fewer *BRAF*-mutant patients received second-line treatment (33% vs 51%, p<0.001), but *BRAF*-mutation was not associated with inferior second-line outcomes (RR adjusted OR=0.56, p=0.45; PFS adjusted HR=1.01, p=0.93).

Significant clinical heterogeneity within the *BRAF*-mutant population was observed: a proportion (24.3%) had good first-line PFS and P-PS (both >6 months; OS=24.0 months), however 36.5% progressed rapidly through first-line chemotherapy and thereafter, with OS=4.7 months.

### **Conclusions**

*BRAF*-mutant aCRC confers a markedly worse prognosis independent of associated clinicopathological features. Chemotherapy provides meaningful improvements in outcome throughout treatment lines. Post-progression survival is markedly worse and vigilance is required to ensure appropriate delivery of treatment after first-line progression.

### **Key messages**

This is the largest study of *BRAF*-mutant aCRC. *BRAF*-mutant aCRC patients derive similar relative benefit from chemotherapy as wild-types; poor prognosis is not primarily due to chemoresistance. Instead, the point at which outcomes differ is following progression on first-line chemotherapy. *BRAF*-mutant aCRC patients can benefit from treatment breaks when stable, and from second-line chemotherapy. However significant clinical heterogeneity was observed within the *BRAF*-mutant

population. Efforts should be concentrated on identifying *BRAF*-mutant patients who benefit from chemotherapy, and alternative strategies tested for those who don't.

## INTRODUCTION

The V600E activating mutation in *BRAF* (*BRAF*-mutant) is found in the tumours of 8-12% patients with advanced colorectal cancer (aCRC). *BRAF*-mutant aCRC is consistently associated with poor overall survival (OS) and progression free survival (PFS) in case series<sup>[1]</sup> and randomised controlled trials (RCTs).<sup>[2]</sup> In a recent RCT of previously untreated aCRC, median OS was 13.4 months in *BRAF*-mutant patients compared with 37.1 months in *RAS* and *BRAF* wild-types.<sup>[3]</sup> There is urgent need to optimise treatment strategies to improve outcomes in this population.

The mechanism for the poor prognosis is poorly understood, and it is unclear at what point in the aCRC treatment pathway that *BRAF*-mutant outcomes diverge from wild-types; whilst OS is uniformly poor, less impact is seen with PFS compared with wild-types.<sup>[4,5]</sup> It has been hypothesised that poor outcomes are secondary to intrinsic chemoresistance but there is a paucity of data describing the outcomes of *BRAF*-mutant aCRC with chemotherapy alone, particularly beyond the first-line. This is particularly important as *BRAF*-mutant patients have questionable benefit from anti-epidermal growth factor receptor (anti-EGFR) therapies<sup>[6]</sup> and *BRAF*-targeted strategies have yet to make clinical impact in aCRC.<sup>[7,8]</sup>

Importantly previous publications have not performed careful multivariate analysis. This is critical as *BRAF*-mutant aCRC is associated with clinicopathological features which are themselves negative prognostic factors,<sup>[9]</sup> including defective mismatch repair (dMMR) status<sup>[4,10]</sup>, right sided primary tumour location (PTL)<sup>[11]</sup> and a high incidence of peritoneal metastases.<sup>[12]</sup> The observed poor outcomes may instead be driven by such factors so it is essential to prospectively factor this into analyses of outcomes. Only one study has adjusted *BRAF* outcomes by one of these factors, dMMR, and found poor outcomes to be independent of this.<sup>[4]</sup>

This paper provides detailed analysis of the natural history of *BRAF*-mutant aCRC to give more clarity about prognosis and an evidence base to quantitate the benefits of different chemotherapy strategies throughout the treatment pathway.

In a pre-planned analysis we have examined individual patient data from three RCTs to identify points on the treatment pathway at which *BRAF*-mutant outcomes differ from *BRAF* wild-type patients treated with cytotoxic chemotherapy, to assess the impact of potential confounders and to provide clinicians with detailed information of outcomes with various chemotherapy strategies. We analysed treatment outcomes in two first-line RCTs with oxaliplatin/fluorouracil (OxFU), behaviour during chemotherapy-free intervals and following disease progression. We then report patterns of, and outcomes

with second-line therapy. In order to avoid potential interactions of *BRAF* status with anti-EGFR drugs we focus on patients treated in arms that did not include targeted therapies. Potential confounding factors were prospectively identified, and analyses adjusted accordingly. *BRAF*-status was unknown to clinicians treating patients in each trial, eliminating potential bias.

## PATIENTS AND METHODS:

### Patient population and treatment:

Individual patient data were obtained from selected arms of three large randomised trials, to reflect different clinical uses of standard cytotoxic chemotherapy (without targeted therapy) in aCRC (Figure 1).

- FOCUS (ISRCTN 79877428) was a sequencing trial of first-line and planned second-line therapy, and provided a cohort of 430 patients receiving single-agent 5FU ahead of planned second-line irinotecan or oxaliplatin-based therapy, plus a cohort of 357 randomised to first-line doublet (IrFU or OxFU).<sup>[13]</sup>
- COIN (ISRCTN 27286448) provided a cohort of 1284 patients randomised to first-line oxaliplatin/fluoropyrimidine (OxFp) doublet either continuously (Arm A) or with planned chemotherapy-free intervals (Arm C).<sup>[14,15]</sup>
- PICCOLO (ISRCTN 93248876) provided a cohort of 511 OxFp-resistant patients treated with second-line irinotecan.<sup>[16,17]</sup>

Inclusion criteria for FOCUS and COIN were consistent and both patient groups were treated in centres in the UK. Full reports of these studies have been published.<sup>[9,17-20]</sup> National ethical approval and patient consent was obtained for all aspects of the clinical and translational research. DNA extraction and genotyping for mutations including *BRAF*<sub>V600E</sub> was performed retrospectively as previously reported.<sup>[16,18,19]</sup>

### Statistical analysis

Stata was used (*Release 12 (2011)*, StataCorp. College Station, Texas). Baseline patient characteristics were compared between *BRAF*-mutant patients (with or without other MEK/AKT pathway mutations) and *BRAF* wild-type patients using two-tailed T-tests, Wilcoxon rank sum tests (for variables with non-normally distributed frequency distributions) and Pearson Chi-squared tests (for categorical variables).

In addition to OS (time from randomisation to death from any cause), three treatment-related clinical endpoints were used: PFS (time from randomisation to first evidence of progression or death); 12-week RECIST response rate (RR), and disease control rate (DCR).<sup>[20]</sup> Finally, we compared post-progression survival time (P-PS), defined as time from progression to death in those with a progression event, however when date of progression data was unavailable date of last chemotherapy cycle was used instead.

The prognostic influence of *BRAF*-mutant status on survival outcomes (PFS, P-PS and OS) for first-line trials (FOCUS and COIN), then the second-line trial (PICCOLO) were analysed using Cox proportional hazards modelling and described using hazard ratios (HRs) and 95% confidence intervals (CIs), adjusted for factors known to be prognostic or likely to interact with *BRAF*-status. In COIN and FOCUS these were: WHO performance status (2 vs 0/1); primary tumour resected (yes vs no); PTL (right colon vs other); platelet count (< vs  $\geq$  400,000/ $\mu$ l); peritoneal metastases (present vs absent) and mismatch

repair (MMR) status. In PICCOLO, adjustment was made for: response to previous therapy; performance status; peritoneal metastases; primary tumour resected and PTL. As these factors individually interact with prognosis, adjusted values are reported primarily but unadjusted values are provided.

Kaplan-Meier (KM) curves were plotted. For response endpoints, odds ratios (ORs) and 95% CIs were estimated from logistic regression models for the effect of *BRAF*-mutant status, adjusted for the markers previously described.

## RESULTS

### Clinicopathological variables associated with *BRAF*-mutant aCRC

*BRAF* status was available for 787/2135 (36.9%) patients in FOCUS, 1284/1630 (78.8%) in COIN and 459/511 (89.8%) in PICCOLO (Figure 1). The *BRAF*-mutant prevalence was consistent with published values (FOCUS 61/787 [7.8%], COIN 130/1284 [10.1%], PICCOLO 40/459 [8.7%]). *BRAF*-mutant patients were more likely than wild-types to be female, have right-sided PTL, have peritoneal or nodal metastases, but less likely to have lung metastases. *BRAF*-mutant tumours were more likely to have dMMR than wild-type tumours (12.6% vs 3.0%,  $p < 0.001$ ). 8/2530 (0.3%) patients' tumours had dual mutations in both *BRAF* and *KRAS* (Table 1)

### *BRAF*-status as a prognostic marker for overall survival

*BRAF*-mutant status was a significant prognostic marker for OS in both first-line studies (COIN 9.8 vs 16.6 months, unadjusted HR =1.78 [1.46-2.17],  $p < 0.001$ ; FOCUS 10.9 vs 16.2 months, unadjusted HR=1.55 [1.18-2.04],  $p = 0.030$ ) (Table 2). Combining these data [ $n = 2071$ ] gave a median OS of 10.8 vs 16.4 months (HR=1.49 [1.23-1.80]  $p < 0.001$ ) (Figure 2).

As *BRAF*-mutant status was associated with clinicopathological characteristics that may interact with survival (Table 1), their prognostic impact was explored in a univariate, then multivariate analysis in data pooled from the first-line trials. Significant factors predicting poor OS on univariate testing were *BRAF*-mutant status, poor performance status, high platelet count, right PTL, peritoneal metastases, primary tumour *in-situ* and dMMR status; in multivariate testing, all factors remained significant other than dMMR status (Supplementary Table 1).

Following adjustment, *BRAF*-mutant status remained a significant prognostic marker in both trials (COIN adjusted HR =1.51 [1.19-1.91],  $p < 0.001$ ; FOCUS adjusted HR=1.44 [1.04-2.00],  $p = 0.030$ ) (Table 2). Given the demonstrated prognostic effect of clinicopathological factors associated with *BRAF*-mutant status all subsequent analyses are adjusted.

There was no evidence that *BRAF*-mutant patients had inferior OS with a planned treatment break when first-line treatment has not yet failed. COIN, which compared continuous or intermittent chemotherapy strategies, found that intermittent chemotherapy in the entire population was non-inferior for OS (adjusted HR=1.04 [0.98–1.10],  $p = 0.16$ ).<sup>[19]</sup> In *BRAF*-mutant patients this was also the case (adjusted HR=0.97 [0.80–1.17],  $p = 0.75$ ) (Supplementary Figure 1).

OS was improved in COIN for those who received subsequent second-line chemotherapy compared with those without, regardless of *BRAF*-status (*BRAF*-mutant 16.1 vs 7.8 months [HR=0.56,  $p = 0.005$ ]; wild-type 21.1 vs 11.6 months [HR=0.48,  $p < 0.001$ ]; interaction  $p = 0.66$ ). However *BRAF*-mutant patients had worse OS whether treated with second-line chemotherapy,

(HR=1.91[1.36-2.69],  $p<0.001$ ), or not (HR=1.44 [1.12-1.84],  $p=0.004$ ), compared with wild-types.

The impact of *BRAF*-status on OS for the 459 patients treated with second-line irinotecan was examined in the PICCOLO trial. Whilst OS was shorter for *BRAF*-mutant patients compared with *BRAF* wild-type, the difference did not reach statistical significance: 6.7 vs 10.2 months (adjusted HR=1.21 [0.84-1.76],  $p=0.31$ )(Supplementary Table 2 and Supplementary Figure 2).

### **Impact of *BRAF*-status on chemotherapy outcomes: progression free survival, response rates and disease control rates.**

In contrast to its marked effect on OS, *BRAF*-mutant status had modest or insignificant impact on the first-line PFS and response endpoints. Although for patients treated with first-line OxFP in COIN *BRAF*-mutant patients had an inferior 12-week RR (34.3% vs 47.5%, adjusted OR=0.58 [0.37-0.92],  $p=0.020$ ), the differences in DCR and PFS were not significant (DCR 59.2% vs 72.0%, adjusted OR=0.76 [0.49-1.20],  $p=0.24$ ; PFS 5.7 vs. 6.3 months, adjusted HR=1.14 [0.91-1.42],  $p=0.26$ )(Table 2). There was no evidence of a differential effect of *BRAF* status according to the doublet used (OxFU or OxCap)(data not shown).

Similarly for patients treated with first-line combination chemotherapy in FOCUS, there were no differences in efficacy endpoints in *BRAF*-mutant compared with *BRAF* wild-type patients: PFS was 8.2 vs 8.8 months (adjusted HR=1.07 [0.69-1.67],  $p=0.75$ ); RR was 43.7% vs 43.1% (adjusted OR=1.09 [0.45-2.65],  $p=0.85$ ); DCR was 68.9% vs 69.9% (adjusted OR=1.01 [0.36-2.84],  $p=0.97$ )(Table 2). There was no evidence of a differential effect of *BRAF*-status according to regimen used (OxFU or IrFU,  $p=0.26$ ). With first-line single agent 5FU in this trial ( $n=430$ ), PFS was similar in *BRAF*-mutant and *BRAF*-wt patients (6.5 vs 6.7 months; adjusted HR=0.96 [0.60-1.52],  $p=0.30$ ); RR was 17.2% vs 21.7% (adjusted OR=0.54 [0.17,1.72],  $p=0.30$ ); DCR 48.3% vs 60.6% (adjusted OR=0.72 [0.27-1.94],  $p=0.52$ )(Supplementary Table 2).

We examined the impact of chemotherapy-free intervals on PFS in *BRAF*-mutant patients in COIN. In all patients progression events in patients during chemotherapy breaks led to shorter PFS (adjusted HR=1.27 [1.21–1.33],  $p<0.001$ ).<sup>[19]</sup> *BRAF*-mutant patients were the only molecular sub-group not to have a PFS disadvantage with intermittent chemotherapy (*BRAF*-mutant PFS adjusted HR=1.09 [0.91–1.31],  $p=0.33$ ; *BRAF* wild-type PFS adjusted HR=1.29 [1.21–1.37],  $p<0.001$ ; interaction  $p=0.14$ )(Supplementary Figure 1).

For patients treated with second-line single-agent irinotecan in PICCOLLO there were no significant differences between *BRAF*-mutant to wild-type patients in PFS (3.5 vs 4.0 months, adjusted HR=1.01 [0.69-1.49],  $p=0.93$ ), RR (5.0% vs. 8.1%, adjusted OR=0.56 [0.13-2.49],  $p=0.45$ ) and DCR (42.5% vs. 47.7% (adjusted OR=0.82[0.41-1.62], $p=0.57$ )(Supplementary Table 2).

### **Impact of *BRAF*-status on post-progression survival**

Following progression on first-line combination chemotherapy, *BRAF*-mutant patients had markedly reduced P-PS compared with wild-types in both first-line trials. In COIN PPS was 3.2 months in *BRAF*-mutant compared with 8.6 months in wild-type patients (adjusted HR=1.72 [1.35-2.19],  $p<0.001$ ). Similarly in FOCUS inferior P-PS was observed between *BRAF*-mutant and wild-types (3.2 vs 8.1 months; adjusted HR=1.65 [1.03-2.67],  $p=0.038$ )(Table 2). Combining this data P-PS was inferior in the *BRAF*-mutant compared with the *BRAF*-wt group (3.2 vs 8.6 months, HR=1.72 [1.35-2.19],  $p<0.001$ )(Figure 3). These marked differences were independent of first-line treatment received (in COIN, OxFU vs OxCap  $p=0.53$ , in FOCUS OxFU vs IrFU  $p=0.91$ )(data not shown). Finally, following progression on single-agent 5FU, PPS was reduced in the *BRAF*-mutant group (3.5 vs 9.3 months; adjusted HR = 2.19[1.30-3.69], $p=0.003$ )(Supplementary Table 2),

When other prognostic factors were tested in a combined multivariate model, a significant negative effect on P-PS was seen after first-line chemotherapy for peritoneal metastases and dMMR status (peritoneal metastases HR=1.39,  $p<0.0001$ ; dMMR HR=1.38,  $p=0.025$ ). However the negative prognostic impact of peritoneal metastases and dMMR appears limited to the *BRAF* wild-type population, and neither factor impacted further on the poor P-PS seen in *BRAF*-mutant patients (interaction  $p=0.005$  and  $p=0.05$  respectively), suggesting that it is the *BRAF*-mutation driving the observed poor outcomes (Supplementary Table 3).

To explore the mechanism for inferior first-line P-PS in *BRAF*-mutant patients, we studied uptake of post-progression therapies. In COIN, *BRAF*-mutant patients were less likely to receive second-line therapy after first-line progression (33% vs. 51%,  $p=0.0002$ ). Similarly, after completion of the FOCUS plan, which for all patients included two drugs (FU and either oxaliplatin or irinotecan, given over 1 or 2 lines), 123/401 (30.7%) *BRAF* wild-type and 3/29 (10.3%) *BRAF*-mutant patients received subsequent salvage therapy ( $p=0.020$ )(data not shown). The duration of second-line therapy (regimens including FU-based, Ir-based, oxaliplatin-based, cetuximab and bevacizumab) for those who received it, was unaffected by *BRAF*-mutant status (COIN  $p=0.55$ , FOCUS  $p=0.18$ ). The only exception was the subgroup of FOCUS patients randomised to receive IrFU after progression on FU alone, where *BRAF*-mutant status was associated with shorter treatment duration ( $p=0.019$ )(data not shown).

We then performed an exploratory analysis to ascertain whether the reduction in P-PS in *BRAF*-mutant patients was due to rapid progression after initial first-line benefit, rapid progression in patients who also rapidly progressed through first-line treatment, or both. Table 3 shows the breakdown of patients by mutational status into 4 groups depending upon duration of first-line PFS and subsequent P-PS: good PFS/ P-PS defined as greater than 6 months, poor PFS/P-PS defined as less than 6 months. Populations were therefore good first-line PFS and good P-PS, good first-line PFS and poor P-PS, poor first-line PFS and good P-PS, and finally poor PFS and poor P-PS.

Fewer *BRAF*-mut patients had good first-line PFS and good P-PS compared with wild-type patients (24.3% vs 39.3%,  $p<0.001$ ). Conversely there was a significantly higher proportion of *BRAF*-mutant patients with very poor outcomes (both less than 6 months first-line PFS and P-PS) compared with wild-type patients (36.5% and 21.9% respectively,  $p<0.001$ ). Thus, around a third of *BRAF*-mutant patients not only fail to obtain useful benefit from first-line therapy but also rapidly progress thereafter. Of note, the difference in median survival of *BRAF*-mutant patients between these 2 groups is 24.0 months to 4.7 months. There were no significant differences in patient demographics between these 2 groups; however there was a trend towards lower median age in the poor PFS/P-PS compared with the good PFS/P-PS group (61.9 vs 65.2,  $p=0.07$ ).

Further difference in treatment patterns were observed: 67.5% of *BRAF* wild-type patients with good initial PFS also had a good P-PS compared with 48.4% of the *BRAF*-mutant patients ( $p<0.001$ ). Whilst 47.4% of *BRAF* wild-type patients in spite of an initial poor first-line PFS went onto have a greater than 6 months P-PS this was the case in just 26.6% of *BRAF*-mutant patients.

#### *BRAF*-mutant patients treated with anti-EGFR agents

The benefit of the addition of anti-EGFR agents to chemotherapy in COIN and PICCOLO in *KRAS* wild-type patients has been previously reported.<sup>[9,18]</sup> *BRAF*-mutant patients treated with anti-EGFR agents had consistently inferior outcomes than *RAS* wild-type patients in both trials.

When including patients treated with anti-EGFR agents, and limiting to the *RAS* wild-type population, *BRAF*-mutant patients had markedly worse outcomes. Within COIN *BRAF*-mutant status was associated with inferior OS (7.2 vs 19.9 mths,  $HR=2.96[1.93-4.53]$ ,  $p<0.001$ ), PFS (4.8 vs 9.3mths,  $HR=1.84[1.23-2.75]$ ,  $p=0.003$ ), and P-PS (1.9 vs 9.7 mths,  $HR=3.12 [2.14-4.54]$ ,  $p<0.001$ ). Similarly in PICCOLO *BRAF*-mutant patients had inferior OS (4.4 vs 11.1mths,  $HR=2.31[1.61-3.33]$ ,  $p<0.001$ ), PFS (2.7 vs 5.5 mths,  $HR=1.70[1.24-2.61]$ ,  $p=0.002$ ) and P-PS (3.2 vs 6.0 mths,  $HR=1.83[1.24-2.61]$ ,  $p=0.002$ )(data not shown).

## DISCUSSION

This is the largest and most comprehensive clinical series assessing the outcomes of *BRAF*-mutant patients treated with chemotherapy at different points of the aCRC pathway. The poor outcomes of advanced *BRAF*-mutant aCRC are well described, but these cancers are associated with specific clinicopathological features: older age, right-sided primary tumour, high grade, deficient MMR, mucinous histology and peritoneal and lymph node metastases,<sup>[4,9-12]</sup> most of which interact with prognosis. In a careful multivariate analysis in a large, prospectively gathered cohort, *BRAF*-mutation still conferred a worse prognosis and is not simply attributable to associated clinico-pathological features.

Within this dataset the poor outlook is not driven by chemoresistance. We observed no difference in the adjusted PFS or DCR between *BRAF*-mutant and wild-type patients receiving first-line chemotherapy. There was also no difference in adjusted PFS or DCR between *BRAF*-mutant and wild-type patients who received second-line irinotecan monotherapy. Results were consistent between both first-line trials, independent of chemotherapy strategy and other standard prognostic factors. OxFU is a commonly used first-line therapy in aCRC, and was the first-line regimen used in the majority of patients analysed herein, and indeed oxaliplatin may provide particular benefits in *BRAF*-mutant patients<sup>[3, 21]</sup>.

Our analyses suggest instead that the point at which outcomes markedly diverge between *BRAF*-mutant and wild-types is following progression on or after benefit from first-line chemotherapy. Further investigation suggested that the observed significantly worse P-PS compared with wild-types may be due to the combined impact of two distinct patterns. Firstly *BRAF*-mutant patients were more likely to rapidly progress through first-line therapy and then subsequently rapidly deteriorate, either too unfit to receive subsequent treatment or progressing through that therapy. Secondly, *BRAF*-mutant patients with an initial good outcome on first-line chemotherapy were more likely to rapidly progress thereafter. Whilst around two-thirds of wild-type patients with good outcomes on initial therapy subsequently survive more than 6 months after progression on first-line chemotherapy this fell to half of *BRAF*-mutant patients.

Although, the study is limited by relative small numbers of *BRAF*-mutant patients compared to wild-types and findings should be interpreted with caution particularly sub-group analyses, the data suggests that a significant proportion of *BRAF*-mutant patients can obtain meaningful benefit from chemotherapy. Thus uniform nihilism about the impact of chemotherapy in deflecting the natural history of *BRAF*-mutant aCRC is unjustified. Furthermore, *BRAF*-mutant patients with disease control can be appropriately counselled about the safety of chemotherapy free intervals even though caution is required in the interpretation of this sub-set analysis. However, post-progression survival after first-line progression is clearly worse in *BRAF*-mutant patients and fewer receive second-line therapy. It is important to emphasise that treating physicians were unaware of *BRAF*-status, so this

latter finding is not due to selection bias. Thus, we suggest that extra vigilance is required when treating *BRAF*-mutant patients, to promptly detect initial progression and then rapidly institute second-line therapy in the knowledge that this has the capacity to significantly improve survival.

A third of *BRAF*-mutant patients rapidly progress on and then after first-line therapy with no obvious benefit from chemotherapy. These patients drive much of the observed poor outcomes of *BRAF*-mutant aCRC and such aggressive clinical behaviour is what clinicians often have in mind when thinking about *BRAF*-mutant aCRC patients.. A biomarker is required to identify such patients who might benefit from an alternative therapeutic strategy, such as targeted therapy. The combination of a *BRAF*-inhibitor dabrafenib, a MEK inhibitor trametinib and an anti-EGFR agent panitumumab demonstrated an unconfirmed response rate of 30%.<sup>[22]</sup>

Recent transcriptional analyses have sub-divided *BRAF*-mutant aCRC into 2 sub-types with widely differing biology.<sup>[23]</sup> BM1 tumours constitute one-third of *BRAF*-mutant cancers and are characterised by enrichment of a *KRAS* signature and sensitivity to *BRAF* and *MEK* inhibition. The other two-thirds of *BRAF*-mutant aCRC, the BM2 sub-type, are characterised by accelerated G2/M phase with low ATM with sensitivity to cdk1 inhibition. These checkpoint abnormalities could contribute to chemosensitivity by preventing DNA damage being repaired prior to mitosis. Thus, application of these signatures to these two clinically divergent groups of *BRAF*-mutant patients appears warranted. Furthermore MMR testing should be encouraged in *BRAF*-mutant aCRC patients and entry into RCT testing immunotherapy agents where available.

This, the largest and most comprehensive analysis of chemotherapy outcomes in *BRAF*-mutant CRC patients provides new and important information with clinical relevance. In summary, *BRAF*-mutation confers a markedly worse prognosis independent of associated clinicopathological features. However, in some patients chemotherapy does provide meaningful improvements in outcome throughout treatment lines and translational efforts need to be made to identify them and those who appear to derive no benefit from chemotherapy. Post-progression survival is worse in *BRAF*-mutant patients and vigilance is required to ensure the appropriate delivery of treatment after first-line progression.

## **ACKNOWLEDGEMENTS**

We are deeply indebted to the patients who participated in this study and to their families and carers. We would like to thank all the staff, past and present, at the Medical Research Council Clinical Trials Unit and the University of Leeds Clinical Trials Unit. We are grateful to staff at all the centres that contributed to the FOCUS, COIN and PICCOLO trials, including clinical management of patients, data collection, and contribution of tumour blocks to each trial biobank.

## **COMPETING INTERESTS**

No authors have declared no conflicts of interest

## **FUNDING**

This work was supported by Cancer Research UK and Yorkshire Cancer Research

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### Legend to Figures

Figure 1- Consort diagram of study participants from the FOCUS, COIN and PICCOLO trials

Figure 2 –OS KM curves for *BRAF*-mut vs *BRAF*-wt for first line chemotherapy (FOCUS and COIN, all strategies)

Figure 3 - Post-progression survival KM curves for *BRAF*-mut vs *BRAF*-wt following failure on first-line chemotherapy (COIN and FOCUS)



