Treatment-related severe and fatal adverse events with molecular targeted agents in the treatment of advanced gastric cancer: a meta-analysis

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Aim: To perform a systematic review and meta-analysis of Phase III randomized controlled trials (RCTs) to determine the incidence and risk of severe adverse events (AEs) with molecular targeted agents (MTAs) in advanced/metastatic gastric cancer (GC) patients.

Methods: A comprehensive literature search for related trials published up to December 2015 was performed. Eligible studies were Phase III RCTs of advanced/metastatic GC patients assigned to MTAs or control group. Data were extracted by two authors for severe and fatal AEs (FAEs).

Results: A total of nine Phase III RCTs involved 4,934 GC patients were ultimately identified. The pooled results demonstrated that the addition of TAs to therapies in advanced GC significantly increased the risk of developing severe AEs (relative risk: 1.12, 95% confidence interval: 1.02–1.24, P=0.02), but not for FAEs (relative risk: 0.97, 95% confidence interval: 0.65–1.45, P=0.88). Additionally, the most common causes of FAEs with MTAs were infections (16.3%), gastrointestinal hemorrhage (8.2%), and arterial thromboembolic events (8.2%), respectively.

Conclusion: With available evidence, the use of TAs in GC patients was associated with an increased risk of severe AEs, but not for FAE. Clinicians should be aware of the risk of severe AEs with the administration of these drugs in these patients.

Keywords: advanced gastric cancer, molecular targeted agents, randomized, meta-analysis

Introduction
Gastric cancer (GC) is one of the most common malignant diseases worldwide, accounting for 8% (989,600 million) of the total new cancer cases and 10% (738,000) of the total cancer deaths in 2008. Generally, GC is a heterogeneous disease, which usually includes different subgroups according to histological, anatomical, genomic, or molecular classifications. Regardless of these subtypes, the current treatment of GC is based on a multidisciplinary approach that combines gastrectomy, radiotherapy, and chemotherapy. Despite the advances in the treatment, nearly 50% of patients with locally advanced-stage GC relapse after gastrectomy. For such patients, palliative chemotherapy is the mainstay treatment to prolong the survival. Currently, combination chemotherapy based on 5-fluoropyrimidines/platinum, with possible addition of docetaxel in fit patients, represent the landmark of first-line treatment of advanced GC patients. However, the efficacy of first-line chemotherapy is modest, with a median survival 8–12 months, and most patients are nonresponders or eventually experience disease progression. Thus, it is clear that novel treatments are badly needed in advanced GC patients.
During the past decades, a better understanding of the molecular events involved in the tumorigenesis of GCs has led to development of new targeted agents. A recent meta-analysis conducted by Qi et al demonstrated that the use of anti-vascular endothelial growth factor (anti-VEGF) agents provided a significant survival benefit in previously treated GC patients. Another meta-analysis conducted by Ciliberto et al also showed that antiangiogenic agents (hazard ratio [HR]: 0.759; 95% confidence interval [CI]: 0.655–0.880; \( P < 0.001 \)) and anti-HER-2 agents (HR: 0.823; 95% CI: 0.722–0.939; \( P = 0.004 \)) significantly improve overall survival, while no benefit was found for anti-EGFR agents (HR: 1.077; 95% CI: 0.847–1.370; \( P = 0.543 \)). To date, two molecular targeted agents (MTAs) targeting VEGF signal pathway, bevacizumab and ramucirumab, and one MTA-targeting EGFR signal pathway, trastuzumab, have been approved for use in advanced GC patients due to survival benefits. Therefore, it is anticipated that the use of these MTAs in GC would increase in the future. However, VEGF and EGFR play multiple roles in physiologic processes, and thus their inhibition could have potentially serious systemic consequences. To our best knowledge, there is no specific meta-analysis to assess the severe adverse events (AEs) and fatal adverse events (FAEs) associated with MTAs in GC. We, therefore, conduct this comprehensive meta-analysis of Phase III randomized controlled trials (RCTs) to assess the toxicities of MTAs in advanced GC patents.

### Materials and methods

#### Study design

We performed this meta-analysis according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statements.\(^1\)

#### Search strategy

In December 2015, an extensive search of the following databases was performed: Embase, Medline, the Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews. The following keywords were used: “gastric neoplasms,” “gastric cancer,” “gastric carcinoma,” “sorafenib,” “unitinib,” “pazopanib,” “axitinib,” “cediranib,” “regorafenib,” “ramucirumab,” “vandetanib,” “bevacizumab,” “angiogenesis inhibitor,” “mTOR inhibitor,” “everolimus,” “cetuximab,” “panitumumab,” “lapatinib,” “trastuzumab,” “molecular targeted agents,” and “randomized controlled trials.” The language of publication and years were not limited.

#### Selection of trials

Clinical trials that met the following criteria were included: 1) Phase III RCTs in patients with pathologically confirmed GC; 2) participants assigned to treatment with or without MTAs; and 3) reported outcomes of interest (ie, severe AE and FAEs). We used the five-item Jadad scale including randomization, double-blinding, and withdrawals as previously described to approximately assess the quality of included trials.\(^2\)

#### Data extraction

Two investigators independently performed data extraction. If reviewers suspected an overlap of cohorts in a report, they contacted the corresponding author for clarification; we excluded studies with a clear overlap. The following information was recorded for each study: first authors’ name, year of publication, study period, median age, MTAs dosage, number of patients enrolled, and events of severe and FAEs. The primary end point of this study was FAE, which was defined by the National Cancer Institute’s Common Terminology Criteria for Adverse Events as deaths occurring during a clinical trial as a result of exposure to an experimental drug. We did not include FAEs that were related to disease progression. The second end point of this study was severe AE, which was defined by the National Cancer Institute’s Common Terminology Criteria for Adverse Events as Grade 3 or 4 toxicities occurring during a clinical trial as a result of exposure to an experimental drug.

#### Statistical analysis

Statistical analysis of severe and fatal AEs was calculated using comprehensive meta-analysis software version 2.0 (Biostat, Englewood, NJ, USA). Between-study heterogeneity was estimated using the \( \chi^2 \)-based \( Q \) statistic.\(^3\) Heterogeneity was considered statistically significant when \( P \) \( \text{heterogeneity} < 0.05 \) or \( \hat{I}^2 > 50\% \). We calculated the pooled relative risk (RR) and 95% CIs by using random-effect or fixed-effect models according to the heterogeneity of included studies. A statistical test with a \( P \)-value less than 0.05 was considered significant. RR \( > 1 \) indicates more toxicities in MTAs group, and vice versa. Finally, publication bias was evaluated through funnel plots and with Begg and Egger’s tests.\(^4,5\)

#### Results

##### Search results

Our literature search revealed 252 potential relevant publications, and 21 reports were retrieved for full-text evaluation;
Incidence of severe and fatal AEs

A total of 2,647 patients from nine treatment arms receiving MTAs were available for severe AEs incidence analysis. Using a random-effects model, the summary incidence of severe AEs was 72.5% (95% CI: 66.4%–77.8%). As for FAEs, a total of 2,647 patients from nine treatment arms were included, and the pooled incidence was 2.2% (95% CI: 1.6%–2.9%) using a fixed-effects model (P=0.051).

RR of severe and fatal AEs

A meta-analysis of RR for severe and fatal AEs attributable to MTAs compared with control was performed. The pooled results showed that the use of MTAs significantly increased the risk of severe AEs (RR: 1.12, 95% CI: 1.02–1.24, P=0.02; Figure 2), but not FAEs when compared with controls (RR: 0.97, 95% CI: 0.65–1.45, P=0.88; Figure 3) using a fixed-effects model.

Specific FAEs

Individual specified and nonspecified causes of FAEs are listed in Table 2. There were 49 FAEs on the treatment arms and 46 FAEs on the controlled arms; 42.9% and 50% of them were nonspecified etiology, respectively. For those specified FAEs in this study, the most common causes of FAEs with MTAs

Table 1: Baseline characteristics of nine included trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment line</th>
<th>Total (N)</th>
<th>Treatment arms</th>
<th>Number for analysis</th>
<th>Median age (years)</th>
<th>Median PFS</th>
<th>Median OS</th>
<th>Jadad score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuchs et al20</td>
<td>Second-line</td>
<td>335</td>
<td>Ramucirumab 8 mg/kg</td>
<td>236</td>
<td>60</td>
<td>NR</td>
<td>5.2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo</td>
<td>115</td>
<td>60</td>
<td>NR</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Wilke et al20</td>
<td>First-line</td>
<td>655</td>
<td>Ramucirumab 8 mg/kg + PTX</td>
<td>327</td>
<td>61</td>
<td>4.4</td>
<td>9.6</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo + PTX</td>
<td>329</td>
<td>61</td>
<td>2.9</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Shen et al21</td>
<td>Second-line</td>
<td>202</td>
<td>Bevacizumab 2.5 mg/kg/wk + capecitabine + DDP</td>
<td>100</td>
<td>54.2</td>
<td>6</td>
<td>11.4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo + capecitabine + DDP</td>
<td>102</td>
<td>55.5</td>
<td>6.3</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lapatinib 1,500 mg qd + PTX</td>
<td>132</td>
<td>62</td>
<td>5.4</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Satoh et al22</td>
<td>Second-line</td>
<td>261</td>
<td>Panitumumab + EOC</td>
<td>278</td>
<td>63</td>
<td>7.4</td>
<td>11.3</td>
<td>3</td>
</tr>
<tr>
<td>Waddell et al23</td>
<td>First-line</td>
<td>553</td>
<td>PTX</td>
<td>129</td>
<td>62</td>
<td>4.4</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Ohtsu et al24</td>
<td>Second-line</td>
<td>656</td>
<td>Everolimus 10 mg/d</td>
<td>439</td>
<td>62</td>
<td>1.7</td>
<td>5.4</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo</td>
<td>217</td>
<td>62</td>
<td>1.4</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Lordick et al25</td>
<td>First-line</td>
<td>904</td>
<td>Cetuximab + capecitabine + DDP</td>
<td>455</td>
<td>60</td>
<td>4.4</td>
<td>9.4</td>
<td>3</td>
</tr>
<tr>
<td>Ohtsu et al26</td>
<td>First-line</td>
<td>774</td>
<td>Bevacizumab 2.5 mg/kg/wk + capecitabine + DDP</td>
<td>386</td>
<td>58</td>
<td>6.7</td>
<td>12.1</td>
<td>5</td>
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<tr>
<td>Bang et al27</td>
<td>First-line</td>
<td>594</td>
<td>Placebo + capecitabine + DDP</td>
<td>381</td>
<td>59</td>
<td>5.3</td>
<td>10.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Trastuzumab + chemotherapy</td>
<td>294</td>
<td>59.4</td>
<td>6.7</td>
<td>13.8</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chemotherapy</td>
<td>290</td>
<td>58.5</td>
<td>5.5</td>
<td>11.1</td>
<td></td>
</tr>
</tbody>
</table>

*Abbreviations: PTX, paclitaxel; DDP, cisplatin; EOC, epirubicin plus oxaliplatin plus capecitabine; PFS, progression-free survival; OS, overall survival; NR, not reported.*
were infections (16.3%), gastrointestinal hemorrhage (8.2%), and arterial thromboembolic events (8.2%), respectively. Additionally, the specified FAEs of eight infections were pneumonia (three), Candida sepsis (one), Klebsiella sepsis (one), sepsis (two), and neutropenic sepsis (one), respectively.

**Publication bias**

We used Begg’s funnel plot and Egger’s test to assess the publication bias. The Begg’s funnel plots did not show any evidence of publication bias ($P=0.89$ for severe AEs and $P=0.54$ for FAEs, respectively). Additionally, Egger’s test also did not suggest any evidence of publication bias ($P=0.56$ for severe AEs and $P=0.30$ for FAEs, respectively).

**Discussion**

During the past decades, the introduction of biological agents targeting specific growth and survival pathways, such as EGFR, PI3K/Akt/mTOR pathway, and angiogenesis through the VEGF signaling cascade, seems to be the most promising strategy to improve outcome of advanced GC patients. Trastuzumab in combination with chemotherapy has been approved by US Food and Drug Administration (FDA) as first-line treatment for patients with HER2-positive advanced gastric or gastroesophageal junction cancer due to its survival benefit when compared to chemotherapy alone. More recently, ramucirumab, a monoclonal antibody VEGFR-2 antagonist, in combination with paclitaxel also significantly increased overall survival in previously treated patients with advanced GC compared with paclitaxel, which led to its approval for use in second-line treatment for advanced GC. However, no clear survival benefit was experienced with agents targeting EGFR (cetuximab and panitumumab), VEGF-A (bevacizumab), or mTOR (everolimus). Because of the wide use of MTAs in GC patients, concerns have arisen regarding the risk of severe and fatal AEs with these drugs. Indeed, several previous meta-analyses have been performed to assess the severe and fatal toxicities associated with these MTAs. For example, a previous meta-analysis conducted by Ranpura et al showed that the addition of bevacizumab

<table>
<thead>
<tr>
<th>Studies</th>
<th>Estimate (95% CI)</th>
<th>Ev/trt</th>
<th>Ev/ctrl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuchs et al(2014)</td>
<td>1.218 (0.240, 6.184)</td>
<td>5/236</td>
<td>2/115</td>
</tr>
<tr>
<td>Wilke et al(2014)</td>
<td>1.207 (0.372, 3.917)</td>
<td>6/327</td>
<td>5/329</td>
</tr>
<tr>
<td>Shen et al(2015)</td>
<td>0.510 (0.159, 1.640)</td>
<td>4/100</td>
<td>8/102</td>
</tr>
<tr>
<td>Satoh et al(2014)</td>
<td>1.466 (0.424, 5.074)</td>
<td>6/132</td>
<td>4/129</td>
</tr>
<tr>
<td>Waddell et al(2013)</td>
<td>0.659 (0.168, 2.311)</td>
<td>4/278</td>
<td>6/275</td>
</tr>
<tr>
<td>Ohtsu et al(2013)</td>
<td>0.741 (0.125, 4.404)</td>
<td>3.439</td>
<td>2.217</td>
</tr>
<tr>
<td>Lordick et al(2013)</td>
<td>0.987 (0.248, 3.921)</td>
<td>4/455</td>
<td>4/449</td>
</tr>
<tr>
<td>Ohtsu et al(2011)</td>
<td>0.576 (0.229, 1.447)</td>
<td>7/386</td>
<td>12/381</td>
</tr>
<tr>
<td>Bang et al(2010)</td>
<td>3.288 (0.914, 11.825)</td>
<td>10/294</td>
<td>2/290</td>
</tr>
</tbody>
</table>

**Figure 2** RR of severe AEs (95% CI) associated with therapies with or without MTAs.

**Figure 3** RR of FAEs (95% CI) associated with therapies with or without MTAs.

Abbreviations: RR, relative risk; AEs, adverse events; MTAs, molecular targeted agents; CI, confidence interval; Ev, events; trt, treatments; ctrl, control.
In a recent meta-analysis conducted by Qi et al., with MTAs, which is consistent with previous studies. We find that infections are the most common FAEs associated with MTAs, owing to its survival benefits, but suggest close monitoring of severe AEs, but not for FAEs. Additionally, the most common causes of FAEs with MTAs were infections (16.3%), gastrointestinal hemorrhage (8.2%), and arterial thromboembolic events (8.2%), respectively. On the basis of these findings, clinicians should pay more attention to severe infections to reduce the risk of FAEs in advanced gastric patients. Before the initiation of MTAs in gastric patients, clinicians should fully treat patients with any active infection and must monitor patients during the course of MTAs treatment. However, patients with active or recently active infections are excluded from clinical trials; therefore, the true incidence of these infections could be widely under-reported. More trials focusing on this issue are still needed.

Several limitations exist in this analysis. First, although AEs are prospectively collected for each individual study, this analysis remains a retrospective research that is subject to the method deficiencies of the included trials. We minimized the likelihood of bias by strictly selecting Phase III RCTs with direct comparison with and without MTAs before the analysis. Second, we included patients treated with different targeted agents, which would increase the clinical heterogeneity among included trials, which also makes the interpretation of a meta-analysis more problematic, although we pooled subgroup analysis according to treatment line. Finally, in the meta-analysis of published studies, publication bias is important because trials with positive results are more likely to be published and trials with null results tend not to be published. Our research detects no publication bias using Begg and Egger tests for severe and fatal AEs.

### Conclusion

In conclusion, this is the first meta-analysis that specifically assessed the severe and fatal toxicities of adding MTAs to therapies in the treatment of GC patients. The results of our study suggest that the addition of MTAs to therapies in GC significantly increases the risk of developing severe AEs, but not for FAEs. Additionally, the most common causes of FAEs with MTAs were infections, gastrointestinal hemorrhage, and arterial thromboembolic events, respectively.

### Disclosure

The authors report no conflicts of interest in this work.
References


