THE CORRECT ANSWER IS INDICATED WITH YELLOW HIGHLIGHTING.

1. **Which of the following patients with KRAS wild-type mCRC do *not* derive clinical benefit from the addition of EGFR antibodies to first-line chemotherapy?**
   a. Patients with left-sided primary cancers
   b. Patients with right-sided primary cancers

2. **The ongoing BEACON CRC Phase III study is evaluating encorafenib and binimetinib in combination with _____ for patients with mCRC with BRAF V600E mutations.**
   a. Cetuximab
   b. Panitumumab
   c. Pembrolizumab

3. **Patients with mCRC with non-V600 BRAF mutations have a worse prognosis than those with BRAF V600-positive disease.**
   a. True
   b. False

4. **Results of the Phase II HERACLES trial for patients with HER2-amplified mCRC in the cohort of patients who received the combination of trastuzumab with lapatinib demonstrated an objective response rate of approximately _____.**
   a. 10%
   b. 30%
   c. 50%

5. **Research indicates that patients with mCRC who receive TAS-102 and develop neutropenia have _____ outcomes than those who receive TAS-102 and do not develop neutropenia.**
   a. Better
   b. Worse

6. **In patients with microsatellite instability (MSI)-high CRC, the mutational load is _____ in comparison to that in patients with microsatellite-stable CRC.**
   a. Higher
   b. Roughly equivalent
   c. Lower

7. **The Phase II TASCO1 study evaluating the combination of TAS-102 or capecitabine with bevacizumab for patients with unresectable mCRC who are not eligible for intensive therapy in the first-line setting demonstrated better progression-free survival in the _____ arm.**
   a. TAS-102
   b. Capecitabine

8. **The combination of nivolumab and ipilimumab is more toxic than nivolumab monotherapy for patients with MSI-high/mismatch repair (MMR)-deficient colorectal cancer.**
   a. True
   b. False

9. **Approximately what proportion of patients with Stage IV CRC have MSI-high/MMR-deficient disease?**
   a. 20%
   b. 10% to 12%
   c. 4% to 5%

10. **The Phase II ReDOS trial comparing lower-dose (80 mg/d with dose escalation to 160 mg/d) to standard-dose (160 mg/d) regorafenib for patients with refractory mCRC demonstrated the following result for patients starting at the lower dose.**
    a. More patients completed 2 cycles and initiated cycle 3
    b. Inferior outcomes
    c. Both a and b