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Evidence- and Guideline-Based Treatment for Advanced/Metastatic Cervical Cancer

Episode 4

Dr. Slomovitz:
Hi, this is Dr. Brian Slomovitz. This is CE on ReachMD, and I'm here today again with Michelle Flint and Casey Cosgrove.

I think one of the most frustrating diseases that we have to treat is metastatic cervical cancer when it's spread throughout the body, when it's outside the pelvis. Treatment options are extremely limited. And historically, outcomes have been very, very, very poor.

So let's get right into it. Traditional therapy here, based on some of the work we saw in GOG 240, is carboplatin, or platinum-based therapy with paclitaxel and bevacizumab. It worked, but it just didn't work for as long as we wanted it to.

Casey, take us down this treatment pathway, a little bit of first-line leading to pembrolizumab in the second-line.

Dr. Cosgrove:
Yeah, I think that GOG 240 was really a game changer for adding bevacizumab to our platinum and our taxols. Unfortunately, that was really hard treatment until progression, or until they couldn't tolerate it anymore.

For our PD-L1 positive cervical cancers now, we have the opportunity to add an immunotherapy with the chemotherapy as well as bevacizumab – so a four-drug recipe that has really kind of I think improved our opportunity to get better disease control. But also importantly, in our practice, patients are excited to hear that we can kind of drop the cytotoxic chemotherapy after six or seven or eight rounds, and then move to more of a maintenance strategy, which was not the way that GOG 240 was approached. So then I kept patients on immunotherapy and bevacizumab for 36 cycles, so for a prolonged period of time, where we're seeing excellent disease control, also at a more tolerable regimen. So I think that's been a really kind of a game changer when we discuss our cervical cancers.

The other thing that I think is really beneficial is with the four-drug recipe, even though it's a little bit more challenging and it's four drugs, it gives us a little bit more flexibility if an individual is not tolerating or not a good candidate for bevacizumab, then we have the immunotherapy. Or vice versa, if they have an immune toxicity, continuing along with the bevacizumab.

Dr. Slomovitz:
Michelle, how do we handle the toxicity profile of the four? How do we handle the patients getting scared about getting four? And really, you and I talk about this all the time – it's a great regimen, it works, and it's not as difficult to give, or not as difficult as we thought it may be.

NP Michelle Flint:
It is a bit surprising that it is well tolerated because it is that four-drug combination. But the addition of the pembrolizumab to the carboplatin, paclitaxel, and bevacizumab is well tolerated by our patients.

So when thinking about the maintenance therapy for these patients, we're looking at side effects over time. Are they going to have cumulative side effects? We see that with chemotherapy – when we give them more than six, eight cycles of chemotherapy – that they have cytopenias, they have a cumulative fatigue, nausea.

And that's not the case with the pembrolizumab and the bevacizumab.

So KEYNOTE-826 showed that patients randomized to the pembrolizumab maintenance arm did not show any evidence of cumulative toxicity.

Yes, we do see some adverse events with the pembrolizumab and bevacizumab, but like Dr. Cosgrove alluded to, we can stop one maintenance drug and they're still on some type of maintenance. And patients appreciate being on maintenance and coming into clinic, having their labs checked, knowing that they're doing something for their cancer care.

Dr. Slomovitz:
And we are seeing patients doing better.

And I think the future is bright for cervix cancer. So right now, I'm just happy that we have a better treatment option in KEYNOTE-826, and we need to continue to do better.

That was a great review. Casey and Michelle, thanks again for your time.