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Evidence- and Guideline-Based Treatment for High-Risk Locally Advanced Cervical Cancer

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Dr. Slomovitz:
Hi. Good day. Now I'm really excited about we have Michelle and Casey back today for our next topic. We're going to talk about newly diagnosed locally advanced cervical carcinoma, or L-A-C-C.

Casey, I get a tissue biopsy from this patient. What are the things you're looking for biologically, translationally, to help us come up with the best treatment options for a newly diagnosed, let's call it a stage II, cervix cancer?

Dr. Cosgrove:
So I try to get together a biomarker-directed panel so that I can provide them the understanding for what treatments are going to be available today, but also give us an idea about what the next steps might be should they need it.

I'm looking at markers for immunotherapy. We have a small percentage of cervical cancers that can have things like mismatch repair deficiency or microsatellite instability. We have some cervical cancers that might have elevated tumor mutational burdens, which also can be a good indicator for immunotherapy.

But perhaps the most important biomarker I'm looking for when I'm sitting across the table for this exact patient is looking at their PD-L1 status to figure out whether or not immunotherapy might be a good fit with our upfront treatment planning.

With that, there's some additional testing I like to get done, because really, time is of the essence sometimes, and it's really nice to be able to have kind of a list of what our treatment plans are going to be looking like now and in the future, so that you're not running backwards and trying to figure things out should they need to have a next line of therapy.

Dr. Slomovitz:
Great. And that's so important that we have these conversations earlier on.

This is a patient with stage II cervical cancer. Imaging reveal that she's actually positive lymph nodes, so she's extremely high-risk locally advanced disease. We've learned to incorporate immunotherapy into our treatments, in addition to radiation and chemotherapy, based on the data from KEYNOTE-A18 which is a study which evaluates pembrolizumab, a checkpoint inhibitor, an immunotherapy, incorporating that into the level of care.

Michelle, I know you're sort of in the trenches firsthand, having these conversations with me, but then constant communications with the patient; give us a little bit of what your thoughts are on how we approach these patients with KEYNOTE-A18.

NP Michelle Flint:

Thanks, Dr. Slomovitz. So yes, with KEYNOTE-A18, we are seeing these patients in clinic a lot more often because they are on the pembrolizumab for a prolonged period. These patients complete intensive chemoradiotherapy with IO added to it, and then they're continuing on pembrolizumab for roughly 21-22 months in maintenance. It is a long time. But they're happy to come into clinic, to be seeing us, to be surveilling their cancer and to be receiving a maintenance treatment at the same time that's hopefully keeping everything at bay and preventing something from coming back.

Fortunately, they tolerate pembrolizumab very well in general, and they usually have a very good quality of life, so it's not hindering their quality of life. Although IO therapy is not without any complications, we know that pembrolizumab can over-activate the immune system, causing a few different autoimmune conditions. So we do have to stay vigilant to ensure early detection and treatment of these adverse events, because when treated early, we're often able to successfully rechallenge the patient on pembrolizumab and keep them on therapy for a prolonged period.

Dr. Slomovitz:
Thank you so much. We found an overall survival benefit in using this –progression-free survival benefits in using this; things we haven't done in the past.

And Casey, to your point, knowing what's going on molecularly really starts the process to what's going to go on, to help our patients live longer, spend more time with their families, and be disease free.

That's the time we have for locally advanced cancer. Thank you very much. I look forward to our more discussions.

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