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Managing Immune-Related Adverse Events in Cervical and Endometrial Cancer

Announcer:
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Dr. Slomovitz:
Hi. This is Dr. Brian Slomovitz. This is CE on ReachMD, and again, I'm pleased to be joined with today Michelle Flint and Casey Cosgrove.

We've been spending a lot of time in our different sessions talking about the most effective drugs, the latest and greatest, how we're improving the care for our patients. But I think going hand in hand with efficacy is making sure the drugs are tolerable, and that side effect profile is something that we could easily manage and mitigate. And we see side effects with these agents, and we need to be prepared to handle these side effects so we can keep the patients on the drugs longer.

Michelle, who's one of our expert nurse practitioners, she really helps out tremendously, really leads the effort. Her and her colleagues, who are nurse practitioners, really help clinicians, physicians, manage these patients. Because a lot of times these patients need to pick up the phone and get someone to answer, and need to get help to handle the side effects that come with these drugs.

Michelle, without further delay, tell us about some of the immune-mediated side effects we see and some of the mitigation strategies and treatment strategies that you employ.

NP Michelle Flint:
Thank you. So yes, with traditional chemotherapy, we see a lot of fatigue, nausea, vomiting, anemia. Immunotherapy has a different side effect profile. So, many patients have mild to no side effects. However, immunotherapy adverse effects can be severe, they can be fatal. They can occur in any organ and can affect more than one body system simultaneously. They can occur right after starting treatment, or even after discontinuing treatment. So you always have to be on the lookout for these side effects.

It's important to monitor these patients very closely. And we monitor them with liver enzymes, kidney/thyroid function at baseline and frequently during treatment. With patients receiving pembrolizumab in our practice, we're commonly seeing thyroiditis, immune-mediated rashes, and colitis. For those experiencing hypothyroidism, we'll initiate hormone replacement. For patients with mild rashes, we can often treat them with moisturizers, topical corticosteroids. And then the patients with colitis, they often present with diarrhea, so an infectious workup should also be done at the same time to exclude any alternative etiologies.

In general, if the patient has this diarrhea, the pembrolizumab-induced colitis, we should not delay therapy with corticosteroid initiation while we're doing that infectious workup.

Dr. Slomovitz:

I want to interrupt you for a second, but what if we have a patient on pembro/lenvatinib who has diarrhea? How do you know where it's coming from?

NP Michelle Flint:
That's a great question. So with pembro/lenvatinib, one of these is a pill, the other one is an IV therapy. So we commonly are stopping the pill, lenvatinib, for a week to see if the lenvatinib was the cause of the diarrhea, it often is.

Pembrolizumab typically will cause some mild diarrhea the week following treatment, but pembrolizumab-induced colitis is 13 episodes of diarrhea a day or mucousy bowel, but a lot of cramping. We work with our GI colleagues to investigate it further, and it requires dose hold for the pembrolizumab and immediate corticosteroid initiation to resolve.

Dr. Slomovitz:
Great. Thank you.

Casey, the side effect that I'm most afraid of is pneumonitis. For me, when I see the earliest signs of it, I'll get my pulmonary team involved. I'm talking to the radiologist every visit. How are you better identifying it, better handling it, and doing what you can to keep the patients on a drug, if possible, as opposed to taking them off a drug that may be working?

Dr. Cosgrove:
Yeah, no, I think those are all great points. And, Michelle, I think we're so reliant on our APPs because they're on the front lines with our nursing staff, so oftentimes handling the phone calls from our patients. And these are sometimes very subtle symptoms that they're experiencing, or sometimes they really have no symptoms at all, and it's incidentally picked up on imaging and things like that.

So if we have any question or concern for pneumonitis, we're getting them started on a steroid protocol. We're getting our pulmonary colleagues involved, and we're also making sure that we provide really in-depth patient counseling so that they are aware of what symptoms and side effects that we need to keep an eye on.

And now, ultimately, if we're able to recover from these, oftentimes we can re-challenge with things like immunotherapy, and hopefully be able to keep them on the treatments that might get their disease under control the best that we can, for as long as possible.

Dr. Slomovitz:
Yeah, no, thank you for that. But my summary of this is: use our team. We have a multidisciplinary team. It's not just our oncology team, it's our pulmonary docs. If there's question about ocular toxicity, bring the ophthalmologist on board. If we have difficulty managing colitis, bring in our GI docs. I think the more people on the team that are experts in these areas can help really, in my view, keep a patient on a drug that may work, but know when to take them off if we're going to get too much toxicity.

Michelle, thanks for your leadership on that session. Casey, thanks for your comments, and I look forward to one of our next sessions.

Announcer:
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