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All Hands on Deck: Multidisciplinary Coordination for Smarter Perioperative Care

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You're listening to GLC on ReachMD. This activity, titled **"Talking Through Treatment: Patient–Clinician Dialogue on Perioperative Immunotherapy in Locally Advanced head and neck squamous cell carcinoma"** is provided by **Global Learning Collaborative**.

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Dr. Luginbuhl:
This is CE on ReachMD. And I'm Dr. Adam Luginbuhl.

Dr. Johnson:
I'm Dr. Jennifer Johnson.

Dr. Luginbuhl:
So Jen, today we are gonna be talking about the new paper that out, KEYNOTE-689, and neoadjuvant and adjuvant immunotherapy for head and neck cancer. Let's first start by telling us and talking about how we determine a patient's eligible for perioperative immunotherapy.

Dr. Johnson:
To be fair, that is a very collaborative question and there's gonna be some pieces of that I'm gonna answer, some pieces that you're going to answer and some that we can both take some responsibility for. Because the key components are, what is their biomarker. So for this, it's that PD-L1 CPS score needing to be 1% or above. And frankly, that is a minority of patients who aren't gonna qualify based upon that. We're gonna be looking at their comorbidities. Do they already have an autoimmune condition? Do they have a solid organ transplant? Is there something about that patient that puts them at risk for immune-related adverse events where we wouldn't wanna necessarily challenge them with neoadjuvant immunotherapy or even necessarily the adjuvant components, which you can consider separately. You are gonna ask whether or not that patient is resectable. And whether resection would be a natural part of the way that we treat them for their head and neck cancer.

Adam, can you give our audience any tips for how you select patients for this and then building a practical workflow for making that happen in the clinic?

Dr. Luginbuhl:
I really think that started with simply recognizing that the time between when I saw the patient to the time when you see the patient is really the spark point. If we delayed that, everything seemed to unravel if we were in lockstep together and we were seeing them either same day or within the same week, I felt as a surgeon, I was comfortable with that handoff and co-management of that patient. So a lot of challenges there that we had to work out and encourage our listeners to really walk into that together with their colleagues.

Jen, now that we have someone that we've identified and we wanna bring them in, how do you manage and think about and monitor for potential immune-related adverse events for someone on perioperative immunotherapy?

Dr. Johnson:
We're looking at some baseline labs. I'm looking at labs when they come in for that second cycle, so that is three weeks after the first dose of immunotherapy that they got. And then I'm looking again about three weeks later before they're going to the operating room.

So I am looking a couple of different times to see if there's any laboratory studies that are pointing me in one direction regarding any immune-related adverse events. And I'm also talking to the patient at each of those points. So the immune-related adverse events we're thinking about, we're thinking thyroiditis, we're talking pneumonitis, we're talking colitis. We are talking dermatitis, and we're trying to think about we're gonna manage them specifically with operative safety.

Now we're used to this at this point as medical oncologists, and if you look at the immune-related adverse events that happened on the trial and that happened in the perioperative period, they're exactly what you expect for single-agent immunotherapy.

We didn't get any surprises here.

Adam, how do we measure success for our perioperative immunotherapy?

Dr. Luginbuhl:
So to the question about success, the trial was set up to activate our immune system. It was not set up as a classic chemotherapy tumor reduction, cytoreduction type protocol. It was the science behind this is really embedded in the idea that the immune system has something wonderful that it can offer our treatment of our cancers. And so when we think about it, we're really looking at the number of patients that have success two, three, four, five years down the road when they don't have that recurrence that we normally see. And so we consider event-free survival. So if I have a patient and they come in and they get on immunotherapy and in two days as I take them to the operating room and I don't see a pathologic response, I don't consider that a failure cause I'm not expecting that.

When it does happen, which it does, we do have a percentage of patients that do have a response, that's wonderful, but it doesn't mean a no response on the pathologic side is a failure of the immune activation. So we really are truly looking at that immune profile shift, which may be invisible to us until those 10, 15, 20 patients in a population three years down the road don't get a metastatic lesion or don't recur.

This has been an amazing time together. Our time is now up. We hope that this overview has been helpful for your practice, and thanks again for listening.

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