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Chemotherapy Strategies for Metastatic PDAC

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Dotan:
My name is Efrat Dotan, and I'm a medical oncologist focused on the care of patients with pancreatic cancer. This video will focus on second-line chemotherapy treatments for patients with metastatic pancreatic ductal adenocarcinoma.

As most of you know, pancreatic cancer is usually diagnosed in advanced, incurable stage, and has very poor prognosis, and conventional chemotherapy remains the core therapy that we use and the standard of care for patients with this advanced disease. We have limited treatment option, and that's why it's really important to make sure patients are exposed and have access to all available therapies during their treatment journey, and really pay attention and think about how we sequence these treatment while treating patients with this aggressive cancer.

So multiple factors come into play when we think about second-line therapy, and the choice of the treatment has to take all these factors into account. Number one, we have to think about what patients received in the frontline setting, and that will inform what we should use in the second-line setting. But additional factors include whether the patients have any residual side effects, what is their performance status, comorbidities, symptoms that may affect their ability to tolerate treatment in the second-line setting. Do they have any actionable mutations that were found on NGS testing, which hopefully was done after their diagnosis? And also, what type of tolerance do we expect them to have from this treatment? And what are their goals of care as they embark on the second-line treatment?

So based on the current treatment guidelines, for patients that received a 5-FU-based therapy in the frontline setting, and this could be FOLFIRINOX or NALIRIFOX, the second-line treatment should be a gemcitabine-based treatment, such as gemcitabine and nab-paclitaxel. However, for patients that received gemcitabine-based therapy in the first-line setting, the preferred second-line treatment should be a 5-FU-based therapy, and usually we would use something like 5-FU and liposomal irinotecan or an NALIRI, FOLFIRI, or even FOLFOX.

Thinking about liposomal irinotecan, just so we understand what is the difference about this drug. This drug has an encapsulated liposomal nanoparticles that cover the irinotecan, and the idea is that this would enhance the accumulation of the SN-38, the active metabolite within the tumor, and also prevent the rapid clearance, thereby increasing the efficacy and reducing the side effects. And the benefit of using this drug was published in the NAPOLI-1 study. This was a phase 3 randomized trials that investigated the effect of liposomal irinotecan in patients with metastatic. Pancreatic cancer in the second-line setting, following gemcitabine-based treatment. The patients were randomized to received 5-FU plus NALIRI, NALIRI alone, or 5-FU alone. And the results of this trial showed an improvement in media and overall survival 6.1 months with the combination of 5-FU and liposomal irinotecan, versus 4.2 months with 5-FU alone.

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