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Released: 01/17/2024
Valid until: 01/17/2025
Time needed to complete: 57m

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Management Strategies for Treatment-Emergent Adverse Events (TEAEs) in HER2-Altered Advanced Solid Tumors

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

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Dr. Moore:
For patients with advanced solid tumors, new treatments in the form of HER2-directed antibody-drug conjugates, or ADCs, are emerging. So what are the best ways to manage care and minimize the side effects of these HER2-directed ADCs?

This is CME on ReachMD, and I'm Dr. Kathleen Moore.

Dr. McGregor:
And I'm Dr. Brad McGregor. I agree, HER2 ADCs are here to stay across tumor types, as we've seen from the DESTINY-PanTumor02 trial. And we know that interstitial lung disease [ILD] and pneumonitis are important adverse events that we have to look out for, you know, about 10% of patients in that trial had some degree of ILD. And if we take a step back and look at this at the broad level, it's really important that we proactively monitor our patients for this and treat, hopefully even before they have any symptoms, with steroids because that's going to be the way to maintain dose intensity and density going forward. And that's going to involve a multidisciplinary evaluation with the patient, the treating doctor, and, you know, pulmonology. And to that end, it's important to educate patients on the signs and symptoms and to have them report any new cough, shortness of breath, fever, or other new or worsening respiratory symptoms. But equally important, you're going to need to really regularly monitor these patients with CT scans. Now, in the trials the imaging is often updated every 6 weeks. I don't think that's really practical in these settings, or insurance is going to cover that, but at least every 9 to 12 weeks, patients should be undergoing CT scans to include the torso.

Because if we look at the guidelines overall for grade 2 pneumonitis or worse, so any symptomatic pneumonitis, the recommendation is to permanently discontinue the drug. Now, if we have grade 1 pneumonitis, that's radiographic evidence without symptoms, that's a situation where we can think about holding the drug, offering steroids in the right situation. If things get better within 28 days, you can actually rechallenge. So to that point, monitoring these patients with or without symptoms is going to be critical to maintain patients on these drugs.

Dr. Moore:
I could not agree with that more, and we need to keep educating on that point. As these drugs become more broadly available to physicians who haven't yet had the experience with trastuzumab deruxtecan.

In addition to really paying attention and monitoring for ILD and pneumonitis, there's the more typical adverse events that we just still need to remember when we're using this exciting new class of agents for our patients. Even though this is a directed chemotherapy, so to speak, we still do see toxicities such as common nausea and vomiting. You know, over 50% of patients will have nausea, vast majority are grade 1 to 2, but just remember, we have to premedicate and send patients home with rescue medications. Fatigue is very

common. We do see a little bit of low-grade alopecia, so that's important to counsel patients about in case they want to use cold caps, for example. And then, we also have to watch for drops in ejection fraction, and so remember to get your baseline either ECHO [echocardiogram] or MUGA [multigated acquisition scan] and make sure that it's normal heading in, and then reassess every 3 to 4 months just to make sure you're not losing any ejection fraction and early consultation with cardiology should this be determined.

Brad, any other management tips for use of trastuzumab deruxtecan?

Dr. McGregor:
No, I mean, I think this really covers it all. I think this is really timely, and we hope this will become more available for a variety of tumors. I think the key point here is that, you know, this requires a collaboration with our patient. So educating the patients early on, continuously discussing with the patients throughout treatment so that we can identify problems early and intervene early is going to be the best way to maintain the dose density and intensity so we can get the best outcomes for our patients.

Dr. Moore:
That is such great information to have. Thank you for sharing and for being here today. And thank you to our audience for joining us.

This has been CME on ReachMD. Thank you very much.

Announcer:
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