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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Optimizing Consolidative Immunotherapy in Unresectable Stage III NSCLC: Case Discussion

Announcer:
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Dr. Reuss:
This is CME on ReachMD and I'm Dr. Joshua Reuss. Here with me is Dr. Jhanelle Gray, and today we're going to be discussing optimizing consolidated immunotherapy [IO] in unresectable stage III non-small cell lung cancer.

So let's begin with a case. So you have a 78-year-old male with a history of COPD, CAD, and peripheral vascular disease who presents to your clinic as a referral from pulmonology following diagnosis of non-small cell lung cancer. He has a 40 pack-year smoking history but quit 10 years ago. His pulmonologist obtained a lung cancer screening CT that identified a 2.5-cm left upper lobe lung mass with enlarged left hilar and subcarinal adenopathy. EBUS bronchoscopy confirms TTF-1 positive adenocarcinoma in the left upper lobe, in addition to left hilar, left paratracheal, and subcarinal lymph nodes. The patient lives alone. He is ambulatory in all ADLs, but just feels that he doesn't get around like he used to.

So, Jhanelle, how would you approach such a patient in determining the appropriate treatment plan for them?

Dr. Gray:
I think the first step is really to work with the surgical team to see if there's any chance they think that this patient would be a candidate for surgery. We have a lot of data now in the neoadjuvant, the perioperative setting. I do have a concern about the multistation N2 disease, where I think that, ultimately, we would likely decide as a group, in addition to the radiation oncologist, that this patient would be considered unresectable. But I still would present it as an option.

We also want to make sure that the patient will be able to tolerate whatever treatment we decide. So if we decide that we're going to go forward with a diagnosis of unresectable stage III, this may be a patient that I might have a question of, should we do sequential or concurrent chemoradiation based on their comorbidities, really diving into their performance status, diving into their living situation. So this is a case where I may even bring in our social worker to make sure that the patient has support, getting the patient navigator involved also.

I also want to talk about this is a patient where I may be a little bit worried with the 40 pack-year history of maybe having some concerns about pneumonitis following the concurrent chemoradiation and with the start of immunotherapy. So following this patient very closely for toxicity, especially, we know, as the pneumonitis is more likely to occur within the first 3 months of starting the IO, following the patient closely is going to be very, very important.

When we think about optimizing the treatment and the durations, I would say I would go for at least 1 year of consolidation immunotherapy. I think looking at the every-4-week dosing will be very important for quality of life, also, and to ensure that the patient can get through the therapy.

Dr. Reuss:

Yeah, I agree 100% with your approach, I think determining is this someone who's fit for surgery? The multistation NT disease makes me a little wary, as well as I don't know what their pulmonary function is. Could the patient even tolerate a resection? But with our improved outcomes with chemoimmunotherapeutic approaches, you know, it's definitely something to discuss. But if unresectable, I agree. I would probably be a little wary of concurrent versus sequential. This is definitely someone where I would look toward, if we did concurrent, weekly carbo/paclitaxel compared to a higher-dose systemic therapy regimen there.

How does NGS, for example, or PD-L1 testing factor into your therapy decisions, particularly when considering the immunotherapy?

Dr. Gray:
I think some of us may be swayed by the 40 pack-year history to shy away from testing from the molecular standpoint. But I do think it is still very, very important to look for those key driver mutations, understand the adenocarcinoma subtype a little bit more so we can make sure that we're selecting the right therapy for patients. We saw the LAURA press release, which is looking at osimertinib in a consolidated setting following chemotherapy and radiation, and it said it was significantly positive. But based on the ADAURA study, I think these are definitely times when we have to do molecular testing for our patients. Given that this patient has multistation N2 disease, I would also consider adding on a liquid biopsy on top of doing a next-generation sequencing on the actual tissue. And I still would do next-generation sequencing in this patient population as opposed to just looking at EGFR or just looking at ALK.

Dr. Reuss:
Unless we're really thinking that we're concerned about the radiation field and about, you know, the definitive approach, I guess it wouldn't necessarily impact my initial recommendation for the chemo sequential or concurrent with radiation therapy. But I agree 100%, particularly when looking at immunotherapy, I think that molecular profile is super important because we do have highly effective targeted agents as you alluded to.

So I think with that, our time is unfortunately up, but I want to thank you, Dr. Gray, for this really important discussion and to our audience for tuning in.

Announcer:
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