Transcript Details

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Panel: Preserving Operability: How To Manage irAEs in the Perioperative Setting During Neoadjuvant Treatment of Melanoma?

Announcer:
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Dr. Weber:
I'm Dr. Jeffrey Weber, I'm a Medical Oncologist, and we'll be discussing the topic of preserving operability, how to manage immune-related adverse events in the perioperative setting during neoadjuvant treatment of melanoma? And with me today, is my good colleague and friend, Dr. Brian Gastman who is a Surgical Oncologist from the Cleveland Clinic. And there are a number of issues when we talk about neoadjuvant therapy. One of the big issues is how to ensure that someone's actually going to get to surgery. So, Brian, what are the issues that you have to deal with? Or how do you deal with the dangers of immune-related adverse events, if you're giving someone two cycles of even flip-dose IPI/NIVO, or do you prefer to use less toxic drugs?

Dr. Gastman:
Well, it's a great question. I think coming out of the trials, we were very nervous because one of the first trials showed that, in patients with monotherapy, the number of them were actually progressing so fast, they didn't go to surgery and then those who were getting full-dose IPI/NIVO, some of them were getting such bad toxicities that they couldn't go to surgery on even some of the worst adverse events occurred in that trial. I will tell you that probably affected our rationale on using either anti or even mild therapy or IPI/NIVO and then to much more quickly go after this patient surgically. So, we do this in a true neoadjuvant method, where we define when we're going to do the surgery and we're pretty done, Mac, about trying to get there, because the type of therapies we do rarely give us AE threes or fours. I can't think of a single patient that I had to delay unless their steroids were extremely high. I would try to take the patient in the operating room anyway. So, I'll say, luckily for us, despite some of the pretty aggressive operations we've done, we've not had a major delay, but we've also probably not have had some of the bigger effects from some of the more powerful immunotherapies on these cancers that we could have seen.

Dr. Weber:
Yeah, I guess one of the, or some of the tricks that we use here, we're pretty liberal at using a Medrol Dosepak for someone who has, you know, grade one or two toxicity after the first go-round of IPI/NIVO just to make sure they get in the second. And then the rare patient who had a history of colitis issues, before I treat them, I'll just say, you know, "We need to get you to the GI Doc and get you scoped," which can be a real challenge because as you know, you want to get these patients treated ASAP, you don't want to mess around. You don't want that tumor to grow. So, getting them to the GI doc is not so easy. And then, if someone is the rare bird that has prior Addison's type disease, you know, we make sure they get that we double, triple check their cortisol and ACTH, and give them stress doses of steroids prior to surgery. But you know, we're very careful because I'm just very paranoid about them missing out on the chance to go to surgery. But I'm very impressed that it sounds like, by doing all these things in your institution, it's pretty rare that somebody doesn't get operated on.

Dr. Gastman:
Very rare and we treat some pretty sick people with underlying cardiovascular disease and very, very large tumors. That being said, we do have a very strong multidisciplinary clinic. So just like you are describing what you do to get your patients ready for whatever they're going to be ready for, we have a separate team that does preoperative optimization. Sometimes they're not the same people. And we know different gastroenterologists and the oncologists do, and we work, we work that in together to expedite these surgeries and get these patients moving along so we don't skip a beat.

Dr. Weber:
Yeah, I think your point reinforces the concept that when you're treating patients with I/O therapy, especially neoadjuvant, you really need a team of consultants, so that if you run into trouble, one phone call gets you a colonoscopy, a consult with an endocrinologist, or a consult with the cardiologist because that's the sort of thing that will ensure that they're going to actually get the surgery.

Dr. Gastman:
Yeah, and we have champions for each of those, especially endocrinology and rheumatology, and GI. We have specific people interested in this. They actually want to see these patients and they'll help move things along, even if it wasn't for surgery, just to continue them on their I/O.

Dr. Weber:
Great. Excellent. And I just want to thank you all for your attention.

Announcer:
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