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Optimizing First-Line Immunotherapy for Recurrent or Metastatic HNSCC

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Dr. Saba:
Hi, this is CME on ReachMD, and I'm Dr. Nabil Saba. Here with me today is Dr. Barbara Burtness.

Barbara, let's look at a case of a patient with recurrent metastatic head and neck cancer who has an early progression and try to discuss this case.

A patient has a history of laryngeal cancer, had a total laryngectomy, adjuvant cis and radiation, and 3 months after completion of concurrent post-op therapy, he presents for scan reviews and now has evidence of pulmonary metastatic disease with 5 lung lesions. All these are less than 1 cm in size, and there's a biopsy-proven recurrence. He's asymptomatic, and he was initiated on single-agent pembrolizumab.

Can you comment on how to utilize biomarkers to select patients for immunotherapy in these particular cases?

Dr. Burtness:
So great case because, you know, very clearly from the CheckMate 141 trial and the original experience in KEYNOTE-012, immune checkpoint inhibitor monotherapy is an appropriate FDA-indicated approach for a patient who relapses within 6 months of cisplatin-based definitive or postoperative therapy. And so you're not really obliged to check PD-L1 status. I have to say I would. So particularly if the patient had a low PD-L1, I would be very keen to find a clinical trial for them. But if that was not available, certainly the drugs are indicated irrespective of PD-L1 status.

Dr. Saba:
And out of curiosity, given the rapid progression, do you consider adding chemotherapy for some of these patients, or I should say, the early progression?

Dr. Burtness:
Again, a great question and one that I wrestle with a lot. I think if they got all of their platinum, to be honest, within 3 months, I'm not sure that I would hold out great hopes that the platinum would add much. There are patients, though, who've had a lot of treatment interruptions or who stopped their platinum. And in those cases, I might go back. Would I think about taxane monotherapy with an immune checkpoint inhibitor here? That's really, you know, not validated. So my interest would be particularly in trying to get them a combination with a targeted therapy or with another immune agent. And I guess, in this context, may be worth mentioning that the cetuximab combinations have been quite active. And that might be something to think about for a patient like this as well.

Dr. Saba:
So in your experience in these situations, what would be your duration of therapy provided the patient continues to benefit, and how

frequently would you assess for response?

Dr. Burtness:
I would generally assess for response every 8 to 12 weeks. And you know, the agents are indicated for 2 years of therapy. There has been a recent publication from Lova Sun based on real-world evidence that does not seem to show a great disadvantage to early discontinuation. But in general, I have continued for 2 years if the patient is tolerating the agent.

I'm curious. Would you consider a different approach in this patient just given the rapid progression?

Dr. Saba:
I struggle with this many times. I think it's on a case-by-case basis. But in general, I completely agree with you about checking the PD-L1 status. Even though these indications were not really driven by biomarker-positive disease, we now know that has to play a role in your decision as far as whether to proceed with single-agent immunotherapy or others. And certainly, if the CPS score is less than 1, I'm not very encouraged about starting immunotherapy as single agent.

And so I would resort to clinical trials, of course, but certainly EGFR inhibitors or combination EGFR inhibitors in patients, let's say, with HPV-negative disease. And with HPV-positive disease, maybe consider a chemoimmunotherapy approach. But I would say it's on a case-by-case basis.

So that has been a great discussion. And so to summarize some of these points I think we agree that in patients with recurrent metastatic disease, regardless of the rapidity of progression, immunotherapy needs to be considered either alone or sometimes in combination, reminding people that in early progressors, pembro and nivo are approved regardless of biomarkers. And if there is a concern for rapid progression or a need to achieve cytoreduction in a timely manner, especially in a situation with a low CPS score, considering other therapy, either cytotoxic therapy or, depending where the disease is, perhaps other modalities should be considered.

It has been a brief but great discussion. And again, unfortunately, our time is up and thank you for listening.

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