Transcript Details

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Redefining Immunotherapy Access: Integrating Subcutaneous Checkpoint Inhibitors Across Solid Tumors

Announcer:
Welcome to CE on ReachMD. This activity, titled **"Redefining Immunotherapy Access: Integrating Subcutaneous Checkpoint Inhibitors Across Solid Tumors"** is provided by **Medcon International**.

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Ms. Orbaugh:
In recent years, we've seen growing interest in both subcutaneous delivery and flat dosing strategies for immune checkpoint inhibitors in solid tumors. How does subcutaneous administration change the treatment experience for both our oncology patients and our oncology clinical practices?

This is CE on ReachMD, and I'm Kristi Orbaugh.

Dr. Felip:
And I'm Enriqueta Felip, medical oncologist at Vall d'Hebron University Hospital in Barcelona, Spain.

Ms. Orbaugh:
Well, let's jump right in. Dr. Felip, let's start our discussion with dosing strategies. What is the scientific rationale behind subcutaneous immune checkpoint inhibitor administration and its benefits for patients with solid tumors?

Dr. Felip:
Thank you. So yes, subcutaneous administration of immune checkpoint inhibitors is a patient-centric delivery method designed to enhance cancer treatment efficiency while maintaining the clinical efficacy of intravenous formulation. So subcutaneous immune checkpoint inhibitor agents are co-formulated with recombinant human hyaluronidase to enhance high concentration drug delivery. And this facilitates the rapid absorption of monoclonal antibodies through the fatty tissue in the bloodstream.

There are randomized trials comparing the flat immune checkpoint inhibitor dosing with subcutaneous formulation, showing noninferiority of pharmacokinetic parameters with subcutaneous formulation compared to intravenous infusions.

So there are a number of advantages for subcutaneous administration. Subq administration time is around 3 to 5 minutes, reducing the time of patients in clinic settings. Patients report higher satisfaction with subcutaneous formulation due to reduced chair time, avoidance of intravenous port placement, and fewer venous access complications. And finally, this subcutaneous formulation may well support decentralized care access, and a subcutaneous formulation allows for treatment closer to home or potentially at home in the future,

addressing disparities in access for patients who live far from hospitals.

Ms. Orbaugh:
Thank you. When clinicians consider switching from IV to subcutaneous immune therapy delivery, what evidence gives them confidence that clinical activity will remain consistent? And does the safety profile differ between the subcutaneous and the intravenous delivery systems?

Dr. Felip:
In my opinion, there is clear evidence from clinical trials to use immune checkpoint inhibitors subcutaneously. And this is also supported by regulatory agency approvals by the FDA and EMA.

I was honored to present at a meeting in 2025 on behalf of all the co-investigators, the results of a trial comparing subcutaneous versus intravenous pembrolizumab plus chemotherapy in metastatic non-small cell lung cancer patients. Participants included newly diagnosed patients with Stage IV squamous or non-squamous non-small cell lung cancer without genomic alterations. And patients were randomized to receive pembrolizumab subcutaneous every 6 weeks, or pembrolizumab IV, also every 6 weeks, each given with platinum doublet chemotherapy. The primary endpoint from this trial was pharmacokinetic exposure in the different time points.

And the study shows that first, the median injection time for pembrolizumab subcutaneous was only 2 minutes. The exposure concentrations of pembrolizumab subcutaneously were noninferior to those of pembrolizumab IV. The response rate was exactly the same for those patients that received pembrolizumab subcutaneous and those that received pembrolizumab IV and also progression-free survival and duration of response.

Importantly—and you mentioned—the pembrolizumab subcutaneous had a manageable safety profile that was consistent with the known adverse events with IV pembrolizumab. So in the patients treated with subcutaneous pembrolizumab, the injection site reactions were infrequent in only 2% of the cases and nonserious.

So these results are consistent with other randomized trials analyzing immune checkpoint inhibitors in IV versus subcutaneous formulation. There is again a randomized trial confirming noninferiority of subcutaneous atezolizumab when compared to IV in pharmacokinetics, efficacy, and safety. And with similar objective response rates and progression-free survival when compared IV atezolizumab and subcutaneous atezolizumab.

Also, we have a trial with nivolumab. And again, the trial compared subcutaneous nivolumab with IV, the subcutaneous formulation was noninferior, and the objective response rate and progression-free survival were comparable between the 2 treatment arms.

So overall, the studies show that the subcutaneous immune checkpoint inhibitor formulation is equally safe and effective when compared to IV formulation.

Ms. Orbaugh:
So we really have some solid data as we chat with our patients about switching from IV to subcutaneous.

Now, the last question I have for you, Dr. Felip, could you summarize how you identify which patients are ideal candidates for subcutaneous versus the patients that you're going to leave on IV, or intravenous, therapy?

Dr. Felip:
Yes, thank you for the question. So it's true that we have seen that subcutaneous formulation achieved the same results as IV formulation, and there are a number of potential advantages. So, in my opinion, we should consider subcutaneous formulation in the majority of patients—candidates for immune checkpoint inhibitors.

Patient preference is the most important aspect, and studies indicate a strong probability towards subcutaneous treatment with most patients' sitting convenience, reduced many punctures, and shorter visits as major advantages. We have also mentioned that subcutaneous formulation reduces active healthcare professional time and patient chair time when compared to IV, and this allows that the time for healthcare professional would be elevated toward additional patient care activities.

It's true that healthcare providers will require training on proper subcutaneous injection techniques, appropriate injection site rotation, and management of potential injection site reactions. And of course, the patient preference is key, and if for any reason patients prefer the IV route, we must prioritize it.

So now let's switch our discussion to focus on a nursing standpoint. So when administering these agents subcutaneously, what practical techniques help ensure safe and consistent subcutaneous delivery of immunotherapy, Kristi?

Ms. Orbaugh:
I appreciate that question. One thing that I think will be important is reminding our nursing staff the proper way to do subcutaneous injections and the importance of rotating sites. We want to make sure that we get in that subcutaneous fat, so it's good to think about the thighs, the upper outer thighs, as well as the abdominal area. You want to make sure that we're documenting each time where we're injecting so we can better monitor the potential, although it's very small, as you've so nicely discussed, of local reactions. We want to make sure that we know exactly where that subcutaneous injection happened. And so then the next time they come in, we'll make sure that it's on either a different thigh or on the opposite side of the abdomen. You just want to really make sure that you're rotating those areas.

Dr. Felip:
Yes, and from your perspective, how does shifting from IV to subcutaneous administration impact the patient experience and day-to-day challenges associated with IV access and infusion-related reactions?

Ms. Orbaugh:
I really see a benefit from this. I know that when I walk around our chemotherapy suite, there really aren't very many empty chairs on a regular basis, so the thought of being able to have a shorter chair time for patients is a great benefit, not only for the patients, but for the clinic.

I'm also seeing things happen where clinics are being very, very unique in how they'll schedule these injections. For example, instead of scheduling an actual chair time, you might see them use 1 room only for subcutaneous injections of all types, and that really frees up the chairs.

And what we're finding is we can actually maybe even do really earlier appointments for patients that might be on their way to work, or later appointments for patients that might be coming home from work or coming home from picking up children, or whatever, that really, again, minimizes any time that they're going to spend in the clinic.

It also takes away a bit of the feeling that they're going to the cancer clinic, that they're a cancer patient; they're just going in for a quick injection, and I think that helps with quality of life. I think that helps with helping them maintain some normalcy in the midst of cancer treatment, which is frequently anything but normal. So I really think from a quality of life standpoint it helps as well.

Dr. Felip:
So finally, one of the major advantages of subcutaneous administration is improved clinical efficiency. How have you seen this translate into real-world workflow improvements in your practice?

Ms. Orbaugh:
We don't have the bottlenecking, if you will, waiting for that infusion to be completed before we can move another patient back. We really utilize 1 particular area for all of our subq injections, and that turnaround time has really increased the speed and it reduces the amount of time that patients are sitting in our waiting room.

I also took the opportunity to check with our secretaries who do the scheduling, and they shared with me that it's actually easier, from their perspective, to schedule these subcutaneous injections because they don't have to worry about finding IV access, taking the time to secure the IV site, and making sure the tubing's ready, all of those things. It just really mainstreams the patient's time that they spend in the clinic.

Dr. Felip:
Yes, thank you. So this has been a fantastic conversation, and perhaps before we wrap up, can you share 1 take-home message with

our audience, Kristi?

Ms. Orbaugh:
I think that seeing some of our intravenous checkpoint inhibitors move into the subcutaneous arena, it just demonstrates the progression and the forward movement that we make every day in oncology to improve, most importantly, quality of life for our patients and their caregivers and their loved ones. But also from a practical standpoint in clinical practice, making things as efficient—not only time efficient but staff-efficient—as possible. I think it's an exciting time.

Dr. Felip:
And I fully agree, Kristi. So perhaps to highlight also the subcutaneous formulation delivers equivalent efficacy when we compare it to IV, and the important point of patient comfort.

Ms. Orbaugh:
That's all the time we have, so I want to thank our audience for listening in. And thank you, Dr. Felip, for joining us and sharing your valuable insights. It was great speaking with you today.

Dr. Felip:
Thank you. And a pleasure working with you, talking to you, and thank you all for being with us today. Thank you.

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