Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/resolving-practice-barriers-to-consolidative-immunotherapy-in-stage-iii-nsclc/24386/

Time needed to complete: 56m

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

Resolving Practice Barriers to Consolidative Immunotherapy in Stage III NSCLC

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Gray:
This is CME on ReachMD and I'm Dr. Jhanelle Gray and I'm here today with Dr. Joshua Reuss.

Joshua, I wonder if you can talk to us about what do you think are some of the practice barriers that ultimately end up delaying treatment?

Dr. Reuss:
I would say that oftentimes in, at least in my experience, the delay in getting from chemoradiation to immunotherapy really hinges a lot on toxicities, experience during treatment, and obviously that itself hinges on the sites of disease that are being radiated. There was some, I think, subgroup data from PACIFIC where there was a question of, you know, did patients who were randomized and started treatment earlier do better? You know, I think this hasn't really borne out in additional subgroup analyses or real-world populations. But I would say, at least in my experience, it's primarily related to the toxicities of the chemoradiation.

Dr. Gray:
I think where we've seen some challenges is, you know, working at an academic versus a community site, and how do you get that multidisciplinary team together and working efficiently and effectively? I also think that if I'm going to go a little bit earlier, I know we're focused on the consolidated immunotherapy, but I also think starting the patients on concurrent chemoradiation or sequential chemoradiation, where appropriate, is important. And then making that decision about whether or not we think they're a candidate for the immunotherapy. And for me, that also includes doing a liquid biopsy or tissue NGS [next-generation sequencing] testing so that we can see if they have some sort of a driver mutation.

Dr. Reuss:
I think that MDT [multidisciplinary team] discussion is critical in determining, especially with the – very fortunate to have the advancements in the perioperative space, though it doesn't mean we should be converting patients who are unresectable to resectable. But at least, I think, it throws another complexity into the equation where we absolutely should be discussing NGS testing. In our practice as well, we try to get both tissue and liquid.

We can run into insurance barriers. I've oftentimes had success and many of these companies do have very good financial support services to help with that. I know that oftentimes there also can be delay just from radiation planning and trying to get proton therapy approved in select scenarios. And then, as you said, I think the discussion is super important because if there is a large volume that's being considered for radiation, and we think the potential for cure is low, you know, do we want to wait for those NGS results to say, hey, if they have a good actionable driver, do we want to start a targeted agent? You know, see if we can maximize response there and then consolidate with radiation? And I think in select cases, you know starting with a systemic chemoimmunotherapy approach under

that same paradigm of considering consolidative RT [radiotherapy] is oftentimes appropriate in someone where there really is a high volume of disease.

Dr. Gray:
I think the other thing we need to pay attention as a group is also to reduce the risk of radiation toxicity, in particular the pneumonitis, and hoping that we can identify the right patients up front. You know, making sure that we look at the CT scans before patients start on therapy. Think about, maybe, avoiding immunotherapy in those patients who have underlying significant interstitial lung disease prior scar tissue where we know that that can make the toxicity a little bit worse.

How do you think these delays of starting immuno checkpoint inhibitor consolidation, how do they impact outcomes, Joshua?

Dr. Reuss:
I think it's probably more indicative of one's underlying disease burden or disease aggressiveness rather than purely the timing of when one initiates immunotherapy. In my practice, I'll try to get the post-chemo RT scan at around the 2-week timepoint, and then aim to start consolidative immunotherapy within about 4 weeks, but obviously there are patients that need more time, either to think about it or just to recover from toxicities. And I'm definitely not foregoing immunotherapy in those patients. I want to kind of hit the right timepoint where someone's likely to tolerate it well and to really maximize their potential for benefit.

Dr. Gray:
I do try to, about 10 to 14 days after completion of chemoradiation, to get that CT scan, get the insurance authorizations in a timely fashion, and get people started.

Well, you know, I think I want to thank everybody for spending a few minutes with us. This has really been great. You heard about how to reduce delays in getting patients timely treatment of consolidation immunotherapy in the stage III setting, and we hope that we've given you something to think about. Thanks for joining us.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.