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Tailoring Your Perioperative Immunotherapy Approach for Resectable NSCLC

Announcer:
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Dr. Awad:
This is CME on ReachMD. I'm Dr. Mark Awad, and it's my pleasure to be joined by my esteemed colleague, Dr. Jessica Donington from the University of Chicago to discuss how we choose between preoperative and perioperative immunotherapy regimens for patients with resectable early-stage non-small cell lung cancer.

Welcome, Dr. Donington.

Dr. Donington:
It's a pleasure to be here. Great discussion points. Let's go.

Dr. Awad:
Well, needless to say, the incorporation of immune checkpoint inhibitors in the neoadjuvant and adjuvant treatment for resectable lung cancer has really shifted paradigms and changed our practice. And we always try to individualize and tailor our treatments as specifically as possible to each patient.

So when we're meeting patients with resectable lung cancer, how do you think about and choose between, say, neoadjuvant only or preoperative chemoimmunotherapy versus perioperative immunotherapy, both treatment before and after surgery? We don't have a randomized clinical trial comparing neoadjuvant only to neoadjuvant plus adjuvant. So what are some of the considerations we should be discussing with our patients?

Dr. Donington:
I think this is a little bit of a change in my practice over the very recent time period. I had really been following 816 protocols pretty religiously and talking my patients into 3 cycles. And that was such an easy sell. Now I do have to kind of go through the complexity of what periadjuvant means, what a path CR is. So I think the main things we've been using in our practice to decide between neoadjuvant and periadjuvant have been the response in the tumor, the pathologic response, also how the patient tolerated their neoadjuvant, their PD-L1, status; all this goes into it. It's become this incredibly complex space, and it's just a lot of discussion. But I would think those are our 3 biggest factors.

Is it different in your practice?

Dr. Awad:
It is challenging. And you know, you make arguments in different directions, but I completely agree with a lot of what you're saying. I think in some patients who have a complete pathologic response, you could say, “Well, you know, that's all you need, and we don't need to give more therapy.” Or some people argue that since it worked so well before surgery, maybe we should keep it going just to

sort of guarantee some added benefit after the surgical period, as long as they're tolerating it well.

And on the flip side, if they didn't have a good response to therapy, you could say, “Well, might as well just stop treatment there, because it didn't work so well.” Or others say, “Well, we don't have a lot else to offer, so maybe we should keep the immunotherapy going in the postoperative setting.” So it's certainly a challenging and complex topic, as you're saying. But, you know, glad to see some positive overall survival data emerging from these perioperative trials as well.

Dr. Donington:
I think the data presented by Tina Cascone from the 77T trial did give us this hint of what we might need to do in those patients who have residual disease, those patients who had N2-positive disease and had residual tumor in their specimens. That was the first real separation of survival curves I saw in the adjuvant setting. That really made me think, ooh, is this really a group, you know, who has risk of micrometastatic disease and may need to see more? But I also like the concept of new trials to possibly escalate or change therapy in that population.

Dr. Awad:
Absolutely. And I think one thing that we see somewhat consistently across these neoadjuvant or perioperative clinical trials is there are a certain percentage of patients that don't make it to surgery, and we never want to be in a position where we can’t offer a potentially curative procedure and operation for our patients. So are there some patients that should go straight to surgery and only receive adjuvant therapy? Or do you really try to prioritize for everyone getting some sort of preoperative systemic therapy?

Dr. Donington:
I think I really prioritize the neoadjuvant. I think we're in the point now where we recognize you need the local and the systemic, and what's the most effective way to deliver those? And I still believe that is the systemic first. At the same time, there are lots of patients who would, despite our best staging, go to the OR as a stage I and come out as the stage II or III. And I am so happy that we have really good adjuvant options for them. And I think we really need to work as a community to make sure everyone who needs those gets those.

Dr. Awad:
Our time is up. I hope you found the information presented here to be helpful and informative for your practice. Thank you so much for listening.

Announcer:
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