Transcript Details
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Exploring the Future of Targeted Therapies: Data on Lung Cancer Treatment from ASCO 2021

Announcer:
You're listening to *Project Oncology* on ReachMD, sponsored by Lilly. On this episode, we're going to hear from Dr. Jacob Sands, a Thoracic Medical Oncologist at the Dana Farber Cancer Institute. Dr. Sands joins us to share key updates that were presented on lung cancer at the American Society of Clinical Oncology Annual Meeting. Here's Dr. Sands now.

Dr. Sands:
Well, like most years, there were a lot of different studies and a lot of interesting data presented at ASCO this year. I'll highlight some of what's going on in targeted therapies because this has been absolutely booming. We look back to IPASS, the trial from 2009, and since that time point, we've just had so many new genomic alterations that have been identified and effective targeted therapies for them. And we really saw that highlighted this year in a number of presentations.

So, I'll start out with by talking about KRAS G12C sotorasib, we saw this presented and this is now an FDA-approved treatment. But the KRAS has been a really challenging target where prior therapies have not really been so effective, and we've really seen some toxicities. And now, KRAS G12C, sotorasib is FDA-approved and showed a response rate of nearing 40 percent in the data that was presented. And so, to see effective treatment for this challenging target was exciting.

In that study, they did mention STK11, and I thought this was interesting. So, STK11, in those with a co-mutation of STK11, it looked like in the data that was presented, the response rates were even a little bit better. And that was interesting to see because this can be a scenario where sometimes, there's suggestion that the immunotherapy is not as effective. And so, in that population, to particularly see effective treatment with a targeted agent was exciting. More data still needs to come on that.

As far as MET exon 14 skipping mutation, we saw data from capmatinib, the waterfall plot in that presentation was very impressive with essentially all of them having some tumor shrinkage, although the response rate was 67 percent in that trial. With MET exon 14 skipping mutation, tepotinib also saw data from that, as well with intracranial activity, as well as looking specifically at a population of patients that were enrolled based upon circulating tumor DNA with a 60 percent response rate in those patients. And so, we've seen increasing use of circulating tumor DNA and it is really nice to see trial data where we have the treatment and responses specifically when diagnosed by circulating tumor DNA. And I think that just adds to the growing data of utilizing circulating tumor DNA as a way of diagnosing.

And then, of course, we saw some data on monitoring, as well. And within that same dataset we saw patients with clearing of circulating tumor DNA and that benefits were better in those patients. And we've seen this before, but it is nice to see increasing amount of data on this that will, I think at some point, will likely end up using blood-based testing to monitor patients. That's not yet standard of care but the data is being accrued.

Looking at RET fusion we have two approved drugs. There was updates on selpercatinib and interestingly it looked at in the prior trial data that led to the FDA approval, looking specifically at response to selpercatinib relative to the prior line of therapy. No matter what the patients had gotten the responses to selpercatinib were consistent and very good.

It was interesting where there was only one patient I believe, who had previously gotten an immunotherapy drug and also responded to the immunotherapy drug. So, this really adds, again, to this data of these patients that have these genomic alterations that are not really smoking-associated these are patients who with very limited or no smoking history and that end up with RET fusion, in general. And amongst that population, we don't really see much of a response in the way of immunotherapy.

Further adding to this, when patients have a targetable alteration using targeted therapy is the way to go. We also saw updates on pralsetinib with very nice response rates, particularly in those who were treatment naïve. But we saw a lot of other targeted therapies, drugs ROS-1, NTRK, I mean it really strengthens all patients need to be getting genomic testing. Anybody with a non-squamous, non-small cell, and I'd say patients with a squamous and even small cell that have no smoking history really need to get genomic testing.

We also saw data that there's really, I'd say an insufficient amount of genomic testing that, that needs to be done. And unfortunately, there was a big dataset that, that showed a number of patients not getting genomic testing. And so, I'd say, anyone that's non-squamous, non-small cell, anyone with a very limited smoking history that's squamous or even small cell should really get genomic testing. And I think we saw that highlighted in the data, this year at ASCO.

Announcer:
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