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Focusing on the Treatment Experience & Shared Decision-Making in HER2m NSCLC

Announcer Introduction
You're listening to *Project Oncology* on ReachMD. This episode is sponsored by AstraZeneca and Daiichi Sankyo.

Here's your host, Dr. Jacob Sands.

DR. SANDS:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands. And joining me to discuss genomic testing and diagnosing HER2 mutated non-small cell lung cancer is Dr. Millie Das, clinical associate professor of medicine in the Division of Oncology at Stanford School of Medicine, and Chief of Oncology at Palo Alto V.A. Dr. Das, welcome to the program.

DR. DAS:
Thanks so much, Jacob. It's great to be here.

DR. SANDS:
So to start, Dr. Das, what aspects of this particular cancer subtype, particularly HER2 mutated non-small cell lung cancer, make it unique in your experience? And what is your experience been in counseling patients around the diagnostics and treatment?

DR. DAS:
Yeah, I think, you know, as we're doing more and more next generation sequencing on tumor samples from our patients, we are detecting these rare driver subset of mutations. And so, HER2 really falls into that category. HER2 mutations make up about 2 to 4 percent of all of our non-small cell lung cancer patients, and most of the mutations are within EXON-20. And I think when we see this, you know, traditionally it had been considered a non-targetable mutation. Though, I think more recently, we do have a number of drugs that have shown activity against a specific target. So, it is really exciting that in non-small cell lung cancer with biomarker testing and more use of next generation sequencing, that we are detecting these smaller subsets of patients who have these potentially targetable mutations.

Of course, another reason to be doing NGS testing is to be able to offer our patients better than the standard of care, which is really platinum-based chemotherapy for most of our patients.

DR. SANDS:
You mentioned that genomic testing and for HER2 diagnosis that now within lung cancer, can you go a little bit into just the testing and how you get to HER2 diagnosis and how you discuss that with patients?

DR. DAS:
Yeah. So, the HER2 mutations are frequently occurring in younger patients and never-smokers, similar to the patient population with the EGFR and the ALK, and the ROS1 alterations. And so, when we're seeing these patients, you know, I think, in the clinic, of course we're not necessarily thinking immediately about HER2, we're thinking about, you know, does this patient have a driver mutation. And so, it becomes key to perform biomarker testing in these patients. Many of us at our institutions have rapid testing for EGFR, ALK, and ROS1, but HER is really not included in that rapid testing. And we get that result back usually on the NGS testing that's done, which can take a little bit longer sometimes on the order of two to three, sometimes even four weeks.

And so, you know, either way, I think it's really important to have that data because it just opens up other treatment options for these patients, and most likely in the relapse setting. Of course, we don't have any FDA approved therapies specifically for HER2 mutations,

either in the first- or second-line setting at this time, but there's a lot of interest and a lot of clinical research that's happening you know, to specifically target these patients so that – that the need to do testing is absolutely there. And you know, I would argue that we should be doing it upfront for all of our patients, whether or not you wait for those results to start treatment, I think is really an individualized decision.

DR. SANDS:
Now, so your reference. So you're discussing the individualized decision and discussion with patients, and that partnership of that decision making. And I think for many oncologists, that's one of the more challenging aspects in counseling patients as they come in, really eager to start treatment. So that scenario you're discussing then and how you decide whether to delay initial treatment for testing results or initiate therapy and testing. How does that counseling go for you? And what are those discussions like with patients? What are some of the things that you find really work well in your discussions?

DR. DAS:
Yeah, I think that's a great question. And I do understand that from a patient perspective, there's an urgency to get started, especially if the patient's not feeling well, and is, you know, symptomatic from their lung cancer. And so, in those situations, we can really never go wrong by starting chemotherapy. So we do always have that as an option. For other patients, you know, we really want to think about offering targeted therapies with the hope of minimizing toxicity and really improving and increasing the odds of a response. And so, again, kind of depending on the clinical situation, you know, we sit down together, and we map out, you know, kind of the different options, and I try to explain to patients, there's usually not a definite right or wrong answer, it's really a matter of, you know, this is the information that we have, this is the additional information I'd like to get, and these are sort of the options that we have right now. And, of course, patients are looking to us for guidance.

DR. SANDS:
So you've discussed the genomic testing that's important that initial diagnosis. What patients are you testing? And amongst those patients that you would say should be tested at Stanford, how many of those are really ultimately getting that testing, would you say? And then the next level is across the community around you in the country, how extensive do you think is the testing being done?

DR. DAS:
Yeah, well, at both the institution's where I practice at Stanford and at the Palo Alto V.A., I sort of alluded to this, we have a rapid testing for EGFR, ALK and ROS1. And that's done , that testing is done reflexively, through the pathology department for any non-squamous lung cancer histology. So typically, you know, I think the NCCN guidelines, you know, recommend, , NGS testing for our non-squamous patients, and then to consider it in squamous patients who may be light or never-smokers or younger age. And so we definitely want to, you know, follow the guidelines and offer testing for these patient subgroups.

I think it really, is easier when testing is done reflexively through pathology, rather than waiting for the, patient to reach oncology, and for the oncologist to request the testing. I think that that unfortunately, just leads to further delays. So working with your pathology colleagues at your institution to ensure that they are doing this testing again, for non-squamous histology, it should just be getting done and so some institutions will have a rapid initial testing for EGFR, ALK, ROS1, others will just go ahead and send the tissue for NGS testing., we know that as these platforms have been around for longer, that the testing time has gone down, which is great. So sometimes we do get results back within two weeks, which is great. And so if that testing was done reflexively at the time of biopsy and the pathology reviewing the slide, by the time that patient gets to see you in clinic, you may already have the results. I mean, I think that is really the ideal scenario.

DR. SANDS:
Yeah, that's a great point. So if we focus on that patient experience through this journey, and the initial counseling in clinic, when you don't have a diagnosis and that discussion, what kinds of things could you advise on how to enhance that patient experience around that discussion of testing?

DR. DAS:
Yeah, I mean, I think when we have patients, who we're seeing, you know, and who have not had the testing performed on their tissue, so we can request that at our own institution when we're seeing that patient you know, and, of course, working with our pathology colleagues to track down the tissue block to get that tested.

Other times I'll, you know, just to expedite things, I'll also, if I'm meeting the patient in person, I'll, you know, recommend that we get a liquid biopsy and you know, again, I think tissue is always considered to be the gold standard. But you know, particularly for those patients who, you know, have a higher burden of disease, where you, feel that there's a higher likelihood of the patient having a targetable mutation, going ahead and sending– a liquid biopsy at the time of the clinic visit, where the turnaround time is generally within a week for that, of course, we know that if we get a negative result on the liquid biopsy, we still want to pursue the tissue testing. But

you know, those are ways that we can work with our patients to try to, you know, start trying to get these answers, in a quickly and expeditious manner.

DR. SANDS:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and I'm speaking with Dr. Millie Das about enhancing the patient experience in dealing with HER2 mutated non-small cell lung cancer.

Now, Dr. Das, considering the heavy toll that cancer diagnosis often has on people, of course, that word itself often changes people's lives and not just the patient but their loved ones. So what do you recommend to help both the patients and their families, manage kind of the burden of this disease, from the time of initial diagnosis?

DR. DAS:
Yeah, I mean, I always think about what it must be like to be in the patient's shoes. And oftentimes the lung cancer diagnosis really comes out of nowhere, and, you know, these patients are pretty distraught, and their family as well. They weren't expecting this news. And I always encourage patients to bring their loved ones with them for their visits, if it's a virtual visit, or an in-person visit, just having that support there.

And so I think, you know, the key is really meeting the patient and their family where they are and, you know, taking the time to answer all of their questions, because they're going to be many.

And then you know, of course, we have many of us work in centers where we have care navigators and we have social workers and we have the resources, it's really considered to be a multidisciplinary team approach to treatment.

DR. SANDS:
Now, continuing with the discussion, of an individual's, journey with the diagnosis at the time when they initially come in, and particularly focusing on individuals with a diagnosis of HER2 mutated non-small cell lung cancer, how does that discussion go with patients?, Not necessarily so much as far as which treatments, but just the process of choosing treatment options, recognizing that individuals are different, so you might have a spectrum of different dynamics that you're able to discuss?

DR. DAS:
Yeah, I think, talking about HER2. So it's not as simple I think as EGFR, ALK, and ROS1 where we have, you know, randomized Phase 3 data and FDA approvals for, first-line targeted therapies. HER2 mutations, I think, are a little bit different. And so I think, framing that in the context of these other more well-known mutations, we have, you know, our patients are, very smart, they have read about their diagnosis, they know about some of these more common mutations. When we think about HER2, most of our patients, are familiar with, like, you know, breast cancer. That's where HER2 has come up. So it's not as common in lung cancer. So explaining that this mutation does occur in lung cancer patients, albeit at a smaller frequency. Again to that 2 to 4 percent frequency, but when we see it, I think, I think it provides an additional treatment option for our patients.

And so, in the first-line setting, I'll generally still offer these patients platinum-based chemotherapy. But in the relapsed or refractory setting, we have other options. We can, use off label, antibody drug conjugates that have been approved in the breast cancer setting., and we also always have clinical trials that are looking for specifically for these patients with the HER2, mutation. So I look not only just at our own center at Stanford, but I'm looking at surrounding, academic facilities to see, you know, if there are trials that are actively recruiting patients for this specific, patient subset.

DR. SANDS:
Well, Dr. Das, you've offered us a lot of insights. Before we close, anything else you'd like to add as far as HER2 mutated, non-small cell lung cancer, counseling patients, the patient's journey, looking forward?

DR. DAS:
Yeah, I think, I think HER2 mutated lung cancer again is just a small subset of our patients. But, , I think the importance here is, , just NGS testing, next generation sequencing testing that we really should be doing for all of our patients, with a goal of personalizing cancer care and offering patients, , the potential for targeted therapies. Either therapies that have already been approved, or on a clinical trial., I think this is the way forward in lung cancer and cancer treatment in general. And, , and I'm really excited to be part of this as a practicing oncologist. Treating lung cancer patients just in the past five years, we've seen tremendous improvements. And we're going to continue to see these improvements and advances, as we're discovering these rarer subsets of patients and of these rare subsets of mutations in our patients, and to really be able to offer them, more hope and better options.

DR. SANDS:
Well, with those final thoughts in mind, I want to thank my guest, Dr. Millie Das, for joining me to share new perspectives on enhancing

the patient experience in managing HER2 mutated non-small cell lung cancer. Dr. Das, wonderful having you on the program.

DR. DAS:
Thank you. It was my pleasure.

Announcer Close:
This episode of *Project Oncology* was sponsored by AstraZeneca and Daiichi Sankyo. To access other episodes in this series, visit reachmd.com/ProjectOncology, where you can Be Part of the Knowledge. Thanks for listening!