

## Question and Answer Session with Dr. Rogerio Lilenbaum on Considerations and Challenges in Treating Elderly Patients with Lung Cancer with Dr. H. Jack West

### **Dr. West:**

Hi, this is Jack West, Seattle-based medical oncologist and Founder and CEO of GRACE, the Global Resource for Advancing Cancer Education. We recently did a live webinar by GRACE in partnership with LUNGeVity Foundation, which featured Dr. Rogerio Lilenbaum, a medical oncologist who is a lung cancer expert and the Director of Hematology and Oncology at the Cleveland Clinic Foundation's facility in Weston, FL. He provided a terrific summary of considerations about treating older and frail patients with lung cancer. Here is the question and answer session that followed his presentation.

You showed results for a wide range of settings for non-small cell lung cancer, what about in small cell? Is there any reason to treat older patients differently with limited disease or extensive disease, or should these same principles apply in small cell lung cancer as well?

### **Dr. Lilenbaum:**

I appreciate the question, because I didn't have the time to discuss small cell in my presentation. I think the same principles apply. In terms of patients with extensive disease, it's been extensively documented that combination regimens are far superior than single agent in the treatment of this disease.

So, in fact small cell is a typical example in which we as physicians tend to push the envelope and we will use combination regimens not just in elderly patients, but also patients who have a low performance status, or patients who have other comorbidities and issues because one: the response tends to be gratifying and it tends to be relatively fast. So, I think we're more willing to use aggressive or standard combination regimens in elderly patients in small cell, in fact, than we are in non small cell patients.

Limited disease I would say is also the same. I think the issue with limited disease is when you get to the chemo and radiation portion of it. And I think we can use some of the data that we discussed for combined modality therapy in non-small cell. The data that exists though for combined modality in limited stage small cell will tell us that 1) the toxicities are much greater in elderly patients, and 2) that even though the benefits still applies it is not of the same magnitude as it is for younger patients.

So again we have – and the data mostly applies to patients between 70 and 75. There's not a whole lot of data in patients between 75 and 80 and, again, very little data in very old patients treated for limited stage, but, I think the same principles in general apply.

### **Dr. West:**

You had mentioned that the patients with greater comorbidities are far more likely to discontinue therapy, and in the BR10 adjuvant therapy trial the older patients were far more likely to discontinue adjuvant therapy earlier. Do you have a sense of whether patients are discontinuing

therapy because of their own refusal, their own decision, or whether it is directed by toxicities that all but mandate it?

**Dr. Lilenbaum:**

That's a great question and I think it's a combination of the two but with the understanding that if a patient asks or decides to discontinue the treatment, it's usually also because of some toxicity that we may not be able to quantify. So, I think it's a combination of the two and I don't think that there is good data out there to tell us which one is more prevalent.

The sense I have is that this is a combination of the two. That there are certain toxicities that mandate discontinuation of treatment: the oncologist simply is not comfortable continuing with that regimen any longer, and sometimes the patient is. Even though they may not have experienced a certain toxicity that we can measure or quantify they just don't feel like they can go on much further. So, I think it's a combination of the two.

**Dr. West:**

You've made the point quite elegantly, and the data back it, that certainly up to age 70, maybe 75, there really are not data to suggest treating older patients differently. But, are the breakdowns looking at how elderly patients tolerate treatment even instructive when the cut off is 65, and especially in a lot of the studies that are done outside of the United States? I mean, is 65, which is six years younger than the median age of the patients coming to us, even a meaningful question?

**Dr. Lilenbaum:**

I think your question in a way gives us the answer. I don't believe that we should be looking at this issue using that cutoff of 65. I have doubts that we should be using 70 as a cutoff. In fact in our most recent discussion within CALGB as far as mounting a clinical trial for elderly patients, pretty much everybody in the committee was in agreement that we should use 75.

So, I think that this is a moving target and I think we're beginning to realize what we just said that 70 to 75 is sort of the median age of the disease. These patients by and large do not pose special challenges or different challenges than the general population.

**Dr. West:**

And one thing I like about 75 is that it might be really hard to find a lot of patients over 80 who can go on a trial and I think that's been your experience and Dr. Hesketh's as well that there just aren't that many, but if you had trials for 75 and older and then could look at the breakdown of 75 to 80 versus over...

**Dr. Lilenbaum:**

Exactly.

**Dr. West:**

...we get information on both groups.

**Dr. Lilenbaum:**

Yes, I think that would be very informative -- yes.

**Dr. West:**

And then again along the lines of Avastin (bevacizumab), you'd showed the age breakdown that Dr. Ramalingam published, and I definitely agree that 72-74 is really not much of a reason to treat

differently. Do you personally get more concerned about it as you move up into the over 75 and especially into 80?

**Dr. Lilenbaum:**

Yes.

**Dr. West:**

And would you say that by the range of 80s it's really got to be mostly clinical judgment on a case by case basis for all of this?

**Dr. Lilenbaum:**

I would agree. In the setting of someone who is otherwise eligible for the drug and has a good performance status, I would say when it starts getting to late 70s I "double check", so to speak. I don't just automatically assume that that patients is a typical Avastin patient. And then when it gets to above 80, and certainly by mid 80s, I am asking myself three, four, five times before I make this decision, because I do think that this becomes a challenging drug in that age category.

**Dr. West:**

Great. Well, thank you so much for taking the time. And I would also like to at this point thank LUNgevity Foundation for their partnership and assistance in sponsoring this program today.

But especially thanks again to Dr. Lilenbaum -- it's really great to have you here.

**Dr. Lilenbaum:**

Thank you.