Ablative Therapy in Pts With Limited Progression

- 55 year old female patient diagnosed with stage III lung cancer. Treated with chemotherapy and radiation.
- Taken to surgery but many of her lymph nodes were positive.
- Because her tumor was EGFR exon 19 mutation positive started on erlotinib
- At 3 years on regular scans developed a left adrenal lesion.
- PET was positive only in the adrenal gland

Weickhardt AJ, et al. J Thorac Oncol. 2012;7:1807-1814.

Ablative Therapy in Pts With Limited Progression

- Brain MRI was negative
- Adrenal gland resected. T790M positive.
- Blood was positive for exon 19 but not for T790M
- Restarted erlotinib
- Now 1 year out with no recurrence.

Weickhardt AJ, et al. J Thorac Oncol. 2012;7:1807-1814.

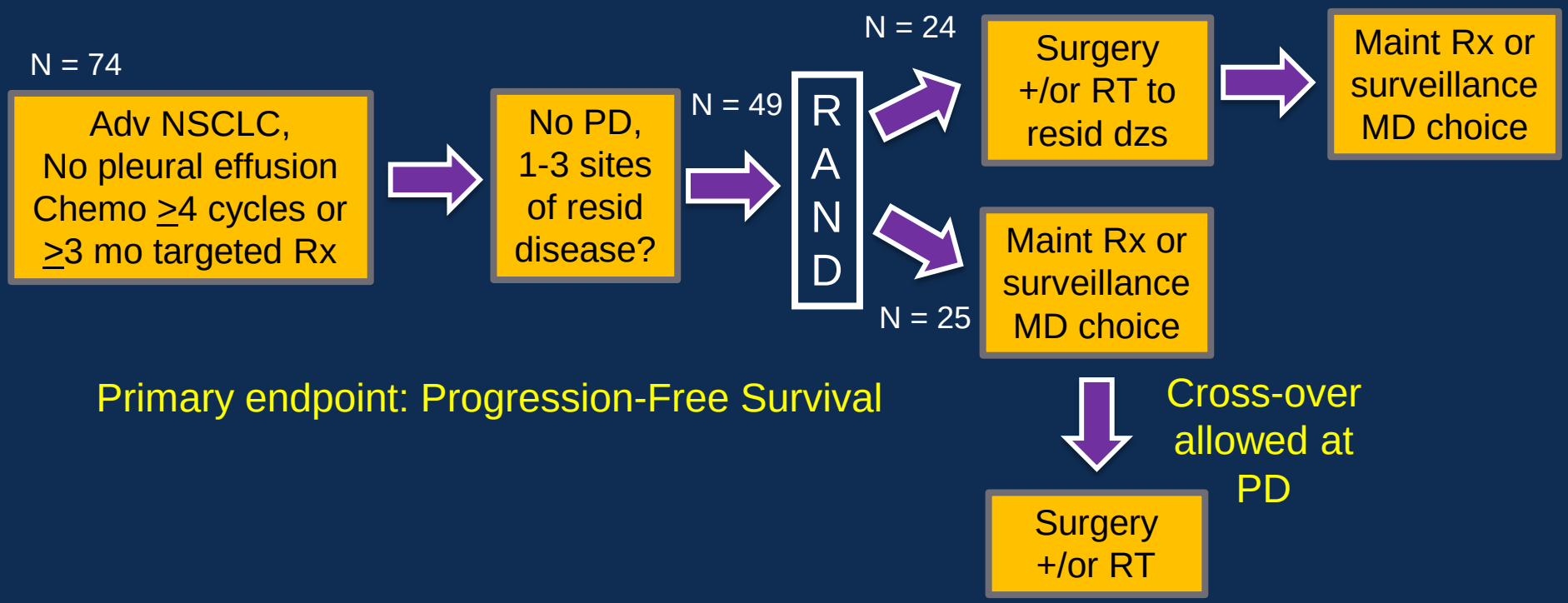
Ablative Therapy in Pts With Limited Progression

- Surgery or RT in pts with initial response to crizotinib or erlotinib and progression to ≤ 4 extra-CNS sites (n = 25)
  - PFS1: 9.8 mos
  - PFS2: 6.2 mos
  - CNS-PFS2: 7.1 mos
  - Extra-CNS-PFS2: 4.0 mos

Weickhardt AJ, et al. J Thorac Oncol. 2012;7:1807-1814.

Slide credit: clinicaloptions.com

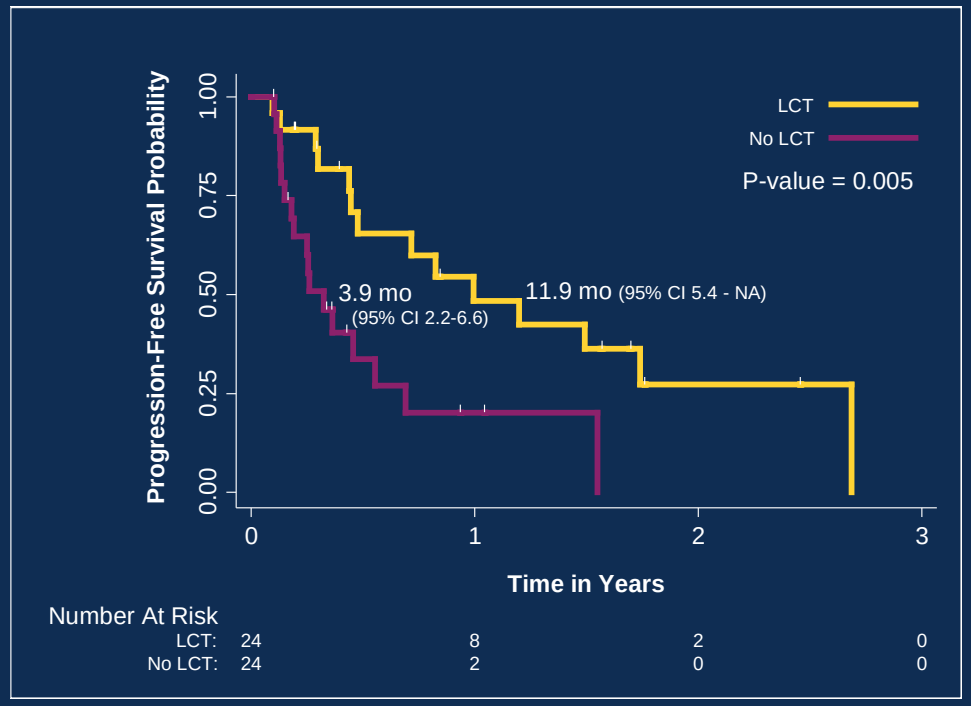
Local Consolidation Therapy: Trial Design



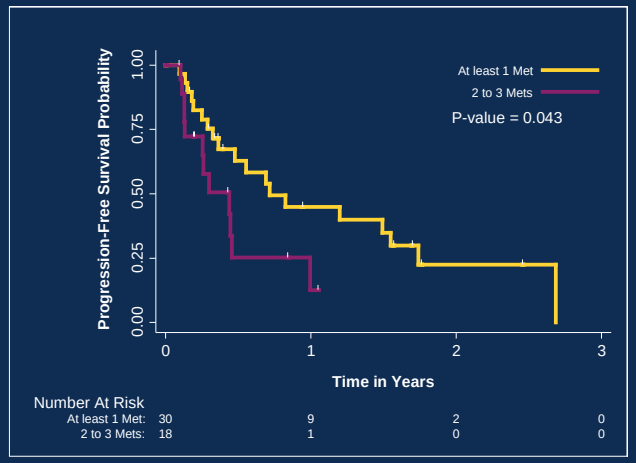
Primary endpoint: Progression-Free Survival

PFS: Overall and by Subgroup

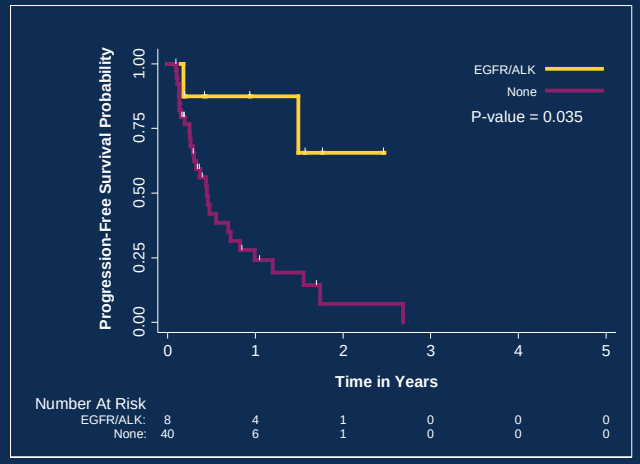
Overall



of Mets after 1st Line



EGFR/ALK Status



Highlights of Day, Lung Cancer Presented by: H. Jack West, MD 6/7/2016
Slide content courtesy of Dr. Gomez, A#9004

Not a definitive answer, but a big step in right direction

- Move on to larger trials, defining more limited range of local treatments
- Test true “oligo-residual” disease (is >1 just “poly-metastatic”?)
- Focus on endpoints that reflect *systemic* disease process (or at least aren’t undermined by the intervention being studied)