Dr. Cathy Pietanza from Memorial Sloan Kettering Cancer Center discusses standard chemotherapy options for treatment of both sensitive and refractory small cell lung cancer (SCLC).

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Transcript

The type of treatment that one receives in second line does depend on whether the disease is refractory to initial chemotherapy, or sensitive to initial chemotherapy. Once again, to define
Second Line Chemotherapy Options for SCLC
by GRACE Video - http://cancergrace.org/lung/2016/01/25/gcvl_lu_second_line_chemotherapy_options_sclc/

Each of those: patients with refractory disease are those whose relapse or progression has occurred while they’re getting first line chemotherapy, or within 60 days of completing their last cycle — some studies have used up to 90 days; for patients with sensitive disease, as the term implies, they have had a good response to initial chemotherapy, have maintained that response for 60 to 90 days, post-completion of their last cycle. The terms refractory and sensitive will help us determine, again, what types of treatment to give, and how effective that treatment will be for them.

In general, patients with refractory disease are less likely to benefit from other treatments, but we will try, and patients who have sensitive disease usually can benefit from additional chemotherapy. It also tells us that one is more aggressive than the other. For patients with sensitive relapse, the time frame is very important — if patients recur after six months of receiving their last cycle of etoposide and platinum, they can then receive more etoposide and platinum; if not, the other options include topotecan, and CAV. Now, there was one phase three study, that compared topotecan and CAV, and found that they were about equal, and Topotecan actually had a better side effect profile, and so it was FDA approved, and it’s actually the only agent that’s FDA approved in the second line setting for small cell lung cancer. Additional studies then showed that both patients with sensitive, and refractory small cell lung cancer can benefit from topotecan, and therefore, even patients with refractory disease can get this agent. We also like to use CAV because it is an effective chemotherapy regimen — CAV is cyclophosphamide, doxorubicin and vincristine, and in patients, especially if we feel that they need a quick response, this generally elicits that.

The other option for patients with refractory disease is to receive best supportive care. Now, in either of these types of relapse, another very, very important option is a clinical trial, and the last two to three years has seen a flurry in clinical trials in small cell lung cancer, which is extremely exciting and was very much needed, and hopefully we will come across new agents for this disease. It is imperative that if patients are in good shape after their disease recurs, that they seek a clinical trial — it may benefit them, and it will hopefully benefit our knowledge of the disease and the treatment of future patients with the disease.

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