



CASE BASED PANEL DISCUSSIONS: LUNG CANCER

Stage III Squamous Lung Cancer with Low PD-L1

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TRANSCRIPT

Dr. Ana Velazquez Manana: It's our last case. It's the 76-year-old former smoker man with a small volume Stage IIIA and two node-positive left upper-lobe squamous lung cancer with a PD-L1 of less than 1%. Received pre-operative chemotherapy with nivolumab, got cisplatin, [00:43 inaudible] and nivolumab as neoadjuvant therapy. His scan shows overall stable findings after neoadjuvant therapy prior to surgery and undergoes a successful resection. But pathology shows very little treatment effects and viable N1 and N2 nodal diseases in multiple nodes. What would you recommend in the post-operative setting for this patient?

Dr. Justin Gainor: I would argue a data-free zone right now. We're going to spend a disproportionate amount of time talking about these cases in tumor board because, unfortunately, this is going to be a majority of patients who get chemoimmunotherapy are not going to have a Path CR, particularly PD-L1 low patients. In CheckMate 816, 20% of patients received additional therapies, postoperatively, but it was at the discretion of the investigator. And we really don't know. So, I think, in this case, PD-L1 being less than 1%; hopefully, that doesn't qualify for adjuvant Atezolizumab nor would I be enthusiastic if they didn't really have treatment effects to begin with. Two, you've already given him three cycles of platinum-based double chemotherapy. So, I think, more chemotherapy, while we want to do something, we don't have data there and it's likely going to be more toxic. And then we talked about the LungART studying the limited benefits of postoperative radiation therapy. I know it's a bit of a cop-out, we don't want to say, "Enroll that person to a clinical trial." But I do think we, as a community, this is where we need to study. We need clinical trials in this space, seeing, can we intensify therapy in these patients? If so, how? I think it's, right now, a major question mark. So, absence of a clinical trial, I would just opt for surveillance as unsatisfying as that is.



Dr. Stephen Liu: The exact same sentiments here, Justin. I think that our call to act further to give more therapy just reflects that we recognize the prognosis is not very good here; that in those patients who did not achieve Path CR with residual disease, the risk of relapse was quite a bit higher. But that's different from saying that giving more therapy will have a positive outcome. I agree, giving more chemotherapy, a few more cycles of platinum-based chemotherapy, I think that's only treating us, just sort of letting me feel like I've done something, when really all I've done is probably just expose them to more risk and increasing toxicity. And I think LungART is a great example of that; we have a high risk of relapse, we're going to radiate that area. And we saw from LungART that the rate of treatment-related morbidity was quite high and tipped the scales in the other direction. So, I think there is the potential to do harm by giving therapy that has clear risk, clear toxicity, but no proven benefit. And I agree that we want to explore this space and trials. When this happen, I think that we would generally recommend close surveillance after this. I completely agree.

Dr. Ana Velazquez Manana: I agree. I think I would do the same and we would probably recommend close surveillance. One big question, of course, this is also an elder person. Even though if they went through neoadjuvant therapy and surgery, they must have some degree of physical fitness. But clearly, adding more chemotherapy will increase a lot of toxicity. So, it's not something that I would recommend in this space either. I think we definitely need studies, or at least real-world data, on what patients now we're going to start treating in this way, what their outcomes are, and what are some of the different characteristics that may allow us to identify who needs therapy or who may benefit from it? And the other part is, it is squamous lung cancer, in particular, we haven't talked about whether this patient should undergo full molecular testing at the same time and genotyping off their tumors. It's something that we routinely do, but we all know that even on guidelines, it is squamous versus adenocarcinoma, and squamous is a lighter recommendation. But I think on this patient, particularly, something that would be helpful also at the same time in determining at the time of recurrence is there going to be any other specific trials that they'd be amenable to, or do they have any alterations that would make us decide for different therapy at this stage?

Dr. Stephen Liu: Excellent point. Completely agree. We'd also be profiling.