



2022 Targeted Therapies Patient Forum

Identifying Oligoprogression in a Patient

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TRANSCRIPT

So, in this era of well-tolerated treatments, we've just heard about patients with ALK-positive lung cancer living up to six to eight years. We know that we are going to encounter some resistance. Cancer continues to evolve over time and continues to overcome these innovations that we're making with targeted therapies. So, it's inevitable that patients will develop resistance to the targeted medication. We don't know exactly when, but we're learning little by little who is at a higher risk for this.

But, I think it's important to understand Oligo Progression, which means a few sites of the disease are growing while the rest of the disease is under control. It's an opportunity to regain control of the tumors that are growing with local treatment. So, Oligo Progression has given us the opportunity to treat those sites that are growing while the patient still remains on targeted therapy.

And why is that important? Well, the quality of life for many of our patients is better when they're on targeted therapy; taking pills is better than undergoing chemotherapy. Also, it provides control for a mutation that we know you have, which is the best-tailored treatment. So, treating these sites of disease that is growing here and there allows us to keep our patients on targeted therapy for a longer time before switching to chemotherapy or to less effective immunotherapy.

But, there are things we need to know about Oligo Progression. The first thing I look at is the presence of symptoms. Is the progression, this Oligo Progression, causing symptoms for my patient? Often, we see it when there is disease progression in the bone; the tumors growing on the bone tend to produce more pain, especially if it's in the back when patients go to bed. Is the disease growing very close to the airway, causing a cough or cough with blood? So, the main thing for me is how is this affecting my patient, and where is the site of the disease progression.



We need to understand that we also need to follow the criteria for disease progression. It needs to be more than 30% of the original size for us to say that the cancer is growing to a significant point. The disease, particularly with immunotherapy, can wax and wane. So, when we call it disease progression, it needs to be over that 30% of the original size to call it.

The second thing is, what resources are available at my institution that will allow me to treat these little spots of disease progression? I'm very fortunate to be in an 'ivory tower' where I have many resources to treat this, but not all these resources are available across the United States or outside of the United States.

And finally, particularly with patients that have an EGFR mutation, we need to make sure that the disease has not transformed to small cell. We're going to talk about that. So, when we talk about the disease growing in certain spots but being controlled in the rest of the body, we consider symptoms, what can I do for this, what do I have available, and I need to make sure I'm not dealing with a different disease that has transformed.

I'm putting this image here to remind us to understand that our patients' health is as delicate as a snowflake. We need to make sure that we communicate and listen to our patients. A lot of signs of Oligo Progression are identified before CT scans. My patient tells me that they just had this new abdominal pain, sometimes it's capsular dilation from the liver, that they have this back pain that returned and looks and sounds similar to when they were diagnosed with lung cancer. So, there is a very fine line to make sure that we don't miss the oligo progression before it becomes a full-on flank progression. Listening to our patients and having good communication allows us to make early diagnoses and control the rest of the disease.

I cannot stress enough that the treatment of oligo progression or little progression needs to happen via a multidisciplinary care team. I wish I could do everything and make scheduling easier for my patients, but we often have to work with surgeons, radiation oncologists, and pulmonologists. We need to talk to interventional radiologists to treat this disease. Also, in cases where we're not sure if the disease has transformed, we need to talk to pathologists to evaluate a repeat biopsy.