Case Based Panel Discussion 2019- Lung cancer Unresectable NSCLC

Case Based Panel Discussion - Stage 3 NSCLC Treatment Standard and the Risk of Potential Pneumonitis

Dr. Millie Das specializes in the treatment of thoracic malignancies. She sees and treats patients both at the Stanford Cancer Center and at the Palo Alto VA Hospital. She is Chief of Oncology at the Palo Alto VA and also leads the VA thoracic tumor board on a biweekly basis.

Dr. Matthew Gubens is a thoracic oncologist who treats patients with lung cancer, mesothelioma and other thoracic malignancies, including thymoma and thymic carcinoma, which are rare tumors of the mediastinum. He is an Assistant Clinical Professor of Medicine at UCSF.

Recently the doctors sat down to discuss a series of case-based scenarios. In this video, the doctors discuss the standard treatment of chemotherapy and radiation followed by immunotherapy and the risk of pneumonitis.

Dr. Jack West: We sometimes have patients in whom we start durvalumab and they develop pneumonitis. It could be because of the durvalumab, it could be because they were destined to get it anyway. And it's just coincidence. Our standard treatment for pneumonitis is time and steroids, and oxygen as needed. And typically if it's more severe, we would also stop durvalumab. If you have a patient who recovers after tapering steroids after two months and say they were three months into their treatment at that point, are you inclined to resume the durvalumab or do you just leave it at that point?

Dr. Millie Das: I think that's a good question. I think it depends on how bad that pneumonitis was and you know, if it landed the patient in the ICU, probably not. You know, if it was a little bit of a milder case where they got started on steroids improved rapidly, you were able to taper them off within a month, it's a conversation. I do worry a lot about the pneumonitis and the potential for retreating and then having another episode of pneumonitis. In which case you may not necessarily be as lucky where, you know, they respond right away to steroids. And so I tend to, I think, not pursue it as aggressively that, you know, once the patients develop pneumonitis. If a patient's really gone home and wants it, you know, again, it's kind of that shared decision making, but it makes me a little bit nervous. And I think that the studies have shown that patients who develop it,

you know, on durvalumab and if you rechallenge that they're at a somewhat higher risk of having it again. And so, that piece of it, I think is what makes me nervous about restarting and challenging.

Dr. Matthew Gubens: Yeah, I completely agree. If I have to give any steroid at all for a pneumonitis, I'm not going to continue the durvalumab in the Imfinzi. And it's a different calculus than if a patient has stage four disease. You get in stage three, maybe we've cured them with chemo radiation and the divine [inaudible]. But because there's a little different risk benefit package there than there is in stage four where I maybe I don't have that many other options beyond this, then I might rechallenge after discussion of, Hey, your chance of having another bad pneumonitis is probably half, half. I mean that's at least what some of the data are showing us [inaudible]. I'm going to say the other thing that I would point out is that in all these immunotherapy discussions, none of us know what the right duration of therapy is to accomplish what we want to accomplish. And we've all probably had patients where, I've had patients get one dose of an immunotherapy have a terrible side effect. I don't give them any more, but they have the disease controlled for years, you know, but other patients where after two years, then they would reoccur as soon as I stopped. So a year is already a little bit artificial, cause we have to have rules, but I.

Dr. Jack West: So it's a circle around the sun.

Dr. Matthew Gubens: Exactly. Exactly.

Dr. Jack West: There you go. That's, that's how it must be biologically. So no, I think that's, that point's very well taken that we do have limited data from the study that you could stop and then resume safely. The patients who stopped after a shorter period seemed to get very comparable benefit to the patients who didn't end in various immunotherapy trials and settings. Largely looking retrospectively, the patients who had more significant side effects do seem to get at least as much benefit, if not more, perhaps because that is a representation of a very active immune function, but much more to learn about this. And I agree, you know, if you had somebody who improved dramatically and stopped, you know, was able to taper steroids after the first month of durvalumab, it's one thing versus getting through 10 months and deciding at that point. But it adds up. And I think that's something we need to learn more about.