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Maintenance Therapy for Advanced NSCLC



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TRANSCRIPT & FIGURES

For patients with advanced non-small cell lung cancer, our typical approach, if we have someone who does not have a driver mutation that we typically treat with a pill-based targeted therapy, is to give chemotherapy. That chemotherapy is typically given in a cycle of three weeks or sometimes a four week period of time where the blood counts go down and then recover. That treatment is typically given once every three weeks, sometimes once or twice on a weekly basis in that three week interval, but we typically give that therapy for about four to six cycles of therapy – that’s about three to five months of treatment. By that time, by four to six cycles in, the two drug combination that includes a drug called platinum is usually creating some cumulative side effects: fatigue, low blood counts, and other complicating issues that make it increasingly challenging to administer more of the same potentially intensive therapy, and by four to six cycles you really tend to reach a point of diminishing returns.

At that point we often favor a maintenance therapy approach. That is, dropping the carboplatin or stopping all of the agents that have been given previously and either continuing one or more of the agents from the first line setting, or using what’s called switch maintenance to give a completely different treatment. These maintenance therapies are designed to do what their name suggests – to maintain a response after we’ve seen the most shrinkage that we’re likely to get from the more intensive first line therapy.

When we do a continuous maintenance approach, it’s typically taking a drug like cisplatin or carboplatin in combination with one or two partner drugs, usually a second chemotherapy agent and sometimes Avastin which blocks a tumor's blood supply, and then after four to six cycles we drop the platinum

and we will typically continue a drug like Alimta if that's been given in the first line setting, and if a drug like Avastin has also been given we might continue that and give Alimta and Avastin together until the cancer progresses.

If a combination like carboplatin and Taxol were given with Avastin, the maintenance therapy is often just the Avastin because Taxol tends to have some cumulative neuropathy issues – numbness and tingling that can lead to a real limitation in how much of that therapy you can give. We might also consider a switch maintenance approach – instead of continuing some of the agents, come in with Alimta as a single agent if a patient has non-squamous histology. Another agent that is approved as a switch maintenance therapy is Tarceva (erlotinib) – this doesn't tend to be as favored as a switch maintenance because the efficacy of Tarceva in patients who don't have an EGFR mutation tends to be on the lower side.

What do these maintenance therapies have in common? Well they're all agents that can be given on a longitudinal basis without a lot of cumulative side effects and they tend to be the agents that have good activity in patients who have already been on prior therapy. So any of these is a reasonable choice, the most common being a continuation maintenance of dropping the platinum and continuing one or two partner drugs that were given with it, or sometimes switching to an agent like Alimta (pemetrexed) or Tarceva (erlotinib). It's also reasonable to not pursue maintenance therapy if a patient has cumulative side effects and really needs a break from therapy. That is certainly something to discuss with the patient; it's not as if maintenance therapy is a mandate for all patients, but it is something that is

a strong consideration if a patient is motivated and can continue to tolerate ongoing therapy after four to six cycles.

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