Lung Cancer

General Small Cell Lung Cancer

Treatment Options for Relapsed SCLC, 2020 Update

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Dr. Owonikoko: I'm Taofeek Owonikoko, Professor of Hematology and Medical Oncology. I'm vice chair in the department of hematology and medical oncology at the Windship Cancer Institute of Emory University. Thanks for joining us and thanks for having me to talk about small cell lung cancer treatment or relapsed disease updates for 2020. As we all know, small cell is one of the major subtypes of lung cancer, constitutes about 13% of all cases diagnosed in the US on an annual basis. More than 30,000 new cancer patients will have a diagnosis of small cell. While we've had some recent, very promising and established new options of treating patients with newly diagnosed disease, etcetera, especially the extensive stage disease patients. The treatment of patients with relapsed disease remains a big challenge. The way I approach the treatment of patients with relapsed disease in 2020, has to do with a number of key factors.

One, is the stage at which the patient was diagnosed. So someone with limited stage disease who is now relapsing after completing chemotherapy and radiation, I want us to look at that in the context of retreatment with the platinum based regimen. If they're relapsed or caught much longer than six months in general, and especially if it's more than a year, I will look at those patients as someone that I'm treating for newly diagnosed, extensive stage disease and consider them for chemotherapy, plus immunotherapy regimen. For patients with relapsed disease, following treatment for extensive stage disease in the frontline. I look at those patients and then look at the various options we have. I make both to say at this point that we probably do not have an established standard with the change in our frontline approach of chemotherapy and immunotherapy. The prior standard of Topotiken in this setting is probably data as this came from data from patient treated only with chemotherapy in the frontline.

Most recently there was the accelerated approval granted [inaudible] based on the single arm phase two trial that showed promise in efficacy of this drug. With the FDA approval of [inaudible] is now one of our standard of care agents to use, of course, pending confirmatory phase three trial. It's important to also recognize that efficacy of [inaudible] varies based on sensitivity to Platinum response rate. For those with Platinum sensitive disease is almost double the response rate with those with Platinum resistance. So why not have it Platinum sensitive patient, I'm more inclined to offer them [inaudible]. And for those who Platinum resistant disease, it's

not like we have a better option. So [inaudible] will still be considered in lieu of a clinical trial option. Secondly, for patients who did not get immunotherapy as part of their frontline regimen for extensive stage disease, I would also consider the approved indications for nivolumab as a single agent, as well as for pembrolizumab, especially for those with PD-L1 positive tumors.

Finally, we should not forget our reliance on other side of toxic chemotherapy agents that we'll be using even before the advent of immunotherapy. I still rely on single agent paclitaxel, gemcitabine, and docetaxel in appropriate patient. There are also ongoing clinical trials now looking at liposomal irinotecan that could be offered to patients as a second line treatment option. So, as we can see this space currently does not have a clear standard. We have an approved drug that is pending confirmatory study in the phase three setting. We have another agent that is currently in phase three trials, and then we have immunotherapy agents that would only be applicable if a patient did not get immunotherapy in the front line. I think I would still consider most of our patients for participation in clinical trials, as the optimal treatment option for patients with relapsed small cell in 2020. Thank you.