



Lung Cancer News and Updates ASCO 2020

SCLC Trial Updates - Gronberg Study

Results From the Gronberg study of Lower vs Higher Dose of Twice Daily Chest Radiation Given Concurrent with First Cycles of Chemo for Limited Stage Small Cell Lung Cancer

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Dr. Jack West:

Hi, I'm Dr. Jack West, I'm associate clinical professor in medical oncology at the City of Hope Comprehensive Cancer Center, and also the founder and president of GRACE, global resource for advancing cancer education. I'm very happy to be joined today for an ASCO highlights presentation in the field of lung cancer with two of my friends and colleagues from other parts of the country who are lung cancer experts with some different perspectives. And we're going to go through some of the key presentations and talk about what we think this means for patients. So first I have Dr. Helena Yu, who is medical oncologist at Memorial Sloan Kettering Cancer Center and Dr. David Spigel, who is chief scientific officer and director of the Lung Cancer Program at the Sarah Cannon Cancer Center in Nashville, Tennessee. Thanks guys for joining.

Let's turn to a different direction of small cell lung cancer, specifically limited stage. And limited stage is about a third of patients with small cell lung cancer. And the standard for decades now has been radiation to the chest, sometimes done twice daily, where there's some data to support it being maybe modestly better than once daily. And that is given concurrent with chemotherapy, long time regimen of cisplatin, or perhaps sometimes substituted carboplatin with etoposide. And this has been really our go-to standard or cornerstone for limited stage small cell for a very long-time. And real improvements have been extremely hard to come. By this study presented by Dr. Greenberg and colleagues out of Scandinavian countries showed very impressive results looking at just two different doses of twice daily chest radiation given with the first couple of cycles of the chemotherapy.



And then patients got a total of four cycles of chemotherapy, and then got prophylactic cranial radiation, or brain radiation to reduce the risk of brain metastases, which we know are a major concern in this setting. And the results demonstrated a very striking significant improvement in two year survival. As you can see here with the absolute number being at the higher dose of 60 gray, which is four weeks of twice daily. 70% versus 46%. So really a striking difference. And what I think is also striking this [inaudible] by any clear evidence of greater toxicity and discuss and reviewed these results actually, which is Jared Weiss, one of the GRACE directors, board of directors, and highlighted that this was so unusual that it kind of was hard to believe. Almost too good to be true. Now twice daily chest radiation has not been broadly used in the United States for lots of reasons.

And I think the practical issues of having patients come in to get chest radiation at 8:30 in the morning, and then come back at 2:30 in the afternoon really basically requires you to spend your whole day going back and forth where, you know, in many of the places we practice traffic could mean that you spend the entire day just circling the cancer center. And perhaps now in a world where there's greater risk of being in an out of the cancer center, because of worry about Coronavirus and infection or exposure, that might be a greater issue. So this didn't get a whole lot of discussion during, or immediately after ASCO. Perhaps part of that's because small cell just doesn't tend to get as much discussion, but the differences in survival are striking. I'm interested in your thoughts on whether this means to you that you would recommend this for patients who you might see with this, should this be a new standard of care? It's not an enormous study as you can see, it's 160 patients, but it's a striking reminding. So Helena, can I start with you and where do you think this takes?

Dr. Helena Yu: Yes, I think that we actually had the good fortune of discussing this presentation with our radiation oncology colleagues at Memorial. So, I think a lot of them felt that the data was incomplete as presented. I think one of the things that I don't think you mentioned is that the progression free survival was not significant in terms of the difference between the two groups, and usually you know, survival benefits are driven by progression free survival benefits. And so that was something, again that sort of gave some pause as to sort of how this survival benefit was derived. So I think, you know, we need to know information about patterns of failure. Was this, you know, somehow changing sort of local recurrence versus distant metastatic disease. And then you did bring up the fact that the 60 gray almost looked too good in terms of toxicity. I think we know that these tumors tend to be central tumors. So, to see equivalent rates of esophagitis versus, you know, when you're giving 15 gray more, just seems a little bit suspect. So I think you know, did all the areas get the required amount of radiation?



There are sort of some outstanding questions. So I think that leads to potentially at the moment, this not being something that would be practice changing in my opinion.

Dr. Jack West: Okay. David, what do you think, did this catch your attention, is this convincing to you? Or do you have some of the same reservations that Helena does?

Dr. David Spigel: Not much to add. I mean, I think it's interesting. It's kind of an old story, right? Just give more of something. And in this case it looked, it looked really good. It's just, the numbers are small. I'd like to, I'm looking forward to the publication and kind of learn more about some of these softer end points that were brought up. It's interesting at our center, we're actually involved in a trial looking at adding immunotherapy to the standard regimen here. And so you wonder has happened sometimes is, is if you change the standard of care and then now immuno gets added, you know, what if you do it all together and we won't know because the studies weren't designed that way. So nothing happens for like 30 years and then suddenly we have two potential things happening in limited stage, small cell. So, yeah, I think it's interesting. Not yet practice changing.

Dr. Jack West: Okay. Very good. Good points. One other thing I will edit this. One other point you mentioned yes, you dose and you might see better results, but in the setting of non small cell lung cancer, the radiation therapy oncology group a few years ago, did a study that escalated the dose of chest radiation with chemo and found that it backfired. That patients actually had a significantly worse survival. So, you know, I don't think we could take for granted that more is necessarily better, even if it is here. That's the opposite of what we saw with its cousin, non small cell lung cancer, but [inaudible]. And I think all these things may lead to judgment being reserved for a while, until we see more.

