2020 Target Therapy Forum

EGFR Question and Answer Panel

Preferred Chemo Regimen when Targeted Therapy Options are Exhausted

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Dr. Jared Weiss: And I do see a clustering of questions essentially around what to do next. And I'll start with the question of what chemo regimen is best once you've run out of targeted therapy?

Dr. Zofia Piotrowska: So, you know, I think it depends a little bit on what prior treatment patients have had, you know, for patients who have not had any chemotherapy, which is often the case. If we find an EGFR mutation, when we start the patients will go onto the TKIs and haven't had any chemotherapy types of treatments. And for those patients, I think carboplatin and pemetrexed, or Alimta being the other name for pemetrexed is my preferred approach. It's a chemo regimen that's given once every three weeks. I have found that generally, it's fairly well tolerated. Although, you know, for most patients they can feel well on it. They don't have to come to clinic too often. And that is my preferred approach. How about yourself Jared?

Dr. Jared Weiss: So, you know, I talk to my patients about two basic regimens and I will confess between you and me and whoever happens to be listening to us here that I'm rooting for a pemetrexed based regimen as well. Because it's just more humane. Everyone's afraid of chemo. Everyone hates chemo. I hate chemo. I know you hate chemo cause you're

nodding and we've talked about it. Our patients hate chemo, we can't ignore two things, first is that our cancer is awful and that chemo while it does create suffering also can prevent or roll back suffering. We can never ignore others. We have to weigh that. And we also can't ignore that not all chemo is equally awful. And I think as chemo goes, thinking in the spectrum of lung cancer and even broader across cancer, Penn Carbo is one of the gentler regimens available to us. And so I also and quite partial to it. It may make me a little bit old school, but I do add bevacizumab. Otherwise know as Avastin.

Dr. Zofia Piotrowska: It's like it was the plan, do we [inaudible].

Dr. Jared Weiss: So, you know you know, prior to our more modern era there was data for that triplet. It was once in Vogue but there's also some non-randomized data suggesting. And I do mean to use a weak word and saying, suggesting that it may be more helpful in patients with EGFR mutants than other patients. But I think we would be remiss if we didn't mention the quadruplet of carboplatin paclitaxel, bevacizumab and atezolizomab. I see I see the smile to laughter and, you know, that was kind of my reaction as well, this regimen it feels like a lot, it's four drugs going from targeted therapy to four drugs. I will say that I bring it up with patients kind of hoping they don't choose it and a shocking number do. And what's you know, the two good things I would say about that regimen are most importantly, it's the only context where we have a hint of immunotherapy clearly helping an EGFR mutated population. I wouldn't call it definitive, but it at least gives the patient that chance in some legitimate way. The other is that once you're done with your four cycles, you don't have to continue any cytotoxic. You're on, it's still infusional, but you're onto atezolizomab and bevacizumab alone without any chemo in there. And for some patients that can be nice getting that done.

Dr. Zofia Piotrowska: Yeah, I agree. I mean, I think it's, as you say, if we're going to use immunotherapy, I think using it in combination with chemotherapy feels better than using immunotherapy alone. I will say that, you know, I I've discussed it with patients, although I have been hesitant to use it. You know, I think the Texas city of that four drug regimen is not insignificant and really has to be weighed carefully you know, neuropathy, hair loss, which is something that we see much more with that regimen than we do with pemetrexed based regimens. Those are important side effects and have an important impact on quality of life. I also personally worry, you know, patients who have had brain metastases. I think this is a big issue. And for patients who've had brain metastases that remain in control on osimertinib. I worry very much about stopping the osimertinib and moving on to the immunotherapy, where if we do see that, that, you know, the osimertinib was helping to control that cancer in the brain. And we start to see some growth, we're a bit worried about adding back the osimertinib, but patients have had immunotherapy. So those are things we have to weigh. It's obviously a patient by patient decision. It really depends on a lot of factors, the sites of disease, patient

preference, I think very, very importantly, how well they are and how, you know, how we think patients would tolerate that regimen, but certainly something to consider.

Dr. Jared Weiss: So you bring up the idea of continuing Osi with chemo in select patients. What about continuing Osi past progression figuratively, putting your finger over a problem on the scan of it and watching it?

Dr. Zofia Piotrowska: I think we do that all the time. You know, in the interest of time, I didn't go into that in great detail, but absolutely I think, you know, progression comes in many, many different varieties and forums, and there are some patients where progression might mean a few millimeters of growth and a few lung nodules that it's not causing the patient any symptoms and is not likely to cause them any symptoms in the near future patients are feeling very well. You know, they're tolerating Tagrisso well, and in those situations, I think you can actually squeeze a lot more goodness out of osimertinib before you have to switch therapy. And ultimately the way that I explain this to my patients is that this is what it's really all about, squeezing as much kind of juice out of each treatment as you can before moving onto another one. And even though we see quote unquote progression on a scan, I think the question I really try to ask myself is this clinically significant progression or is it likely to become clinically significant in the near future? And to me, those are the reasons to switch.

Dr. Jared Weiss: My practice is identical. I've been shocked at how long I've been able to watch things post-progression in, in select patients. Philosophically I think what we care about is how long our patients live and their quality of life during that time. And if the cancer isn't threatening that, then I don't really have, as you know, such a problem.

Dr. Zofia Piotrowska: I will say, sometimes it can be a hard thing for patients, you know, once you start to see some growth, I think understandably that sometimes it's really hard to say, we'll just sit on it and watch it, you know, but I think with close surveillance and, you know, care follow-up, that can be done very safely and well. And I think, you know, something that, that is absolutely worth discussing. And I think the other thing too, is local therapy. So radiation or other treatments, you know, if it's a single solitary side of progression, that can also be another way to kind of squeeze more time out of a particular treatment that hasn't completely failed, but maybe just, you know, isn't working quite as well in one area.