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TRANSCRIPT

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Clinical Pearls for Challenging Cases of Advanced NSCLC

Announcer:
This is ReachMD, and you're listening to Closing the Gaps in NSCLC, sponsored by Lilly.

Dr. Birnholz:
From the ReachMD studios in Fort Washington, Pennsylvania, I'm Dr. Matt Birnholz. On this episode, we connect with Dr. Everett Vokes, Professor of Medical Oncology at the University of Chicago. Dr. Vokes reflects on the clinical strategies he uses when handling challenging cases of advanced Non-small Cell Lung Cancer. Here's what he told us from his office in Chicago.

Dr. Vokes:
We have to look at lung cancer really stage-by-stage, and I will start with stage IV, where knowing the histology, knowing the driver, whether or not there is a driver mutation, and knowing the susceptibility to an immune oncology intervention is key now. And out of that comes a more and more complex treatment decision tree that will guide us. So, a patient who has a driver mutation should absolutely be treated with—particularly if it is ALK, ROS, or EGFR, and likely BRAF—with the specific targeting agent. The patient who does not have a driver mutation and is a candidate for chemotherapy or systemic therapy, we need to know the PD-L1 status, and maybe the tumor mutation burden status, but certainly the PD-L1 status. And patients that are PD-L high, so that is 50% or more, should be treated, in all likelihood, with a single agent, PD-1 inhibitor, pembrolizumab, while patients that are below that, particularly when the adeno could be treated with pembrolizumab, but I think in my mind more likely should be treated with a combination of chemotherapy and a PD-1 inhibitor, or a PD-L1 inhibitor. So here, both pembrolizumab or a combination of atezolizumab with bevacizumab, could be considered. Now, the latter combination, chemotherapy with bev and atezo, is where we have some data for patients with driver mutations, so it wouldn't be first-line therapy, but it would come after patients have progressed on targeted therapy. So, there is some data there to suggest that that 4-drug combination could be of benefit for those patients. And then, of course, we have patients with less-good performance status, elderly patients. That's a little bit vague. A lot of clinical judgement comes in there. There certainly are some emerging data for using single-agent immune inhibitors in that population, but it needs to be very carefully considered. Similarly, patients with autoimmune disease, we want to be very careful what immune inhibitory therapy we subject them to.

Dr. Birnholz:
That was Dr. Everett Vokes speaking to the factors guiding his clinical decisions for challenging cases in Non-small Cell Lung Cancer. For ReachMD, I'm Dr. Matt Birnholz, encouraging you to be part of the knowledge. Thanks for listening.

Announcer:
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