

Immunotherapy for Extensive-Stage Small Cell Lung Cancer: Uncovering Clinical Gaps in Physician Knowledge and Practice

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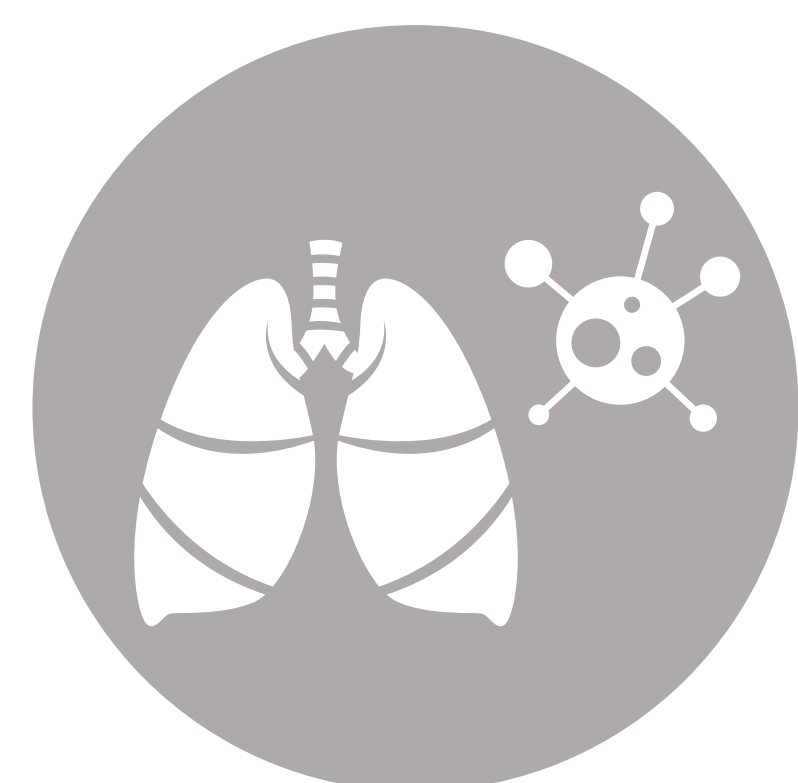
Publication Number: 152P

Presented at the
the European Lung
Cancer Congress 2022

30 March-2 April 2022

BACKGROUND

- Immune checkpoint inhibitors (ICIs) are changing the management of extensive-stage small cell lung cancer (ES-SCLC)
- This activity was designed to understand the gaps in knowledge, competence, and confidence of oncologists regarding ICI use for treating ES-SCLC



METHODS

A continuing medical education (CME)-certified clinical practice assessment comprising 31 multiple-choice questions that measured knowledge, attitudes, and perspectives regarding ICIs for ES-SCLC was developed.

The self-assessment was available online to physicians without monetary compensation or charge.

Respondent confidentiality was maintained, and responses were de-identified and aggregated prior to analysis.

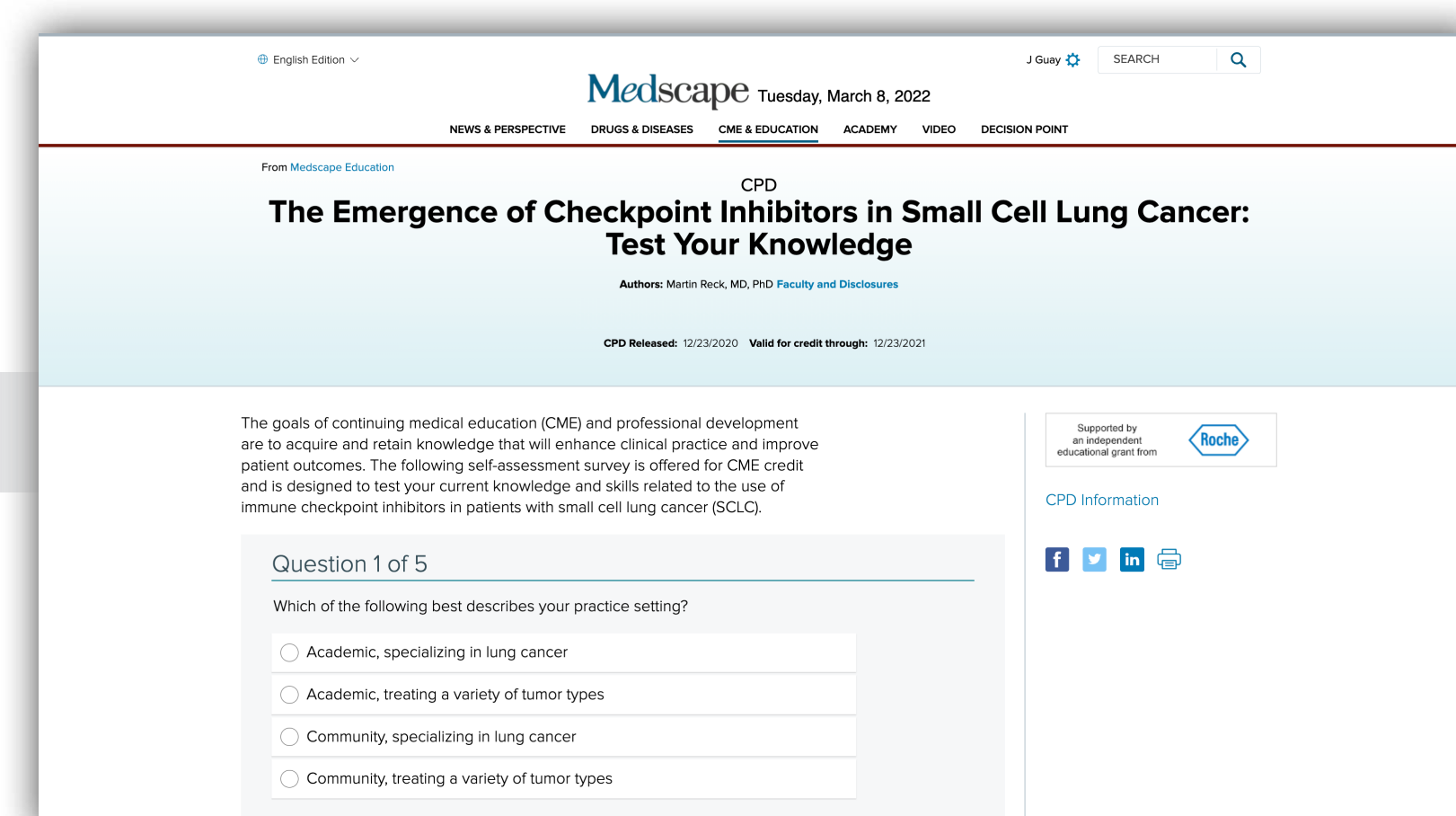
The activity launched Dec 23, 2020; data through April 7, 2021 are presented.

The Emergence of Checkpoint Inhibitors in Small Cell Lung Cancer: Test Your Knowledge

www.medscape.org/viewarticle/942985



Oncologists (n=72)



At the time of this analysis, 72 oncologists who manage patients with SCLC completed the assessment.

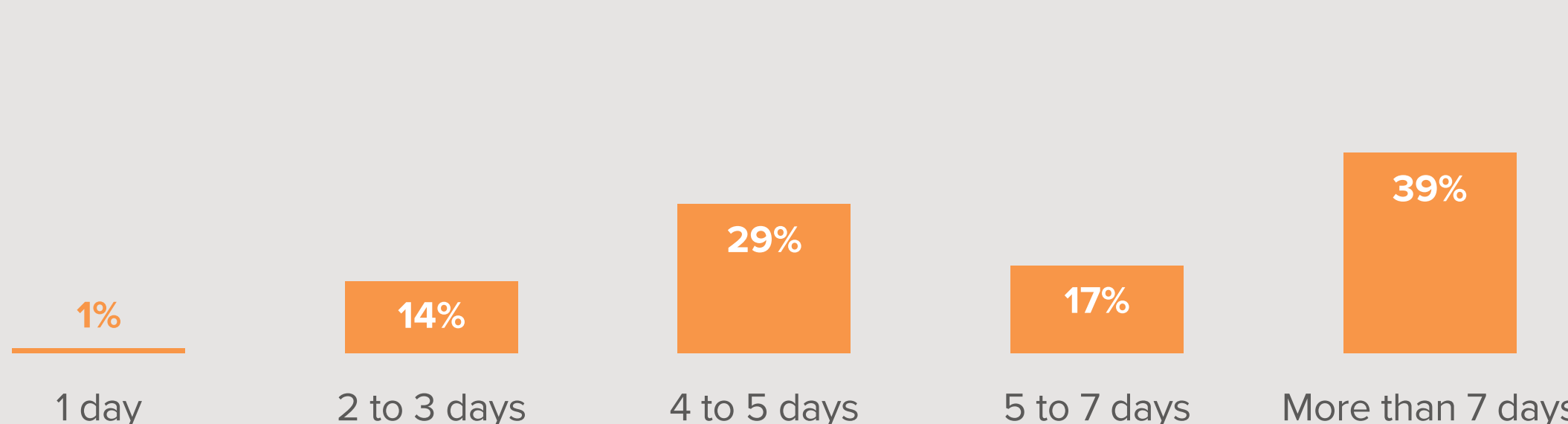
RESULTS

Note: Percentages are rounded and may not add up to 100%

Time to Diagnosis of SCLC

Median waiting time to receive a diagnosis of SCLC from pathologists was 5.5 days, with a median class range of 5 to 7 days

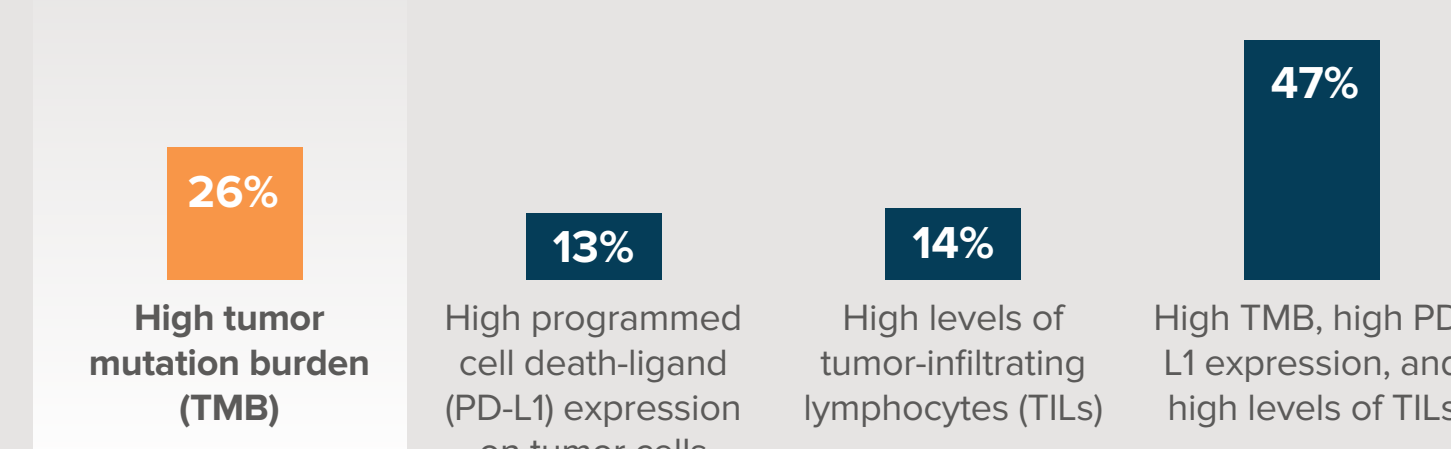
On average, how long does it take to receive a diagnosis of SCLC from the pathologist in your practice or institution?



Knowledge of the Rationale for Using ICIs in SCLC

Approximately 74% did not know the rationale for using ICIs in SCLC

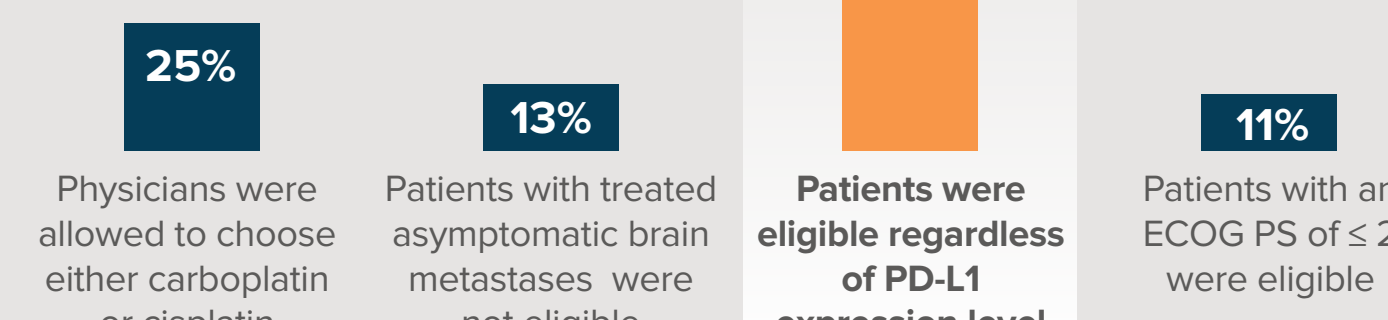
Which of the following best describes the rationale for using ICIs in patients with SCLC?



Knowledge of Phase 3 Clinical Trial Data With ICIs for ES-SCLC

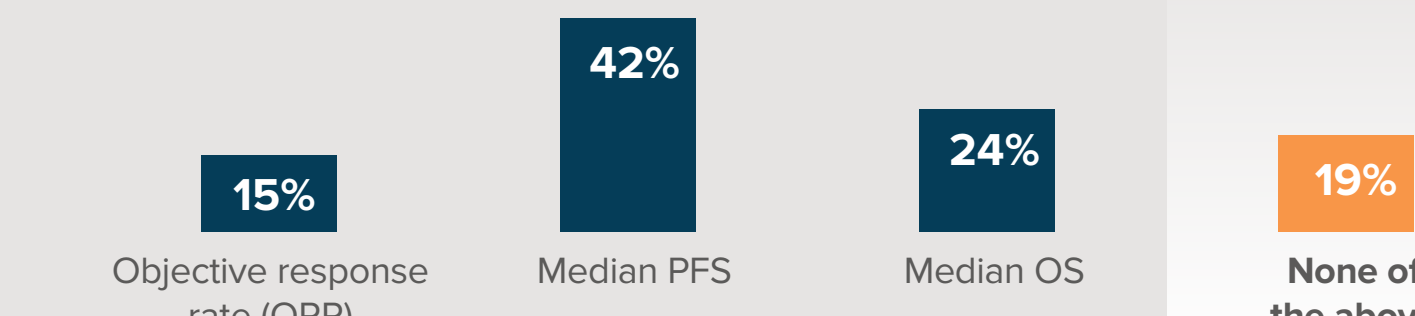
Approximately 49% lacked knowledge of the phase 3 trial designs for first-line ICIs

The phase 3 IMpower133 (atezolizumab) and CASPIAN (durvalumab/tremelimumab) trials investigated the addition of ICIs to first-line platinum-based chemotherapy in patients with ES-SCLC. Both study designs included which of the following?

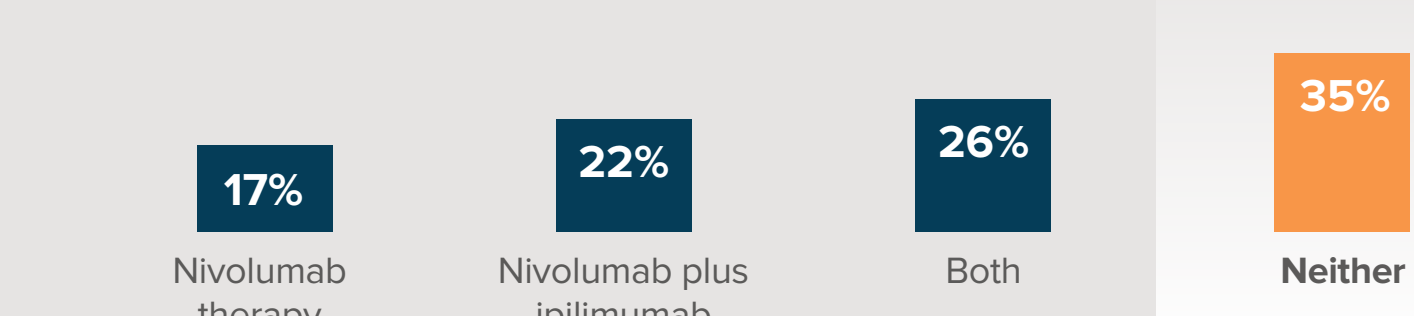


Between 50% and 80% answered various questions incorrectly regarding clinical data with ICIs for SCLC

Participants lacked knowledge of second-line nivolumab data for recurrent SCLC... In the CheckMate 331 trial of patients with recurrent SCLC after first-line platinum-based chemotherapy, second-line nivolumab monotherapy significantly improved which of the following outcomes compared with chemotherapy?

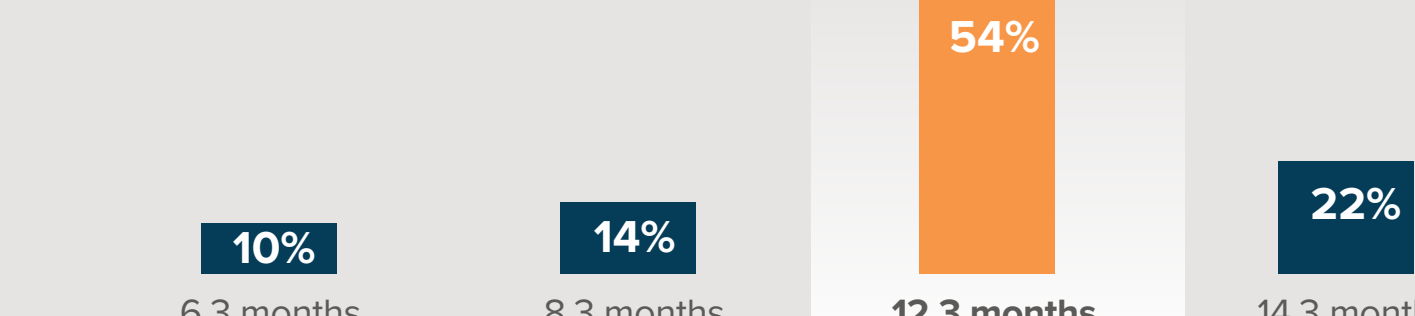


...as well as data for nivolumab maintenance in patients with ES-SCLC who did not progress on first-line chemotherapy. In the CheckMate 451 trial investigating nivolumab and ipilimumab as maintenance therapy in patients with ES-SCLC who did not progress on first-line platinum-based chemotherapy, which of the following significantly improved median OS compared with placebo?



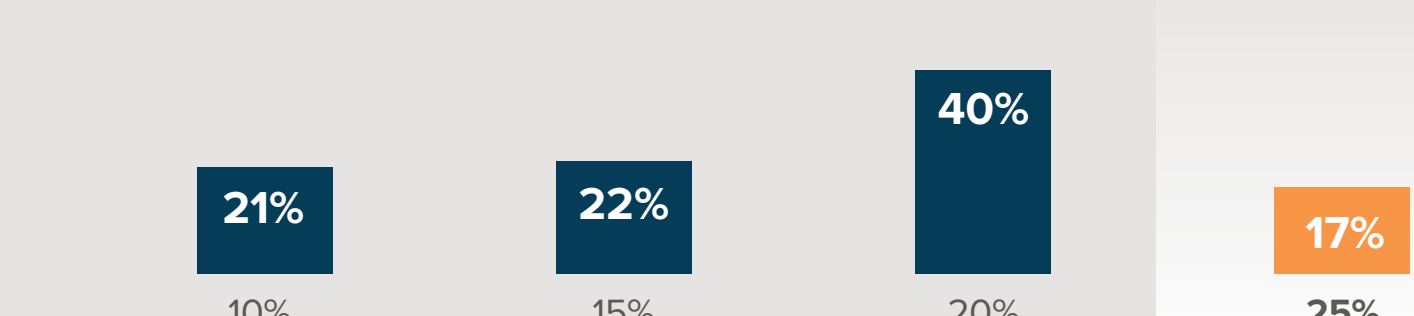
Only approx. 40% identified the median OS provided by atezolizumab + chemotherapy in the IMpower133 trial for front-line ES-SCLC

Based on data from the IMpower133 trial, the addition of atezolizumab to primary chemotherapy resulted in a median OS of which of the following in patients with ES-SCLC?



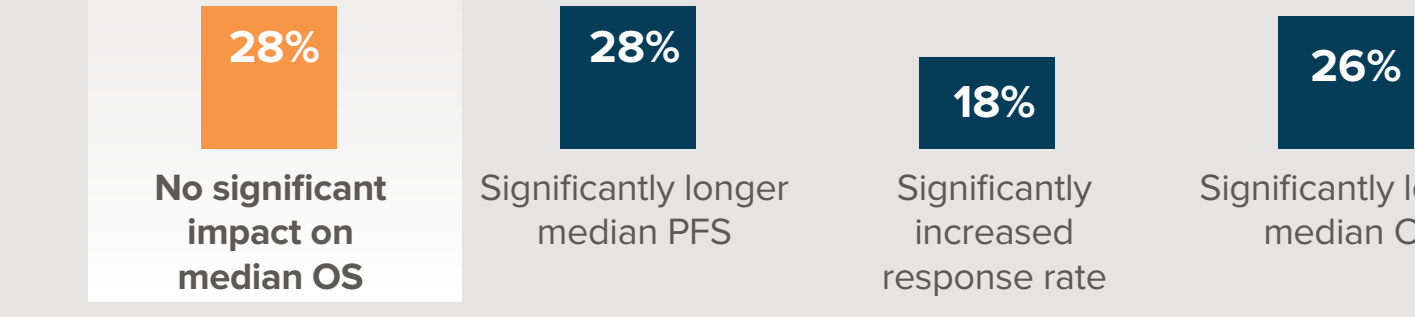
Participants struggled to identify the efficacy benefit with durvalumab + chemotherapy in the CASPIAN trial for front-line ES-SCLC

In the CASPIAN trial, adding durvalumab to first-line chemotherapy reduced the risk of death by how much compared with chemotherapy alone in patients with ES-SCLC?



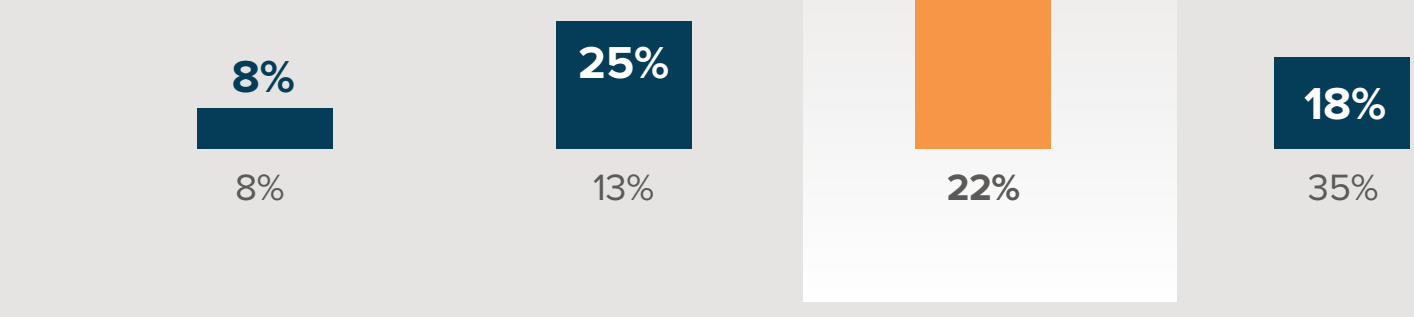
Participants did not recognize that adding durvalumab + tremelimumab to front-line chemotherapy did not improve survival

In the CASPIAN trial, the addition of both durvalumab and tremelimumab to first-line platinum-based chemotherapy demonstrated which of the following outcomes compared with chemotherapy alone?



Only approximately 45% were aware of the 2-year OS rate for front-line ICI therapy in the IMpower133 and CASPIAN trials

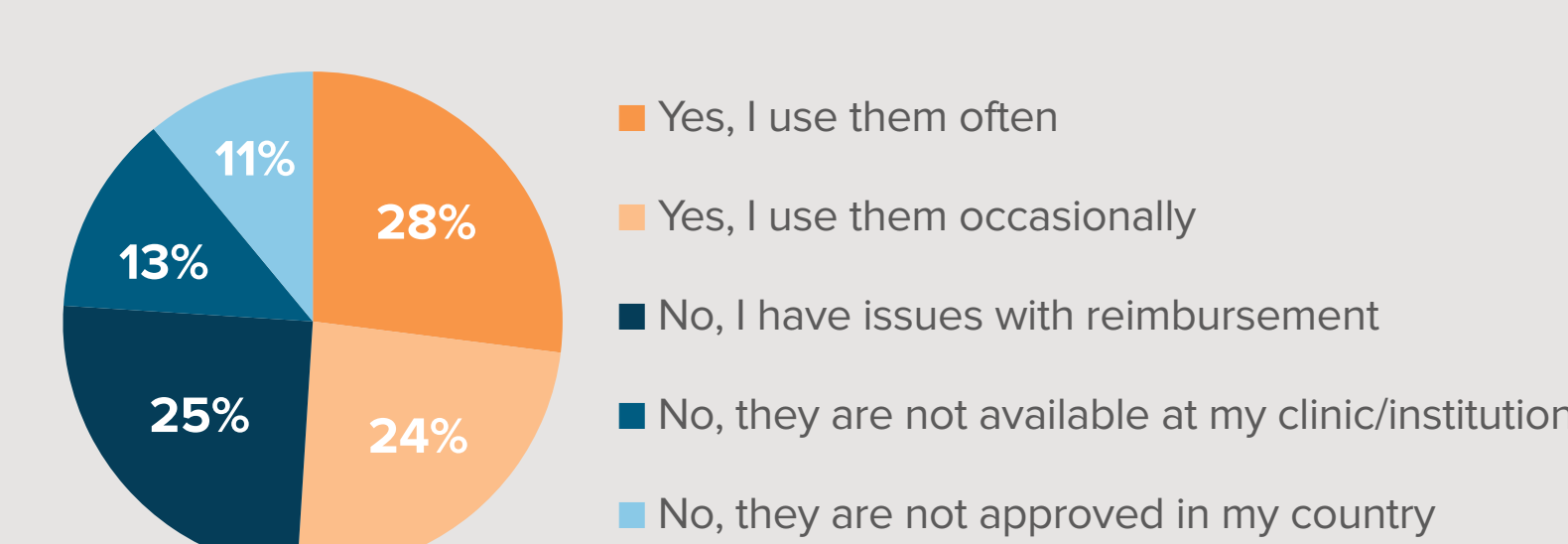
Among patients receiving ICI therapy in the IMpower133 and CASPIAN trials, the 2-year overall survival (OS) rate was:



Practical Application of ICIs for ES-SCLC

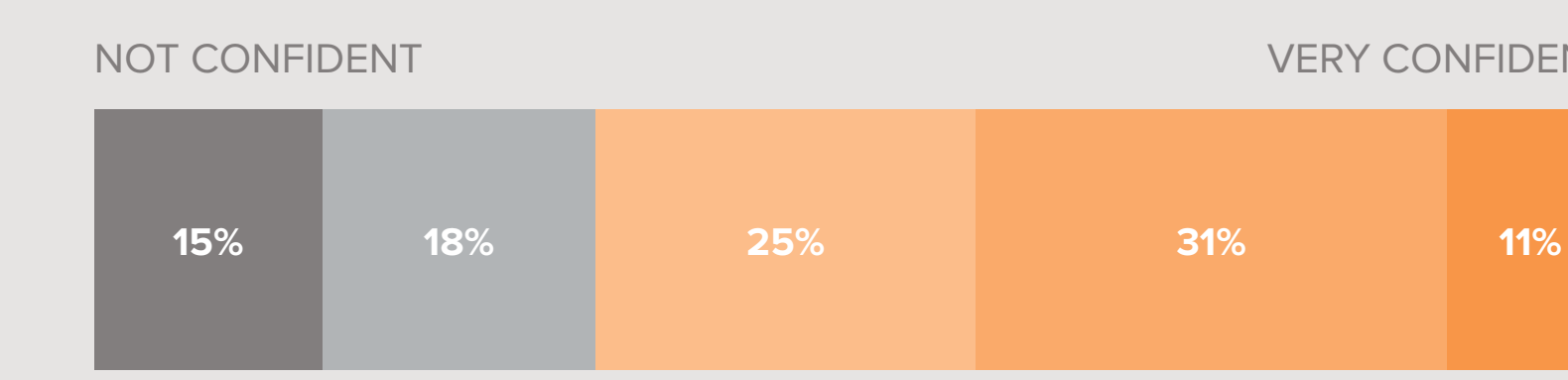
Only 28% used ICI regimens often in the treatment of their patients with ES-SCLC

Do you currently use ICIs in the treatment of your patients with ES-SCLC?



Only 42% were moderately/very confident in selecting and applying a front-line ICI regimen for ES-SCLC

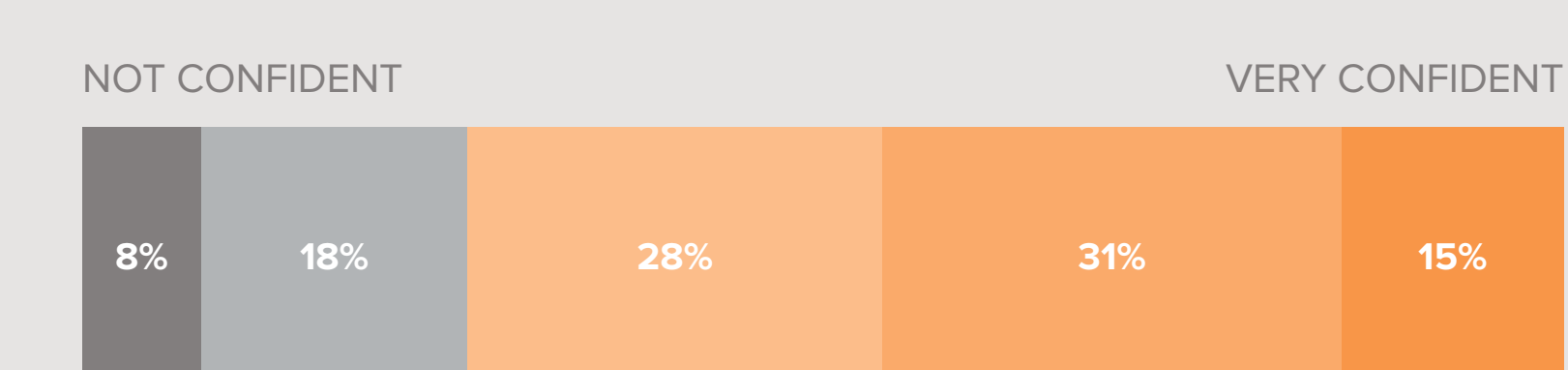
How confident are you right now regarding your ability to select and apply an ICI regimen for the front-line treatment of patients with ES-SCLC? (Select ranking from 1 [not confident] to 5 [very confident])



About 44% were not aware that irAEs are rare in patients with ES-SCLC and differ from events associated with chemotherapy

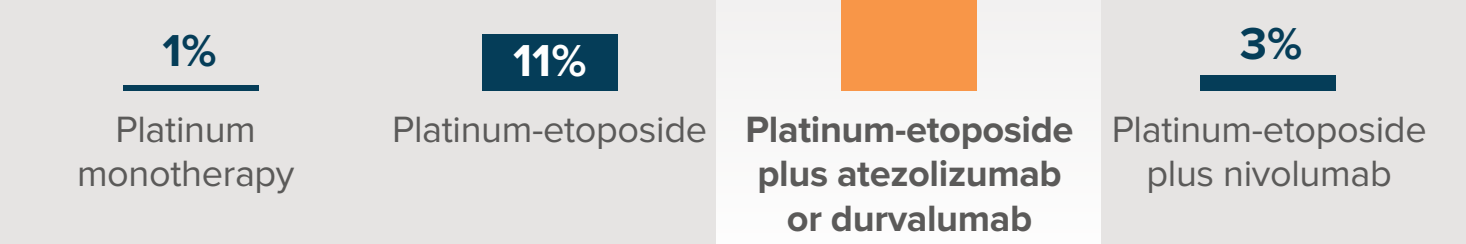
Only 46% were moderately/very confident in managing immune-related adverse events (irAEs) associated with ICIs

How confident are you right now regarding your ability to effectively manage irAEs associated with ICI regimens? (Select ranking from 1 [not confident] to 5 [very confident])



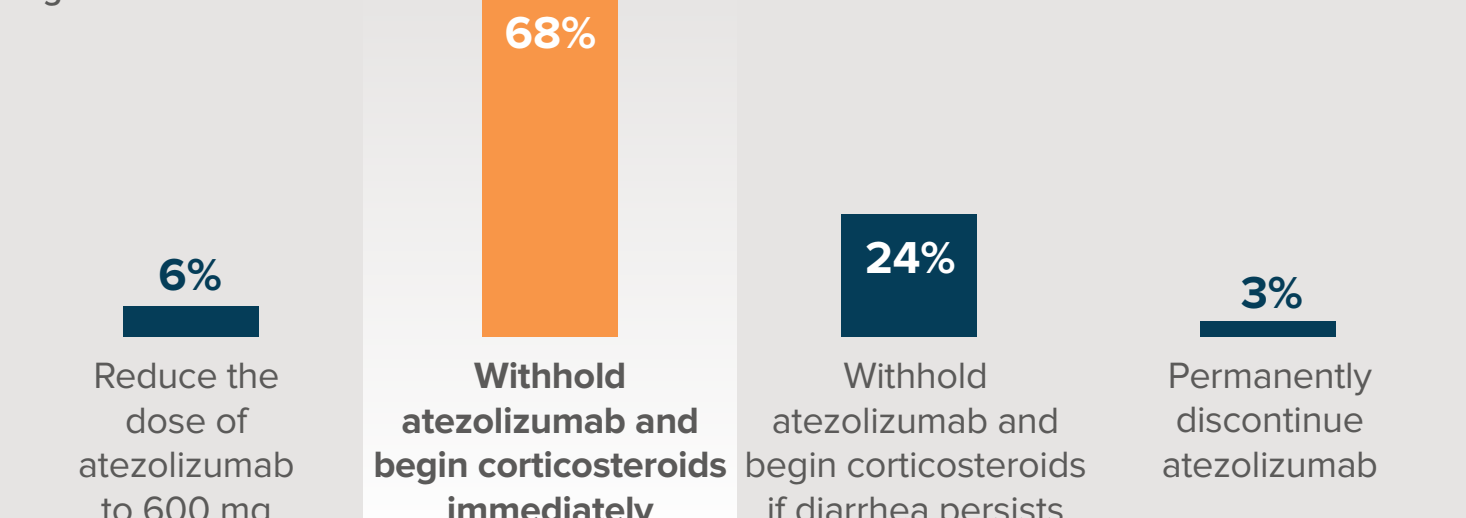
The majority (85%) identified the correct ICI-based treatment for front-line management of ES-SCLC

A 71-year-old man with a 35 pack-year smoking history and chronic obstructive pulmonary disease (COPD) presents with worsening cough and severe dyspnea. Chest radiograph and positron emission tomography (PET)/computed tomography (CT) confirm a large mass in the right lung with bulky hilar and mediastinal node involvement and 2 bone metastases. A transbronchial biopsy confirms SCLC. Brain magnetic resonance imaging (MRI) is negative. Based on current clinical trial data and regulatory approvals, which of the following options would you recommend as initial therapy?



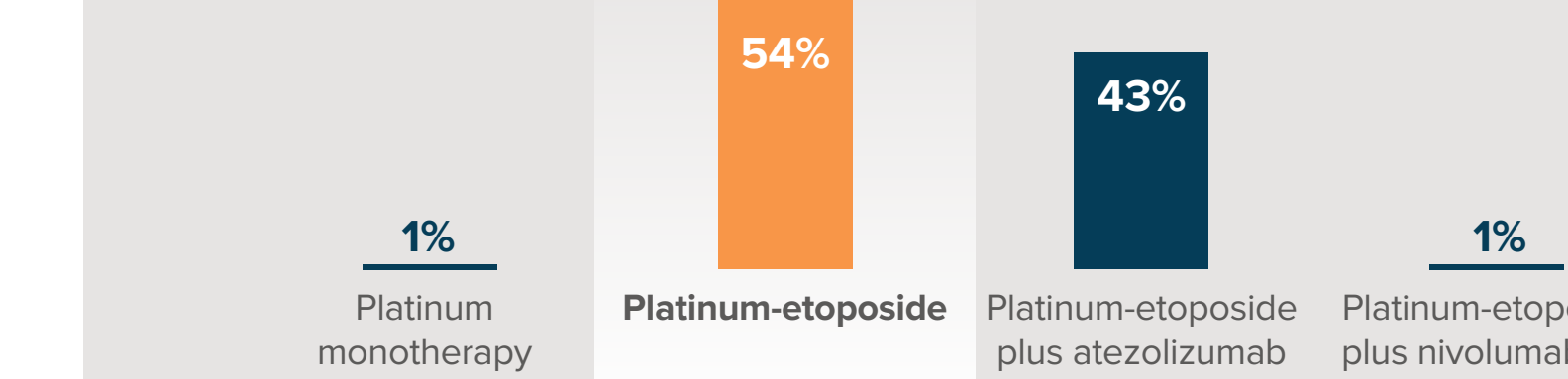
About 32% struggled to identify the correct approach to AE management following first-line ICIs

A 74-year-old man is diagnosed with ES-SCLC with bone and liver metastases and begins first-line therapy with carboplatin-etoposide plus atezolizumab (1200 mg on day 1 of each cycle). After his first cycle of therapy, he reports worsening diarrhea with small amounts of blood in his stool and abdominal pain. He comes into the clinic the next day and indicates that he is now having approximately 8 bowel movements per day (compared with a baseline of 1 bowel movement/day). Infectious workup of his stool culture is negative. In addition to fluids and anti-diarrheal medication, what would you recommend based on current ESMO guidelines?



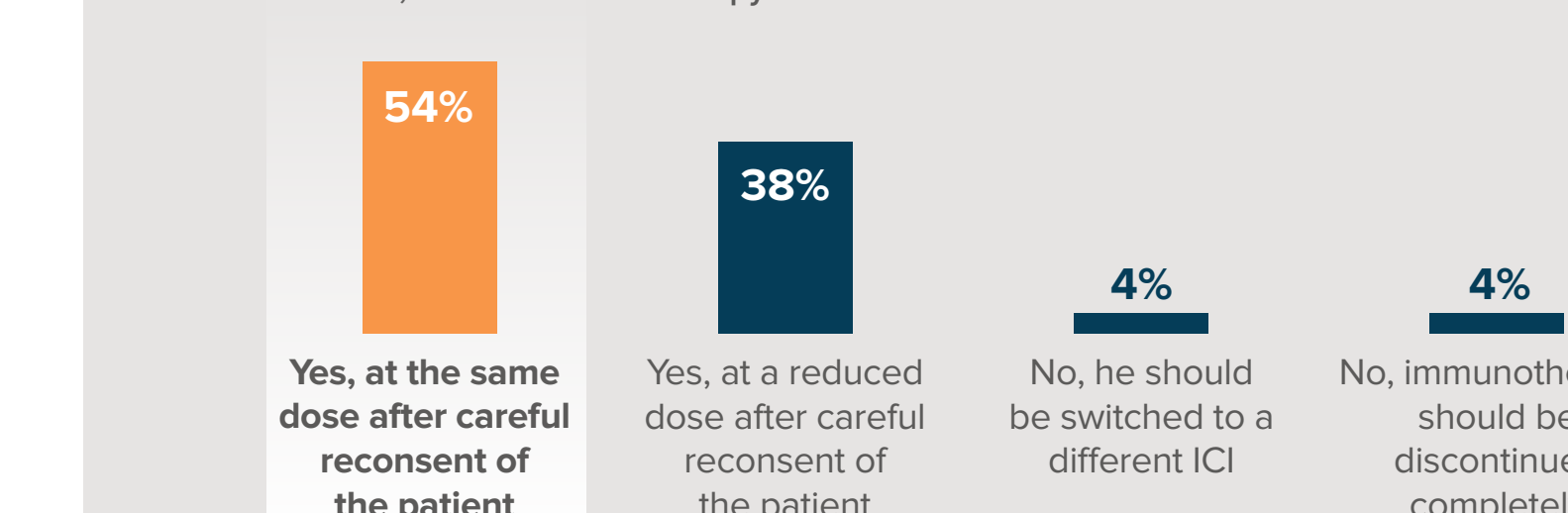
About 46% struggled to identify the correct treatment for a patient who had a clinically relevant autoimmune disorder, and an ICI was not the optimal choice

A 63-year-old woman with a heavy smoking history presents with severe cough and chest pain. Her medical history includes stage 3 active rheumatoid arthritis and well-controlled hypertension. Chest radiograph and PET/CT confirm a large central mass and multiple liver metastases. Biopsy of the liver lesions confirms a diagnosis of SCLC and brain MRI is negative. Based on current clinical trial data and regulatory approvals, which of the following options would you recommend as initial therapy?



About 46% did not choose the correct re-initiation of ICI therapy after toxicity was managed appropriately

A 53-year-old man with a heavy smoking history and hypertension is diagnosed with ES-SCLC with metastases to the liver and bone. Assessment of organ function at baseline is within normal limits and he begins first-line therapy with carboplatin, etoposide, and an ICI. Four weeks into treatment his alanine aminotransferase (ALT) levels are 4 times the upper limit of normal (ULN) and his blood bilirubin is 2 times the ULN. ICI therapy is withheld and corticosteroids are administered. Liver function tests return to normal within 4 weeks and his steroid therapy is tapered and is now 10 mg prednisone per day. Based on current recommendations, can his immunotherapy be reinitiated?



CONCLUSION

The findings reveal important knowledge, competence and confidence gaps amongst oncologists who manage ES-SCLC. These focus on the rationale for ICIs, clinical data, individualizing treatment and the optimal management of irAEs. Addressing these gaps is required to improve the management of patients with ES-SCLC with ICI-based therapy.



ACKNOWLEDGMENTS

The educational activity was supported by an independent educational grant from Roche.

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Dr Harvey-Jones has no conflicts of interest to declare.

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