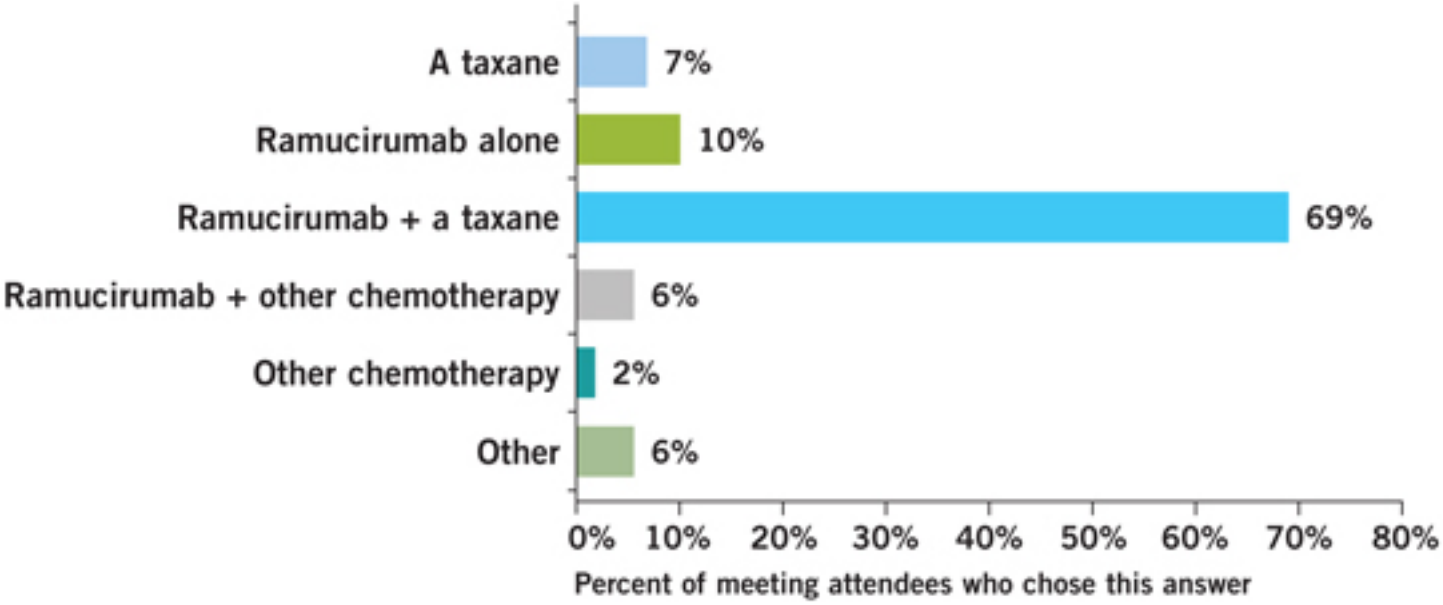
Year in Review

Proceedings from a Multitumor CME Symposium Focused on the Application of Emerging Research Information to the Care of Patients with Common Cancers

Emerging Data in the Management of Noncolorectal GI Cancers — Johanna C Bendell, MD

A 60-year-old patient with metastatic HER2-negative gastric cancer receives FOLFOX with initial stable disease but experiences disease progression after 8 months. Which systemic treatment would you prefer to use?



DR LOVE: Johanna, we asked a very common situation. The patient's 60 years old, metastatic, HER2-negative gastric cancer, gets FOLFOX, stable disease, then progression at 8 months. What's next? It looks like the audience is pretty strongly oriented towars giving taxane and ramucirumab. Johanna, how do you think that one through?

DR BENDELL: I think that just shows how quickly good data picks up in the community. When we had not a lot of good treatment options for our patients for second line and, all of the sudden, this one emerged, it was picked up very fast. That's great.

DR LOVE: I was reflecting, Axel, on the fact that there's actually very similar data in lung cancer with ramucirumab. But so far people haven't reacted to it. Any thoughts about that and, also, the whole process of trying to integrate this kind of trial data into your decision-making? We've had the data on this for a couple of years. Lung is just a few months. I wonder if it takes a while for people to think it through.

DR GROTHEY: I think it reflects the perception of an unmet need. We really didn't have any clear second-line therapy in gastric cancer. We did have data on second-line therapy in lung cancer for quite some time.

DR LOVE: Right, the checkpoint inhibitors, particularly.

DR GROTHEY: Exactly. There's a lot of positive data. Even docetaxel had positive data in second line initially. There was a paucity of really accepted second-line treatment options. A trial comes around with a good design, ramucirumab/taxane versus taxane alone, and shows benefit, with a hazard ratio of 0.81. I think people embrace it. The timing was right. We didn't have any second-line therapy — unmet need. I think it adds to the credibility of ramucirumab, that it's approved in three cancers; colon cancer, lung cancer and gastric cancer.

DR LOVE: Johanna, I see here that 10% of the audience said, "Ramucirumab alone." We do have data on that. It definitely is an effective strategy. Is that a strategy you use and, if so, in what situations?

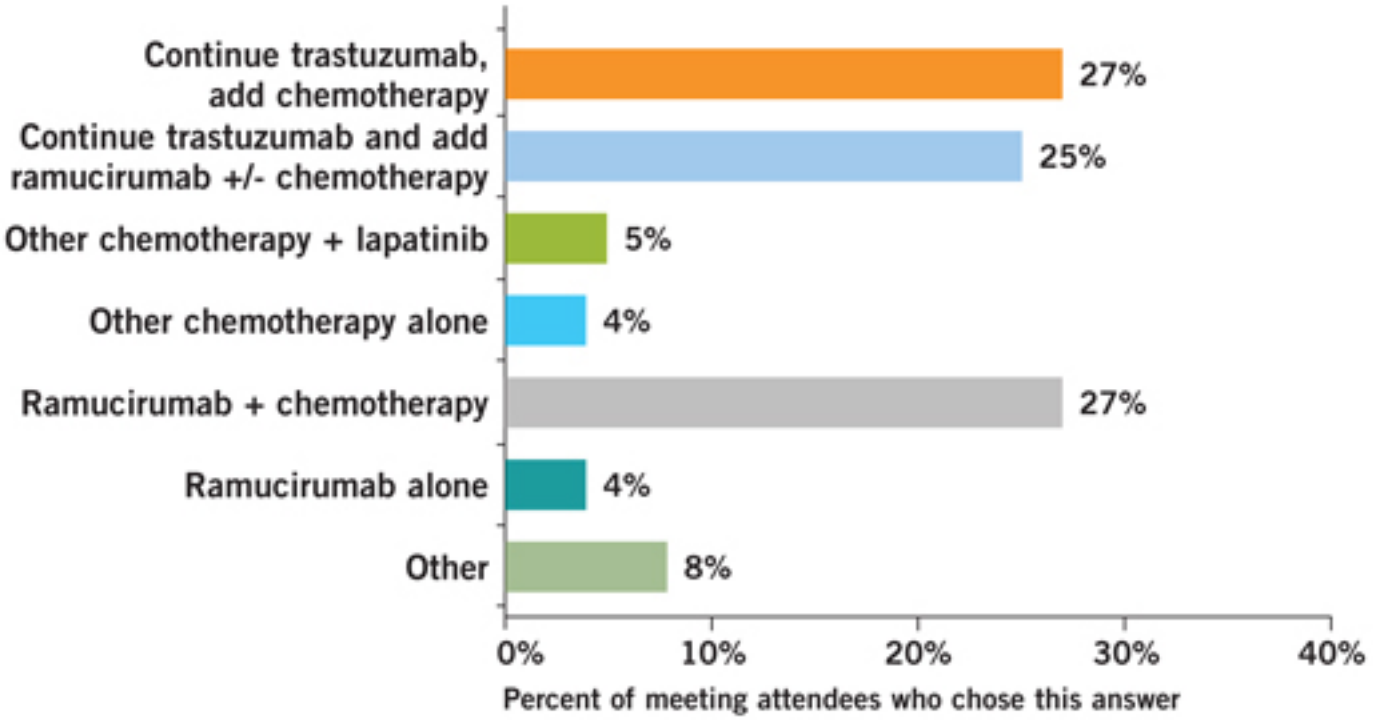
DR BENDELL: Occasionally, yes. I think if somebody has had a taxane in previous therapy, I might use ramucirumab alone. If I worry about somebody's tolerance of the chemotherapy, that maybe they couldn't handle weekly paclitaxel, that's a pretty good drug. It's not very, very toxic. But ramucirumab alone is very viable and a reasonable option.

DR LOVE: What about ramucirumab with another type of chemotherapy, Johanna, another taxane or even a nontaxane?

DR BENDELL: That's where I might hold myself a little bit more. I mean, we've seen randomized Phase II data looking at ramucirumab. You guys were involved very heavily in this clinical trial with FOLFOX plus or minus ramucirumab in the first-line setting. What we saw from this study was that we did not see a benefit to ramucirumab for these patients.

Now is that a chemotherapy issue? Was it a line-of-therapy issue? Was it an issue with the types of patients that were treated on the study? We don't know right yet. But I don't know that I would include ramucirumab with something besides a taxane yet.

A 60-year-old patient with metastatic HER2-positive gastric cancer receives FOLFOX/trastuzumab for 5 months with a partial response. After 1 year he experiences objective disease progression while receiving maintenance trastuzumab. What would you most likely recommend?



DR LOVE: Axel, I'm always fascinated by how people ask questions. Many of these, we've asked for years. We can really get a feel for how it changes. And this thing's changing, which is second-line therapy of HER2-positive gastric cancer. Granted, it's not that common.

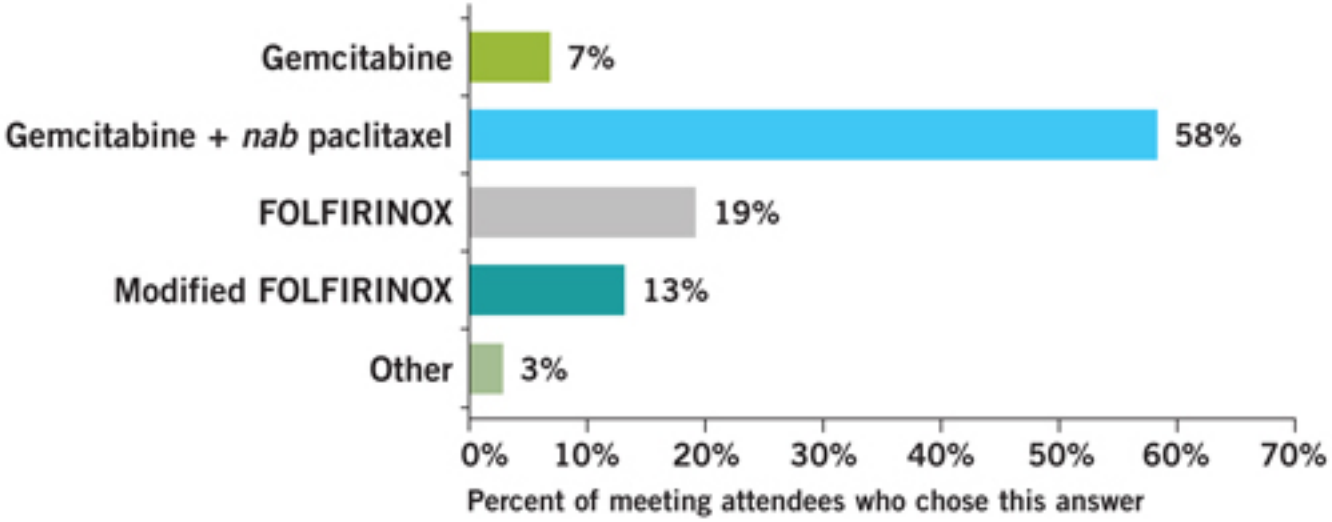
But we presented a scenario of a patient, gets FOLFOX/trastuzumab, PR, then has disease progression. And the question of: Are we going to bring in the breast cancer paradigm and keep anti-HER therapy, trastuzumab, continuing? Looks like most of the audience would. I don't think I've seen more data, but just people are starting to do it. Are you doing it?

DR GROTHEY: I would, in this setting, probably vote for continuing trastuzumab. That's something that has evolved over time. In this particular case, I voted for trastuzumab. Because this patient had a long-lasting benefit from trastuzumab, from HER2 inhibition, that's why I voted for continuation of trastuzumab. I think ramucirumab/chemotherapy is perfectly fine. The RAINBOW study allowed patients with HER2-positive disease to get on. So we have data on that. I think the audience really reflects what can be done.

DR LOVE: I have all the answers of the faculty for all three meetings. And I see that only two people actually picked ramucirumab and chemo, and it was Charlie Fuchs and you, Johanna. You must have similar mindsets. But what is your thinking? It sounds like you're not too excited about keeping HER2 therapy going.

DR BENDELL: I was Charlie Fuchs' fellow. I have to answer with Charlie. What I noticed is that he had progression while receiving maintenance single-agent trastuzumab. So that was my argument in saying, "Well, maybe we need to switch to something different." To be honest with you, I think at least from the data that we have, both answers are right. I think you could do either/or.

Which first-line systemic therapy would you generally recommend for an otherwise healthy 70-year-old patient with metastatic pancreatic cancer?



DR LOVE: We asked a pretty straightforward situation in a 70-year-old patient, metastatic pancreatic cancer. We see that the most common answer is gem/*nab*. I see both our faculty gave that same answer, and most of the other faculty we've had before. How do you think this one through, Johanna? At what age do you start thinking about FOLFIRINOX?

DR BENDELL: Not to be an ageist, but 70 years old, I start to think, "Okay. What does this patient look like? Does he look like a 70-year-old 70-year-old? Do they look like an 80-year-old 70-year-old? Or do you look like a 60-year-old 70-year-old?" And that might influence my choice too.

The other thing that'll influence my choice is how symptomatic the patient is from their disease. Do I need a bigger response rate potentially? That might be something that I would use a modified FOLFIRINOX for. Without all those other details, that's why I picked gem/*nab*. There's no data or nothing in the question that they're really symptomatic from their disease, so I think gem/*nab* is reasonable.

In a randomized Phase II study evaluating capecitabine with or without ruxolitinib as second-line treatment for patients with metastatic pancreatic cancer, patients with elevated C-reactive protein who received the combination...