CECOG ACADEMY

1st TIGER Tumorboard, June 11th, 2018

Participants:

CECOG: Christoph Zielinski (Host)

Christiane Thallinger

Barbara Schaljo – Kapp

Ursula Fischer

Fabian Fischer

Bosnia: Emina Bicakcic

Croatia: Luka Simetic

Greece: George Penthedourakis, Davide Mauri

Hungary: Zsuzsanna Kahan, Gabriella Fabian, Laszlo Torday

Poland: Anna Wrona (Site Jassem), Dawid Sigorski (Site Krzakowski)

Romania: Rodica Anghel, Laurentia Nicoletta Gales, Tudor Ciuleanu, Adelina Dan

Serbia: Lazar Popovic

Slovakia: Peter Berzinec

Slovenia: Tanja Cufer, Urska Janzic

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Case CC-_2018_0031

Presented by Emina Bicakcic, Bosnia

Date of birth: 01/1965

Ethnic origin: white/Caucasian

Sex: male

Diagnosis: Malignant melanoma regio femoris l. sin. et regio scapularis lat. dex. melanoma metastaticum hepatis et pulmonis.

Patient was talking to doctors in Turkey and they recommended because of his bone metastasis – Zoledronic acid.

Q1: Are there problems with the combination of Pembrolizumab and Zoledronic acid?

Discussion: CC.Zielinski and T.Cufer: Both are not aware of any problems with this combination. They recommended using both agents.

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Case CC_2018_0025

Presented by Urska Janzic, Slovenia

Date of birth: 10/1965

Ethnic origin: white/Caucasian

Sex: male

Diagnosis: NSCLC (adenocarcinoma)

Previous therapy: Cisplatin/Pemetrexed, Pembrolizumab

The patient had a history of psoriasis that was never treated with systemic therapy. 10 months after immunotherapy initiation, a G3 psoriasis-like rash developed. Immunotherapy was discontinued and he was treated with glucocorticoids. The rash gradually reduced but did not disappear, nor could he end treatment with glucocorticoids, hence immunotherapy was ended. 6 months after treatment stop, he is in excellent condition, with only 1 metastasis (in right psoas) growing.

Q1: What sort of treatment should be applied next (local treatment of only viable lesion / systemic therapy)?

Q2: Would you recommend restarting treatment with immunotherapy and continue the use of steroids for psoriasis-like rash?

Recommendation: Hyperfractionated radiotherapy, continuation of immunotherapy with Pembrolizumab until systemic progression than starting with chemotherapy

Psoriasis: Biopsy was done of many different lesions on the skin -- dosing of corticosteroid

Suggestion of Zielinski: Corticosteroide 1mg/kg / Wrona: Hyperfractionated radiotherapy, 25 Gy: measure the volume and go as high as possible

Comment from the dermatologist: Oral steroids are contraindicated to treat psoriasis. Oral steroids are only indicated to treat psoriasis arthritis. Psoriasis-like rash is different from psoriasis and very uncommon during treatment with Pembrolizumab, treatment with oral steroids is recommended with starting dose of 1mg/kg BW. However, Pembrolizumab has the potential to activate a pre-existing psoriasis.

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CASE CC_2018_0039

Presented by Laurentia Nicoletta Gales, Romania

Date of birth: 04/1948

Ethnic origin: white/Caucasian

Sex: female

Diagnosis: NSCLC (squamous cell G2) stage IV right inferior lobe

Previous therapy: Gemcitabine + carboplatin

The patient is suffering from bladder cancer and was repeatedly operated.

HP report was urothelium carcinoma. She was treated with local intravesical BCG instillations.

The patient is a smoker. After bladder cancer, she had regular follow-up visits with cystoscopy and CT scans.

9/2017 CT scan reveals a lung tumor with mediastinal lymph nodes and adrenal metastasis.

Bronchoscopy with biopsy revealed a squamous cell lung cancer G2.

The patient has significant cardiac comorbidity.

5/2018 CT scan showed 17% progression.

Q1: What should be the next treatment? Should we start immunotherapy? If we could choose between Nivolumab and Pembrolizumab, what would you recommend? Pembrolizumab will be available in a month – should we wait?

Recommendation: Local therapy; patient not qualified for surgery, rather radiotherapy (depends on tumor volume) than radical surgery (Anna Wrona)

After local therapy, start with immunotherapy

T.Cufer: If PD L1 expression is low, combination of chemotherapy plus immunotherapy should be started.

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CASE CC_2018_0033

Presented by Daniela Sirbu, Romania

Date of birth: 11/1964

Ethnic origin: white/Caucasian

Sex: female

Diagnosis: Melanoma with lymph node metastasis (left axillary lymph node conglomerate, left infraclavicular lymph node) with unknown primary, all lesions surgically removed

Patient is now tumor free.

Q1: What would be your treatment recommendation for this patient knowing that BRAF is mutated but not elevated?

Zielinski: Is a BRAF inhibitor in adjuvant setting available in Romania.

Answer: it is not, and Immuno therapy is not covered by the National Insurance Company.

Recommendation: Considering the limitations of drug availability, Interferon is the only option and should be initiated

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CASE CC_2018_0036

Presented by D Mauri, Greece

Date of birth: 12/1954

Ethnic origin: white/Caucasian

Sex: male

Diagnosis: NSCLC (adenocarcinoma)

Previous therapy: Pemetrexed 800mg, Nivolumab 200mg

Nivolumab-induced hypothyroidism and selective pituitary insufficiency

He tolerated immunotherapy but after the 11th cycle the patient became worse.

Nivolumab was stopped. Patient has developed hypothyroidism.

There is no clinical question

Zielinski: How will you proceed with the immune checkpoint Inhibitor?

Mauri: As the patient is stable at the moment, we will not do any intervention currently.

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CASE CC_2018_0035

Presented by Zsuzsanna Kahan, Hungary

Date of birth: 05/1953

Ethnic origin: white/Caucasian

Sex: male

Diagnosis: Bladder carcinoma stage IV

Previous therapy weekly platinum 30 mg/m2

Previously TUR interventions were performed and chemo-radiotherapy with a dose of

33x1.8 Gy was delivered. Routine follow-up examination revealed multiple metastases (lung, liver and bone). Since December 2017 the patient notices cough and minor dyspnea. He has lost 6 kg, and physical activity deteriorated slightly, however, ECOG: 0.

Recommendation: Optional: Initiation of chemotherapy combined with immunotherapy (inclusion of the patient in an ongoing trial, if available).

If there is no clinical trial, cisplatin-based chemotherapy should be started.

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CASE CC_2018_0037

Presented by Luka Simetic, Croatia

Date of birth: 03/1941

Ethnic origin: white/Caucasian

Sex: female

Diagnosis: metastatic melanoma

Previous therapy: Radiotherapy: right foot, intransit metastasis

Chemotherapy/targeted therapy: Dacarbazine, Pembrolizumab

Now the patient is in a F/U program in good performance status and immunotherapy was stopped.

Q1: How can we detect progression? Are side effects signs of progression?

Zielinski: No, side effects are not really related to progression

Recommendation: As the next PET-CT will be performed in August 2018; continuation of immune therapy until relapse or progression.

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CASE CC_2018_0038

Presented by Anna Wrona (Poland, site Jassem)

Date of birth: 04/1951

Ethnic origin: white/Caucasian

Sex: male

Diagnosis: Metastatic NSCLC (adenocarcinoma)

Previous therapy: Pem/Cis, PDR001 (anti-PD-1 antibody, administered within the frame of a clinical trial CPDR001X2101)

First, the patient was enrolled in a clinical trial, but was randomized to the control arm with chemotherapy. After PD with metastases in the adrenal grand and in retroperitoneal lymph nodes, the patient received PDR001 (see above)

After two cycles, a major response was seen and the patient is still on treatment with PDR001.

Q1: Should PDR001 be continued?

Recommendation: Continuation of treatment with PDR001 underlining the importance of clinical trials.