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# Before the Scalpel: Identifying Candidates for Perioperative Immunotherapy

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You're listening to GLC on ReachMD. This activity, titled **"Talking Through Treatment: Patient–Clinician Dialogue on Perioperative Immunotherapy in Locally Advanced head and neck squamous cell carcinoma"** is provided by **Global Learning Collaborative**.

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**Dr. Luginbuhl:**
This is CE on ReachMD. And I'm Dr. Adam Luginbuhl. Today I'll share my thoughts on identifying eligible patients for locally advanced head and neck cancer for perioperative immunotherapy. Recent publication in *New England Journal of Medicine*, looking at neoadjuvant and adjuvant immunotherapy, pembrolizumab in locally advanced disease has recently been FDA approved. So I'd like to start off by really focusing on what was the purpose of the trial, the KEYNOTE trial, and patient counseling.

So the thought was, okay, if we can prime the immune system ahead of time before we actually operate, can we get an advantage? So the trial was not designed to look at this being a cytoreductive technique, but more so can it provide that immune sensitization. This is not a recommendation that a patient can avoid surgery or reduce the operative approach.

It's really, as you counsel your patients, it's looking at talking about biology and how biology can be used to our advantage before we operate. Identifying that patient is really the first step. So the identification of the patient, really. Five things. One. Previously untreated head and neck cancer. Two. Is it stage three and stage four? Three. Are they lacking comorbidities such as autoimmune disorders, infectious disease, transplants? Number four, the CPS score, or the PD-L1. To be approved, it does have to be over 1, which is the vast majority of patients.

The final thing to mention is that I think is sometimes the most nuanced and challenging and why it's so important to have that partnership is it has to be resectable. There's been a number of times where this has been rolled out by a colleague of mine in medical oncology. Patient shows up in my office having already received immunotherapy and essentially having an unresectable tumor or borderline resectable tumor.

And so I think that resectability is critical to establish before we start giving the drug and before we start thinking about this as a strategy to employ and that resectability is so important.

The surgical timing is the next thing I'd like to talk through and just review. This is critical. Surgeons, we are super protective of our OR time, and this is really scary for us to think that we're gonna drop a patient off a medical oncology and hope they come back and hope the timing works out. I can't stress enough that this is not a drop off technique. This is definitely a co-management technique. So whether you're a medical oncologist in your same institution or even out in the community, you have to truly co-manage these patients.

So let's talk about co-management. It's a really critical part of this as we look at a new paradigm shift. What does it mean and how do I employ it? So first it's getting that CPS score, getting the PD-L1 stained ASAP. If your institution does it, great, if you have to send it out, no problem.

Work out that workflow based on your own home institution. Getting that drug within two weeks of seeing the patient is critical, 'cause there's a six week period of time where they're getting treatment neoadjuvantly and then surgery happens. The final thing I'll say about that is having that critical interim analysis at three weeks before the second dose.

Three important things happen there. One, you identify any adverse events. Two, you make sure your patient's properly consented. You have an OR date, you have a recon team. Everything's ready for surgery. You're not trying to backpedal at the end trying to say, where did this patient go? What happened? Why am I so far behind?

And then three, you're assessing the tumor to catch any possibility of hyper progression. It's rare, but it's real, and you have to be watching for it. And the surgeon can somehow have that nuance of saying, you know what? We're not gonna do the second dose, we're going right to the operating room. Again, a rare phenomenon, but definitely a real one, and you have to be ready to confront that.

So implementing this KEYNOTE-689 in summary. First, understanding the intent of the paradigm shift, knowing how to talk to your patients about it, understanding how important the CPS score and the PD-L1 score is to get as soon as you can. Having that communication with your medical oncologist, wherever they might be, local to the patient, local to you, that's not as important as having the communication.

And finally, and most importantly, making sure that patient is a co-managed patient, not someone you drop off at medical oncology and then they drop back to you at the end. I think those are the key things I'd like to share with you. My time is up. I hope you have found this brief overview helpful. And again, thanks for listening.

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