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Building the Team: Integrating Immunotherapy Into Multidisciplinary Care

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Dr. Le Tourneau:
Welcome to CE with GLC. I am Dr. Christophe Le Tourneau. Here with me today is Dr. Marc Oliva. Hi, Marc.

Dr. Oliva:
Hello.

Dr. Le Tourneau:
Let's take some time to discuss how we can incorporate perioperative immune checkpoint inhibitors into the treatment paradigm for locally advanced head and neck cancer.

So, Dr. Oliva, how do you and your team integrate immunotherapy into multidisciplinary care?

Dr. Oliva:
Yeah, I think that's a very interesting question. I think we are all still working on that. There are several parts and restructures that we have to take in mind before placing immunotherapy in the locally advanced setting.

And the first, for example, is when to do the PD-L1 testing. PD-L1 testing in the locally advanced setting, it's not standard. As you know, it's used for the treatment decision in the recurrent setting until now. But because the KEYNOTE-689 led to the approval of pembrolizumab in CPS at least 1 or above, then we need to implement the PD-L1 testing in the daily practice. And we have to decide whether we do that as a reflex, meaning that all patients diagnosed with a locally or locoregionally advanced head and neck squamous cell carcinoma that is resectable just do the testing, or we just requested it after the tumor board decision or once the surgeon knows whether that patient may be a potential candidate for immunotherapy.

And that, it's actually an important matter as the timing here; it's important. We are treating these patients with curative intent. We don't want to delay surgery, and therefore we need to make the diagnosis and decide whether that patient is a candidate or not as soon as possible.

And that leads me to the second, also, issue, which is when to present that patient at the tumor board and when to refer him to the medical oncology team in order to evaluate whether he's actually able to receive the immunotherapy, perhaps due to a performance

status, comorbidities that contraindicate, and so forth.

Ideally, I would recommend to do an early referral to medical oncology by the surgeon once the patient is identified as a potential candidate in order to have an early evaluation and then an early presentation at the tumor board by both the medical oncologist and the surgeon to decide whether that patient is a potential candidate for immunotherapy.

Other things that are important, I think the cross talks between the surgeon and medical oncology team will need to be strengthened, and that's because we have risk of having immune-related AEs during immunotherapy, so early on detection by the medical oncologist during the neoadjuvant portion is critical. But also we need to identify those patients that potentially are progressing to immunotherapy or that may develop complications related to that progression during the neoadjuvant treatment. And for that, the surgical view and evaluation during the neoadjuvant treatment is going to be crucial.

We also need to decide the timing of the adjuvant approach, and that will basically depend on the pathological response assessment and also the radiological response assessment. So we need to implement a radiological or at least discuss if we want to implement a radiological evaluation prior to surgery, especially in those patients that are borderline resectable or that are suspected to be progressing.

And regarding the pathology, the pathological response assessment is also important to consider that this evaluation is not standard yet in head and neck squamous cell carcinoma. It has become standard in other tumors like melanoma or lung cancer, but definitely we will need to implement guidelines for the pathological response assessment, and obviously that will require training by pathologists and will require also more time by the pathologists to do that post-treatment assessment and decide whether there's viable tumor or not and also whether this is a major pathological response or a complete pathological response.

Now, practical approaches, I think we also need to have the patient on board, and that will mean that we will need to have probably a continuous assessment of the patient on how he's feeling, how is he tolerating treatment, how is he feeling the tumor, whether the symptoms are increasing or not increasing, and also evaluate the quality of life of these patients once we have this treatment in the real-world setting.

And also it's important to probably count on the nursing team and the practice advanced nurses that are usually the communication between the patient and medical teams doing the treatments, so definitely have those teams involved with the patients is going to be really important.

What do you think, Dr. Le Tourneau, about this implementation? Do you think this is going to be an easy task or that the challenges are going to be tough?

Dr. Le Tourneau:
I think you covered many aspects of the new organization that needs to be set up. It's really like a paradigm shift indeed because, I mean, before KEYNOTE-689, patients were seen by surgeons and then underwent surgery after discussion in a tumor board. Now, this will be completely different, since medical oncologists will have to play a major role, starting with immunotherapy for some of the patients.

The other point that is critical, and you mentioned it, the patient has to be reassessed after the first infusion, so before the second infusion of pembrolizumab, not only by the medical oncologist but also by the surgeon, because some patients actually will progress during immunotherapy, and in some cases it might be important not to deliver the second injection and let the patient go straight away to surgery.

And obviously the surgeons have to see the patient again before surgery with, as you said, Marc, restaging imaging. That's really important to plan the surgery.

So yes, indeed, this is really a paradigm shift.

Well, this has been a great discussion. Our time is up, so thank you for listening.

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