Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting: https://reachmd.com/programs/cme/implementing-guideline-concordant-care-into-the-management-of-frontline-patients-with-recurrent-endometrial-cancer/29748/

Released: 12/20/2024
Valid until: 12/20/2025
Time needed to complete: 1h 03m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Implementing Guideline-Concordant Care Into the Management of Frontline Patients With Recurrent Endometrial Cancer

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Salani:
This is CME on ReachMD, and I'm Dr. Ritu Salani.

Dr. Campos:
And I'm Dr. Susana Campos.

Dr. Salani:
Well, I'd like to start off our discussion by looking at a case. So we have a 64-year-old woman who's diagnosed with a stage IB endometrial cancer, which is a grade 1, and she undergoes surgery with hysterectomy, bilateral salpingo-oophorectomy, and a nodal dissection in September of 2022. At that time, her tumor revealed loss of MSH6, so she was defined as dMMR status. She was ER and PR positive, HER2 negative, and wild-type p53. She was monitored with surveillance after surgery and had hypertension but no other medical issues. She also underwent genetic testing and was found to have Lynch syndrome.

Unfortunately, in May of 2024, she started reporting abdominal and back pain. A CT scan was done and revealed enlarged para-aortic lymph nodes. She underwent a biopsy, which revealed recurrent endometrial cancer with a similar molecular profile. She was started on carboplatin/paclitaxel and pembrolizumab, and she received 6 cycles and tolerated the therapy well. She then transitioned to pembrolizumab maintenance, which she was receiving every 6 weeks, and during this time, she developed thyroid dysfunction, which required treatment with levothyroxine.

And this is a pretty typical case that we see. And, Dr. Campos, I'd love to just discuss with you some of the options of evidence- and guideline-driven treatment in this case setting.

Dr. Campos:
No, I think this is an example of many patients that we actually both, you and I, treat. Patients that had an endometrial cancer and then, unfortunately, have returned. In this particular case, the patient is dMMR and she has Lynch syndrome, so again, another pivotal point in terms of understanding who you should send to genetic counseling, the role of a family history, and so forth. Because that has even implications, as we all know, beyond that of uterine cancer.

But in this particular case, I think given the fact that she's deficient MMR and given the data of NRG-018, given the data of RUBY-1, the durvalumab plus that of chemotherapy, I think I'd be very hard-pressed not to employ the use, in this particular case, of pembrolizumab, carboplatin, and paclitaxel. But you bring up a great point in that these drugs have toxicities, and we're very used to managing paclitaxel and carboplatin, and we're getting much better at IO therapy, in this particular case, pembrolizumab. And in our practice, we measure

thyroid even before we give pembrolizumab, but this is something easily to recognize, easily to circumvent and keep the patient on a regimen that really has a tremendous progression-free survival benefit in the long run.

Dr. Salani:
Yeah. I think just to kind of piggyback on that, we're fortunate that we have a very robust formulary. So we have options of different checkpoint inhibitors. But I think the NCCN Guidelines also kind of highlight that regardless of what your familiarity is, what your formulary is, you have different options, and the utilization of checkpoint inhibitors in this setting, I think, is really the standard of care unless there's a strong contraindication.

And just like you mentioned, hypothyroidism is actually really easily managed, and we often partner with endocrinologists or primary care specialist as needed, although we've become more sophisticated in prescribing thyroid medications. But I think monitoring for toxicities is really important. And just like you, we actually incorporate TSH and reflex free T4/T3 as needed for patients who are on checkpoint inhibitors throughout their course of therapy because it may develop at any time. We also have other autoimmune diseases that we monitor for and other symptoms such as diarrhea or rash that may also be a side effect of immunotherapy. But I do want to highlight we've been using immunotherapy not only in endometrial cancer but other gynecologic malignancies, and so our familiarity and comfort with it is becoming more and more comfortable and complete. But it's important to continue to monitor this.

Any other key points or summary that you'd like to discuss?

Dr. Campos:
No, I think that really quite summarizes that. I think I'm just so grateful to have this regimen to give to patients, as I'm sure you are too.

Dr. Salani:
Absolutely. And last point is, don't forget about genetic testing that we mentioned earlier. This patient had a loss of MSH6, and that's a trigger that should result in genetic testing. So just important key points with this case.

With that, our time is up. We hope you found this brief case review useful. Thanks so much for listening.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.