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Real-World Challenges, Real-World Solutions in 1L EGFRm advanced NSCLC

Announcer:
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Dr. Leighl:
This is CME on ReachMD, and I'm Dr. Leighl. Here with me today are Dr. Cho and Dr. Kerr. In this episode, we're going to review a patient case example of someone with EGFR-mutated non-small cell lung cancer.

Dr. Cho, what can you tell us about our patient?

Dr. Cho:
Okay, so today I want to share one of my first-line EGFR-mutant NSCLC patients. This is a 41-year-old woman. She presented with severe cough and shortness of breath, and she was a never-smoker. This is very common—never-smoker, stage IV EGFR-mutant lung cancer. She had no past medical history, ECOG performance 1.

So we had diagnostic procedures. Bronchoscopic biopsy confirmed TTF1-positive lung adenocarcinoma. EGFR L858R mutation was detected by tissue real-time PCR as well as cobas plasma ctDNA.

So based on MARIPOSA high-risk analysis, this patient really had high-risk features, L858R mutation, and a detected baseline EGFR mutation. So the patient—in the past CT scan and brain MRI—showed right around a 4-cm mass and multiple hematogenous bilateral lung metastases, and brain MRI showed also multiple brain lesions.

Back in 2024, the patient started amivantamab and lazertinib combination for this case in a clinical trial program, and we observed a massive response in the bilateral lung metastases, and also the patient had a CNS response.

When it comes to side effect toxicity, the patient had a mild infusion-related reaction on Cycle 1/Day 1, and then IRR was well managed with dexamethasone and other prophylactic measures. Two weeks after initiation of combination, the patient developed grade 2 AST/ALT elevation. Four weeks after initiation, the patient developed a grade 2 scalp rash, dry skin, and grade 2 paronychia.

So how did I manage this patient's dermatologic toxicity? So scalp rash had developed 4 weeks after initiation of the combination. Scalp rash sometimes accompanies itching sensation and pain, and I prescribed oral doxycycline and antihistamine as a PRN basis and topical clindamycin lotion on scalp daily before bedtime. And I also prescribed skin moisturizers.

So all these skin toxicity management worked well, and then the patient is still ongoing on this combination treatment.

Also, in my clinical practice, in my experience, paronychia responds very well to oral minocycline and chlorhexidine hand wash every day.

Oral anticoagulants was given for the VTE prophylaxis for the first 4 months following initiation of combination.

Dr. Kerr:
So from a diagnostic point of view, this case highlights one or two issues that we have already discussed in previous episodes. The diagnosis seems fairly straightforward. The patient has an adenocarcinoma, TTF1 positive from a primary site in the lung. The presence of an EGFR mutation, the L858R mutation, was identified using a standalone real-time PCR test, which, as Dr. Cho mentioned before, is commonly used as a first test visit, particularly in Eastern Asian countries, because EGFR mutation has such a high prevalence, perhaps before reflexing a case to next-generation sequencing.

And it also highlights the fact that in the knowledge that the patient has an L858R mutation, we can actually use another PCR-based standalone test, such as the cobas test, using blood to identify whether or not there is baseline ctDNA positivity for that mutation, rather than a much more complicated approach using NGS, so that this poor prognostic factor may be identified in a patient such as this.

Dr. Leighl:
That was a really great case. And I think scalp rash is one of these challenges, as well as paronychia. And so in my own practice, we do use a lot of steroid-based shampoos, and maybe we need to add that to part of the regimen.

With that, our time is up. We hope you found this brief case review useful, and thank you for listening.

Announcer:
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