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Time needed to complete: 34m

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Turning Evidence Into Action: Applying Perioperative Data to Real-World Practice

Announcer:
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. Johnson:
This is CE on ReachMD and I'm Dr. Jennifer Johnson. Today I'll review how to apply clinical data on perioperative immunotherapy in locally advanced head and neck cancer to practice.

Unfortunately for our patients, we have high unmet needs for them. That means that despite patients going through their surgery and going through radiation with or without chemotherapy, these diseases can come back. They can come back locally. They can come back distantly and we need a new strategy to help them.

KEYNOTE-689 is our opportunity to do better for our patients. The researchers led by Dr. Ravindra Uppaluri have applied a perioperative paradigm to treatment for head and neck cancer. This was a phase three international randomized trial that has changed the way that we treat locally advanced resectable head and neck cancer for the first time in over two decades.

What it did was take over 700 patients and randomize them to either going straight to surgery the way that we normally would, followed by their risk adjusted adjuvant strategies of radiation with or without cisplatin chemotherapy, and randomize them against a new way of treatment incorporating two doses of neoadjuvant pembrolizumab, followed by 15 additional doses of pembrolizumab that ran through their adjuvant treatment, and beyond. When you look at this strategy, we can see that patients qualified for this clinical trial because they had resectable stage three or stage four tumors.

The primary endpoint for the KEYNOTE-689 clinical trial was event-free survival. What you can see here is that there is a clearer event-free survival benefit for those who were given the perioperative strategy of neoadjuvant and adjuvant pembrolizumab.

This has changed the way that we think about our resectable locally advanced head and neck cancer patients. While the trial incorporated data from all patients showing us the event-free survival of people who had any PD-L1 CPS score, after the FDA reviewed this data, their ruling was that it would only be FDA approved for use in patients who had a PD-L1 CPS of 1% or greater.

How to apply KEYNOTE-689 to cancer patients? We need to remember that we need a PD-L1 CPS score from the beginning. This is a bit of a change in our normal strategy because before this, we were only checking PD-L1 CPS in the recurrent and metastatic setting, and now we need this early. This could be ordered by our surgical colleagues.

It can be ordered by medical oncology when they're meeting the patients. But the earlier we do so the better. We also know that we need to keep interdisciplinary cooperation high. We need to be able to move a patient from whoever their first provider is, be that medical oncology or surgical oncology in the form of otolaryngology to the other provider in rapid succession, and that there needs to be cooperation in the early neoadjuvant space to understand what the timing of neoadjuvant therapy is, assess patient for any toxicities during that period, and then move them into the operative period during a specific window.

We also need to understand that we can have intradisciplinary cooperation as well, and I mean that because we need to account for geography and what we can do to help patients through their journey where their support structures are.

If a patient comes to a particular location, because that's where they're seeing the surgical expertise that they need, they may choose to have their neoadjuvant treatment at that place. The adjuvant road is long and it can be arduous, and they may choose to have that adjuvant treatment somewhere closer to where they see their support.

If someone hasn't gotten their neoadjuvant doses, we know that from GORTEC NIVOPOSTOP trial, that there is a benefit to adjuvant immunotherapy as well. And so if you haven't been able to give these patients their neoadjuvant doses, we should consider the adjuvant doses still for this patient population.

And now it’s up to you to put this knowledge into practice. Thanks for listening.

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