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## Keys to Managing Myelosuppressive Events in SCLC: A Review of the NCCN Guidelines

### Announcer:

You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by G1 Therapeutics. Here's your host, Dr. Jacob Sands.

### Dr. Sands:

Welcome to *Project Oncology* on ReachMD. I'm Dr. Jacobs Sands. And joining me today to review the latest NCCN guidelines for preventing and managing chemotherapy-induced myelosuppression in patients with small cell lung cancer is Dr. Millie Das. Dr. Das is Chief of Oncology at the Palo Alto V.A., and a Clinical Associate Professor of Medicine and Oncology at Stanford University. Dr. Das, welcome to the program.

### Dr. Das:

Thank you, Jacob. It's really great to be here.

### Dr. Sands:

So, let's dive right in. How do the NCCN guidelines define a patient's risk of chemotherapy-induced myelosuppression?

### Dr. Das:

Yeah, I think when you look at the NCCN supportive care guidelines, they look at febrile neutropenia risk, and then they risk stratify, according to the percentage of risk for febrile neutropenia occurring with a given chemotherapy regimen. And so they have three different categories. They have a high, intermediate, and low category. So, the high category is really a regimen that's expected to have a greater than 20 percent risk of febrile neutropenia. The intermediate category is a 10 to 20 percent risk of febrile neutropenia. And then the low category is less than 10 percent risk.

### Dr. Sands:

And what do the guidelines recommend for preventing myelosuppressive events in each of these subgroups?

### Dr. Das:

Yeah, I think when we look at the different categories of risk, for the high-risk regimens, it is recommended that we use growth factor support. And generally, that's either filgrastim or peg filgrastim given after the chemotherapy. For the intermediate-risk category the recommendation is to consider GCSF or filgrastim based upon patient risk factors. And, for the low category of chemotherapy regimens routine use of growth factor support is generally not recommended.

### Dr. Sands:

Now, if we turn our attention to the management of these events from cytopenias in patients with small cell lung cancer on treatment, what do the guidelines recommend when there are events?

### Dr. Das:

Sure. I think for small cell lung cancer patients, the regimens that we're most commonly using are platinum etoposide in the first-line setting, or topotecan in the second-line setting. Interestingly, when I was reviewing the NCCN supportive care guidelines, the platinum etoposide regimen fell into the intermediate stage category, so about a 10 to 20 percent risk of febrile neutropenia with this particular regimen. And so again, I think in this situation, we can consider GCSF based upon patient risk factors. I will say that I pretty much routinely use prophylactic growth factor support with either again filgrastim or peg filgrastim given on the day after the last day of the chemotherapy. And the reason is that in my experience, these patients do tend to drop their blood counts quite significantly, and I've

had many patients develop infections related to this particular regimen sometimes requiring hospitalization even when they do receive growth factor support. So, this is something that I am commonly doing in my clinical practice. And that's really specifically with regard to neutropenia risk.

For anemia, if the hemoglobin is less than 11 grams per deciliter, I generally will observe these patients. If the hemoglobin drops below eight, I will usually proceed with a blood transfusion. I don't use erythropoietin-stimulating agents, given the blackbox warning that the ESAs have been shown to potentially accelerate oncogenesis.

And then for platelets, I will generally hold or delay chemo if the platelet count is less than 100,000. And I will also evaluate for any other additional causes that could be causing or contributing to the thrombocytopenia such as concurrent medications.

**Dr. Sands:**

Now, in the more than two years that we've been having this COVID-19 pandemic have the guidelines changed at all since then? And as a follow-up to that, have you seen differences in clinical practice or changes in management around times of surges in particular?

**Dr. Das:**

Yeah, I think that we, of course, are all paying very close attention to the cytopenias that can occur with the chemotherapy that we're giving to our patients. And I wouldn't say that the guidelines have really necessarily changed. I will mention that in the past year or two, we've learned about this a new novel CDK4 inhibitor, Trilaciclib, that can support bone marrow and reduce myelosuppression, particularly in patients who receive chemotherapy for extensive stage small cell lung cancer. This is a drug that's now FDA approved, and it's included as a bullet in the updated NCCN guidelines for small cell lung cancer. This agent does involve increased costs and a few extra steps in terms of its use. So, I haven't yet adopted it into my clinical practice, but it certainly offers a novel way of potentially managing and preventing myelosuppression.

So I think this is particularly important in the era of COVID, where we want to try to minimize risks and hospitalization and perhaps reduce the number of visits to the infusion center for either transfusions or visits related to getting growth factors. I think this may be a nice option because it's really aimed to be a preventative adjunctive medication.

**Dr. Sands:**

For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Jacobs Sands, and today I'm speaking with Dr. Millie Das about the NCCN guidelines for preventing and managing chemotherapy-induced myelosuppressive events in patients with small cell lung cancer.

So, let's dive a little further into how we can better manage these patients. How do you approach talking to your patients about the risk of myelosuppression when you're starting treatment?

**Dr. Das:**

I think this is really important because although we're trying to, of course, control the cancer with chemotherapy, there are definite risks that are involved. And I think particularly with the frontline treatment with platinum etoposide usually in combination with immunotherapy in our patients with extensive stage disease, there are considerable risks. And the myelosuppression, as we've been talking about, is a real risk. And I always let patients know that we will try to mitigate the risk as best we can, but at times, it can be difficult to avoid. I make sure that my patients understand to take any signs or symptoms of an infection seriously, and to report them to our care team as soon as they develop. If a patient develops any temperature over 100.5, they've been told to contact our care team.

And again, because we can't predict when the blood counts are going to nadir or drop down I think it's really important that we make sure that our patients are maintaining communication with us, and that we bring them in to check their labs whenever needed. And then it's not uncommon that we have to hospitalize our patients when they do have very low blood counts associated with their chemotherapy and/or are exhibiting any signs or symptoms of an infection. As we really want to jump on that and really treat that maximally to avoid any further complications.

**Dr. Sands:**

Now we've gone through in quite detail about neutropenia and the different risk categories and, of course, management. You also mentioned drops in hemoglobin, anemia, and some risk of thrombocytopenia. How often are you seeing drops in hemoglobin and platelet count? And how often do you perceive that as either being a problem or even symptomatic to some degree?

**Dr. Das:**

Yeah, I think the anemia is probably a little bit less frequent than the neutropenia that we see in our patients treated with frontline therapy. I would say probably about a quarter to a third of our patients are going to have significant anemia. And that will impact their quality of life and usually the symptom is fatigue. And sometimes that fatigue can be quite profound. I think it's always difficult to tease

out because we know that chemotherapy in and of itself can cause fatigue. And so, when we do have reports of fatigue we want to, of course, check a CBC to look at the hemoglobin level and to figure out if the anemia could be contributing. Again, if it's generally above the eight to nine range, I tend to observe and avoid transfusing. But when we get closer to the eight, 8.5 range and a patient's reporting fatigue and/or any other symptoms related to the anemia, then I'll go ahead and arrange for a blood transfusion. Sometimes it's possible to be able to arrange the transfusions on the same day, as we're seeing the abnormal hemoglobin; other times we'll arrange for that transfusion to take place later in the week.

**Dr. Sands:**

And in addition to what the NCCN guidelines recommend, are there any other strategies that you share with patients to help them manage the risk?

**Dr. Das:**

So patients want to know whether they can continue to interact with family members and friends, and do the things that they generally enjoy doing. I think, especially in the COVID era I think we're all doing a pretty good job of trying to avoid transmission of COVID and that includes making sure that we're wearing masks. With mask mandates being lifted in most parts of the country, I do encourage my patients receiving chemotherapy to continue to wear a mask when they're indoors and particularly when they're inside a grocery store or out, in, potentially crowded areas. So even though the mask mandate may have been lifted for indoors wherever they live, I think it is prudent for our patients who are receiving chemotherapy to continue to mask and obviously to hand sanitize.

I think it's a balance. We want our patients to continue to be able to interact with the people that they want to interact with. And I think the main thing that I tell them is just to make sure that there are no people that are known to be sick or have symptoms. Generally, this was even before COVID, we would tell people to avoid people who we know may be sick because of the risk of that infection being transmitted to the patient. I think other things that I advise patients, of course, in the COVID era is to make sure that, they've been vaccinated and boosted against COVID to again, mitigate the risk of COVID transmission and infection.

And generally speaking, I think if friends and family members are healthy and feeling well and haven't recently been exposed to COVID I think it's safe for them to be able to interact with our patients receiving chemotherapy. And again, just I think, just to use common sense, and, wearing masks in indoor settings whenever possible. I know it's not always the easiest thing. And then trying preferentially to maybe meet outdoors, especially in the summer months if that's an option because we know that the risks of COVID and any other airborne illness is much reduced in the outdoor setting. And so, I think these are important considerations. I do think it's important for people to be able to interact with people, or for our patients to be able to interact with their friends and family, even during this time of the pandemic. But I think we all just need to use these extra precautions to allow that.

**Dr. Sands:**

Well, that is a very comprehensive review of recommendations around the management of myelosuppression along with treatment of small cell lung cancer. I want to thank my guest, Dr. Millie Das, for joining me today to talk about this important topic. Dr. Das, it was wonderful having you on the program.

**Dr. Das:**

It was great to be here. Thank you so much.

**Announcer:**

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