

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/project-oncology/managing-adc-toxicities-in-nslc-care/49135/>

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Managing Antibody-Drug Conjugate Toxicities in NSCLC Care

Announcer:

Welcome to *Project Oncology* on ReachMD. On this episode, we're joined by Dr. Laura Alder, who's an Assistant Professor of Medicine at Duke University School of Medicine in Durham, North Carolina. She'll be sharing strategies for managing toxicities associated with antibody-drug conjugates for non-small cell lung cancer. Here's Dr. Alder now.

Dr. Alder:

So the most common adverse events vary depending on the specific antibody-drug conjugate we're discussing, the biomarker association, and the payload. But in general, at the end of the day, these are still chemotherapy payloads. So we're seeing GI toxicities, like nausea, mucositis, and diarrhea. Hematologic toxicities are still very common, so low blood counts, neutropenia, anemia, and thrombocytopenia. And then, of course, one of the more unique ones is interstitial lung disease, known as ILD or pneumonitis, which is inflammation of the lung. And that's what we've seen across a couple of these ADCs, such as the deruxtecan-based ones like T-DXd and Dato-DXd. So this is a big concern for a lot of us, and we really want to keep an eye out. Median onset is usually around four months, but it can happen a little bit earlier or a little bit later.

A few of the other unique ones that we've seen, like with Dato-DXd now that we're using that in clinical practice, are eye toxicities that sometimes require ophthalmology. And then sometimes, there are infusion-related reactions. And with TalisoVi, peripheral neuropathy is one of the more unique ones and one of the important ones to be on the lookout for there.

So the best thing for ADC toxicity management is proactive monitoring and early intervention. This is especially true for ILD; it's really important to get that baseline and serial CT chest imaging. And then if there's any concern for that pneumonitis or ILD, you want to stop the drug and start steroids at the first sign and then continue to keep an eye on it. You don't want to restart unless it's completely resolved. And if it's a grade two or higher and if it's more severe, symptomatic, requires hospitalization, etc., you want to stop the drug and move on to something else and be very aware because that is something that can be very deadly.

For hematologic toxicities just like with other drugs, dose reductions and treatment delays are totally okay. We'd rather have the patient be safe. We don't want to give the patient a toxic amount of the drug. We can always consider growth factor support like G-CSF. And then of course, we want to make sure that they have support with prophylactic measures, like anti-nausea medicine, oral care for any mucositis, and lubricating eye drops for any type of ocular toxicities.

So it's always a really important discussion on the balance between treatment benefit and treatment burden. I think the backbone of this is shared decision-making. That involves clearly communicating the benefits but also the risks and the harms of these ADCs. We want to make sure that the patient understands and that the treatment goals are in line with the patient's values and priorities. So that could mean discussing what it would look like if we didn't do any treatment, discussing these ADCs and what that would look like, and making sure that the patient understands and that we understand the patient's values and priorities before we give our recommendation in a shared decision-making approach.

This quality of life is extremely important. We talk a lot about overall survival and progression-free survival, but quality of life goes hand-in-hand with those outcomes. So I think continuously bringing up the patient and their family's treatment goals is really important throughout this whole process because the course of any cancer, including lung cancer, is more of a marathon, and we want to make sure that we check in and that we're meeting them where they are every step of the way.

Announcer:

That was Dr. Laura Alder talking about how we can manage toxicities associated with antibody-drug conjugates for non-small cell lung

cancer. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!