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/optimizing-nivolumab-in-nsclc-implications-for-cost-access-and-outcomes/32997/

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Optimizing Nivolumab in NSCLC: Implications for Cost, Access, and Outcomes

Announcer:
You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Aline Fares, who's an Associate Professor in the Division of Hematology and Oncology at the University of Florida. She'll be discussing a poster she co-authored and presented at the 2025 American Society of Clinical Oncology Annual Meeting that focused on low-dose nivolumab combined with chemotherapy as a neoadjuvant treatment for lung cancer. Here's Dr. Fares now.

Dr. Fares:
We already know that full-dose anti-PD1 therapy in the neoadjuvant setting boosts cure rates for resectable non-small cell lung cancer. We know this based on data from CheckMate 816, and it is made crystal clear. What isn't as widely appreciated is that PD1 receptors on circulating T-cells are saturated at serum concentrations far below the conventional 240 mg flat dose.

Two things follow from that pharmacology. First, we may be able to prime the immune system with a fraction of the drug but still walk into the response rate with the T-cell response. Second—and this is important to me as someone who has worked in both high and middle-income countries—a lower dose could slash costs and potentially immune-related toxicities, making perioperative immunotherapy more accessible and better tolerated globally. So the scientific and health equity rationales line up perfectly. If we give a microdose and we can still deliver the same biologic punch everybody wins: patients, payers, and surgeons.

Based on those trends, I see three downstream implications. The first one is that dose optimizations become a real study variable, so future perioperative trials could stratify or even randomize by dose rather than assuming one size fits all. The second—and the most important, I think—is the economic scalability. Showing equivalence at one-tenth the cost makes guideline uptake feasible in resource-constrained settings where surgery is standard but immunotherapy is priced out. Third is the biomarker-guided tailoring. We're banking sequential blood and tissue; if we can link early T-cell repertoire expansion to response at low dose, we could reserve higher doses or adjuvant therapy for those who truly need it.

Most people worldwide still lack access to expensive cancer drugs. If we want a truly equitable oncology, we have to design trials for them, not just for well-resourced settings. So if a precisely timed, lower-dose immunotherapy could cure more lung cancers at a fraction of the cost, why wouldn't we pursue it?

Announcer:
That was Dr. Aline Fares discussing low-dose nivolumab combined with chemotherapy as a neoadjuvant treatment for lung cancer, which she talked about at the 2025 American Society of Clinical Oncology Annual Meeting. 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!