XXIV

Simposio de Revisiones en Cáncer

"Tratamiento médico del cáncer en el año 2022"

Importancia del tratamiento de primera línea en cáncer de cabeza y cuello recurrente/metastásico

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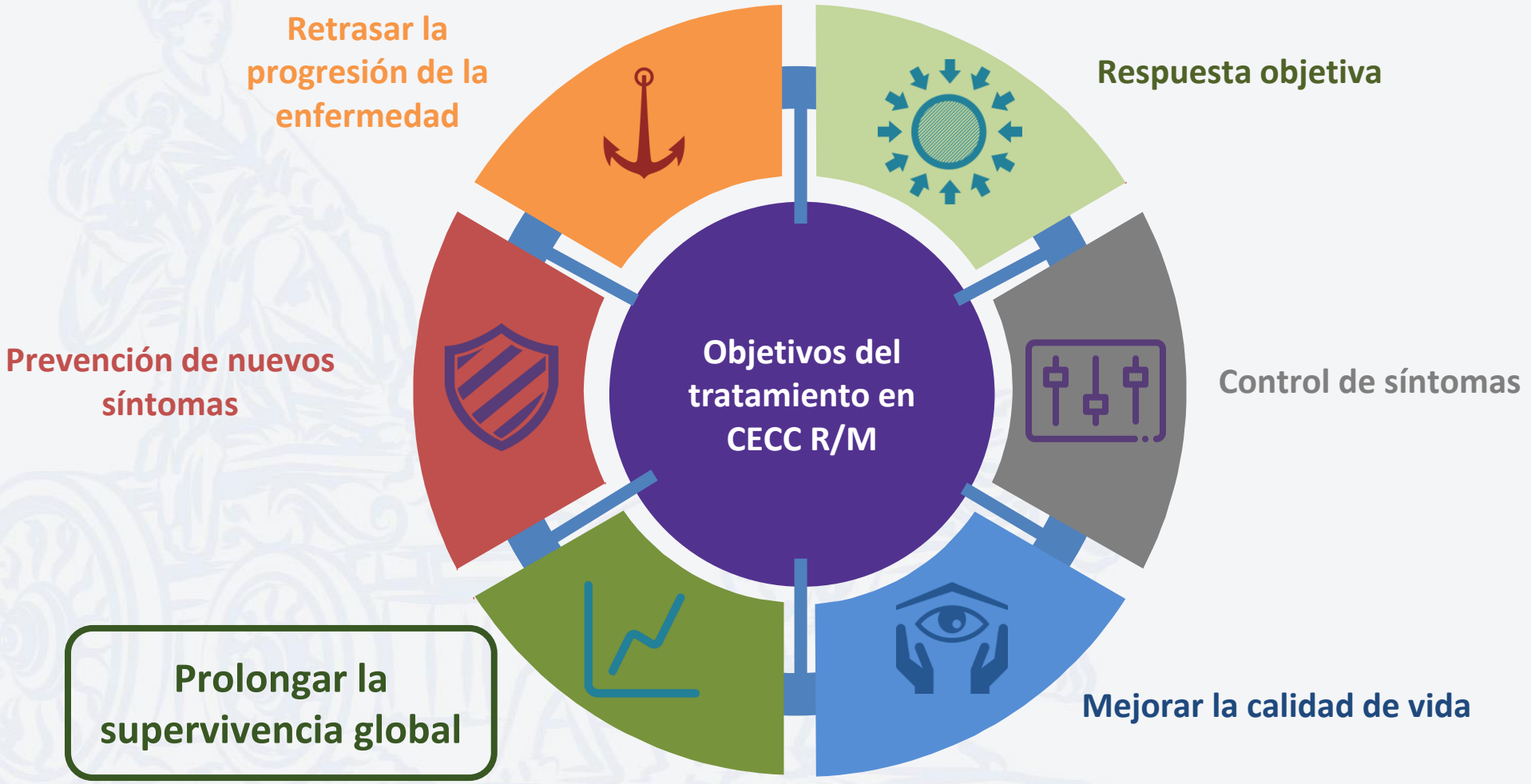
Disclosure

- Lectures and advisory fees: Roche, Takeda, Celgene, BMS, MSD, Merck, Novartis, Kern Farma, Gilead.
- Investigational grant : Celgene.

Objetivos del tratamiento médico del CECC R/M

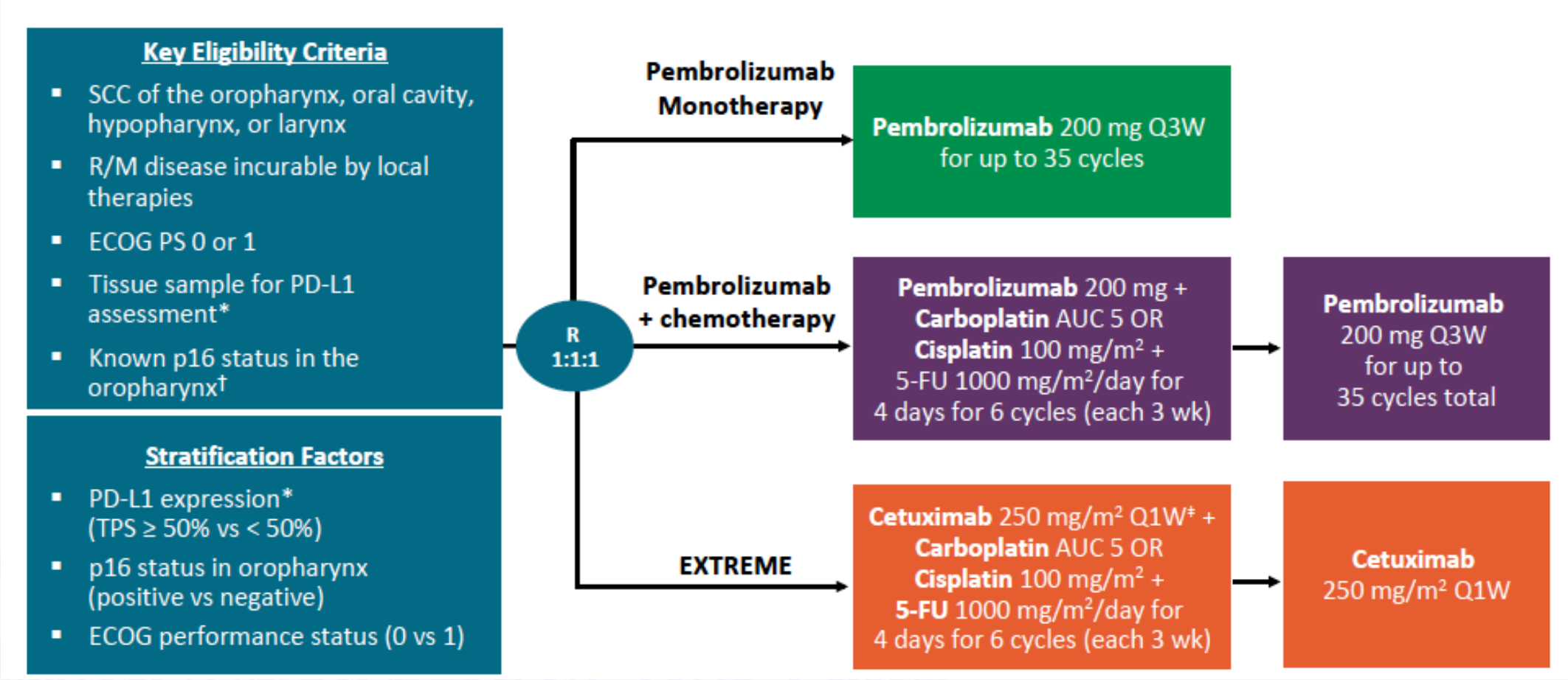


Vermorken JB and Specenier P. Ann Oncol 2010;21(Suppl 7):vii252–vii261.

Ensayos clínicos que definen la nueva terapia de primera línea

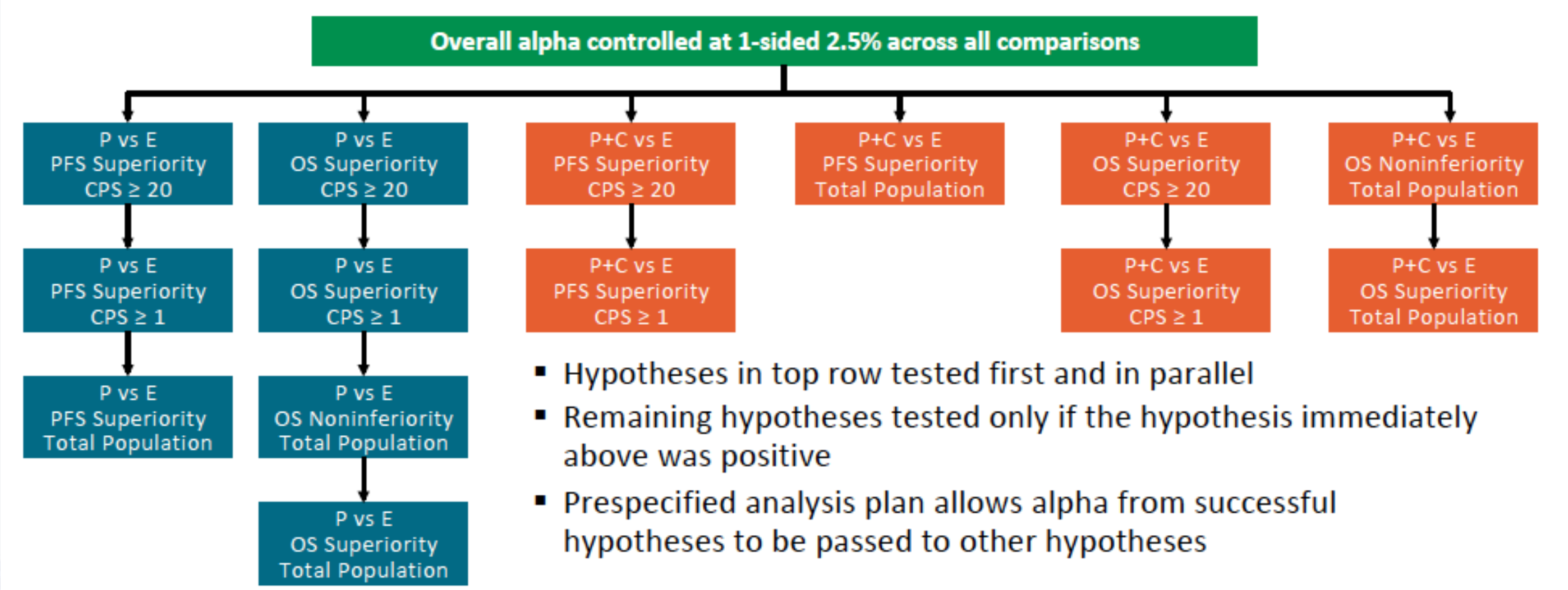
- Aumento de supervivencia global:
  - Keynote-048.
  - CheckMate-141 en pacientes refractarios a platino.
- Mejora la calidad de vida:
  - TPEXTREME.

Keynote 048



Burtness B, et al. ESMO 2018
Rischin D, et al. ASCO 2019

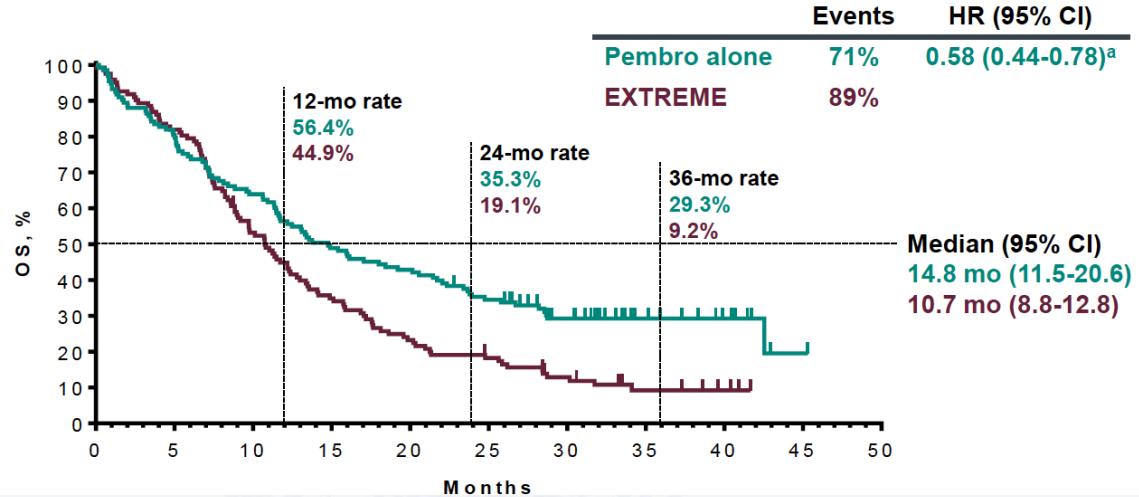
Keynote 048: consideraciones estadísticas

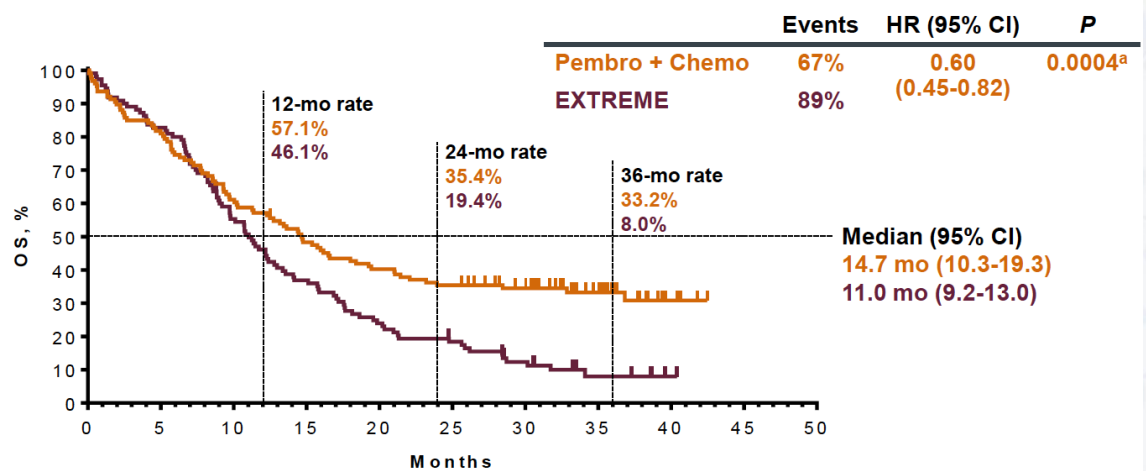


Keynote 048: características de los pacientes (ITT)

	Pembrolizumab Alone vs EXTREME		Pembrolizumab + Chemo vs EXTREME	
Characteristic, n (%)	Pembrolizumab (n = 301)	EXTREME (n = 300)	Pembro + Chemo (n = 281)	EXTREME (n = 278*)
Age, median (range), yrs	62 (22-94)	61 (24-84)	61 (20-85)	61 (24-84)
Male	250 (83.1)	261 (87.0)	224 (79.7)	242 (87.1)
ECOG PS 1	183 (60.8)	183 (61.0)	171 (60.9)	170 (61.2)
Current/former smoker	239 (79.4)	234 (78.0)	224 (79.7)	215 (77.3)
p16 positive (oropharynx)	63 (20.9)	67 (22.3)	60 (21.4)	61 (21.9)
PD-L1 status				
▪ TPS ≥ 50%	67 (22.3)	66 (22.0)	66 (23.5)	62 (22.3)
▪ **CPS ≥ 20**	**133 (44.2)**	**122 (40.7)**	**126 (44.8)**	**110 (39.6)**
▪ **CPS ≥ 1**	**257 (85.4)**	**255 (85.0)**	**242 (86.1)**	**235 (84.5)**
Disease status†				
▪ Metastatic	216 (71.8)	203 (67.7)	201 (71.5)	187 (67.3)
▪ Recurrent only‡	82 (27.2)	94 (31.3)	76 (27.0)	88 (31.7)

Keynote-048: resultados en población CPS > 20



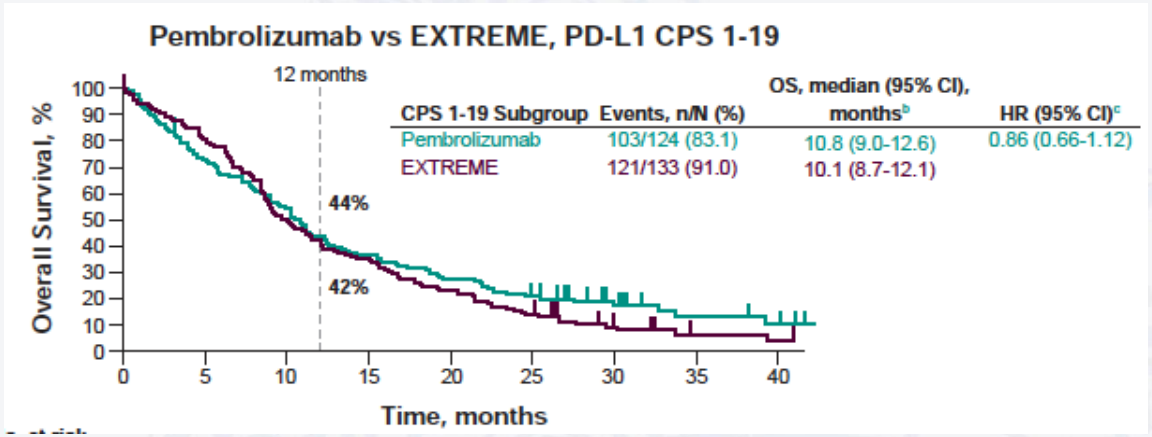


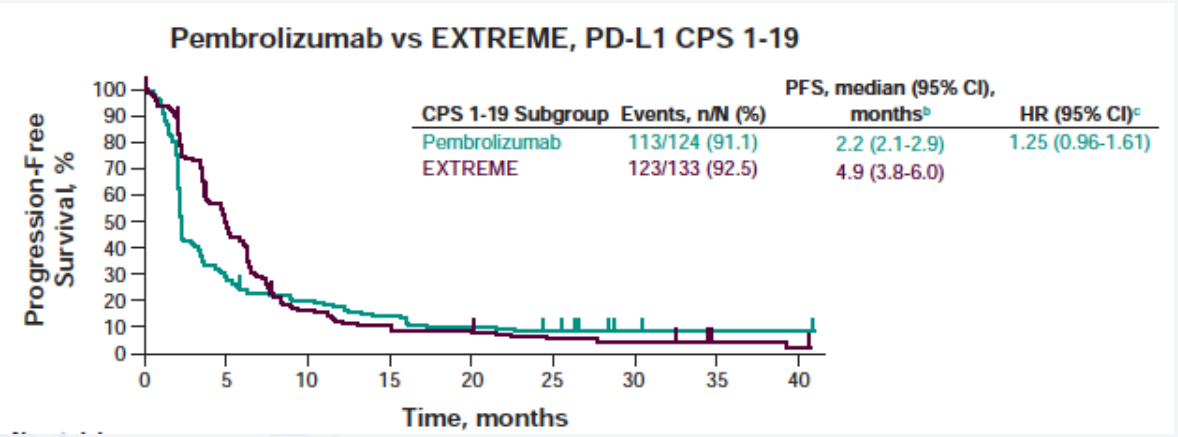
	P	E	P+C	E
mOS (m)	14,9	10,7	14,7	11
mPFS (m)	3,4	5	5,8	5,2
PFS 24 m	14,9%	4,8%	14,7%	3,3%
ORR	23,3%	36,1%	42,9%	38,2%
CR	7,5%	3,3%	9,5%	3,6%
mDoR (m)	20,9	4,2	7,1	4,2

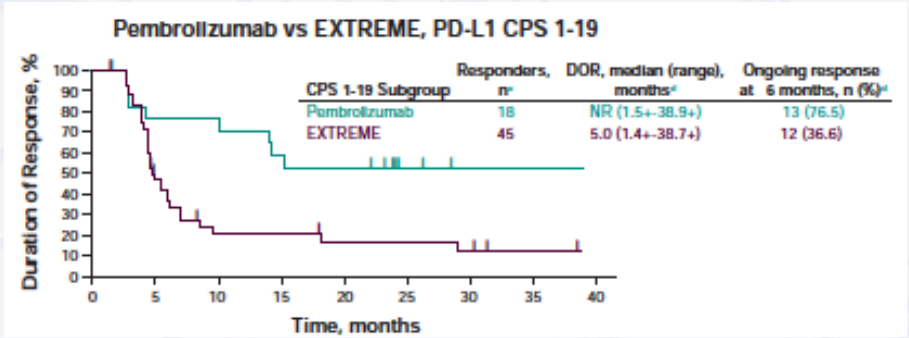
Burtness B, et al. ESMO 2018
Rischin D, et al. ASCO 2019

KN-048: Pembro vs EXTREME en CPS 1-19

257 pac.	mOS meses	OS 24 meses	mPFS meses	PFS 6 meses	ORR	DOR meses	DOR > 6 meses
PEMBRO	10,8	22%	2,2	24,2%	14,5%	NR	76,5%
EXTREME	10,1	15,9%	4,9	41,4%	33,8%	5	36,6%
HR (p)	0,86 (0,12)		1,25 (0,95)				



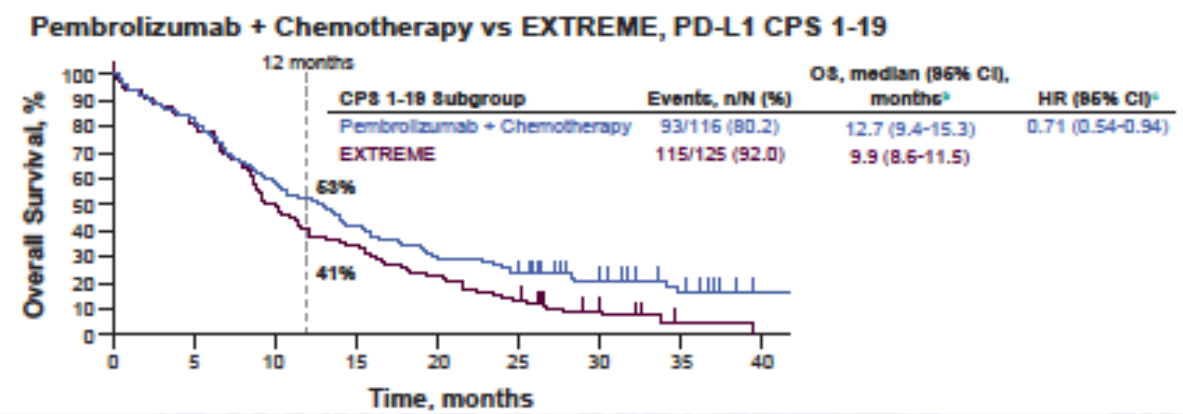


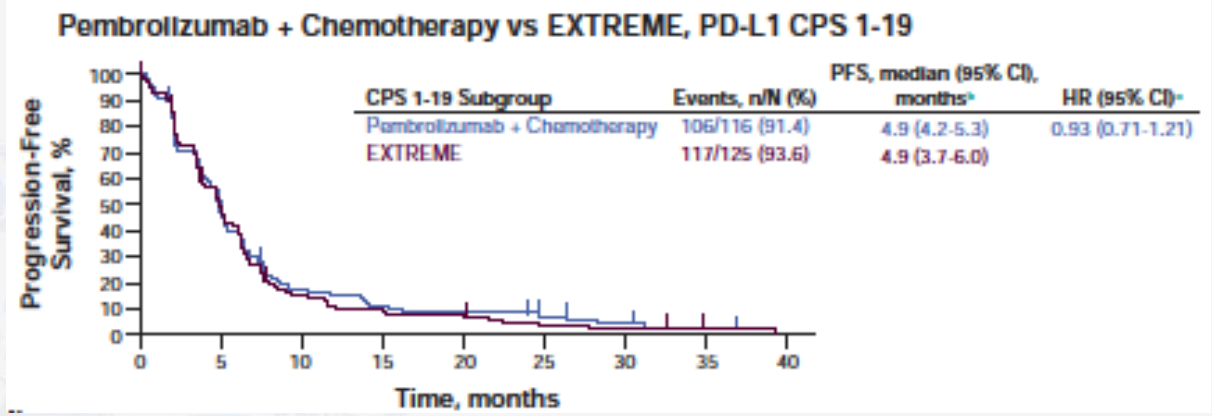


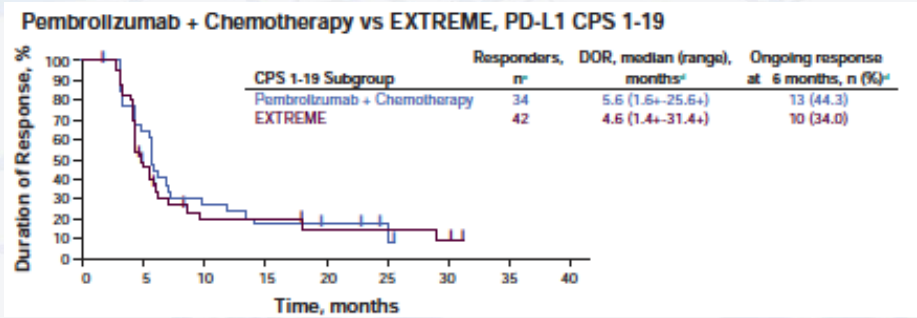
EMA/CHMP/591139/17-OCT-2019.
Burtness B, et al. AACR 2020.

KN-048: P+C vs EXTREME en CPS 1-19

241 pac.	mOS meses	OS 24 meses	mPFS meses	PFS 6 meses	ORR	DOR meses	DOR > 6 meses
P + QT	12,7	25,9%	4,9	40%	29,3%	5,6	44%
EXTREME	9,9	14,5%	4,9	40%	33,6%	4,6	34%
HR (p)	0,71 (0,007)		0,93 (0,29)				

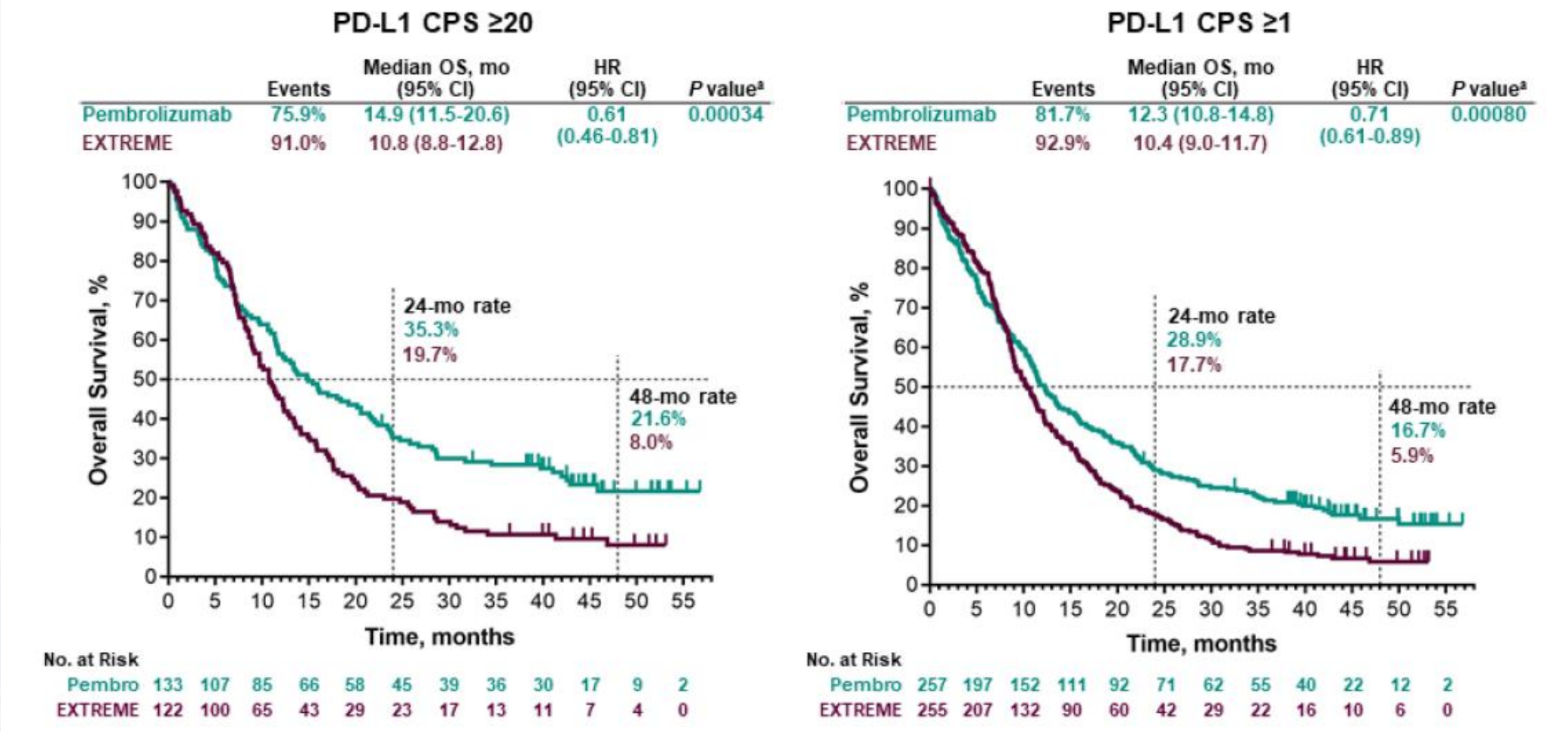






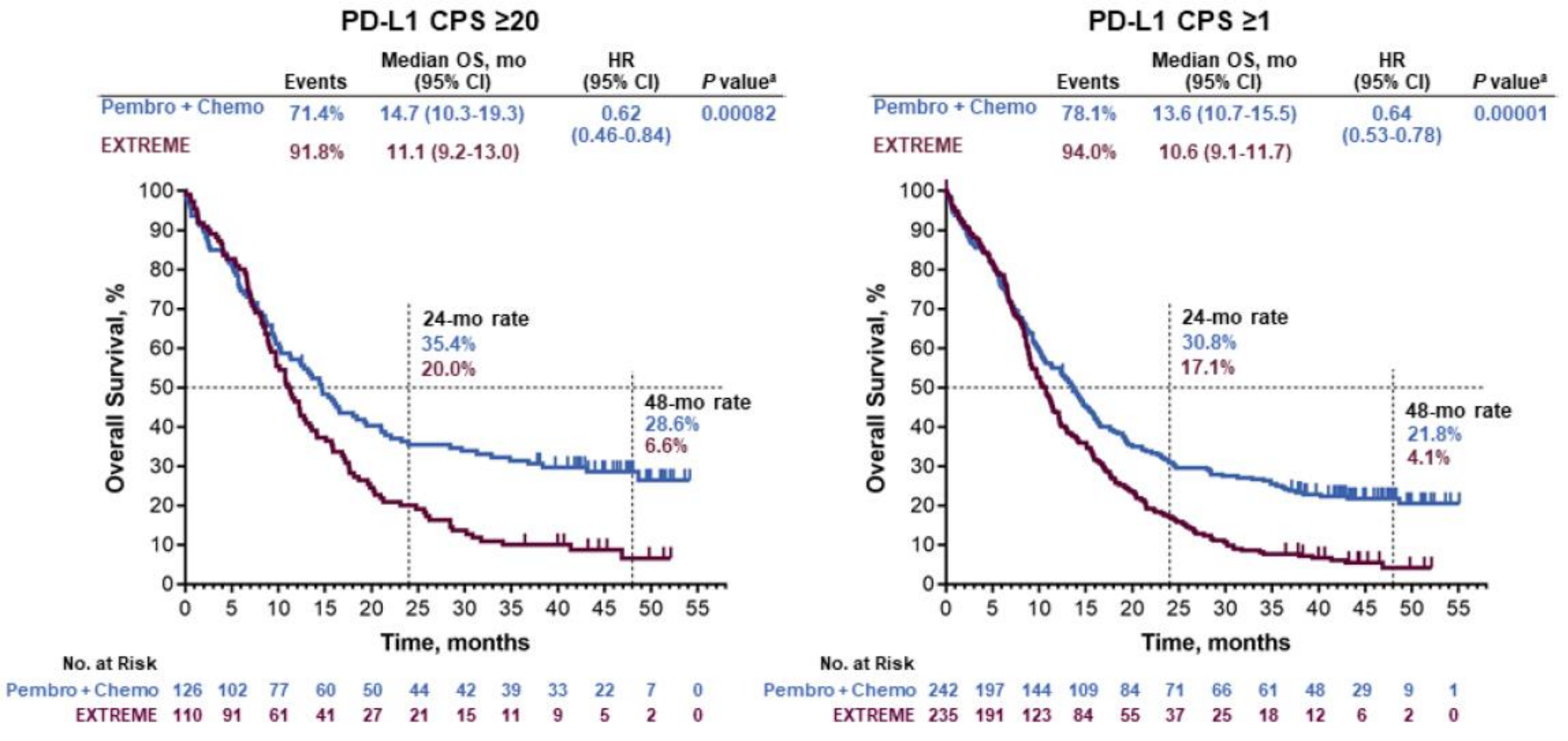
EMA/CHMP/591139/17-OCT-2019.
Burtness B, et al. AACR 2020.

KN-048: supervivencia global a 4 años (Pembro vs EXTREME)



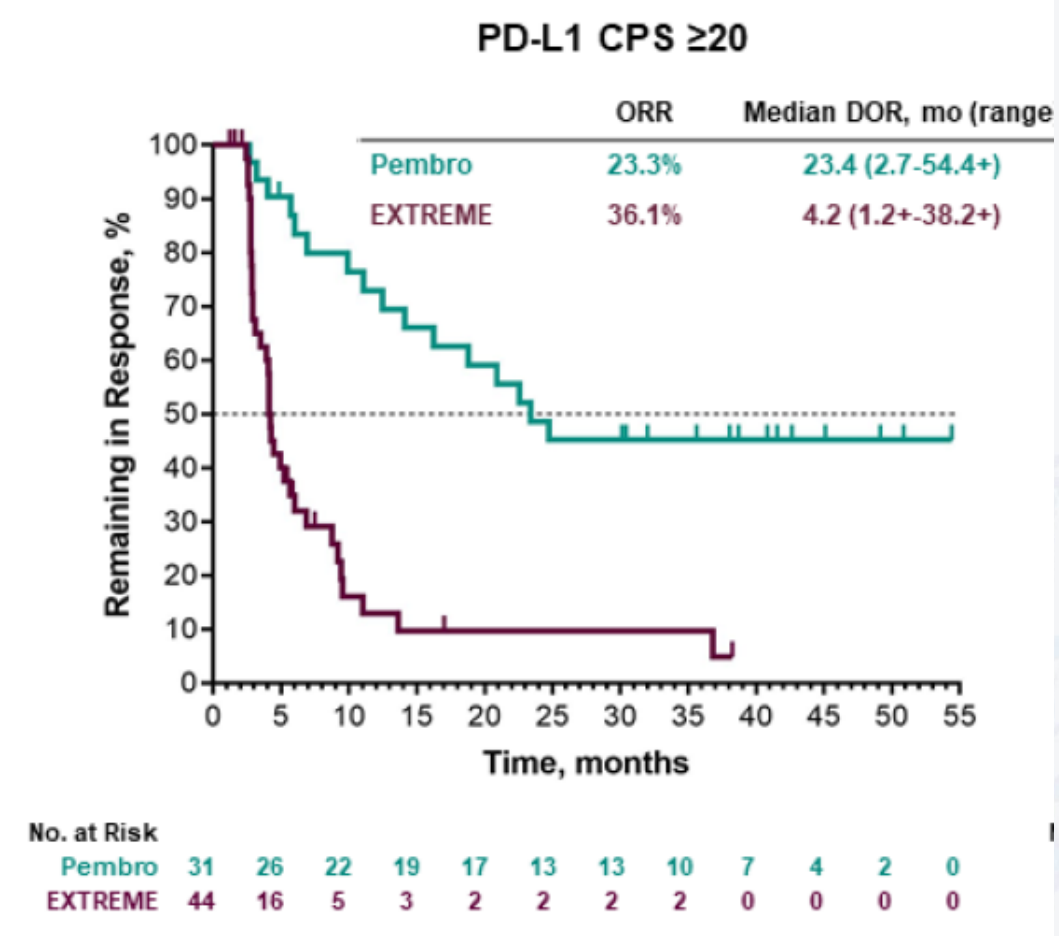
Greil R, et al. ESMO 2020.

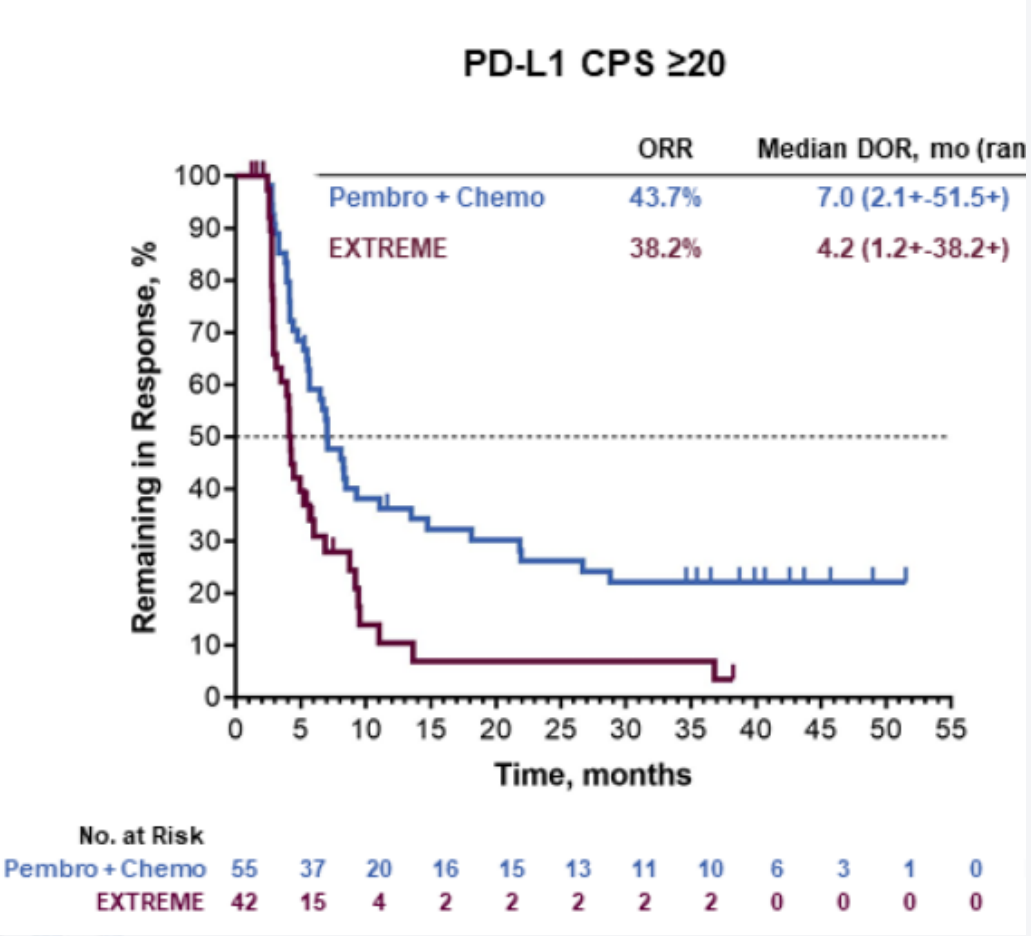
KN-048: supervivencia global a 4 años (P+C vs EXTREME)



Greil R, et al. ESMO 2020.

Duración de la respuesta y largas supervivencias

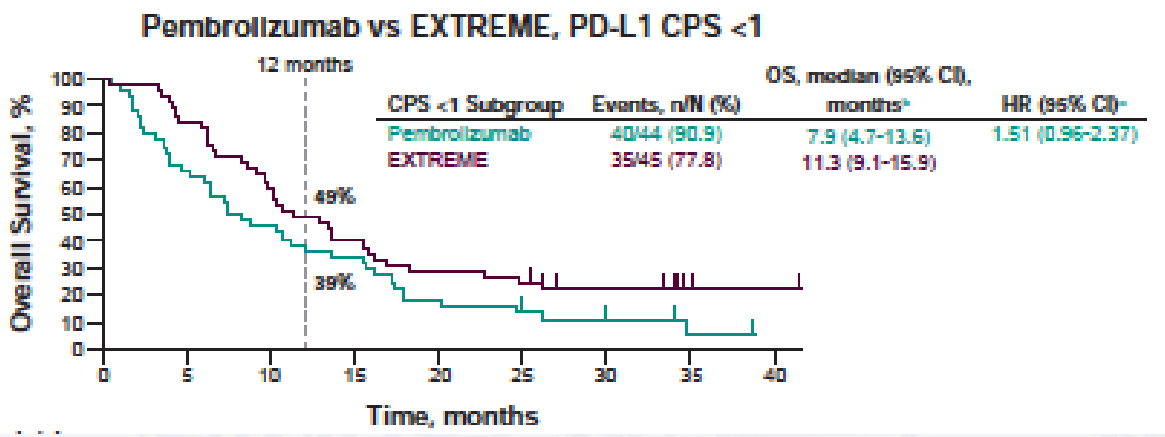


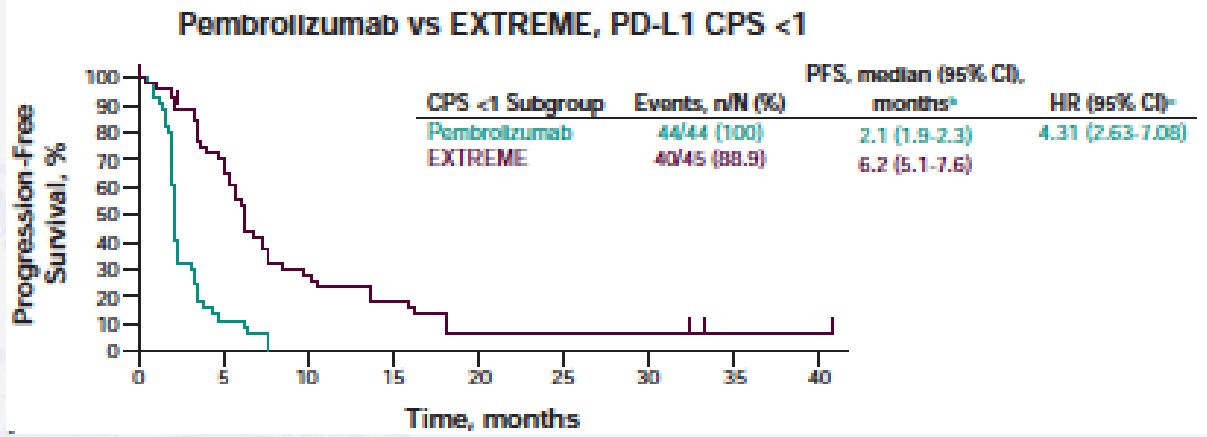


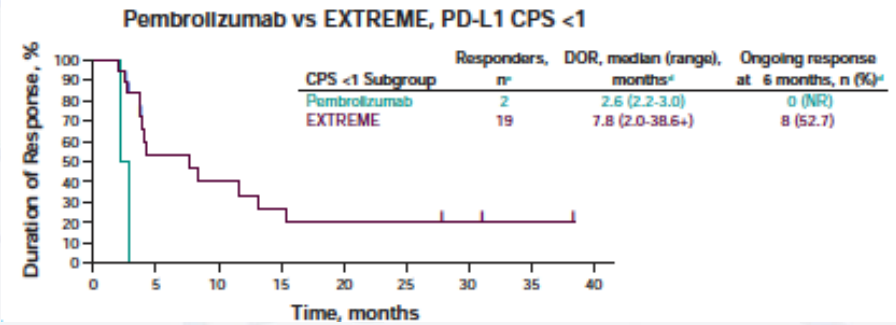
Greil R, et al. ESMO 2020

KN-048: Pembro vs EXTREME en CPS <1

89 pac.	mOS meses	OS 24 meses	mPFS meses	PFS 6 meses	ORR	DOR meses	DOR > 6 meses
PEMBRO	7,6	15,9%	2,6	11,4%	4,5%	2,6	0%
EXTREME	11,3	26,7%	6,2	56%	42,2%	7,8	52,7%
HR (p)	1,51 (0,96)		4,31 (1)				



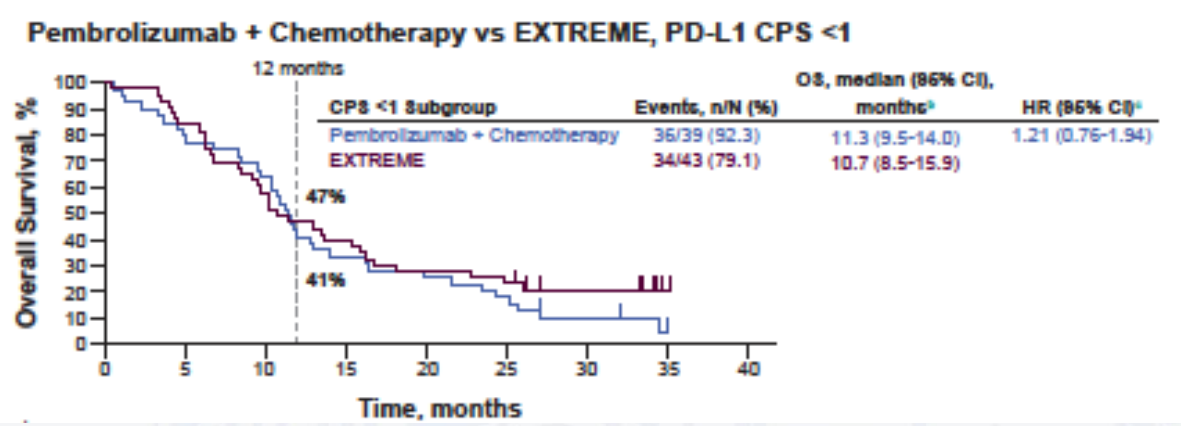


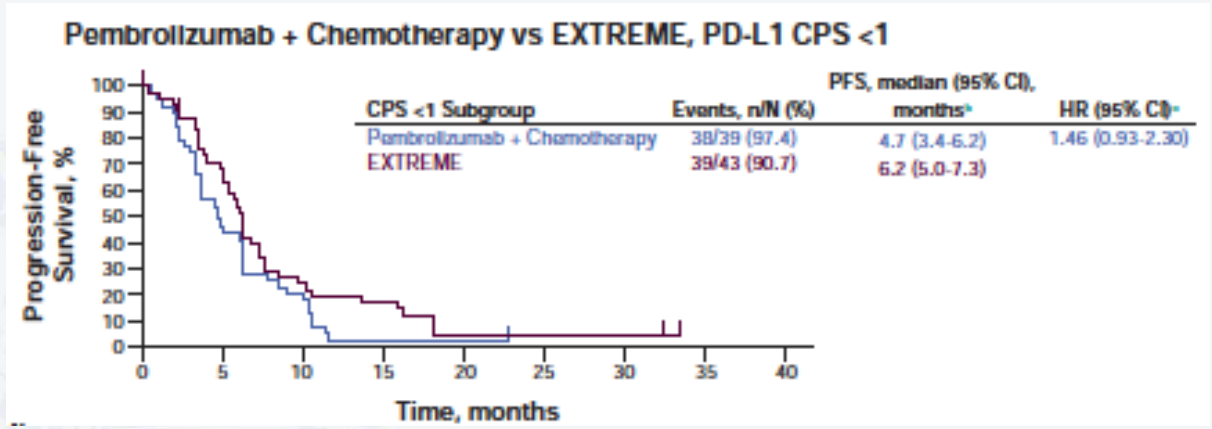


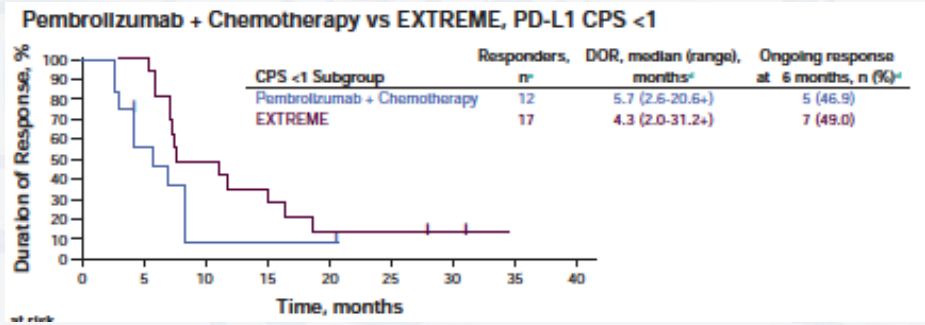
EMA/CHMP/591139/17-OCT-2019.
Burtness B, et al. AACR 2020.

KN-048: P+C vs EXTREME en CPS <1

82 pac.	mOS meses	OS 24 meses	mPFS meses	PFS 6 meses	ORR	DOR meses	DOR > 6 meses
P + QT	11,3	20,5%	4,7	43,6%	30,8%	5,7	46,9%
EXTREME	10,7	25,6%	6,2	53,8%	39,5%	4,3	49%
HR (p)	1,21 (0,78)		1,46 (0,94)				

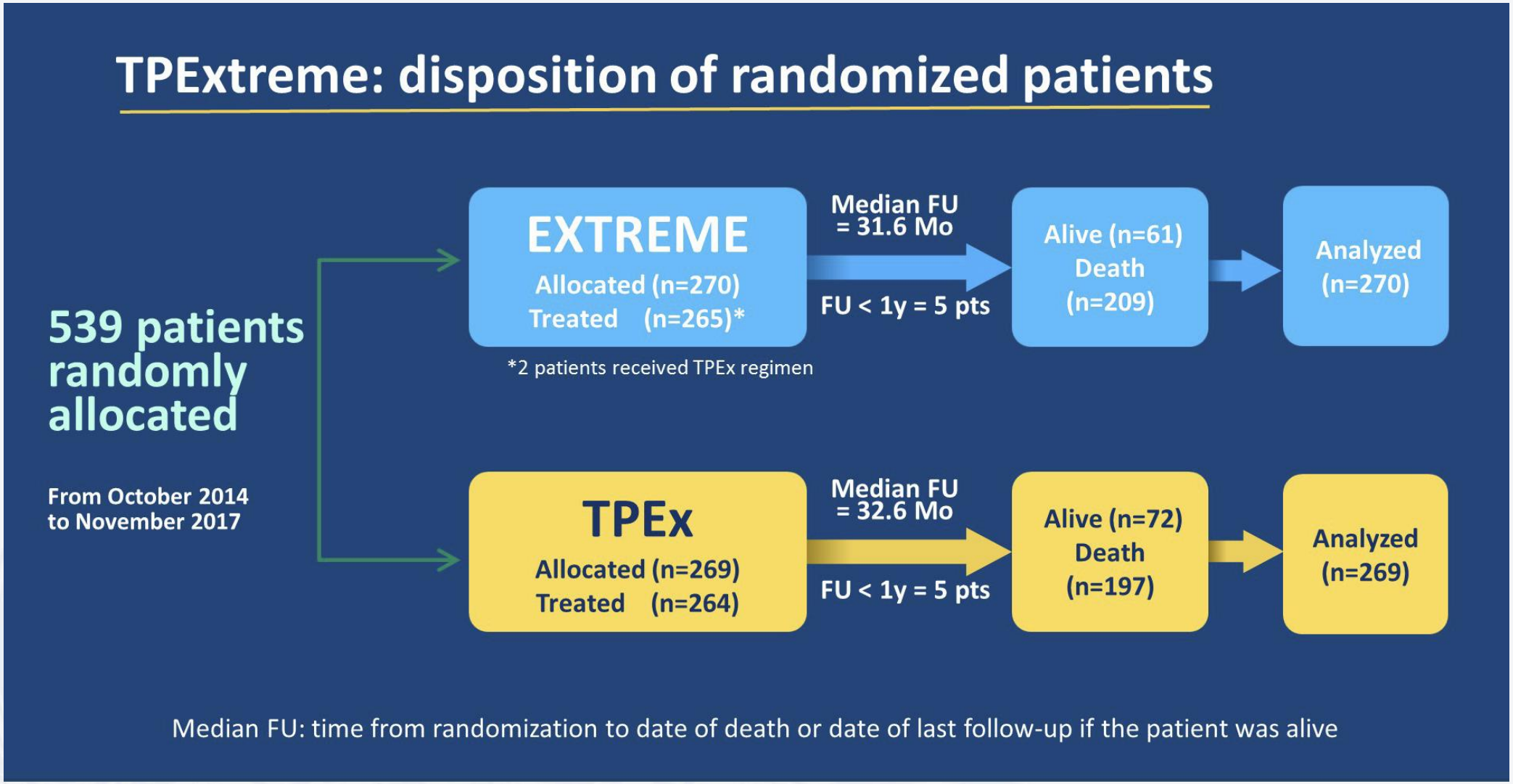






EMA/CHMP/591139/17-OCT-2019.
Burtness B, et al. AACR 2020.

TPExtreme: disposition of randomized patients



Guigay J, et al. ASCO 2019

Overall Survival

Median OS higher than expected:
14.5 months in TPEx arm and
13.4 months in EXTREME arm

Hazard ratio TPEx vs EXTREME:
HR=0.87 (95% CI: 0.71-1.05)
p-value=0.15

Guigay J, et al. ASCO 2019

TPEXTREME: toxicidad y cumplimiento terapéutico

Maximal grade of AEs	EXTREME	TPEx
% patients with no AE or AE grade 1-2	8%	19%
% patients with AEs grade 3	41%	45%
% patients with AEs grade 4	44%	30%
% patients with AEs grade 5	7%	6%

	EXTREME	TPEx	P-value
Median number of CT cycles delivered	5	4	
% of pts who received all planned cycles of CT	44%	72%	<0.0001
% of cycles administered with delay	27%	10%	<0.0001
% of pts switched to carboplatin	34%	9%	<0.0001
% of pts who received G-CSF	43%	98%	<0.0001
% of pts who received the planned number of Cx injections during CT phase	30%	51%	<0.0001

		EXTREME	TPEx	P-value
% of pts who started maintenance		52%	72%	<0.0001
% of pts without maintenance		48%	28%	
Main reasons:	Progression or death	21%	13%	
	Toxicity	11%	6%	
	Patient refusal	6%	2%	
	Other reasons	10%	7%	
Dose of Cx received during maintenance (median in mg/m²)		3 246	3 858	0.015
Duration of maintenance (median)		12 weeks	14 weeks	
Duration of treatment (CT + maintenance) (median)		18 weeks	21 weeks	

Guigay J, et al. ASCO 2019

Tratamiento de primera línea del CECyC R/M

CECyC R/M
Progresión < 6 meses tras recibir platino para enfermedad L/R[1]

CECyC R/M[1]
Progresión > 6 meses tras recibir platino para enfermedad L/R o en caso de no haber recibido nunca platino

1L*

Nivolumab
ERBITAX

Pacientes "fit"

Candidato a IT

Pembrolizumab
Pembro +QT

No candidato a IT

TPEx
EXTREME
ERBITAX

Pacientes "unfit"

Objectivo: Paliación

ERBITAX

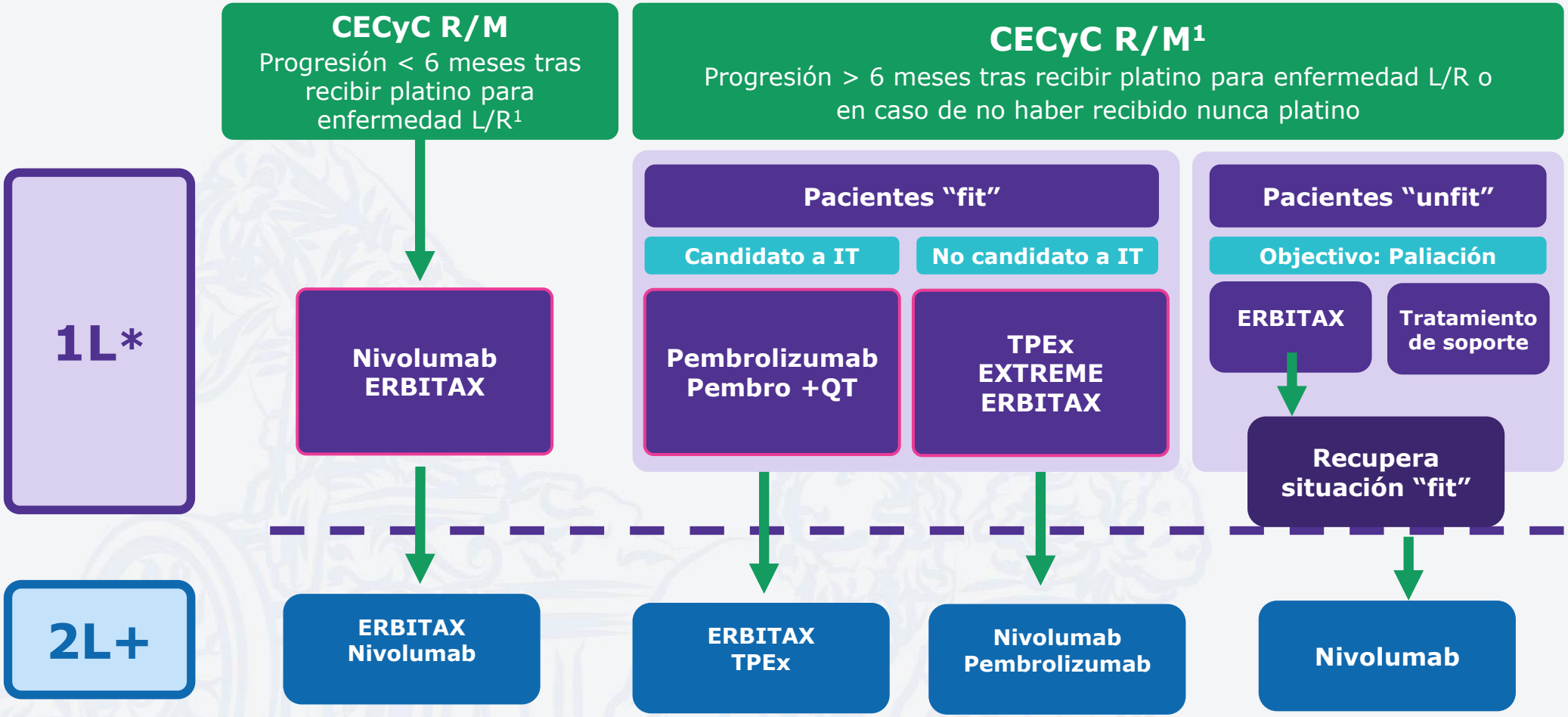
Tratamiento de soporte

Perfil clínico del paciente

- Expresión de PD-L1 (CPS)
- ECOG > 1[1]
- Contraindicaciones a inmunoterapia
- Medicación concomitante
  - ✓ Corticoides (equivalente a > 10 mg/día de prednisona)
  - ✓ Antibióticos 30 días antes o después de la inmunoterapia[2]
- Paciente con necesidad urgente de respuesta[3]
  - ✓ Muy sintomáticos
  - ✓ Enfermedad rápidamente progresiva
- Riesgo de hiperprogresión[4]

1.- Ueki Y, et al. Eur Arch Oto-Rhino-Laringol 2020.
2.- Vellanki PJ, et al. ASCO 2020.
3.- Inoue H, et al. Auris Nasus Laryns 2020.
4.- Saada-Bouzid E, et al. Ann Oncol 2017.

Continuum of care del paciente con CECyC R/M no curable



Opciones potenciales en 2L (aprobadas o no en el contexto de un ensayo clínico)

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Gracias

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