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Effective Monitoring and Management of Adverse Effects in Metastatic ESCC

Announcer:
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Dr. Yoon:
This is CME on ReachMD, and I'm Dr. Yoon. Here with me today is Dr. Ajani. The evolving treatment landscape of advanced or metastatic esophageal squamous cancer requires that clinicians be aware of how to manage and identify side effects of combination immune checkpoint inhibition and the chemo regimens properly. Early detection, timely intervention, patient education, and collaboration among healthcare professionals are necessary to optimize treatment outcomes in these patients.

Dr. Ajani, could you discuss immune-related adverse events and how you monitor for them and manage them in your practice?

Dr. Ajani:
Yes. So thank you for that. And it's my pleasure to participate in this program.

All of us have been using checkpoint inhibitors for more than 10 years, so we have all become familiar. But you bring up an important point as to how you implement monitoring as well as intervention. So for that, I feel like the whole team really needs to know the side effects, especially the common ones, and then be able to educate the patient and caregivers and then intervene as quickly as you can. So you have to identify and intervene and then bring it to resolution with guidance from variety of sources, including NCCN.

So what we normally do is when we are teaching about the anti-PD-1, we are explaining to patients what are the common side effects: skin reactions or thyroid problems or diarrhea, liver function, other things we monitor closely. So the whole team is sort of very aware of all these side effects that occur. And thyroid function, et cetera, you can monitor at a certain frequency.

So I think over the years, the comfort level is higher. But I still want to mention that some of the, for example, the gastroenterologists and pulmonary medicine individuals that become very familiar with this. So I pretend not to be an expert if there is significant pneumonitis or hepatitis, colitis, so I refer patients to them. Very early side effects I try to manage with the group.

We don't always hold the drug. I see lot of patients with rash that certainly is bothersome to them. But we can ride through that, treat them topically, and continue the checkpoint inhibitor. And of course, you have to carefully monitor. We take a lot of pictures. I ask them to take pictures. And we can use a variety of topical.

For liver function, the complication is that you use oxaliplatin and use anti-PD-1 often together, and then oxali can also cause liver function abnormality. So it can get tricky. But normally we will reduce the oxali dose, or hold oxali, and if the liver enzymes come down, we continue anti-PD-1. So there are ways to do it in early grades. This is as opposed to some other toxic reaction from other drugs where you have to hold the drug.

So in the circumstances where patient experiences toxicity where you have stopped anti-PD-1 and managed the toxicity, under what

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circumstances would you resume anti-PD-1? And if you can kind of give us some guidance on that?

Dr. Yoon:
Sure, that's a great question. So I do rechallenge with an anti-PD-1 antibody in most patients, but there's some key exceptions when I don't. And I should clarify first, that at Mayo Clinic, most patients with a serious ICI toxicity are comanaged by an ICI team who sees the patient in clinic with us, and they do phone follow-up visits with the patient, and they manage their steroid tapers. But going back to the question, the situations where I tend not to rechallenge is when there's been a grade 4 toxicity. And there's some key examples are myocarditis of any grade, and those start at grade 2, grade 4 pneumonitis. Now, I almost never see a grade 4 pancreatitis or skin reaction, or a myasthenia gravis, but those would be other situations where I would consider not rechallenging

For most other ICI toxicities, if we can get the prednisone down to about 10 mg daily, or even less than 20 mg and keep it there for at least 2 to 4 weeks while still maintaining the toxicity at a grade 1 or less, then I tend to reconsider rechallenge.

And when I do rechallenge, I sometimes do so at a lower dose of the IO drug, especially if the toxicity was severe and the steroid taper took a while, especially if there was some hiccups along the way, where we couldn't continue to steroid taper. So I start with a lower dose of the IO drug, and then it tends to work out much better, it seems, anecdotally. And the hope is that then I would up titrate the IO dose in the future based on their tolerance.

Well, this has been a great discussion. Hopefully you can put some of these tips into your own practice tomorrow. Our time is up. Thanks for listening.

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