Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/multidisciplinary-collaboration-facilitates-multimodality-therapy/36636/

Released: 08/22/2025
Valid until: 08/22/2026
Time needed to complete: 45m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Multidisciplinary Collaboration Facilitates Multimodality Therapy

Announcer:
Welcome to CE on ReachMD. This activity is provided by TotalCME. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Adkins:
This is CE on ReachMD, and I'm Dr. Douglas Adkins.

Dr. Uppaluri:
I'm Dr. Ravi Uppaluri.

Dr. Lee:
I'm Dr. Nancy Lee.

Dr. Adkins:
Dr. Uppaluri, can you provide your perspective on incorporating perioperative immune checkpoint inhibitors into the treatment paradigm for locally advanced head and neck cancer?

Dr. Uppaluri:
So what we learned from KEYNOTE-689 is that locally advanced head and neck cancer patients—stage III and IV—will be most appropriate for these attractive approaches, given the risks of recurrence and other issues that we consider in these patients.

These patients typically come in very often through surgeons in our offices but are also seen in multidisciplinary settings. And I think that's a big aspect of the referral challenges and strategies for improving access for these patients in terms of being selected for and put on this regimen.

So the major challenge is the appropriate coordination in a multidisciplinary setting. And I think we've seen a variety of different settings and how these patients are seen with that approach. Specifically, the multidisciplinary approach is critical for this strategy and it needs to be considered going forward.

Finally, with respect to surgical intervention, my perspective is that it's both phase 2 studies and this phase 3 study of KEYNOTE-689 have really shown that this window that we've introduced of 6 to 8 weeks after a patient is seen is a very safe approach and still results in a safe approach of standard of care intervention of surgery.

Dr. Adkins:
Thank you, Dr. Uppaluri. Dr. Lee, what are your thoughts on perioperative immune checkpoint inhibitors from a radiation oncologist's perspective?

Dr. Lee:
Sure, thank you, Dr. Adkins. And as Dr. Uppaluri stated, these are very locally advanced head and neck cancer patients. So from a radiation oncology perspective, our concern will always be, will there be a delay in giving radiation as a result of the administration of immunotherapy? And KEYNOTE-689 did not show that. In fact, patients were able to receive less chemoradiation, which means possibly a suggestion that the administration of pembrolizumab before surgery might have downstaged some patients, whereas they would have received chemoradiation for 6-plus weeks down to just radiation alone with immunotherapy.

And what that really means is less toxicity. And this is a huge win for our field, because head and neck radiation, especially in a post-op setting, is very large field.

It's 6 weeks of daily radiation, Monday through Friday, for 6 to 6 1/2 weeks. You can imagine the mucositis, the xerostomia, the taste changes, the pain that patients experience. And then on top of that, after surgery, you have to add chemotherapy, which will enhance the side effects.

In terms of fractionation, given the fact that these are large field, I think the current standard is still to keep within the standard 2 Gy per day of daily dose to a total of 60 to 66 Gy. And I think with the administration of immunotherapy, we noticed that not only there's an improvement in event-free survival, what I am seeing—and that's most exciting actually to me—is not only the downstaging and possibly that the surgery itself—and Dr. Uppaluri will have to speak on this—doesn't have to be as morbid of a surgery.

Dr. Adkins:
Thank you, Dr. Lee.

A key message we wish to deliver is that optimal outcomes occur when a treatment recommendation is made by a multidisciplinary team—surgeons, radiation oncologists, and medical oncologists. And when that uniform message, that consensus, that recommendation is delivered to the patient directly, very reassuring to patients to know that a team of physicians are uniformly making a treatment plan recommendation.

And secondly, it's important to identify appropriate candidates for perioperative pembrolizumab. This would be patients who have resectable locally advanced head and neck cancer, have a tumor PD-L1 combined positive score 1 or greater, have adequate organ function, and no contraindication to immune checkpoint inhibitors.

And finally, it's important that team coordination occurs so that the flow, the order of events occur to offer patients optimal outcomes.

Well, this has been a great micro discussion. Our time is up. Thanks for listening.

Announcer:
You have been listening to CE on ReachMD. This activity is provided by TotalCME and is part of our MinuteCE curriculum.

To receive your free CE credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.