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Strategies for Navigating First-Line Treatment Selection in Metastatic ESCC

Dr. Yoon:
Hi. This is CME on ReachMD, and I'm Dr. Yoon.

Dr. Ajani:
Hi, and I'm Dr. Ajani.

Dr. Yoon:
So Dr. Ajani, what can you tell us about the guideline recommendations for the first-line treatment of advanced esophageal squamous cancer?

Dr. Ajani:
Yeah, so guidelines such as NCCN, ASCO, and European Commission, reflect positive results from three studies, in this program that we have mentioned before, but I'll just repeat the names of the study. It will be KEYNOTE-590, CheckMate 648, and RATIONALE-306. So, all these three studies resulted in positive results for combination of anti-PD-1 with chemotherapy, and they are reflected in the guidelines.

Also, I think it is noted that if the PD-L1 is negative, and usually using CPS score, then we don't recommend, and the guidelines will not recommend, the use of immunotherapy. So, I think it's really important that your next patient comes along, that you consider checking PD-L1, along with the microsatellite status.

So, Dr. Yoon, can you discuss how you approach first-line treatment selection?

Dr. Yoon:
Sure. So, in terms of the chemotherapy backbone, I tend to use FOLFOX. This is generally well tolerated by patients. In our practice, we tend to avoid cisplatin because it tends not to be well tolerated. And in terms of the immunotherapy agent, I think most of the available ICI agents are comparable, and nivolumab scheduling every 2 weeks matches well with FOLFOX.

Dr. Ajani:
So what I understand is that tislelizumab data are already being reviewed by the FDA, and I think deadline is approaching very soon. So in other words, we expect FDA’s ruling any day, and I suspect that it will be a positive response from the FDA, because the data are excellent. And European agency has already approved tislelizumab, which makes nivolumab, pembrolizumab, tislelizumab available to various practices in Europe.

The question is, I ask you, Harry, how do you think the practicing oncologists will be affected by having 3 anti-PD-1s? Is there a differentiation? Or will there be a preference because we are used to a certain drug? Will there be other considerations for choosing one drug over the other?

Dr. Yoon:
I think that's a great question. I think a lot of it's going to be based on the matching with the chemotherapy backbone, until, as you were saying, the subcutaneous versions might become available. And in general, in our practice, in the US, we tend to be using FOLFOX for

lots of different reasons. And every 2-week dosing or every 6-week dosing, seems to work best with that. I think tislelizumab is the new drug on the block. And tislelizumab was the only one that was tested in a global phase 3 that allowed different chemotherapy backbones. The other two global phase 3s used cisplatin/fluoropyrimidine. So if people are thinking of a, for example, non-5-FU-based regimen, then that could be a place where tislelizumab could fit.

Well, thank you for listening, and I hope this discussion will be helpful in your clinical practice to inform you on the first-line treatment selection for patients with metastatic esophageal squamous cancer.