Case-Based Discussion on Difficult Lung Cancer Cases from Thailand

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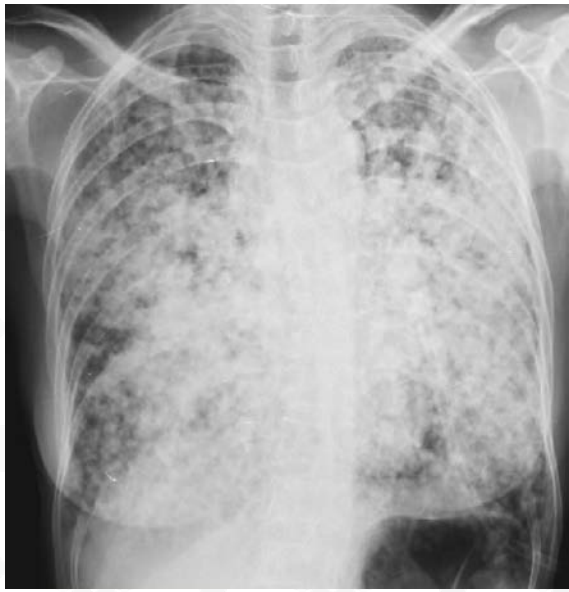
Faculty Disclosure

- Honoraria: Astra Zeneca, Boehringer Ingelheim, Roche
- Research funding: Astra Zeneca, Boehringer Ingelheim, Roche, Novartis, Samsung

- If you have any question of comment during the presentation, please feel free to ask (or comment) at anytime.

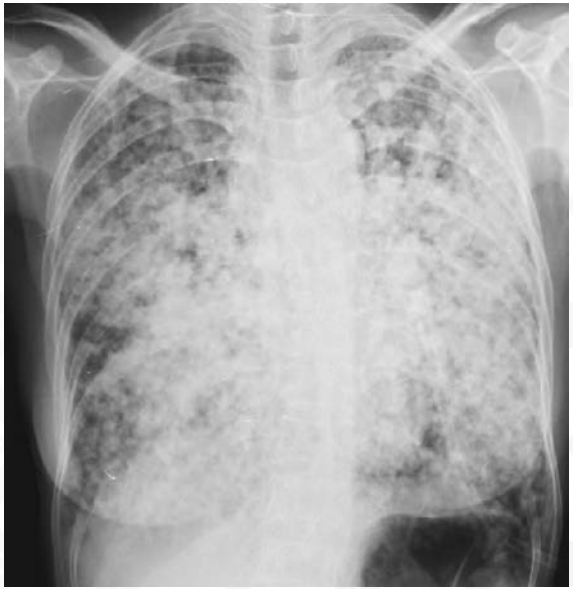
Case presentation: 1st case; P-P

- A 53 YO Thai Female, consulted form Province Hospital due to dyspnea (with impending respiratory failure)
- Never smoke
- PS III, SpO2 82% on room-air
- An middle-age female, looked fatigue/dyspnoea
- LN -ve
- Abnormal bronchial and crackles at both lungs
- Heart and abdomen: WNL
- Ext: one leg, no clubbing, no edema



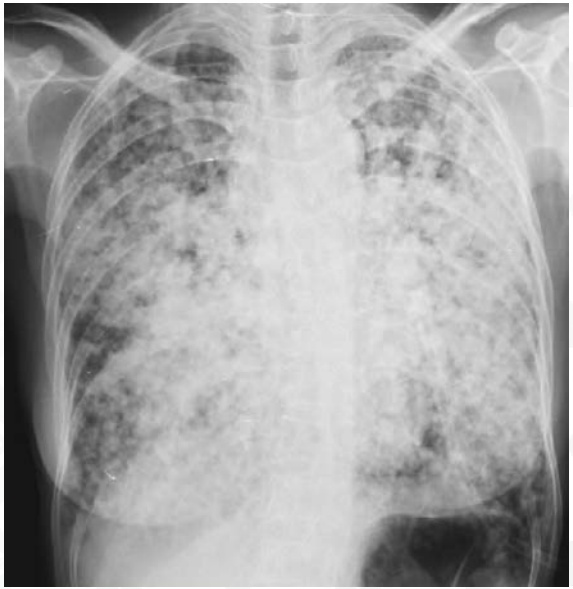
PS III: SpO2 82%

- What's the next step?
  - A. Let her for peacefully
  - B. FOB or TTNBx
  - C. Intubate (then make decision again)
  - D. Blood-based diagnosis
  - E. Start treatment with some targeted Rx



PS III: SpO2 82%

- What is the life expectancy for this subject?
  - A. 2 weeks
  - B. 2 months
  - C. 6 months
  - D. 1 year
  - E. 2 years



Progression

- FOB was done
- Pathological report: Adenocarcinoma with *EGFR* del-19
- Advise for best supportive (palliative) care
- EGFR-TKIs could not be reimbursed in Thailand for first-line treatment at that period
- The patient cannot support the cost of treatment for EGFR-TKIs
  - Drug cost: 2600-2800 USD/month
  - GNI-Thailand: 5000 USD/year

Case 1: Adv-NSCLC, *EGFR* del19, poor PS, financial problem

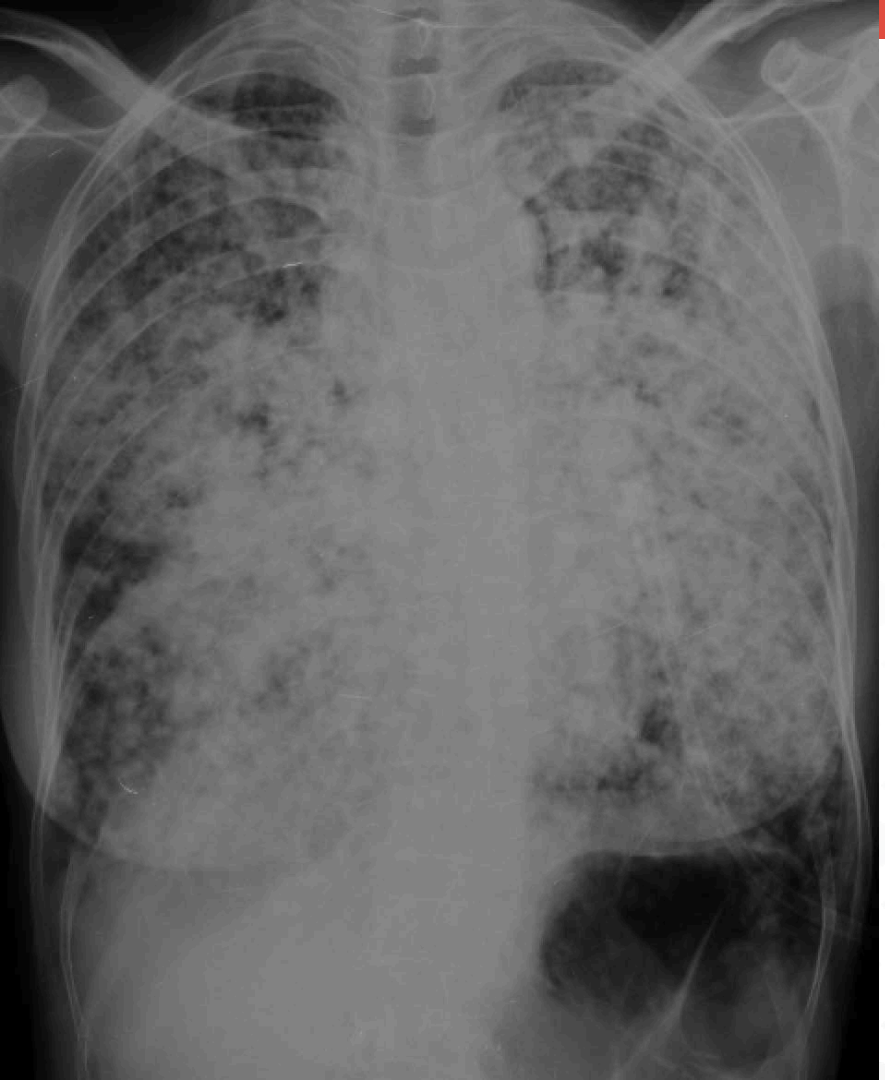
- Gefitinib(250) 1x1 was given
  - (only 5 tab from another passed away patient)
- Dramatically response, all daily activity to be normal.

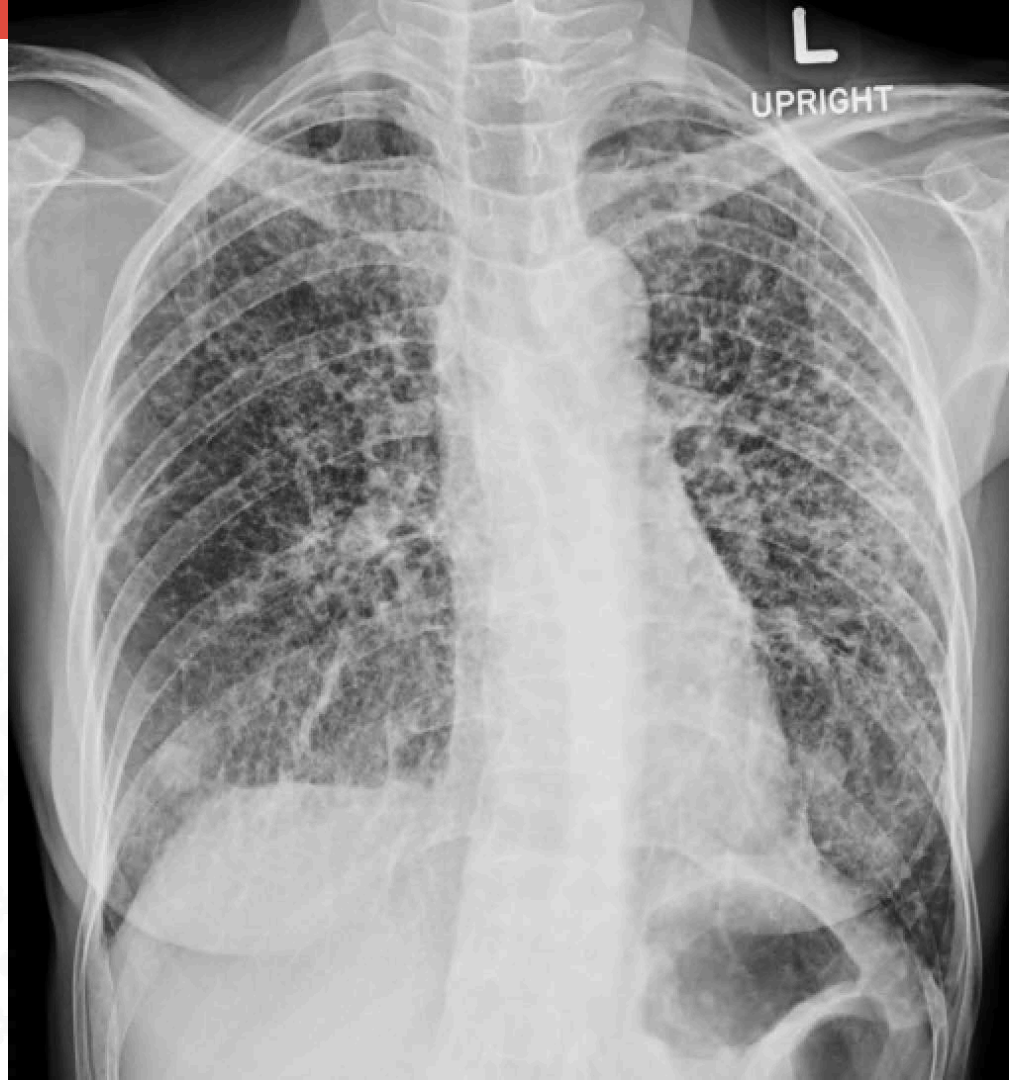
- What is the life expectancy for this subject?
  - A. 2 weeks
  - B. 2 months
  - C. 6 months
  - D. 1 year
  - E. 2 years

- What's the next step?
  - A. Let her for peacefully
  - B. Start CMTs ASAP (during improve PS)
  - C. Gefitinib or Erlotinib
  - D. Call for help from Patient-Benefit Unit
  - E. Ask for support from company

IRESSA Patient Access Program (I-PAP)

- Need to pay for 3 boxes, then free-of-charge until PD.




L
UPRIGHT

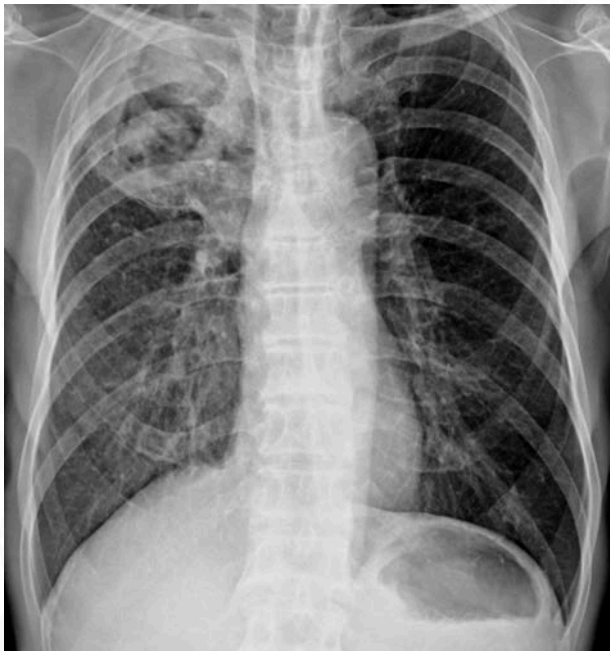
- PD after 12 months of Gefitinib

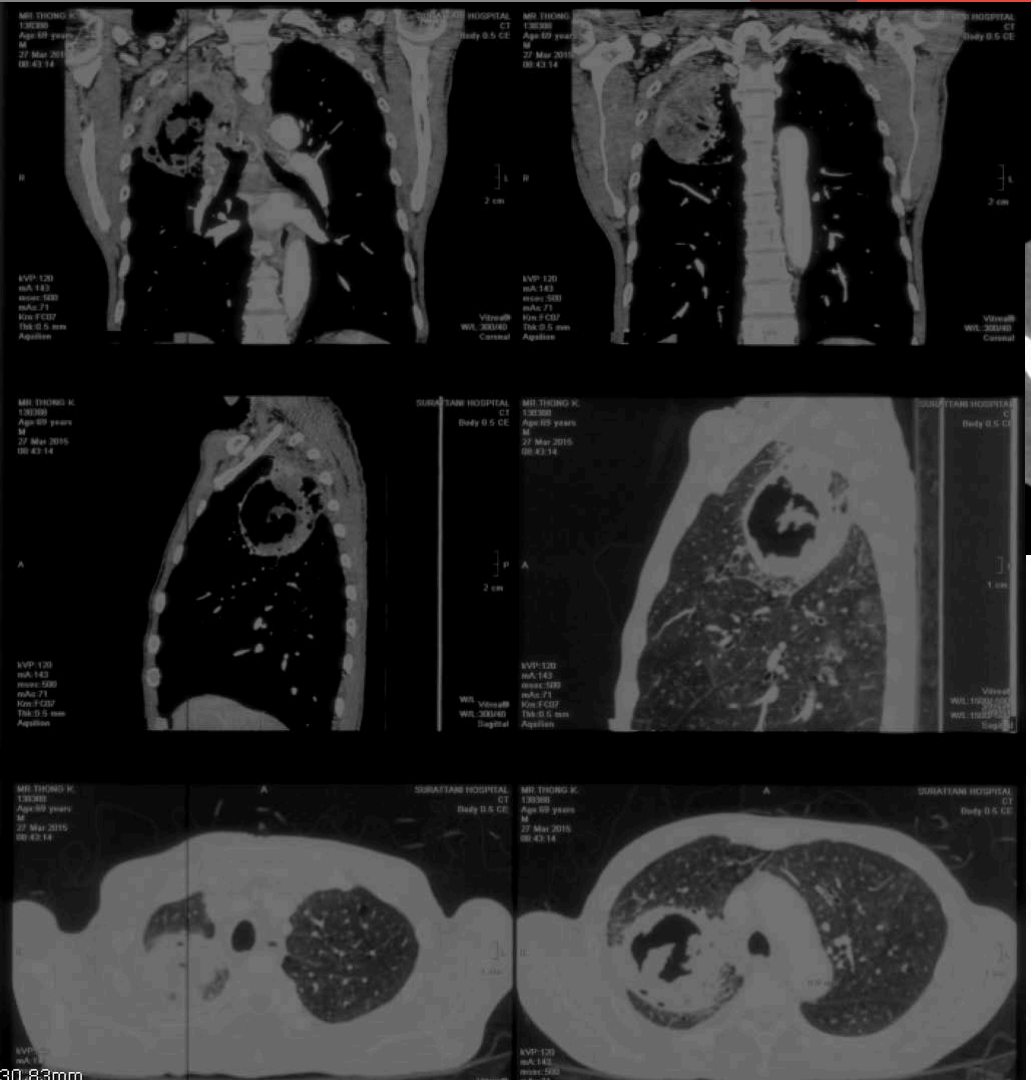
- Paclitaxel carboplatin x 6 cycles
- Best response: SD

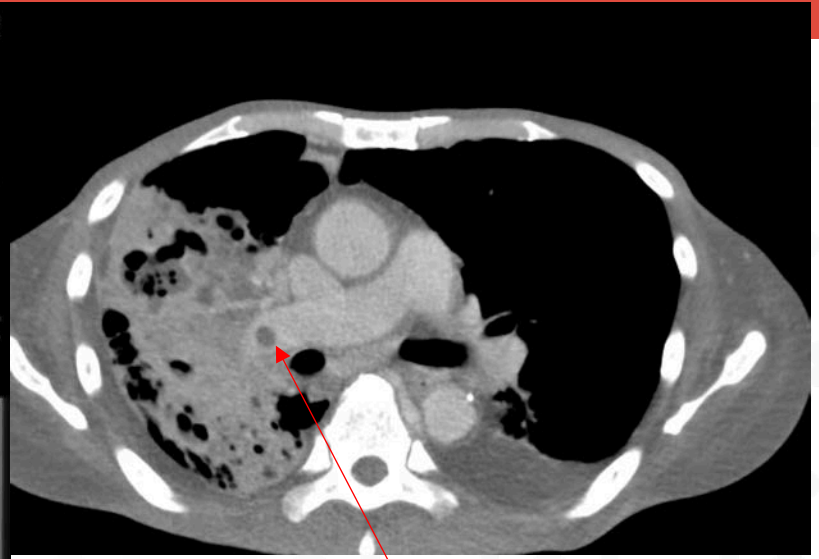
- PD again at 26 months after diagnosis → Docetaxel
- Passed away from brain metastasis at 37 months after diagnosis

Case presentation: 2nd case; T-K

- A 69 YO male,
- Chronic cough for 1 year,
- off and on minimal hemoptysis
- Heavy smoked
- PS II







T2 N2 M0

Acute PE

TBBx

- Presence of focal areas of large atypical cells (mucin-, AE1/AE3+, EMA+, CK7+, CK20-, TTF1+, p63-) with necrotic tissue, suggestive of malignancy, adenocarcinoma, poorly differentiated.
- Presence of fungal ball (GMS - septate hyphae with dichotomous branching), consistent with aspergilloma.
- EGFR: wt
- BAL c/s: Aspergillus spp, Candida tropicalis

- T2 N2 M0
- PS II
- Acute pulmonary embolism
- Aspergilloma
- Clinically not fit for Sx (cannot perform spirometry)
- Poorly diff adenocarcinoma

What's next?

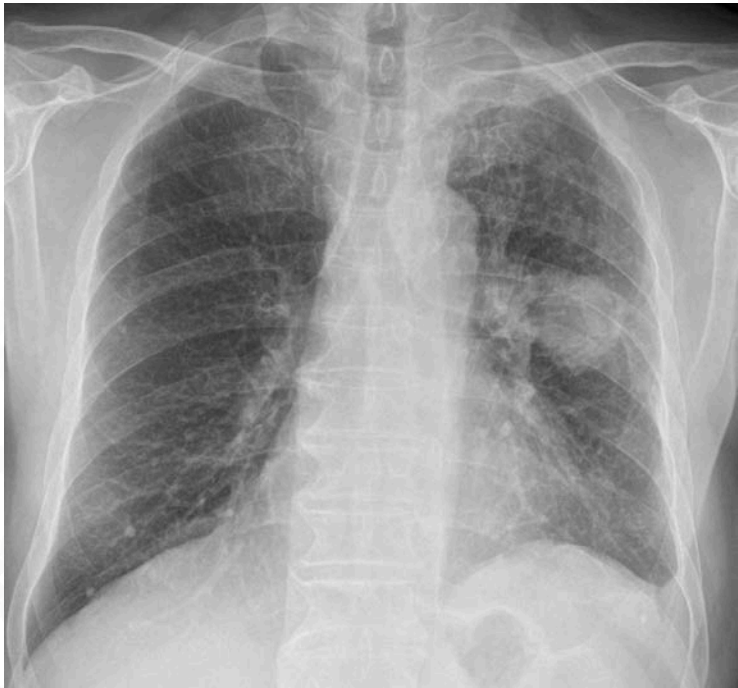
- A. Embolization for hemoptysis ?
- B. LMWH for PE ?
- C. Curative XRT (not for for Sx) ?
- D. Intra-lesional anti-fungus ?
- E. IVC filter and Curative XRT and anti-Fungus ?

- LMWH for PE
  - No PE seen at 2 months-CT
  -
- Palliative XRT for lung cancer/hemoptysis
  - Incomplete XRT due to abrupt worsening of the RUL lesion (fungal/cancer)

- Best supportive, passed away at 4 months after diagnosis

Case presentation: 3rd case; P-K

- A 74 YO Thai male, presented with dyspnea for 2 months
- Smoke 40 PY, exsmoke for 3 yrs
- PS I, SpO2 97% room-air
- An old man, looked fatigue,
- LN -ve
- Normal breath sound both lungs
- Heart and abdomen: WNL
- Ext: one leg, no clubbing, no edema



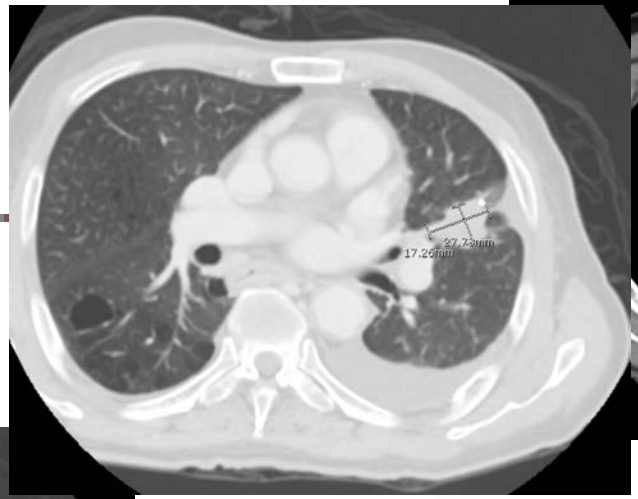
- TBBx : LUL, non-small cell carcinoma, favor adenocarcinoma,
  - TTF1 +, P53 –
- EGFR –wt
- PD-L1: no expression
- ALK-FISH assay: rearrangement

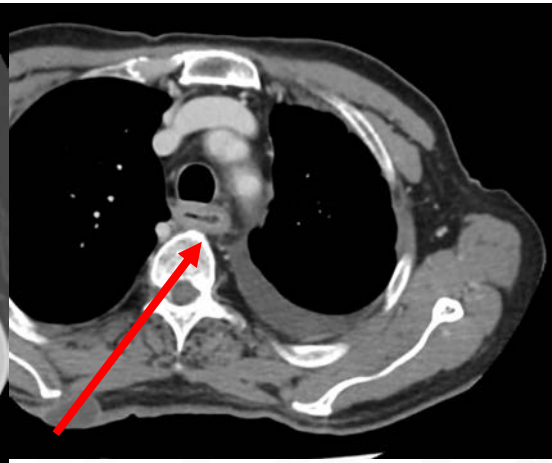
- T3N2M1

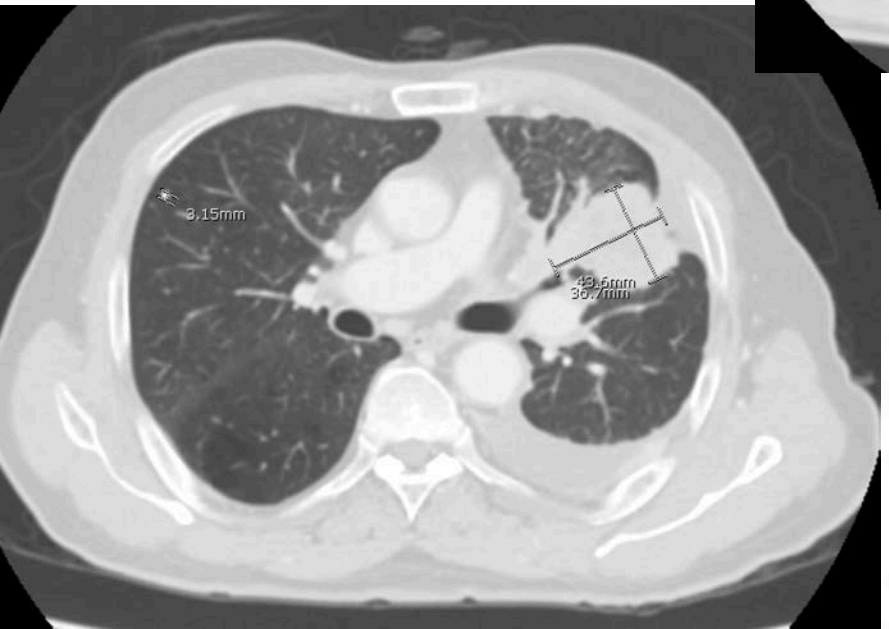
Which one ?

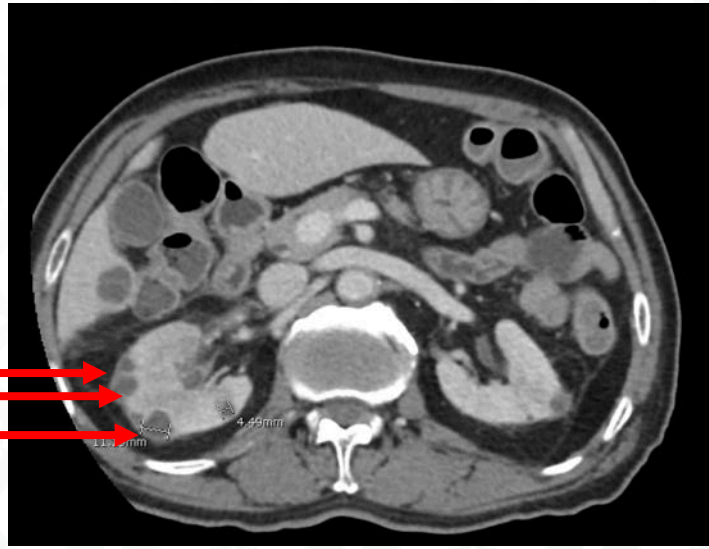
- A. Crizotinib
- B. Ceritinib
- C. Alectinib
- D. Brigatinib

Crizotinib (250) 1x2









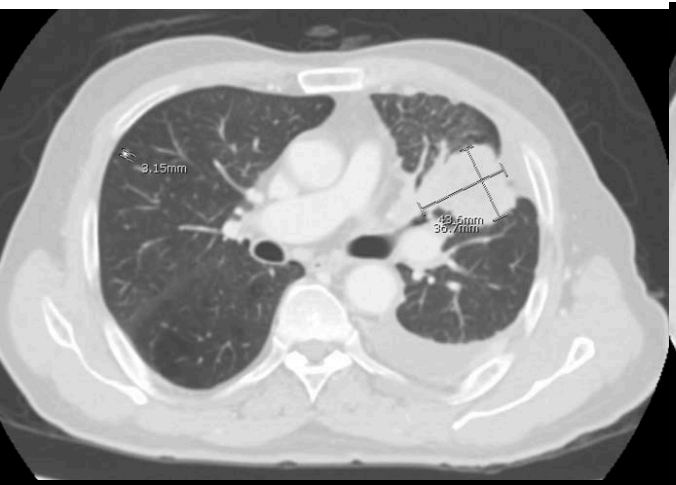
Severe esophagitis after crizotinib

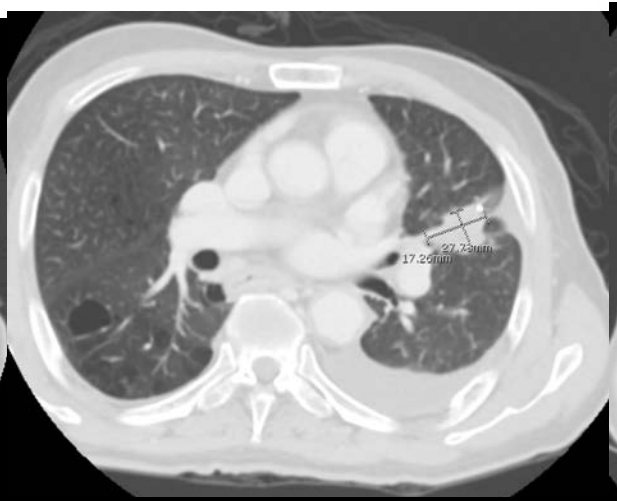
- Severe esophagitis
- Cr 1.0 → 1.42 → 3.63 mg/dl
- Hct 31 → 21 %
- TB / DB 4.25 / 3.72 mg%
- SGOT / SGPT 122 / 75

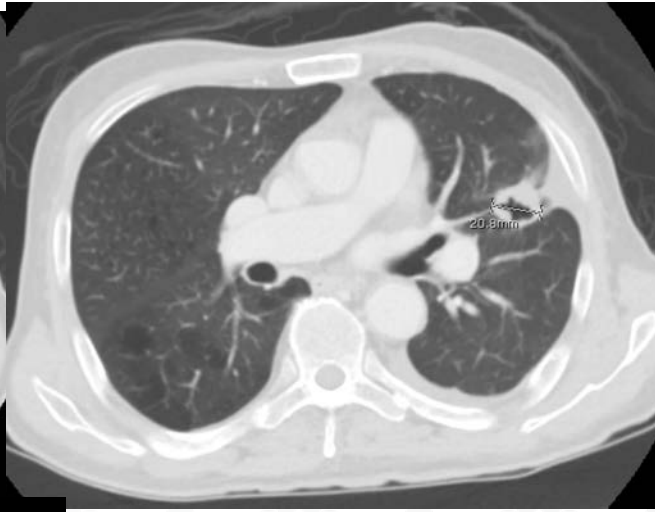
23/07/18

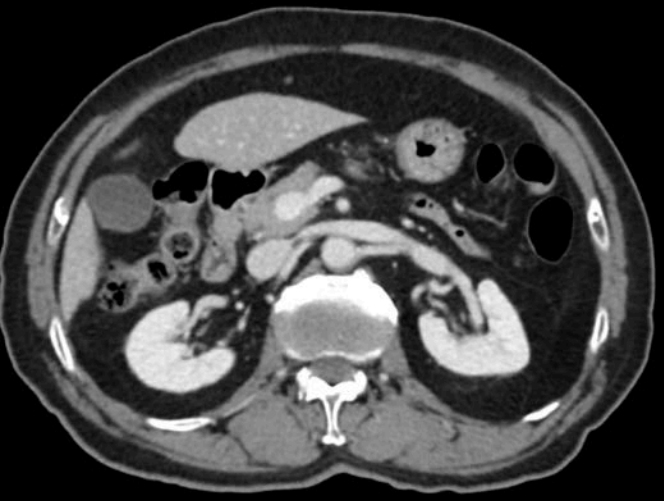
05/10/18

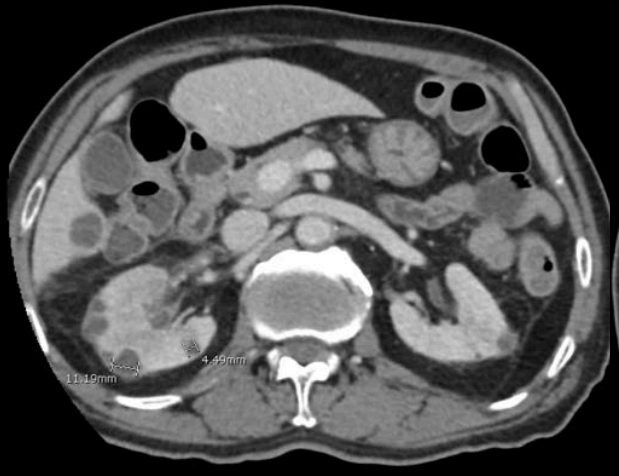
04/12/18

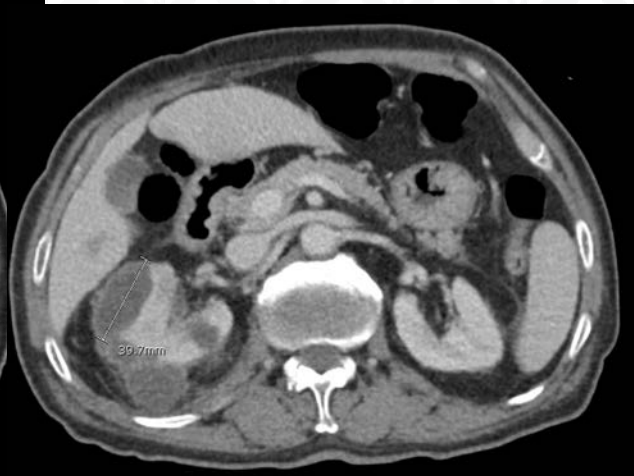








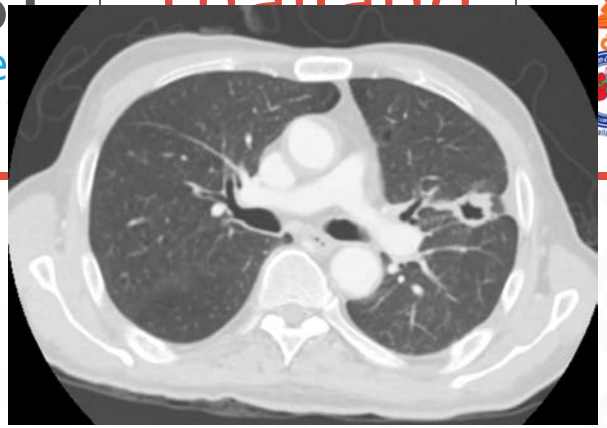




After supportive Rx

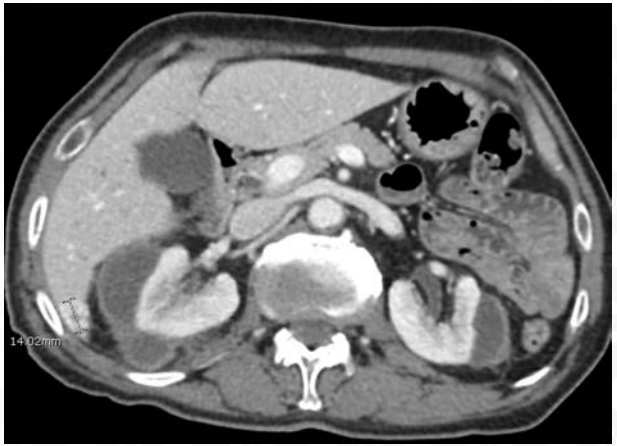
- What's next?

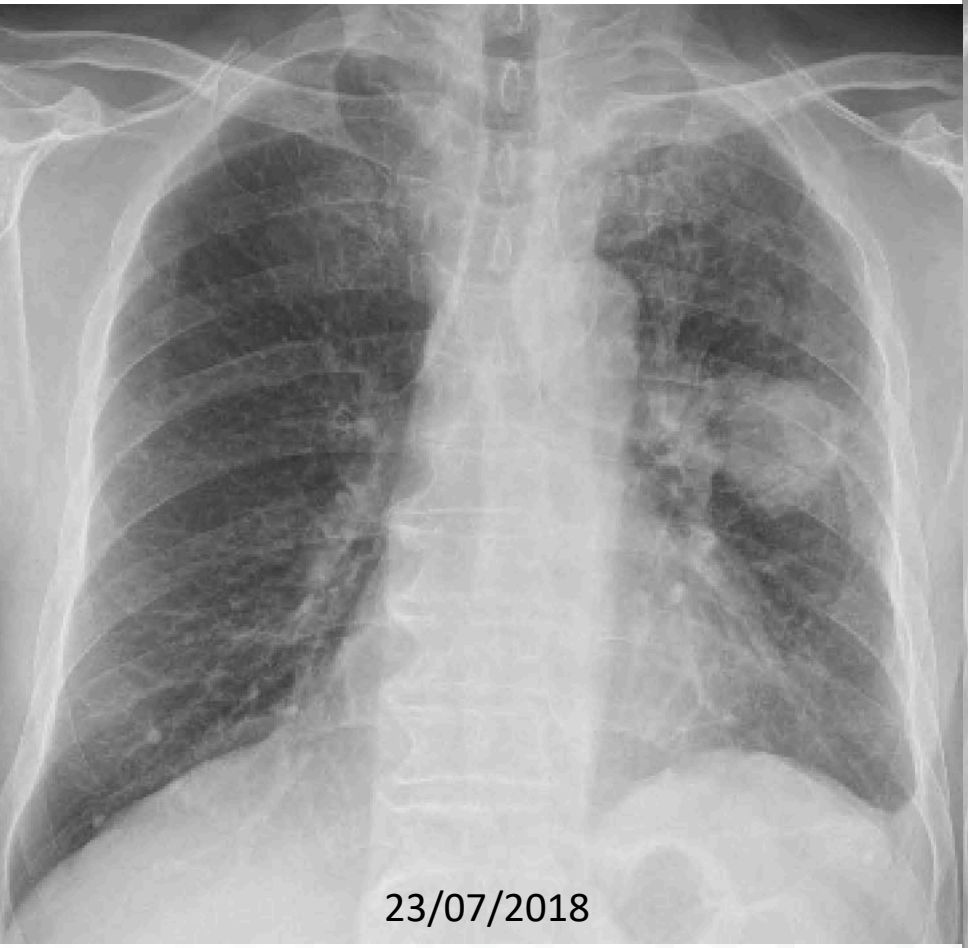
- A. Stop ALK-TKIs→ best supportive care
- B. Switch ALK-TKIs → ceritinib/alectinib
- C. Chemotherapy ?
- D. IO



- 17/01/2019 ceritinib 450mg -> 300 mg with low fat meal

- Previous visit 03/04/2019 ceritinib 150 mg with low fat meal





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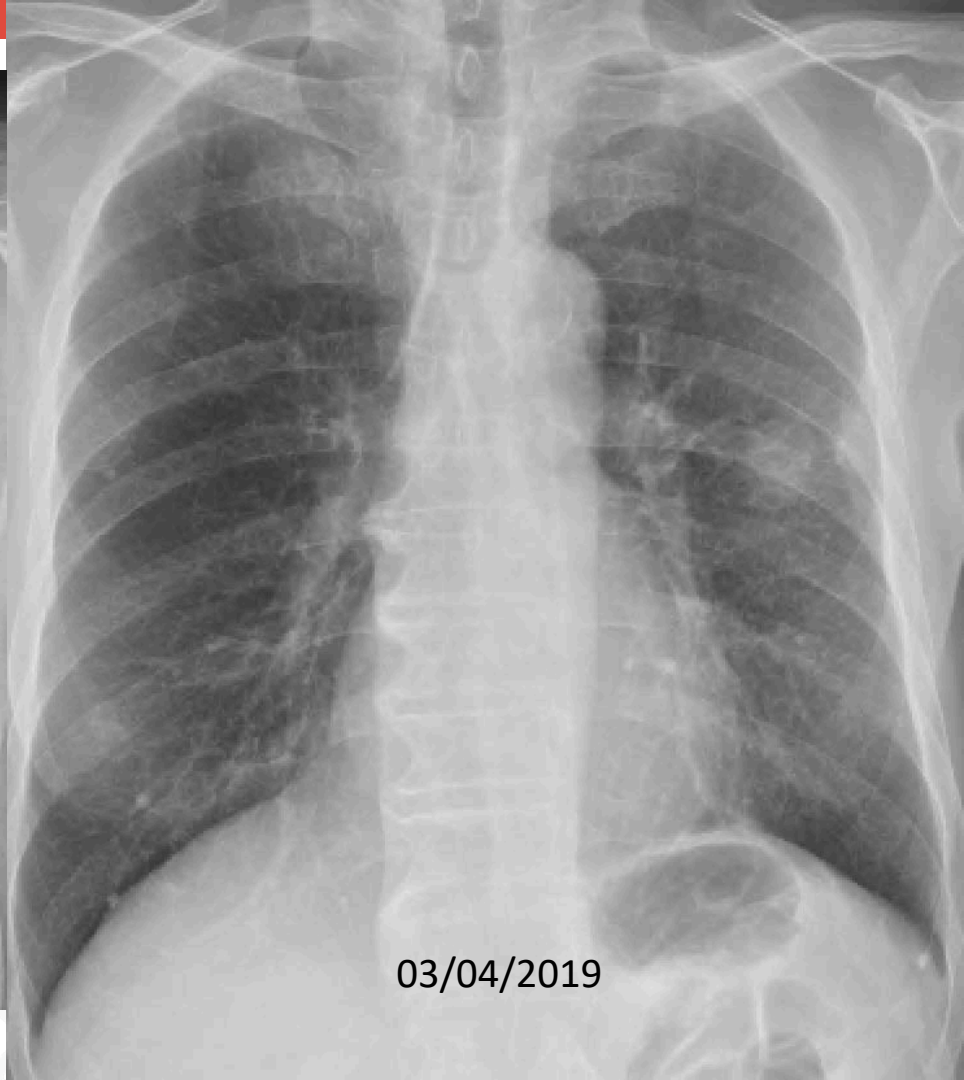

03/04/2019

Summary

- Case 1- Poor PS patient with EGFR-mt
- Case 2- Tumor, with aspergilloma and pulmonary embolism
- Case 3- Rare side effect of ALK-TKIs

Any Questions?
Thank you for attention:)

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