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10 Years

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NEWS AND VIEWS FROM THE WORLD OF CLINICAL ONCOLOGY AND HEMATOLOGY

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ASCO20 VIRTUAL SCIENTIFIC PROGRAM

Responses Achieved With Belantamab Mafodotin in Relapsed or Refractory Myeloma

by CAROLINE HELWICK

➔ **THE ANTIBODY-DRUG** conjugate belantamab mafodotin yielded responses as a single agent and in combination with bortezomib and dexamethasone in the treatment of relapsed or refractory multiple myeloma, according to two reports from the DREAMM team at the ASCO20 Virtual Scientific Program.[1,2]

In the phase I/II DREAMM-6 trial, belantamab mafodotin plus bortezomib/dexamethasone led to responses in 78% of patients, with a median of three prior regimens.[1] "This aligns with other triplet combinations using the bortezomib and dexamethasone backbone. Of note, 50% of patients achieved a deep response, greater than a very good partial response, which is encouraging at this point in time," said lead author **Ajay Nooka, MD, MPH**, Associate Professor, Division of Bone Marrow Transplant, Winship Cancer Institute of Emory University, Atlanta.

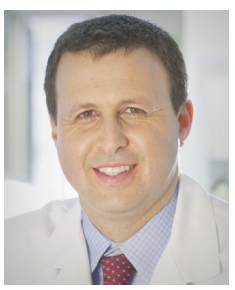
Ajay Nooka, MD, MPH

Belantamab mafodotin is a first-in-class antibody-drug conjugate that targets the B-cell maturation antigen (BCMA) expressed on malignant plasma cells. Its effect is multimodal: Upon binding to the myeloma cell surface via the BCMA receptor, belantamab mafodotin is internalized, and the active microtubule inhibitor is released into the cell, leading to apoptosis. This antibody-drug conjugate exerts tumoricidal effects on myeloma cells through CONTINUED ON P. 8

IMMUNOTHERAPY

IMbravel50 Trial: Atezolizumab Plus Bevacizumab Improves Survival in Unresectable Hepatocellular Carcinoma

by MATTHEW STENGER



Richard S. Finn, MD

➔ **AS REPORTED IN** *The New England Journal of Medicine* by **Richard S. Finn, MD**, of Jonsson Comprehensive Cancer Center, Geffen School of Medicine at the University of California, Los Angeles, and colleagues, the phase III IMbravel50 trial has shown that anti–programmed cell death ligand 1 (PD-L1) plus anti-VEGF therapy with atezolizumab plus bevacizumab improved progression-free and overall survival vs sorafenib in patients with unresectable hepatocellular carcinoma who had received no prior systemic therapy and had well-compensated liver disease.[1]

Study Details

IN THE OPEN-LABEL TRIAL, 501 patients from 111 sites in 17 countries with unresectable hepatocellular carcinoma were randomly assigned CONTINUED ON P. 32

Geriatric Assessment: What Are You Waiting For?

by STUART M. LICHTMAN, MD, FACP, FASCO

➔ **THE ASCO20** Virtual Scientific Program was the forum for an unusual but profoundly important event in oncology. Four studies that should be practice-changing were presented.[1-4] These studies provided irrefutable evidence that we can improve the quality of life of older patients by reducing toxicity. It can be accomplished by the simple application not of an expensive supportive care drug nor a molecularly designed therapy, but by something inexpensive and readily available: taking a history from the patient.

How is that possible? Don't advances in the care of patients have to be costly and complicated? Not so. The ability to help older patients with CONTINUED ON P. 161

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"These data highlight the negative impact of socioeconomic background on access to state-of-the-art therapy in clinical trials and in the real world."

—ANTONI RIBAS, MD, P. 48

Stuart M. Lichtman, MD, FACP, FASCO

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cancer has been available for decades. It needed the hard work and dedication of a few geriatric oncology investigators over the years to bring together the studies confirming what we had thought was possible. During this year's ASCO meeting, four prospective randomized trials all showed that some type of geriatric assessment can reduce toxicity and improve various outcomes. I repeat—four prospective randomized trials.

If this were a drug, we would be seeing stories on the national news, interviews on television, and the stock shooting up. But we will have none of those things, because this therapy is ultimately simple and basic, not sexy. These results cannot be ignored.

How Did We Get Here?

HOW DID WE get to this important moment? Geriatric oncology research has spanned almost 40 years. It was given a great push forward by B.J. Kennedy in his Presidential Address in 1988 and led forward by investigators such as Lodovico Balducci and Rosemary Yancik. They all told us that older patients with cancer represented a special group in need of specialized evaluation. They are special due to their unique problems, such as multimorbidity, polypharmacy, functional decline, increased cancer risk, and geriatric syndromes.

Despite being the majority of patients with cancer, older patients were never the object of clinical trials and more often were excluded from studies. This made the holy grail of treatment—evidence-based medicine—impossible to do. Unfortunately, there was little interest. Why that was the case, I am not sure. I think ageism played a role; the issues were thought unimportant; fear of toxicity of therapy was a part; and questions arose about whether it really would help in a significant or meaningful way.

"The results of geriatric assessment may be more important than those of a molecular study or a scan."

—STUART M. LICHTMAN, MD, FACP, FASCO

Things changed around 1990. A small group of clinicians showed interest and began to discuss these issues. At first, it was necessary to accumulate the available information on these patients. A major event that moved the field forward was the formation of a Cancer in the Elderly committee by the legacy cooperative group CALGB, chaired by Drs. Harvey Cohen and Hyman Muss.[5] This led to numerous clinical trials, database analyses, and educational opportunities.

In 2000, a group of clinicians formed the organization SIOG (www.siog.org; International Society of Geriatric Oncology). It was preceded by a series of informal meetings that became organized and has contributed to treatment guidelines, an annual meeting for education and research presentations, and the *Journal of Geriatric Oncology*.

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A true visionary in the field, Dr. Arti Hurria came on the scene in the early 2000s (unfortunately, she passed away in 2018). Dr. Hurria had a great influence on clinical trial development, patient evaluation, quality of life, and mentoring. One of her great achievements was the development of the Cancer and Aging Research Group (CARG), which is still very active in the professional development of young investigators and research. The development of a chemotherapy risk assessment tool has also been influential.

Making a Clinically Significant Difference

SO, WHAT WAS presented at ASCO20? The INTEGRATE study, from Australia, which included integrated oncogeriatric management, also showed an increase in quality of life (its primary endpoint) and a reduction in unplanned hospitalizations. The GAIN study, from City of Hope, which explored multidisciplinary team recommendations implemented by the primary team, showed an increase in the completion of advanced directives. The study by Mohile et al, conducted in private oncology practices, included an initial geriatric assessment, with recommendations sent to the primary oncologist. It resulted in treatment modifications and reduced toxicity. The final study was of perioperative oncogeriatric management. The intervention group showed a better Edmonton Symptom Assessment Scale score and fewer depressive symptoms. It also resulted in decreased length of stay and ICU admissions.

"Older patients need to become the focus of our endeavors. We must start now."

—STUART M. LICHTMAN, MD, FACP, FASCO

Although each of these trials has slightly different methodologies and endpoints, the message is the same: Some type of geriatric assessment makes a clinically significant difference.

The pushback to geriatric evaluation has been it is time-consuming, expensive, not educated on this, etc. This is not the case. Also, even if a few extra minutes are required, the benefit is worth the effort. As Dr. Hamaker noted: "Geriatric assessment is not too time-consuming; it is time well spent."[6,7] ASCO, SIOG, the European Society for Medical Oncology, and others have websites to help guide and simplify these evaluations. An ASCO guideline publication offers guidance to determine the most important evaluations.[8]

There is no expectation that a busy oncologist will do a comprehensive assessment; that is probably not necessary. Various components can be introduced gradually. It is a way for clinicians to begin to feel comfortable with geriatric evaluation and to make a tangible impact on patient care. Evaluation of polypharmacy and the ability to take medications correctly is a part of routine drug reconciliation. It also is a part of the instrumental activities of daily living (IADL; organizing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, managing medications, and overseeing a household).

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Deficiencies in components of IADL have consistently been associated with increased therapy-related toxicities and poor outcomes.

It takes seconds to ask about falls and to test memory. Other aspects of geriatric evaluation can be gradually introduced into a physician's practice so the value of each component can be appreciated. Polypharmacy, one of the geriatric syndromes, can be evaluated during routine drug reconciliation.[9] Technologies are already available to streamline this process.[10,11]

A Call to Action

FORTY YEARS of dedication and research have led to this point. These four trials, along with some others, have shown that some type of geriatric-specific evaluation for older patients has value.[12,13] It improves outcomes and quality of life.

Isn't that what we want for our patients? Why wouldn't we do this? There are no barriers, no toxicity, and proven benefit. Many evaluations can be done by office staff or self-assessment. Physician time is devoted to acting on the results. These results may be more important than those of a molecular study or a scan. This is personalized medicine in its highest form. This is evidence-based medicine. The COVID-19 epidemic has dramatically demonstrated the vulnerability of older patients. The number of older patients with cancer is rising rapidly and will be the majority of patients we treat. They need to become the focus of our endeavors. We must start now.

So, what are you waiting for? ■

DISCLOSURE: Dr. Lichtman has served as a consultant or advisor to Magellan Health and Remedy One.

REFERENCES

1. Qian CL, Knight HP, Ferrone CR, et al: Randomized trial of a perioperative geriatric intervention for older adults with cancer. ASCO20 Virtual Scientific Program. Abstract 12012.
2. Soo WK, King M, Pope A, et al: Integrated geriatric assessment and treatment (INTEGERATE) in older people with cancer planned for systemic anticancer therapy. ASCO20 Virtual Scientific Program. Abstract 12011.
3. Li D, Sun CL, Kim H, et al: Geriatric assessment-driven intervention (GAIN) on chemotherapy toxicity in older adults with cancer: A randomized controlled trial. ASCO20 Virtual Scientific Program. Abstract 12010.
4. Mohile SG, Mohamed MR, Culakova E, et al: A geriatric assessment intervention to reduce treatment toxicity in older patients with advanced cancer: A University of Rochester Cancer Center NCI community oncology research program cluster randomized clinical trial. ASCO20 Virtual Scientific Program. Abstract 12009.
5. Cohen HJ, Muss HB: The Cancer and Leukemia Group B Cancer in the Elderly Committee: Addressing a major cancer need. Clin Cancer Res 12:3606s-3611s, 2006.
6. Hamaker ME, Te Molder M, Thielen N, et al: The effect of a geriatric evaluation on treatment decisions and outcome for older cancer patients: A systematic review. J Geriatr Oncol 9:430-440, 2018.
7. Hamaker ME, Wildes TM, Rostoft S: Time to stop saying geriatric assessment is too time consuming. J Clin Oncol 35:2871-2874, 2017.
8. Mohile SG, Dale W, Somerfield MR, et al: Practical assessment and management of vulnerabilities in older patients receiving chemotherapy: ASCO guideline for geriatric oncology. J Clin Oncol 36:2326-2347, 2018.
9. Lichtman SM: Polypharmacy: Geriatric oncology evaluation should become mainstream. J Clin Oncol 33:1422-1423, 2015.
10. Shahrokni A, Lichtman S, Korc-Grodzicki B: When it comes to geriatric assessment, Rome was not built in one day. Oncologist 25:279-280, 2020.
11. Shahrokni A, Loh KP, Wood WA: Toward modernization of geriatric oncology by digital health technologies. Am Soc Clin Oncol Educ Book 40:1-7, 2020.
12. Corre R, Greillier L, Le Caër H, et al: Use of a comprehensive geriatric assessment for the management of elderly patients with advanced non-small-cell lung cancer: The phase III randomized ESOGIA-GFPC-GECP 08-02 study. J Clin Oncol 34:1476-1483, 2016.
13. Kalsi T, Babic-Illman G, Ross PJ, et al: The impact of comprehensive geriatric assessment interventions on tolerance to chemotherapy in older people. Br J Cancer 112:1435-1444, 2015.

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