A Vision of Hope: A Kidney Cancer Educational Symposium

What’s new for my cancer beyond first line treatment?

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Pavia
The Castle
The Old Bridge
The Cathedral
The river Ticino
The old University

The new University Campus

IRCCS Istituti Clinici Scientifici Maugeri
## My disclosures

<table>
<thead>
<tr>
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| Other relationship, namely ...   | - Expert testimony: Pfizer, EUSA  
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Few considerations on 2nd line therapy

When I start talking to a patient of mine about 2nd-line, is because 1st-line therapy has failed, or at least has stopped doing its job, i.e. controlling tumor progression …

This is always a tough moment for a cancer patients, like the entire world is on the edge of falling on his/her head

For the vast majority of You, fortunately, this is not true ... this is an unpleasant, but obliged, step in Your personal war against cancer
Very few individual agents proved able to impact on OS

Sunitinib, Pazopanib, Sorafenib, Bevacizumab + Interferon, Axitinib, Everolimus, Lenvatinib + Everolimus, Avelumab + Axitinib, all are active agents/combos, which yielded just a PFS benefit, not an OS one ...

Only Temsirolimus (in a niche of patients), Ipilimumab + Nivolumab and Pembrolizumab + Axitinib prolonged OS in 1st line, while Nivolumab monotherapy, and Cabozantinib did the same in 2nd line
Since mRCC patients’ survival has greatly improved over the years ...

... it is clear that any OS benefit is achieved by a sequence of active treatment, not by a single agent

The number of patients receiving more than 2 lines of therapy is increasing, and this often leads to long survival times ...
And fortunately enough, Tom’s axiom is no longer necessarily true ...
No separation for the first months

... AND
after few years a survival plateau is observed, and we start to see long-term survivors (cured?)

BUT...
separation of curves and survival impact occurs thereafter – and median OS is thus increased
A universal rule ...

Not every Physicians are equal, but all cancer patients are ...

They simply want to live longer ... and better

Whatever «better» means to each of them; for sure «better» is hardly captured by usual QoL questionnaires

That’s why we are developing and validating across different countries, patients’ reported outcomes
The trade-off between benefits (survival gain) and harms (treatment-related toxicities) a typical 2\textsuperscript{nd} line patient is willing to accept, is often different as compared to that usually accepted by a newly diagnosed patient. Safety and thus quality of life is usually more important in later treatment lines ... though, of course, this is not an universal rule
This means that ...

The treatment experience of each given patient is key in order to select 2\textsuperscript{nd} line therapy.

Just an example: if a patient has experienced huge toxicities in 1\textsuperscript{st}-line, than a more «gentle» agent is probably the better choice for subsequent therapy.
RCC remains an angiogenesis-driven tumor throughout its whole natural history

... meaning that, after the failure of an antiangiogenic agent, another one can be active and continue to control disease progression

A truly paradigm shift from the era of cytotoxic chemotherapy
Disparities (either geographical, social, or racial) in the access to active anticancer treatments ... across different tumor types

And I am going to show You some of the slides Cora presented yesterday to explain this ...
Geographical distribution of the enrolling centers

Concentration of centers in USA and Canada, Europe, Australia and China
The distribution of enrolling centers doesn’t align with the burden of RCC
Unequal distribution of clinical trials is related to income in the countries

HIC: High income countries, UMIC: Upper middle income countries, LMIC: lower middle income countries
Patterns of clinical practices for mRCC in the US and Italy

**1L**
- Axitinib + Avelumab
- Pazopanib
- Sunitinib
- Ipilimumab + Nivolumab
- Cabozantinib
- Axitinib + Pembrolizumab
  - Axitinib
  - IL-2 (HD)
  - Temsirolimus

**>1L**
- Cabozantinib
- Nivolumab (+/- ipilimumab)
  - Lenvatinib + Everolimus
  - Everolimus
  - Axitinib +/- Pembrolizumab (or Avelumab)
  - Pazopanib, Sunitinib, Sorafenib
  - IL-2 (HD)
  - Temsirolimus
  - Bevacizumab

**Pharma expanded access**

- Bevacizumab + IFNa
- Ipilimumab + Nivolumab **

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In conclusion ...

I WANT TO BELIEVE
Thank You very much for Your kind attention!!!

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