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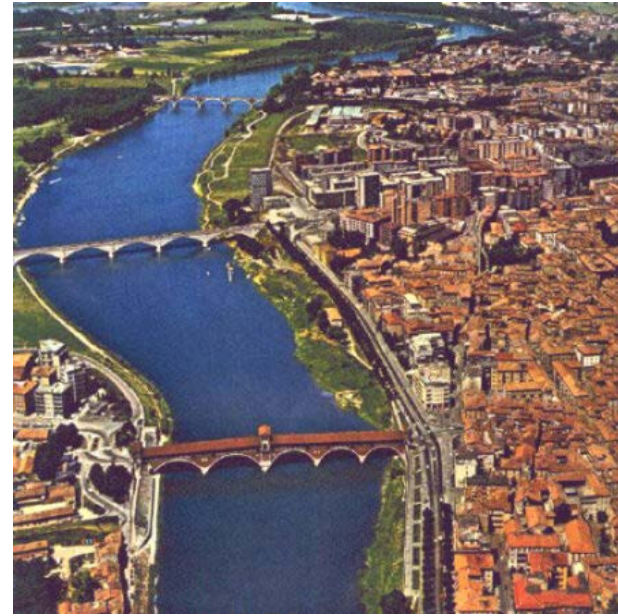
A Vision of Hope: A Kidney Cancer Educational Symposium

## What's new for my cancer beyond first line treatment?

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**The river Ticino**



**The Old Bridge**



**The Castle**



**The Cathedral**





**The old University**



**The new University Campus**



**IRCCS Istituti Clinici Scientifici Maugeri**

# My disclosures

(Potential) conflicts of interest	Company name
<ul style="list-style-type: none"><li>• Research funding</li></ul>	Pfizer
<ul style="list-style-type: none"><li>• Consultancy/Speakers' bureau</li></ul>	Ipsen, BMS, MSD, Pfizer, Novartis, Eisai, EUSA, Janssen, General Electrics, Roche
<ul style="list-style-type: none"><li>• Stock ownership</li></ul>	None
<ul style="list-style-type: none"><li>• Other relationship, namely ...</li></ul>	<ul style="list-style-type: none"><li>- Expert testimony: Pfizer, EUSA</li><li>- Protocol Steering Committee Member: Eisai, EUSA, Pfizer</li></ul>



## **Few considerations on 2<sup>nd</sup> line therapy**

**When I start talking to a patient of mine about 2<sup>nd</sup>-line, is because 1<sup>st</sup>-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 ...**

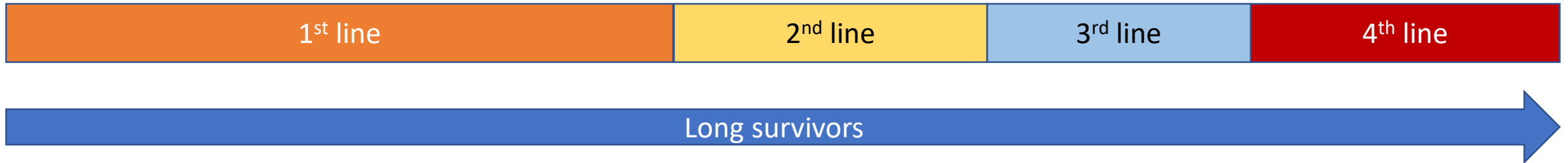
**Only Temsirolimus (in a niche of patients), Ipilimumab + Nivolumab and Pembrolizumab + Axitinib prolonged OS in 1<sup>st</sup> line, while Nivolumab monotherapy, and Cabozantinib did the same in 2<sup>nd</sup> line**





**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 ...

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Second-line therapy after VEGF targeted therapy in metastatic renal cancer... Second-Line Therapy After VEGF Targeted Therapy in Metastatic Renal... come fotografare lo schermo del mac - Cerca con Google

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Clin Genitourin Cancer. 2012 Jun;10(2):67-8. doi: 10.1016/j.clgc.2012.04.001.

**Second-line therapy after VEGF targeted therapy in metastatic renal cancer: a law of diminishing returns.**

Powles T.

PMID: 22608779 DOI: 10.1016/j.clgc.2012.04.001

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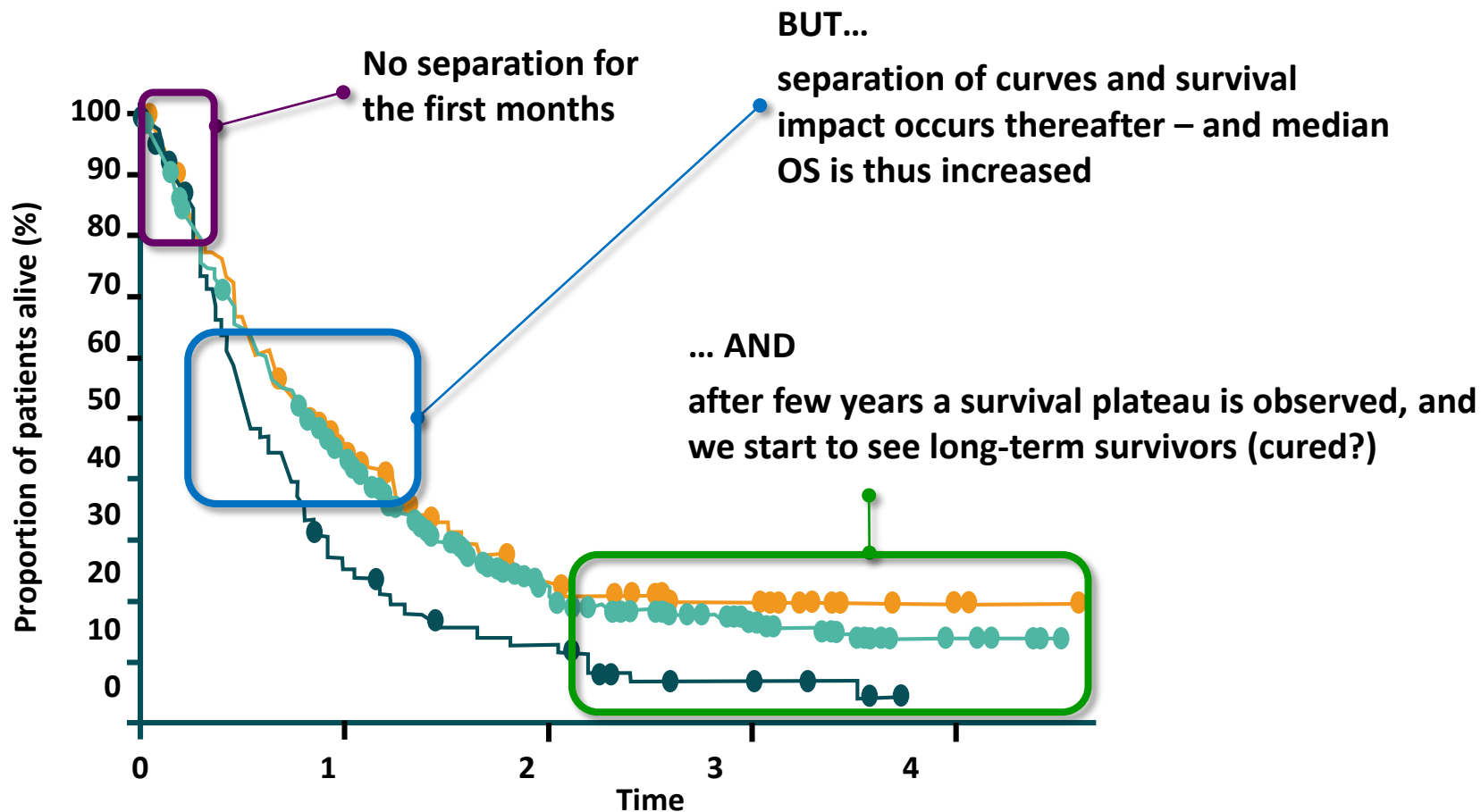
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## Immunotherapy: a step toward cure?





## **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**



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## Another rule ...

**The trade-off between benefits (survival gain) and harms (treatment-related toxicities) a typical 2<sup>nd</sup> 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**



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## **This means that ...**

**The treatment experience of each given patient is key in order to select 2<sup>nd</sup> line therapy**

**Just an example: if a patient has experienced huge toxicities in 1<sup>st</sup>-line, than a more «gentle» agent is probably the better choice for subsequent therapy**





## **Taking into account that ...**

**RCC remains an angiogenesis-driven tumor throughout its whole natural history**

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

**A truly paradigm shift from the era of cytotoxic chemotherapy**



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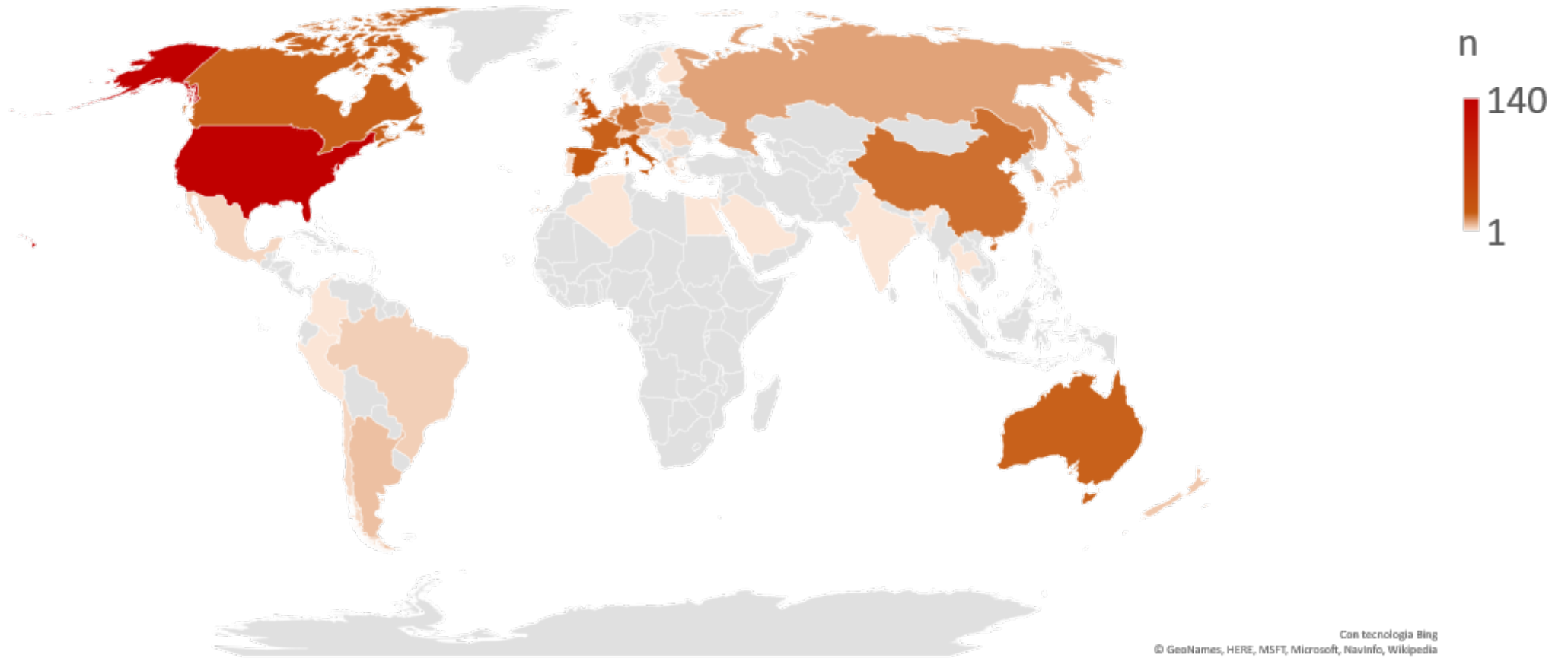


## **The greatest issue is ...**

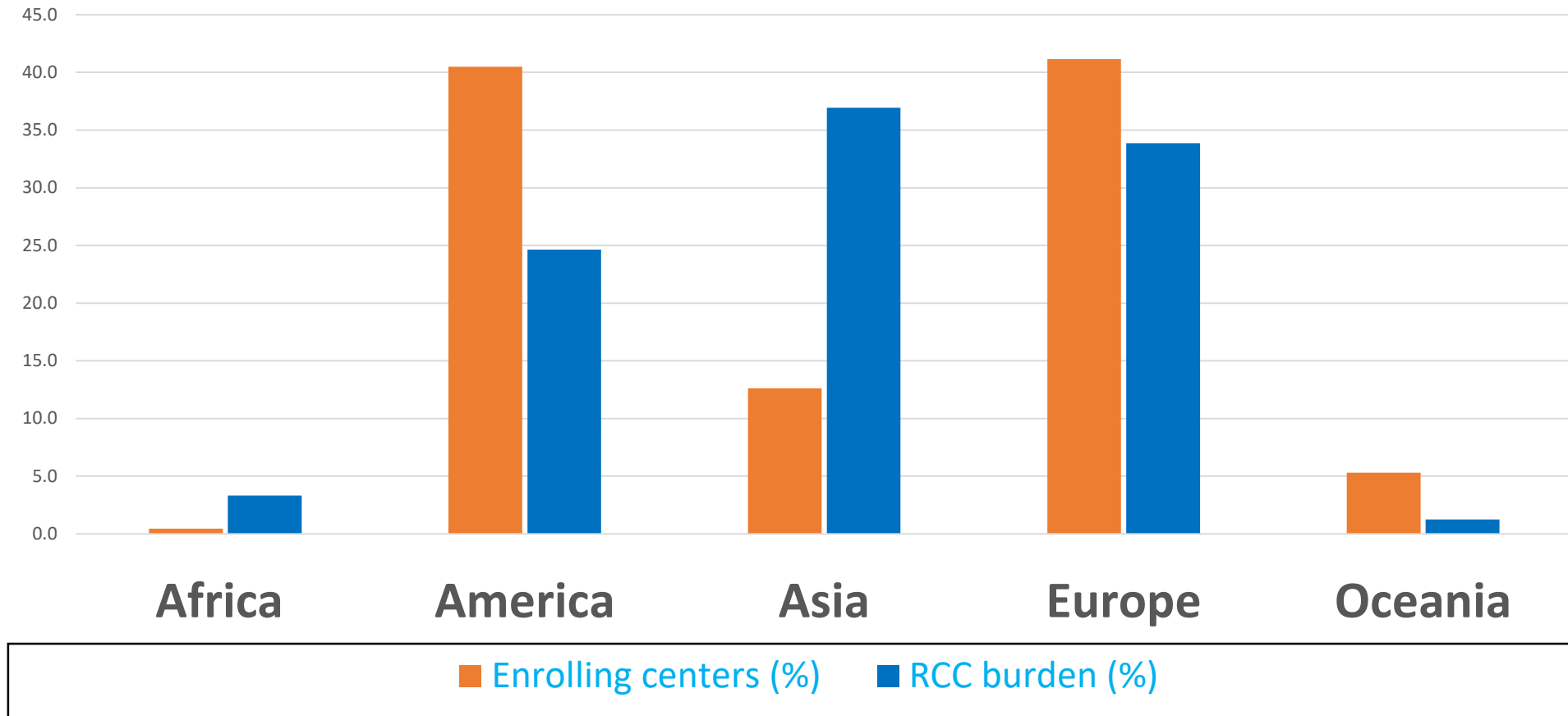
**Disparities (either geographical, social, or racial) in the access to active anticancer treatments ... across different tumor types**

**And I am going to show You some of the slides Cora presented yesterday to explain this ...**

# Geographical distribution of the enrolling centers

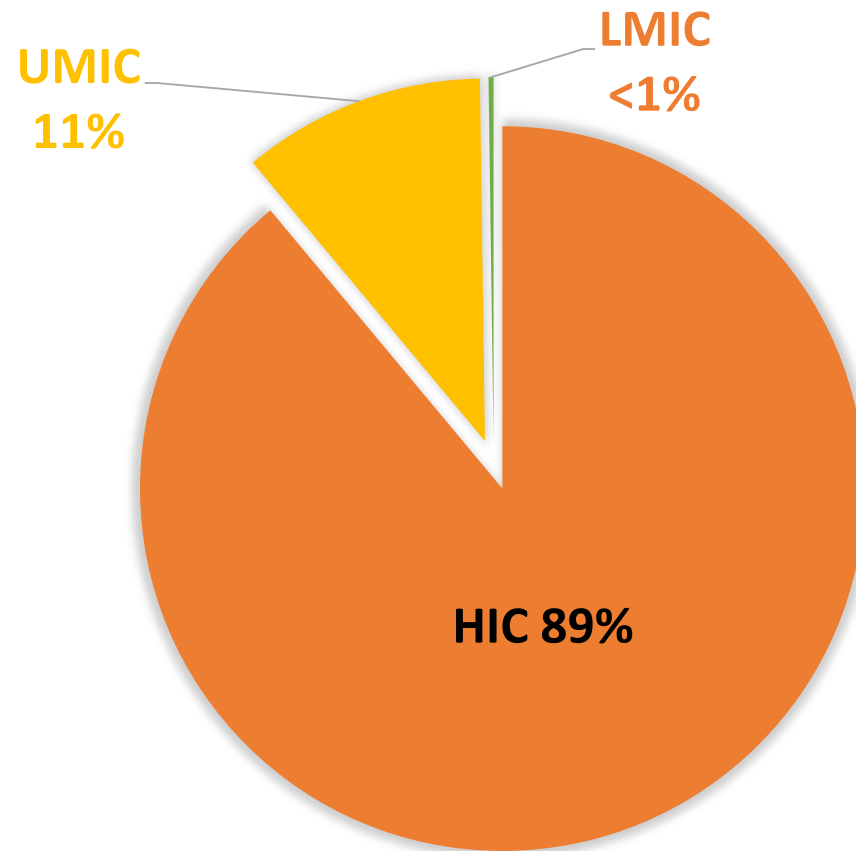


# The distribution of enrolling centers doesn't align with the burden of RCC



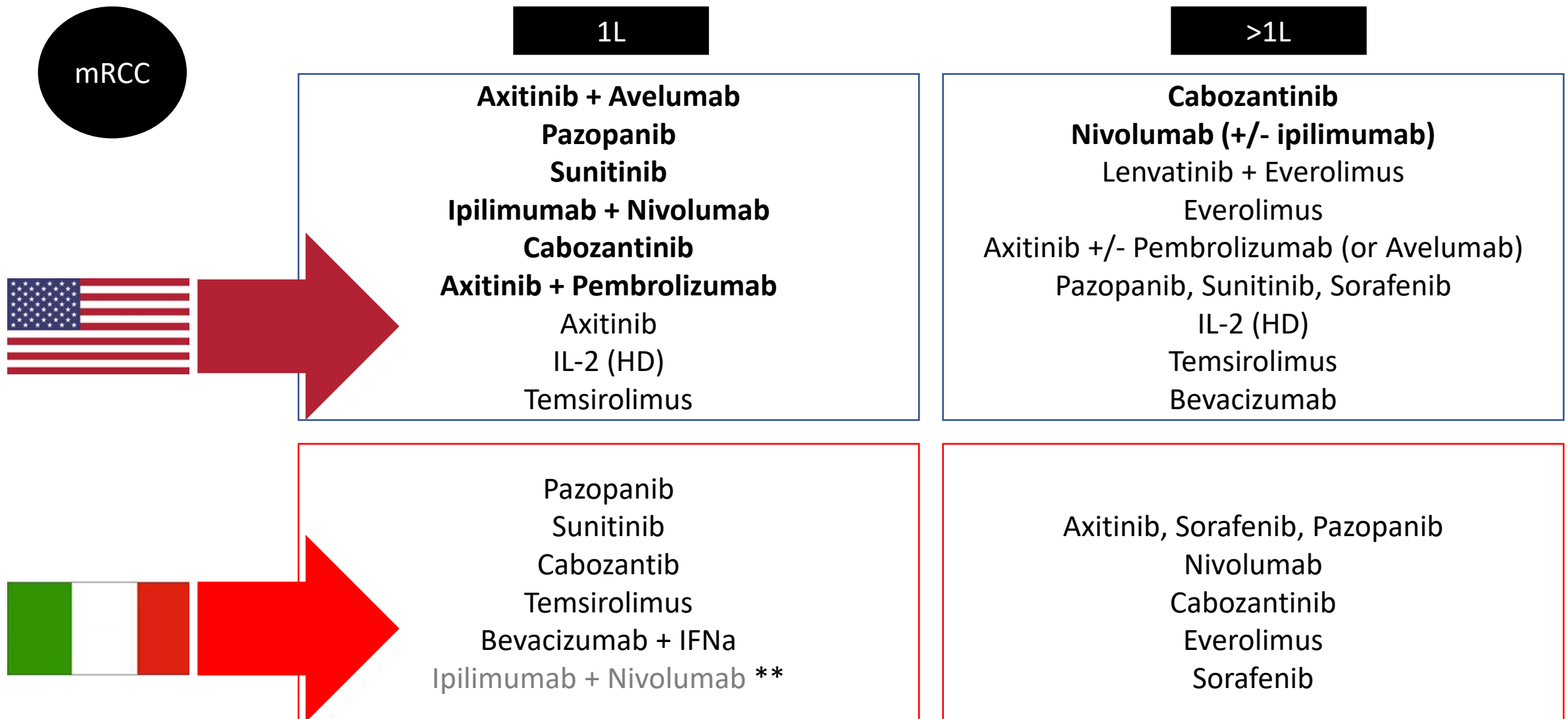


# Unequal distribution of clinical trials is related to income in the countries



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



**\*\*pharma expanded access**



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**In conclusion ...**



**Thank You very much for Your kind attention!!!**



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