Inside the Issue: Optimizing the Management of Nonmelanoma Skin Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, October 3, 2023
5:00 PM – 6:00 PM ET

Faculty

Nikhil I Khushalani, MD
Anna C Pavlick, DO, MBA

Moderator

Neil Love, MD

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Faculty

Nikhil I Khushalani, MD
Senior Member and Vice Chair
Department of Cutaneous Oncology
Moffitt Cancer Center
Tampa, Florida

Moderator
Neil Love, MD
Research To Practice

Anna C Pavlick, DO, MBA
Professor of Medicine
Division of Hematology and Medical Oncology
Associate Director for Clinical Research
Weill Cornell Medicine Meyer Cancer Center
Founding Director of the Cutaneous Oncology Program
Weill Cornell Medicine and NewYork-Presbyterian
New York, New York

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Dr Reddy — Disclosures

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Equity (Options)	Biond Biologics, OncoC4
Patents	Moffitt Cancer Center filed a patent on an ipilimumab biomarker and on TIL preparation that I am named on, and Biodesix filed a PD-1 patent that I was named on
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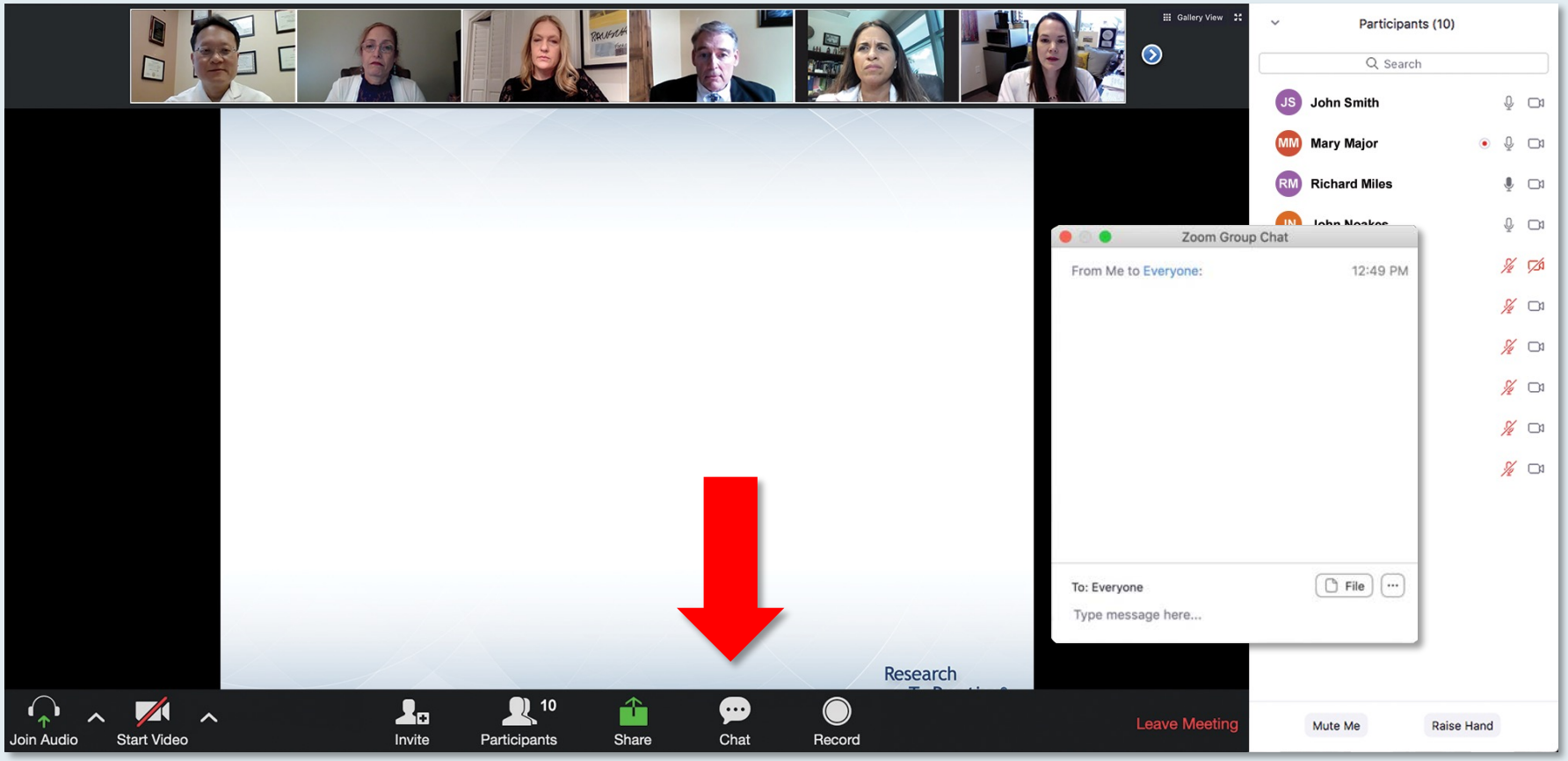

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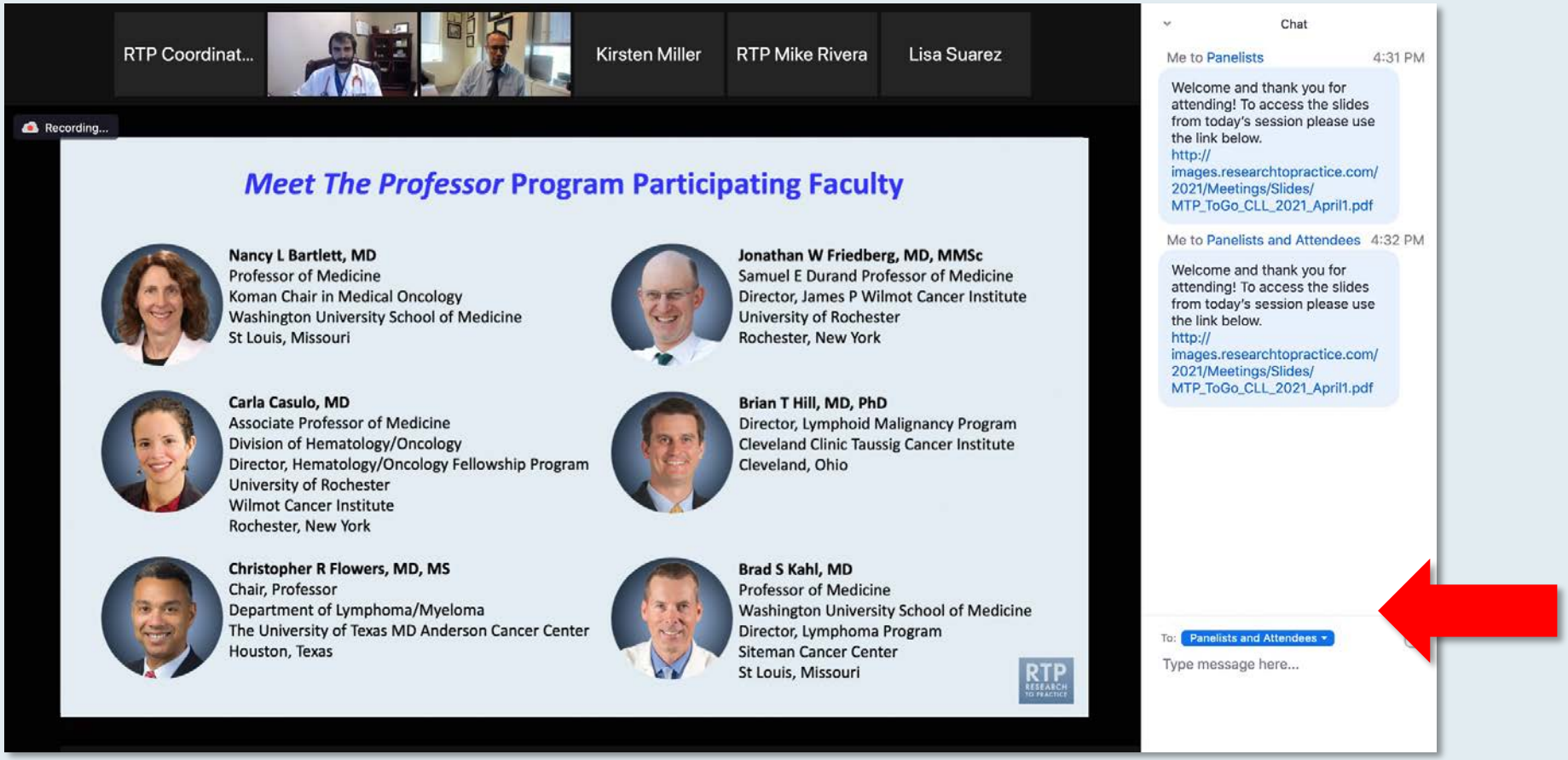

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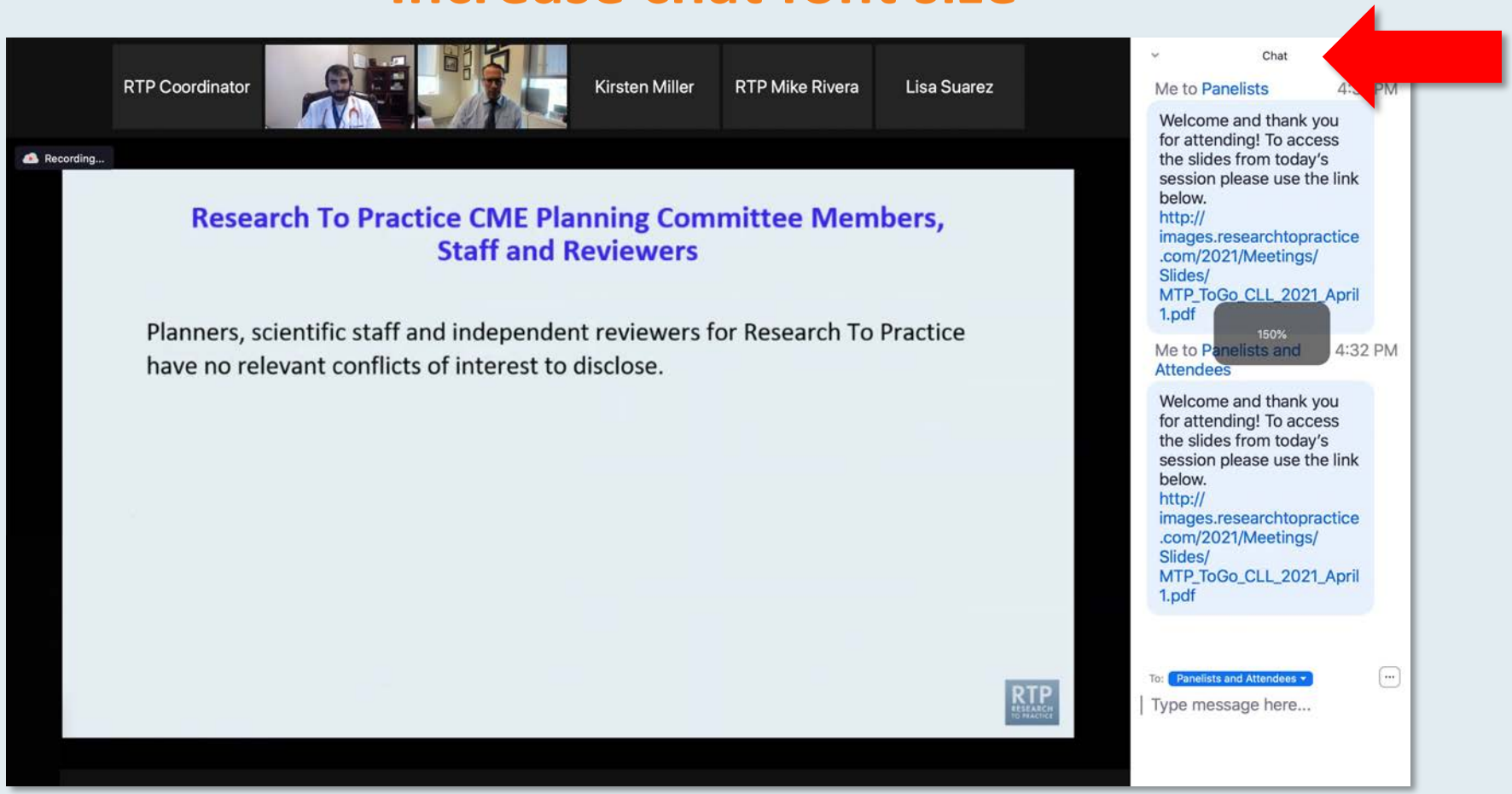

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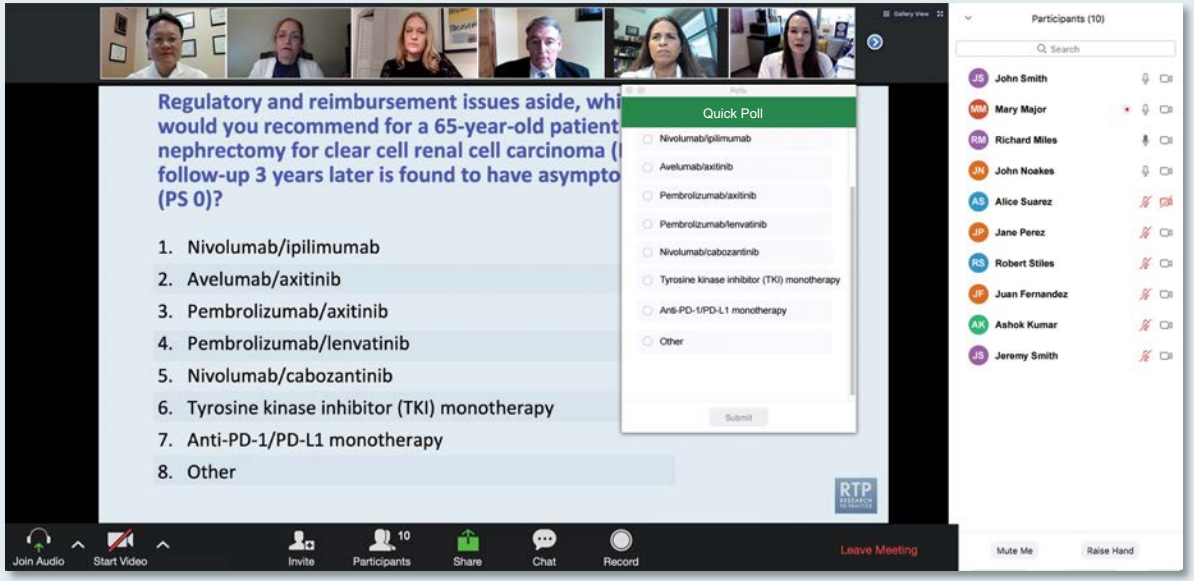

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Jeffrey S Weber, MD, PhD
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(NCI-Funded Comprehensive Cancer Center)
Professor of Medicine
NYU Grossman School of Medicine
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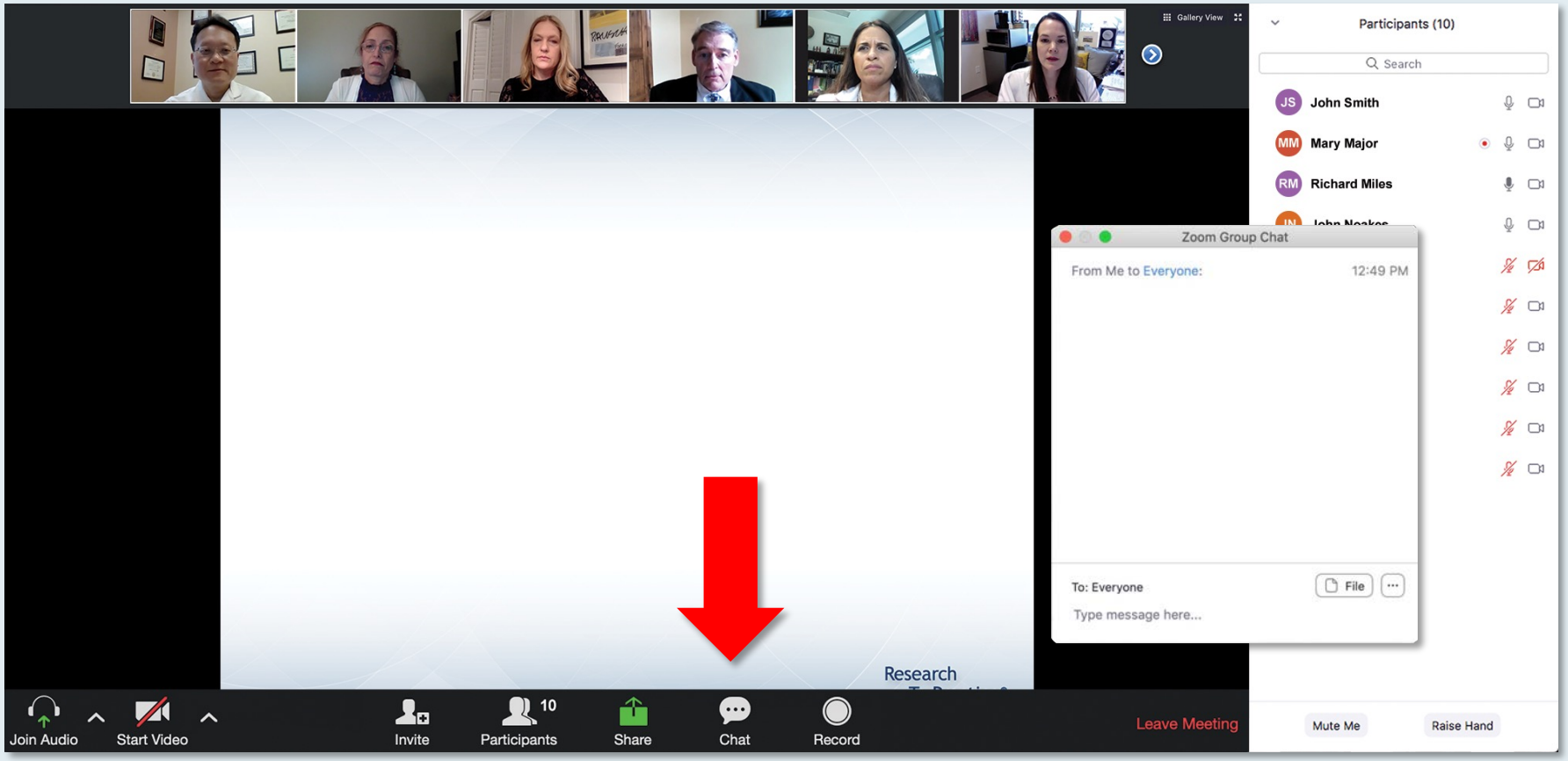

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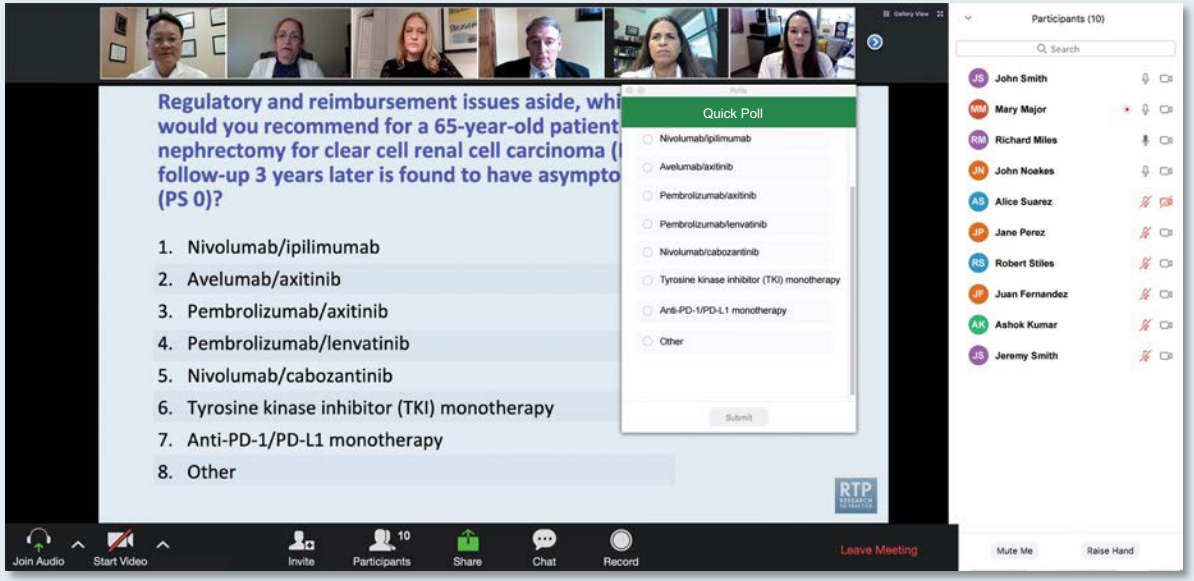

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Cutaneous Squamous Cell Carcinoma

Nikhil I. Khushalani, MD
Assistant Center Director, Clinical Research Review and Partnerships
Vice-Chair and Senior Member, Cutaneous Oncology
Moffitt Cancer Center

Department of Cutaneous Oncology

MOFFITT CANCER CENTER

Basal Cell Carcinoma

Anna C. Pavlick, DO, MBA
Weill Cornell Medicine, Professor of Medicine and Dermatology
WCM-Meyer Cancer Center, Associate Director for Clinical Research
WCM-Meyer Cancer Center, Founding Director, Melanoma and Cutaneous Oncology

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Key Data Sets

Nikhil I Khushalani, MD

- Carter JB et al. Outcomes of primary cutaneous squamous cell carcinoma with perineural invasion: An 11-year cohort study. *JAMA Dermatol* 2013 January;149(1):35-41.
- Karia PS et al. Evaluation of American Joint Committee on Cancer, International Union Against Cancer, and Brigham and Women's Hospital tumor staging for cutaneous squamous cell carcinoma. *J Clin Oncol* 2014 February 1;32(4):327-34.
- Garrett GL et al. Incidence of and risk factors for skin cancer in organ transplant recipients in the United States. *JAMA Dermatol* 2017 March 1;153(3):296-303.
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- Lam JKS et al. Immunocompromised patients with metastatic cutaneous nodal squamous cell carcinoma of the head and neck: Poor outcome unrelated to the index lesion. *Head Neck* 2018 May;40(5):985-92.
- Jarkowski A 3rd et al. Systemic therapy in advanced cutaneous squamous cell carcinoma (CSCC): The Roswell Park experience and a review of the literature. *Am J Clin Oncol* 2016 December;39(6):545-48.

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Key Data Sets

Nikhil I Khushalani, MD (continued)

- Maubec E et al. Phase II study of cetuximab as first-line single-drug therapy in patients with unresectable squamous cell carcinoma of the skin. *J Clin Oncol* 2011 September 1;29(25):3419-26.
- Pickering CR et al. Mutational landscape of aggressive cutaneous squamous cell carcinoma. *Clin Cancer Res* 2014 December 15;20(24):6582-92.
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Key Data Sets

Nikhil I Khushalani, MD (continued)

- Grob J-J et al. Pembrolizumab monotherapy for recurrent or metastatic cutaneous squamous cell carcinoma: A single-arm phase II trial (KEYNOTE-629). *J Clin Oncol* 2020 September 1;38(25):2916-25.
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- Brahmer JR et al. Management of immune-related adverse events in patients treated with immune checkpoint inhibitor therapy: American Society of Clinical Oncology clinical practice guideline. *J Clin Oncol* 2018 June 10;36(17):1714-68.
- Marin-Acevedo JA et al. Cetuximab for immunotherapy-refractory/ineligible cutaneous squamous cell carcinoma. *Cancers (Basel)* 2023 June 14;15(12):3180.

Key Data Sets

Nikhil I Khushalani, MD (continued)

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- Gross ND et al. Neoadjuvant cemiplimab for stage II to IV cutaneous squamous-cell carcinoma. *N Engl J Med* 2022 October 27;387(17):1557-68.
- Schenker M et al. Adjuvant pembrolizumab versus placebo in high-risk locally advanced cutaneous squamous cell carcinoma: The phase 3 KEYNOTE-630 study. AADA 2022;Abstract 34762.
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Key Data Sets

Anna C Pavlick, DO, MBA

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- Nikanjam M et al. Advanced basal cell cancer: Concise review of molecular characteristics and novel targeted and immune therapeutics. *Ann Oncol* 2018 November 1;29(11):2192-99.
- Habashy S et al. Hedgehog pathway inhibitors: Clinical implications and resistance in the treatment of basal cell carcinoma. *Cureus* 2021 March 12;13(3):e13859.
- Sekulic A et al. Efficacy and safety of vismodegib in advanced basal-cell carcinoma. *N Engl J Med* 2012 June 7;366(23):2171-9.
- Sekulic A et al. Long-term safety and efficacy of vismodegib in patients with advanced basal cell carcinoma: Final update of the pivotal ERIVANCE BCC study. *BMC Cancer* 2017 May 16;17(1):332.
- Dummer R et al. The 12-month analysis from basal cell carcinoma outcomes with LDE225 treatment (BOLT): A phase II, randomized, double-blind study of sonidegib in patients with advanced basal cell carcinoma. *J Am Acad Dermatol* 2016 July;75(1):113-25.e5.

Key Data Sets

Anna C Pavlick, DO, MBA (continued)

- Migden MR et al. Treatment with two different doses of sonidegib in patients with locally advanced or metastatic basal cell carcinoma (BOLT): A multicentre, randomised, double-blind phase 2 trial. *Lancet Oncol* 2015 June;16(6):716-28.
- Dummer R et al. Long-term efficacy and safety of sonidegib in patients with advanced basal cell carcinoma: 42-month analysis of the phase II randomized, double-blind BOLT study. *Br J Dermatol* 2020 June;182(6):1369-78.
- Lear JT et al. Long-term efficacy and safety of sonidegib in patients with locally advanced and metastatic basal cell carcinoma: 30-month analysis of the randomized phase 2 BOLT study. *J Eur Acad Dermatol Venereol* 2018 March;32(3):372-81.
- Lacouture ME et al. Characterization and management of hedgehog pathway inhibitor-related adverse events in patients with advanced basal cell carcinoma. *Oncologist* 2016 October;21(10):1218-29.

Key Data Sets

Anna C Pavlick, DO, MBA (continued)

- Barrios DM et al. Immune checkpoint inhibitors to treat cutaneous malignancies. *J Am Acad Dermatol* 2020 November;83(5):1239-53.
- Stratigos AJ et al. Cemiplimab in locally advanced basal cell carcinoma after hedgehog inhibitor therapy: An open-label, multi-centre, single-arm, phase 2 trial. *Lancet Oncol* 2021 June;22(6):848-57.
- Brahmer JR et al. Management of immune-related adverse events in patients treated with immune checkpoint inhibitor therapy: American Society of Clinical Oncology clinical practice guideline. *J Clin Oncol* 2018 June 10;36(17):1714-68.

Agenda

INTRODUCTION: Why did it take so long?

MODULE 1: Cutaneous Squamous Cell Carcinoma – Dr Khushalani

MODULE 2: Basal Cell Carcinoma – Dr Pavlick

MODULE 3: Ongoing Clinical Trials

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RTP
RESEARCH
TO PRACTICE

How many patients with either basal cell carcinoma (BCC) or cutaneous squamous cell carcinoma (cSCC) are currently in your practice (total)?

1. 0
2. 1
3. 2
4. 3
5. 4
6. 5-10
7. 11-20
8. More than 20

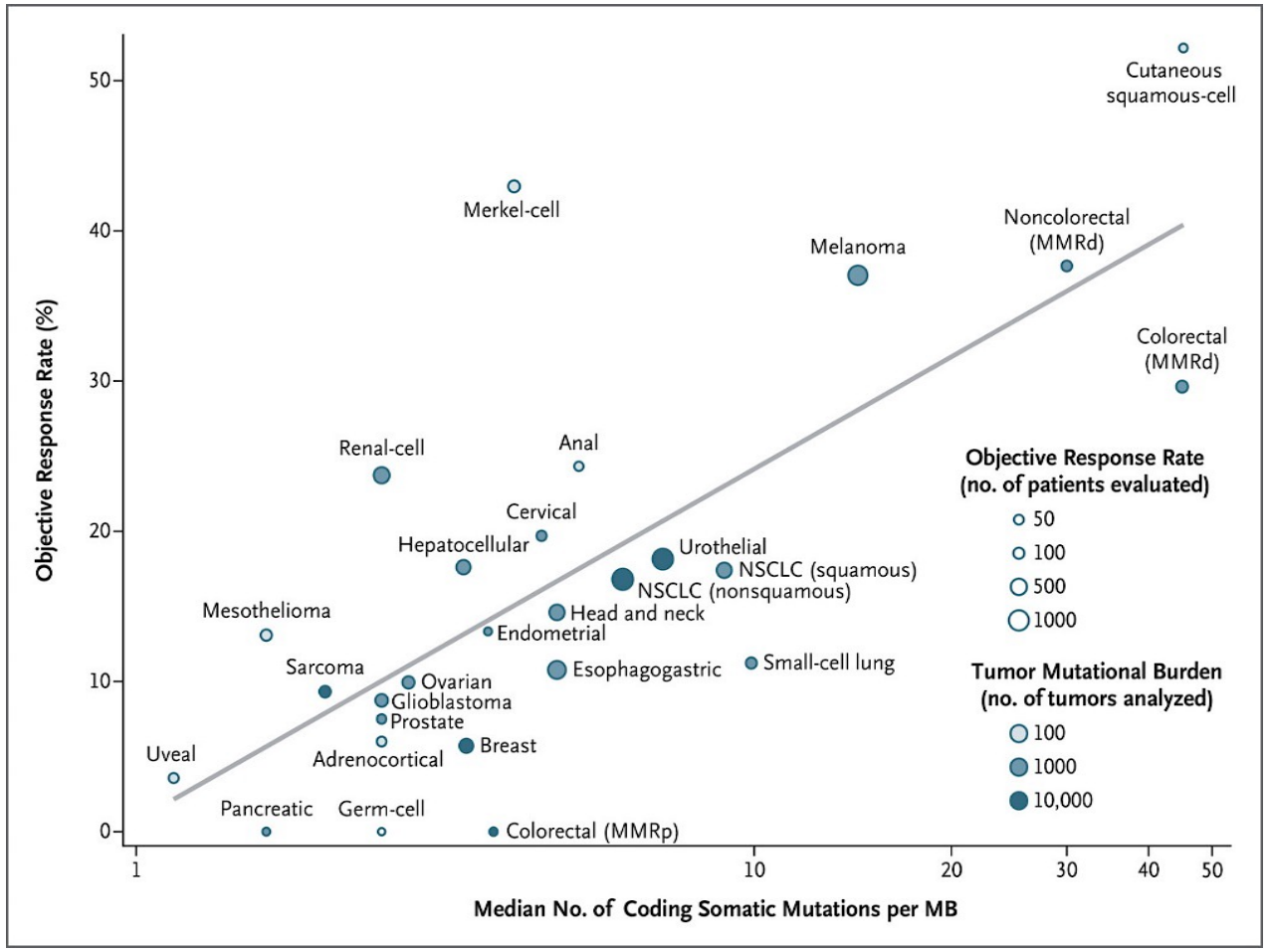
RTP
RESEARCH
TO PRACTICE

How many patients with either BCC or cSCC to whom you've administered an anti-PD-1/PD-L1 antibody have not required additional treatment for 3 or more years?

1. 0
2. 1
3. 2
4. 3
5. 4
6. 5-10
7. 11-20
8. More than 20
9. I have not used an anti-PD-1/PD-L1 antibody for a patient with BCC or cSCC

RTP RESEARCH TO PRACTICE

TMB and Response to anti-PD1 Therapy



Yarchoan M. N Engl J Med. 2017;377:2500.

Immunosuppression and Skin Cancer

	BCC	CSCC	Melanoma	MCC	KS
Transplant	10	65-250	2-5	5-50	80-500
CLL	8*	8*	2-4	-	-
HIV	2	5	1	2-10	100,000

- Skin is the most common site of malignancy post solid organ transplant
- Incidence rate: 1437/100,000 person-years
  - CSCC: 812/100,000 person-years
  - Male, white race, increased age and thoracic organ transplant conferred higher risk

Garrett, Blanc, et al. *JAMA Dermatol* 2017;153:296; Collins, Quinn, et al. *Dermatol Clin.* 2019;37-83

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RTP
RESEARCH
TO PRACTICE

Cemiplimab: EMPOWER Study

Phase 1 (n = 26): adult patients with locally advanced or metastatic cSCC who are not candidates for surgery

Phase 2 (n = 59): cSCC with distant or regional metastases

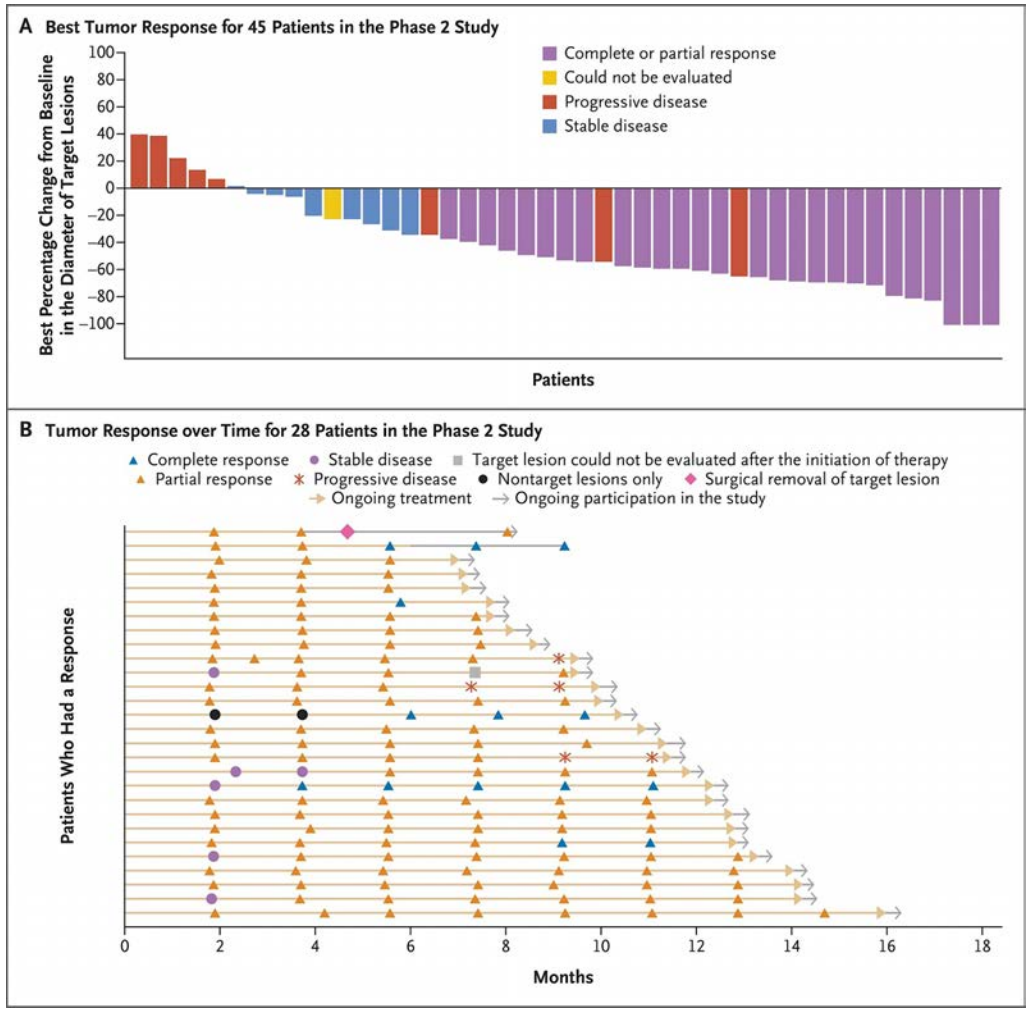
IV cemiplimab (3 mg/kg of body weight) Q2W for up to 48 weeks (phase 1) or up to 96 weeks (phase 2)

Inclusion criteria: ECOG of 0 or 1, adequate organ function, at least 1 lesion that could be measured (RECIST 1.1)

Exclusion criteria: Ongoing or recent autoimmune disease treated with systemic immunosuppressive therapy, previous treatment with anti-PD-1 or PD-L1 therapy, solid organ transplantation, concurrent cancer

Migden MR, et al. N Engl J Med. 2018;379:341

EMPOWER: Summary of Results

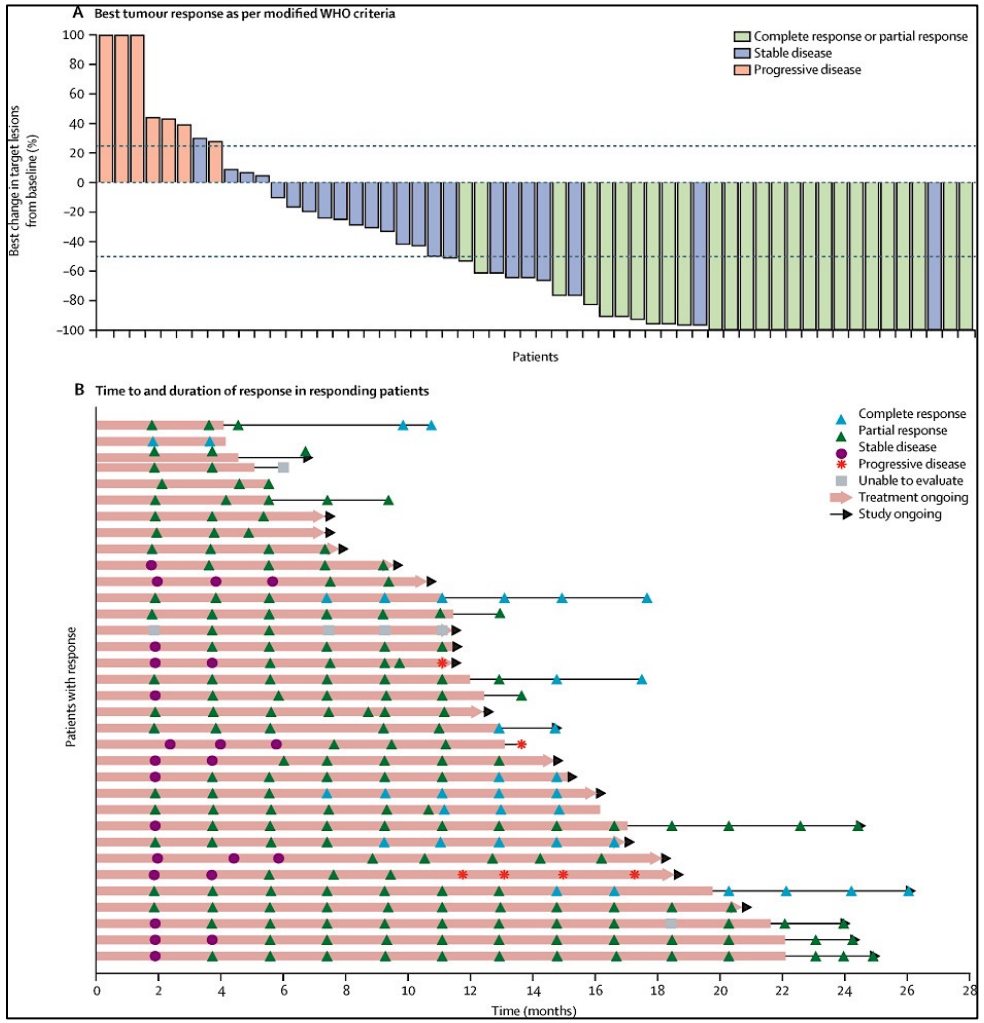


Results:

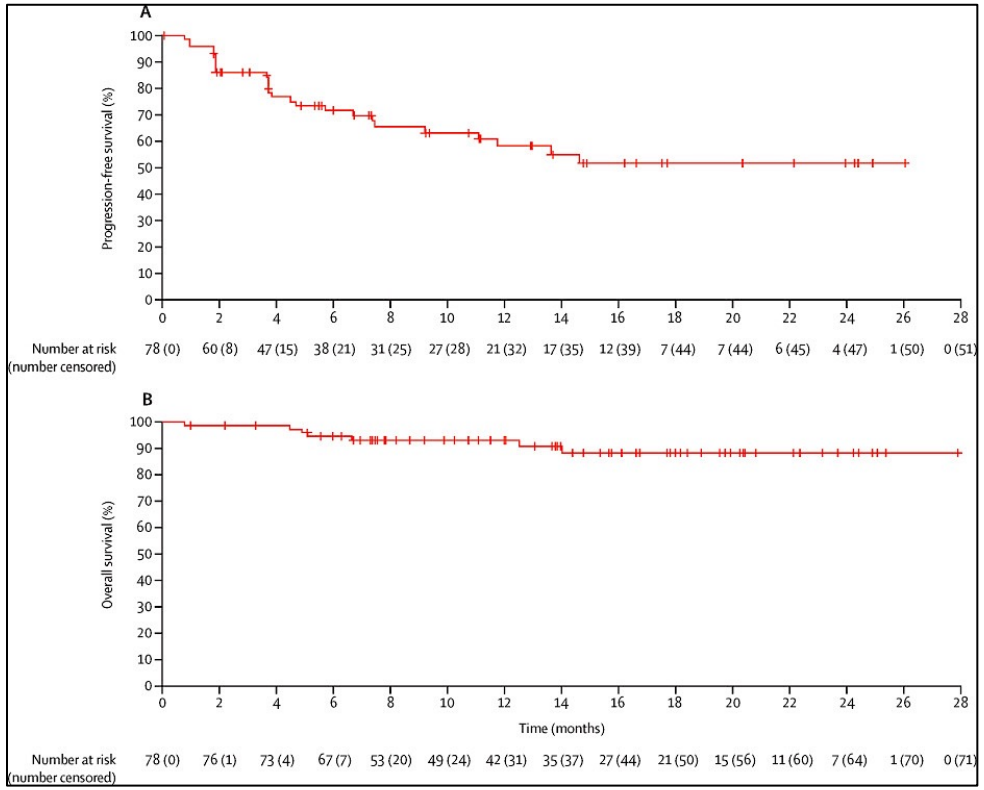
- **Response Rate**
  - 50% in phase 1 study
  - 47% in phase 2 study
- Duration of response exceeded 6 months in 57% of patients with a response
- 82% of patients with a response continued to have a response at the time of data cutoff

Migden MR, et al. N Engl J Med. 2018;379:341

EMPOWER: Locally Advanced Cohort



Migden MR, Khushalani NI, et. al Lancet Oncol 2020;21:294



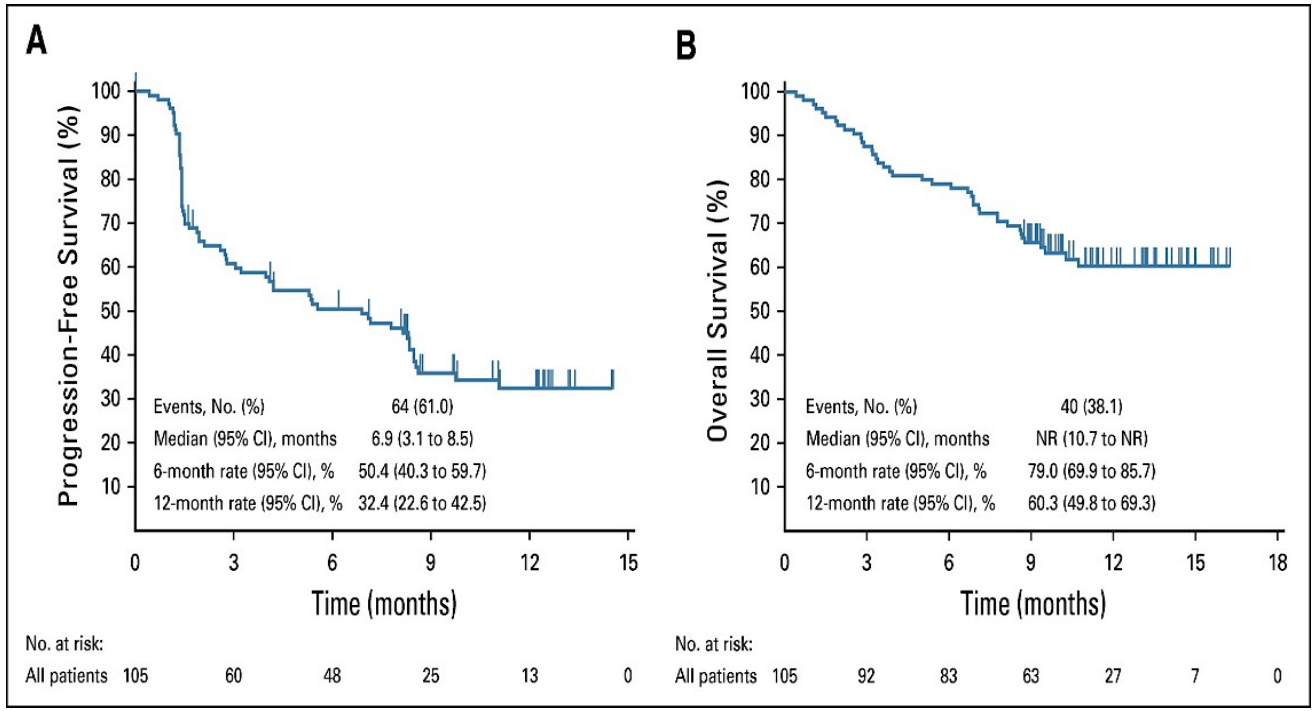
N=78; ORR 44% (13% CR)

G3/4 treatment emergent adverse events: 44%

KEYNOTE-629

Pembrolizumab for Advanced CSCC

Endpoint	Patients (N = 105)
Median follow up	11.4 (0.4-16.3) months
Objective RR	**34.3%**
Best overall response • CR • PR • SD • Progressive disease • Not evaluable	 3.8% 30.5% 29.5% 26.7% 1.9%
Disease control (CR+PR+SD)	52.4%
SD ≥12 weeks	18.1%
Median time to response	1.5 months
Median DoR	NR
Estimated 12-month PFS/OS	32.4%/60.3%



Grob. J Clin Oncol 2020;38:2916

CARSKIN

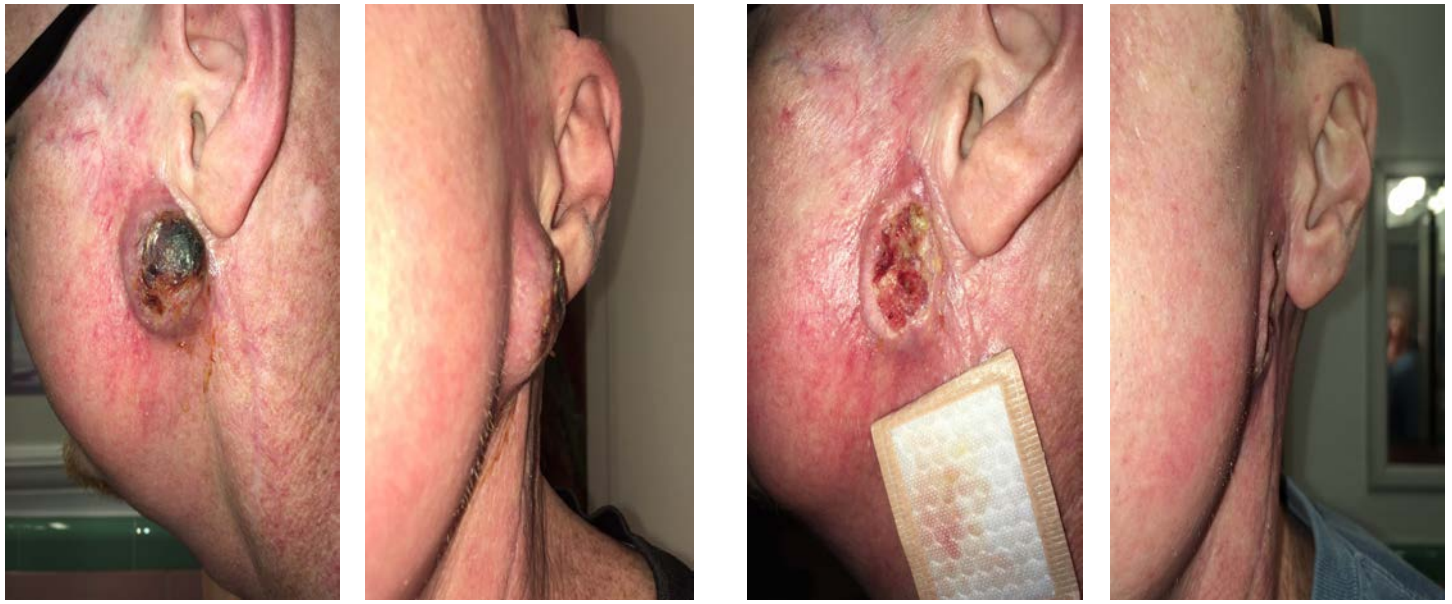
Pembrolizumab for Advanced CSCC

- Phase II; chemotherapy-naive, unresectable, LA or metastatic cSCC
  - ➢ Median age: 79 years
- PEMBRO: 200 mg every 3 weeks
- Primary endpoint: ORR at 15 weeks
- Secondary endpoints: DoR, OS, PFS
- Expanded cohort (N = 57) for analysis of response by PD-L1 status

Endpoint	Patients (n = 39)
Objective RR	**41% (26-58)**
Best overall response • CR • PR	 8 8
At median follow up of 22.4 months: • PFS • DoR • OS	 6.7 months NR 25.3 months
Objective RR by PD-L1 status • Overall • TPS ≥1 • TPS <1	N = 57 42% 55% 17%

Maubec. J Clin Oncol. 2020;38:3051

Response to Pembrolizumab

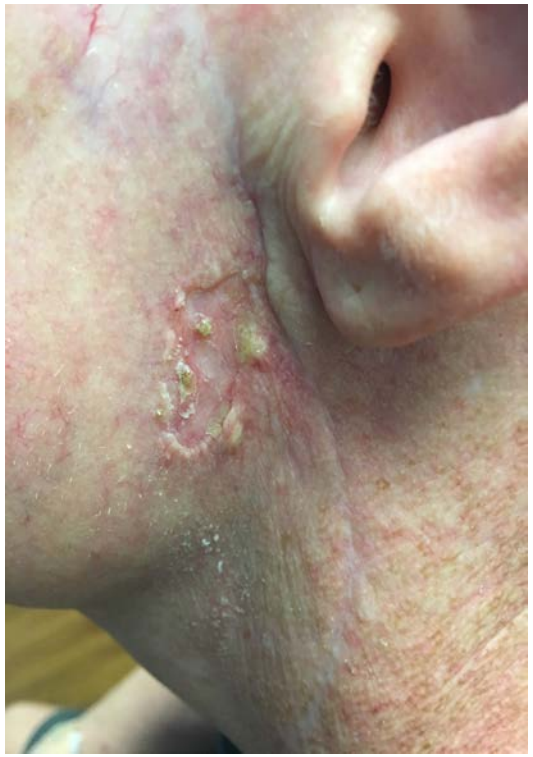


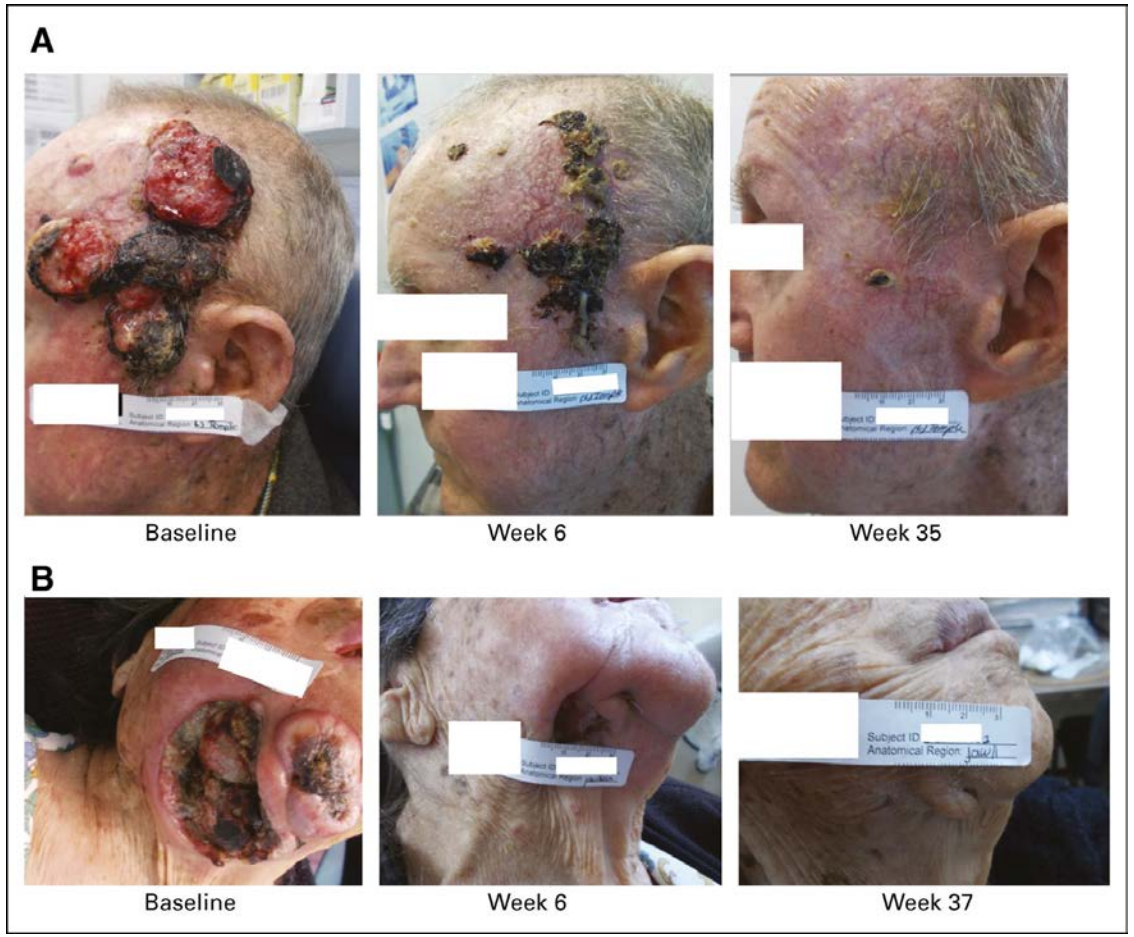
Pretreatment

Day 15

Image Courtesy: Khushalani NI

Response to Pembrolizumab





Left Image Courtesy: Khushalani NI Grob. J Clin Oncol 2020;38:2916

Phase II Neoadjuvant Study (CSCC)

Primary endpoint:

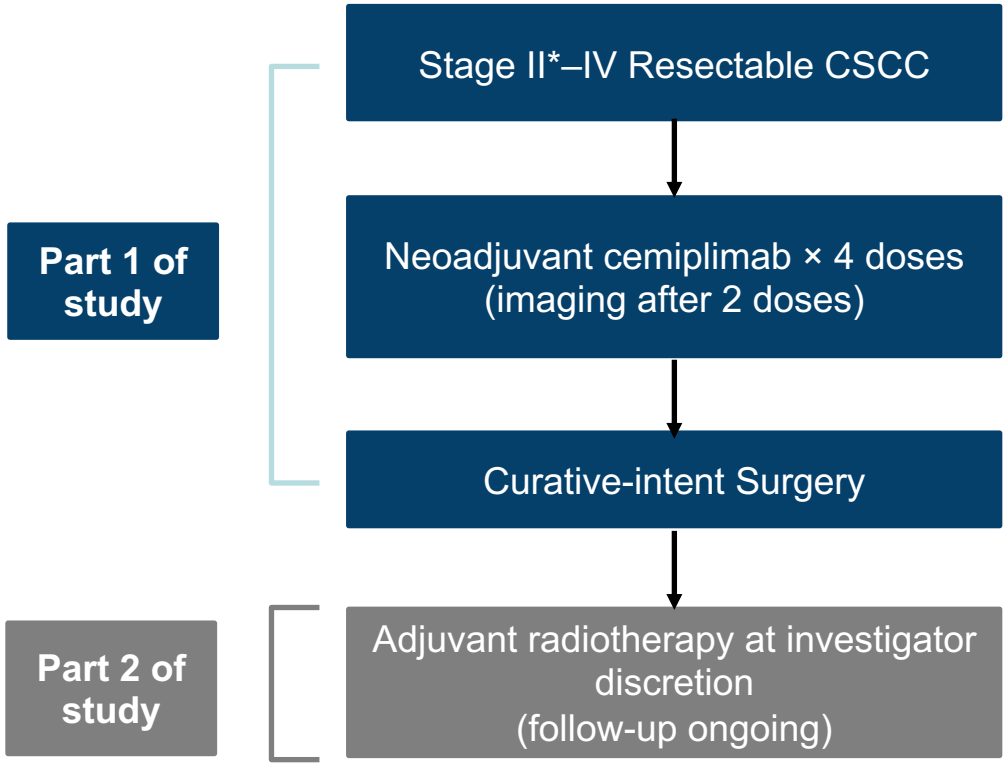
- **pCR** (0% viable tumor) rate per ICPR
  - null hypothesis: pCR rate = 25%

Secondary endpoints:

- **MPR** (>0% but ≤10% viable tumor) rate per ICPR
- **pCR** and **MPR** rates per local pathology review
- **Radiological ORR** per RECIST 1.1
- **Safety** and **tolerability**

Correlative analyses:

- Exploration of TMB and PD-L1 expression with treatment response



*Stage II required to have primary tumor ≥3 cm in an aesthetically-sensitive region.

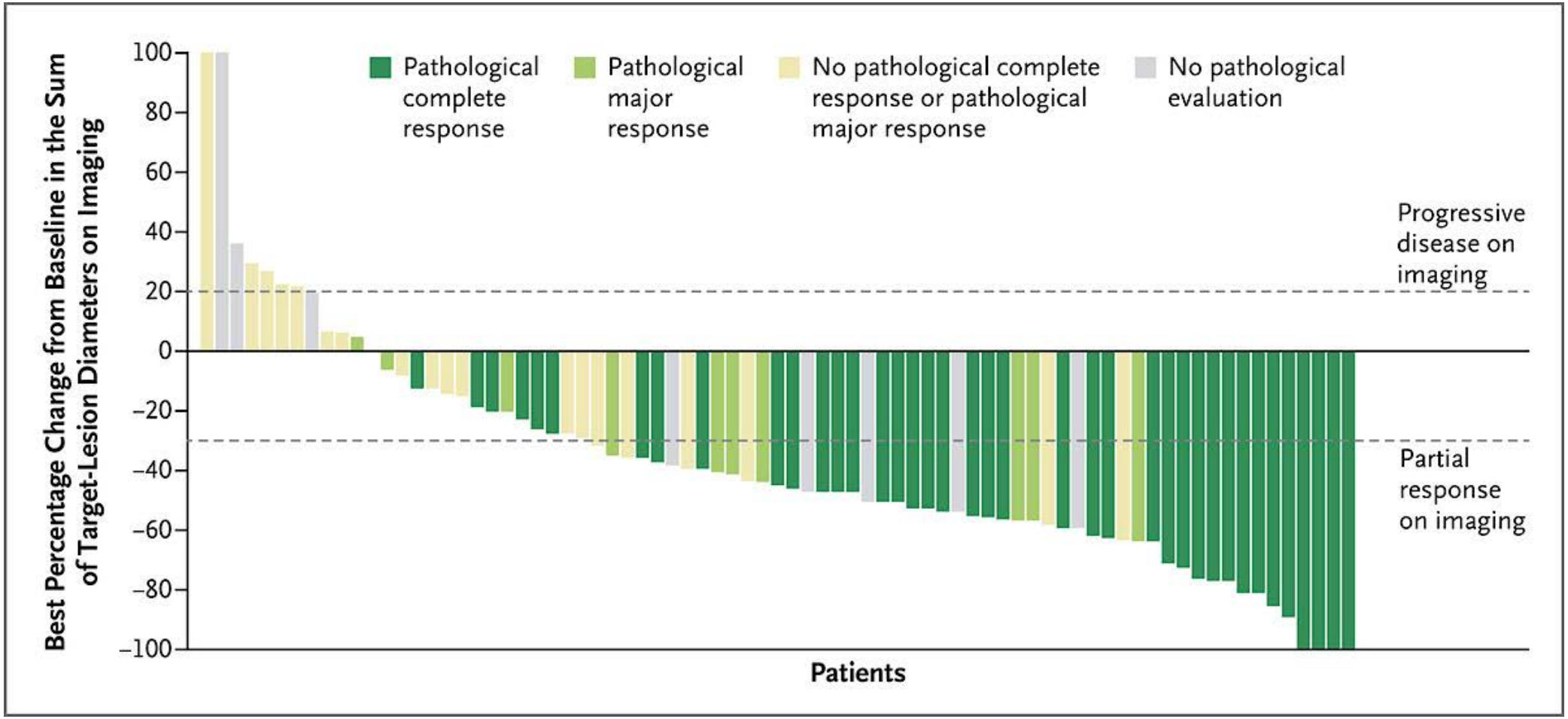
Gross, Miller, Khushalani, et al. *N Engl J Med* 2022;387:1557

Pathologic Response

	Neoadjuvant cemiplimab (N=79)	
Pathologic response	**ICPR N (%) [95% CI]**	**Local pathology review N (%) [95% CI]**
pCR (0% viable tumor cells)	**40 (50.6) [39.1–62.1]**	42 (53.2) [41.6–64.5]
MPR (>0% and ≤10% viable tumor cells)	10 (12.7) [6.2–22.0]	10 (12.7) [6.2–22.0]
Combined pathologic response (pCR + MPR)	50 (63.3) [51.7–73.9]	52 (65.8) [54.3–76.1]
Non-pCR/MPR	20 (25.3)	NA*
Not evaluable (no surgery)	9 (11.4)	9 (11.4)
Radiological response		**Local imaging review N (%) [95% CI]**
Objective response rate (ORR), RECIST 1.1		54 (68.4) [56.9–78.4]
Best overall response		
Complete response		5 (6.3)
Partial response		49 (62.0)
Stable disease		16 (20.3)
Progressive disease		8 (10.1)
Not evaluable		1 (1.3)

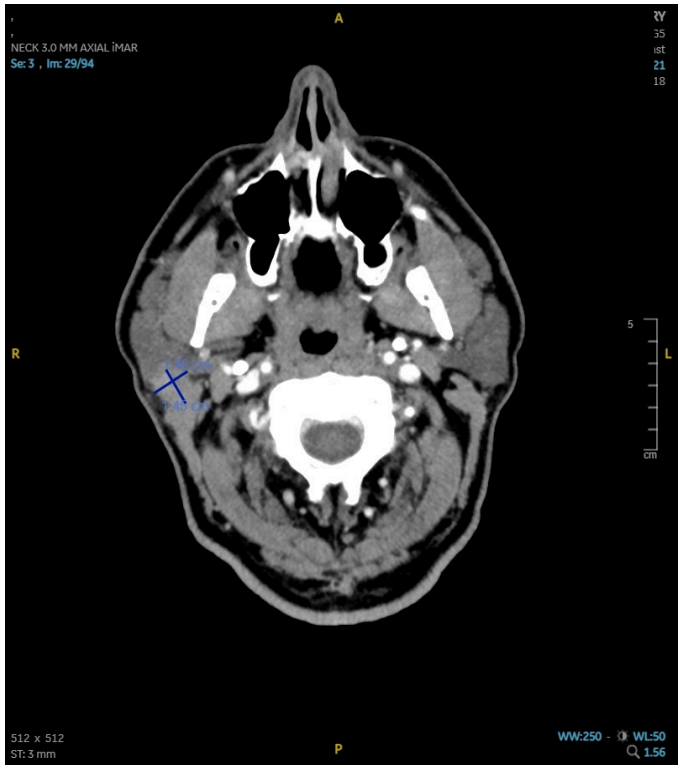
Gross, Miller, Khushalani, et al. *N Engl J Med* 2022;387:1557

Response: RECIST and Pathology

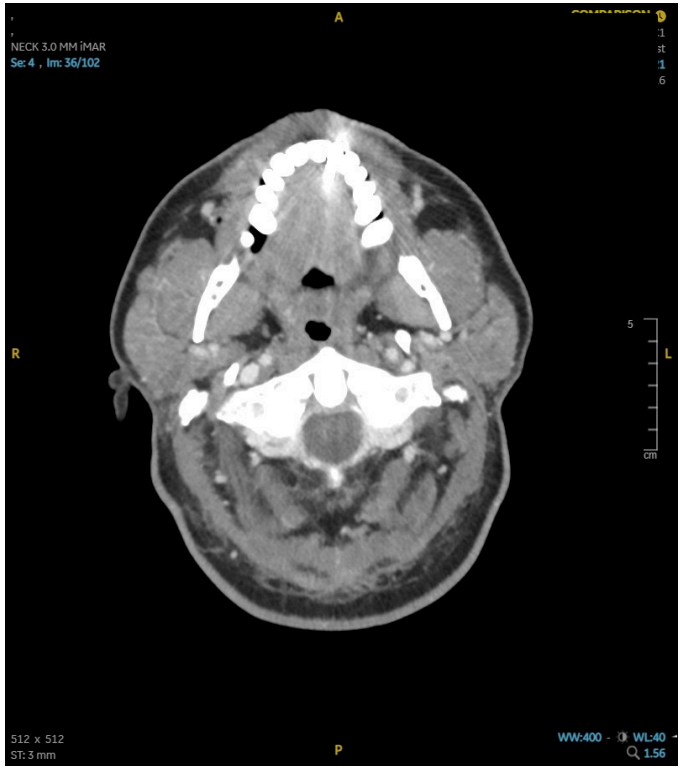


Gross, Miller, Khushalani, et al. *N Engl J Med* 2022;387:1557

Neoadjuvant Cemiplimab Case

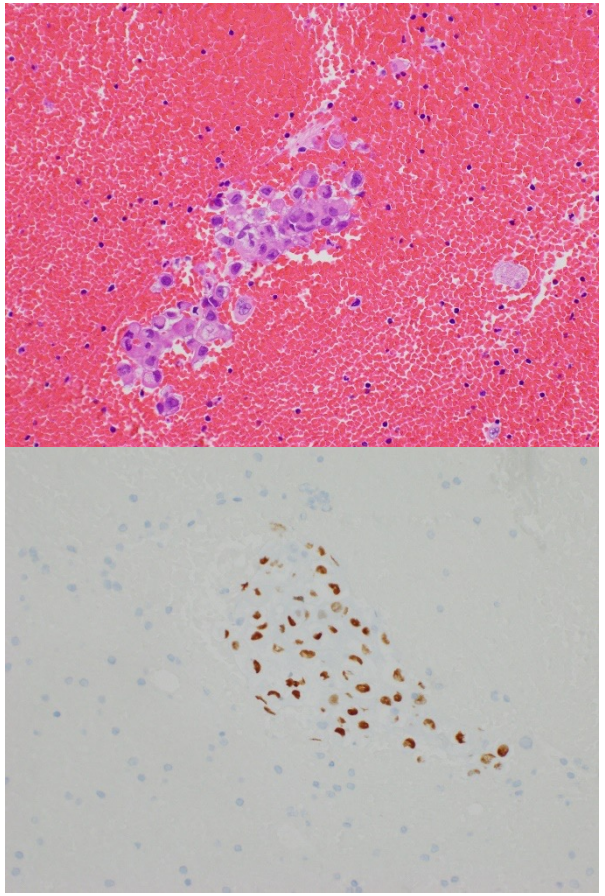


Pre-treatment

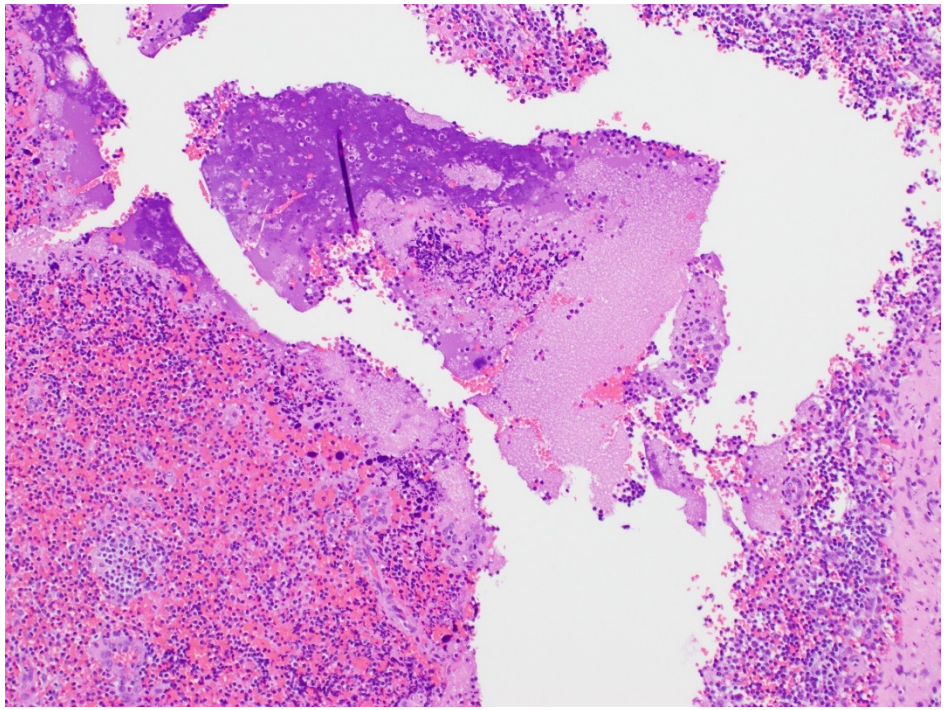


Post 4 cycles of cemiplimab

Image Courtesy: Khushalani NI



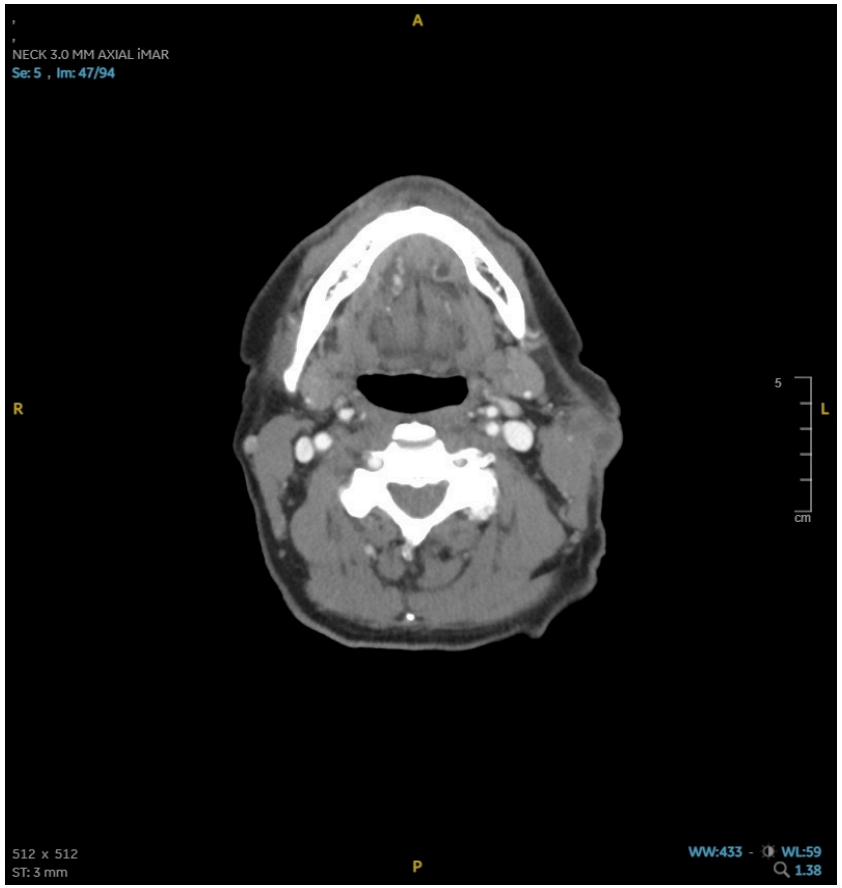
Pre-Rx FNA (H&E and p40 IHC)



Post Rx Excision – LN with area of necrosis

Image courtesy: Ken Tsai, MD, PhD

Another case…



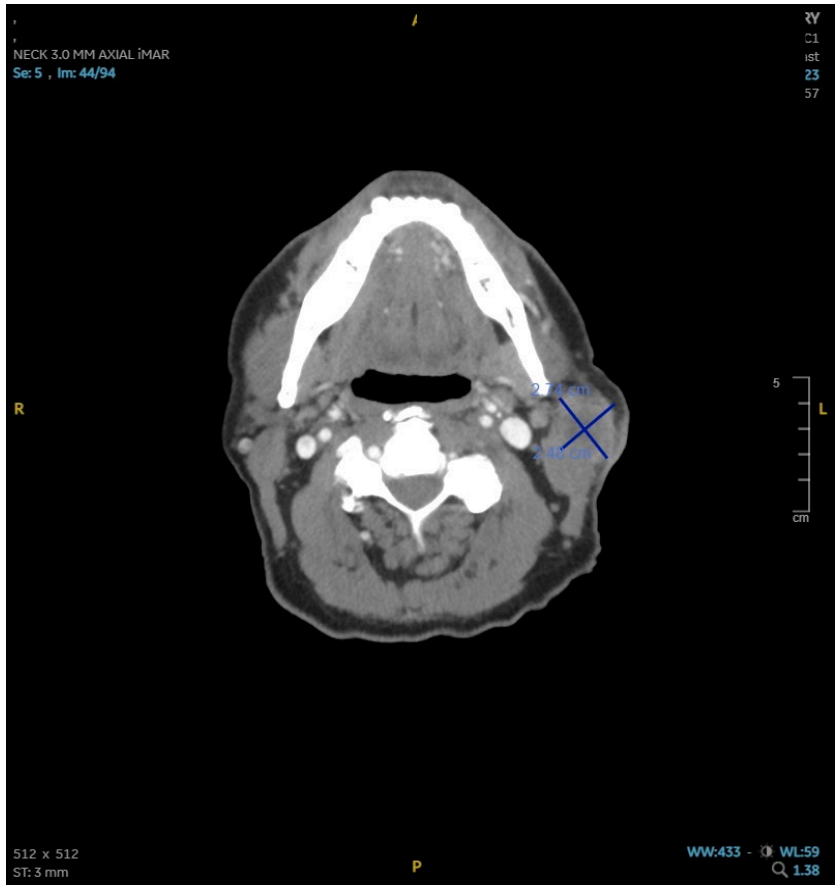


Image Courtesy: Khushalani NI

Post-neoadjuvant Cemiplimab: is surgery even needed?

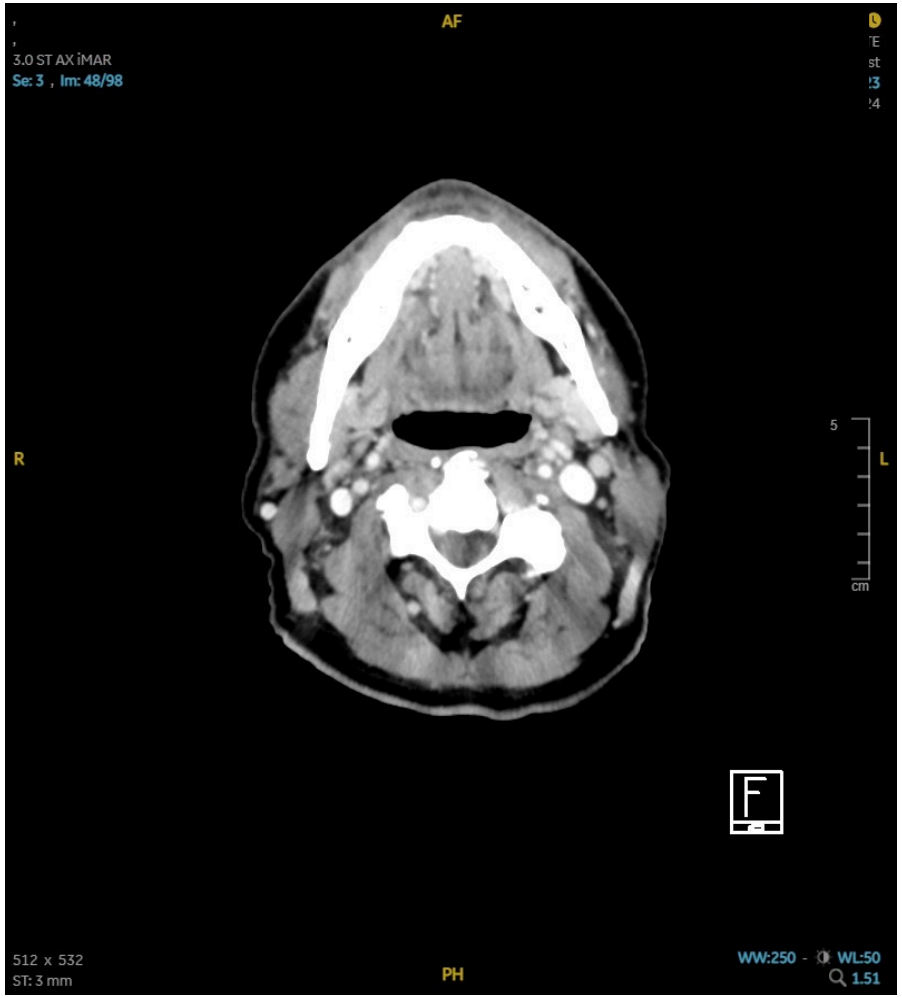


Image Courtesy: Khushalani NI

Unanswered Questions

- Duration of neoadjuvant therapy?
- Correlation of radiographic response to pathologic response
- Need for adjuvant therapy?
- Risk-stratification by pathologic response?

Courtesy of Nikhil I Khushalani, MD

Think of the last patient with cSCC to whom you administered systemic therapy for local recurrence after radiation therapy. What was their …?

	Age	Sex	Treatment	Outcome
 Dr Khushalani	78 years	Male	Cetuximab	PD after 4 cycles
 Dr Pavlick	79 years	Male	Cetuximab	Resolution of disease
 Dr Hamid	79 years	Female	Cemiplimab	Disease control and deep PR
 Dr Lipson	66 years	Male	Cemiplimab	Complete response per RECIST v1.1
 Dr Reddy	Have not done this	—	—	—
 Dr Weber	52 years	Male	Pembrolizumab	Good response, resection with residual tumor

PD = progressive disease; PR = partial response

For patients with locally advanced, recurrent or metastatic cSCC for whom radiation therapy or surgery is not feasible, what is your preferred anti-PD-1/PD-L1 antibody?

 Dr Khushalani	Cemiplimab
 Dr Pavlick	Cemiplimab
 Dr Hamid	Cemiplimab
 Dr Lipson	Cemiplimab
 Dr Reddy	Pembrolizumab
 Dr Weber	Pembrolizumab

RTP RESEARCH TO PRACTICE

Do you believe level of PD-L1 expression or tumor mutational burden (TMB) is useful in predicting the benefit of anti-PD-1/PD-L1 antibodies for patients with advanced cSCC?

	PD-L1 expression	TMB
 Dr Khushalani	No	No
 Dr Pavlick	No	No
 Dr Hamid	No	Yes, somewhat useful
 Dr Lipson	No	Yes, somewhat useful
 Dr Reddy	Yes, somewhat useful	Yes, very useful
 Dr Weber	Yes, somewhat useful	Yes, somewhat useful

How long do you typically continue anti-PD-1/PD-L1 antibody therapy for a patient with advanced cSCC who achieves a complete response and is tolerating treatment well?

 Dr Khushalani	Will consider discontinuation after 9-12 months of therapy
 Dr Pavlick	Minimum 1 year and maximum 2 years
 Dr Hamid	No clear data so I continue until toxicity. Sometimes I discuss 6 months after CR, sometimes discuss full 2 years
 Dr Lipson	Once the patient experiences a CR, I generally treat for another 6-12 weeks, then stop
 Dr Reddy	1-2 years depending on overall potential morbidity using 3 months after CR as a guide
 Dr Weber	No more than 12 months

CR = complete response

What would you estimate is the likelihood that a patient receiving an anti-PD-1/PD-L1 antibody for advanced cSCC will need to have therapy held or discontinued due to tolerability issues?

In your experience, what are the 3 most common autoimmune complications experienced by patients with advanced cSCC who are receiving anti-PD-1/PD-L1 antibody therapy?

	Chance of hold or discontinuation	Common autoimmune complications
 Dr Khushalani	15%	Rash, hypothyroidism, diarrhea
 Dr Pavlick	<5%	Rash, pruritus, hypothyroidism
 Dr Hamid	15%-18%	Itching/rash, fatigue, hypothyroidism
 Dr Lipson	10%	Dermatitis, thyroiditis, sicca syndrome
 Dr Reddy	10%-20%	Rash, hypothyroidism, fatigue
 Dr Weber	15%-20%	Skin, endocrine, GI

What is the age of the oldest patient with cSCC you have treated with an anti-PD-1/PD-L1 antibody? Did the patient respond to therapy? Did the patient tolerate therapy?

	Age	Responded?	Tolerated?
 Dr Khushalani	92 years	Yes	Yes
 Dr Pavlick	101 years	Yes	Yes
 Dr Hamid	Late 80s	Yes	Yes
 Dr Lipson	98 years	Yes	Yes
 Dr Reddy	90 years	No	Yes
 Dr Weber	92 years	Yes	Yes

Have you administered an anti-PD-1/PD-L1 antibody to a patient who developed cSCC after a solid organ transplant, and if so, what was the patient's age and clinical outcome?

 Dr Khushalani	Yes, 75-year-old patient with kidney transplant had PR, but developed allograft rejection and is on dialysis, and 58-year-old patient with liver transplant expired due to PD, but without rejection
 Dr Pavlick	No
 Dr Hamid	No
 Dr Lipson	Yes, for a 63-year-old patient who experienced a partial tumor response; allograft remained functional
 Dr Reddy	Yes, for a 60-year-old patient who did not experience a response and passed away
 Dr Weber	Yes, 59-year-old patient, rapid progression, passed away

RTP RESEARCH TO PRACTICE

Have you administered an anti-PD-1/PD-L1 antibody to a patient who developed cSCC after an allogeneic hematopoietic stem cell transplant, and if so, what was the patient's age and clinical outcome?

 Dr Khushalani	No
 Dr Pavlick	Yes; 57 years and minimal response due to continued immunosuppressants but no graft loss
 Dr Hamid	No
 Dr Lipson	Yes, for a 72-year-old patient who experienced disease progression and passed away
 Dr Reddy	No
 Dr Weber	No

RTP RESEARCH TO PRACTICE

What is your usual second-line systemic therapy for a patient with advanced cSCC who has experienced disease progression on first-line anti-PD-1/PD-L1 antibody therapy?

 Dr Khushalani	Cetuximab
 Dr Pavlick	Cetuximab + chemotherapy
 Dr Hamid	Carboplatin + paclitaxel
 Dr Lipson	Cetuximab
 Dr Reddy	Carboplatin + paclitaxel OR Nivolumab + ipilimumab OR T-VEC
 Dr Weber	Cetuximab + chemotherapy

T-VEC = talimogene laherparepvec

RTP RESEARCH TO PRACTICE

Do you or your institution employ intralesional therapy alone or in combination with anti-PD-1/PD-L1 antibody therapy for cSCC, and if so, what type of intralesional therapy do you employ and in which situations?

 Dr Khushalani	Yes, dermatologists have used interleukin or methotrexate alone; combination with anti-PD-1/PD-L1 therapy is on clinical trial
 Dr Pavlick	Yes, on clinical trial; derm will inject with methotrexate and med onc has a clinical trial with RP1 and nivolumab
 Dr Hamid	Yes, T-VEC or IL-2
 Dr Lipson	No
 Dr Reddy	Yes, sometimes; T-VEC or clinical trial
 Dr Weber	No

Think of the last patient with cutaneous squamous cell carcinoma (cSCC) to whom you administered neoadjuvant systemic therapy. What was their …?

	Age	Sex	Treatment	Outcome
 Dr Khushalani	64 years	Male	Cemiplimab	pCR
 Dr Pavlick	75 years	Male	Pembrolizumab	Complete pCR
 Dr Hamid	84 years	Female	Cemiplimab	Resection
 Dr Lipson	79 years	Male	Cemiplimab	Complete pathologic response
 Dr Reddy	80 years	Male	Radiation therapy	Faring okay
 Dr Weber	62 years	Female	Pembrolizumab	Excellent response, minimal resection needed

pCR = pathologic complete response

Which anti-PD-1/PD-L1 antibody do you generally employ as neoadjuvant therapy for patients with cSCC, and how many cycles do you typically administer?

	Preferred agent	Number of cycles
 Dr Khushalani	Cemiplimab	4
 Dr Pavlick	Pembrolizumab	2 to 3
 Dr Hamid	Cemiplimab	3
 Dr Lipson	Cemiplimab	3 to 4
 Dr Reddy	Pembrolizumab	3
 Dr Weber	Pembrolizumab	4

Regulatory and reimbursement issues aside, would you present the option of adjuvant anti-PD-1/PD-L1 antibody therapy to a patient with cSCC and … ?

	Nodal disease with ECE	In-transit metastases	T4 lesion
 Dr Khushalani	No	No	No
 Dr Pavlick	Yes, cemiplimab and XRT	Yes, cemiplimab	No
 Dr Hamid	No	No	No
 Dr Lipson	No	No	No
 Dr Reddy	Yes, no preference	Yes, but would not encourage pembrolizumab	No
 Dr Weber	Yes, pembrolizumab	Yes, pembrolizumab	Yes, pembrolizumab

ECE = extracapsular extension; XRT = radiation therapy

Regulatory and reimbursement issues aside, would you present the option of adjuvant anti-PD-1/PD-L1 antibody therapy to a patient with cSCC and perineural invasion?

 Dr Khushalani	No
 Dr Pavlick	No
 Dr Hamid	No
 Dr Lipson	No
 Dr Reddy	No
 Dr Weber	No

RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, would you present the option of adjuvant anti-PD-1/PD-L1 antibody therapy to a patient with cSCC and locally recurrent disease with no evidence of disease after surgical resection?

 Dr Khushalani	No
 Dr Pavlick	No
 Dr Hamid	Yes, cemiplimab
 Dr Lipson	No
 Dr Reddy	Yes, I would present it as an option to the patient
 Dr Weber	Yes, pembrolizumab for a high-risk lesion

RTP RESEARCH TO PRACTICE

In which situations, if any, do you recommend postoperative radiation therapy for patients who undergo resection of cSCC?

 Dr Khushalani	Perineural invasion, recurrent disease, multiple nodes involved, ECE, R1/R2 resection
 Dr Pavlick	Close margins, perineural invasion, multifocal disease
 Dr Hamid	Positive margins, ECE, perineural extension
 Dr Lipson	Nodal disease with ECE, in-transit metastases, T4 lesion, perineural invasion, locally recurrent disease NED after resection
 Dr Reddy	Positive margins or 2 to 3 risk factors
 Dr Weber	Lack of clean negative margin or extensive local disease/nodal involvement

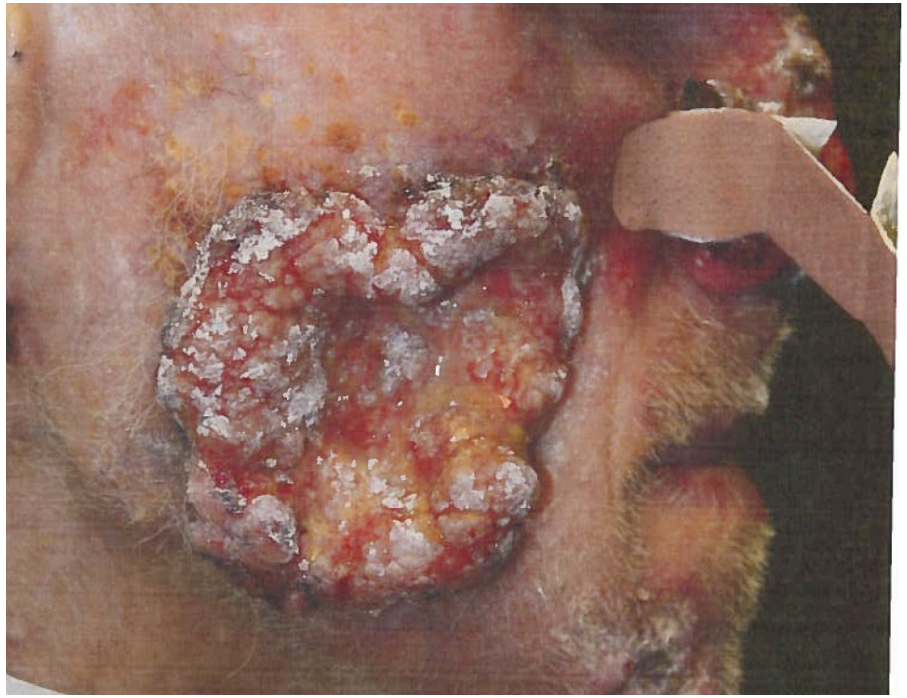
ECE = extracapsular extension; NED = no evidence of disease

Case Presentation – Dr Khushalani: A man with locally advanced cSCC

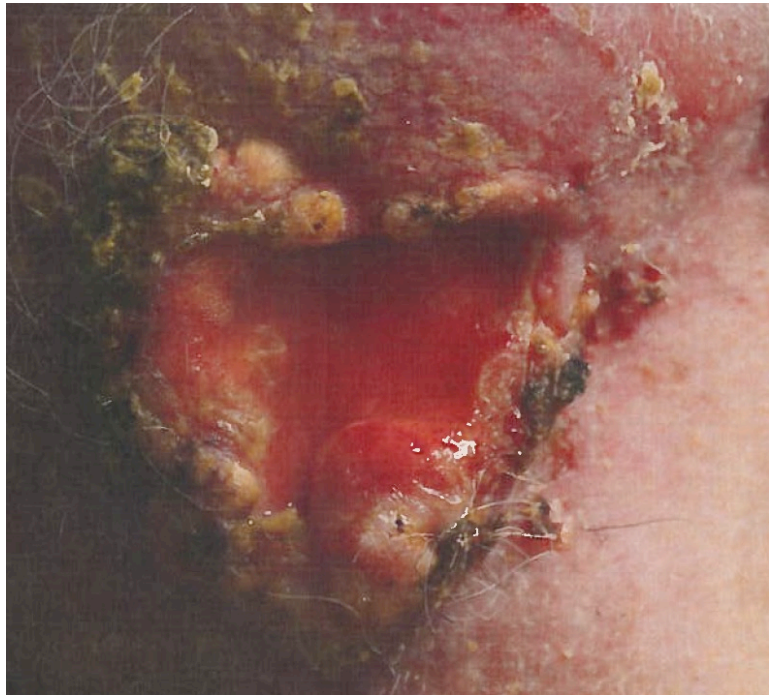
Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man with locally advanced cSCC (continued)

Dramatic Response



Post one dose pembrolizumab

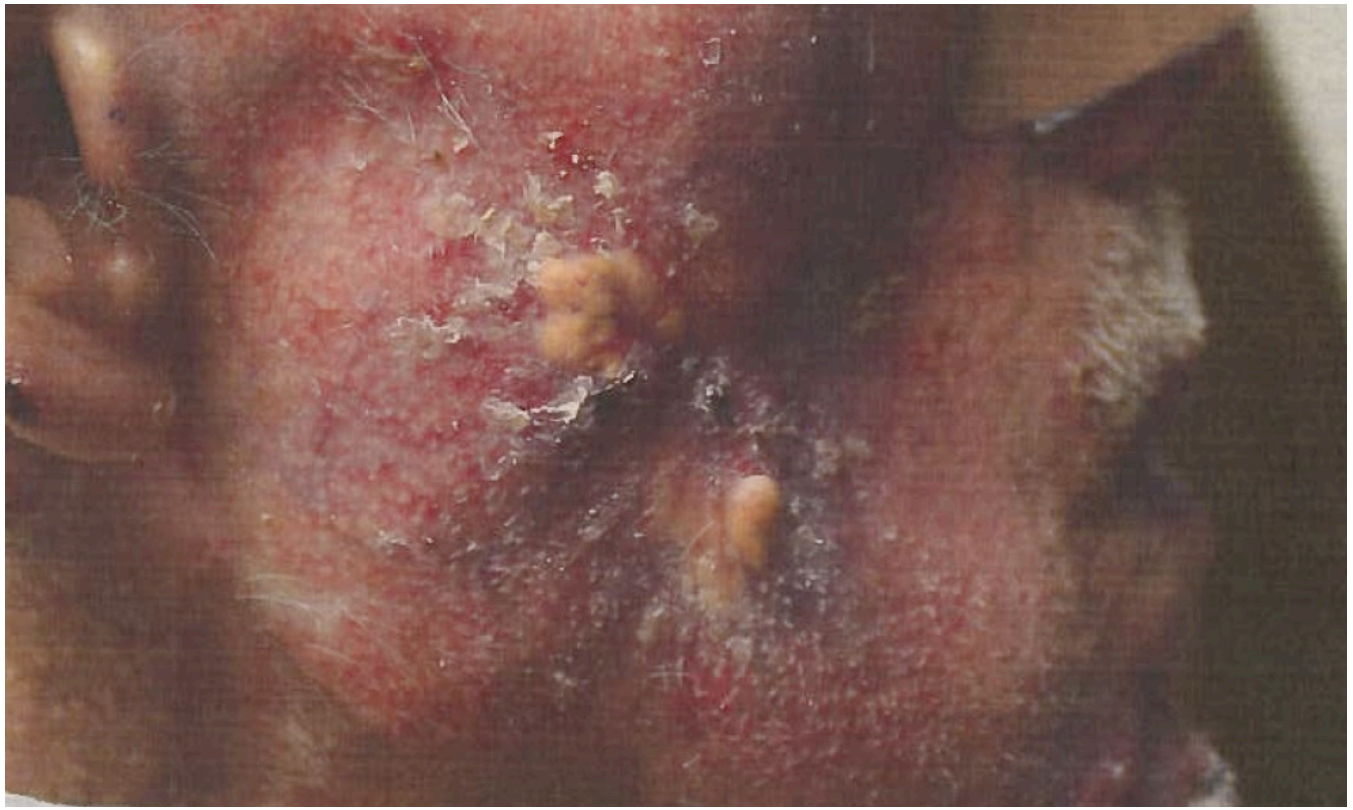


Post two doses of pembrolizumab

Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man with locally advanced cSCC (continued)

Post 6 months therapy



Completed 1 year of therapy with clinical CR – then lost to follow-up.
Primary irAE of G1-2 arthritis

Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man in his late 60s with moderately to poorly differentiated SCC

- M/67; right forehead SCC in 2015 – surgery
- 2017 – local recurrence – electron beam RT (52.5 Gy)
- Several additional local recurrences requiring multiple surgical resections including tangential craniectomy – pathology with moderately to poorly differentiated SCC
- In 2022 – new right forehead mass; biopsy shows SCC

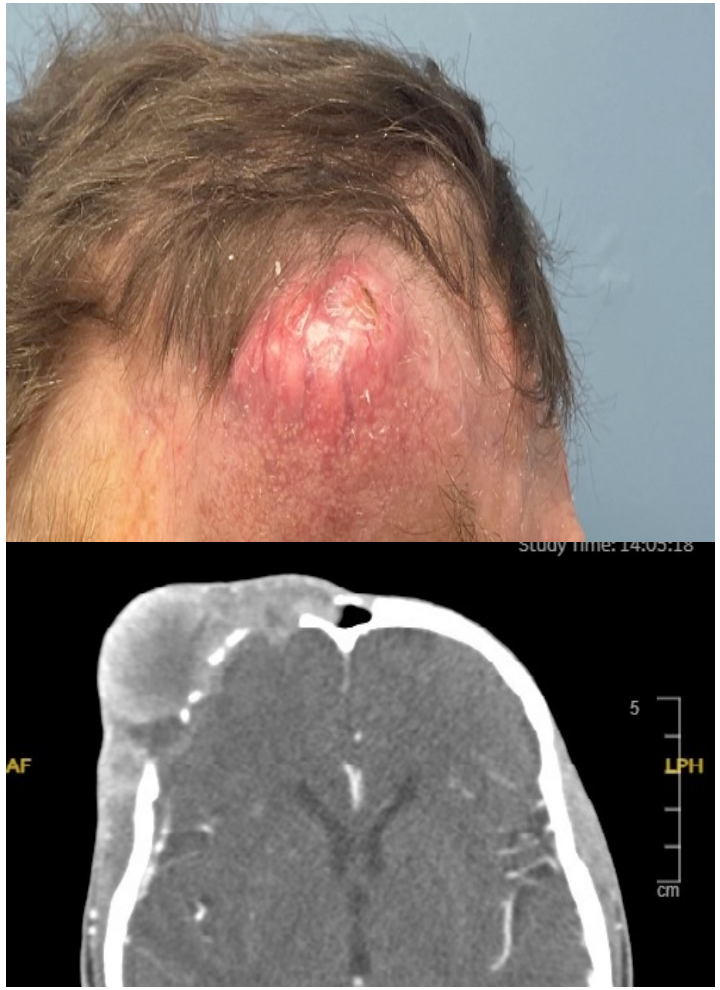
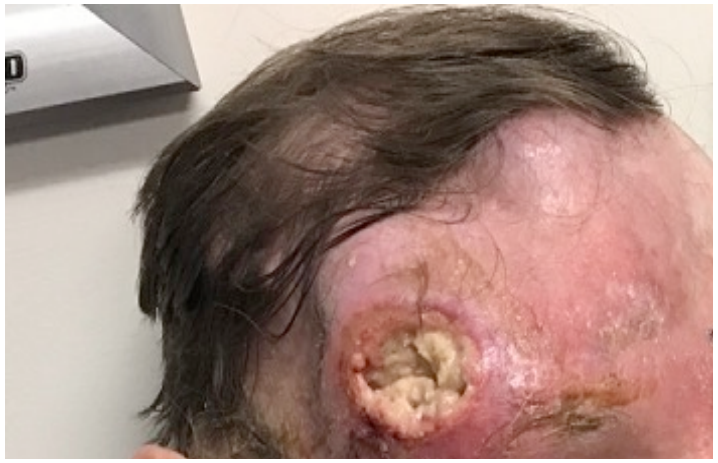


Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man in his late 60s with moderately to poorly differentiated SCC (continued)

- Multi-disciplinary evaluation
  - Unresectable; infiltration of the dura with sub-dural collection and infiltration of the right frontal sinus
- Plan for Cemiplimab plus palliative course of IMRT due to pain and location with ocular compressive symptoms
- Re-irradiation: 40 Gy
- Dramatic clinical and radiographic response within 2 cycles of cemiplimab



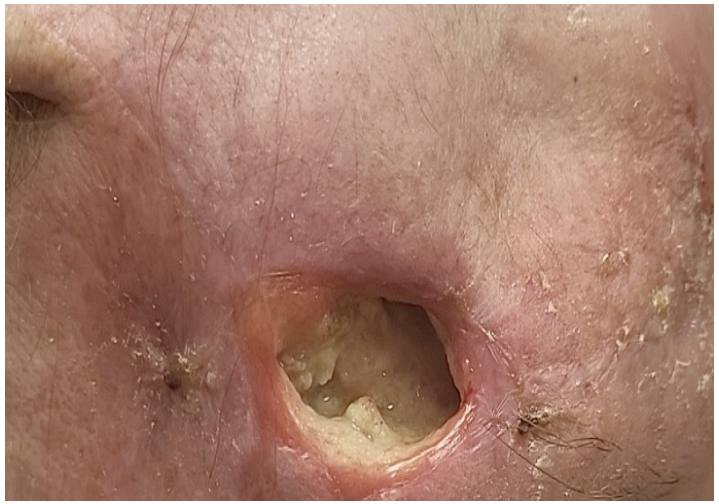
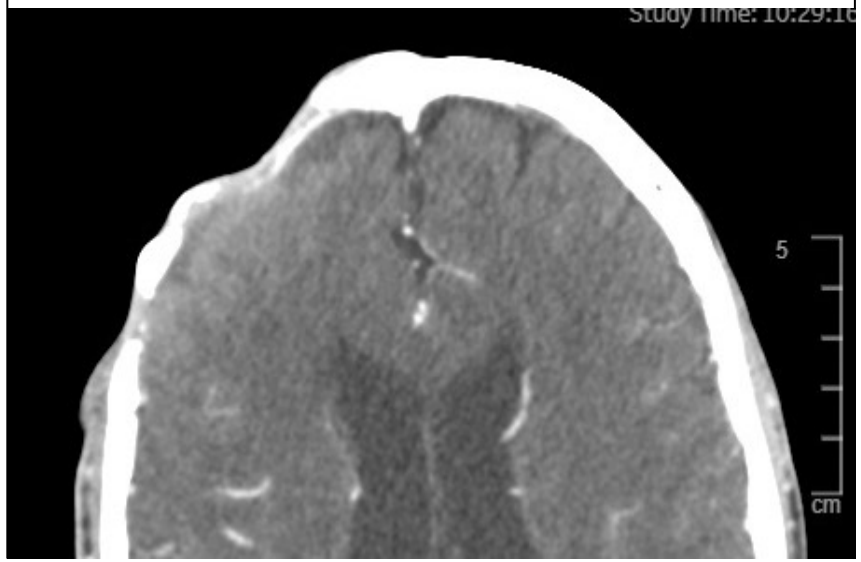
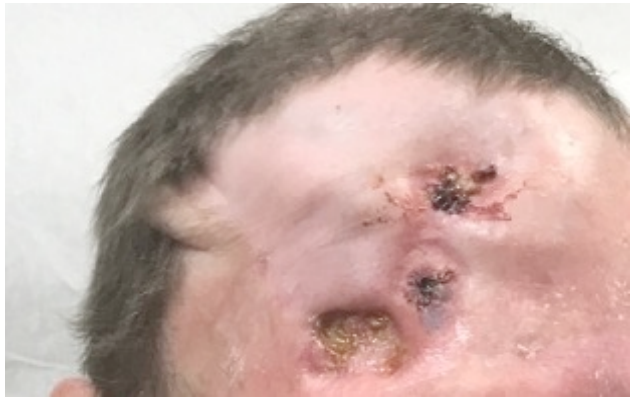


Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man in his late 60s with moderately to poorly differentiated SCC (continued)

- Progressive improvement in tumor and symptoms.
- Completed 12 months of Cemiplimab – now on surveillance





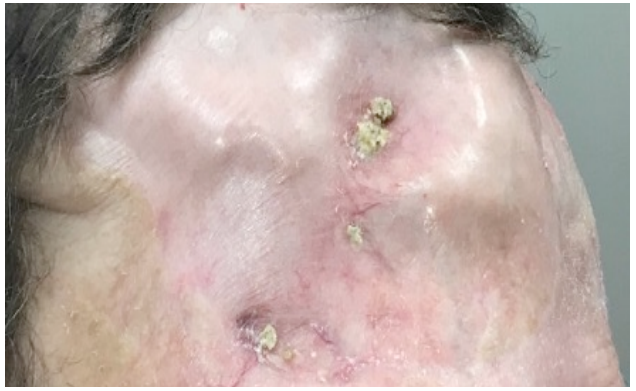


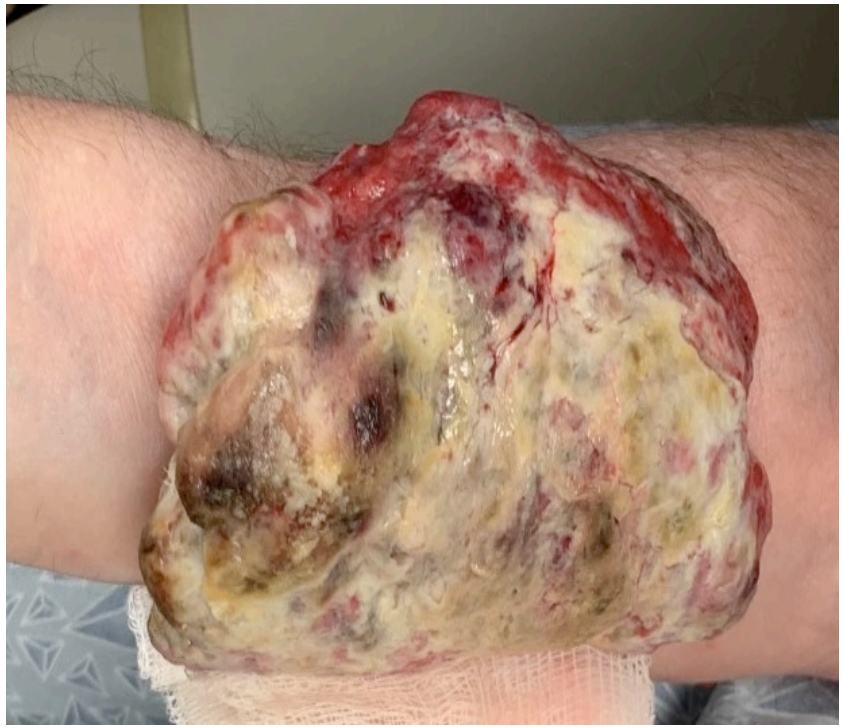
Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man in his late 50s with poorly differentiated SCC

- M/57: flesh colored mass on right forearm that increased over 2 years; then developed a palpable right axillary swelling.
- CT imaging: 7.5cm X 4.4cm X 10.3cm mass of the distal forearm encasing cephalic vein; 3.9cm right axillary nodal mass
- Biopsy of right axillary mass: Poorly differentiated SCC (p40+)
- Started cemiplimab

Case Presentation – Dr Khushalani: A man in his late 50s with poorly differentiated SCC (continued)

Pre-Cemiplimab Images



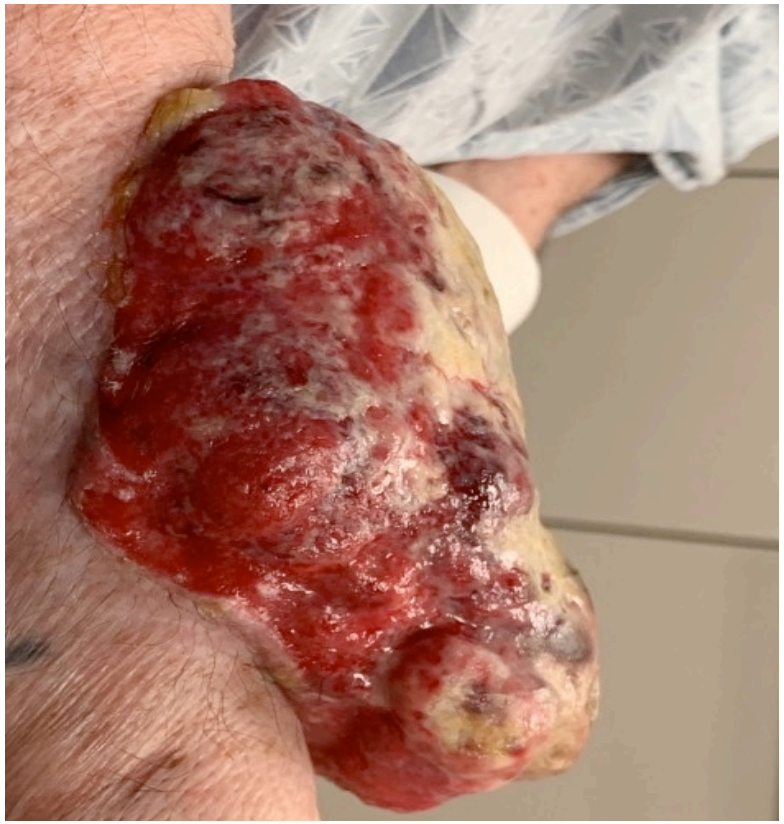
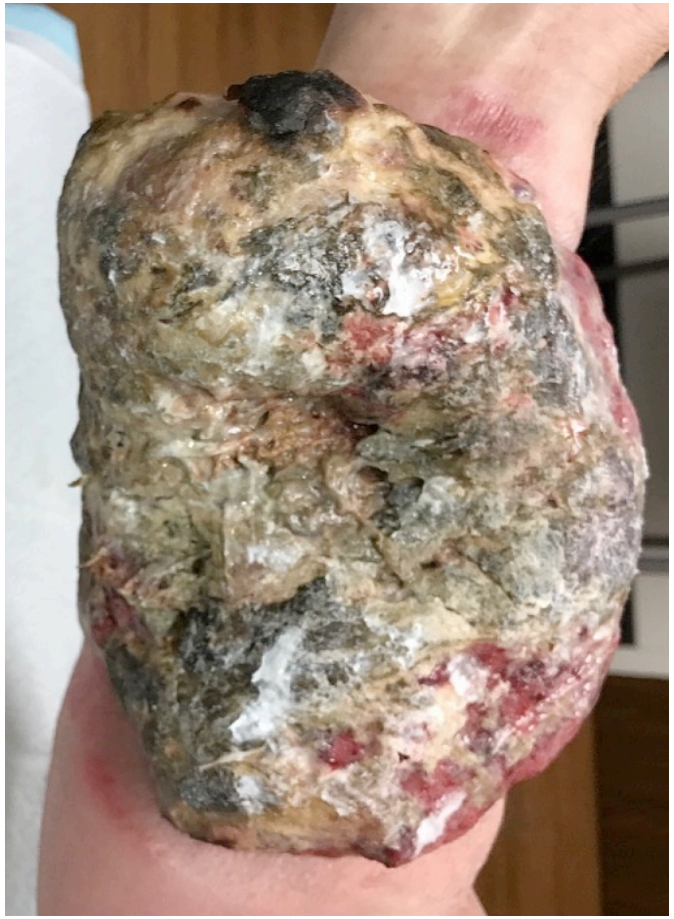
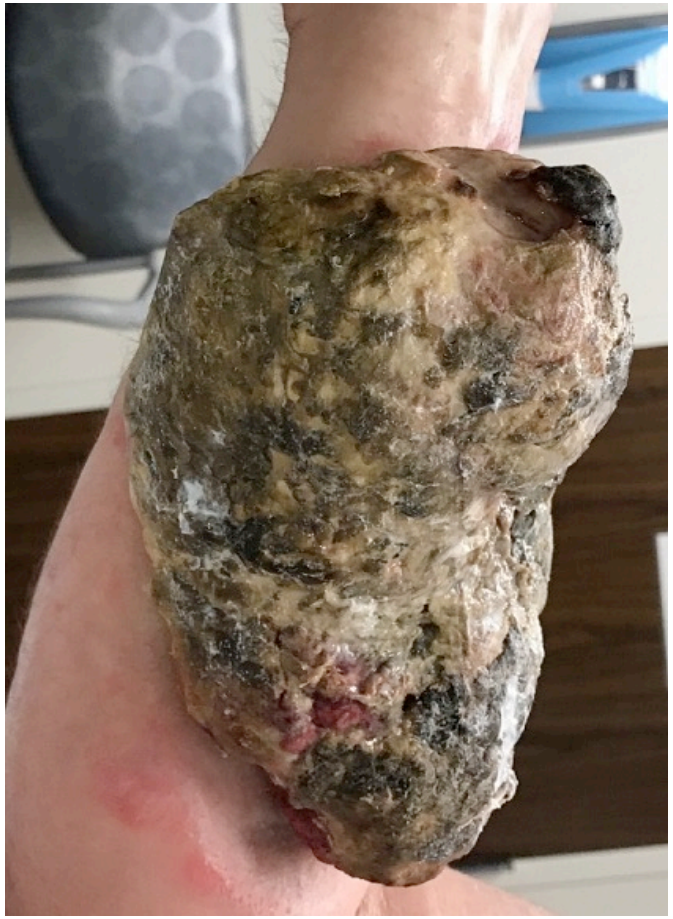


Image Courtesy: Khushalani NI

Case Presentation – Dr Khushalani: A man in his late 50s with poorly differentiated SCC (continued)

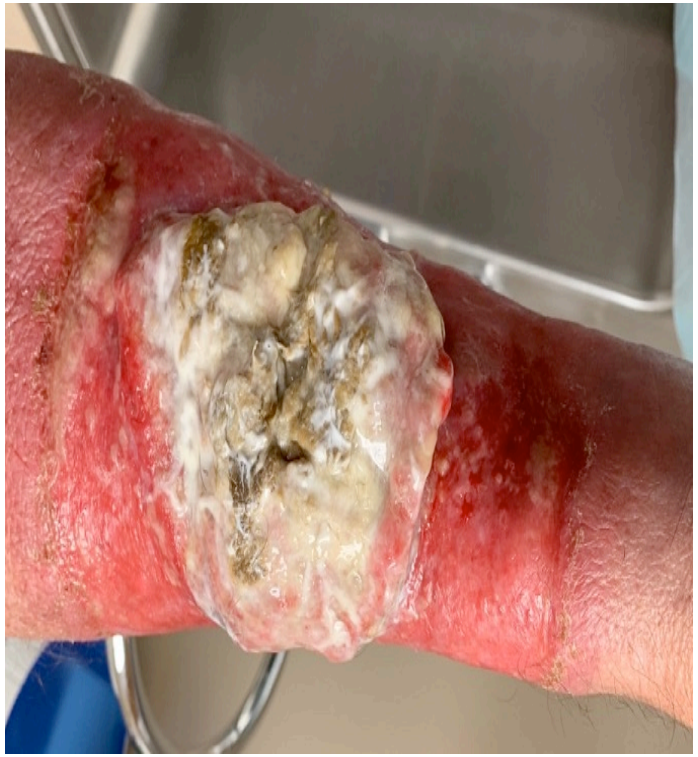
Progression on Cemiplimab (4 Cycles)



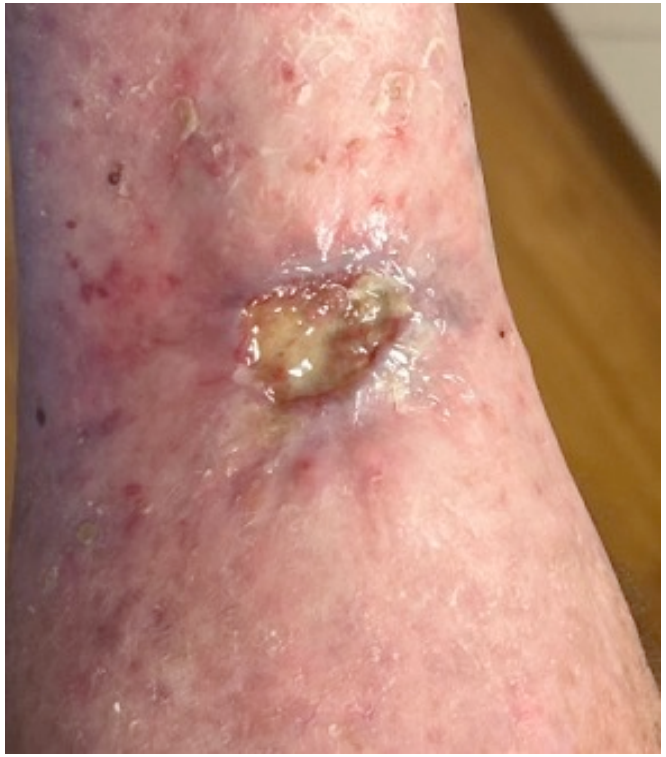


Case Presentation – Dr Khushalani: A man in his late 50s with poorly differentiated SCC (continued)

Cetuximab + concurrent RT
(35 fractions, 2 Gy each; forearm and axilla)



Last week of RT



Ongoing cetuximab; 4m post RT

Agenda

INTRODUCTION: Why did it take so long?

MODULE 1: Cutaneous Squamous Cell Carcinoma – Dr Khushalani

MODULE 2: Basal Cell Carcinoma – Dr Pavlick

MODULE 3: Ongoing Clinical Trials

RTP
RESEARCH
TO PRACTICE

Pathophysiology and Molecular Characteristics

- Hedgehog signaling pathway controlled by Hh genes (Sonic, Indian, Desert) is crucial to normal basal cell proliferation and dysregulated in ≥85% of BCC
- Genetic characteristics
  - Mutations in sonic Hh pathway genes: *PTCH1* and *SMO*
  - Mutations in *TP53* due to UV/radiation exposure
  - Very high TMB due to UV damage (median 47.3 mut/Mb)
  - Other mutations of interest: *EGFR* (38%), *ERBB2*, *PIK3CA*, *RAS* (all <10%)
- Molecular characteristics
  - Approximately 90% have high PD-L1 expression on IHC
  - PD-L1 intensity increases with number of prior treatment types

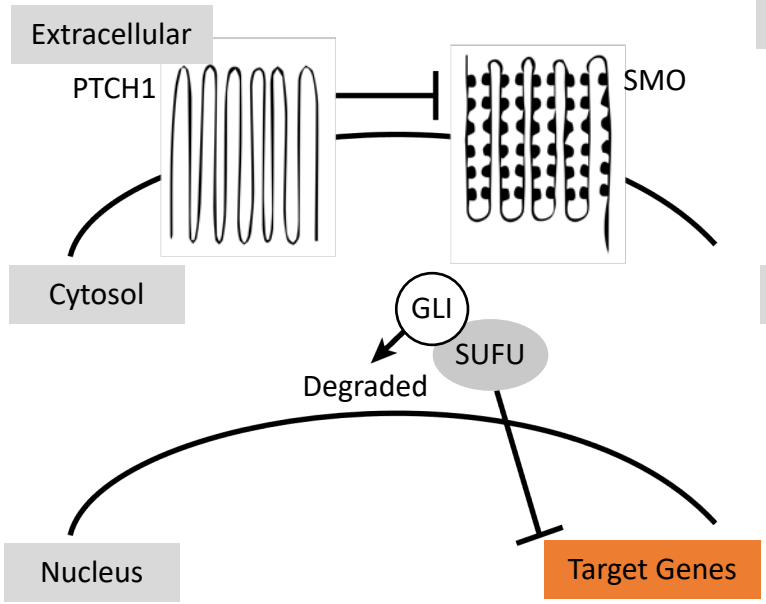
Hh = hedgehog; IHC = immunohistochemistry; mut/Mb = mutations per megabase; TMB = tumor mutation burden.

Cives. Int J Mol Sci. 2020;21:5394. Goodman. OncoImmunol. 2018;7:e1404217. Habashy. Cureus. 2021;13:e13859. NCCN. Basal Cell Cancer. Version 2.2021. www.nccn.org. Nikanjam. Ann Oncol. 2018;29:2192.

Courtesy of Anna C Pavlick, DO, MBA

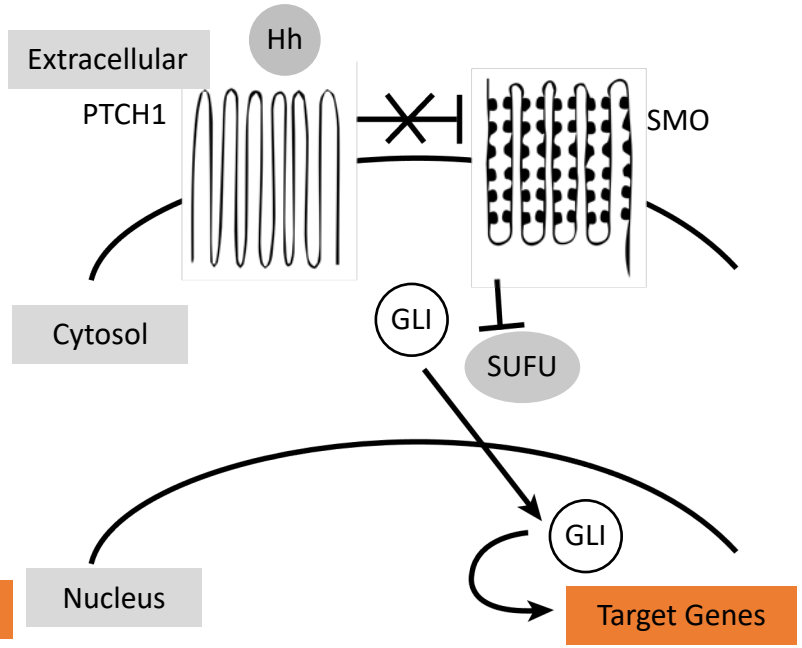
Molecular Pathways in BCC

Normal cell in absence of Hh



GLI pathway inactivated:
Autoregulation of growth

Normal cell in presence of Hh



GLI pathway activated:
Proliferation and differentiation

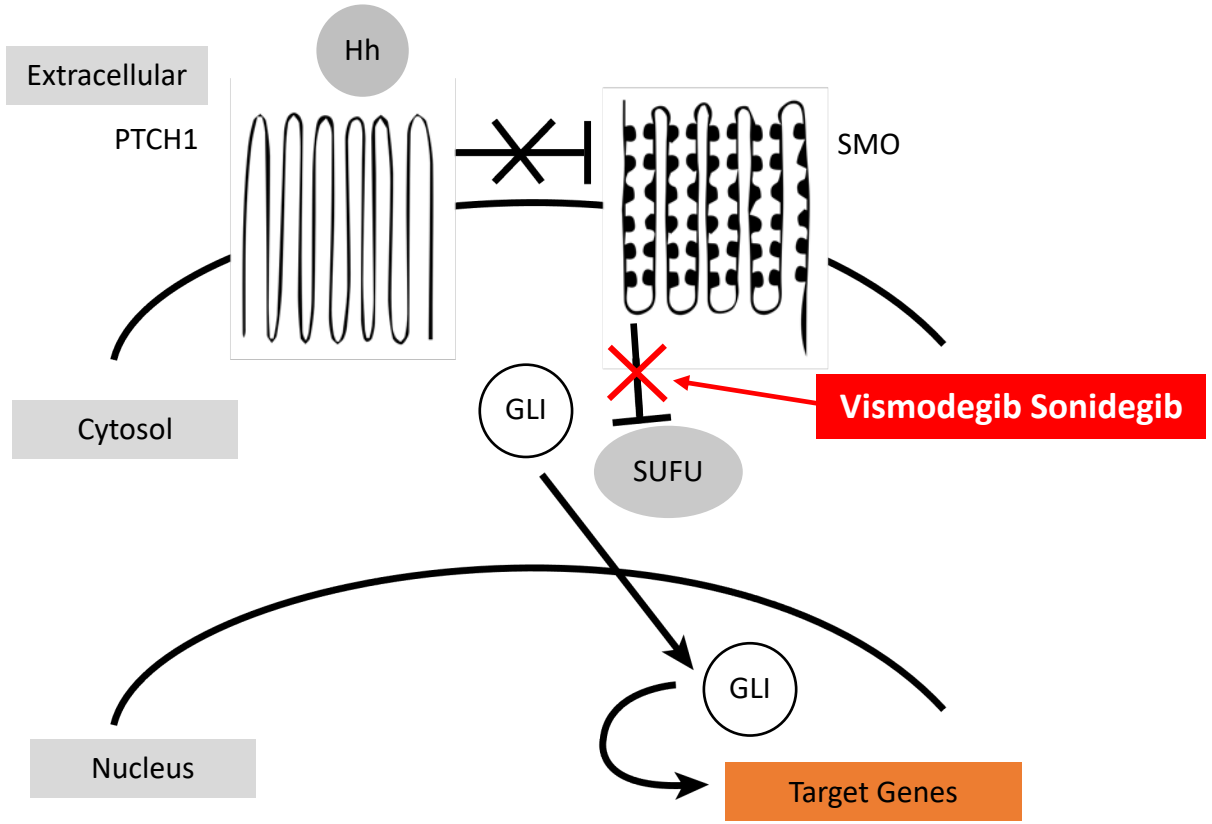
- *PTCH1* or *SMO* mutations trigger constitutive activation of GLI downstream pathway
- *TP53* mutations potentiate Hh signaling
- Frequency in advanced BCC
  - *PTCH1*: 67% to 73%
  - *TP53*: 40% to 61%
  - *SMO*: 10% to 20%
- Frequency in mBCC
  - *PTCH1*: 32%
  - *TP53*: 79%
  - *SMO*: 17%

Courtesy of Anna C Pavlick, DO, MBA

mBCC = metastatic BCC; SUFU = suppressor of fused protein. Goodman. OncoImmunol. 2018;7:e1404217. Nikanjam. Ann Oncol. 2018;29:2192.

Hedgehog Inhibitors

- HHIs bind the SMO receptor to prevent inactivation of SUFU and downstream activation of GLI, which facilitates restoration of normal cell regulation
- 2 HHIs currently approved for BCC
  - Vismodegib
  - Sonidegib
- Each is a once-daily oral medication



HHI = hedgehog inhibitor.

Habashy. Cureus. 2021;13:e13859. Nikanjam. Ann Oncol. 2018;29:2192.

Courtesy of Anna C Pavlick, DO, MBA

Frequent AEs With HHIs

AE, %	Vismodegib 150 mg		Sonidegib 200 mg	
	Any grade	Grade 3 or 4	Any Grade	Grade 3 or 4
Muscle spasms	68	4	52	3
Alopecia	63	0	49	0
Dysgeusia	51	0	41	0
Weight loss	46	5	29	3
Fatigue	36	4	29	4
Nausea	29	1	35	1
Appetite loss	23	3	23	1
Diarrhea	22	1	30	1
Potential serious AE	• Severe cutaneous reactions • Embryo-fetal toxicity: females must use effective contraception, and males must use condom with pregnant partner or female partner of reproductive potential because of potential risk of exposure through semen • Premature fusion of epiphyses			

Courtesy of Anna C Pavlick, DO, MBA

Dummer. J Am Acad Dermatol. 2016;75:113. Lacoutre. Oncologist. 2016;21:1218
Sekulic. N Eng J Med. 2012;366:2171. Sonidegib PI. Vismodegib PI.

Suggested Management of HHI AEs

AE	Grade 0	Grade 1-2
Muscle spasms	• Maintain hydration, gentle physical activity • Sonidegib only: check creatinine kinase before/during treatment	• Passive stretching, heat, cold, massage • Consider CCBs, gabapentin, magnesium • If abdominal: CCBs, antimuscarinics
Dysgeusia	• Nutrition counseling, patient education	• THC or zinc supplements • Check renal function
Alopecia	• Rule out other causes; consider prophylactic minoxidil or other	• Camouflage (eg, wig) • Minoxidil, oral DHTi, bimatoprost (eyelid)
Weight loss	• Nutrition counseling, patient education	• Ongoing nutrition support and evaluate and correct deficiencies • THC, megestrol, corticosteroids
Fatigue	• Maintain physical activity, yoga or other, physical rehab	• Test/treat anemia • Consider psychostimulants
All	• Any severe (grade ≥3) or intolerable AE: Continue grade 1-2 management plus 2-4 week drug holiday or change regimen (alternate agent or alternate day/week dosing)	

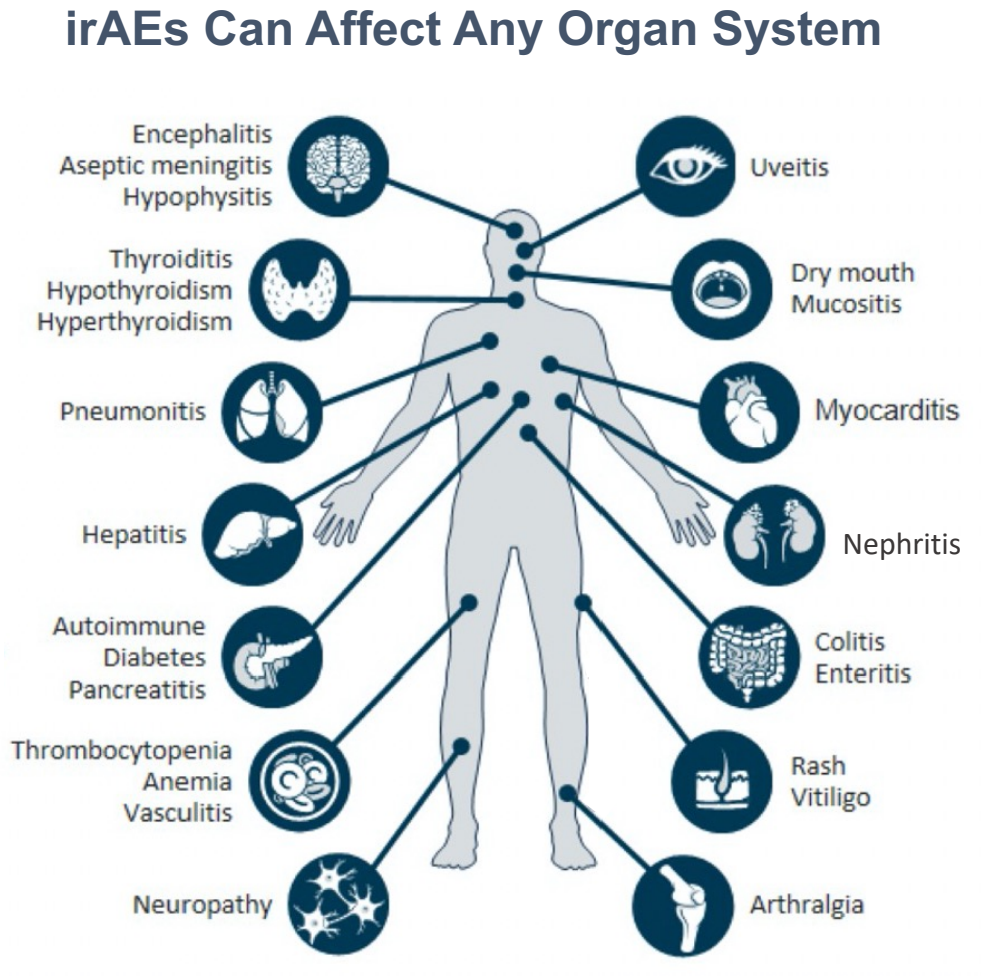
CCB = calcium channel blocker; DHTi = spironolactone, finasteride; THC = delta-9-tetrahydrocannabinol.

Lacoutre. Oncologist. 2016;21:1218.

Courtesy of Anna C Pavlick, DO, MBA

Immune Related Adverse Effects

- Unique to ICIs and related to immune system damage to healthy organs
  - Activated T-cells mistakenly attack healthy tissue
  - Inflammatory or autoimmune-type symptoms
- Maintain high level of suspicion for irAE with any changes in patient on ICI
  - Bloating or weight loss
  - Bowel, vision, or mood changes
  - Cough, dyspnea, chest pain
  - Headache
  - Rash and/or itchy skin
  - Severe fatigue or muscle weakness/pain



Courtesy of Anna C Pavlick, DO, MBA

Brahmer. J Clin Oncol. 2018;36:1714. NCCN. Management of immunotherapy-related toxicities, v3.2021. www.nccn.org.

General Guidance for Management of irAEs

Maintain Low Threshold for Systemic Steroids With Grade 2-3 irAE

Grade	Management*
1 (mild)	• Symptomatic management (eg, topical steroid) • Continue therapy (some cardiac, neurologic, or hematologic reaction may require discontinuation)
2 (mild to moderate)	• Symptomatic management • Hold ICI for most grade 2 until resolution to grade 1; consider rechallenge after resolution; permanently discontinue if reaction reoccurs • Initiate low-dose or topical corticosteroids (eg, prednisone 0.5-1.0 mg/kg/d)
3 (moderate to severe)	• Hold ICI • Initiate high-dose corticosteroids (eg, prednisone 1-2 mg/kg/d), taper steroids over 4-6 weeks • At resolution to grade ≤1, cautious rechallenge with ICI, especially in patients with early development of irAE
4 (severe)	• Permanently discontinue ICI, except for endocrinopathies controlled with hormone replacement

*Consult prescribing information for detailed recommendations.

Brahmer. J Clin Oncol. 2018;36:1714. Cemiplimab PI. NCCN. Management of immunotherapy-related toxicities, v3.2021. www.nccn.org. Pembrolizumab PI.

Courtesy of Anna C Pavlick, DO, MBA

What is your usual first-line systemic therapy for a patient with advanced basal cell carcinoma (BCC) not amenable to radiation therapy or surgery?

 Dr Khushalani	Sonidegib or vismodegib, no preference
 Dr Pavlick	Vismodegib
 Dr Hamid	Anti-PD-1 antibody
 Dr Lipson	Anti-PD-1 antibody
 Dr Reddy	Vismodegib
 Dr Weber	Sonidegib or vismodegib, no preference

RTP RESEARCH TO PRACTICE

How long do you typically continue hedgehog inhibitor therapy for a patient with advanced BCC who achieves a complete response (CR) and is tolerating treatment well?

 Dr Khushalani	Usually 9-12 months
 Dr Pavlick	If no toxicity, usually an additional 3 months past CR
 Dr Hamid	Indefinitely
 Dr Lipson	Once the patient experiences a CR, I stop hedgehog inhibitor therapy right away
 Dr Reddy	3 months after CR, depending on tolerance
 Dr Weber	12 months

RTP
RESEARCH
TO PRACTICE

What would you estimate is the likelihood that a patient receiving a hedgehog inhibitor for advanced BCC will need to have therapy held or discontinued due to tolerability issues?

In your experience, what are the 3 most common toxicities experienced by patients with advanced BCC who are receiving hedgehog inhibitor therapy?

	Chance of hold or discontinuation	Common toxicities
 Dr Khushalani	100%	Muscle cramps, dysgeusia, fatigue and alopecia
 Dr Pavlick	65%	Dysgeusia, anorexia, muscle cramps
 Dr Hamid	80%	Dysgeusia, alopecia, cramps
 Dr Lipson	75%	Hair loss, dysgeusia, muscle cramps
 Dr Reddy	50%	Taste alterations, fatigue, bowel disturbances
 Dr Weber	100%	Dysgeusia, muscle spasms, loss of hair

What supportive care measures do you employ to manage dysgeusia in patients receiving hedgehog inhibitor therapy?

 Dr Khushalani	None for dysgeusia per se, suggest small volume frequent meals to ensure adequate caloric intake and prevent weight loss
 Dr Pavlick	Interrupt therapy or have patients eat spicier or sour tasting food
 Dr Hamid	Therapy hold
 Dr Lipson	Avoidance of metal silverware, addition of salt or hot sauce
 Dr Reddy	Use of extreme tastes such as lemon, discuss utilizing bland foods
 Dr Weber	Intermittent dosing and zinc

RTP RESEARCH TO PRACTICE

What other supportive care measures do you employ to manage other side effects in patients receiving hedgehog inhibitor therapy?

 Dr Khushalani	Adequate oral fluid intake; consider tonic water if cramps noted
 Dr Pavlick	Increase exercise and hydration with sports drinks to decrease muscle cramps, small frequent meals to keep up calories
 Dr Hamid	Hydration, muscle stretches, treatment holiday/hold
 Dr Lipson	IV fluids, exercise/yoga
 Dr Reddy	None
 Dr Weber	Dietary consult for the weight loss and dysgeusia

Outside of a clinical trial, have you administered or would you administer the alternative hedgehog inhibitor to a patient with advanced BCC who had experienced disease progression on prior hedgehog inhibitor therapy?

 Dr Khushalani	I have not and would not
 Dr Pavlick	I have not and would not
 Dr Hamid	I have not and would not
 Dr Lipson	I have not and would not
 Dr Reddy	I have
 Dr Weber	I have not and would not

RTP RESEARCH TO PRACTICE

What is your usual second-line systemic therapy for a patient with advanced BCC who has experienced disease progression on first-line hedgehog inhibitor therapy?

 Dr Khushalani	Cemiplimab
 Dr Pavlick	Cemiplimab
 Dr Hamid	Cemiplimab
 Dr Lipson	Cemiplimab
 Dr Reddy	Cemiplimab or pembrolizumab
 Dr Weber	Cemiplimab

What is the longest duration of response (DoR) you have observed in a patient with advanced BCC receiving anti-PD-1/PD-L1 antibody therapy?

How long do you typically continue anti-PD-1/PD-L1 antibody therapy for a patient with advanced BCC who achieves a CR and is tolerating treatment well?

	Longest DoR	Duration of anti-PD-1/PD-L1 therapy
 Dr Khushalani	12+ months and ongoing	Will consider discontinuation after 9-12 months
 Dr Pavlick	3 years	3 months after CR and PET/CT with no avidity
 Dr Hamid	3 years	Indefinitely
 Dr Lipson	5 years	Once the patient experiences a CR, I generally treat for another 12-16 weeks, then stop
 Dr Reddy	6 months	3 months after CR
 Dr Weber	Multiple years	At least 12 months

What is the age of the oldest patient with BCC you have treated with an anti-PD-1/PD-L1 antibody? Did the patient respond to therapy? Did the patient tolerate therapy?

	Age	Responded?	Tolerated?
 Dr Khushalani	74 years	Yes	Yes
 Dr Pavlick	99 years	Yes	Yes
 Dr Hamid	78 years	Yes	Yes
 Dr Lipson	97 years	Yes	Yes
 Dr Reddy	90 years	No	Yes
 Dr Weber	88 years	Yes	Yes

How many patients with nevoid BCC syndrome (Gorlin syndrome) have you cared for?

What role, if any, do you believe anti-PD-1/PD-L1 antibodies play in treating this syndrome, and for approximately how many patients have you employed topical patidegib gel?

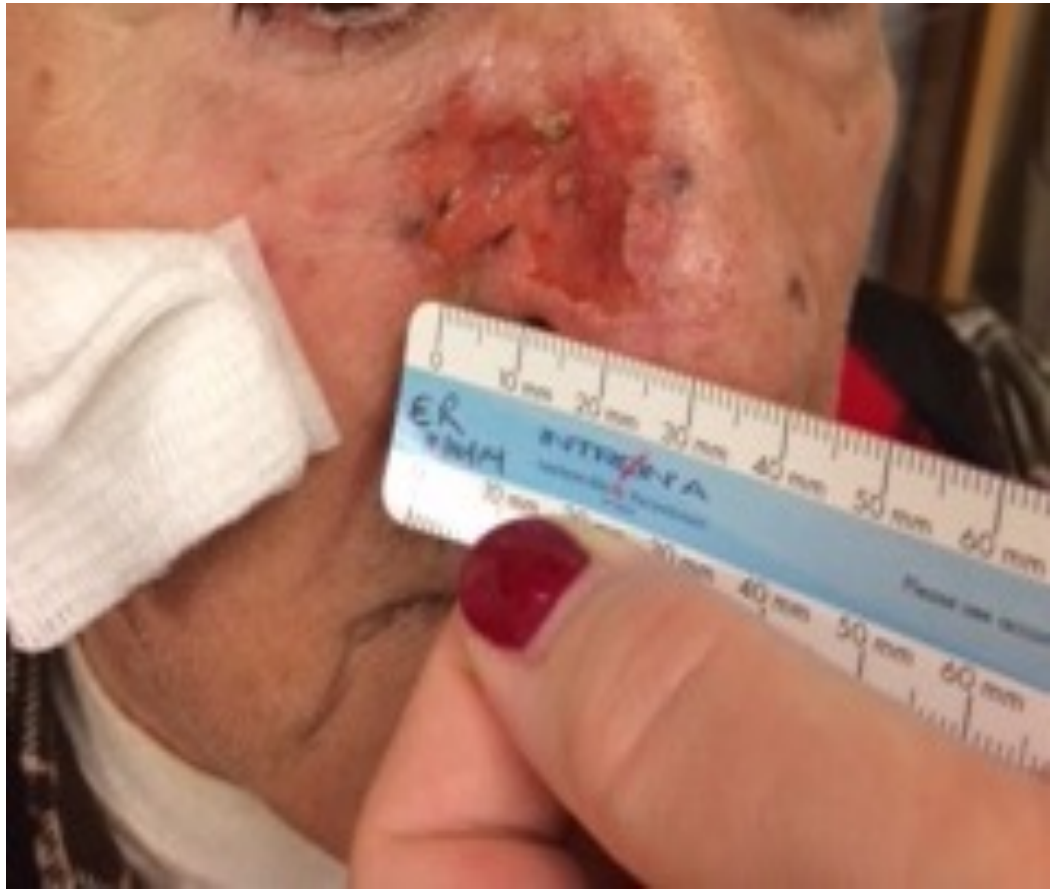
	No. of patients	Role of anti-PD-1/ PD-L1 therapy	No. administered patidegib gel
 Dr Khushalani	2	Similar indications as sporadic BCC	0
 Dr Pavlick	6	Unclear	0
 Dr Hamid	2	Therapeutic option	0
 Dr Lipson	10	Potentially effective therapy, though little data in this patient population	0
 Dr Reddy	2	It is worth considering	0
 Dr Weber	2 or 3	May be useful	0

Case Presentation – Dr Pavlick: A man in his late 80s with advanced BCC

- An 88-year-old man who grew up in Puerto Rico presents to the dermatologist with a non-healing ulcer on the lateral aspect of his nose.
- A biopsy is done which demonstrates invasive BCC.
- What are this man's treatment options?

Case Presentation – Dr Pavlick: A man in his late 80s with advanced BCC (continued)

The location and size of this lesion made surgery and radiation difficult and not without significant side effects. He refused surgery and Radiation therapy.

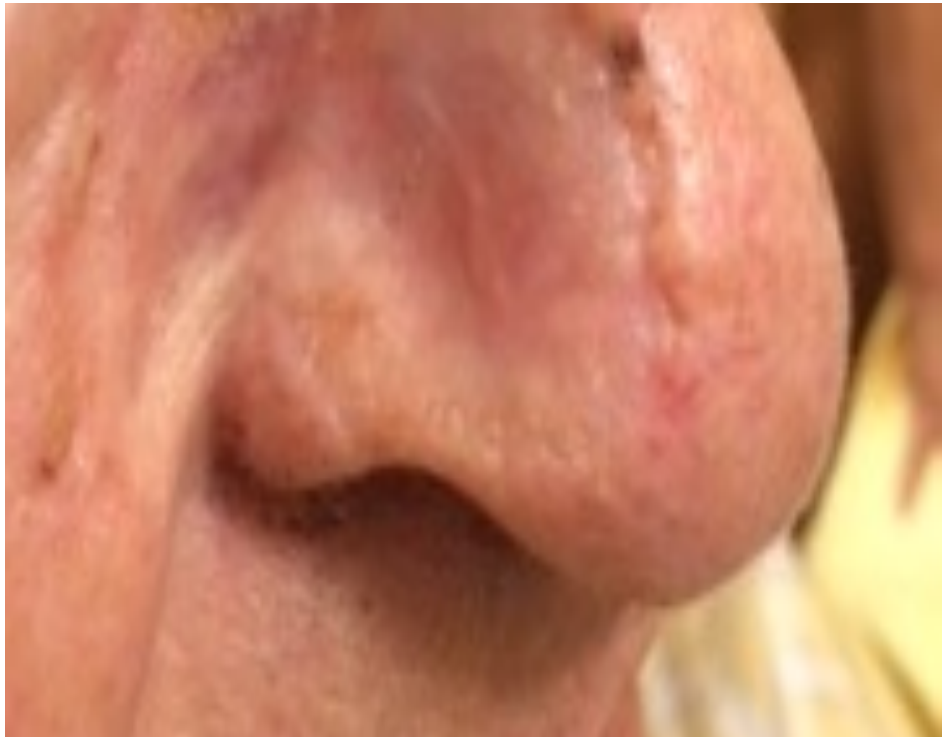


Case Presentation – Dr Pavlick: A man in his late 80s with advanced BCC (continued)

- He was started on vismodegib 150 mg po daily.
- He had a dramatic response to therapy.
- After approximately 6 months on vismodegib, he developed muscle cramps in his lower extremities that would wake him up from his sleep.
- As he had resolution of his lesion, the vismodegib was stopped and his cramps resolved.

Case Presentation – Dr Pavlick: A man in his late 80s with advanced BCC (continued)

- As the vismodegib was stopped, he was then sent to the dermatologist for several blind biopsies in the area.
- All biopsies were negative for BCC
- He remains disease free and is monitored closely by dermatology.



Case Presentation – Dr Pavlick: A man in his early 80s with advanced BCC receives cemiplimab

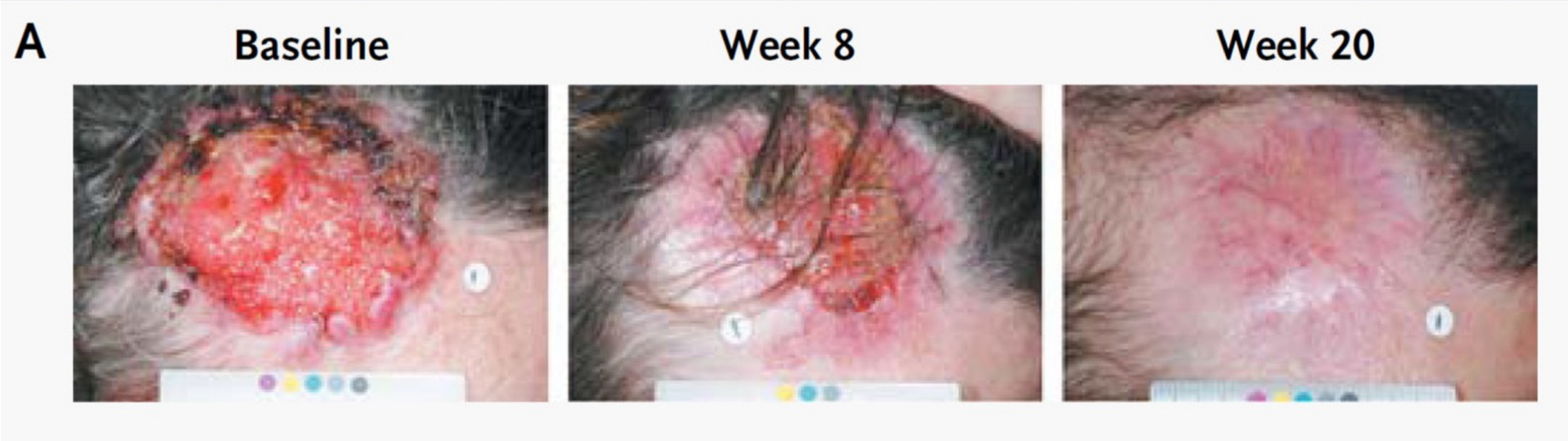
- An 80-year-old man who has recurrent BCC
- First diagnosed with 1.5 cm basal cell lesion on his scalp 8 years ago
  - Underwent extensive Mohs surgery to remove lesion
  - No sign of local spread
- Presents today for follow-up with concerns about a lesion in the same area
- Workup reveals
  - 5 cm lesion with poorly defined borders
  - No evidence of other lesions on full-skin exam
  - Imaging reveals no distant disease

Case Presentation – Dr Pavlick: A man in his early 80s with advanced BCC receives cemiplimab (continued)

- Patient was referred to medical oncology for a discussion of medical therapy, since he refused surgery and radiation therapy.
- He was started on a hedgehog inhibitor, but within 3 months he lost his desire to eat as food had no taste and he lost almost 20 pounds.
- The HHI was stopped and when he recovered from this toxicity, he was offered immunotherapy with cemiplimab 350mg IV every 3 weeks which he agreed to.
- He tolerated this infusion well and denied any IRAE's.
- He received treatment for nearly 2 years with complete resolution of his recurrent BCC.

Case Presentation – Dr Pavlick: A man in his early 80s with advanced BCC receives cemiplimab (continued)

Tumor Response to Cemiplimab



Case Presentation – Dr Pavlick: A man in his mid-70s with hedgehog inhibitor refractory advanced BCC

- A 76-year-old man who noticed a pink nodule on his right upper outer arm in July 2020. He was afraid it was cancer, so he ignored it hoping it would go away.
- The lesion continued to grow, then the COVID pandemic hit and he refused to seek any medical care for fear of contracting COVID and dying.
- In January 2022, he collapsed at home and was rushed to the ER. He was found to be septic due to an infected large fungating right upper arm mass. He recovered from the sepsis and the large fungating mass was removed. The pathology was consistent with basal cell carcinoma.

Case Presentation – Dr Pavlick: A man in his mid-70s with hedgehog inhibitor refractory advanced BCC (continued)

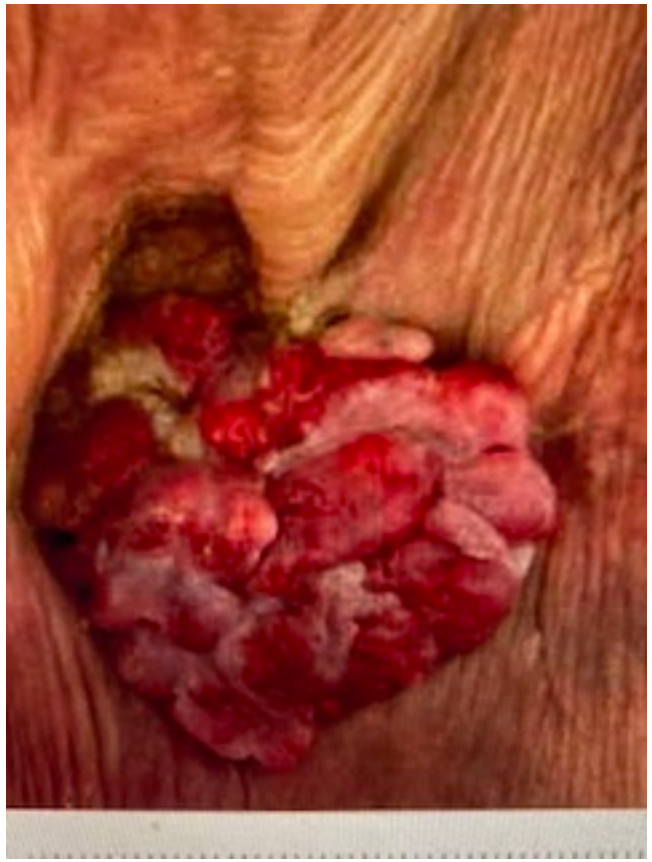
- He was referred to medical oncology and on exam was found to have a nodular, fungating mass in his right axilla with RUE edema and decreased fine motor skills in his hand.
- His metastatic work up demonstrated this right axillary mass encircling the right brachial plexus which was deemed unresectable.
- He was started on vismodegib 150 mg po daily.
- He tolerated this well except for occasional muscle cramps and hair loss.
- While on vismodegib, his right axillary mass started to grow and he developed new right chest wall nodules.
- Metastatic work up was negative for any distant disease.
- Vismo was stopped and he was started on cemiplimab.

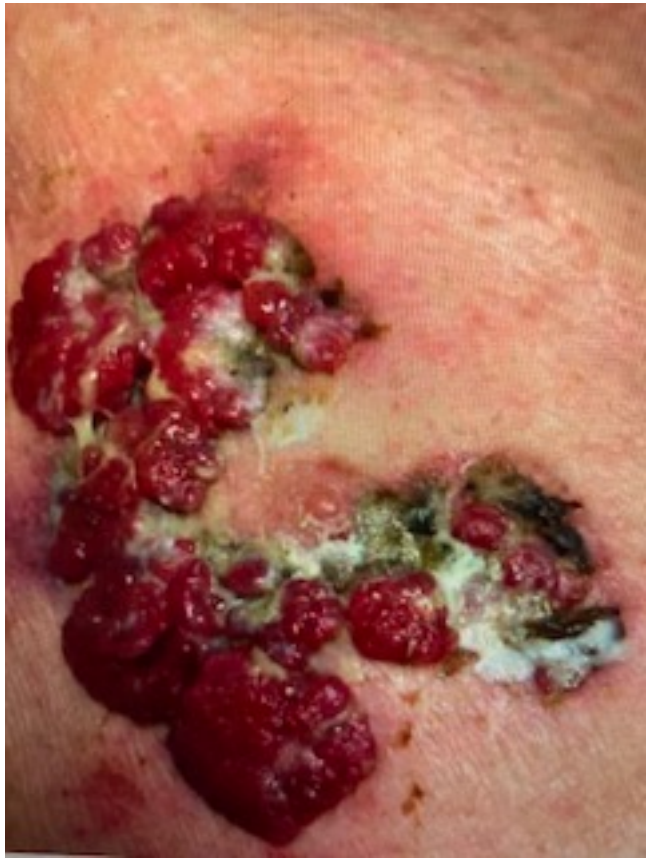
Case Presentation – Dr Pavlick: A man in his mid-70s with hedgehog inhibitor refractory advanced BCC (continued)

- He had some decrease in the axillary mass, but the chest wall nodules continued to increase in size.
- Cemiplimab was stopped after 6 months due to progression of disease.
- The patient was offered a clinical trial using a herpes simplex virus vaccine that would be injected directly into his tumors in conjunction with an anti-PD-1 agent.
- The patient has been on therapy for 18 months with resolution of his chest wall nodules and improvement of his axillary mass. He continues treatment on this research study with slow but continued improvement. He has no adverse reactions throughout the course of his treatment.

Case Presentation – Dr Pavlick: A man in his mid-70s with hedgehog inhibitor refractory advanced BCC (continued)

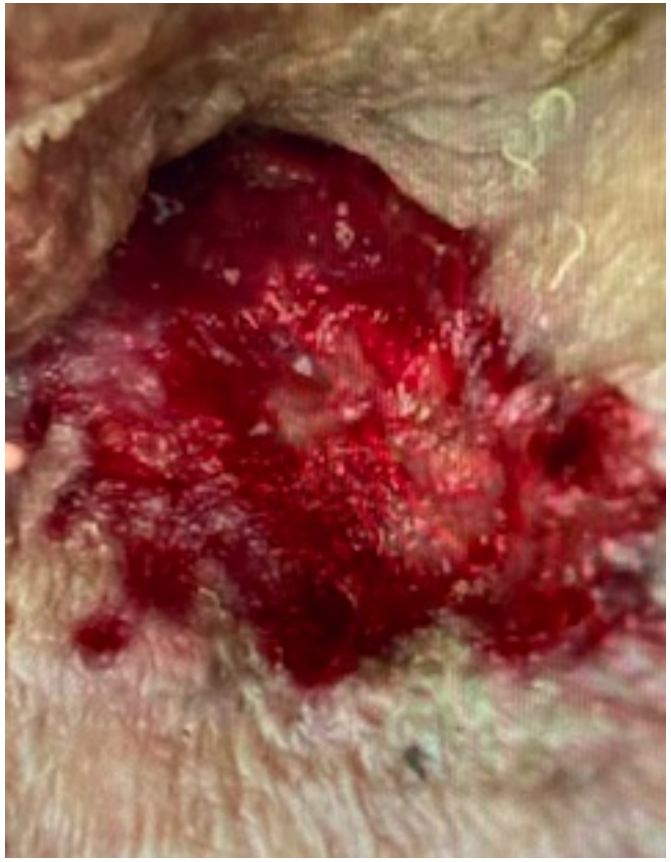
Axillary mass and chest wall lesions prior to starting clinical trial.

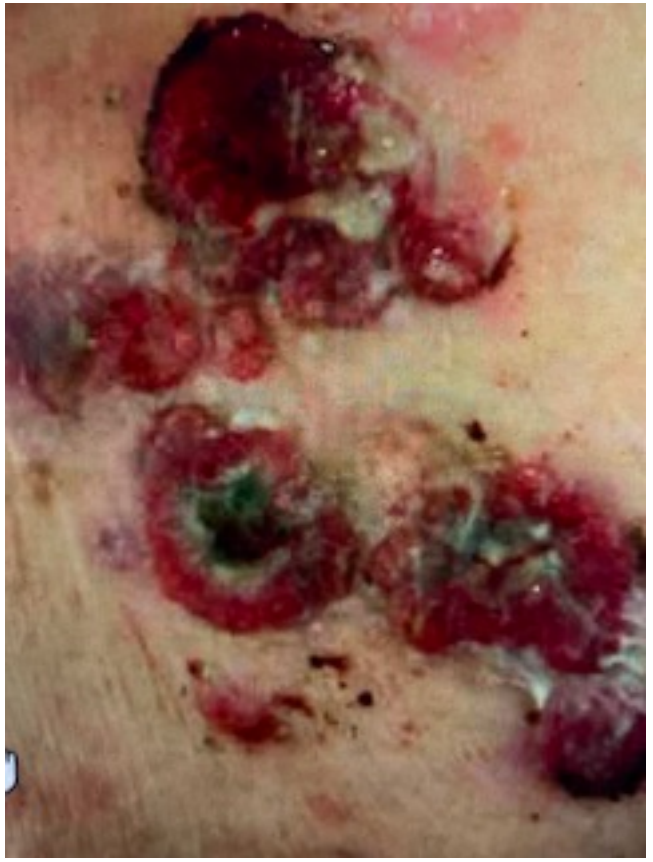




Case Presentation – Dr Pavlick: A man in his mid-70s with hedgehog inhibitor refractory advanced BCC (continued)

Axillary mass and chest wall lesions after 18 months on a clinical trial with an intratumoral vaccine and systemic anti-PD-1





Agenda

INTRODUCTION: Why did it take so long?

MODULE 1: Cutaneous Squamous Cell Carcinoma – Dr Khushalani

MODULE 2: Basal Cell Carcinoma – Dr Pavlick

MODULE 3: Ongoing Clinical Trials

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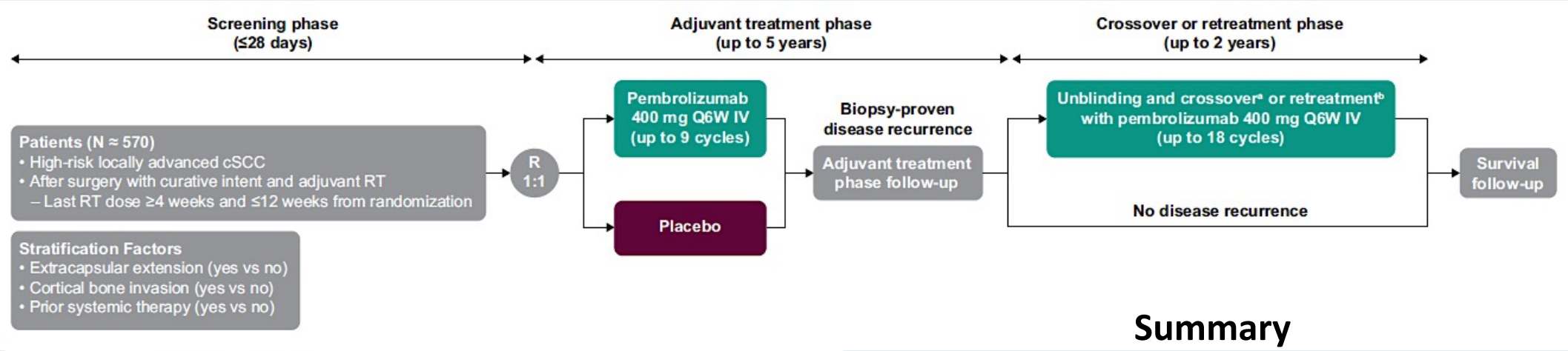
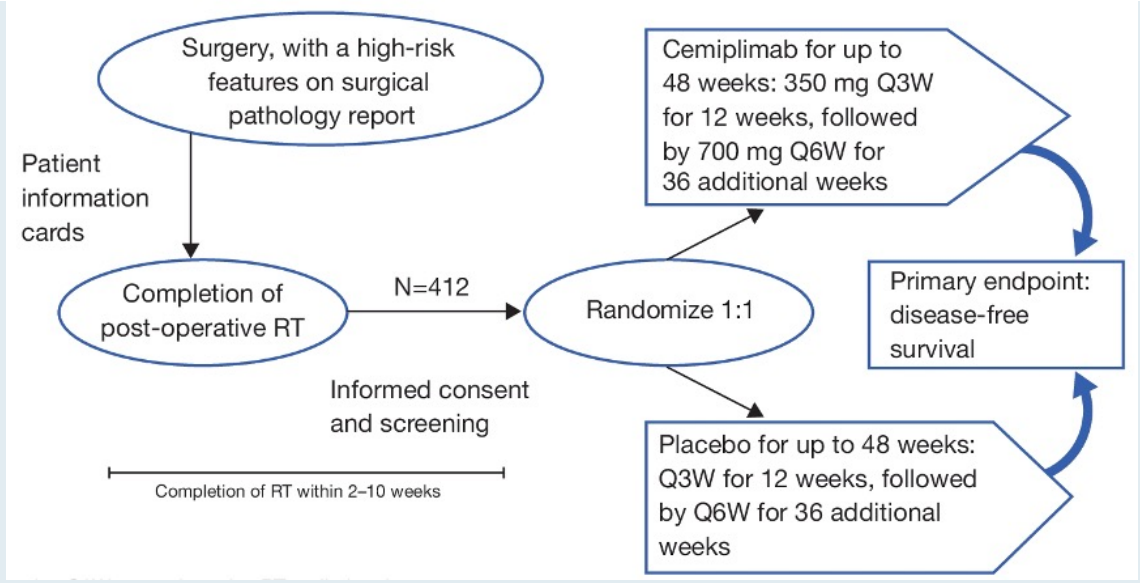
Ongoing Phase III Trials Evaluating the Role of Adjuvant PD-L1 Antibodies in Patients with High-Risk cSCC After Surgery and RT

KEYNOTE-630



C-POST



Summary

- Patients with high-risk cSCC often experience relapse with locoregional recurrence or distant metastases. There is an unmet need to reduce the risk of cSCC recurrence in these patients who are not candidates for curative surgery or radiation.
- Cemiplimab, an anti-PD-1 antibody, was the first immunotherapy to demonstrate clinical benefit in advanced cSCC, based on a clinically meaningful rate of objective responses that were durable and a manageable safety profile.
- The C-POST study is evaluating the efficacy of cemiplimab as adjuvant therapy for patients with high-risk cSCC after surgery and postoperative radiotherapy.

cSCC = cutaneous squamous cell carcinoma; RT = radiotherapy

Schenker M et al. AADA 2022;Abstract 34762, Rischin D et al. ASCO 2022; Abstract TPS9592

NEO-CESQ Study: Neoadjuvant plus Adjuvant Treatment with Cemiplimab in Surgically Resectable, High Risk Stage III/IV (M0) Cutaneous Squamous Cell Carcinoma

Ascierto PA et al.
ASCO 2023;Abstract 9576.

Winship 4851-19: A Pilot Study of Neoadjuvant and Adjuvant Cemiplimab for High-Risk Cutaneous Squamous Cell Carcinoma

Lowe MC et al.
ASCO 2021;Abstract TPS9593.

A Randomized, Controlled, Open-Label, Phase 2 Study of Cemiplimab ± RP1 in Patients with Advanced Cutaneous Squamous Cell Carcinoma (CERPASS)

Haydon AM et al.

ASCO 2022;Abstract TPS9593.

An Open-Label, Multicenter, Phase 1b/2 Study of RP1, A First-in-Class, Enhanced Potency Oncolytic Virus in Solid Organ Transplant Recipients with Advanced Cutaneous Malignancies (ARTACUS)

Migden MR et al.
ASCO 2022;Abstract TPS9597.

Investigation of Calcium Electroporation (CaEP) Therapy in Malignant Cutaneous and Subcutaneous Tumours: A Non-Randomized Phase II Clinical Trial of a Novel Palliative Therapy

Pervan M et al.
ESMO 2022;Abstract 1295TiP.

Nivolumab (NIVO) + Tacrolimus (TACRO) + Prednisone (PRED) +/- Ipilimumab (IPI) for Kidney Transplant Recipients (KTR) with Advanced Cutaneous Cancers

Schnek KM et al.
ASCO 2022;Abstract 9507.

Towards Organ Preservation and Cure via 2 Infusions of Immunotherapy Only, in Patients Normally Undergoing Extensive and Mutilating Curative Surgery for Cutaneous Squamous Cell Carcinoma: An Investigator-Initiated Randomized Phase II Trial — The MATISSE Trial

Zuur CL et al.
ASCO 2023;Abstract 9507.

Join Us In Person or Virtually

Current Approaches and Future Strategies in Oncology

A Multitumor Educational Symposium in Partnership with Florida Cancer Specialists & Research Institute

Saturday, October 7, 2023

ER-Positive Breast Cancer

7:15 AM – 8:15 AM ET

Faculty

Harold J Burstein, MD, PhD

Komal Jhaveri, MD

Prostate Cancer

8:15 AM – 9:15 AM ET

Faculty

Alicia K Morgans, MD, MPH

Matthew R Smith, MD, PhD

Moderator

Neil Love, MD

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Current Approaches and Future Strategies in Oncology

A Multitumor Educational Symposium in Partnership with Florida Cancer Specialists & Research Institute

Saturday, October 7, 2023

Non-Small Cell Lung Cancer

9:30 AM – 10:30 AM ET

Faculty

Gregory J Riely, MD, PhD

Heather Wakelee, MD, FASCO

Colorectal and Gastroesophageal Cancers

10:30 AM – 11:30 AM ET

Faculty

Tanios Bekaii-Saab, MD

Philip A Philip, MD, PhD, FRCP

Moderator

Neil Love, MD

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Current Approaches and Future Strategies in Oncology

A Multitumor Educational Symposium in Partnership with Florida Cancer Specialists & Research Institute

Saturday, October 7, 2023

Chronic Lymphocytic Leukemia

11:30 AM – 12:30 PM ET

Faculty

Asher Chanan-Khan, MD

Brad S Kahl, MD

Moderator

Neil Love, MD

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Thank you for joining us!

Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us. The survey will remain open for 5 minutes after the meeting ends.

CME and MOC credit information will be emailed to each participant within 5 business days.

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