Survey of 50 General Medical Oncologists: Hepatobiliary Cancers

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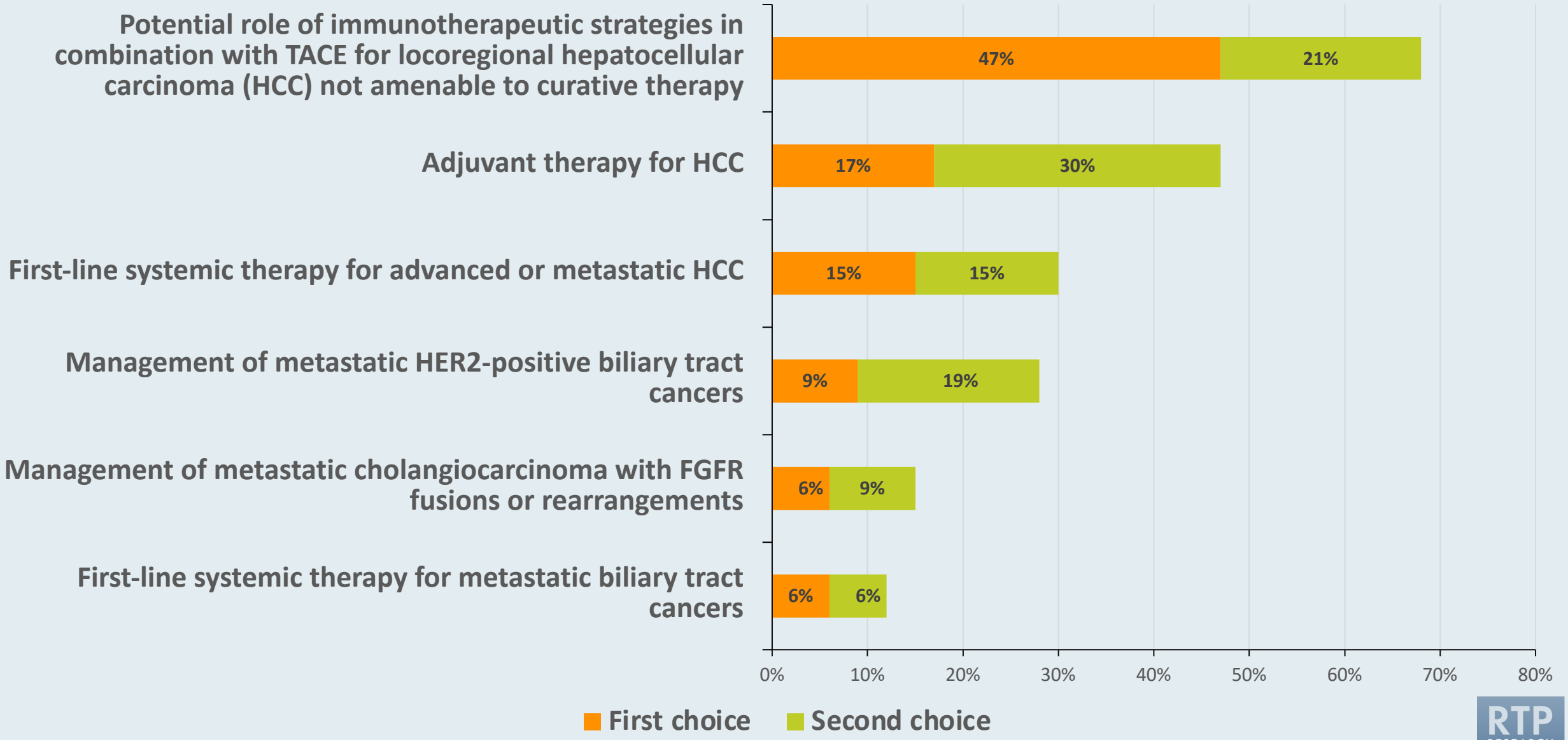
TO PRACTICE

Topics of Interest for Future CME Programs



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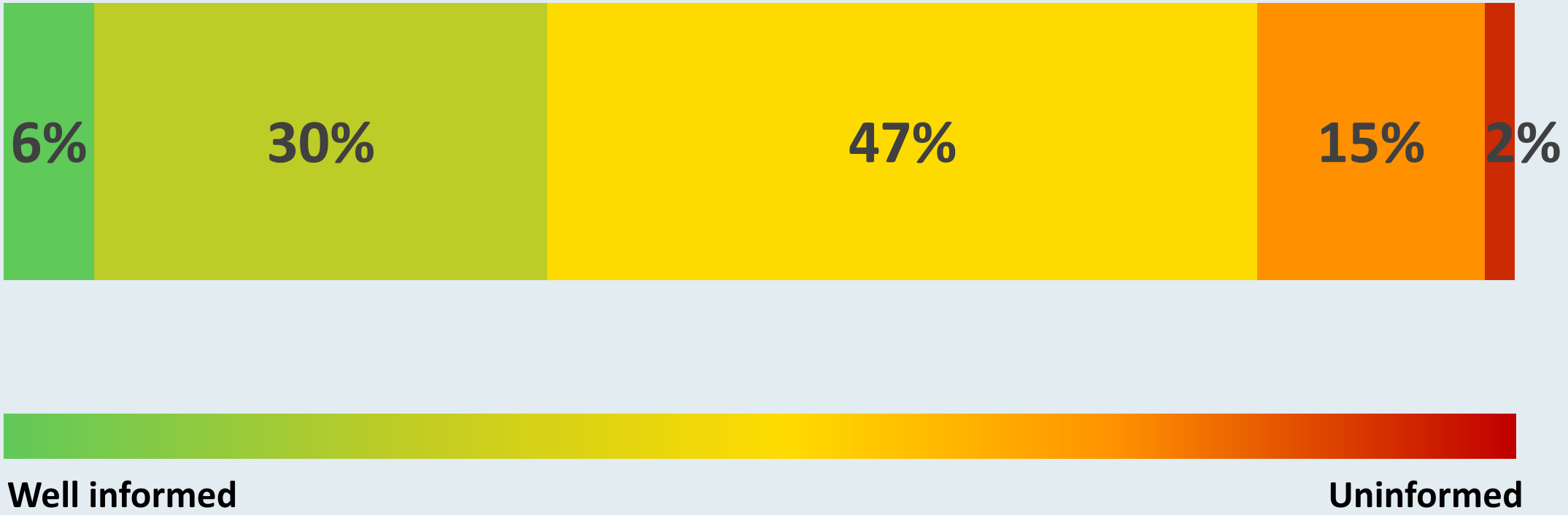
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to adjuvant therapy for HCC?



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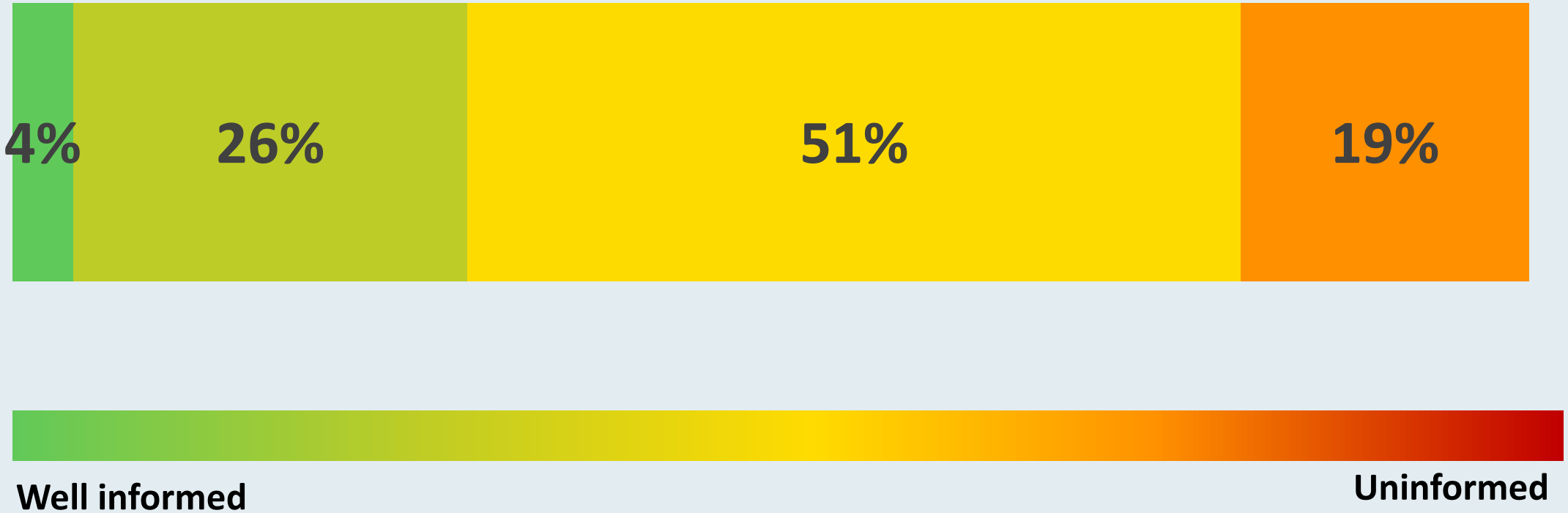
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to the potential role of immunotherapeutic strategies in combination with TACE for locoregional HCC not amenable to curative therapy?



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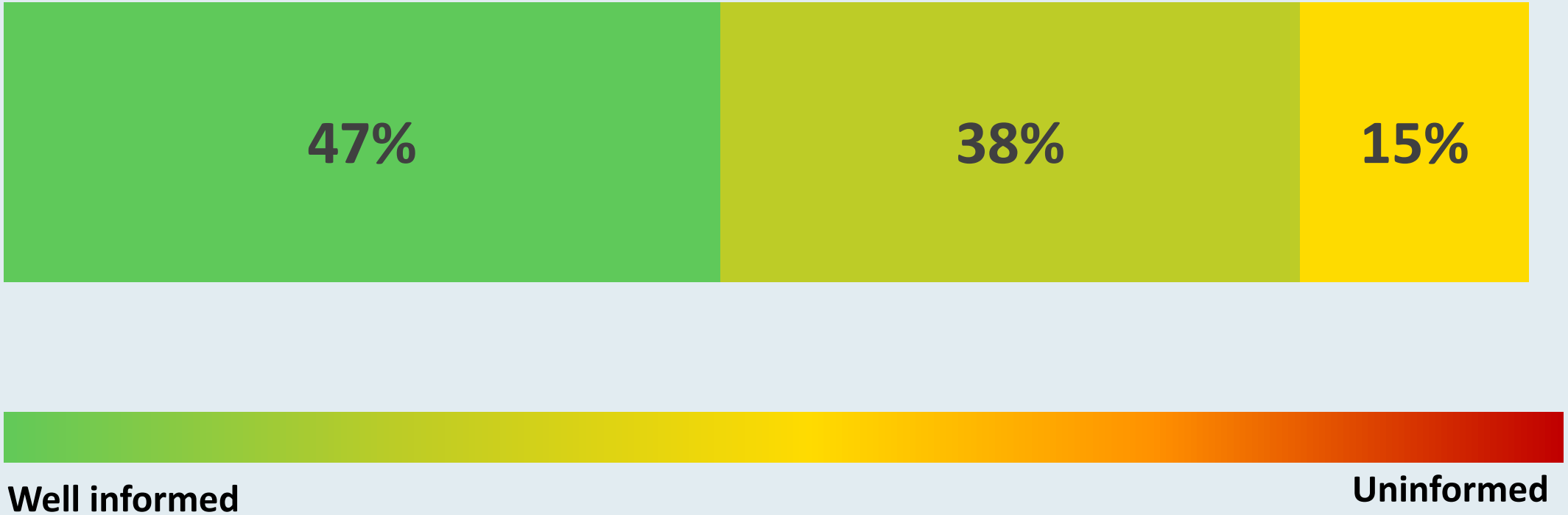
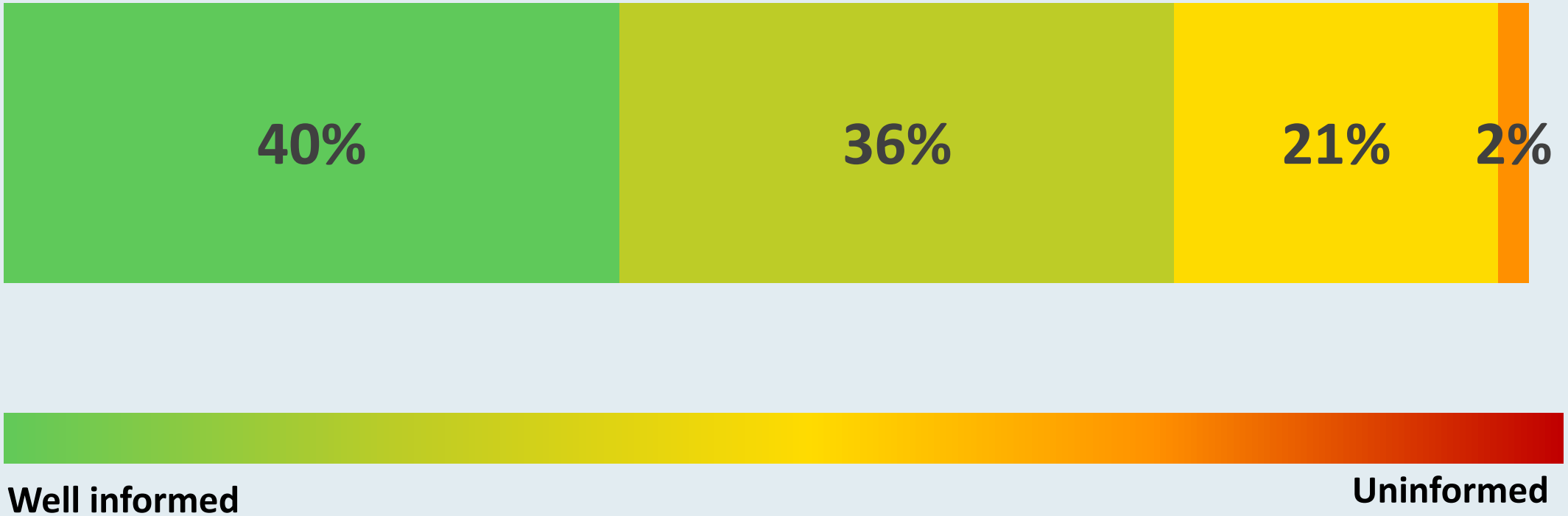
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to first-line systemic therapy for advanced or metastatic HCC?



How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to first-line systemic therapy for metastatic biliary tract cancers?



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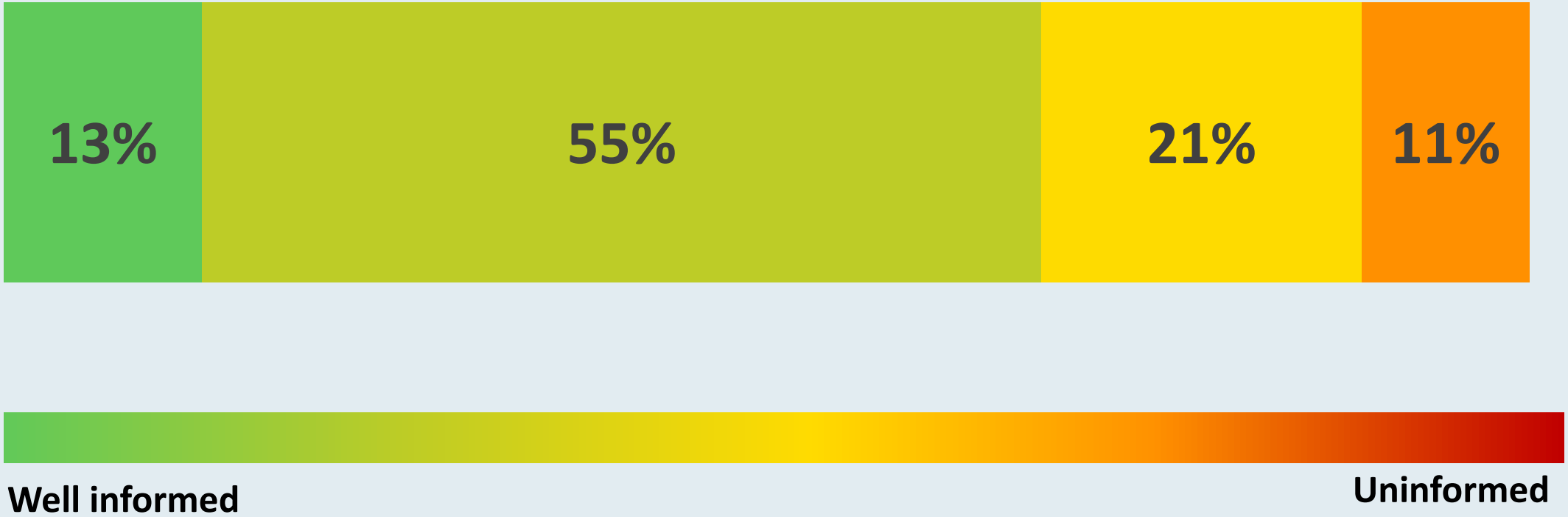
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to the management of metastatic cholangiocarcinoma with FGFR fusions or rearrangements?



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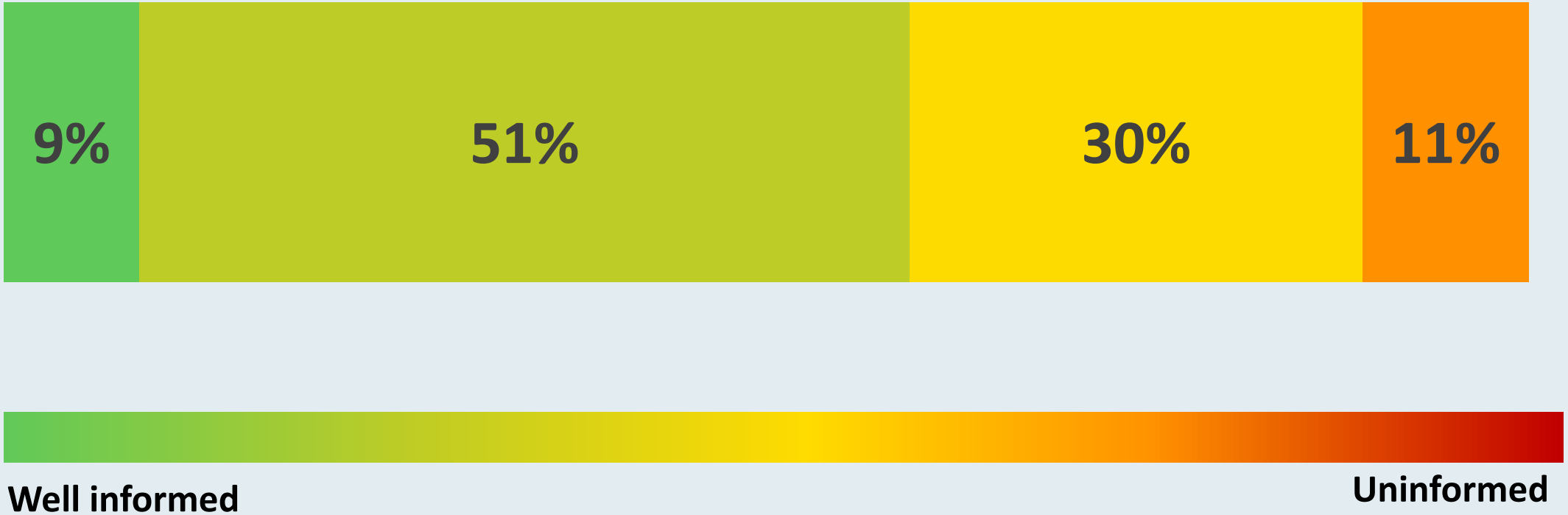
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to the management of metastatic HER2-positive biliary tract cancers?



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Questions from General Medical Oncologists on the Use of Immunotherapy for HCC

- Is there any role for adjuvant immunotherapy?
- Hepatitis vs ETOH vs MASH related HCC treatment?
- I started IO after MRI showed cancer progression after TACE. Should IO be started along with TACE?
- What do you recommend first-line if patient is Child Pugh B?
- For patients who have unstable Child Pugh, who have issues requiring inpatient stay (both social and medical related to HCC), what is your approach to early institution of systemic therapy?
- Is there a certain platelet count below which you would hold a treatment with bevacizumab due to bleeding concerns since these patients have cirrhosis of the liver with thrombocytopenia?
- For patients who have stable disease but IO toxicity do you ever continue with bevacizumab maintenance?
- Is bevacizumab necessary?
- What do you do if patient has VTE on bevacizumab?

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Questions from General Medical Oncologists on the Use of Immunotherapy for HCC (Continued)

- How important is the addition of bevacizumab? Would the presence of varices alter the recommendation?
- Apart from varices, are there any other contraindications to atezolizumab/bevacizumab that might lead you to durvalumab/tremelimumab or nivolumab/ipilimumab?
- Is the ipilimumab/nivolumab combination better than atezolizumab/bevacizumab?
- Is durvalumab/tremelimumab better?
- How do you decide between different systemic therapy options, eg, atezolizumab plus bevacizumab, durvalumab plus tremelimumab, sorafenib, or lenvatinib?
- Duration of therapy after complete response with atezolizumab/bevacizumab?
- My patient has SD, but AFP normalized from 50,000 to 4: Should I stop treatment after 2 yrs of IO or should I continue?
- Any role for finite duration of immunotherapy with re-challenge upon relapse?
- Would you switch from durvalumab/tremelimumab to atezolizumab/bevacizumab or vice versa in patients that do not respond to therapy or switch to TKI?
- What is the ideal second-line regimen after progression on atezolizumab/bevacizumab?

Questions from General Medical Oncologists on the Use of Immunotherapy for HCC (Continued)

- After achieving CR on atezolizumab/bevacizumab, the patient developed GI perforation from bevacizumab and it was discontinued. They have been on atezolizumab single agent. How long do I continue with atezolizumab? It will be 3 years in September 2024.
- For patients who don't respond to durvalumab/tremelimumab, is lenvatinib or cabozantinib the next line of treatment? Is there a role for atezolizumab/bevacizumab in these situations even though there is no data?
- In patients who progress after 1st-line therapy with immunotherapy, should immunotherapy be continued second line? Single agent or immunotherapy doublet?
- Are there any clinical trials comparing the STRIDE regimen versus STRIDE regimen plus bevacizumab?
- Are there any biomarkers to predict which patients respond to IO therapy?
- How do you sequence treatment for patients without an oncogenic alteration?

Questions from General Medical Oncologists on the Use of Anti-FGFR or Anti-HER2 Targeted Treatment for Biliary Tract Cancers (BTCs)

- What is the best way to test for anything actionable in these genes?
- Any role for these agents in the neoadjuvant setting?
- Any role for maintenance molecular targeted therapy, adjuvant setting?
- What is the data on frontline targeted therapy for BTC with targetable mutations?
- Can these treatments be used first line?
- Would you use a targeted therapy in frontline therapy if a patient requested?
- How do you decide between the different FGFR inhibitors?
- Which is your preferred FGFR-targeted therapy and why?
- What first-line therapy do you recommend for an FGFR mutation-positive patient?
- Are there any circumstances that you'll consider FGFR TKI as first line treatment?
- What is your HER2-targeted therapy of choice?
- Would you use targeted therapy frontline in a patient with poor ECOG PS that cannot tolerate the TOPAZ regimen?

Questions from General Medical Oncologists on the Use of Anti-FGFR or Anti-HER2 Targeted Treatment for BTCs (Continued)

- For patients with HER2 amplification, what is the optimal first-line therapy — Chemotherapy + IO + trastuzumab?
- Should anti-FGFR therapy be reserved as the second line therapy? Is this the right choice?
- What are the adverse effects associated with anti-FGFR agents?
- Can you provide advice on the management of side effects?
- Should HER2 status be checked upon disease progression?
- How do you select among the available HER2 agents? They appear to have similar PFS.
- How do you monitor for pemigatinib-related eye changes/electrolyte imbalances?
- In which cases would you opt for trastuzumab deruxtecan with <+3 IHC?
- How do you decide between pertuzumab/trastuzumab versus trastuzumab/tucatinib?
- Would you treat a patient with PS of 3 with trastuzumab deruxtecan?
- Are targeted therapies such as trastuzumab deruxtecan best used initially or second line?
- What are some newer HER2-targeted treatment options?

Impediments or Barriers to the Delivery of High-Quality Care

- Early detection — any thoughts on tests?
- How sick these patients are and ability to administer treatment to them
- Lack of time to fully review current standards and research
- Patients clinically decompensate quickly
- Patients who have biliary obstruction that can be difficult to manage
- No barriers encountered
- Getting approval for targeted therapies based on NGS testing
- NONE
- Lack of access to clinical trials
- Poor performance status, jaundice, coordination of care with multiple specialties
- Insurance
- Very poor responses to therapies and fewer choices
- Tissue testing availability
- Lack of skillful surgeons
- Insurance coverage
- Cohesive multidisciplinary team among all community members

Impediments or Barriers to the Delivery of High-Quality Care (Continued)

- Patients are not well — fragile
- Lack of knowledge and/or awareness of physicians in other specialties about advances in the management of HBC
- Timely diagnosis, role of NGS
- Identification of targeted therapy and treatment sequence
- I need to see more clinical data in HCC management
- Patient understanding
- Need to know newer targeted therapies for hepatobiliary cancer
- Role of ctDNA in hepatobiliary cancers
- Biliary obstruction limiting treatment options
- Rare tumor with aggressive biology; see it very infrequently so hard to keep up
- HCC patients tend to have advanced disease with encephalopathy — they need family involved to coordinate care, or they get lost to follow up or relayed care
- The surgeons in the community are too aggressive and try to operate on even the most advanced and commonly inoperable cases, delaying the right treatment for patients
- Insurance approval

Impediments or Barriers to the Delivery of High-Quality Care (Continued)

- Insufficient tissue for biomarker testing
- Timely approvals for newer medications
- Lack of all the subspecialists needed
- Lack of biomarker testing, lack of referrals to clinical trials
- Compromised liver function/CPC
- Lack of tissue for adequate NGS
- Difficulty coordinating multidisciplinary care
- Tissue for NGS is a barrier
- Liver function
- Patient comorbidities
- NGS testing turnover
- Insurance
- Short duration of response
- Poor liver function interfering with my ability to deliver effective systemic therapy
- Access to multidisciplinary team — interventional radiology and hepatology, transplant
- Lack of compliance to oral targeted therapies