FDA DIGEST

Nivolumab/Ipilimumab Gets Approval for Advanced HCC

The treatment choices for patients with hepatocellular carcinoma (HCC) have broadened with the accelerated approval of nivolumab (Opdivo) in combination with ipilimumab (Yervoy) for those who previously received sorafenib (Nexavar).

The approval is based on cohort findings from the phase I/II CheckMate040 study (NCT01658878), in which the doublet regimen induced an objective response rate (ORR) of 33% (95% CI, 20%-48%) in this patient population at a median follow-up of 28 months. This included an 8% complete response (CR) rate and a 24% partial response (PR) rate.

The duration of response ranged from 4.6 to 30.5-plus months, with 88% of responses lasting ≥6 months; 56%, ≥12 months; and 31%, ≥24 months. In an analysis by blinded independent central review, the ORR was 35% (95% CI, 22%-50%), with a 12% CR rate and a 22% PR rate.

The combination regimen's approval in this setting is contingent on the results of a confirmatory trial.

TO READ MORE, VISIT onclive.com/link/7533.

EGFR-MET Antibody Secures Breakthrough Status in NSCLC

JNJ-61186372 (JNJ-6372), a novel bispecific antibody, received a breakthrough therapy designation for the treatment of patients with *EGFR*-positive metastatic non–small cell lung cancer (NSCLC) who harbor exon 20 insertion mutations and whose disease progressed on or after platinum-based chemotherapy.

The agent demonstrated its efficacy in a phase I trial (NCT02609776), in which treatment with JNJ-6372 elicited preliminary responses in this patient population with a manageable safety profile. Investigators of the first-in-human study are evaluating JNJ-6372 as a monotherapy and combined with lazertinib, an EGFR tyrosine kinase inhibitor, in approximately 400 adults with advanced NSCLC.

As of January 17, 2019, 116 patients were enrolled and received treatment. Results showed that 28% of the 88 patients evaluable for a response achieved best time-point response of partial response (PR). Several (6 of 20) patients with exon 20 insertions had best time-point response of PR, with 3 confirmed, investigators said.

TO READ MORE, VISIT onclive.com/link/7534.

FDA Clears Next-Generation Cytology Test for Cervical Cancer Detection

Roche's CINtec PLUS Cytology test is newly cleared for use in women whose primary cervical cancer screening yields positive results for the human papillomavirus (HPV), as detected by the cobas 4800 HPV Test.

The next-generation cytology test, which simultaneously detects p16 and Ki-67 to identify women whose HPV infections are most likely to be associated with cervical precancers, is the first biomarker-based test specifically approved for use in women with HPV-positive/Pap cytology–negative cotesting results. When a cell expresses both p16 and Ki-67, it is highly likely that the patient has transforming HPV infections that could progress to precancer or cancer.

By providing definitive information about which HPV-positive women would likely benefit most from immediate referral to colposcopy versus repeat testing, Roche stated, CINtec PLUS Cytology can streamline care, helping clinicians direct women to the appropriate diagnostic procedures before their disease progresses to a more advanced stage.

The approval was supported by data from the registrational IMPACT (Improving Primary screening And Colposcopy Triage) trial, in which investigators evaluated the test as a triage tool in several screening scenarios among more than 35,000 women. Data have not been published, Roche stated, adding that it expects the test to be widely available in the United States later this year.

TO READ MORE, VISIT onclive.com/link/7536.

Breakthrough Device Designation May Expand HCC Toolkit

The Elecsys GALAD score will receive expedited development and review as a result of a breakthrough device designation for the diagnosis of early-stage hepatocellular carcinoma (HCC). The algorithmic score is a serum biomarker-based tool designed for use with ultrasound, which is widely used to check α-1-fetoprotein (AFP) levels. In chronic liver diseases including hepatitis and cirrhosis, AFP can be chronically elevated, indicating the potential presence of AFP-producing tumors associated with HCC.

Although other methods of assessing AFP, such as liver biopsy and abdominal computed tomography scans, are more invasive than ultrasound, they may offer a more accurate alternative. Data from a recent meta-analysis suggested that ultrasound may miss >50% of early-stage HCCs.

When used in tandem with ultrasound, the Elecsys GALAD score, which combines gender and age with biomarker results of the Elecsys AFP, AFP-L3, and PIVKA-II tests to project risk, may facilitate earlier detection of HCC, potentially improving patient outcomes while offering a minimally invasive, more cost-effective option for evaluation, according to Roche, the score's developer.

TO READ MORE, VISIT onclive.com/link/7558.

COVID-19

Trial Will Test Oncology Support Drug as COVID-19 Intervention

Tocilizumab (Actemra), an interleukin-6 (IL-6) receptor antagonist, will be evaluated as a therapeutic option for patients with coronavirus disease 2019 (COVID-19) in the phase III COVACTA trial, according to Genentech, the drug's developer. The agent is currently approved for the treatment of severe or life-threatening cytokine release syndrome caused by chimeric antigen receptor T-cell therapy.

The first global study of tocilizumab in this setting, COVACTA will enroll approximately 300 adults hospitalized with COVID-19 beginning this month. Investigators will randomize patients to tocilizumab plus the standard of care (SOC) or SOC alone. COVACTA's primary and secondary end points include clinical status, mortality, mechanical ventilation, and intensive care unit variables. Patients will be followed for 60 days after randomization, after which an interim analysis will be conducted to assess early efficacy.

Genentech is initiating the trial in collaboration with the Biomedical Advanced Research and Development Authority, which is part of the US Health and Human Services Office of the Assistant Secretary for Preparedness and Response. COVACTA is among several other clinical studies of tocilizumab in this patient population, according to Genentech, who added that data on the agent's safety and efficacy in the treatment of COVID-19 is limited.

Of note, China's National Health Commission has added tocilizumab to its diagnosis and treatment plan for COVID-19.

TO READ MORE, VISIT onclive.com/link/7593.

"The Biggest Medical Issue We Have Faced in Modern Times"

by **RACHEL NAROZNIAK, MA**

THE RAPID EVOLUTION OF coronavirus disease 2019 (COVID-19) has required institutions to adopt pandemic-specific protocols to minimize the potential for virus exposure and transmission. Broadly, these preventive measures have included travel restrictions for faculty and staff, as well as putting COVID-19 screening procedures in place for patients seeking care at oncology clinics.

The risk that COVID-19 poses for patients with cancer, many of whom are receiving immunosuppressive therapies such as mTOR inhibitors, has been a key question for clinicians, particularly because infectious diseases are the second-leading cause of mortality among this subgroup of the American population.[1]

In recent interviews, members of the *OncologyLive*® advisory board discussed how COVID-19 has affected their patient interactions, what preemptive steps they are advising patients to take to protect themselves, and the pandemic's impact in the oncology field.

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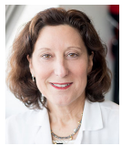
I think the most important thing to note here is latency. If [COVID-19] is not an issue now, it will be soon and we must prepare ourselves, our clinics, and our patients for it. If you don't believe this, just look at the initial cases reported in Japan 3 weeks ago and the follow-up. This will be the case in most places.

I tell my patients to limit nonessential [travel] and as for foreign travel—cancel. [Isolate yourself] if you have symptoms and minimize contact with others in a large setting. No handshakes, no hugs. Practice ENHANCED hygiene.

As [COVID-19] becomes more prevalent, our hospitals and emergency rooms will become flooded and access to care for our patients, whether for their cancer care or surgical/maternity care, will be compromised.

The real people in danger are those with comorbidities and pulmonary conditions. Think of them.



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COVID-19 is the biggest medical issue we have faced in modern times and has had an impact on all aspects of society around the world. This novel viral infection is very communicable, and patients may be asymptomatic while communicable. The virus can live on surfaces for a long duration of time. Although the majority of deaths have occurred in elderly patients and those with underlying health issues, younger and healthy individuals have been very ill, requiring intensive support.

As the cases and deaths in Italy exploded over [the week of March 9], it became clear that the United States would not be far behind. The United States has had limited ability to test for the viral infection, which in turn markedly limits our ability to control spread of the infection. Finally, [the weekend of March 13], our local and national governments reacted to limit spread of the infection with strict guidelines for containment of populations. We don't yet know if this will be enough and whether it was enacted soon enough.

In oncology, we are deluged now from 2 sides: our patients who are scared to come for treatment and scared to miss treatment, asking for guidance that we ourselves are learning along the way, and our institutions that are scrambling to create structures to protect staff and patients. We are screening all patients the day before their clinic appointments, and the viral pandemic has already led to much broader use of telemedicine, as we "see" our patients using videoconferencing to avoid exposing everyone to greater risk. It is clear that this [pandemic] will take a big toll on clinical research, as our coordinators are barred from patient areas, and in San Francisco, [they are barred] from coming in to work at all. The bottom line: [we must] protect our patients by canceling routine visits and imaging, [which allows] us to take the best care of those who need ongoing treatment. We need to all work a little harder, as efficiently as possible, and wash our hands!

For patients, there is still plenty of food and dry goods in the United States. Panic buying hurts everyone. Don't come to clinic or go out if you have any viral symptoms, and get tested if you have a fever. There are guidelines online from the Centers for Disease Control that are updated regularly. For providers, the American Society of Clinical Oncology has guidelines specifically for oncology providers.

Debu Tripathy, MD
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The impact of the rapid development of activities and events with the novel COVID-19 is unclear at this point. In our modern era, it is an interesting phenomenon to be involved in, in a virus that is a pandemic.

We've seen mini-pandemics with the Ebola virus. Ebola had a more virulent case fatality ratio but had very limited exposure. Now, COVID-19 does not have as high of a morality rate but is so widespread. Currently, the mortality rate is estimated to be between 1% and 3%, which is, in orders of magnitude, higher than the flu.

There is much about COVID-19 that we don't know yet. It appears that a group of asymptomatic patients can be carriers and contagious, which is concerning in terms of containment. Many countries and institutions are adopting different policies for containment.

[COVID-19] is fundamentally going to change the way we live our lives, at least in the short term. We don't know which way this is going to move. I liken it to a tropical storm off the coast of Africa. Many storms begin there and mature into hurricanes as they move into the Western Hemisphere. They may wreak havoc, or they may move out to sea. The same happens with viral epidemics; there are so many factors that determine how they will operate. ■

REFERENCE

1. Elfaituri MK, Morsy S, Tawfik GM, et al. Incidence of infection-related mortality in cancer patients: trend and survival analysis. *J Clin Oncol*. 2019;37(suppl 15; abstr e23095). doi: 10.1200/JCO/2019.37.15_suppl.e23095.