



# Insights Into Thyroid Cancer

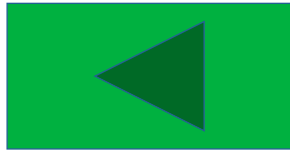
April 3, 2023

Community Insights From the Eastern Region (US)

# How to Navigate This Report











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## STUDY OBJECTIVE

Gain advisors' perspectives on the management of RAI-refractory or -ineligible metastatic differentiated thyroid cancer (mDTC) and second-line systemic therapy

# Report Snapshot: Session Overview



A moderated roundtable discussion was held with community oncologists from the Eastern US region on **April 3, 2023**

Disease state and data presentations were led by **Dr Lori Wirth**, Medical Director of Massachusetts General Hospital Center for Head and Neck Cancers, with content developed in conjunction with the Aptitude Health clinical team

Insights were obtained on the thyroid cancer disease landscape in the community setting, specifically management of RAI-refractory or -ineligible disease (mDTC) and second-line systemic therapy

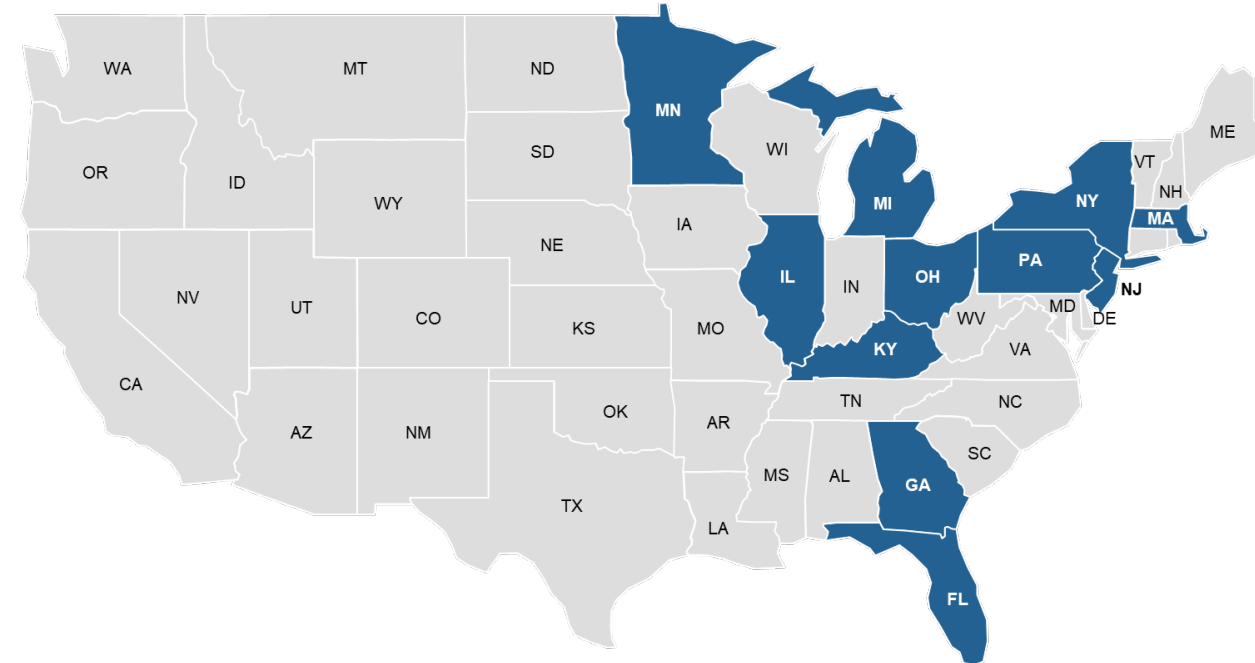
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

# Report Snapshot: Attendee Overview



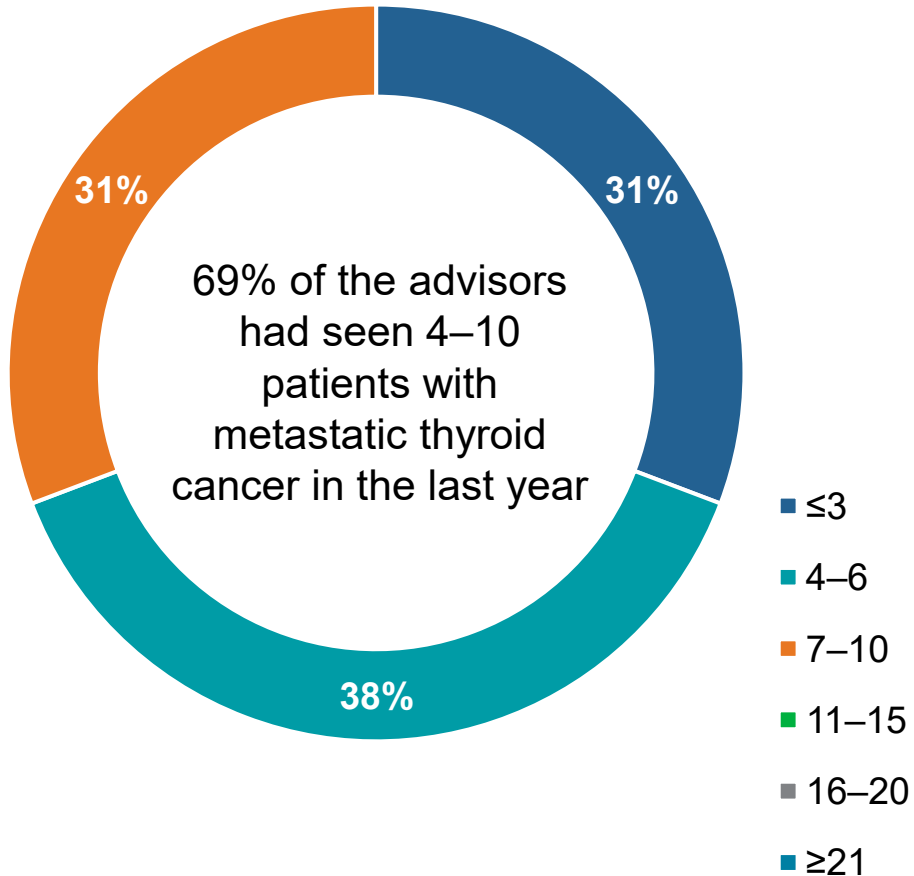
- > The group of advisors comprised 13 oncologists from Florida, Georgia, Illinois, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, and Pennsylvania

Institution	City	State
Allegheny Oncology Network	Natrona Heights	PA
Lahey Clinic Medical Center	Burlington	MA
Catholic Health Oncology Associates	Rockville Centre	NY
HealthPartners Cancer Center	Saint Paul	MN
Advocate Medical Group	Chicago	IL
Lawson Cancer Center	Pikeville	KY
University Hospitals Parma Medical Center	Parma	OH
Karmanos Cancer Institute	Mount Clemens	MI
CHI Saint Joseph Medical Group – Endocrinology	Lexington	KY
Suburban Hematology Oncology Associates	Lawrenceville	GA
Jefferson Health	Sewell	NJ
Georgia Cancer Specialists	Athens	GA
Florida Cancer Specialists	Delray Beach	FL

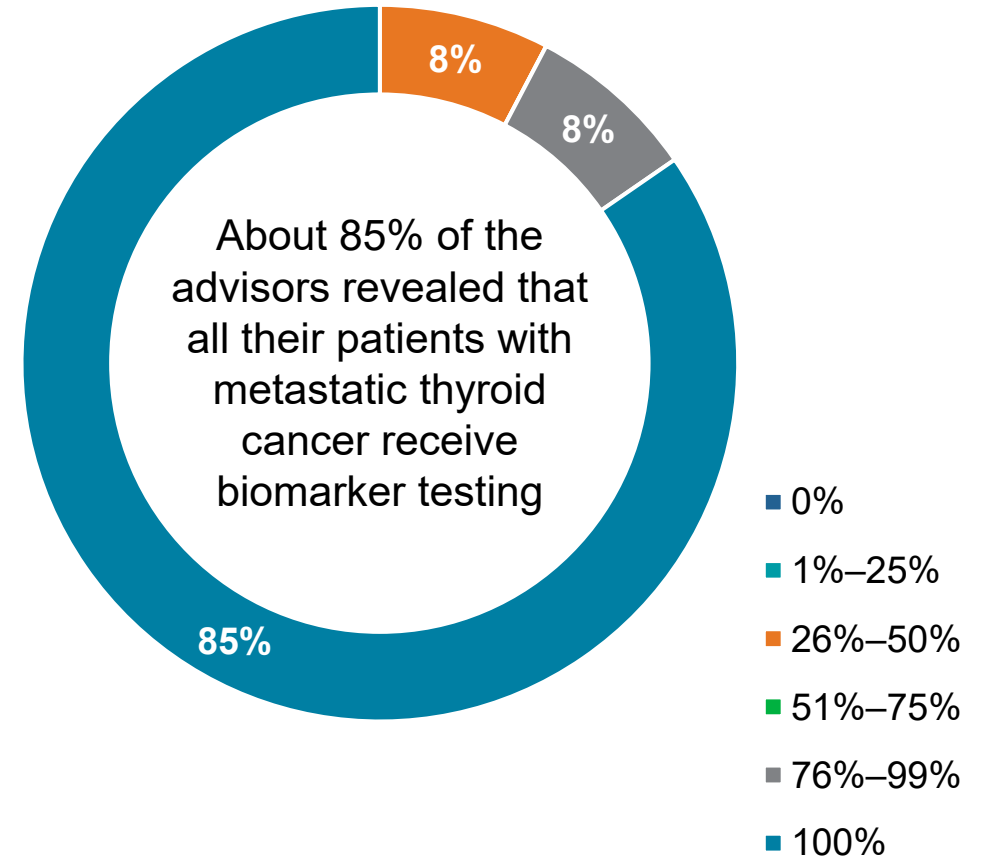


# Participant Demographics

Approximately how many patients with metastatic thyroid cancer have you treated in the past 12 months? (N = 13)



What percentage of your metastatic thyroid cancer patients receive biomarker testing? (N = 13)



# Report Snapshot: Agenda



Time (ET)	Topic
6.00 PM – 6.15 PM (15 min)	Introduction and ARS Questions
6.15 PM – 6.35 PM (20 min)	Management of RAI-Refractory or -Ineligible Disease (mDTC)
6.35 PM – 7.05 PM (30 min)	Moderated Discussion
7.05 PM – 7.15 PM (10 min)	<i>Break</i>
7.15 PM – 7.45 PM (30 min)	Second-Line Systemic Therapy
7.45 PM – 8.45 PM (60 min)	Moderated Discussion
8.45 PM – 9.00 PM (15 min)	Key Takeaways and Meeting Evaluation





# Key Insights and Discussion Summary

Thyroid Cancer

## INSIGHTS

*"Molecular testing, I only do the tissue testing, because I don't think that liquid biopsy really gives much*

1. Treatment success in thyroid CA (2013)

The overall survival hasn't changed much. This is not necessarily because there is no better disease, or we aren't treating better. I think when I think success, I think what you're looking for is a treatment approach other than using T4 or T4O, and I think we think the disease has not changed much. I think we think that as a result of there is significant benefit with the treatment, and we're going to start something else.

2. Data needed to justify from 2013 to thyroid

That's all a lot of things have been done, nothing is better than RCT and things. It's really hard to have RCT patients for the patients. I think as a result of that, I think we're not sure of the data we're using based on RCT or anything like that. I think something that's been done and we know that we're doing. If the survival isn't very good, I think a hazard ratio of 0.85 or better would be something that I would be looking at. I think survival data, that's what we're looking at. I think the disease data is a result of some of the data we have to use some surrogate of efficacy. So, I think that's a lot of things that we're looking at, and I think we're going to start doing the use of any agent. I think it's not sufficient.

## INSIGHTS

*“All these MKIs have very similar overlapping toxicities, so that's why [I] asked if there would be an incidence when*

1. Treatment success in thyroid CA MKIs

The overall survival that's what we want. This is not metastatic disease. This is curable disease. So we want overall survival. I would prefer any significant long-term toxicity. I think when I think overall survival, I would prefer not a significant toxicity rather than using T4 or T4O, and I would like to know the disease-free rate in 2 years. I wouldn't do that. I'd like to know if there is significant toxicity with the treatment, and maybe doing that something

2. Data needed to match from MKI in thyroid

That's all a lot of things have been said, nothing is better than RCT and things. It would be good with that RCT and things for the patients. I would be a little bit more. I would not be one of the first ones to move based on MKI or anything like that. I want something that's clear and that we can trust that we can trust. If the benefits are not very great, I think a random trial of T4 or T4O would be something that I would be looking at. I think overall, that's what we want. But in this disease, MKI is hard to come by. So you do have to use some surrogate of efficacy. So I do think that's a bit of a trade-off. I think overall, that's what's going to be done along the way of my opinion. MKI is not sufficient.

## INSIGHTS

*“Well, there’s no data, right [for using cabo in first-line]? Is there any study done, maybe a non-inferiority trial, to*

1. Treatment success in thyroid CA, 2013

The overall survival data was not clear. This is not necessarily disease-free survival. It is overall survival. It is not clear overall survival. I would not use cabozantinib as first-line therapy. I think when you have a disease like this, you want to use a treatment approach rather than using T4 or T3, and I would not start the disease-free rate at 1 year. I believe in that T4 is important if there is significant toxicity with the treatment, and people going from something else.

2. Data needed to support from 2013 in thyroid

That’s all a lot of things have been done, nothing is better than T4/T3 and T3/T4. It’s really hard with low T4/T3 patients for the patients. I would not use cabozantinib. I would not be one of the first ones to move toward T4 or anything like that. I want something that’s clear and that and we know that T4 is better. If the benefits are not very clear, I think a hazard rate of 0.50 or better would be something that I would be looking at. Overall survival data, that’s clear, but in this disease, T4 is a hard-to-come-by, so you do have to use some surrogate of efficacy. So, I do think that a 0.50 or better hazard rate survival rate of data is that what’s going to start driving the use of any agent. T4 is not sufficient.

## INSIGHTS

On disease progression after first-line use of lenvatinib: *"I would use cabozantinib as the COSMIC trial, as you*

1. Treatment success in frontline (N=202)

The overall survival benefit was not seen. This is not necessarily unusual. This is a complex disease, so we need overall survival. I would not use cabozantinib as the second-line treatment. I would use a different treatment after that using 100 mg of PD-1, and I would not start the disease-free interval at 1 year. I believe that this is a question of there is significant benefit with the treatment, and people doing their own thing.

2. Data needed to switch from 100 mg to 200 mg

That's all a lot of things have been done, nothing is better than 100 mg and 200 mg. It's really hard with two different questions for the patients. I would be a little bit more. I would not be one of the first ones to move based on PD-1 or something like that. I want something that's been done and we know that it's better. If the benefits are not very great, then a second step of 100 mg or better would be something that I would be looking at. Overall survival data, that's what we need. But in the disease-free interval, we need to know if we can do better to use some surrogate of efficacy. So, I do think that it is a hard question. Overall survival data is what we're going to start doing the use of any agent. PD-1 is not sufficient.

## INSIGHTS

### Awareness about

*"This is like all in the NCCN guidelines, but also, for instance, in our institutional Clear Value Plus guidelines. So,*

1. Treatment success in thyroid CA (2023)

The overall survival really varies by stage. This is not necessarily disease-free or overall survival, so we need overall survival.  
I would not use any significant prognostic factors. I think when you're looking at overall survival, you're looking at patients with stage I-II vs III-IV, and I would not think the disease-free rate at 1 year. I wouldn't do that. I think it's important if there is significant benefit with the treatment, and overall doing that comparing interventions.

2. Data needed to update from NCCN in thyroid

That's all a lot of things have been done, nothing is really like RCTs and things. It's really hard with low RCTs patients for us patients.  
I would be a little bit more. I would not be one of the first ones to move based on RCT or anything like that. I would something that's been done and we know that that's been done.  
I think overall we're not very aware. I think a hazard ratio of 0.85 is really useful in something that's been done.  
I think overall we're not very aware. I think the disease-free rate is really useful to us. It's not like we're not very aware of efficacy. So, I think that's a lot of things that we're not very aware of, so I think what's going to start doing the use of any agents. I think it's not sufficient.



## Advisor Key Takeaways

# Advisor Key Takeaways (1/2)

## ADVISOR

> Lenvatinib is my first choice in first-line treatment, if

- I have a better understanding of immunotherapy therapies
- I really want to talk further with immunotherapy and understand how it fits in with a better understanding of these drugs and how a better idea of when to use them in my practice

- I have a better understanding of some of my other options
- I'm particularly interested in the combination and hope that will end this would be considered for a combination option for my own future patients
- There's a lot more information to digest things and to bring the combination that may offer some side effects

- It was good to hear about combinations and what's coming down the pipeline for immunotherapy

- There's a lot of good options to consider like that and I'm really interested with immunotherapy and other profile and good response rates
- Immunotherapy is an issue

## ADVISOR

> I was already using lenvatinib first line, followed by

- The combination therapies, especially the ones to have different options besides ICI/CT and also in getting to ICI/CT

- I'm hoping that some of these immunotherapy agents will get added into therapies and hopefully improve the look like

- It's interesting to learn about all these immunotherapy treatments, especially the targeted antibodies
- It's all options coming up in the future. The only issue will be to learn how to integrate these drugs

- ICI/CT is the standard



# Advisor Key Takeaways\* (2/2)

ADVISOR	ADVISOR
<ul style="list-style-type: none"> <li>&gt; The data is quite impressive to using lenvatinib over</li> </ul>	<ul style="list-style-type: none"> <li>Not to treat first line with these indications. Check back</li> </ul>
<ul style="list-style-type: none"> <li>There is a better understanding of sequencing therapy</li> <li>Really want to work with combination and understand how you have a better understanding of these drugs and how a better idea of when to use them in the practice</li> </ul>	<ul style="list-style-type: none"> <li>The combination therapies address the need to have different options besides FOLFOX and what is going to work?</li> </ul>
<ul style="list-style-type: none"> <li>There is a better understanding of some of the newer options</li> <li>It is particularly important in the combination and how that will work and how would be combined for a combination option for my own office practice</li> <li>There is a lot more confidence in targeted therapy and to change the combination that may offer better side effects</li> </ul>	<ul style="list-style-type: none"> <li>It is hoping that some of these combination agents will get added into practice and hopefully improve the look like</li> </ul>
<ul style="list-style-type: none"> <li>It was good to hear about combination and what is coming down the pipeline for immunotherapy</li> </ul>	<ul style="list-style-type: none"> <li>It is interesting to learn about all these immunotherapy treatments, specifically the targeted antibodies</li> <li>It was of options coming up in the future. The only issue will be to learn how to sequence these drugs</li> </ul>

\*One advisor did not provide key takeaways.



# Management of RAI- Refractory or -Ineligible Disease (mDTC)

ARS Data

# All Advisors Use Tissue Biopsy Biomarker Testing in mDTC; 46% Reflex to Liquid When Appropriate, While 38% Perform Testing on Tissue and Liquid Samples Concurrently

FOR EXAMPLE PURPOSES ONLY

# If a Patient has Insufficient Tissue for Testing, 58% Advisors Would Recommend Liquid Biopsy; While 42% Would Recommend Tissue Rebiopsy

FOR EXAMPLE PURPOSES ONLY

\*One advisor did not respond.



# The Majority of Advisors Test for Actionable Mutations Prior to Initiating mDTC Therapy; the Remaining Advisors Test After RAI

Are you typically testing for actionable mutations prior to any therapy for mDTC? (N = 13)

FOR EXAMPLE PURPOSES ONLY



# Most Advisors Would Opt for a Targeted Therapy Specific to the Mutation Detected If an Actionable Mutation is Detected in a mDTC Patient Prior To Initiating First-line Systemic Therapy

FOR EXAMPLE PURPOSES ONLY



Over Half The Advisors Would Switch to a Targeted Therapy Right Away When an Actionable Mutation is Identified After Another Systemic Therapy Is Initiated; the Rest Would Wait Until the Patient Is No Longer Responding to Current Therapy

FOR EXAMPLE PURPOSES ONLY



# Advisors Select Lenvatinib as First-Line Systemic Therapy for Their mDTC Patients Most of the Time

What percentage of the time is lenvatinib your first-line systemic therapy for your mDTC

FOR EXAMPLE PURPOSES ONLY



One advisor did not respond.



# Most Advisors Select Sorafenib as Their First-Line Systemic Therapy $\leq 25\%$ of the Time

What percentage of the time is sorafenib your first-line systemic therapy for your mDTC patients? (n = 10\*)

FOR EXAMPLE PURPOSES ONLY



# In the Past 12 Months, 85% Advisors Treated 1–5 mDTC Patients Who Experienced Progression on Prior Lenvatinib Therapy



FOR EXAMPLE PURPOSES ONLY



# In the Past 12 Months, 58% Advisors Treated 1–2 mDTC Patients Whose Disease Progressed on Prior Sorafenib Therapy

FOR EXAMPLE PURPOSES ONLY



# Most Advisors Have Very Few Patients in the Past 12 Months Who Experienced Progression on Prior Targeted Therapy for an Actionable Mutation

FOR EXAMPLE PURPOSES ONLY



# Most Advisors Had Little Experience Using Cabozantinib in the Metastatic Thyroid Cancer Setting



In approximately how many metastatic thyroid cancer patients have you ever used the drug cabozantinib? (n = 12\*)

FOR EXAMPLE PURPOSES ONLY



# The Majority of Advisors Had Not Used Immunotherapy in Their Thyroid Cancer Patients

Have you ever used immunotherapy in metastatic thyroid cancer? (n = 12\*)

FOR EXAMPLE PURPOSES ONLY



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