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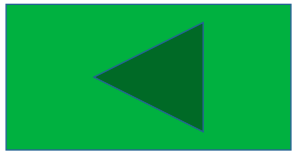
Insights Into Thyroid Cancer

April 3, 2023

Community Insights From the Eastern Region (US)

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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Report Objectives

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

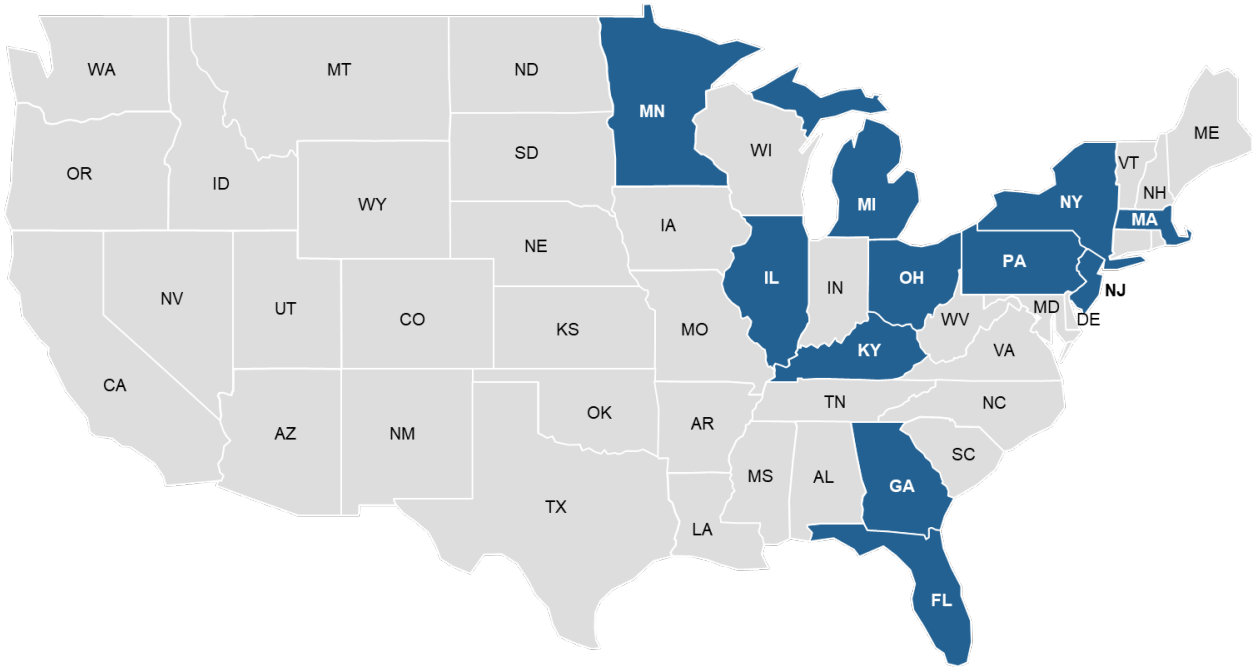
Insights were obtained on the thyroid cancer disease landscape in the community setting, specifically management of RAI-refractory or -ineligible disease (mDTC) and second-line systemic therapy

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

Report Snapshot: Attendee Overview

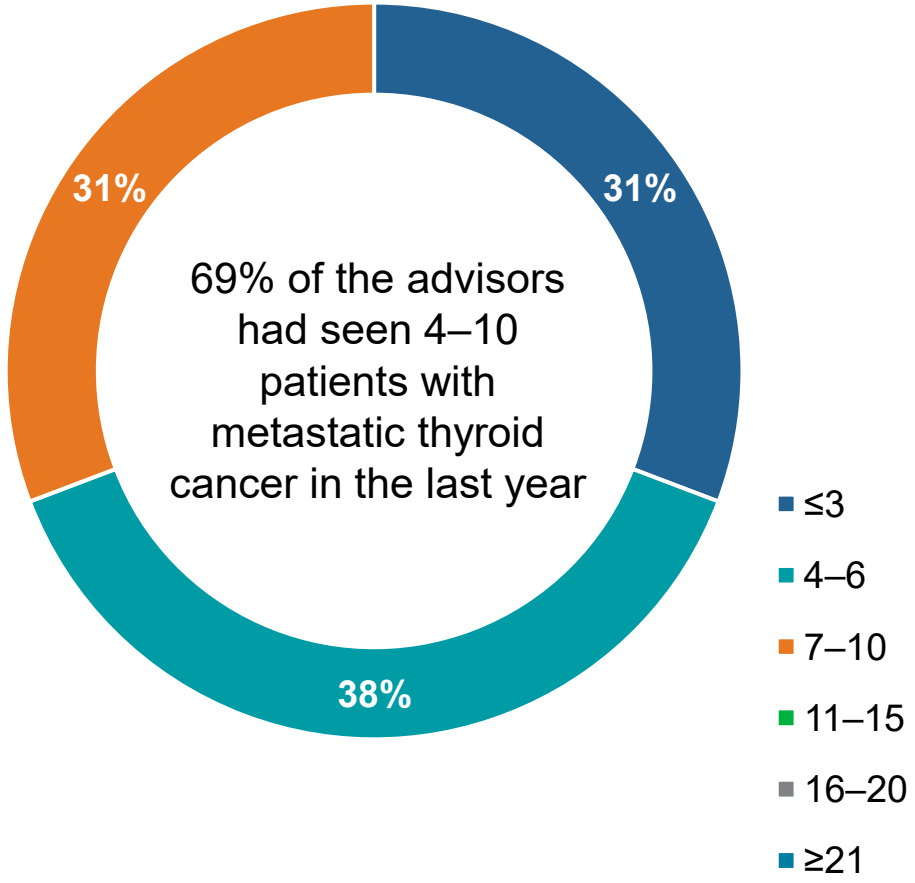
> The group of advisors comprised 13 oncologists from Florida, Georgia, Illinois, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, and Pennsylvania

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

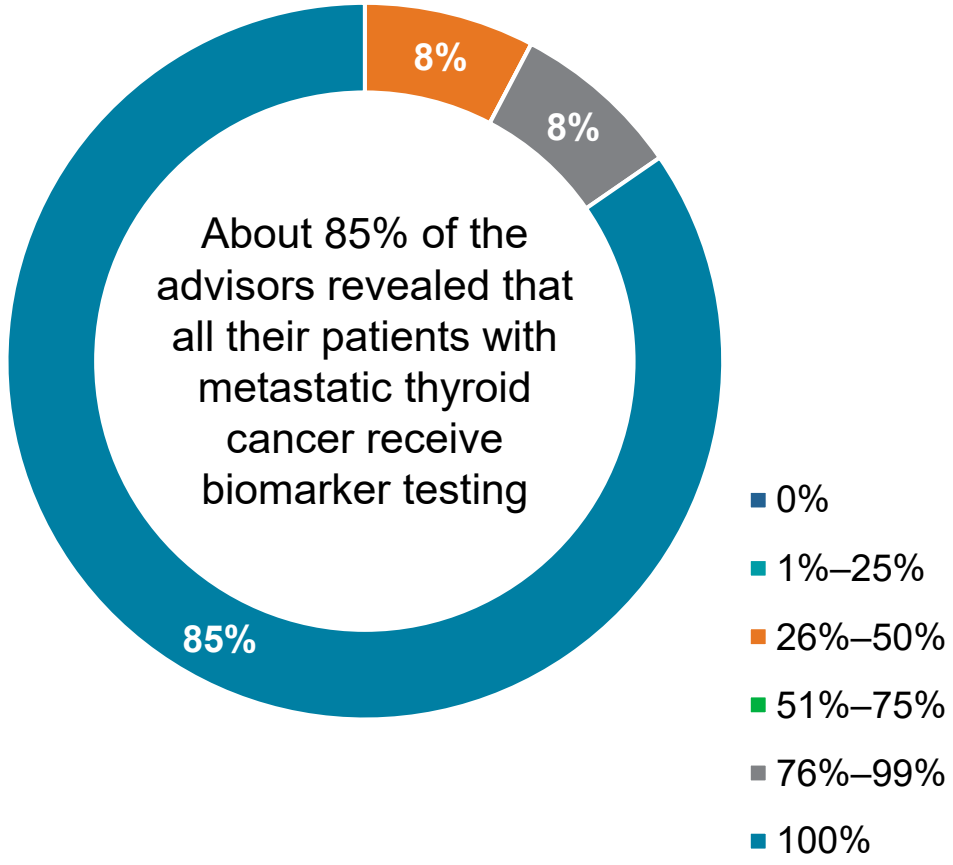


Participant Demographics

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)	*Break*
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

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Key Insights and Discussion Summary

Thyroid Cancer

Discussion: Thyroid Cancer (1/5)

INSIGHTS

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

- Treatment success in frontline DLBCL
- Data needed to switch from BCC in frontline

Discussion: Thyroid Cancer (2/5)

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INSIGHTS

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

- [illegible]

[illegible]

- [illegible]

[illegible]

Discussion: Thyroid Cancer (3/5)

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INSIGHTS

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

- [illegible]

[illegible]

- [illegible]

[illegible]

Discussion: Thyroid Cancer (4/5)

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INSIGHTS

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

- [illegible]

[illegible]

- [illegible]

[illegible]

Discussion: Thyroid Cancer (5/5)

INSIGHTS

Awareness about

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

- Treatment success in frontline (1L/2L)

"It's overall survival, that's what we need. This is not metastatic disease, this is curable disease, so we need overall survival."
"... cure without any significant long-term toxicity. ... I think when I define success, I would rather use a landmark endpoint rather than using OS or PFS, and I would say what's the disease-free rate at 3 years. I definitely do think OS is important if there is significant toxicity with the treatment, and people dying from competing comorbidities."

- Data needed to switch from 3/3C in frontline

"First of all, a lot of things have been tried, nothing is better than R-CHOP, and frankly, I'm pretty happy with how R-CHOP performs for my patients."
"I would be a late adopter. I would not be one of the first ones to move based on PFS or anything like that. I want something that's tried and true and we know how well it works."
"If the toxicities are not very severe, I think a hazard ratio of 0.85 or better would be something that I would be looking at."
"Overall survival data, that's ideal, but in this disease state OS is hard to come by, so you do have to use some surrogates of efficacy. So, I do think that a 3- or 5-year event-free survival kind of story is likely what's going to start driving my use of any regimen. ... PFS IS NOT sufficient."

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

ADVISOR		ADVISOR	
1	> Lenvatinib is my first choice in first-line treatment, if [illegible]	5	> I was already using lenvatinib first line, followed by [illegible]
2	[illegible]	6	[illegible]
3	[illegible]	7	[illegible]
4	[illegible]	8	[illegible]

Advisor Key Takeaways* (2/2)

ADVISOR		ADVISOR	
1	> The data is quite impressive to using lenvatinib over	5	
2		6	
3		7	
4		8	

*One advisor did not provide key takeaways.

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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

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

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*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)

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

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

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

One advisor did not respond.

Most Advisors Select Sorafenib as Their First-Line Systemic Therapy ≤25% of the Time

What percentage of the time is sorafenib your first-line systemic therapy for your mDTC patients? (n = 12*)

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

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

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

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*)

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

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

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