Maintenance Therapy for Small Cell Lung Cancer: What Patients Should Know

Dr. Martin Edelman (00:00):

When I see somebody upfront, I say this is a little like, let's make a deal. You got door number one, door number two, and door number three.

Jill Feldman (00:06):

Living with lung cancer looks different for everyone, but no one should go through it without answers. This is Hope with Answers, where patients lead and experts help guide the way. Hi everyone. I'm Jill Feldman. I am a lung cancer patient and advocate. And today on Hope With Answers, we are talking about a timely topic and a very important option for people diagnosed with extensive stage small cell lung cancer and that's maintenance therapy. So small cell lung cancer often responds quickly and well to the first line treatment, which gives people hope, but it can also come back quickly, which is a major challenge clinically, but it also creates a lot of anxiety and uncertainty for patients and families who want to know what can be done to keep the cancer from progressing for as long as possible. Now, physicians and scientists have been working tirelessly to find ways to keep the disease under control and that's where maintenance therapy comes in.

(01:19):

Maintenance therapy is treatment given after first-line treatment with the goal of keeping the cancer stable for as long as possible. And today we're joined by Dr. Martin Edelman, who is a thoracic oncologist and the chair of hematology-oncology at FoxChase Center. Dr. Edelman, you have been a leader in lung cancer research for many years and we are so grateful to have you with us today.

Dr. Martin Edelman (01:52):

Thank you, Jill.

Jill Feldman (01:53):

So let's start with the basics. When we talk about maintenance therapy and extensive stage small cell lung cancer, what exactly does that mean? When does it begin and why is this phase in treatment so important?

Dr. Martin Edelman (02:11):

So I think that one can get lost in terminology. I wouldn't look at so much as maintenance as it can these days as more of a continuation. I think in small cell lung cancer, what we're really doing is either continuing one of the drugs that we started with and what's best established there is immunotherapy where after the initial chemotherapy, which combines now with immunotherapy, the immunotherapy component.

Jill Feldman (02:39):

Can we talk just a little bit about why it's so prone to rapid recurrence? And I like your term continuation of treatment as well. I think maintenance therapy can be ambiguous. And how does continuation of therapy help delay that return?

Dr. Martin Edelman (03:10):

So why is small cell such a painful disease to deal with obviously for the patients and also for the physicians because there's that frustration of that great initial response then followed usually within months by recurrence because it's a very genetically complex disease. The majority of lung cancer small cells. In small cell carcinoma, there's those that occur that do not have a lung primary. Those are sort of a different set of diseases. They look similar under the microscope. They're all what we call neuroendocrine carcinomas and there's a whole spectrum of that disease. There are some instances of some of the mutation-driven non-small cells evolving into small cell carcinoma. It's still unclear exactly how that occurs and even how to necessarily treat that. But so let's talk about the typical small cell usually occurs in people who are smokers, usually heavy smokers, people who started young, not unusual to hear somebody who started 12, 13 years old.

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There's a thing about smoking history and that virtually everybody starts before age 25 if you're ever going to smoke. So I've had one exception to that rule over the years and most people it's late in high school, early college as far as ages say 16 to say 25 is sort of 20 or so is sort of the prime age and you can see that in tobacco industry advertising. But it's the younger, the people who start 12, 13 years old, the one to two pack per day, typically that's sort of your typical, not always, but typical person who gets small cell. So why is that relevant to this? It's relevant because the tobacco carcinogens, the more exposure you have to that, the more genetically messed up for lack of a better term, your tumor is. And if you look at a spectrum of the number of mutations in a small cell lung cancer, it's at the extreme end in cancer.

(05:29):

And what does that mean? So the more mutations you have, the more abnormal proteins, the more there are preexisting before we ever start, the preexisting mechanisms for resistance, pumps to get rid of drugs, something called multi-drug resistance proteins, they're there at the beginning. There are more potential ways to evade the immune system. Strangely, small cell lung cancer, despite all of those abnormal proteins, does not seem to have a very favorable in some of the subsets, the environment that allows the immune system to kill it off. We know that there are many subsets of small cell. There's at least four major ones that are currently discussed, but they're not like the mutational subsets in non-small cell. They're more what are called transcriptional. They have to do with the kinds of proteins that are evolved. And there's variability even within the tumor as well as plasticity, which means that they can change.

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So it's a very sneaky disease. It's got a lot of ways of evading our treatments, ways of repairing the DNA damage that occurs from the typical cytotoxics, ways of evading the immune system, ways that are evading our other, what are called targeted therapies, things that typically target a specific mutation because we just don't have that

Jill Feldman (07:00):

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Dr. Martin Edelman (07:00):

Small cell lung cancer. So those are some of the reasons and it's been a very frustrating disease to deal with.

Jill Feldman (07:08):

It makes sense though that it's genetically complex and I think as opposed to some of the oncogene-driven cancers that aren't, so that really can illustrate that difference. So then are you able to predict, or maybe I should say, are there certain patients who tend to benefit more from the continuation of therapy or does everybody get the continuation of therapy and maybe a certain drug for one population, a combination for another? How does that

Dr. Martin Edelman (07:51):

Work? So we don't really have a good way of tailoring therapy currently. We can sort of predict, and not much has changed in the sense that who is most likely to live longer versus not almost regardless or where the patients that tend to do best are those that do not have large volumes of disease, particularly liver disease is a particularly bad sign in this. If you look at the staging, it doesn't have very much in it about the volume of disease. It has a lot about is disease confined to the chest or not confined to the chest, but there's a big difference between, say, a patient who's quite extensive disease because they've got one adrenal gland metastasis and a lymph node in their neck. Those patients may very well be and occasionally are the long-term beneficiaries of treatment. One of the differences in all this is I think immunotherapy is what I call the ticket to the lottery and there are occasional winners.

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We have patients who have durable long-term responses and extensive disease, which was just not seen very much previously. There's no good way in May 2026 of predicting who will benefit and who will not in the sense of a laboratory test to guide therapy, very different from our situations in non-small cell. I think the field is moving that way. I think we will have that, but it's not six months away. It's probably still several years away.

Jill Feldman (09:34):

When you think about key questions that people diagnosed with extensive stage small cell lung cancer should ask their oncologists about what this will look like in the context of my everyday life, I think that that's a really important one. And are there any other questions that they should be asking their oncologist or that they should consider asking their oncologist?

Dr. Martin Edelman (10:09):

I mean, I think I'm a great advocate for clinical trials. I think we need to get real answers to questions. There's a lot of stuff on the horizon, new immunotherapeutics, knowledge various groups are now evaluating, relevant to your earlier question, can we better figure out who will benefit from these various treatments that we have? I think that there's a ton of stuff on the horizon and we're never going to be able to bring it in until to fruition unless the studies get done. So certainly asking about those studies is always a good idea if possible. But I think that I always spend a lot of time with people

educating about side effects. And I think it's important that before somebody gets the next drug that they ask the questions and think about it.

Jill Feldman (11:07):

When should somebody ask about clinical trials? Should it be at diagnosis even if they plan to start the first line of treatment?

Dr. Martin Edelman (11:20):

So depending upon the place, I mean, I think that a clinical trial is appropriate from day one if one is available. I think one of the issues we always have with studies, and it's recognized in small cell, something I've advocated for a long time is that we know some people will come in and they're quite ill. We need to get something started immediately. And I think the pendulums keep swinging around with this and we now allow people to frequently get one course of treatment before they would get whatever usually another drug in addition or in substitution for the standard of care. But I think the sooner somebody potentially goes on a trial, the better it's always worth asking about. It may not always be feasible. This is not a disease you can go shopping around, generally don't have the luxury of time. However, once one begins treatment, then one can certainly ask, well, what else is out there?

(12:28):

There are some newer things and a lot of people have to understand that there are many, many different kinds of trials. Some will, for the most part, they don't let you go on until there's disease progression. That's our classic thing.

Dr. Martin Edelman (12:45):

But the maintenance, this is continuation, that's an exception. There are some drugs that are being now looked at to put in.

Jill Feldman (12:51):

So now bringing it all back to the patients because both time and quality of life is important and people weigh things based on their preferences, but what advice would you give patients to specific questions or advice when they talk to their clinicians about or their team about treatment options and are there any supportive care resources they should be asking for upfront so that they could try to really balance both that time and quality?

Dr. Martin Edelman (13:33):

Yeah, I mean, I think this always varies institution to institution, what your resources are. There's no question that good supportive care is good all around in the sense that people tolerate their treatments better, their quality of life is better. The resources available or that are needed are going to vary from place to place. So I trained in an era where I was part of the investigators that developed a lot of anti-nausea drugs and 35 years ago, there were no palliative care physicians. There were medical oncologists. Who were the people who were doing this? They were the people that were treating lung cancers, GYN cancers, GU cancers. Why those people? Because we all use platinum and that was a big barthogenic drug. And so I'm pretty good with anti-nausea drugs.

Jill Feldman (14:34):

I like that. Barthogenic.

Dr. Martin Edelman (14:37):

It was really bad news. And now we've taken drugs that we could ... I mean, there's a reason that I almost never treat somebody as an inpatient because we could switch it all to the outpatient setting with these good anti-nausea drugs.That issue of nausea is not entirely but largely solved. So we do have aggressive ways of dealing with this. What should patients ask? Well,

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What do I do if ... And again, this should be just part of routine education. What do I do if this problem develops? We go through a laundry list of issues because we have to as part of consent. I mean, it would terrify anybody if they're ready like the Tylenol people. Most of them don't occur, thankfully, but I think it helps to talk to the physicians. I think it helps to ... A lot of times we do a lot of education in the infusion area with the nurses that are there. Some people benefit from additional work with palliative and supportive care, trained physicians. That's useful. I think going to places that have reliable information, Lung Cancer Foundation of America, LCFA, and the American Cancer Society, is a good place to go. International Association for the Study of Lung Cancer, good place to go. American Society of Clinical Oncology, good place to go.

Jill Feldman (16:02):

One last question here. I guess for somebody who's listening, who may be recently diagnosed, you've talked about what's on the horizon and what gives you hope, but what is the one message you want them to remember about maintenance therapy or continuation of therapy and the future?

Dr. Martin Edelman (16:28):

So I think that the message is that we are improving outcomes. Certainly the use of sustained immunotherapy clearly benefits patients and a small number will actually have really durable benefits. So where before things were ... I would talk to people and say at a certain point invariably it will progress. It's not quite as 100% as it used to be, so that's important. There is real reason. As I say, it's not a way to bed, it's a way to hope.

Jill Feldman (17:04):

Thank you, Dr. Edelman for joining us on the Hope With Answers podcast. For more information and resources about lung cancer, please visit lcfamerica.org. Thank you.