



IV vs. Subcutaneous Cancer Treatment: What Patients Should Ask

Stephanie Williams (00:00):

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James Hiter (00:13):

Living with lung cancer, Ask Me Anything. Real conversations with people living with lung cancer. Learn from their personal journeys and expert insights. Subscribe now and never miss an episode. Welcome to Living with Lung Cancer Ask Me Anything. I'm James Hiter and I'm living with lung cancer. And joining me today is Stephanie Williams. Uh, Stephanie is a longtime LCFA volunteer and member of our speakers bureau. Um, Stephanie, I've enjoyed getting to know you over time. I would love for the audience to also get to know you. Can you share a little bit about your background?

Stephanie Williams (00:52):

Sure. I think, James, when we first met, my daughter was maybe only six years old or so. I was diagnosed over four years ago with non-small cell lung cancer when I was 37 years old and mom to a kindergartner. Now my daughter's about to turn 11 and I kind of can't believe that we've already known each other that long in this lung cancer journey. Um, when I was diagnosed, it was caught by a persistent cough that I had. It was kind of dry and wheezy. I say persistent, um, because I can't say that it was like moderate or severe. It was very mild. But since it wasn't going away, I finally brought it up at a regularly scheduled doctor's appointment, ended up getting a chest x-ray at that appointment where a mass was found, and the rest is kind of history. It was stage two.

I had surgery. I had chemo. Now I'm on targeted therapy. Um, so we're just trucking along here and any chance I get to sit down and advocate a little bit about new treatments or the patient experience, I'm happy to do it. And I'm happy to be doing it with you today.

James Hiter (01:58):

Well, I'm super excited to have you here and also for the audience to get to learn you, get to learn you about you and the things that you know and the wisdom that you have from your years of living with lung cancer. So today we're doing a little bit deeper dive on subcu or subcutaneous drug delivery. Um, and I know some, this is something you have some familiarity with, not only as a patient, but also with your background. Can you share a little bit about that?



Stephanie Williams (02:23):

Yes. I was a registered nurse all the way up until I had my daughter. And while I was nursing, I would administer subQ injections, usually in the form of insulin, sometimes blood thinners, um, allergy shots are another medication that can be given subcu. So when it was brought up to me during my lung cancer treatment, it was something I already felt pretty comfortable with.

James Hiter (02:48):

Gotcha. So, uh, and we'll get to that here in a little bit, but I think the key point here is that subcu is not new, it's just new to lung cancer drug delivery.

Stephanie Williams (02:57):

Yes.

James Hiter (02:58):

Yeah. So let's dial the clock back just a little in your own lung cancer journey and tell me, was there ever a spot that was kind of a, a turning point for you in your treatment journey?

Stephanie Williams (03:11):

Yes. When I finished my chemotherapy regimen, I transitioned to a targeted therapy medication, which is an oral pill. And I was able to take that on a daily basis without having to go to a clinic setting for treatment, which was huge because as a cancer patient, in a post-pandemic world, every time I entered a clinical setting, I was worried about picking up a bug or a germ that might kind of shake up my treatment journey or derail my healing in some way. So the fact that I was on a treatment that now allowed me to not spend that time in the clinic or in an infusion chair really felt like I was getting my life back.

James Hiter (03:54):

Yeah. So was there something that triggered being able to have that treatment option for you?

Stephanie Williams (04:00):

Yes. For me, it was biomarker testing that was done on my tumor and it revealed a genetic mutation that has a targetable, um, druggable alteration within the genes. So there's several of them. Mine is ALK positive. Others might be EGFR, KRAS, ROS1, and more. And depending on your genetic mutation, you can have different types of treatment, targeted therapy and things that are specialized to treating that specific driver of your cancer.

James Hiter (04:30):



Every week on the Living with Lung Cancer Ask Me Anything podcast, we explore the questions that matter most to people living with lung cancer. We talk about new treatments, everyday challenges, breakthroughs in research, and the stories of patients and caregivers finding strength and hope. If you want these insights delivered straight to you, subscribe on any podcast platform or go to lcfamerica.org. And if you know someone who could benefit from understanding and encouragement, share the show with them and don't forget to subscribe. Now, let's get back to our conversation. Now, as we jump into sub-Q more, uh, I think it's important to think back to the time in lung cancer treatment where the only option was, uh, an IV, and now you've experienced kind of that next generation and now the next generation.

Stephanie Williams (05:23):

Yes.

James Hiter (05:24):

Yeah.

Stephanie Williams (05:24):

I think, uh, when most people think of cancer treatment, not even just lung cancer treatment, but cancer treatment, they automatically think about the movies and TV shows that have portrayed chemotherapy and, you know, days spent in those infusion chairs, um, getting all sorts of fluids and medications put in through a port maybe, or an IV in your arm. And it's exciting to see that that's changing for a lot of people. And cancer patients, and now including lung cancer patients, are able to get treatments that don't feel so disruptive to their life and their, their daily routines.

James Hiter (06:01):

And so why is it less, why is sub-Q less disruptive?

Stephanie Williams (06:06):

It's less disruptive because it takes such a shorter amount of time than a traditional IV therapy would take. The PrEP doesn't involve trying to find a suitable vein or a suitable access to your vein, and the recovery is just slapping on a wrap or a bandaid on that spot. And it's typically given, um, maybe in, in seconds to a minute or so versus the minutes to hours that an IV would take.

James Hiter (06:36):

Right. And, and obviously anytime you're piercing skin or vein, there's risk, but – Yes. Talk a little bit about, and this is kind of pulling on your nurse experience – Sure. More so than your patient experience, but talk a little bit about your, um, yeah, the, the risk factor

Stephanie Williams (06:51):

Difference. Yes. Each time you access your circulatory system through a vein, there's a slight risk. And many of us, and James, you know this, I'm sure you've had hundreds of IVs and blood draws yourself, but anytime you access a vein, there's a little risk of, for example, cellulitis or some infection. And when you go subcu, you're not going as deep into the body. It's not as intrusive to your system, and it takes away a little bit of that risk. Anytime you're going into the body, there's a risk. So I don't wanna say, you know, there's no risk with, with any method, including even oral methods. There's, there's risk to medication, but it feels like something that I don't have to worry about quite as much as when I go in for an IV or a blood draw.

James Hiter (07:38):

Right. Now, in, in most things in life, you think about if it's easier and quicker, then there's probably like a give up that you're, it's not as effective, it's not gonna work as good. Can you talk a little bit about that as it relates to subq treatments with lung cancer?

Stephanie Williams (07:53):

I think as it relates to any treatment, when you're given a formulation of a drug, it's because that has been formulated to the specific method of administration. For example, if you take something orally, that oral pill or tablet, maybe it's enteric coated, maybe it's not. However it's prepared, it's designed to work with your digestive system to get the drug into your body. Um, when you get something subcu, that's been formulated to work inside the tissue in your subcutaneous fat to get into your body and do what it needs to do. So thankfully, the scientists have developed these medications in such a way that whatever method they're recommended to be administered is the method to get the drug effective in the body.

James Hiter (08:40):

Sure. That, that. So probably not exactly the same because it's been reformulated to work better as a subcu delivery, but still the same.

Stephanie Williams (08:48):

It's being offered to you as a one or the other, the differences has to be marginal on the effectiveness.

James Hiter (08:55):

Right. Exactly. And I think most studies that I've read, the effectiveness is exactly the same. Yeah. Um, so when we think about how, uh, uh, somebody new thinking about getting this, how, how would you explain kind of the process of actually getting a subcu or what that might be like?

Stephanie Williams (09:13):

I would say the process of getting a subcu injection is showing up at the doctor's office, being taken into a patient room, having the skin on your arm or on your abdomen, cleansed with an alcohol prep. The injection is given, you get a bandaid and you're on your way after that. Depending on the clinic or the medication, they may wanna hold you for, for a certain amount of time afterwards, especially if it's your first time receiving the medication to make sure that there aren't any adverse reactions happening in that immediate post-injection time period. But when you compare it to IV therapy, it's a much less disruptive, um, process.

James Hiter (09:55):

Sure. And, and when you think about observation after a new medicine, that's not unique to sub-cu either. No. I mean, all of us have had to sit there and wait. Yeah. Um, even sometimes, uh, after getting the contrast dye, some, in some places will make you sit and wait a bit to make sure you're not gonna have even a reaction to that. Um, Stephanie, I know we, we talked about this a little bit earlier, but I wanna ask you, uh, with the cameras rolling, what, um, what do you, have you heard about insurance approvals or working to kind of, uh, make sure that this is approved or available, um –

Stephanie Williams (10:34):

Well, anytime you are recommended a medication from your doctor, there's usually an insurance approval process, specifically with cancer medications. Fortunately, there's resources, off the top of my head, I'm thinking of resources through your insurance agency. There's also, there's often a case manager, especially if you have cancer, you may have been reached out to by your insurance saying, "Hey, we can help you out with this, this, and this, uh, case management style." There's also, at oncology offices, often a nurse navigator who's very helpful in navigating the insurance aspect of things. Um, some drug manufacturers have resources on their website for helping to navigate insurance issues. So I think it's a matter of if an issue arises, knowing that there are resources to go through to, to pursue the options you really want.

James Hiter (11:23):

Sure. That's helpful. Um, I, I wanna revisit the, um, the idea of the time aspect of this. And, um, I wanna talk to you just about your own experience. When you shifted from traditional therapies to a TKI, to something that was new and time-saving for you, what did, what did that do for your life?

Stephanie Williams (11:45):

Well, my targeted therapy is a TKI that I take orally, and I do take it twice a day. Um, some of them are offered once a day and I'm like, "Uh-oh, you know, if only, but so sad, mine's twice a day." Um, it's nice because I don't have to work that into my daily schedule with transportation, with childcare, with, um, taking time off work to go to a clinic and receive a



treatment that could take up to hours out of my day. So there's just a lot of fewer logistics to consider. And anytime you can take some of that, that burden of efforting off of a cancer patient, I think it's a win.

James Hiter (12:26):

Yeah. I mean, I know for me, take cancer's taken away a lot, but I, I also say cancer's given, lung cancer has given me a lot as well, perspective and other things, lots of great friends. Um, but anytime we can steal a little back, I, it feels good. And this time with sub-Q feels like that.

Stephanie Williams (12:43):

It does. And I'm so excited that we're seeing these administration methods come out for drugs that were historically given a different way, that are making it easier for the patients to take. I remember when I was little and I was given maybe, you know, a shot that I didn't want. I would think to myself, "Well, why can't I just take it as a pill?" And this is kind of an example of, "Well, maybe now you can take this in a way that's easier on the body, easier on you." And it makes me think, like, how great would it be if we keep seeing developments like this in therapies that used to require more time, more effort, sometimes more pain becoming available in ways that don't have any of those things nearly to the extent that they have.

James Hiter (13:27):

Yeah. Right on. Well, I know I just recently had a vaccine. I'm gonna be a new grandpa – Oh.

Stephanie Williams (13:34):

For the

James Hiter (13:34):

First time.

Stephanie Williams (13:35):

Congratulations. Um,

James Hiter (13:36):

And my daughter requested that the family members that are gonna be spending a lot of time with the baby have this vaccine that would help make sure the baby's safe. Um, and they did it IM. Mm-hmm. And my arm is still sore. Yes. And so I think about the, the difference between IM and sub-Q. Yeah. Big

Stephanie Williams (13:53):

Difference. That's a great point because with IM injections, they're going into the muscle and that muscle often feels sore. I say sometimes it feels like I pitched a no-hitter, you know,



having never touched a baseball. But sub-Q rarely has that lingering soreness. If anything, potentially there could be a small bruise in the area, but I've never, in my personal experience after a sub-Q injection, have not felt that lingering soreness as I have with intramuscular.

James Hiter (14:22):

So somebody new diagnosed, um, how would they, or not new, let's just say somebody who's going through treatment, because this actually affects people new and not newly diagnosed. Somebody's going through treatment, they're thinking about this, maybe they heard this podcast. What, uh, would be your recommendation as far as, um, what they should do relative to their care team or their doctor?

Stephanie Williams (14:44):

I think if someone is newly diagnosed, one of the best things they could do, um, I'm gonna go kind of in reverse order from what I usually say. I usually save the patient support for one of my last points, but when I think about my own journey, it was patient support that actually got me started in the right direction. I was able to connect with a patient advocate in the lung cancer space, and she actually encouraged me to pursue biomarker testing, which we mentioned a little while ago. Um, after the biomarker testing, she encouraged me to seek a second opinion, which I did. And it was actually very informative to my treatment plan to get a second opinion from a doctor, highly experienced in the kind of cancer I have. And then the group. Um, I had connected one-on-one with a patient advocate, but she also helped me get in touch with a patient organization specific to my biomarker that I found to be a great wealth of information for treatments and just commiserating with other patients who have been through the same kinds of things.

James Hiter (15:47):

Mm. That makes sense. A lot of sense. So, um, when we think about, um, uh, all the things that I've read so far, people I've talked to, the sub-Q seems to have a really high s – patient satisfaction, which is really fantastic. Why do you think that is?

Stephanie Williams (16:04):

I think it's because it's so, uh, simple compared to some of the other ways of getting treatment. It feels very non-disruptive to their routines, and I would imagine that if you tell a patient that something that used to take hours to give now can take just a few minutes, it's always going to be an increase in satisfaction. Not to mention, like we said, maybe less pain, less anxiety about finding a vein or if that vein is gonna hold up. I know I had so many IVs and blood draws over the years. I'm just waiting for old trusty here in my right arm to give up on me. Um, but so far we're hanging on. But that's not something I have to worry about with a sub-Q method.



James Hiter (16:44):

Yeah. Boy, that you're bringing back a lot of memories though. My trusty is also the right side. My left side apparently is very valvy. You as a nurse would know what that really means. I as a per – I just know it makes it hard to get an IV in. Um, so for me, um, not having to have that IV access, I was also the stubborn guy who never got a port, um, despite two and a half years of this nonsense. Um, so I,

Stephanie Williams (17:11):

I- I got a port.

James Hiter (17:11):

Yeah.

Stephanie Williams (17:12):

Yeah. Yeah,

James Hiter (17:13):

Yeah.

Stephanie Williams (17:13):

It's gone now. I had my port removed shortly after chemo. And they even said, "You know, some people like to keep this in for a while because you never know. I wanted it out as soon as I could." Yeah. And I've got my little scar here to remind me how far I've come.

James Hiter (17:26):

That's awesome. Very cool. Well, I, uh, the idea of being able to get medicine delivered in such a convenient, effective, easy way, um, relative to IV access and all of that is r- really important. Is there anything else that you would wanna share with your experience, uh, both as a patient, as a, a, a nurse, um, that, that might be helpful to the audience?

Stephanie Williams (17:51):

I think from a nursing, a healthcare perspective and patient perspective, I mentioned that it's less disruptive to the routine of the patient. From a healthcare standpoint, it doesn't require all of the IV tubing, the resources, the pull, the monitoring that an IV does. So it's actually nice on a grander scale that we're freeing up some clinic time and some chair time that otherwise would be taken up with methods that take longer to give.

James Hiter (18:18):

Stephanie, you, you bring a unique position to the question I'm about to ask, which a lot of patients are, um, kind of hesitant to bring stuff up to their doctor. They expect the doctor to be



the smart person and they're just kind of along for the ride, but we know that that is not necessarily always the best avenue. Talk a little bit about people who maybe are a little fearful of bringing things up to their doctor like sub-Q.

Stephanie Williams (18:42):

I think doctors, especially oncologists, the superstars that they are, I don't know how they keep track of so many new and changing treatments all the time, but they seem to do a really great job at it. I think a way we can advocate for ourselves is to let them know what we've been hearing and seeing from the lung cancer community. And that includes this podcast. You could approach your doctor and say, "Hey, I just heard that some lung cancer medications may now be available in a sub-Q form. Is that something that I have an option of doing with my treatment?" And that would, uh, trigger the doctor to review your medications, see what you're on, and maybe with a few strokes of the keys, find out if that is something that's available to you and would be applicable to your treatment. It's always worthwhile to ask.

Um, if it's not an option, then no harm. If it is an option, it can have a great benefit for you. And thank goodness you asked the question, otherwise you may have been slogging along with a treatment that is taking more time and being more of a logistical nightmare depending on if there's a dance recital that week or, or a pizza party at school you need to volunteer at. So it's always worthwhile. It could give you back hours that accumulate into days and all of that time making memories with family or just being out in the community and not feeling like such a patient all the time is so valuable. So definitely ask your doctor, bring it up, let them know you heard it from a friend. I'll be the friend.

James Hiter (20:15):

Well, Stephanie, I thank you so much. I, um, appreciate you so much. I appreciate you using your voice for, uh, lung cancer advocacy. It's, uh, you're a tremendous friend and so, um, nice of you to join us here and share your wisdom with, uh, those that are ask, uh, looking to Ask Me Anything for some answers.

Stephanie Williams (20:32):

Thanks, James.

James Hiter (20:33):

Yeah, thanks a lot. If you're looking for more information about lung cancer, subcutaneous drug delivery or anything else, check out lcfamerica.org and thanks for tuning in. Thanks for watching and listening. Your support helps these stories reach more people. Never miss an episode by subscribing to the channel.



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