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Risk Reduction and Management Protocols for Gastrointestinal Adverse Events With ADC Therapy in Breast Cancer

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Harbeck:
Hello, this is CME on ReachMD, and I'm Dr. Nadia Harbeck. In this episode, I'll review the gastrointestinal adverse events related to antibody-drug conjugate therapy that we reported in the breast cancer trials. I'll also offer some strategies for how to manage them.

Now, we'll review the safety data regarding GI adverse events in the clinical trials in breast cancer. Nausea and vomiting: With T-DXd, it's the most common cause of grade 3 adverse events, together with the hematological toxicities. And we have in about 6% to 7% nausea and vomiting and about 1.6% to 4% grade 3 or higher in the clinical trial. It's the most common cause of dose reduction in the trials, and the median onset of nausea is about a week after infusion. So I think the key takeaway here is that we have to look at the delayed onset of nausea and vomiting and try to prevent that.

With sacituzumab govitecan [SG], we have about 50% to 60% nausea and about 20% to 40% vomiting; and grade 3 or higher, we see this in less than 3% of the patients. The median onset of nausea is about a week after infusion. And as SG is given on days 1 and 8 of each cycle, the management of acute onset nausea and vomiting is important. With regard to diarrhea with SG, we have diarrhea in about 60% of the patients, 10% grade 3, median onset is about 2 weeks, a little bit longer for grade 3, and the median duration about 5 to 7 days. And there's a boxed warning for neutropenia and diarrhea.

With nausea and vomiting, sacituzumab govitecan, I would recommend 2-drug prophylactic regimens on day 1 of each cycle, which should include a 5-HT_3 receptor antagonist and dexamethasone. And with regard to the delayed-onset emesis particular with T-DXd, we can offer the single agent also on day 2 or 3, after the standard prophylactic regimen on day 1. But we can also use the NK1 receptor antagonist for days 2 or 3, like aprepitant.

For the diarrhea, we need to be aware of it and give prescription of loperamide to the patient so the patient can take this as soon as an episode happens. I would encourage the patients to start with loperamide as soon as they experience diarrhea and then take it continuously until the diarrhea resolves, and then we can continue the loperamide about 12 hours after the last diarrhea episode. If it doesn't resolve, we have to escalate the therapy a little like with octreotide or a tincture of opium.

And again, it's important to collaborate with the multidisciplinary team, educate patients and their caregivers about the potential side effects, and use the patient resources that are provided by the drug manufacturers.

With regard to GI toxicities, I think it's key to not underestimate them. ADCs are more like chemotherapy in this regard than a simple antibody treatment. And we should provide a 2- or 3-drug antiemetic regimen right from the start like we do with some of our chemotherapy agents.

And with that, our time is up, and thank you for listening.

Announcer:
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