Testimony on the path for access – a medical professional perspective

CDDF-EORTC workshop on Rare Cancers 24 September 2024

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Another day in my sarcoma clinic…

please join me

Patient 1 in the room

42 years. Always healthy, married, teacher, 2 children 6 and 8 years of age

Ultrarare sarcoma intraabdominal metastases – fusion positive (characteristic for diagnosis) no targetable mutations

No standard treatment even not in first line **-** what to do?

- PubMed: case reports – mostly chemotherapy or in first line setting however: unavailable TKI
- Email to expert colleagues – nice answers < 24 h, all had seen 0-1 patients, but: replies not really helpful
- Ask the colleague who proposed a study last year in this disease at MCCR (!) – MEK inhibitor: not available, evidence not convincing
- Phase 1 study locally (phase 1 'all-comers' cohort)? Or elsewhere national? – nothing available

So what will we do with patient 1 ?

according to guideline for all soft tissue sarcomas…: doxorubicin = Adriamycin) ☹

Medical and Pediatric Oncology 1:6 (1975)

ADRIAMYCIN: A NEW EFFECTIVE AGENT IN THE THERAPY OF DISSEMINATED SARCOMAS*

Robert S. Benjamin, M.D.,† Peter H. Wiernik, M.D.,
and Nicholas R. Bachur, M.D., Ph.D.

*National Cancer Institute, Baltimore Cancer Research Center, Baltimore, Maryland 21201***

Thirty-six patients with disseminated sarcomas were treated with adriamycin according to an intermittent single high-dosage schedule based on our prior pharmacologic observations. The dose of 60 mg/M^2 IV q 3 weeks was reduced 50–75% in the presence of liver disease. Complete remission occurred in 9%, partial remission in 32%, and improvement in 21% for median durations of 37, 18, and 15 weeks, respectively. Survival was prolonged in responding patients. Hematologic suppression was mild in the absence of liver disease or prior extensive radiotherapy. Congestive heart failure, a well-known long-term complication of therapy with anthracycline drugs, occurred in two out of four patients who had cumulative doses of 600 mg/M^2 or more. Mucous membrane toxicity was not observed. Adriamycin is an effective new agent in the therapy of disseminated sarcomas and can be used with relative safety by following pharmacologic principles.

Patient 2 in the room

33 years male, single, works in IT

Spindle cell sarcoma of the left leg with lung metastases – Progressed after three cycles of doxorubicin

WGS: **MSI high** tumor (only 3% **-** good news…or..?)

No standard second line but there may now be gain of an **anti PD1 AB. However not EMA approved for MSI high sarcoma pts**

What to do?

- Study (phase 1) local, national?
- Ask his healthcare insurance company (time consuming)
- Ask pharma (time consuming)
- Ask hospital (unlikely, too expensive)
- But wait, in The Netherlands we are allowed to prescribe nivolumab for MSI high tumor agnostic if regular treatment is exhausted ☺

Patient 3 in the room

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Nirogacestat, a γ-Secretase Inhibitor for Desmoid Tumors

45 years old woman,
nasty **desmoid** in her pelvic area
Doesn't tolerate standard sorafenib

Study with new drug nirogacestat in which we participated closed 2 years ago and was positive (NEJM 2023).
No standard second line

What to do?

- Study with similar drug locally or elsewhere national: none
- Compassionate use: application very time consuming, approval uncertain: "Why no chemo first"?
- After 6 weeks: application approved ☺

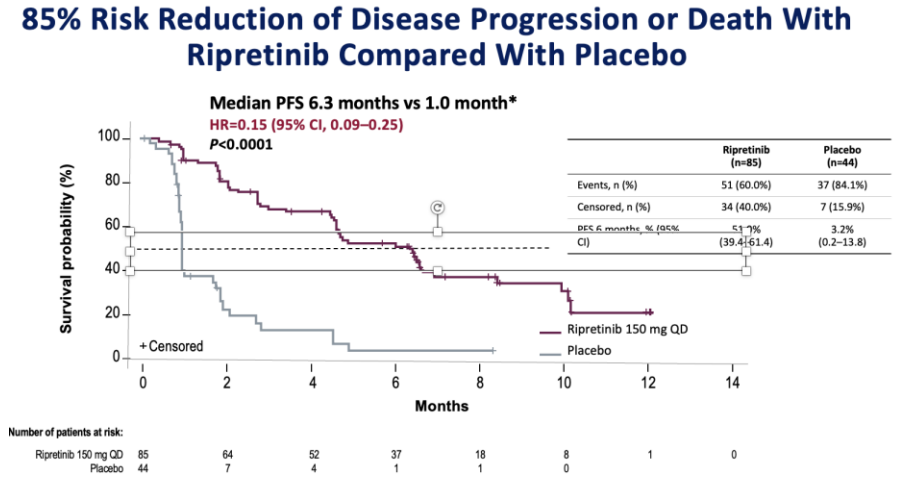
Patient 4 in the room

65 year old male with GIST with liver metastases who -after 5 years- progressed on three lines of TKIs: Imatinib-sunitinib-regorafenib

According to the guideline (based on Lancet Oncology paper 2020) he should be able to get ripretinib which is EMA approved (11/2021)

However…….it is not reimbursed and not available in any country in Europe

Why submitting a dossier to EMA and have no idea about reasonable pricing in Europe?



The oncologist's perspective

With a clinic full of such rare (sarcoma) patients…

This is a lot of extra work, frustration, sensitive communication with patients and families who are in despair.

The reimbursement for such hospital visits is not related to all the extra time investment.

What can we learn from all these pts?

- The knowledge about them sits in my head and in the EPR
- But nobody knows it elsewhere – also not how the outcome of the patients has been on treatment X-Y-Z

Improving Diagnosis and Care for Patients With Sarcoma: Do Real-World General Practitioners Data and Prospective Data Collections Have a Place Next to Clinical Trials?

Emily I. Holthuis, MSc[1]; Marianne J. Heins, PhD[2]; Winan J. van Houdt, MD, PhD[3]; Rick L. Haas, MD, PhD[4]; Jetty A. Overbeek, PhD[5]; Tim C. Olde Hartman, MD, PhD[6]; Annemarie A. Uijen, MD, PhD[6]; Leonard Wee, MD, PhD[7]; Winette T.A. van der Graaf, MD, PhD[1,8]; and Olga Husson, PhD[1,9]

Holthuis, JCO Clin Cancer Inform 2024

No central registry but a novel way:

Federated learning - Blueberry project (KWF)

OPEN

Federated learning in medicine: facilitating multi-institutional collaborations without sharing patient data

- Cell line
- In vivo

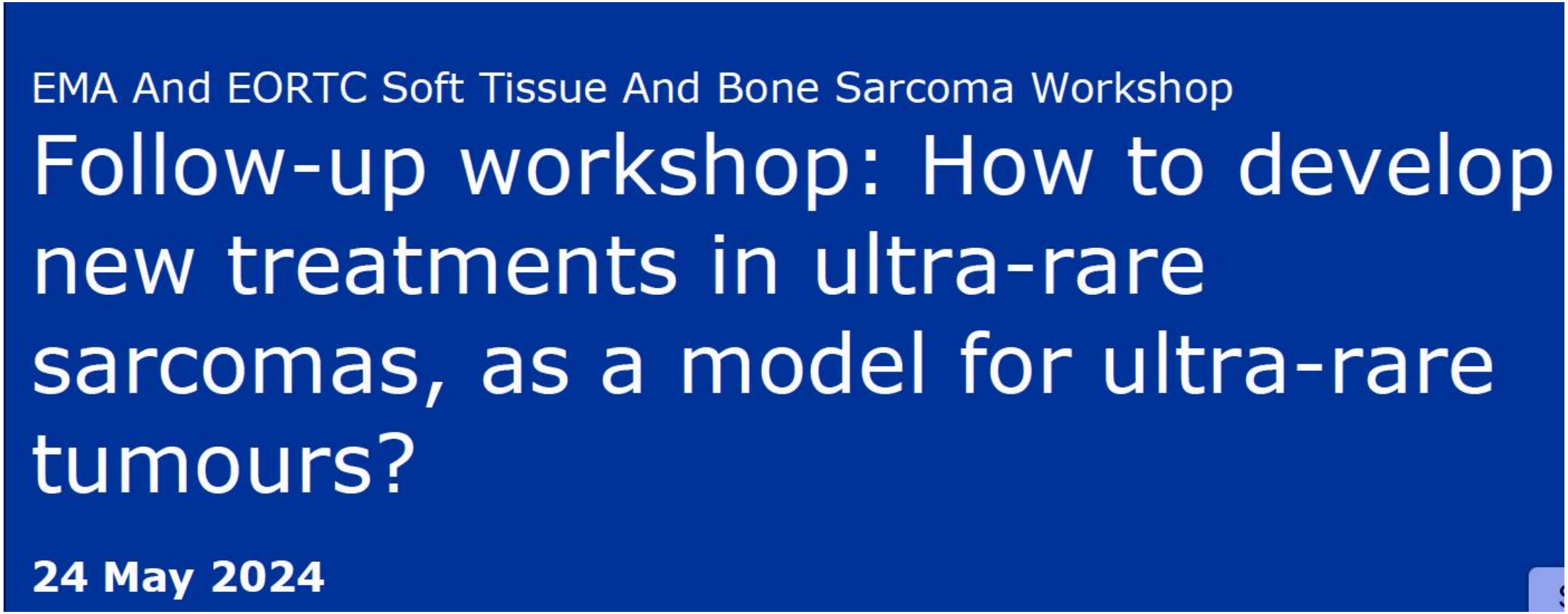
- Phase 1
- Phase 2-3 or phase 3 registration study

- Regulatory submission Approval
- ……..Availability – reimbursement ???

- Have a good research question
- Explore first what is necessary to ultimately be practice changing and (in case of drugs) make **EMA approval** and **national reimbursement** happen
- Initiate the study that will generate the necessary robust data

Time for a change…why not work the other way around ?!

Workshops at EMA to discuss challenges for drug approval in ultrarare cancer indications- started in 2024



Summary: Path for access to treatment in Rare Cancers

Collaborate locally, at national level, and internationally

Collaborate with patients – they are the best advocates

Collaborate in international setting with cooperative groups and experts in clinical research methodology to enable practice changing research

EORTC
European Organisation for Research and Treatment of Cancer
The future of cancer therapy

Collaborate with the regulators and HTA bodies

Collaborate with pharma on shared responsibility to improve lives of rare cancer patients with new drugs and good trial methodology

Collaborate with charities and funders for grant opportunities

Thank you for your attention!

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RARE CANCER CLINIC

NEVER GIVE UP