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Aken, E.S.M. van; Linden, Y.M. van der; Thienen, J.V. van; Langen, A.J. de; Marijnen, C.A.M.; Jong, M.C. de; Dutch Platform Palliative Radiothe

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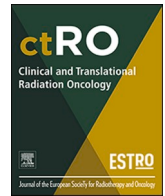
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Original Research Article



Hypofractionated radiotherapy combined with targeted therapy or immunotherapy: Dutch survey on current practice, knowledge and challenges

Evert S.M. van Aken^a, Yvette M. van der Linden^b, Johannes V. van Thienen^c,
Adrianus J. de Langen^d, Corrie A.M. Marijnen^{a,b}, Monique C. de Jong^{a,*}, on behalf of the Dutch
Platform for Palliative Radiotherapy (LPPR)¹

^a Department of Radiation Oncology, Netherlands Cancer Institute - Antoni van Leeuwenhoek, Plesmanlaan 121, 1066CX Amsterdam, The Netherlands

^b Department of Radiation Oncology, Leiden University Medical Center, Albinusdreef 2, 2333ZA Leiden, The Netherlands

^c Department of Medical Oncology, Netherlands Cancer Institute - Antoni van Leeuwenhoek, Plesmanlaan 121, 1066CX Amsterdam, The Netherlands

^d Department of Thoracic Oncology, Netherlands Cancer Institute - Antoni van Leeuwenhoek, Plesmanlaan 121, 1066CX Amsterdam, The Netherlands

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ABSTRACT

Introduction: With the introduction of tyrosine kinase inhibitors and systemic antibodies, including immune checkpoint inhibitors, the survival of advanced-stage cancer patients has improved for many tumor types. These patients are increasingly referred for radiotherapy, but it is unclear whether radiotherapy combined with these drugs is safe. No international guidelines exist on whether or how to combine these drugs with radiotherapy. Therefore, we investigated the current clinical practice in the Netherlands regarding hypofractionated radiotherapy in patients using targeted drugs and immunotherapy.

Materials and methods: We sent a survey to all 21 Dutch radiotherapy institutes. Dedicated radiation oncologists, medical oncologists and pulmonologists were asked to fill out the survey. The questions explored their familiarity with the combination of targeted drugs and immunotherapy with radiotherapy, the encountered clinical difficulties and factors influencing treatment decisions.

Results: The survey was filled out by 54 respondents from 19 different institutes. The median annual number of patients per radiation oncologist referred for radiotherapy when using targeted drugs or immunotherapy was 10 and 15, respectively. Despite this high number, only 11% of the radiation oncologists stated that they had sufficient information (resources) for adequate treatment decision making. Among all physicians, 44% stated that there was insufficient knowledge within their institute regarding this topic. Only 17% stated that there was a multidisciplinary protocol available. The application of radiotherapy treatment adaptations (technique, dose, fractionation, field size) varied widely. Generally, there seemed to be no consensus regarding the expected toxicity of combined drug-radiotherapy treatments and the expected risk of tumor flare upon temporary drug discontinuation.

Conclusion: There is no consensus amongst involved medical specialties on expected toxicity. Consequently, it is necessary to perform clinical studies examining the safety of combined drug-radiotherapy treatments, to add radiotherapy to phase I-III clinical trials for new drugs and to incorporate outcomes into multidisciplinary, evidence-based guidelines.

Introduction

Systemic treatment options for cancer patients have changed considerably over the last few decades. With the introduction of tyrosine

kinase inhibitors (TKIs) and monoclonal antibodies (mAbs), including immune checkpoint inhibitors (ICIs), the overall survival of advanced-stage cancer patients has improved for many tumor types [1,2]. In these patients, hypofractionated radiotherapy is frequently used as a

* Corresponding author.

E-mail address: m.d.jong@nki.nl (M.C. de Jong).

¹ See Appendix B.

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convenient and effective treatment option, in order to treat local symptoms or oligoprogression [3–5]. However, the use of a higher dose per fraction is less favorable for normal tissues, potentially leading to increased (particularly late-responding) normal tissue toxicity [4,6]. This risk may be further augmented by concomitant use of systemic therapy [7–9].

TKIs and mAbs are pharmacodynamically and pharmacokinetically heterogeneous drug types [10]. First, a wide variety of cellular pathways and receptors is targeted. The diverse mechanisms of action and possible off-target effects lead to different toxicity profiles and degrees of radiosensitization [10–12]. Second, the plasma half-lives vary largely [13]. Targeted drugs with long plasma half-lives (particularly mAbs) can require a discontinuation period up to several months to reach low plasma levels [13]. This is often not desirable and may lead to tumor flare [14–16]. Therefore, combining systemic drugs with concurrent radiotherapy is sometimes inevitable. Additionally, differences in distribution throughout the body may influence radiotherapy toxicity. For example, limited blood–brain barrier permeability may reduce the contribution of a drug to normal tissue radiotherapy toxicity in the brain, whereas radiotherapy may at the same time increase blood–brain barrier permeability, leading to increased drug concentrations in the brain [17,18].

For the combination of radiotherapy with targeted drugs and immunotherapy, toxicity data are often scarce and primarily based on retrospective studies and case reports [19–21]. Still, increased and even severe radiotherapy toxicity has been reported in patients treated with targeted drugs or immunotherapy [22–25]. Apart from the hazards that may arise from combining radiotherapy with targeted drugs and immunotherapy, there is also evidence for potential benefit [26–29]. Several treatment options can be considered for these patients, including concomitant therapy, temporary drug discontinuation, radiotherapy plan adaptations or radiotherapy dose reduction. However, there is no international guideline or consensus regarding the most appropriate clinical approach, which creates a challenge for radiation oncologists, medical oncologists, pulmonologists and for these patients.

In the present study, we investigated the current clinical practice in the Netherlands regarding hypofractionated radiotherapy in cancer patients using targeted drugs and immunotherapy. A survey was developed for radiation oncologists, medical oncologists and pulmonologists. Our goal was to explore their knowledge, the main clinical difficulties they encounter, the treatment decisions and the decision-making processes.

Materials and methods

We developed an online survey (Appendix A), consisting of 26 clinical questions and statements for radiation oncologists and 8 for medical oncologists and pulmonologists, since primarily these two specialties prescribe targeted therapy and immunotherapy for cancer patients in the Netherlands. As these patients are referred for primarily hypofractionated radiotherapy, of which the radiobiological effects may be different and in order to reduce heterogeneity, this survey only comprised the use of hypofractionated radiotherapy (fractions ≥ 3 Gy, including palliative and stereotactic radiotherapy). All questions and statements concerned the current patterns of care regarding the combination of hypofractionated radiotherapy with targeted drugs and with immunotherapy. Attention was paid to information resources and knowledge, multidisciplinary decision making and radiotherapy treatment adaptations. Additionally, the expected risk of toxicity or tumor flare was analyzed for different targeted therapies. For statements, a 5-point Likert scale was used to express the level of (dis)agreement.

After an internal pilot survey, the survey was distributed via the Dutch Platform for Palliative Radiotherapy (LPPR), which is part of the Dutch Society of Radiotherapy and Oncology (NVRO) and focuses on palliative and stereotactic radiotherapy. We asked members to let the survey be filled out by at least one radiation oncologist and by one or

two medical oncologists and pulmonologists. This method was used in order to select radiation oncologists, medical oncologists and pulmonologists who are more actively engaged in this topic. All participating physicians gave permission for anonymized publication of the results. We analyzed data from respondents who fully completed the survey. The survey was developed using Exploratio (Newcom Research & Consultancy B.V., Enschede, The Netherlands). Data analyses were performed using SPSS Statistics for Windows, version 25 (IBM Corp., Armonk, NY, USA). Visualizations were created with Microsoft Excel 2016 (Microsoft Corp., Redmond, WA, USA).

Results

The survey was filled out by 65 respondents and fully completed by 54 respondents, which resulted in a completion rate of 83%. The responding population consisted of 27 radiation oncologists from 13 different centers, 10 medical oncologists from 7 different centers and 17 pulmonologists from 12 different centers. All tumor subspecialties were represented (Table 1). The median annual number of patients per radiation oncologist referred for hypofractionated radiotherapy when using targeted therapy or immunotherapy, was 10 and 15, respectively. However, just 11% (3/27) of the radiation oncologists stated that they had sufficient information (resources) and only 7% (2/27) considered themselves to have sufficient ready knowledge for adequate treatment decision making in these patients (Fig. 1).

Among all physicians, 44% (24/54) stated that there was insufficient knowledge within their institute regarding the possible interaction between hypofractionated radiotherapy and targeted therapy or immunotherapy. According to only 17% (9/54) there was a multidisciplinary accepted protocol available in their institute, but in none of these institutes, all respondents agreed with that statement, which makes the

Table 1
Respondent characteristics.

Respondent characteristics	Radiation oncologists		Medical oncologists		Pulmonologists		Total	
	n	%	n	%	n	%	n	%
<i>Hospital type</i>								
Academic hospital	16	59%	5	50%	7	41%	28	52%
General hospital	11	41%	5	50%	10	59%	26	48%
<i>Experience</i>								
Resident	1	4%	0	0%	0	0%	1	2%
Staff (since 0–10 years)	12	44%	5	50%	10	59%	27	50%
Staff (since 11–20 years)	9	33%	5	50%	4	24%	18	33%
Staff (since 21–30 years)	4	15%	0	0%	3	18%	7	13%
Staff (since >30 years)	1	4%	0	0%	0	0%	1	2%
<i>Subspecialty</i>								
Neurological tumors	8	30%	0	0%	0	0%	8	15%
Head and neck tumors	5	19%	2	20%	0	0%	7	13%
Lung tumors	9	33%	0	0%	17	100%	26	48%
Breast tumors	13	48%	4	40%	0	0%	17	31%
Gastro-intestinal tumors	10	37%	5	50%	0	0%	15	28%
Urological tumors	2	7%	5	50%	0	0%	7	13%
Gynaecological tumors	2	7%	3	30%	0	0%	5	9%
Melanoma/renal cell carcinoma	3	11%	4	40%	0	0%	7	13%
Soft tissue tumors	5	19%	1	10%	0	0%	6	11%
Hematological tumors	4	15%	0	0%	0	0%	4	7%
Palliation	20	74%	5	50%	1	6%	26	48%
Other	2	7%	1	10%	0	0%	3	6%

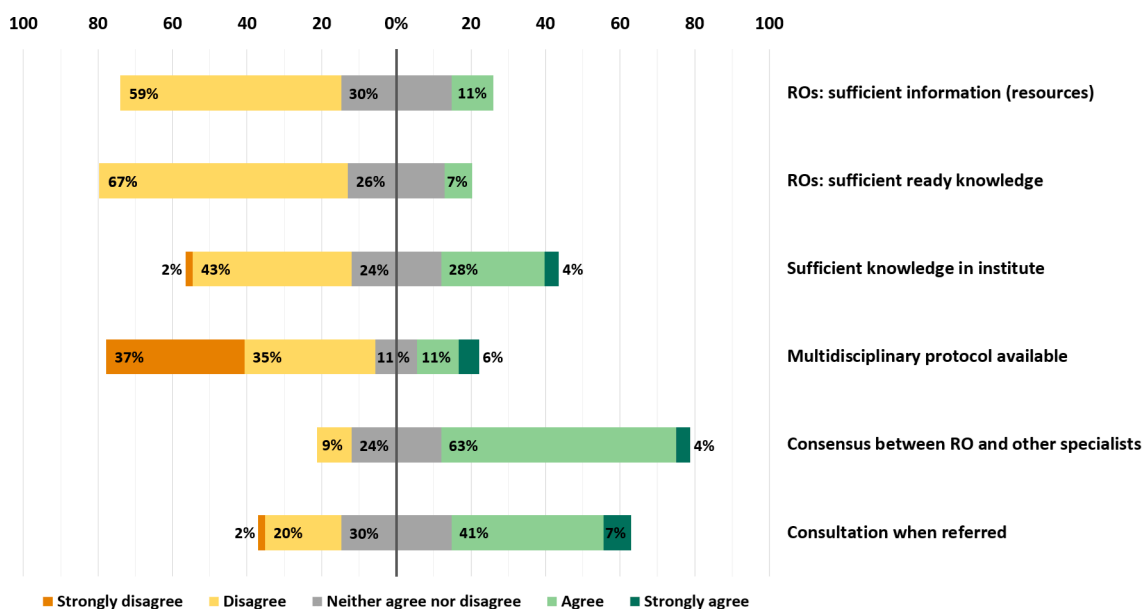


Fig. 1. Knowledge, information resources and multidisciplinary decision making. Answers on statements regarding the combination of radiotherapy with targeted therapy or immunotherapy. First two statements only answered by radiation oncologists. The proportion answering ‘Neither agree nor disagree’ was centered. Abbreviation: RO = radiation oncologist.

existence of a widely accepted protocol unlikely in these institutes. Before patients were referred for radiotherapy, interdisciplinary consultation with a radiation oncologist did not always take place. Nonetheless, 67% (36/54) stated that there was consensus between radiation oncologists and other treating physicians regarding the combination of hypofractionated radiotherapy with targeted therapy or immunotherapy (Fig. 1).

When patients continued to use targeted therapy or immunotherapy during radiotherapy, various treatment adaptations were applied (Fig. 2). On average, radiation oncologists were more likely to adapt treatment when radiotherapy was combined with targeted therapy than with immunotherapy (32% vs. 21%). The fractionation scheme was adapted most often (44%, 12/27 and 37%, 10/27 respectively). For targeted therapy, the next most common adaptations were field size

(37%, 10/27) and treatment technique (33%, 9/27). For immunotherapy, these were treatment technique (22%, 6/27) and radiation dose (15%, 4/27). However, 22% (6/27) of the radiation oncologists did not regularly adapt their treatment at all. Complete omission of radiotherapy was not often considered for these patients (Fig. 2). All radiation oncologists took the irradiated tissue type into account and 89% (24/27) took the plasma half-life of a drug into account when deciding whether or not to combine hypofractionated radiotherapy with targeted therapy or immunotherapy.

We asked all respondents which drug types would ring alarm bells when patients are referred for radiotherapy (Fig. 3). The majority of the radiation oncologists regarded VEGF(R) inhibitors (78%, 21/27) and multi-target TKIs (52%, 14/27) as potentially hazardous in combination with radiotherapy. BRAF, EGFR and CDK4/6 inhibitors followed with

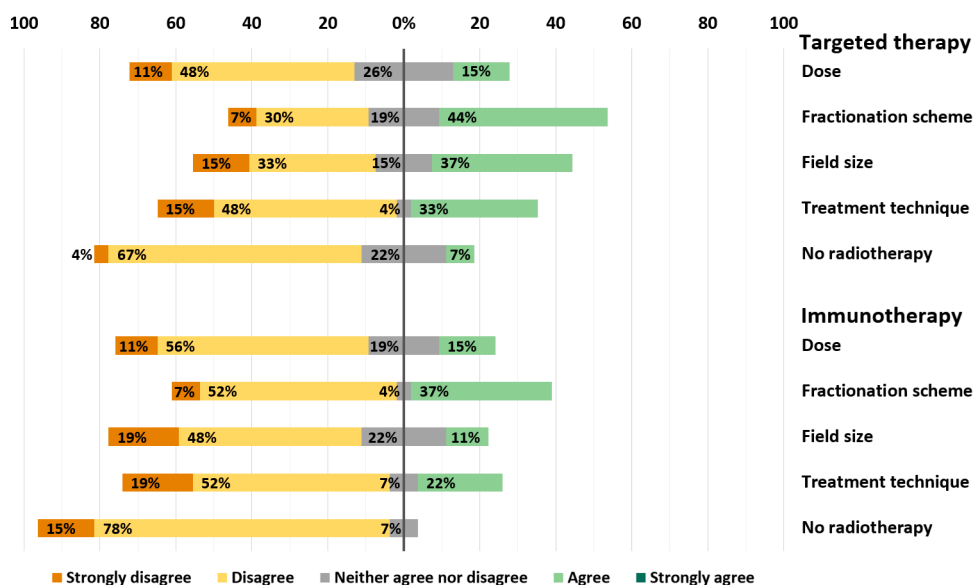


Fig. 2. Regularly applied treatment adaptations by radiation oncologists, when targeted therapy or immunotherapy is continued. The proportion answering ‘Neither agree nor disagree’ was centered.

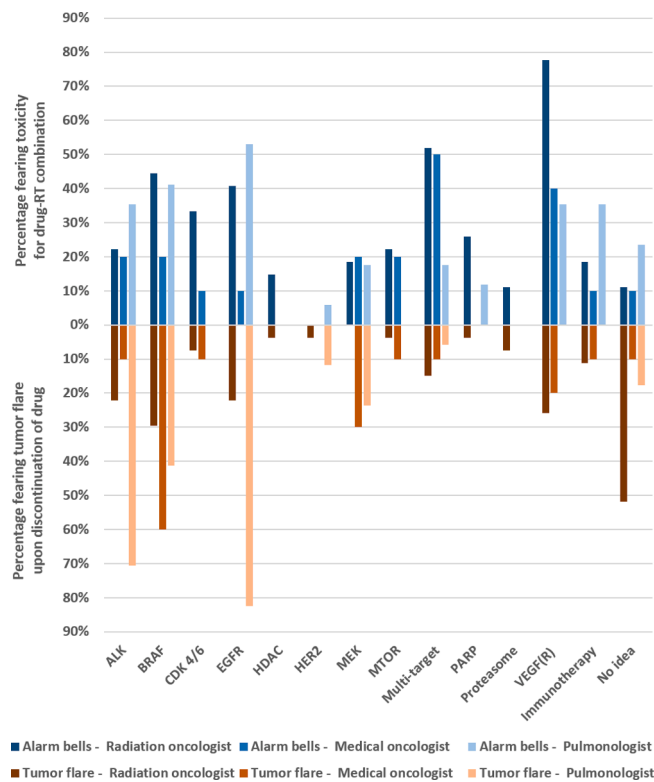


Fig. 3. Percentage of respondents that fear toxicity from a drug-radiotherapy combination (alarm bells) vs. fear of tumor flare upon discontinuation of a drug. Bars are per drug target, split by radiation oncologist vs. medical oncologist vs. pulmonologist. *Abbreviation:* RT = radiotherapy.

44% (12/27), 41% (11/27) and 33% (9/27), respectively. Other drug types, including immunotherapy, were considered less harmful. Among medical oncologists, particularly multi-target TKIs (50%, 5/10) and VEGF(R) (40%, 4/10) inhibitors were mentioned. Pulmonologists mentioned EGFR (53%, 9/17) and BRAF (41%, 7/17) inhibitors, but also ALK, VEGF(R) inhibitors and immunotherapy (all 35%, 6/17). Among radiation oncologists, 11% (3/27) stated that they had insufficient ready knowledge to answer the question. Among medical oncologists and pulmonologists, this answer was given by 10% (1/10) and 24% (4/17), respectively.

The respondents were asked whether they expected a real risk of tumor flare upon temporary drug discontinuation (Fig. 3). Particularly, many radiation oncologists (52%, 14/27) stated that they had insufficient ready knowledge to answer the question, but they also regularly mentioned BRAF (30%, 8/27), VEGF(R) (26%, 7/27), EGFR and ALK inhibitors (both 22%, 6/27). Medical oncologists expected a real risk of tumor flare upon discontinuation of BRAF (60%, 6/10) and MEK (30%, 3/10) inhibitors. Pulmonologists primarily expected tumor flare for EGFR (82%, 14/17), ALK (71%, 12/17) and BRAF (41%, 7/17) inhibitors.

Discussion

This study demonstrates a knowledge gap among physicians regarding the implications of combining radiotherapy with targeted agents or immunotherapy in cancer patients. This important issue is regularly faced in clinical practice. Despite the number of patients who are referred for radiotherapy when using targeted therapy or immunotherapy, the amount of information resources and knowledge among physicians and within institutes is often regarded insufficient. The expected toxicity of the combination of specific targeted drugs with radiotherapy varies widely. Furthermore, this study demonstrates the

lack of consensus regarding radiotherapy treatment adaptations. When systemic therapy is continued, the application of adaptations to the radiotherapy dose, fractionation scheme, field size and treatment technique is highly physician-dependent. This, combined with the potential toxicity and the lack of knowledge, stresses the need for the implementation of multidisciplinary guidelines.

During guideline development, all relevant disciplines should be involved, in order to increase quality and acceptance. The different expertise per discipline with regard to radiosensitization and tumor flare is illustrated by the answers shown in Fig. 3. Additionally, the low number of physicians expecting toxicity from the combination with PARP inhibitors, which are known to increase radiosensitivity [30–33], underlines the need for the involvement of experts on the field of radiosensitization. Finally, the guidelines should encompass the radiobiological, preclinical and clinical evidence, along with hands-on recommendations for clinical practice.

Kroeze et al. show similar results among radiation oncologists, concerning the combination of stereotactic body radiotherapy (SBRT) and targeted therapy in German-speaking countries [34]. In their study, consensus was reached regarding the statements that SBRT should not be combined with antiangiogenic agents, BRAF inhibitors and sorafenib, which roughly corresponds to our results [34]. However, in our survey, there was less agreement regarding these drug-radiotherapy combinations. Furthermore, in their study almost no radiation dose reductions were applied, while several respondents in our survey considered radiotherapy treatment adaptations, including dose adaptations. This might be explained by their specific focus on SBRT, while our survey comprised all (heterogeneous) types of hypofractionated radiotherapy, including SBRT. In case of SBRT, there is often an indication for radical treatment, whereas other, often palliative indications for hypofractionated radiotherapy may allow more room for alternative dose-fractionation schemes [34,35]. Additionally, the steep dose gradient of SBRT may allow for better normal tissue sparing, reducing the need for dose reduction [34].

Two other surveys recently evaluated the combination of radiotherapy with immunotherapy [36,37]. As in our study, the vast majority of the radiation oncologists did not adapt the radiation dose when combined with immunotherapy [36] and immunotherapy was regularly continued during radiotherapy [37]. In the survey of Amin et al., radiation oncologists primarily based their treatment decisions on personal or colleagues' experience and on experience with concurrent chemoradiotherapy and radiotherapy [36]. In accordance with our results, this shows that there is a lack of information resources. This is further illustrated by the survey of Kraus et al., where only 29% of the radiation oncologists gave their own knowledge about ICIs a grade higher than 6 on a scale of 1 (very limited knowledge) to 10 (excellent knowledge) [37].

This study has some limitations. The limited size of the study and the varying number of respondents per center limit reliable extrapolation of the results. Also, the lack of consensus regarding the expected toxicity and risk of tumor flare is inevitably influenced by the level or absence of experience with specific drug types. Additionally, by aiming to create a compact survey with clear questions, it was not possible to pay attention to all different aspects influencing clinical decision making, including the radiotherapy target area, the treatment indication and preferences of patients. Furthermore, treatment choices also depend on the indication of radiotherapy. For example, for radical radiotherapy in case of oligometastatic disease, higher toxicity risks might be accepted than for palliative radiotherapy. Nonetheless, for both indications, there are many uncertainties regarding the safety of the combination with targeted therapy or immunotherapy, but the amount of toxicity data for particularly the combination with immunotherapy has increased [24,38].

To conclude, this study clearly illustrates the consequences of the absence of high-quality clinical data and evidence-based clinical guidelines, combined with the clinical complexity of these drug-

radiotherapy combinations. This emphasizes the urgent need to perform clinical studies examining the safety of these combined treatments and to incorporate radiotherapy into phase I-III clinical trials for new targeted drugs and immunotherapy. Furthermore, this study shows that there is a need for multidisciplinary, evidence-based clinical guidelines, encompassing the radiobiological, preclinical and clinical evidence, along with hands-on recommendations for clinical practice.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendices. Supplementary data

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