BOPA Bursary Scheme

ASCO Daily Blog: Day 1

Steve Williamson, BOPA Chair, Consultant Cancer Pharmacist

Friday was the first day of the conference; it's a quieter day giving time for delegates to register and collect their badges so the #BOPA Bursary Group used it to orientate themselves around the McCormack Centre, guided by the Why Health team who are experienced ASCO attenders. We were able to identify the key locations and discuss our plans for capturing and presenting the key data, which is the rationale for the BOPA Bursary Scheme.

Friday was very light on new clinical data, there were a number of educational sessions, although these don't bring any new data of potential value to the teams' CPD. The key sessions that we identified and attended captured myeloma, upper GI and lung. These were poster abstract sessions. For BOPA members who are unfamiliar with how ASCO works it is a huge conference and there are thousands of abstracts published and presented at the conference. Compare this to the BOPA conference where we had a record number 75 poster last year. However, this is to be expected as it is the world's premier oncology conference.

The theme was consolidation of data that we already knew, discussion of early trial results and testing scientific hypothesis. There wasn't a huge amount of new exciting clinical data to share but our team captured and sent them via Twitter. Search #BOPA on Twitter you will be able to go back through and see what the team has been tweeting. We know that tweets are immediate and can quickly get lost, so on the ASCO 2018 section of our website look at the video section and there you will see some video summaries from Calum and Alkis: http://www.bopawebsite.org/ASCO 2018/videos.

Calum and Charlie updated us on the MMY1001 Phase I trial of Carfilzomib + Daratumumab (DARA) + Dexamethasone. As oncology pharmacists we know that Phase 1 data often does not lead to significant advances in therapy that we can see in the clinic. However, Calum and Charlie highlighted the split day dosing regimen for daratumumab which potentially benefits the NHS.
The rest of my myeloma section featured Car-T cell therapy [Car-T], which if you're not already aware of is the next big thing in oncology. However, this is still quite an experimental therapy and currently very expensive. Whilst there is some excellent data suggesting that this can be a game charger, altering the course of the disease, we are still learning. My understanding with Car-T trials have mainly focused on acute lymphoblastic leukaemia (ALL) in both children and adults. It seems to work very well with a third of patients achieving disease remission however we still need long-term data to see how long this lasts. It does not seem to work (initially) in a third of patients and finally the last third of patients it may work very well in, but these patients have significant adverse events and toxicity is leading to prolonged hospital admission.
The big risk is cytokine release syndrome, Calum highlighted the use of tocilizumab (another expensive drug) as an antidote.
The key points for us in the UK is Car-T is going to have a complex commissioning pathway, but we need to make sure that we also fund the antidote.
In Myeloma it seems that there is potential benefit, but I think the conclusion is we need more data and more evidence.

A lot of the rest of Friday focused on patient selection looking at biomarkers in early trials.
The Lung immune therapy biomarker session looked at the combination of ALK TKI plus PD-L1 inhibitors for patients with ALK mutations.
We didn't learn very much, the data had very small patient numbers (12) as this is a very rare mutation; there is little extra benefit and more toxicity and cost. However, this research is something that we should perhaps be grateful is funded, as it would be easy to dismiss this as something that big Pharma would not find worth investing in. It is fantastic to see that there is scientific innovation even if the outcome is slightly predictable; very expensive drug that works very well in small population (ALK inhibitor) so by adding a second very expensive drug you get a marginal benefit, a lot of toxicity – and it's unlikely to be affordable for UK.

The upper GI session looked at the future, so didn't give us any real new data but highlighted some scientific direction, perhaps very predictably, immunotherapies and combination of immunotherapies with the TKI's and/or radiotherapy.

Finally, perhaps the personal highlight of the day was the session Marcus attended @eRxPharmacist and tweeted about, abstract 6501, looking at Patient Reported Outcomes [PROMs] captured via emoji selection in an apple watch app.

The great thing about this is it validated the fact that using digital technology (which is now becoming more common place) to capture patient data is as effective as traditional methods. This could be of interest to oncology pharmacists wanting to engage in practice research and assess patients' views.
I reflected when learning about the bursary team trip through the airport where there were stations with buttons with emoji faces to assess the service we received. So, this type of thing is gradually creeping into our day- to-day lives and becoming something patients will be familiar with, so we must embrace it to improve healthcare outcomes for our patients.

Day two is a lot busier and there is a lot more new data; the team will be attending on the poster presentations (to put this in context we have 75 posters on display at BOPA in each of these clinical streams, ASCO poster sessions have at least 100 posters and this is into subdivisions of disease example, not just breast, but early breast and metastatic etc.). So, there's a lot of content to get through and the team will be tweeting pictures, vlogging and updating our website throughout Saturday evening and into the early hours of Sunday morning.

That's it for now bye from Chicago, Steve