WORKSHOP 1B: Co-medications

CHUM Microbiome Centre

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Case #1 Co-medication

60F, HTN, cardiac disease with stent 2012, normal ejection fraction, COVID that required admission 2020

Med: Amlodipine, Aspirine, Trandolapril, Atrovastatin

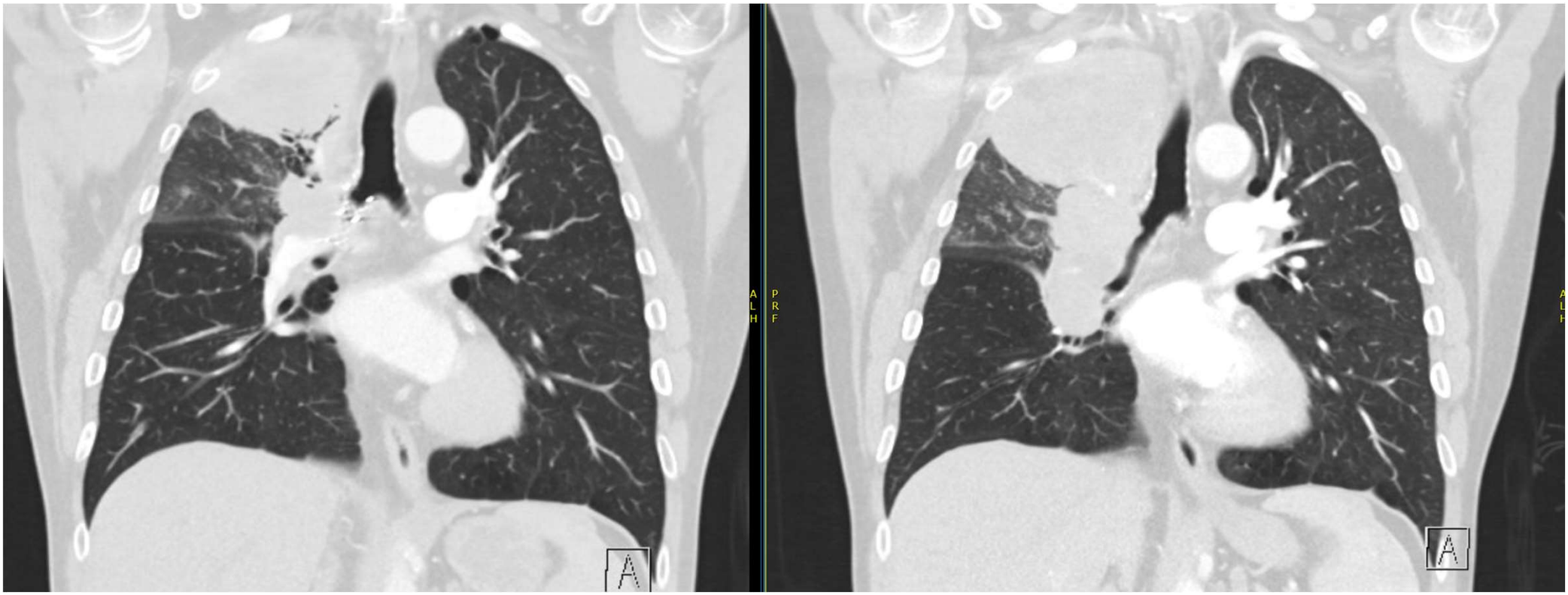
Diagnosed with RUL 9 x 8 x5 cm + mediastinal LN + 6^{th} rib. Biopsy: Adenocarcinoma PD-L1 1-49%, ampliseq focus panel 52 genes was negative

Was seen by oncologist and the decision was to start Cisplatin-Pemetrexed-Pembrolizumab (delay in Montreal 2 weeks)

Case #1 Co-medication

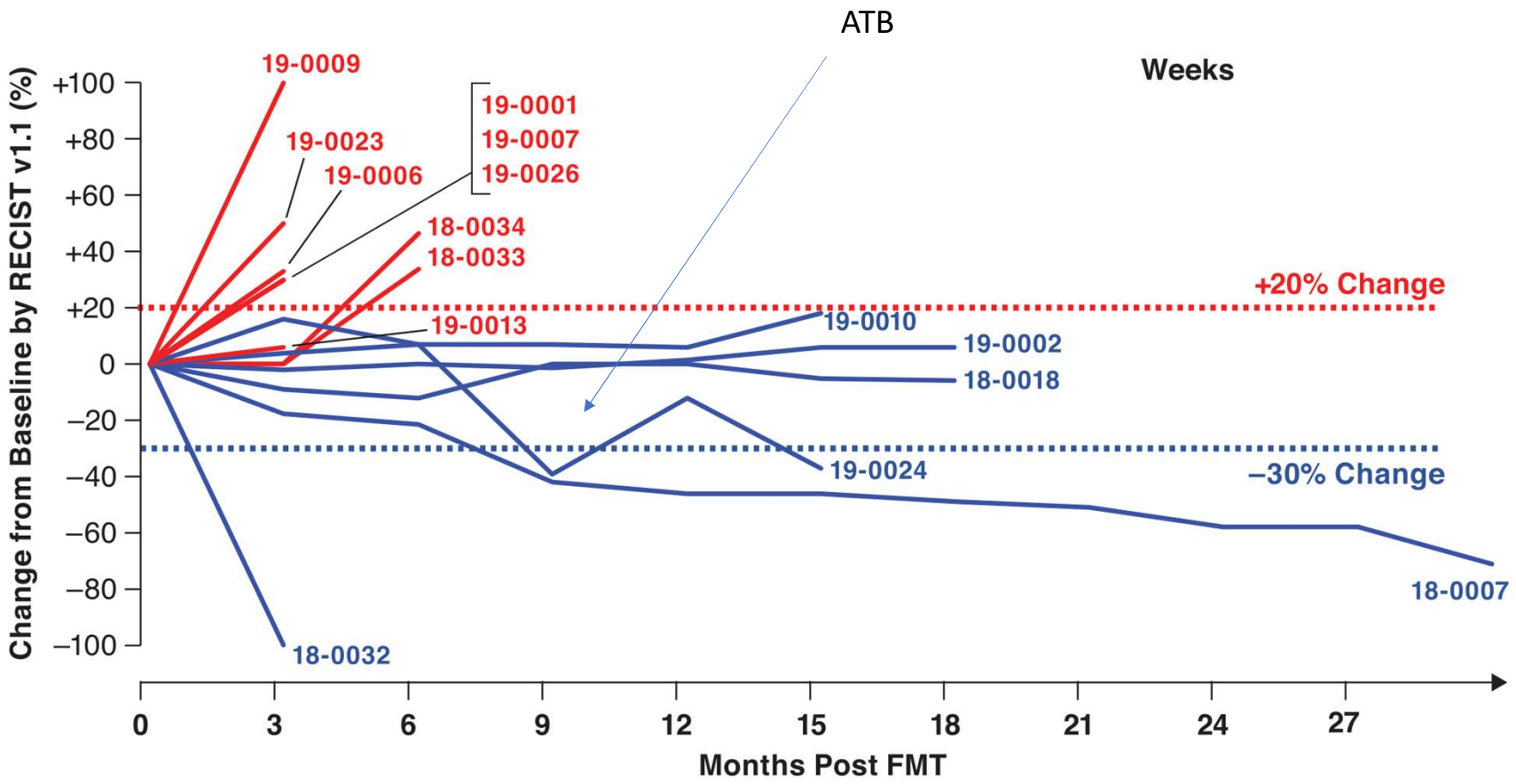
- 5 days later patient calls the nurse to report temperature 38.5
- FSC, Blood culture, COVID, Urine analysis + Xray performed no ATB started immediately
- Urine Analysis + for leukocytes and mild dysuria
- Ciprofloxacin 500 mg po twice daily started for 3 days
- Decision to start treatment 6 days later
- Follow-up scan after 4 cycles

Case #1 Co-medication



CLINICAL TRIALS

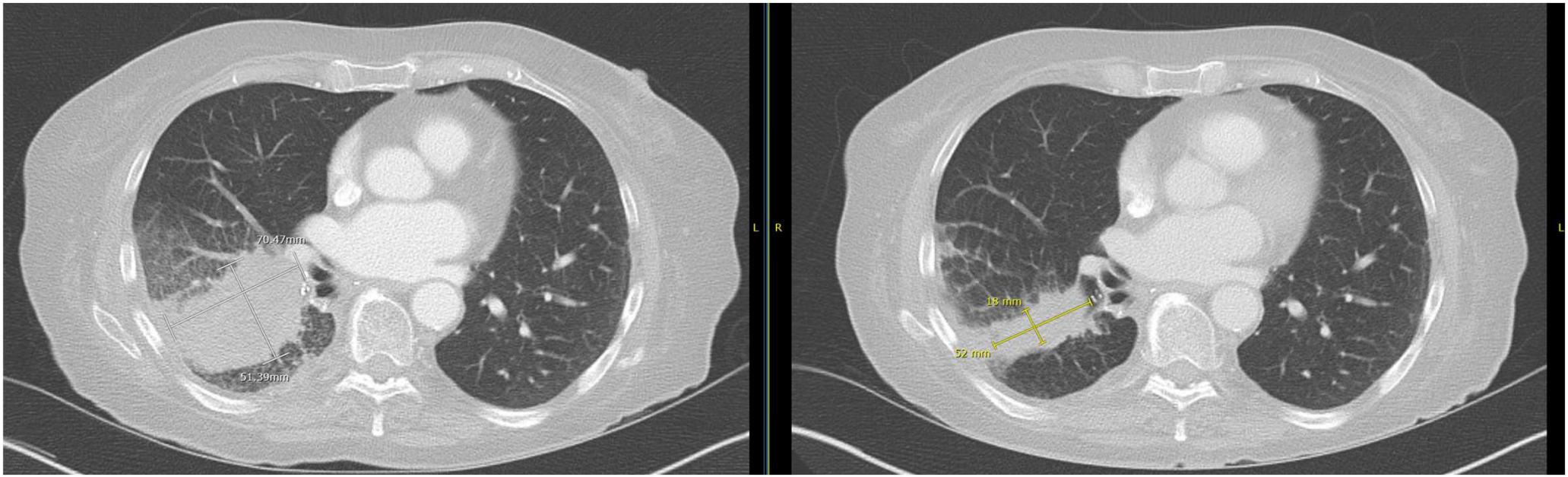
Fecal microbiota transplant overcomes resistance to anti–PD-1 therapy in melanoma patients



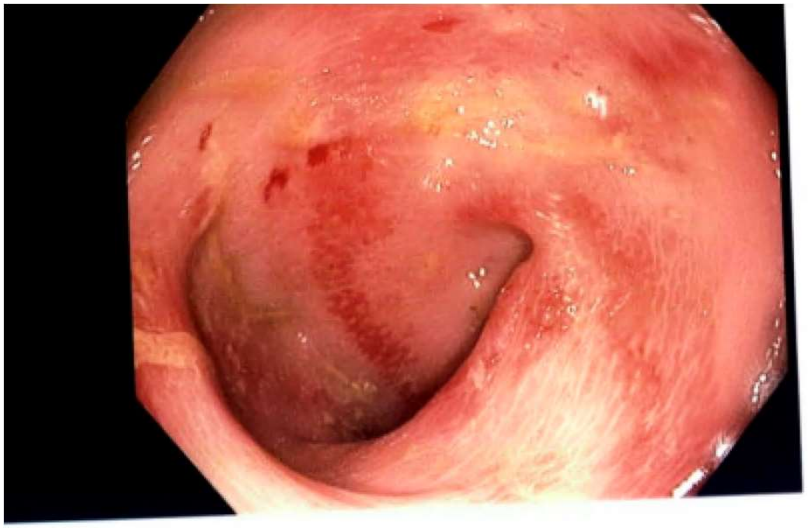
Davar, Science 2021

Case #2 Co-medication

- 60F known for HTN, DM2 on Norvasc and Metformin, ex-smoker 20p/y, no allergy
- Adenocarcinoma T2N0 operated in 2019
- New progression of Right upper lobe 7.5 x 5.2 x 5.3 cm + 2 bone metastases. New biopsy showed adenocarcinoma, PD-L1 1-49%, ampliseq focus panel 52 genes was negative
- Patient started Cisplatin-Pemetrexed-Pembrolizumab, no grade 3 complication


70.47mm
51.39mm
L
R
18 mm
52 mm
L

- Before starting maintenance called nurse with history of 7 diarrhea/day, no temperature, able to drink water
- Investigations: FSC, Electrolytes, C diff, stool culture
- Started on Pred 1mg/kg, then 24 hr later colonoscopy performed



2.1 Colitis
Definition: A disorder characterized by inflammation of the colon
Diagnostic work-up
G2
Work-up of blood (CBC, comprehensive metabolic panel, TSH, ESR, CRP), stool (culture, *Clostridium difficile*, parasite, CMV or other viral etiology, ova and parasite) should be performed
Consider testing for lactoferrin (for patient stratification to determine who needs more urgent endoscopy) and calprotectin (to follow up on disease activity)
Screening laboratories (HIV, hepatitis A and B, and blood quantiferon for TB) to prepare patients to start infliximab should be routinely done in patients at high risk for those infections and appropriately selected patients based on infectious disease expert's evaluation
Imaging (eg, CT scan of abdomen and pelvis and GI endoscopy with biopsy) should be considered as there is evidence showing that the presence of ulceration in the colon can predict a corticosteroid-refractory course, which may require early infliximab
Consider repeating endoscopy for patients who do not respond to immunosuppressive agents; repeating endoscopy for disease monitoring can be considered when clinically indicated and when planning to resume therapy
G3-4
All the work-up listed for G2 (blood, stool, imaging, and scope with biopsy) should be completed immediately
Consider repeating endoscopy for patients who do not respond to immunosuppressive agents; repeating endoscopy for disease monitoring should only be considered when clinically indicated and when planning to resume ICPi

ASCO Guidelines

- Gastroenterologist recommended solumedrol 1 mg/kg IV

Evolution

1. **Improvement after 48 hr**

2. **No improvement after 48 hr**

3. **No improvement after 48 hr + increase LFT**

4. **Rechallenge?**

Evolution

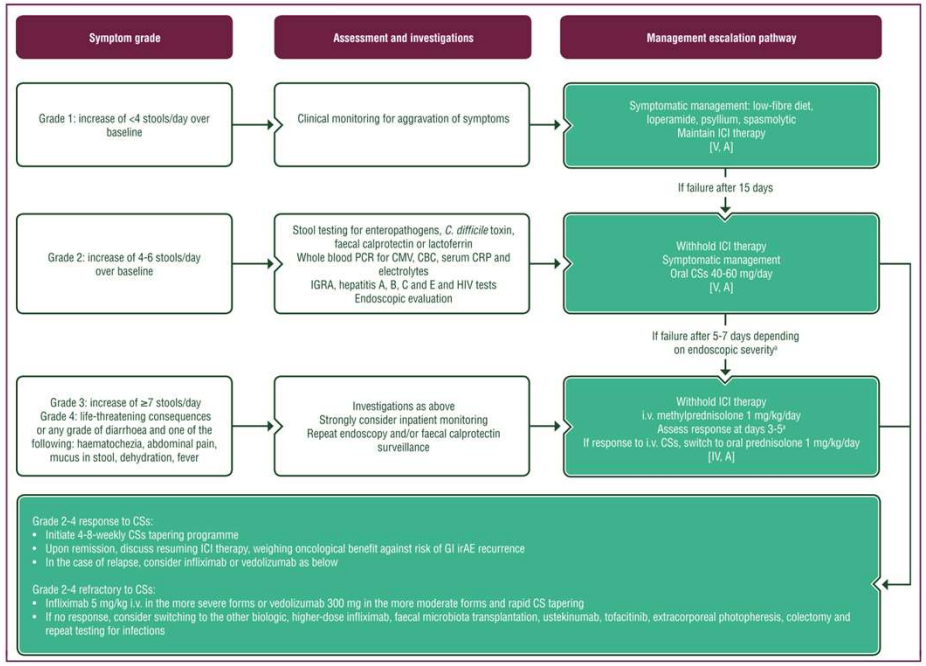
1. Improvement after 48 hr

Switch to prednisone taper 4-6 weeks

Don’t forget PJP prophylaxis

2. No improvement after 48 hr

Infliximab 5 mg/kg IV or Vedolizumab 300 mg



ESMO guideline

3. No improvement after 48 hr + increase LFT

Report of hepatitis with infliximab but need to treat colitis + hepatitis

4. Rechallenge