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LETTER

A Response to Article Anlotinib Hydrochloride and PD-1 Blockade as a Salvage Second-Line Treatment in Patients with Progress of Local Advanced Non-Small Cell Lung Cancer in Half a Year after Standard Treatment [Letter]

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Dear editor

The works performed by Yu et al[1] were much appreciated and brought a novel insight in the use of two types of anti-cancer medications as the proposed option for treatment of the progressive local advanced non-small cell lung cancer (NSCLC). This treatment was suggested to be applied at least 6 months after the standard treatment, the synchronous radiotherapy and chemotherapy, as the second-line treatment substituting the standard second-line chemotherapy, either checkpoint blockade blocker, docetaxel or pemetrexed. The results of the study performed were quite promising, as the median progressive-free survival (PFS); duration from the initial treatment to the disease progression or death, of the monitored patients reached 9–10 months. The resulting PFS in this study was higher than the PFS observed in patients receiving the standard second-line chemotherapy. A previous study by Reck et al[2] had also reported the advantages of a combination of docetaxel, antineoplastic cytotoxic agent with multiple tyrosine kinases and anti-angiogenic chemotherapy agent, nintedanib, which was in the same class chemotherapy with anlotinib, as the second-line therapy after being treated with either chemo- or immunotherapy.

However, a few issues could be questioned. The combination of anlotinib and the PD-1 blockade still caused toxicity or intolerance in a few recruited patients (3.5%).[1] How? There is no information related to the conditions of the intolerances. Since it was mentioned in the article that the patients without brain or liver metastases showed higher PFS that those with, could it be due to the brain or liver metastases that the patients had or occurring in a few patients?[3] Or, could it be the length of treatment period designed and performed in this study? Probably, an explanation regarding this intolerance with a clinical point of view could help the readers better understandi, such as the detection of related markers during the treatment or when the intolerance symptoms started to become observable.[4,5] Even though the toxicity mentioned here was only shown by two patients in this study, this issue still could also be proposed for a further study. In addition, the typical toxicities, explained as treatment-related adverse events, were listed without detailed information of each point, such as the liver, kidney, and thyroid function.[6]

For suggestion only, detailed information related to measurements used for claiming the organ dysfunction could also be explained in the study report, since better and deeper information could be collected to propose any further study. Without this, it will be very unlikely to understand what these therapies combination do and affect, at the molecular level particularly.[7]

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Disclosure

The author reports no conflicts of interest in this communication.

References

1. Yu C, Jiang L, Yang D, Dong X, Yu R, Yu H. Anlotinib hydrochloride and PD-1 blockade as a salvage second-line treatment in patients with progress of local advanced non-small cell lung cancer in half a year after standard treatment. *Onco Targets Ther*. 2022;15:1221–1228. doi:10.2147/OTT.S380615
2. Reck M, Syrigos K, Miliauskas S, et al. Non-interventional LUME-BioNIS study of nintedanib plus docetaxel after chemotherapy in adenocarcinoma non-small cell lung cancer: a subgroup analysis in patients with prior immunotherapy. *Lung Cancer*. 2020;148:159–165. doi:10.1016/j.lungcan.2020.08.004
3. Zhang L, Xiao P, Meng F, Zhong D. STRN-ALK fusion in lung adenocarcinoma with brain metastasis responded well to ensartinib: a case report. *Curr Oncol*. 2022;29(10):6749–6753. doi:10.3390/curroncol29100530
4. Zhou S, Ren F, Meng X. Efficacy of immune checkpoint inhibitor therapy in EGFR mutation-positive patients with NSCLC and brain metastases who have failed EGFR-TKI therapy. *Front Immunol*. 2022;13:1–16. doi:10.3389/fimmu.2022.955944
5. Li Z, Liang N, Wang N, Jia Y, Tian C. WDR5 is a prognostic biomarker of brain metastasis from non-small cell lung cancer. *Front Oncol*. 2022;12:1–7. doi:10.3389/fonc.2022.1023776
6. Adderley H, Blackhall FH, Lindsay CR. Toxicity with small molecule and immunotherapy combinations in non-small cell lung cancer. *Cancer Immunol Immunother*. 2021;70(3):589–595. doi:10.1007/s00262-020-02714-5
7. Yi M, Zheng X, Niu M, Zhu S, Ge H, Wu K. Combination strategies with PD-1/PD-L1 blockade: current advances and future directions. *Mol Cancer*. 2022;21(1):1–27. doi:10.1186/s12943-021-01489-2

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