JOURNAL OF ONCOLOGY PHARMACY PRACTICE

J Oncol Pharm Practice
2021, Vol. 27(4) 1052–1056

DOI: 10.1177/10781552211004680
journals.sagepub.com/home/opp
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Re: Long-term control in a patient with metastatic lung adenocarcinoma after discontinuation of nivolumab

We would like to thank the authors for their keen interest in our case "Long-term response control in a patient with metastatic squamous cell lung cancer after treatment with nivolumab: a case reported" and sharing your experience with us. Effectively, your case is a particular one, since it presented a EGFR mutation and the patient could be treated with both EGFR-TKI and immune checkpoint inhibitors.[1]

We agree with you when you point that it is desirable to refrain from high-dose corticosteroid administration in order to sustain the effects of immunotherapy, especially when side effects can be controlled with other treatments.[2]

It is interesting to observe that both tumor control and side effects persist over the time, as happened to our patient who had to go through surgery for the bilateral ectropion he presented, while the rest of cutaneous toxicities are still evident. In the last computed tomography of February 26, 2021, we checked that the tumor remains in response, observing a lesion with a residual aspect in both pulmonary vertices without changes in appearance or size. Our patient is asymptomatic at this time, maintaining a durable response after 2 years and 8 months of discontinuation of nivolumab due to immune-related skin toxicities.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Long-term control in a patient with metastatic lung adenocarcinoma after discontinuation of nivolumab

To the Editor,

We read with interest the article by Pampín-Sánchez et al. (Oct 2020) on long-term response control in a patient with metastatic squamous cell lung cancer after treatment with nivolumab.[1] We would like to share our experience. We treated the case of a 73-year-old male diagnosed with EGFR-mutated metastatic adenocarcinoma of the lung, who was treated with nivolumab after EGFR-TKI. After discontinuation of nivolumab, due to grade 3 hypothalamic toxicity, the patient is maintaining with durable partial response for more than two year with close follow-up. Hydrocortisone was given for replacement, but no high doses of steroids were prescribed. Thereafter, the patient developed regrowth of the primary lesion, and he was successfully treated with erlotinib for two years. The patient is well 6 years from the diagnosis of lung adenocarcinoma.

The common point in the patient treated by Pampín-Sánchez et al. and in our patient was that a long-term control of lung cancer without recurrence despite of discontinuation of nivolumab due to adverse