So I would like to invite Dr. Avikrishna for moderating the next session which is the
CNS and I would like to invite the panelists Dr. Nalini Maynan, Dr. Anshu Vardai, Dr.
Rakhajal Arisar is online and Dr. Bikar, Ms. Arisar is also online.
Dr. Arvadinsar and Kumar sir you want to add something your expert comment on this.
Yeah, so good evening everyone and thank you Vijeser for giving me this opportunity.
So I will just quickly brief the case.
So he is a 26 year old male who has no comorbidities and with an eco performance status
of 1 and diagnosed with case of right frontal gbm and IDH was wild type and then initially
patient underwent surgery with gross tumor resection and after that adjuvant RT along
with the Tmozalamide has been given and which has been followed by the adjuvant emozalamide
and within 3 months patient has developed progression and at this point of time patient underwent
NGS and there is a mutation in the TP53 for Albi 2, RAT50, Poly mutation and MLH1 and
MLH3 are positive.
So considering this because patient has been progressed on adjuvant emozalamide started
on Lomestin along with the vivarcysmap and patient took this Lomestin place vivarcysmap
for almost like 9 months and after that again patient had progressive disease and
then because of the mutation status based on the NGS patient has been started on ollapary
plasmeralizumab but within a short duration of time within 2 months patient again got
developed progressive disease but the performance status of the patient is very preserved the
PFC is 1.
So the question to the like none of you know was like is it common in our day to day practice
to have this course like patient with gbm progressing within 6 months and 9 months.
So it is not it is quite common even in the trial setting the median survival with the
addition of Tumozalamide to RAT was around it increased by 3 to 4 months to around 14
to 18 months.
So it is not uncommon to see this kind of a scenario so we do have patients I mean not
all but about 32 around 20 to 30 percent may be these early progresses.
So whereas in case of the recurrent cases is it uncommon to have this progression free
survival of 4 months or 6 months in the recurrent setting so in the day to day clinical
practice is it common to have a progression free survival of 4 months 6 months or you
are seeing patient more than 1 year or 2 years like that.
Yeah it is possible but it is very rare but it is IDH wild types usually the prognosis
is better with IDH mutant types.
Yeah so exactly the data also these are the NCCN guidelines in the recurrent relapse setting
the systemic therapy options available or either Bewa ancyzemap or combination of Tumozalamide

plus Bewa cyzemap or Karmestin or Lomastin along with the Bewa cyzemap.
If you look at the data so these are the treatments which are all available in the recurrent setting
and if you look at the response rates on the median progression free survival it is hardly
4 months and 4 to 4.5 months and even if you look at the overall survival data it is hardly
like 9 months.
So yes this case scenario is not uncommon and even the data also bags this and we routinely
see this kind of presentation in our day to day practice.
So in such settings so what exactly we should do when all the NCCN options has been exhausted
and there are no other treatment options available and then even if the patient performance status
is good so what are all options we can consider is the next question.
So I will just show you some data and then I will take the panelist opinion.
So there is an EGFR V8 expression in about 30% of the newly diagnosed GBM cases and in
patients surviving a year or longer the expression is thought to be negative prognostic indicator.
So a single dose infusion of this EGFR V3 directed CAR-T has been studied and it was
studied in almost 10 patients and the response is happened in all the patients and if you
see the response it was not sustained in all the patients.
Only one patient the response was sustained almost for like 450 days.
So rest of all the patients the response was not sustained and if you look at the median
overall survival it is hardly like 250 days but the point we should remember in this study
was these are not the up front cases.
Out of 10 patients one patient is in second line, four patients are in third line and
four more patients are in fourth line.
So patients in the third line and fourth line achieving a median survival of nine months
is like a significant number.
Similarly there is an interventricular CAR-T also which has shown the similar data and
there is another Markle-Korla's interleukin 13 R alpha 2.
Initially they have studied the bioactivity and safety of this interleukin 13 R alpha
CAR-T and what they have noted was after infusion of these interleukin 13 R alpha CAR-T into
intra-cavitatorily and they have noted the expression of this CAR-T in the tumour tissue
and what they have found was almost like 40% to 70% expression is noted in the tumour
tissue and they have conducted a study the response can has been done.
So there is necrotic component of the tissue has significantly increased and there is
not tumour at the primary side which indicates the therapeutic response.
So similarly the low-corrhizional delivery of these CAR-T cells has shown significant
benefit in the recurrent high-grade tumour.
It is a phase one trial but the point to be noted was all of the patients were post-surgery,
RT and Tymozolomide and many patients has received Bewess's map and more than one

third
of the patients were post-third recurrence and if you look at the survival graphs and
it is almost the median overall survival for this patient is 10-1.
So what I am trying to highlight was like if the patient has completed all the treatment
options though the patient is in third line or fourth line.
There also if you consider this kind of therapies the median survival is like in the range of
9 to 10 months which is hardly we will achieve with the conventional therapies especially
in case of the GBM.
So similarly there is a combination data for EGFR and interleukin 30 which is unfortunately
a negative study.
Similarly, the HER2 target is also there.
Here we have achieved an objective response rate of almost like 50 percent and the last
thing that if you look at the diffuse midline glioma where surgery is also not feasible
the hardly the survival range from 8 to 11 months and in such cases also with the help
of CAR-T they have noted the median survival up to 18 to 20 months.
So these are all phase one data I know but considering all these data if all the NCCN
options are exhausted will you consider that patient if there are no financial toxicity
for a CAR-T.
My question to the back.
So this patient has actually exhausted everything and whatever other trials agents that have
been tried in glioblastoma have been negative like immune check bond inhibitors anti-EGFR
vaccines which have failed so we know.
So in this kind of a patient this phase one is very promising and EGFR variant 3 is a
specific target to glioblastoma.
So if the patient is PS1 and 26 years old yes I would refer him for a clinical trial
for cellular therapy CAR-T if he can get an access I think that would be great because
all the alkylators bev everything has failed and he doesn't have a BRAF V600D mutation
which is seen in about 2 to 3 percent so if that was the order prefer to target the BRAF
first and then send to for a CAR-T maybe but in this case since it's not there and we
have exhausted standard therapy probably this would be the way to go.
Sir your opinion sir.
I think this is purely a oncological topic so I think yes.
So Kumar sir I would like to hear from you any opinion or any difference of thoughts.
Sir.
Sir.
Sir.
Sir.
Sir.
See I think so we come across this situation multiple times in oncology and multiple tumors

where you have those routine treatment which we fail and then we invoke this that you have
those treatment used in certain in this setting or certain setting which is safer and we invoke
and we do use that so you know yes you know if we have some data looks promising we won't
mind invoking that in all in fact if I ask you might be doing the practice so beyond second
line there's hardly any drug which has a label to be used in third line and beyond
and in many tumors like now we are using lung also over he used to do a lot breast cancer
used to do a lot four, five, six, seventh line therapy so yes one can invoke that see that
patient safety is ensured and yes one can use.
Yes thank you sir thank you so much and that's it from my said and thank you bandlist for it.