


Combined immunotherapy for renal-cell carcinoma (RCC) in geriatric patients

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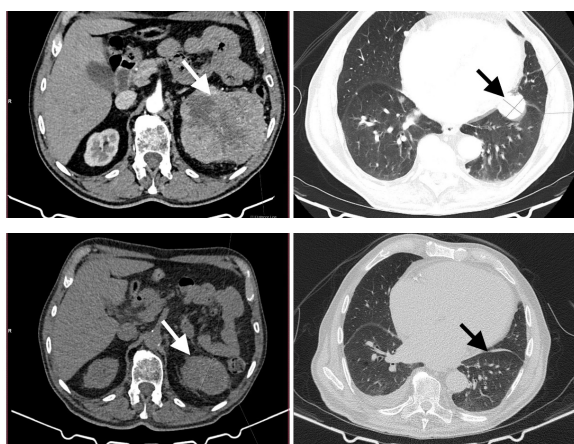


Figure 1. A baseline CT revealed a 96-mm-sized primary tumor in the left kidney and a metastatic tumor in the left lung (A, B). The best overall response with reduction in diameter in both target lesions (C, D)

Combined immunotherapy with nivolumab and ipilimumab has become the standard first-line therapy for intermediate and poor-risk patients with RCC specifically those with clear cell (ccRCC) and sarcomatous components. However, in a pivotal CheckMate 214 trial [1], the median age was 62, and patients 65 years did not benefit. An octogenarian patient with ccRCC presented to our Unit. A CT confirmed the disease stage as cT3aN1M1 (fig. 1 A, B). The patient was unsuitable for nephrectomy due to biological age and advancement of the disease. According to the prognostic criteria of the IMDC [2], the patient fell into the inter-

mediate-risk group (time from diagnosis to treatment <1 year and KS <80%). He was qualified for combined immunotherapy, adhering to the criteria of the National Drug Program (NDP). The initial treatment cycles were well-tolerated, with no significant treatment-related adverse events (trAEs). The CT scan performed after 4 cycles of nivolumab (3 mg/kg every 3 weeks) and ipilimumab (1 mg/kg every 3 weeks), revealed PR per the iRECIST criteria. Subsequently, the patient experienced general malaise (G1 CTCAE), kidney injury (G2), and hepatotoxicity (G2), which did not preclude the continuation of maintenance monotherapy with nivolumab (480 mg every 4 weeks per protocol). These trAEs were successfully managed with treatment interruption. In summary, the patient received 11 cycles (4 in combination and 6 in monotherapy) with stable disease per iRECIST in the last CT scan (fig. 1 C, D). This case highlights that chronological age alone should not be a direct contraindication for combined immunotherapy, as it may offer improved outcomes with manageable trAEs also in the elderly population.

References

1. Motzer RJ, McDermott DF, Escudier B, et al. CheckMate 214 investigators, CheckMate 214 Investigators. Nivolumab plus ipilimumab versus Sunitinib in Advanced Renal-Cell Carcinoma. *N Engl J Med.* 2018; 378(14): 1277–1290, doi: 10.1056/NEJMoa1712126, indexed in Pubmed: 29562145.
2. Heng DY, Xie W, Regan MM, et al. External validation and comparison with other models of the International Metastatic Renal-Cell Carcinoma Database Consortium prognostic model: a population-based study. *Lancet Oncol.* 2013; 14(2): 141–148, doi: 10.1016/S1470-2045(12)70559-4, indexed in Pubmed: 23312463.

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