Successful erlotinib rechallenge for leptomeningeal metastases of lung adenocarcinoma after erlotinib-induced interstitial lung disease: a case report and review of the literature.

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Lung cancer (Amsterdam, Netherlands) (2012), 77(2): 464-468

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Successful erlotinib rechallenge for leptomeningeal metastases of lung adenocarcinoma after erlotinib-induced interstitial lung disease. A case report and review of the literature

Authors:

Yosuke Togashi *, Katsuhiro Masago, Yasuhiro Hamatani, Yuichi Sakamori, Hiroki Nagai, Young Hak Kim, Michiaki Mishima

Department of Respiratory Medicine, Graduate School of Medicine, Kyoto University, 54 Shogoin-Kawaharacho, Sakyo-ku, Kyoto 606-8507 Japan

Grant support: none

* Corresponding author:

Yosuke Togashi, M.D.

Department of Respiratory Medicine, Graduate School of Medicine, Kyoto University, 54 Shogoin-Kawaharacho, Sakyo-ku, Kyoto 606-8507 Japan.

Tel: +81-75-751-3830; Fax: +81-75-751-4643
18 E-mail: ygashi@kuhp.kyoto-u.ac.jp

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Abstract

The most serious adverse reaction associated with treatment with epidermal growth factor receptor-tyrosine kinase inhibitors (EGFR-TKIs) is drug-induced interstitial lung disease (ILD). Because EGFR-TKIs are key drugs for patients with non-small cell lung cancer who have somatic activating mutations of the epidermal growth factor receptor gene (*EGFR* mutations), several cases of retreatment with EGFR-TKIs after ILD induced by these drugs have been reported. Here, we present a 68-year-old man with lung adenocarcinoma and leptomeningeal metastases having an *EGFR* mutation who was retreated with erlotinib after erlotinib-induced ILD. He suffered no ILD recurrence and his leptomeningeal metastases dramatically improved. In addition to the present case, reports of nine patients who were retreated with EGFR-TKIs after ILD were found in the literature. Only one patient had recurrence of ILD (although seven were retreated at a reduced dose of EGFR-TKIs, including the patient with recurrence). In contrast, three patients had no recurrence of ILD even without dose-reduction. These reports suggest that dose-reduction plays a limited role in preventing recurrence. Many patients received corticosteroids during retreatment, but not the one with recurrence of ILD. This may suggest that corticosteroids can prevent recurrence due to their
antiinflammatory properties.

Key words: epidermal growth factor receptor tyrosine kinase inhibitor, gefitinib, erlotinib, interstitial lung disease, rechallenge, epidermal growth factor receptor gene mutation, leptomeningeal metastases
1. **Introduction**

Because patients with non-small cell lung cancer (NSCLC) who have somatic activating mutations of the epidermal growth factor receptor (EGFR) gene ($EGFR$ mutations) generally respond to EGFR-tyrosine kinase inhibitors (EGFR-TKIs; gefitinib or erlotinib) and can achieve long-term progression-free survival, the presence of $EGFR$ mutations is a very useful marker for facilitating the choice of treatment for NSCLC [1-7]. Although systemic chemotherapy for leptomeningeal metastasis (LM) has been thought to play a limited role because of the belief that the brain is a pharmacologic sanctuary site, several studies have documented the effectiveness of EGFR-TKIs in the treatment of LM of NSCLC with $EGFR$ mutations [8-10].

The most common adverse events associated with treatment with EGFR-TKIs are rash and diarrhea [11, 12]. Although not too frequent, the most serious adverse reaction is drug-induced interstitial lung disease (ILD) [13-16]. Because EGFR-TKIs are key drugs for patients with NSCLC having $EGFR$ mutations, several cases of drug rechallenge after ILD induced by EGFR-TKIs have been reported. Here, we present a case report of a 68-year-old man with lung adenocarcinoma and LM having an $EGFR$
mutation who received erlotinib retreatment after erlotinib-induced ILD. No evidence of ILD recurrence was seen, and his LM dramatically improved. We also review the relevant published literature in this topic.

2. Case presentation

A 68-year-old Japanese man with a 40 pack-year history of smoking was diagnosed with stage IV lung adenocarcinoma (bone metastases). After one cycle of carboplatin plus pemetrexed as first-line cytotoxic chemotherapy, he suffered fatigue and electrolyte abnormality (both grade 3) as complications and elected to discontinue these drugs chemotherapy. EGFR mutational analysis revealed an exon 20 point mutation (L858R), and he therefore started erlotinib at 150 mg daily. Although he achieved a partial response (Fig 1A and 1B), he had cough and dyspnea on effort 8 weeks after initiation of erlotinib therapy. Chest computed tomography (CT) showed bilateral air space consolidations (Fig. 1C). Bronchoalveolar lavage (BAL) fluid contained no malignant cells and no pulmonary pathogens including bacteria, fungi, and Pneumocystis were identified. The fraction of lymphocytes in BAL fluid was
increased to 60%. Therefore, erlotinib-induced ILD (organized pneumonia [OP] pattern) was strongly suspected. Erlotinib was discontinued and 30 mg daily prednisolone (PSL) was initiated. Symptoms and bilateral consolidations in the CT improved, and PSL was gradually tapered to 5 mg (Fig. 1D).

After cessation of erlotinib, he had received no treatment for 6 months because his lung cancer did not progress and he refused any further treatment. However, after 6 months without treatment, he had headache and impaired consciousness, and his Eastern Cooperative Oncology Group performance status (ECOG PS) deteriorated to 2. Cerebrospinal fluid (CSF) testing revealed the presence of malignant cells and he was diagnosed with LM. He refused any cytotoxic chemotherapy; instead administration of 250 mg daily gefitinib and 4 mg daily betamethasone in addition to whole brain radiotherapy was initiated. His symptoms and CSF test, however, worsened, and his ECOG PS deteriorated to 4. The patient requested erlotinib retreatment despite the risk of ILD, so we initiated administration of 150 mg daily erlotinib together with 4 mg betamethasone. Soon after initiation of erlotinib, his symptoms dramatically improved and ECOG PS improved to 1. Both his CSF test and brain magnetic resonance imaging also improved (Fig. 2). His LM has not worsened for 8 months of erlotinib rechallenge.
During the period, betamethasone was gradually tapered to zero and ILD recurrence has not been observed.

3. Literature review

In addition to the present case, a literature search identified a total of nine cases who received EGFR-TKI retreatment after ILD induced by these drugs (Table 1) [17-24]. Three received gefitinib after gefitinib-induced ILD [17, 18, 24], 5 were treated with erlotinib after gefitinib-induced ILD [19-22], and the remaining one (two including the present case) received erlotinib after erlotinib-induced ILD [23]. Two patients were Asians and the other reports were also from Asia, but the ethnicity of the patients was not stated. Six patients were never-smokers and many had severe ILD as revealed by bilateral diffuse ground glass opacities (GGO) on CT. ILD of all patients went into remission on cessation of EGFR-TKIs and initiation of corticosteroid therapy. Two patients (cases 2 and 10 in Table 1) could not be given any chemotherapy other than EGFR-TKIs due to their poor PS. Although the others were fit enough to receive chemotherapy, they requested EGFR-TKIs again instead. During the EGFR-TKI
rechallenge, only case 3 suffered recurrence of ILD. Seven patients were retreated with
a lower dose of EGFR-TKIs including case 3 who nonetheless recurred. In contrast,
cases 5, 6, and 10 had no recurrence in spite of receiving 150 mg daily erlotinib. Many
patients were given corticosteroids during EGFR-TKI rechallenge, but not case 3.
However; case 2 also received no corticosteroids but did not recur.

4. Discussion

In this article, we presented a case of successful erlotinib rechallenge for LM after
erlotinib-induced ILD and have summarized previous similar reports (Table 1).
Although nine of these ten cases successfully rechallenged with EGFR-TKIs without
the recurrence of ILD, most of the cases that do suffer recurrence might simply not be
reported. Therefore, the risk of ILD should be considered whenever reinitiating
EGFR-TKI treatment after ILD induced by these drugs. Eight of these ten cases could
have received other chemotherapies, but the patients requested EGFR-TKI therapy
again despite their awareness of the risk of ILD. This was permissible because the
efficacy of EGFR-TKIs was predicted from EGFR mutations or previous tumor
response. Our case (case 10 in Table 1) was not eligible for other chemotherapy due to
his poor PS, and the treatment of choice remained erlotinib or best supportive care.

Several cases in which LM resistant to gefitinib were improved by erlotinib due to its
higher CSF concentration have been reported [25-27] and ILD with an OP pattern on
CT seems to be associated with good prognosis [28]. Therefore, we used 150 mg daily
erlotinib because of its expected clinical benefit and efficacy despite the risk of ILD.

Seven patients were retreated with lower doses of EGFR-TKIs. Three received a
lower dose of erlotinib after gefitinib-induced ILD. However, the area under the curve
(AUC) of serum concentration of erlotinib at the approved dose (150 mg daily) is 7
times larger than gefitinib at the approved dose (250 mg daily) [29]. Therefore, in
spite of dose-reduction, higher AUC could be achieved by erlotinib than gefitinib in
these patients. In addition, case 3 had recurrence of ILD despite dose-reduction, and
three cases (cases 4, 5, and 10) had no recurrence of ILD although they received 150
mg daily erlotinib. From these findings, we speculate that blockade of the EGFR
signaling pathway by EGFR-TKIs is not necessarily associated with the occurrence of
ILD and that EGFR-TKI dose-reduction plays only a limited role in preventing
recurrence.
Dallas et al. have reported a similar case of successful erlotinib rechallenge after erlotinib-induced ILD (case 9). As with the case reported here, that patient had also received erlotinib retreatment together with corticosteroid after erlotinib-induced ILD. Many cases were also given corticosteroids together with the EGFR-TKIs, resulting in clinical benefit. In contrast, case 3 had recurrence of ILD without administration of corticosteroid. This is consistent with the general use of corticosteroids for treating drug-induced ILD [30, 31]. Thus, corticosteroid can prevent the recurrence of ILD, probably because of its antiinflammatory action.

Six patients were never-smokers and CT finding of many patients revealed bilateral diffuse GGO. We can predict the recurrence of ILD from these factors. In fact, a previous report has shown that smoking status is one of the risk factors for ILD [14]. In contrast, another report has shown that the incidence of the bilateral GGO pattern on CT was relatively high and that such patients have high mortality rate [28]. Therefore, great caution is required when undertaking rechallenge in these patients.

The mechanism responsible for ILD induced by EGFR-TKIs remains unclear and several instances of successful EGFR-TKI rechallenge after ILD have been reported, as described above. EGFR-TKIs are key drugs for patients with NSCLC having EGFR
mutations. Therefore, rechallenge after ILD should be undertaken considering the balance between risk and benefit. This present case had an EGFR mutation and was not eligible for other chemotherapy due to his poor PS. Therefore, the treatment of choice remained erlotinib or best supportive care. Although he recognized the risk of ILD, he requested erlotinib retreatment, and this was successful. From these findings, we suggest 3 criteria before deciding on EGFR-TKI rechallenge after ILD: a) The patient has an EGFR mutation. b) Few other treatment options except EGFR-TKI remain. c) The patient recognizes the risk of ILD and makes an informed decision to go ahead with the rechallenge. In order to assess the safety and the risk of this approach, more similar cases including other ethnicities need to be accumulated and, if ethically possible, prospective studies in patients who meet these criteria should be performed are required.
Conflict of interest statement

None declared.


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Figure 1. Chest computed tomography (CT) in a 68-year-old man. A: CT scan before erlotinib treatment showing a mass in the left upper lobe. B, C: CT scan 10 weeks after initiation of erlotinib treatment showing a decreased mass (B), but visible bilateral air space consolidations (C). D: Eight weeks after cessation of erlotinib and initiation of corticosteroid, showing improvement of the bilateral air space consolidations.

Figure 2. Brain magnetic resonance imaging (MRI). A: Contrast (gadolinium)-enhanced T1-weighted MRI during gefitinib treatment before erlotinib rechallenge, revealing leptomeningeal metastases (arrowheads). Patient performance status (PS) had deteriorated to 4. B: Two weeks after the initiation of erlotinib, showing improvement of the leptomeningeal metastases. PS also improved to 1.
Table 1. Patient characteristics

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (yr)</th>
<th>Sex</th>
<th>Ethnicity</th>
<th>EGFR status</th>
<th>Smoking status</th>
<th>Onset of ILD</th>
<th>Cause of ILD (dose)</th>
<th>CT of ILD</th>
<th>Respiratory condition</th>
<th>Treatment for ILD</th>
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<tbody>
<tr>
<td>1</td>
<td>62</td>
<td>F</td>
<td>NA</td>
<td>Ad</td>
<td>NA</td>
<td>Never</td>
<td>13 months</td>
<td>Gefitinib (125 mg/day)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2</td>
<td>56</td>
<td>M</td>
<td>NA</td>
<td>Ad</td>
<td>Exon 21; L858R</td>
<td>15 pack-year</td>
<td>45 days</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>Severe</td>
</tr>
<tr>
<td>3</td>
<td>59</td>
<td>M</td>
<td>NA</td>
<td>Ad</td>
<td>Wild type</td>
<td>60 pack-year</td>
<td>23 days</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>PaO₂, 46.9 mmHg</td>
</tr>
<tr>
<td>4</td>
<td>28</td>
<td>F</td>
<td>NA</td>
<td>Ad</td>
<td>Exon 19 deletion</td>
<td>Never</td>
<td>28 days</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>Need nasal oxygen</td>
</tr>
<tr>
<td>5</td>
<td>62</td>
<td>M</td>
<td>NA</td>
<td>Ad</td>
<td>Exon 19 deletion</td>
<td>18 pack-year</td>
<td>24 days</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>Severe</td>
</tr>
<tr>
<td>6</td>
<td>62</td>
<td>M</td>
<td>NA</td>
<td>Ad</td>
<td>NA</td>
<td>Never</td>
<td>6 weeks</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>Oxygen saturation, 84%</td>
</tr>
<tr>
<td>7</td>
<td>77</td>
<td>F</td>
<td>NA</td>
<td>Ad</td>
<td>NA</td>
<td>Never</td>
<td>7 weeks</td>
<td>Gefitinib (250 mg/day)</td>
<td>Diffuse GGO</td>
<td>Oxygen saturation, 93%</td>
</tr>
<tr>
<td>8</td>
<td>41</td>
<td>F</td>
<td>NA</td>
<td>Ad</td>
<td>NE</td>
<td>Never</td>
<td>20 days</td>
<td>Gefitinib (250 mg/day)</td>
<td>Patchy air space consolidation</td>
<td>Cessation and corticosteroid</td>
</tr>
<tr>
<td>9</td>
<td>77</td>
<td>F</td>
<td>Asian</td>
<td>Ad</td>
<td>Exon 19 deletion</td>
<td>Never</td>
<td>5 weeks</td>
<td>Erlotinib (150 mg/day)</td>
<td>Diffuse GGO</td>
<td>PaO₂ &lt; 45 mmHg</td>
</tr>
<tr>
<td>10</td>
<td>68</td>
<td>M</td>
<td>Asian</td>
<td>Ad</td>
<td>Exon 21; L858R</td>
<td>40 pack-year</td>
<td>8 weeks</td>
<td>Erlotinib (150 mg/day)</td>
<td>OP pattern</td>
<td>PaO₂, 78.6 mmHg</td>
</tr>
</tbody>
</table>

F, female; M, male; EGFR, epidermal growth factor receptor gene; ILD, interstitial lung disease; CT, computed tomography; GGO, ground glass opacity; OP, organized pneumonia; PaO₂, arterial oxygen pressure; NA, not available; NE, not evaluated.

*The ethnicity of eight cases was not available, but all reports were from Asia.

*Gefitinib was administered every other day due to blepharitis.

*Case 1 had alveolar hemorrhage.

*There was no description of actual PaO₂ or oxygen saturation in Cases 2, 4 and 5. But Cases 2 and 5 had severe ILD and Case 4 needed nasal oxygen supplementation (1 L/minute). Case 9 was supported by mechanical ventilation.
<table>
<thead>
<tr>
<th>Case</th>
<th>ECOG PS (symptoms)</th>
<th>Period between EGFR-TKIs</th>
<th>Rechallenge (dose)</th>
<th>Corticosteroid during rechallenge</th>
<th>Recurrence of ILD</th>
<th>Response of initial/rechallenge</th>
<th>References</th>
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<tr>
<td>1</td>
<td>1</td>
<td>12 months</td>
<td>Gefitinib (125 mg/day)</td>
<td>NA</td>
<td>No</td>
<td>SD/SD</td>
<td>[17]</td>
</tr>
<tr>
<td>2</td>
<td>NA (Severe dyspnea and confined to bed)</td>
<td>5 months</td>
<td>Gefitinib (125 mg/day)</td>
<td>No</td>
<td>No</td>
<td>PR/PR</td>
<td>[18]</td>
</tr>
<tr>
<td>3</td>
<td>NA (General fatigue)</td>
<td>3 months</td>
<td>Gefitinib (Intermittent)</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>[19]</td>
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<tr>
<td>4</td>
<td>NA (Dyspnea)</td>
<td>4 months</td>
<td>Erlotinib (50 mg/day)</td>
<td>Yes → tapered</td>
<td>No</td>
<td>PR/PR</td>
<td>[20]</td>
</tr>
<tr>
<td>5</td>
<td>NA (Neurological symptoms)</td>
<td>3 months</td>
<td>Erlotinib (150 mg/day)</td>
<td>NA</td>
<td>No</td>
<td>NA/PR</td>
<td>[21]</td>
</tr>
<tr>
<td>6</td>
<td>NA</td>
<td>6 days</td>
<td>Erlotinib (150 mg/day)</td>
<td>Yes</td>
<td>No</td>
<td>PR/PR</td>
<td>[22]</td>
</tr>
<tr>
<td>7</td>
<td>NA</td>
<td>6 weeks</td>
<td>Erlotinib (100 mg/day)</td>
<td>Yes</td>
<td>No</td>
<td>PR/PR</td>
<td>[22]</td>
</tr>
<tr>
<td>8</td>
<td>NA</td>
<td>NA (about 6 months)</td>
<td>Erlotinib (75 mg/day)</td>
<td>Yes → off</td>
<td>No</td>
<td>PR/PR</td>
<td>[23]</td>
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<tr>
<td>9</td>
<td>NA</td>
<td>10 days</td>
<td>Erlotinib (100 mg/day)</td>
<td>Yes → off</td>
<td>No</td>
<td>PR/NA</td>
<td>[24]</td>
</tr>
<tr>
<td>10</td>
<td>4 (Impaired conscious)</td>
<td>7 months</td>
<td>Erlotinib (150 mg/day)</td>
<td>Yes → off</td>
<td>No</td>
<td>PR/PR</td>
<td>Present case</td>
</tr>
</tbody>
</table>

ECOG PS, Eastern Cooperative Oncology Group Performance Status; EGFR-TKI, epidermal growth factor receptor-tyrosine kinase inhibitor; SD, stable disease; PR, partial response.

Gefitinib was administered every other day.

Gefitinib (250 mg daily) was administered for 7 days followed by 2 weeks rest.