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A melanoma breakthrough? Too soon to tell.

By ACSH Staff — June 1, 2015

Today s New York Times features a story [1] on a topic we have discussed frequently very expensive cancer drugs that provide only a modest benefit to most patients, but maybe a large benefit to some.

ACSH s Dr. Josh Bloom, wrote about this issue in a 2013 New York Post op-ed [2]: Pfizer s Inlyta, which was approved to treat advanced kidney cancer, provides patients with 6.7 months of progression-free survival time, as opposed to 4.7 months for those on conventional chemotherapy. Inlyta costs about $11,000 per month. Doesn t sound like such a great deal.

Indeed, the bar is set much lower for cancer treatments, since, for many patients, this is their last hope. Today s *Times* article addresses this. In particular, a study, which was presented at the ongoing American Society of Clinical Oncology (ACSO) meeting in Chicago, and is published online [3], found that in the case of advanced melanoma, two drugs both immunotherapies from Bristol-Myers Squibb work better than one. But not by much.

The combination of Opdivo and Yervoy provided patients with advanced melanoma with 11.5 months without the disease worsening, while either drug alone (Opdivo, 6.9 months;) (Yervoy, 2.9 months) was less effective.

The cost of the drug combination is about $150,000 per year, and the benefits are modest at best. And there are significant side effects. Is it worth it?

Dr. Bloom compares this therapy to that of hepatitis C: The newest drugs for hepatitis C are also expensive roughly half of that amount but the outcome is completely different. Once therapy is completed, more than 95 percent of the patients will be cured, and will not have further costs from their disease. It is night and day.

On balance, it would seem that the melanoma drugs are not such a good deal. But, what if the drugs work much better on a subset of the patients? Rapid advances in personalized cancer care have already been used to find drugs that work well in people with specific genetic mutations. A tool that to determine this would be of paramount importance in helping doctors decide which patients should be treated and those who should not.

Dr. David R. Gandara, a professor and lung cancer [4] specialist at the University of California,

Davis. said, We don t want to give these to 100 percent of the patients if only 59 percent or 20 percent will benefit. Thus a biomarker of the particular cancer that could predict the drug's efficacy would make this new class of drugs easier on the wallet, the national health wallet.

However, at the present time, there is no reliable biomarker to determine who will benefit and who will not from this therapy.

Dr. Bloom says, Since most new cancer drugs are very expensive, the developing science of determination of efficacy of a given drug at the molecular level will not only help control these costs, but will also help to prevent exposing patients to side effects, which can be severe, when the drug will not help them.

This is made clear by Dr. Jedd D. Wolchok, chief of the melanoma and immunotherapeutics service at the Memorial Sloan Kettering Cancer Center: We don t want to be wrong, because these medicines have an effect that, in some cases, is durable for years. We don t want to have an imperfect biomarker.
