



# Ask the Lung Cancer Expert: Dr. Paul Paik

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**Tamara Lobban-Jones:**

I'm joined by Dr. Paul Paik, medical oncologist at Memorial Sloan Kettering. Dr. Paik, thank you so much for joining this Ask the Experts interview.

**Dr. Paik:**

Thank you for inviting me.

**Tamara Lobban-Jones:**

So I'm going to fire off some questions that we received from patients. Ready?

**Dr. Paik:**

Yes.

**Tamara Lobban-Jones:**

Here we go. So, number one, I've got a question from Maria, "Erlotinib (Tarceva), How effective is a dosage of 100 versus 150 milligrams daily when it comes to metastasized non-small cell lung cancer contains within the lungs?"

**Dr. Paik:**

Right. That's a good question, and it's a common question that I think patients ask and also doctors ask. The approved dose is 150 milligrams daily. I think a couple of things. One is that not everyone can tolerate a dose that's that high. You get quite a lot of the skin toxicity that I'm sure Maria may be familiar with, and the diarrhea toxicity as well. And so it's important to try and find a balance between a dose that's well tolerated, that allows a patient to really do everything that he or she wants to do, and one that's also effective.

I can tell you that it appears, essentially for the dose range probably between 25 milligrams and 150 milligrams, there is a lot of variability in how much of that drug is circulating in your blood. But all of it is within what we think is a therapeutic range so a range that is effective for fighting the cancer. And so really we let the side effects in this case guide what the dose is going to be, which may mean that you need less than 150 milligrams. It may mean 100 or 75, but we think after treating thousands and thousands of patients that that's okay.

**Tamara Lobban-Jones:**

Okay. I'm going to fire off the next question, which is from Debbie, "Are my children more at risk because as a nonsmoker I have non-small cell lung cancer and I also have the EGFR deletion 19?"

**Dr. Paik:**

Right, so for the EGFR exon 19 deletion we don't think—none of the studies that we've done so far show that this is a heritable risk factor, so these changes occur specifically in the DNA of the tumor itself, not in the rest of the cells in your body. And so for that particular mutation there's no risk we believe in terms of passing it down to your kids.

**Tamara Lobban-Jones:**

Well, that's good news.

**Dr. Paik:**

Yes.

**Tamara Lobban-Jones:**

The next question comes from Sue, “Are there any vitamins that work against erlotinib (Tarceva)?”

**Dr. Paik:**

There are not so many studies that have been done in the development Tarceva and vitamins themselves in terms of high doses of different antioxidants or vitamin D. We do know that there are certain drugs that interfere with how Tarceva is metabolized, and these are things that your doctor should tell you to avoid. There [are] some citrus fruits also which interfere with this, which is why we say don't take grapefruits and don't take these more exotic citrus fruits.

But the vitamins themselves I don't think, we don't think tend to interfere at regular doses with Tarceva. So what I usually recommend to my patients is take a single multivitamin a day, and that's okay.

**Tamara Lobban-Jones:**

Next yes comes from Sam, “Why is erlotinib (Tarceva) so expensive?” And he mentions his insurance considers Tarceva a specialty drug, therefore bumping him up to a higher-priced insurance.

**Dr. Paik:**

Yes. So Tarceva is a specialty drug. There are only a number of different pharmacies now in the United States that dispense, and most of these are mail order, and you're right, it is expensive. It is like most new anticancer drugs very expensive.

Why that's the case I can't directly address for you. The drug company at the end of the day is the one that sets what the price is going to be in any given market, in any given country, so they determine what that's going to be. They are cognizant I think of the fact that they're--the price is expensive and that the co-pay can be quite expensive also. So they do have mechanisms set in place to try to defray the cost of that. Other patient advocacy groups also have funds that are set up to try to defray the cost of that.

But you are absolutely right. At the end of the day for many patients it is an extra financial burden that's there, and one I think that we just in general as a community need to try to work against in terms of having that dialogue of cost when it comes to these drugs that we know the patients who will benefit from them do need, that withholding that from them because of issues of cost is just not ethical at the end of the day.

**Tamara Lobban-Jones:**

Next question comes from Lorraine, who lives in Florida, “Erlotinib (Tarceva) is available for 2 EGFR lung cancer patients. Much is made of the skin issues and diarrhea, as you spoke about earlier. Can more specific information on side effects, skin side effects be provided: hair, eyebrow changes, nail redness, deterioration? And how often do they occur? How are they best handled?”

**Dr. Paik:**

Sure. So the skin side effects in particular are very common, so about 70 to 80 percent of our patients will get some kind of rash that develops. The majority of these rashes are fairly easy to manage in terms of over-the-counter emollients and low-potency steroid creams, things that you can just buy over the counter, the 1 percent hydrocortisone cream.

There are a smaller percentage of patients, about 10 percent, that develop a severe rash, one that we try to mitigate by upping the potency of this steroid, which can be quite effective, by administering oral antibiotics that are very good. This rash tends to be one that centers around hair follicles, so sort of like a pimple. So if you get antibiotics, these can be quite effective in getting the rash to go away.

And at the end of the day if the rash is proving to be very just recalcitrant to the treatments, you can interrupt the course of Tarceva, wait for it to calm down, and then reintroduce it at the same dose or at a lower dose. Again, this question of the dose factors into the toxicity also. There's a dose-dependent increase in the amount of skin toxicity.

In terms of the other components, there are other side effects apart from rash. There are nail changes that happen. This thing called paronychia, which can be quite painful. It's basically ulcerations of the fingernails. These can be more difficult to treat. In that setting, we ask patients to try diluted bleach soaks, for instance, or vinegar soaks, which can help prevent infections from happening. Sometimes these things get what are called super infected, so in addition to just being ulcerated they get bacterial infections. And so trying to identify what that is just by a small culture, basically, and providing a topical antibiotic or an oral antibiotic you can take can help with that.

**Tamara Lobban-Jones:**

The next question comes from Samantha, "I have a gas cook top. Does that put me at any risk because I can smell gas sometimes?"

**Dr. Paik:**

Yes. We don't think so. In terms of I think natural gas, we don't think that that's a risk factor for lung cancer. There are clearly other risk factors including radon, which is odorless and something that the detectors can detect, but the gas itself is not we think harmful.

The fact that you can smell the gas is probably a good thing. They add things to natural gas so that you can smell it as a warning sign, so that's where that component comes from. So generally, though, it's not a risk factor for lung cancer. Nothing to worry about I think, yeah.

**Tamara Lobban-Jones:**

The next question comes from Natalie, slightly long, but to sum it up she wonders if there's any medication prescribed for loss of appetite.

**Dr. Paik:**

So there are. That's a particularly difficult I think symptom from the cancer to have or side effects from treatment. I think—if we think the symptom is arising from just having the cancer, then some of the time by trying to get control of the cancer by treatment, you can improve the loss of appetite. So that's probably the number one thing that we try to do.

There are medications we can add to supplement or stimulate appetite. That includes—things like prednisone (Deltasone) steroids can increase appetite. There's a drug called megestrol acetate (Megace), which is a liquid that you can take once a day to try to stimulate appetite. Some patients do find dronabinol (Marinol), which is a drug version of marijuana, can stimulate appetite, and some of the Marinol derivatives as well can stimulate appetite.

So there are a number of different things that we can try, not always successful, and sometimes it means going from one thing to another, but there are things that you can try to improve appetite.

**Tamara Lobban-Jones:**

Next question comes from Laura. She would like to know whether immunotherapy is becoming accepted as a maintenance option for both limited- and extensive-stage small cell lung cancer.

**Dr. Paik:**

So as a maintenance, not yet. We're still stuck at trying to figure out what the role of immunotherapy is just in extensive-stage small cell lung cancer by itself. There are responses we know from the trial work that's been done. It's

been a little bit challenging doing the trial work, because many of these or some of these do require getting a fresh biopsy up front. But as many of us know small cell lung cancer is a fast-moving cancer, so waiting is not always an option.

And so it has been a bit more difficult trying to do this trial work in patients with small cell lung cancer, although that initial signal for effectiveness is there. So I think a lot of us are hopeful that this is going to continue to unfold basically as we get more patients treated on these studies.

**Tamara Lobban-Jones:**

And while I have you on that question, let's talk about immunotherapy and side effects. What do we know?

**Dr. Paik:**

Yes. So it's a very important question because the side effects for immunotherapy are things that we are just not used to dealing with, and they come primarily from the way that the drug works. The drug itself does not damage other cells the way that chemotherapy does, and that's why you get side effects. It basically ramps up your immune system, so a component of your immune system ends up recognizing cancer cells, but it can also in that process recognize other normal parts of your body, and so the side effects are these autoimmune side effects that we see. It's your immune system sort of fighting against parts of your normal body.

So we see things like rash, things like inflammation of the lung, inflammation of the colon so you get diarrhea, of the kidney or any other organ. Most of these are not, not terribly bothersome, so by and large immunotherapy is still much better tolerated than chemo. But it's important I think as the patient to know that these inflammatory things can happen, so if you are feeling something unusual, [you've] got to mention it to your doctor. This could be the early sign that something like that is happening.

So if you're developing a cough where a cough didn't used to be there, a little bit of shortness of breath, a little bit of a rash or some diarrhea, anything like that, I think it's important to mention it to your doctor so that he or she knows and can monitor you very closely at that point and then start treatments that we know can help turn that around in terms of a side effect.

**Tamara Lobban-Jones:**

Absolutely. Our last question is from also from Laura, and she wonders if there's any emerging evidence on the better second-line treatment for a recurrence of small cell lung cancer, both limited and extensive.

**Dr. Paik:**

So there are. There's good work taking a look at some of the mechanisms that cause DNA damage in lung cancer and coupling these specialized targeted therapies, actually, that work against this in conjunction with some normal chemotherapy. We're getting very good signals for this. The clinical trials for this, these things are ongoing.

There's new work taking a look at some other signals that have to do with how small cell lung cancers and other lung cancers just survive. There's a particular pathway that's basically a survival pathway. And while we have not been successful targeting that before, there's a new approach to basically using this in conjunction with another drug that seems to be working in the laboratory, which is going to be taken now into the clinic.

And, of course, as mentioned by the prior questioner, there is immunotherapy also, which again we're seeing some initial signals of promise. And I think the third thing it is that while the small cell lung cancer has been left behind in the targeted therapy evolution, we're still in process of look at targets, still in the process of trying to vet these things. It's taking longer, unfortunately, because it's less clear-cut, but again we're trying to make headway on that front also.

**Tamara Lobban-Jones:**

Absolutely. Dr. Paik, thank you so much for joining us. And most of all, thank you for all you do and your dedication to patients.

**Dr. Paik:**

Thank you.

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