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SPECIAL ARTICLE

ESMO—EURACAN Clinical Practice Guideline update for nasopharyngeal carcinoma: adjuvant therapy and first-line treatment of recurrent/metastatic disease

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INTRODUCTION

This article provides updates to the recommendations for treating nasopharyngeal carcinoma (NPC) as given in Nasopharyngeal carcinoma: ESMO—EURACAN Clinical Practice Guideline for diagnosis, treatment and follow-up.[1] View the full ESMO—EURACAN Clinical Practice Guideline (CPG) here: https://www.esmo.org/guidelines/head-and-neck-cancers/nasopharyngeal-carcinoma.

MANAGEMENT OF LOCAL AND LOCOREGIONAL DISEASE

In high-risk locoregionally advanced NPC, the addition of metronomic or standard dose adjuvant capecitabine to chemoradiotherapy (CRT) may be considered, according to the results of two phase III trials that showed an improvement of failure-free survival when compared with no adjuvant therapy (Figure 1).[2,3]

Recommendation

- In high-risk locoregionally advanced NPC, the addition of metronomic or standard dose adjuvant capecitabine to CRT may be considered [II, B].

MANAGEMENT OF ADVANCED AND METASTATIC DISEASE

Treatment of metastatic disease or locoregional recurrences not amenable to curative approaches

Recently, two randomised phase III trials showed an increase in progression-free survival (PFS) when immunotherapy (camrelizumab or toripalimab) was added to first-line treatment with cisplatin and gemcitabine followed by maintenance immunotherapy (camrelizumab or toripalimab) for recurrent and/or metastatic disease. The addition of immunotherapy should therefore be considered, pending long-term results of overall survival benefit and the assessment of the role of maintenance therapy (Figure 2).[4,5] This recommendation is based on data from two phase III trials of East-Asian populations.[4,5] At the time of publication, camrelizumab and toripalimab are neither European Medicines Agency (EMA)- nor US Food and Drug Administration (FDA)-approved for NPC and the applicability of the results to NPC patients in non-endemic areas warrants further investigation. Details on the ESMO-Magnitude of Clinical Benefit (MCBS) scores for these treatments are included in Table 1.

Recommendation

- The addition of immunotherapy to cisplatin and gemcitabine and as maintenance should be considered as first-line treatment [II, A; camrelizumab—gemcitabine—cisplatin ESMO-MCBS v1.1 score: 3; toripalimab—gemcitabine—cisplatin ESMO-MCBS v1.1 score: 3]. At the time of publication, camrelizumab and toripalimab are neither EMA- nor FDA-approved for NPC.

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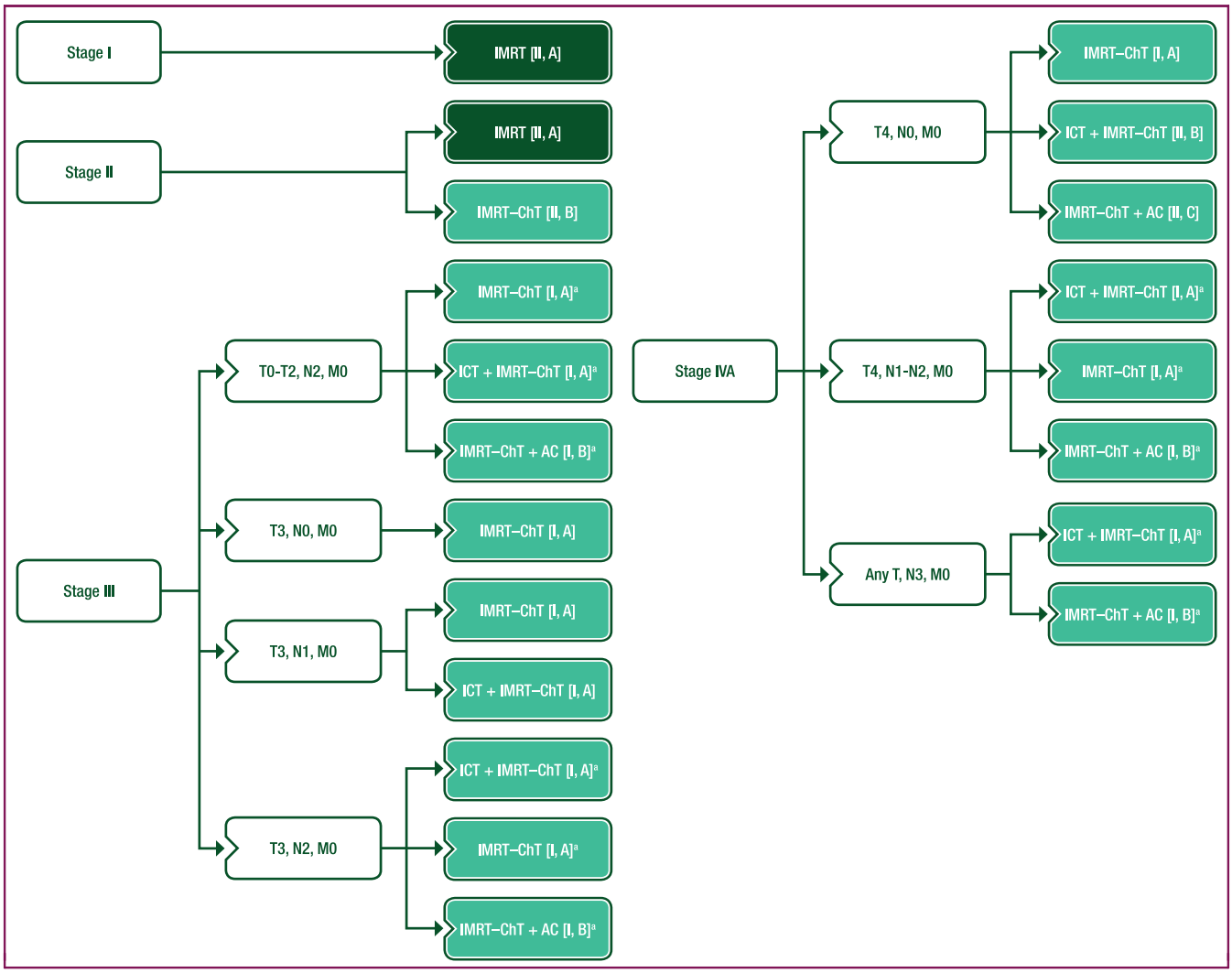

Figure 1. Treatment algorithm for stage I-IVA NPC.
AC, adjuvant chemotherapy; ChT, chemotherapy; ICT, induction chemotherapy; IMRT, intensity-modulated radiotherapy; M, metastasis; N, node; NPC, nasopharyngeal carcinoma; T, tumour.
[a]In high-risk locoregionally advanced NPC, the addition of metronomic or standard dose adjuvant capecitabine to CRT may be considered [II, B].

Chair of the ESMO-MCBS Working Group, Urani Dafni ESMO-MCBS Working Group Member/Frontier Science Foundation Hellas and Giota Zygoura of Frontier Science Foundation Hellas provided review and validation of the ESMO-MCBS scores. Nicola Latino (ESMO Scientific Affairs staff) provided coordination and support of the ESMO-MCBS scores and Angela Corstorphine and Sian-Marie Lucas of Kstorfin Medical Communications Ltd provided medical writing and editing support in the preparation of the ESMO-MCBS table. All support was funded by ESMO.

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DISCLOSURE

PB has reported personal fees for advisory board membership from Angelini, Bristol Myers Squibb (BMS), GSK, Merck, Molteni, Merck Sharp & Dohme (MSD), Nestlé, Sanofi and Sun Pharma; institutional fees as coordinating principal investigator (PI) for GSK, Kyowa Kyrin, MSD and Pfizer. He has also reported non-financial interests as a member of the board of directors of Gruppo Oncologico del Nord Ovest and the Multinational Association of Supportive Care in Cancer. ATC has reported personal fees as an invited speaker from BeiGene; for advisory board membership from Tessa Therapeutics Ltd; for advisory board membership, consultancy and biomarker testing for the MK-3475-KN122 program from MSD; and writing engagement for Springer. He has reported institutional funding from Merck Serono for research grants from Merck Serono, MSD, Novartis and Pfizer. He has reported non-remunerated advisory roles for Angene Biotechnology, Immunomic Therapeutics, Inc. and Owlstone Medical Limited. CE has reported personal fees for advisory board membership from BMS, Innate Pharma, Merck Serono and MSD. She has reported institutional funding for advisory board membership from F-Star Therapeutics; as a local PI from AstraZeneca, Ayala, BMS, Debiopharma, ISA Pharmaceuticals and MSD; and as a coordinating PI from BMS and

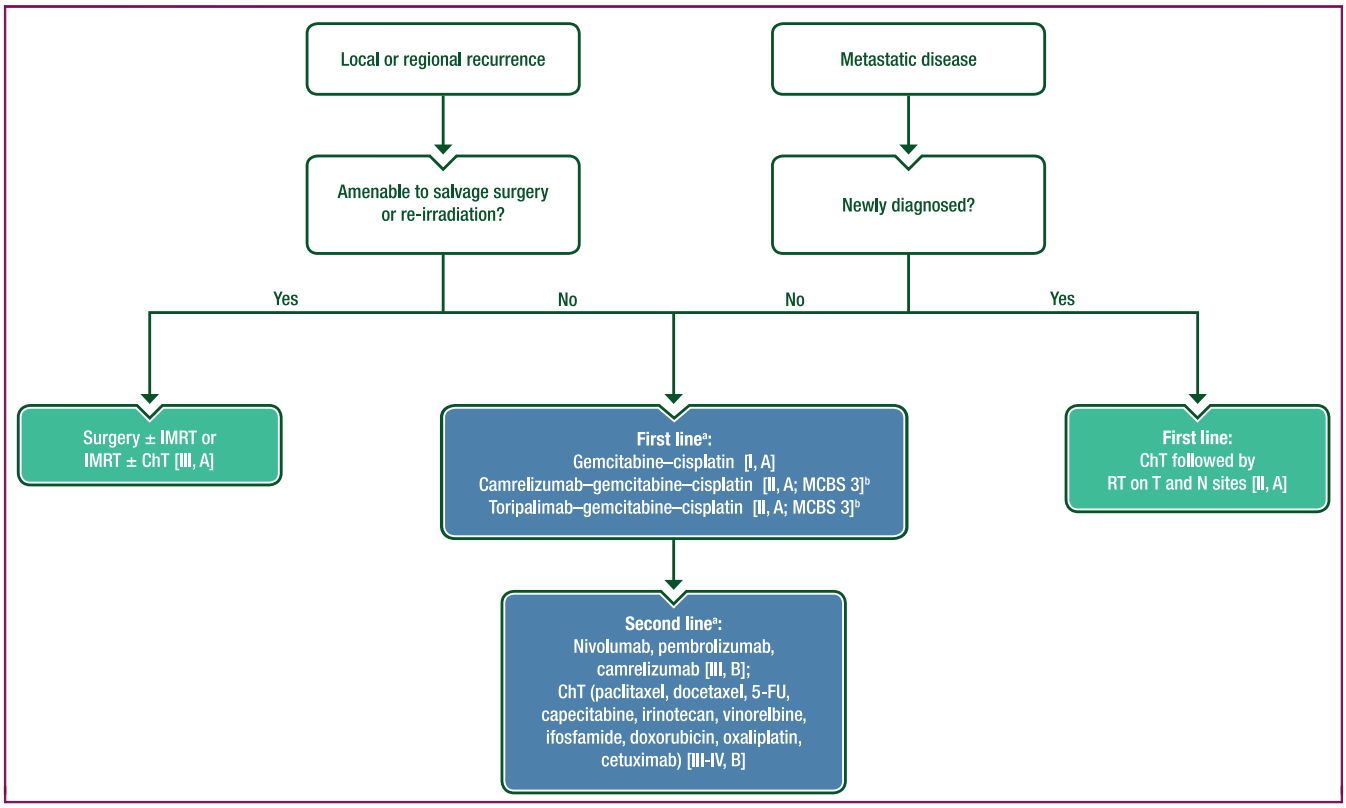

Figure 2. Treatment algorithm for recurrent and/or metastatic NPC.
5-FU, 5-fluorouracil; ChT, chemotherapy; EMA, European Medicines Agency; FDA, US Food and Drug Administration; IMRT, intensity-modulated radiotherapy; MCBS, Magnitude of Clinical Benefit; N, node; NPC, nasopharyngeal carcinoma; RT, radiotherapy; T, tumour.
[a]Consider RT [III, B] or surgery [IV, C] on metastatic sites.
[b]ESMO-MCBS v1.1[6] was used to calculate scores for therapies/indications approved by the EMA or FDA. The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee (https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms).

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Table 1. ESMO-MCBS table for therapies/indications in nasopharyngeal carcinoma

Therapy	Disease setting	Trial	Control	Absolute survival gain	HR (95% CI)	QoL/toxicity	ESMO-MCBS score[a]
Camrelizumab—gemcitabine—cisplatin[b]	First-line treatment of recurrent or metastatic nasopharyngeal carcinoma	CAPTAIN-1st [4] Phase III NCT03707509	Placebo—gemcitabine—cisplatin PFS: 6.9 months (prespecified interim analysis)	PFS gain: 3.9 months	PFS HR: 0.51 (0.37-0.69)	QoL not a prespecified endpoint 4% versus 1% treatment-related deaths ($P = 0.21$)	3 (Form 2b)
Toripalimab—gemcitabine—cisplatin[c]	First-line treatment of recurrent or metastatic nasopharyngeal carcinoma	Toripalimab injection combined with ChT versus placebo combined with ChT for recurrent or metastatic nasopharyngeal cancer[5] Phase III NCT03581786	Placebo—gemcitabine—cisplatin PFS: 8.0 months (prespecified interim analysis)	PFS gain: 3.7 months	PFS HR: 0.52 (0.36-0.74)	QoL data pending	3 (Form 2b)

ChT, chemotherapy; CI, confidence interval; COMP, Committee for Orphan Medicinal Products; EMA, European Medicines Agency; ESMO-MCBS, ESMO-Magnitude of Clinical Benefit Scale; FDA, US Food and Drug Administration; HR, hazard ratio; NMPA, National Medical Products Administration; PFS, progression-free survival; QoL, quality of life. Administration; PFS, progression-free survival; QoL, quality of life.
[a]ESMO-MCBS version 1.1[6] was used to calculate scores for approved therapies/indications. The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee (https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms).
[b]Not EMA or FDA approved. Approved in China by the NMPA.
[c]Not FDA approved, COMP positive opinion adopted June 2022. Approved in China by the NMPA

PI from eTheRNA, iTeos and MSD. He has reported a non-remunerated leadership role for the European Organisation for Research and Treatment of Cancer head and neck group.

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